New England Prevention Technology Transfer Center

Needs Assessment

PREPARED FOR

New England Prevention Technology Transfer Center

BY

Public Consulting Group, Inc.
373 Broadway
South Portland, ME 04106

December 2019

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New England (HHS Region 1)

PTTC Prevention Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

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Executive Summary

Substance use and misuse remains to be a major concern across the nation. Substance use prevention, treatment, and recovery are no longer emerging fields, with the continuum of care being expanded to include prevention (primary and secondary), early intervention, harm reduction, treatment, continuing care, and recovery support. Professionals from across the continuum must work together to achieve a more impactful result. This report focuses on the beginning of the continuum and the professionals that encompass the substance use prevention workforce.

Substance use prevention takes on many forms and definitions. The most cost-beneficial approaches to substance use prevention address the environmental, interpersonal, and personal factors that affect all youth as they mature. Youth at high risk can benefit from effective programs that are offered to all youth or through targeted services specific to risk factors they might exhibit. In addition, research shows that the most effective way to help someone who has engaged in early substance use and may be at risk for developing a substance use disorder is to intervene early, before the condition can progress.

The substance use prevention workforce is also comprised of varying staff types (*e.g.,* prevention specialist, school counselor, public health nurse, coalition director) and differs in composition from state to state. Several states have conducted independent studies of their prevention workforce; however, no one group has been successful in coordinating prevention workforce efforts between and among states to maximize resources and impact.

In September 2018, New England Prevention Technology Transfer Center (PTTC) contracted with Public Consulting Group, Inc. (PCG) to conduct a prevention workforce needs assessment in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont with the following five objectives:

1. Define substance use prevention, concretely and operationally, in a way that is meaningful for professionals in the field and can be used across state lines to discuss prevention on a larger scale;
2. Identify the current landscape of the New England prevention workforce;
3. Identify strengths and needs among New England states in the prevention workforce;
4. Evaluate current prevention workforce recruitment strategies; and,
5. Offer recommendations for training and technical assistance for new and advanced prevention professionals in the field.

This report outlines current service availability, gaps, and needs for substance use prevention professional education and accreditation. Specifically, it highlights state-level prevention workforce recruitment strategies, the utilization and promotion of prevention certification and training needs for the New England prevention workforce.

Key Findings

- Substance use in the 21st century is evolving, and prevention specialists must evolve with the times. The rise in opioid use, legalization of marijuana, increased use of vaping products, and the increasingly interconnected relationship between substance use and mental health have major impacts on the work of prevention specialists.
- Workforce recruitment and retention are very real issues for prevention. The workforce is already experiencing high turnover. It is predicted that there will be a workforce shortage when current prevention professionals retire or leave the field.
- Only one-third of prevention workforce survey respondents agreed or strongly agreed that their state has adequate educational or training opportunities for advanced prevention professionals, and only half of respondents indicated that they had access to career development opportunities that matched their career goals.
- Most New England states have identified certification as a strength of the prevention workforce and use certification as a mechanism for promoting consistency, professionalism, legitimacy, and quality in the field. However, some states, such as Vermont, are still considering the capacity to adopt certification, and some prevention professionals fear that if there is too much of a barrier to enter the prevention workforce, recruitment of new staff will be even more difficult.
- The New England prevention workforce generally has a high degree of knowledge on topics such as alcohol, tobacco, opioids and other substances. Survey responses and interviews indicate a lack of confidence in interpersonal skills, such as management, organizational change strategies, ethics, and strategies for working with diverse populations.

There are several opportunities for the New England PTTC to offer relevant training and technical assistance, promote workforce diversity, and help New England states develop recruitment and retention initiatives. Specific recommendations are summarized in the following categories:

Promote a Consistent Definition of Prevention

It cannot be understated that defining prevention in a way that offers clear guidance to the roles of states and professionals has several challenges. The prevention field now has a range of programs, policies, and systems we know work to support health and prevent substance misuse. These are referred to as “evidence-based.” This assessment offers that New England stakeholders start with a common definition. PCG suggests the following:

> Prevention is a strategy or set of strategies for creating protective factors and conditions that promote individual and community health while reducing

> risk factors that have a substantial impact on well-being. Proactively addressing these factors via evidence-based education, programs, policies, and practices can help prevent substance misuse and have an impact on related topics such as mental health and violence.

Using this as a basis of discussion, stakeholders can further operationalize and define target populations, strategies, and prevention partners. Having a complete definition will help states more clearly: collaborate with each other and the appropriate strategic partners, request funding, track data, provide training and education to the workforce, and develop comprehensive programs, policies, and practices.

Partner with State-level Prevention Training and Technical Assistance Agencies

The needs of the New England prevention workforce are complex, with several agencies (state and national) currently engaged in providing some level of training and technical assistance. The New England PTTC should seek to partner with current providers to avoid duplication of training and services, increase workforce reach, and maximize funding sources to meet as many needs as possible.

In addition to offering regional trainings and technical assistance, the New England PTTC could assist training and technical assistance partners in the development of specific trainings to meet the needs of the workforce, such as interpersonal skill trainings on cultural competence/humility and how to work with diverse populations. The extended reach of training and technical assistance may also allow for greater ability to coordinate and contract with local schools in less centralized areas to provide in-person trainings and other prevention events.

Expand Repository of Data and Prevention Resources

The national PTTC Network has already begun to create a repository of resources for the prevention workforce. The New England PTTC should continue to support development of this repository with specific focus on state and federal policy changes and development of curriculum around emerging issues such as marijuana legalization and vaping.

Additionally, several stakeholders interviewed for this assessment were unaware that such a resource now exists. The New England PTTC should work to promote and publicize this resource among stakeholders.

Standardize Prevention Data Collection

While states collect similar data about substance use and the prevention workforce, they are not identical; thus, it can be difficult for prevention professionals, researchers, or the general public to know if “apples to apples” comparisons can be made. This impacts not only informed decisions about prevention services but also the ability to demonstrate change over time and program impact. The creation of standardized prevention data collection could allow for baselines metrics to be calculated between and among states not only for substance use but also for workforce strengths, gaps, and needs.

Create Networking Platform for Professionals Across New England

Several stakeholders identified a lack of collaborative opportunities for prevention professionals. As conferences and trainings are largely the places where people network, opportunities are limited for professionals who cannot afford to travel or who have inter-state travel restrictions.

The New England PTTC is primed to support a collaborative platform for prevention professionals. The organization should seek to develop a comprehensive platform that includes but is not exclusive to: an annual strategic planning meeting with each state NPN representative and other driving agents, routinized conference or web-based calls with high-level facilitation so that professionals can discuss specific issues/needs, financial support for prevention agencies to send representatives to key prevention conferences, and a web-based discussion forum.

Online System to Track Certification Progress

Currently, each state independently tracks prevention board certifications, but there is no single source for national certification. It is also not currently possible to identify or track professionals who are in the process of becoming certified. Thus, the transfer process of professional certification between states can be cumbersome and the recruitment of prevention professionals is operating in a vacuum without knowing which geographic areas are most in need.

Creation of a system to track certification on a larger scale will enable more effective recruitment and decrease barriers for service provision of professionals working across state borders.

Introduction

Overview of the New England PTTC

AdCare Educational Institute of Maine, Inc. (AdCare Maine) was awarded the cooperative agreement for Prevention Technology Transfer Center (PTTC) for New England (HHS Region 1) in September 2018 by the federal Substance Abuse and Mental Health Services Administration (SAMSHA). This region encompasses six states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

SAMHSA began investing in professional development for substance use prevention professionals with the inception of the Center for the Application of Prevention Technologies (CAPT) in 2009. CAPT was designed to offer trainings and technical assistance to help prevention professionals understand and apply best practices in prevention planning, implementation, and evaluation. According to the Education Development Center (EDC), CAPT supported tens of thousands of substance use and behavioral health providers in all fifty states prior to its discontinuation in 2017.[1]

The PTTC seeks to advance this agenda for providing professional development as well as emphasizing the need for prevention certification and recruitment of a diverse workforce. Specifically, the New England PTTC aims to improve understanding of prevention science, the use of epidemiological data for informed decision making, and the implementation of evidence-based and promising practices to a wide variety of substance use prevention stakeholders. It will also develop tools and conduct outreach to engage the next generation of prevention professionals.

As part of this work, New England PTTC seeks to:

Figure 1. New England PTTC Purpose

[1] https://www.edc.org/center-application-prevention-technologies-capt

The New England PTTC will focus on prevention professionals and stakeholders implementing prevention programs in New England. This includes prevention professionals in community coalitions, state government, public health departments, school districts, as well as youth focused, faith-based, and other organizations addressing substance use. The work also will encompass stakeholders supporting prevention professionals (*e.g.,* sector members of Drug Free Communities coalitions). This focus aligns with the stated goal of SAMHSA's Assistant Secretary for Mental Health and Substance Use, Elinore McCance-Katz, to make technical assistance (TA) services available to all Americans engaged in prevention.[2]

To launch the five-year initiative, the New England PTTC conducted a needs assessment with the following objectives:

1. Concretely and operationally define substance use prevention in a way that is meaningful for professionals in the field and can be used across state lines to discuss prevention on a larger scale;
2. Identify the current landscape of the New England prevention workforce;
3. Identify strengths and needs among New England states in the prevention workforce;
4. Evaluate current prevention workforce recruitment strategies; and,
5. Offer recommendations for training and technical assistance for new and advanced prevention professionals in the field.

Prevention in the 21st Century

Substance use makes media headlines on a daily basis. While everyone agrees that substance use is a problem in the United States, growing trends in vaping, marijuana legalization, and fentanyl have further complicated the prevention landscape and muddied previous attempts to unite prevention efforts. To develop a plan for prevention services and workforce recruitment in New England, substance use prevention must be more well defined, and a picture of current resources developed.

How prevention efforts and substance use is regarded and targeted is evolving. Prevention specialists throughout New England have expressed that "they [policy makers] use prevention like they use the word wellness. They don't know what it means." Approaches have shifted away from educational scare tactics and criminal prosecution to a more holistic understanding of the mental health implications associated with substance misuse.

[2] SAMHSA *Revamping TA-Contractors Model to Deliver More Support to American Communities* https://blog.samhsa.gov/2018/03/22/samhsa-revamping-ta-contractors-model-to-deliver-more-support-to-american-communities/#.WzuiLthKi8o

However, this has made it more difficult for prevention specialists to define what prevention is and their role in the substance use continuum. Traditionally, efforts have been focused on primary prevention for youth. However, "while substance use typically declines with age, for a variety of social, cultural, and economic reasons, baby boomers appear to be using and abusing alcohol, illicit drugs, and prescription drugs at higher rates than previous cohorts."[3] Therefore, it may be pertinent for a more modern definition to incorporate lifespan prevention strategies.

Cost Savings and Funding

Decisions surrounding how prevention and treatment efforts are funded have also changed in the last decade. In 2008, SAMHSA estimated that every dollar invested in prevention saved between $7.40 and $36 with a median estimate of $18 in healthcare and law enforcement/judicial costs.[4] Conversely, investment in substance use treatment saved between four and seven dollars. The costs associated with not curtailing substance use and misuse have been exacerbated by the opioid epidemic over the last decade.

In the last two decades deaths by overdose have risen by over 200 percent. In 2017, overdose deaths throughout the nation exceeded 70,000 and about 48,000 were opioid related. .[5] The opioid epidemic has disproportionately impacted New England states. New Hampshire, Maine, and Massachusetts overdose death rates all exceeded 27.8 overdoses per 100,000 people in 2017, and all six states are in the top 12 of US states for overdose related deaths.[6]

New federal policies have been created to address the pervasive nature of substance use and misuse. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 passed to address the opioid epidemic. Legislation includes: "provisions to strengthen the behavioral health workforce through increasing addiction medicine education; standardizing the delivery of addiction medicine, expanding access to high-quality, evidence-based care; and, covering addiction medicine in a way that facilitates the delivery of coordinated and comprehensive treatment."[7] It followed the passage of the Comprehensive Addiction and Recovery Act (CARA) of 2016 and the 21st Century Cures Act.

CARA 2016 authorizes over $181 million in federal funds each year to respond to the opioid epidemic, targeting both prevention and treatment. Some successes of CARA 2016 include: launching an evidence-based opioid and heroin treatment and intervention program; strengthening prescription drug monitoring programs; expanding prevention and education efforts; expanding recovery support for students in high school or enrolled in institutions of higher learning; and, expanding resources to identify and treat incarcerated individuals suffering from addiction disorders.[8]

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[3] https://archives.drugabuse.gov/meetings/2004/09/drug-abuse-in-21st-century-what-problems-lie-ahead-baby-boomers
[4] https://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf
[5] https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates
[6] https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state
[7] https://www.samhsa.gov/about-us/who-we-are/laws-regulations
[8] https://www.samhsa.gov/about-us/who-we-are/laws-regulations

The 21st Century Cures Act was passed in 2016 to address critical issues including: leadership and accountability for behavioral health disorders at the federal level; the importance of evidence-based programs; and, the imperative to coordinate efforts across government agencies. “The Interdepartmental Serious Mental Health Illness Coordinating Committee (ISMICC) was created by the Cures Act to assure better coordination across the entire Federal Government related to addressing the needs of individuals with serious mental illness or serious emotional disorders and their families.[9]

Marijuana Legalization

Another influencing factor in prevention is the legalization and potential legalization of marijuana across the U.S., which has allowed the marijuana industry to flourish, impacting policy and decision makers. These changes have impacted the perceived harm associated with marijuana use by both adolescents and adults and has potential impacts on mental health outcomes.[10] Currently, Maine, Massachusetts, and Vermont have legalized adult-use marijuana, while Connecticut, New Hampshire, and Rhode Island are grappling with potential adult-use legalization.

Youth marijuana use continues to rise in states that have legalized marijuana for adult-use. “According to the University of Michigan Monitoring of the Future survey of American youth, between 2017 and 2018, the percentage of eighth and tenth graders who report ‘vaping’ marijuana has increased 63 percent.”[11] Additionally, the percentage of adolescents who use marijuana is declining more quickly in states where it has not been legalized and has increased in states that have. According to the NSDUH State Reports 2016-2017, the percentage of youth aged 12 to 17 who are using marijuana is 7.7 percent in states where it is legal versus 6.2 percent in non-legal states.[12]

There are also impacts for the legalization and decriminalization of marijuana on motor vehicle safety. Drugged driving and motor vehicle fatalities have continued to rise in states that have legalized adult-use marijuana. In 2017, the American Journal of Public Health reported that “epidemiological studies have clearly established that acute cannabis impairment increases the risk of motor vehicle accident involvement, including fatal collisions.”[13] They propose more efforts on creating effective policies to prevent drugged driving.

[9] https://www.samhsa.gov/about-us/who-we-are/laws-regulations
[10] https://www.samhsa.gov/marijuana#targetText=Mental%20health%3A%20Studies%20link%20marijuana,which%20can%20harm%20athletic%20performance.
[11] https://learnaboutsam.org/wp-content/uploads/2019/07/2019LessonsFinal.pdf
[12] NSDUH. (2016-2017). National Survey on Drug Use and Health, SAMHSA, HHS, State Estimates.
[13] Hasin, D. S., Kerridge, B. T., Saha, T. D., Huang, B., Pickering, R., Smith, S. M., ... & Grant, B. F. (2016). Prevalence and correlates of DSM-5 cannabis use disorder, 2012-2013: findings from the National Epidemiologic Survey on Alcohol and Related Conditions–III.

The National Highway Traffic Safety Administration recommends that field sobriety tests for marijuana use be developed; data be collected to support the linking of serious crashes to marijuana use; and new questions be developed on state surveys surrounding age of first use and driving within three hours of marijuana use.[14]

Co-occurring Disorders, Mental Health, and Substance Use

Additionally, mental health disparities and dual diagnoses are strongly linked to substance misuse. For example, according to Colorado toxicology reports, adolescent suicide victims testing positive for marijuana continue to increase.[15] There is a growing understanding that prevention efforts need to incorporate a trauma-informed approach and understanding of mental health and prevention specialists should work closely with mental health professionals to do so.

In 2017, over 47 thousand Americans died by suicide and there were 1.4 million suicide attempts.[16] According to the CDC, suicide is the second leading cause of death among children aged 10 to 24, and adults aged 25 to 42.[17] Alcohol misuse is a particularly high-risk factor for suicide. "Among alcohol-related deaths that are not the result of a motor vehicle accident, over 20 percent are due to suicide."[18] Co-occurring mental health conditions can be responsible for elevated suicide rates for people who struggle with substance use. For example, opioid use is associated with a 40 to 60 percent increased likelihood of suicidal thoughts, and a 75 percent increased likelihood for a suicide attempt.[19] Greater efforts have been made to spread awareness about the dangers of opioid misuse and promoting positive mental health.

Fentanyl

Another emerging concern as it relates to substance use prevention is the rising emergence of potentially lethal drugs such as fentanyl. Fentanyl is a synthetic opioid approved for treating sever pain often associated with cancer. However, illicitly manufactured fentanyl is the main driver of recent increases in synthetic opioid deaths.

According to the CDC, synthetic opioid deaths across the U.S. increased by 264 percent between 2012 and 2015.[20] Fentanyl is 50 to 100 times more potent than morphine and is often mixed in heroin or cocaine without the user's knowledge. Although prescription drug rates have fallen, overdoses associated with fentanyl have risen dramatically contributing to a sharp spike in synthetic opioid deaths.

[14] https://www.ghsa.org/sites/default/files/2017-06/ncrep_062617.pdf
[15] https://learnaboutsam.org/wp-content/uploads/2019/07/2019LessonsFinal.pdf
[16] https://afsp.org/about-suicide/suicide-statistics/
[17] https://store.samhsa.gov/system/files/sma16-4935.pdf
[18] https://www.therecoveryvillage.com/drug-addiction/drugs-and-suicide/#gref
[19] https://www.addictioncenter.com/addiction/addiction-and-suicide/
[20] https://www.cdc.gov/drugoverdose/images/pbss/CDC-Fentanyl-overdoses-rise.pdf

Vaping

The advent of vaping products is another concern of prevention specialists. Products such as Juul, which are targeted to children with fruity flavored nicotine cartridges, have caused a spike in underage tobacco use after years of falling rates. In addition, these products are easier for children and youth to conceal and hide from parents or use in schools. Recently, concerns have risen as illegal cartridges are being sold and causing vaping related illnesses, and in severe instances even death.

All of these factors—the rise in opioid use, the change in legalization of marijuana, the increasingly interconnected relationship between substance use and mental health, and the rise of synthetic opioid use and vaping—have major impacts on the work of prevention specialists and provides a number of areas for the New England PTTC to consider. In other words, substance use in the 21st century is evolving, and prevention specialists must evolve with the times.

Methodology

PCG utilized a mixed-method approach to conduct the needs assessment. Results stem from qualitative and quantitative data collection methods and use multiple data sources to triangulate findings.

Strategic Prevention Framework (SPF) Process

Prevention professionals use SAMHSA's Strategic Prevention Framework (SPF) model to develop strategies predicted to forestall substance misuse. The SPF approach embraces and promotes data-driven decision making and outcomes-based programming. The SPF model was created to address factors that cause or have an impact on substance use that can be mitigated with intervention strategies.

Figure 2. SPF Model

SPF is intended to build state and local capacity to decrease substance use and misuse using five modalities, pursued at both the state and community levels:

1. Conduct a community needs assessment,
2. Mobilize and/or build capacity,
3. Develop a comprehensive strategic plan,
4. Implement evidence-based prevention programs and infrastructure development activities, and
5. Monitor process and evaluate effectiveness.

This needs assessment is focused on the first step of the SPF process, to identify and examine strengths and challenges of the prevention workforce in New England.

Research Questions

Ten key research questions were used to guide the assessment, focusing on current capacity and gaps in training. They are provided below together with the data sources used to address each.

Table 1. Needs Assessment Research Questions and Data Sources

Assessment Question	Data Source
1. What are current prevention workforce skillsets?	***Quantitative:*** • Workforce survey ***Qualitative:*** • Stakeholder interviews • Literature review
2. What is the current workforce capacity and how is certification used to promote capacity?	***Quantitative:*** • IC & RC database • Census data ***Qualitative:*** • Stakeholder interviews • Literature review • Document review
3. How are states currently engaging community stakeholders in substance use prevention?	***Quantitative:*** • Workforce survey ***Qualitative:*** • Stakeholder interviews • Document review
4. What are the current prevention workforce development initiatives, including distance learning?	***Quantitative:*** • Workforce survey ***Qualitative:*** • Stakeholder interviews • Document review
5. Where do states go for technical assistance now and what are the outstanding technical assistance needs?	***Quantitative:*** • Workforce survey ***Qualitative:*** • Stakeholder interviews
6. What evidence-based prevention strategies are currently utilized and to what degree are prevention professionals trained in the strategies?	***Quantitative:*** • Workforce survey ***Qualitative:*** • Stakeholder interviews • Literature review • Document review

Assessment Question	Data Source
7. To what degree are states using data to inform prevention strategies?	***Quantitative:*** • Workforce survey ***Qualitative:*** • Stakeholder interviews • Document review
8. To what degree are states ready to implement prevention science?	***Quantitative:*** • Workforce survey • NSDUH (substance use database) • YRBS (substance use database) ***Qualitative:*** • Stakeholder interviews • Literature review • Document review
9. What prevention media campaigns (medium and message) are states currently using?	***Quantitative:*** • Workforce survey ***Qualitative:*** • Stakeholder interviews • Document review
10. What are the current training gaps and needs?	***Quantitative:*** • Workforce survey ***Qualitative:*** • Stakeholder interviews • Document review

Data Sources

Each of the data sources used for the need's assessment, referenced in Table 1, are described below.

Literature Review

PCG conducted a literature review to gather information on current best practices in workforce development in the prevention field, such as needed education, training, and skillsets to be effective. The review also encompassed data on substance use and misuse and their consequences and recent laws and national initiatives to combat misuse. It included certification practices and standards as well as evidence-based programs in the prevention field and identified factors which promote prevention workforce development and inhibit it, particularly for culturally diverse populations. This information further informed survey and interview development.

Document Review

PCG identified and reviewed current state level assessments, strategic plans and workforce surveys generated during the past three years in the New England states. Information was used to show similarities and differences between and among the states and to target state-specific efforts. A matrix was created to highlight key similarities and differences among state prevention efforts.

International Certification & Reciprocity Consortium (IC & RC) Database

This database was used to gather information about individual state certification requirements as well as demographic information for current certified prevention professionals. Due to limited survey responses, results from the 2018 IC & RC workforce survey could not be broken out by state. According to national tester demographics, the survey received 339 responses from across the country, including six from Connecticut, three from Rhode Island, eight from New Hampshire, one from Massachusetts, one from Vermont, and none from Maine. Therefore, results from this survey are reported only in aggregate for the US.

Key Stakeholder Interviews

Interviews were conducted with various stakeholders to fill in gaps which arose from the literature and document reviews regarding scope or depth of workforce knowledge, cultural diversity, needed skillsets and recruitment. PCG tailored interview protocols for each stakeholder group. During this time PCG staff also assessed readiness activities and the kinds of infrastructures states have already put into place.

As illustrated in Figure 3, those to be interviewed were identified beginning with state agency directors who are also NPN representatives charged with implementing the strategic mission and vision for prevention services in the state; their responsibilities include growth of the prevention workforce. Interviewers then reached out to each state's certification board which promotes prevention certification using national standards set forth by the International Certification & Reciprocity Consortium (IC & RC) and Drug Free Community (DFC) grantees. Next, state agency and certification board directors were asked to name other important primary driving agencies within each state. Finally, interviewers contacted agencies with an indirect role or those doing prevention work at the field level, for feedback on each state's prevention agenda.

Figure 3. Stakeholder Interviewee Recruitment Model

This process created a pool of candidates resulting in 57 completed interviews across all six states: six National Prevention Network representatives, five state certification board directors, 17 directors and program managers of other driving prevention agencies, 21 members of coalitions or Drug-Free Communities, and seven data specialists.

Researchers also interviewed a national representative from the IC & RC Consortium and one from the National Prevention Network office to obtain a big-picture perspective of New England prevention compared to the nationwide landscape.

Workforce Survey

Using existing prevention workforce surveys from the IC & RC, as well as those conducted in Connecticut, Maine, Massachusetts, and Rhode Island, PCG developed a refined, web-based workforce survey which was disseminated in late July 2019. PCG used a snowball sampling method to disseminate the survey, wherein prevention leadership and stakeholder interviewees helped PCG in emailing the survey to their respective listservs.

The resulting workforce sample included 209 total stakeholders from various levels of prevention, comprising state level policy makers, prevention administrators, and prevention field staff, from all six states. The largest proportion of responses came from substance use prevention specialists, as shown in Table 2. However, 20 percent of respondents indicated other professions such as program coordinators, data analysts, grant managers, school-based clinicians, juvenile justice workers, and public health advisors.

Table 2. Workforce Survey Respondents Primary Profession

Stakeholder Type	Percentage
Substance use prevention specialist	40%
Other	20%
Community Health Worker/ Health Educator	11%
Social Worker	9%
Public or Business Administrator	6%
Addiction Professional	3%
Registered or Advance Practice Nurse	3%
Mental Health Professional	2%
Recovery Specialist	2%
Researcher	2%
Teacher/ Educator (post-secondary or continuing)	1%
Pharmacist	1%

Participants were asked about current prevention platforms, current certification and training, use of evidence-based practices, needed workforce skillsets, and funding for state and local-level prevention efforts.

National Survey on Drug Use and Health (NSDUH) Data

NSDUH is an annual national survey administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) to youth grades 6 through 12 and adults ages

18 and older. The instrument collects information on substance use and health at the national, regional and state levels. However, NSDUH is not as current as some other data sources. The most recent data are from the 2016–17. Information about underage drinking and marijuana, cigarette, alcohol, and prescription drug use were considered.

Youth Risk Behavior Survey (YRBS) Data

YRBS is an annual national survey administered by the Centers for Disease Control and Prevention (CDC) to high school students. The survey collects information on health-related behaviors that are known to contribute to leading causes of death and/or contribute to disability and social problems and includes questions related to substance use behaviors. The most recent dataset is from 2017. Information about high school drinking, as well as marijuana and vapor product use were reviewed for this assessment. While YRBS is a national survey, it is usually conducted during the spring of odd-numbered years (9th and 11th grade) which means that not every grade is being surveyed every year.

States can also opt out or implement their own youth surveys. Many Connecticut towns, for example, have created their own versions of the survey. For this assessment, this means that data for electronic vapor product use in Connecticut are unavailable for comparison as they did not utilize the standard YRBS. Therefore, when the YRBS reports results, they generally offer ranges for substance use to include confidence intervals around median scores.

United States Census Bureau Data

United States Census Bureau Data from July 2018 were used to outline demographic information and population density for each of the six identified New England states. These data further informed observations of workforce capacity.

Data Analysis

Data were assembled to address each of the ten research questions in Table 1. Each question had multiple information sources. Data was gathered in a stepwise fashion to inform each subsequent activity. Information from the literature review and documents generated by each state were used to describe the landscape of current prevention practice relating to the question. Next, data listed as *quantitative* in Table 1 were analyzed to address research questions, building on the first two sources, the literature and state documents. Qualitative data collected from interviews were then used to expand upon the information from other sources.

Tools used for analysis were SPSS statistical software for the surveys and Excel software for the qualitative components such as interview responses. Further analysis related to the domains of the interview questions, such as current prevention efforts, available training or educational opportunities within the state, and service gaps. Cross tabulations were used further to analyze surveys to determine, for example, if years of experience of the workers alters their perceptions of what training is needed.

Limitations

As reality rarely matches the scientific design, some limitations of methodology and logistics were anticipated. First, the assessment relied on select state-level prevention agencies to disseminate the workforce survey to their respective membership listservs. Although state agencies were willing to share the workforce survey to their respective listservs, sampling was still not random nor necessarily comprehensive of the state's prevention workforce. Only prevention professionals who were members of those listservs received the survey. Further, because PCG did not request listservs from every prevention professional association in each state, it is likely that people were missed or left out if they were not a member of the requested agency, especially nontraditional prevention professionals, like hospital workers or school-based personnel.

Second, not every state had completed a workforce needs assessment recently (within the last five years). Therefore, available data about current state-level demographics and prevention strategies varied from state to state.

Findings

The demand for substance use treatment providers is obvious when there are people actively seeking treatment and recovery services. However, prevention professionals have fallen into the age-old battle of trying to show the importance of a service by proving a negative or that something did not happen. This has made prevention workforce recruitment a challenge. The following sections outline a common definition of prevention, current prevention initiatives, the composition of the prevention workforce as it stands, New England's capacity to develop the workforce, current strategies for improving the quality of the workforce, and approaches for community engagement.

Prevention Defined

The first objective of the New England PTTC is to define substance use prevention in a way that can be used across state lines to discuss prevention on a larger scale. This is particularly challenging as each state defines prevention differently. For example, Connecticut and Rhode Island identify prevention as a systems approach, suggesting a necessary collaboration between a wide variety of stakeholders. The other New England states, in contrast, view the topic as more narrowly encompassing substance use and mental health or only alcohol and other drug use. Interviewees from each state also disagreed on which stakeholders' the field of prevention should include. Some felt strongly that prevention should network with substance use treatment and recovery, whereas others were strongly opposed.

Further, states disagree on who the target population for prevention services should be. Rhode Island focuses prevention efforts on youth and young adults, generally under the age of 21, while New Hampshire focuses on prevention across the lifespan.

There was, however, some overlap in definition. For the purpose of this assessment:

Prevention is a strategy or set of strategies for creating protective factors and conditions that promote individual and community health while reducing risk factors that have a substantial impact on well-being. Proactively addressing these factors via evidence-based education, programs, policies, and practices can help prevent substance misuse and have an impact on related topics such as mental health and violence.

Note that this definition does not define a target population or require specific strategies. It also does not expressly outline or exclude categories of stakeholders who could or should be involved in prevention. These are all areas where further discussion and consensus are needed to operationalize the definition fully.

Workforce Skillsets, Capacity, and Community Engagement

"Improving the quality and capacity of prevention and treatment programs for substance use disorders (SUDs) is of vital importance to the nation's health." While several US states have conducted workforce needs assessments and incorporated workforce development as part of state substance use strategic plans (including many in New England), assessment measures have not been consistent between states. Therefore, obtaining an accurate picture of the prevention workforce has been challenging. To curb this gap, PCG developed a survey to gain insight and collect baseline data for New England's substance use prevention workforce.

> Improving the quality and capacity of prevention and treatment programs for substance use disorders (SUDs) is of vital importance to the nation's health.
>
> https://aspe.hhs.gov/basic-report/substance-use-disorder-workforce-issue-brief

PCG was unable to assign an exact response rate to the 209 submissions, since the survey relied on various prevention organizations to disseminate it through their respective listservs. However, based on stakeholder interviews we estimate that there are more than 800 prevention professionals in New England, including those who are directly funded by state and federal prevention grants but excluding coalition members. Therefore, in addition to the estimated 25 percent response rate overall, we can loosely estimate representative percentages based on the approximate size of each state's workforce also presented in Table 3.

Table 3. Workforce Survey Percentage

	CT	ME	MA	NH	RI	VT	Total
Estimated number of prevention professionals	100	100	300	180	75	65	820
Number of survey respondents	44	45	52	26	22	15	209
Estimated percentage of workforce	44%	45%	17%	14%	29%	23%	25%

While there was variation between states, most survey participants (84%) were white, non-Hispanic (97%), and 50 years or older (41%). More than half of survey participants had a master's degree, and more than a quarter had a bachelor's degree. Nearly half of respondents had been in the prevention field for more than 10 years.

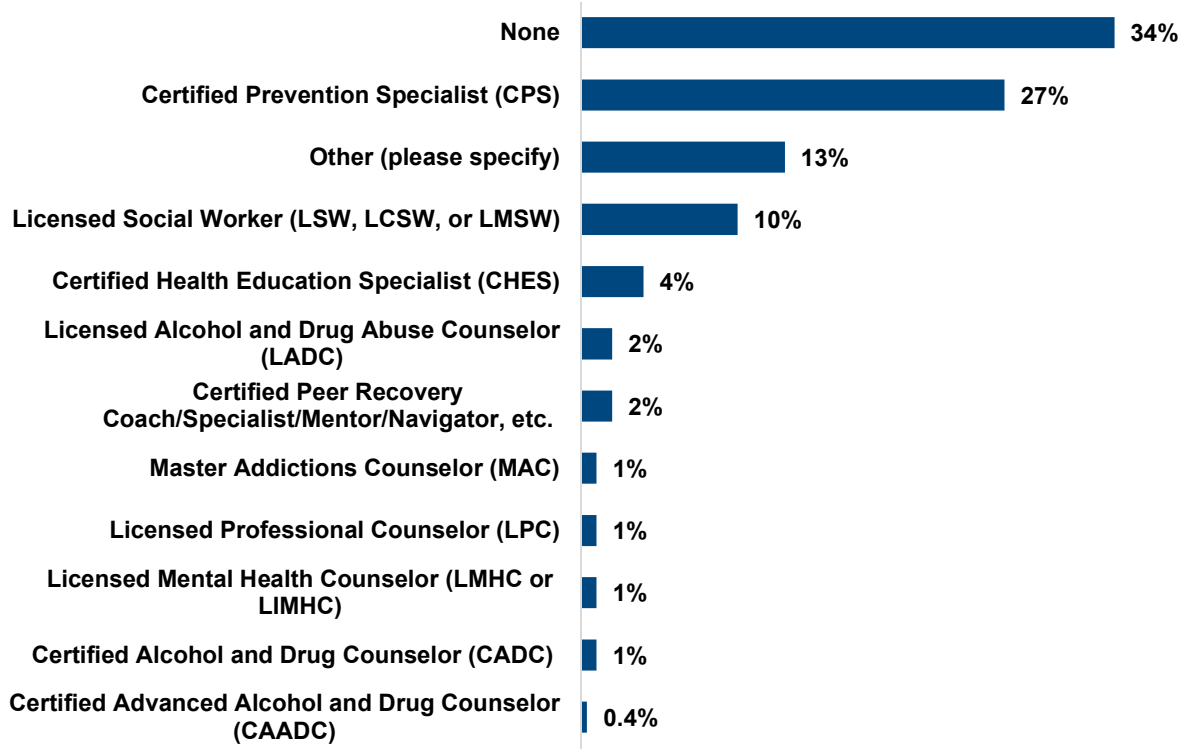
To confirm validity of the surveyed population, PCG compared demographic characteristics of respondents to those of the 2018 IC & RC survey of prevention professionals. Of the IC & RC respondents, approximately 47 percent held bachelor's degrees and 33 percent held master's degrees. One-third of respondents were between the ages of 45 and 74. While age breakouts were similar between the two survey populations, more PCG survey respondents indicated graduate-level education than IC & RC respondents.

The IC & RC stated that while it recognizes credentials, it does not track the number of current/active certifications at a state level. Instead, they obtain estimates of workforce certifications based on annual survey respondents. According to the IC & RC survey, nearly three-quarters of respondents indicated that a certification or license was required for their current position; however, less than 40 percent had any type of licensure or certification at the time they were surveyed. Of respondents who had a certification or licensure, the most common types were Certified Prevention Specialist (24%), Licensed Social Worker (11%), and other (32%), including nurses, people with a master's degree in social work or public health, nonprofit certification, school counselors, paramedics, and PhDs.

In comparison, 34 percent of PCG's survey participants did not have a certification or licensure, 27 percent were Certified Prevention Specialists, 10 percent were Licensed Social Workers, and 13 percent indicated they had other licenses or certifications such as a master's or doctoral degree, nonprofit certification, early intervention certification,

school social work certification, or registered nursing degree (See Figure 4.)

Figure 4. Workforce Participant Certifications and Licensures



When comparing survey respondents by state, New Hampshire respondents were the most likely to be CPS certified (54%) whereas Massachusetts respondents were least likely (10%). Though this is relatively small sample, the variation is likely due, in part, to how prevention is defined, how the state has structured prevention services, and certification requirements of each state.

For example, Massachusetts prevention services primarily work through grants to municipalities that organize and energize multiple systems in the community. The state receives federal SAMHSA dollars to fund numerous municipalities and formal partnerships. Stakeholders estimate that there are approximately 300 people working in prevention. This includes all funded agencies whose work includes substance use prevention and individuals who work for community coalitions receiving SAMHSA block grant funding. Massachusetts does not currently require prevention certification for providers who were working for coalitions or organizations receiving any federal block grant funding; however, BSAS funded programs may decide to make certification a requirement for employment.

To the contrary, New Hampshire divides prevention services into 13 Regional Public Health Networks (RPHN) which encompasses local health departments, law enforcement, healthcare providers, social services agencies, fire departments,

emergency medical services, behavioral health groups, faith communities, advocacy groups, and local government/ community leaders. Stakeholders estimate that there are more than 90 vendors conducting prevention work, each with one to three staff doing prevention work in the state. According to the state certification board, prevention certification is required for some state contracts but not everyone who works in prevention is required to be certified in New Hampshire.

Prevention Education, Experience, and Certification Requirements

While the IC & RC supports national certification, each state operates a state certification board, thus requirements vary slightly from state to state and not all states have a certification program. Further, individual state boards can also choose which states they will offer certification reciprocity. This means that a state may require professionals to receive more training before a certification will be recognized. Professionals moving between states are advised to contact the state board to clarify requirements.

In New England, every state except Vermont uses the IC & RC standards for certified prevention specialists. While Vermont has certifications for substance use treatment professionals, the state does not currently endorse a prevention certification. Instead, Vermont has a reciprocal relationship with surrounding New England states to recognize prevention certifications achieved in other states. The five New England states who *do* have a prevention certification meet or exceed the minimum criteria identified by the IC & RC. For instance, New Hampshire requires 175 hours of education as opposed as the 120-minimum set forth by the national IC & RC guidelines. Massachusetts has a specific number of hours that need to be spent on different topics to meet their 120-minimum education hours requirement. These include: six hours of prevention ethics; 10 hours of cultural competence; 10 hours of mental health; five hours of gambling; five hours of HIV/AIDS and Hepatitis C; five hours of violence prevention; 30 hours of ATOD specific; and 30 hours of Prevention Practice and Theory (PPT) categories.

Experience and education required for certification are based on six IC & RC Performance Domains:

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

To become a Certified Prevention Specialist, at a minimum, an applicant must meet the requirements set forth in Table 4 and Table 5. Table 6 represents the variation in state's certification requirements.

Table 4. Certification Experience Requirements

Requirements
✓ **2,000 hours of prevention work, internship, or volunteer experience**
✓ **120 hours supervised practicum with at least 10 hours in each IC & RC performance domain**
✓ **At least 50 hours in specific ATOD prevention**

Nearly all states require at least a high school degree. However, Maine and New Hampshire require additional experience for certification if applicants do not have a bachelor's degree. While Rhode Island requires only a high school diploma, it does require applicants to have some college credit, and Massachusetts requires a minimum of a bachelor's degree for certification.

In addition, applicants generally must have 120 hours of education, but Rhode Island requires 175 hours. Of the total training hours, all states require at least 24 hours of ATOD training and six hours of ethics training. Some states, like Maine, also require part of the hours to be spent on Substance Abuse Prevention Skills Training (SAPST) training or an approved equivalent.

Table 5. Certification Education Requirements

Requirements
✓ **High school diploma (some states require more experience or bachelor's)**
✓ **At least 120 hours education/ training**
✓ **At least 24 hours in ATOD**
✓ **6 hours in Prevention Ethics**

Applicants must also sign the IC & RC ethical code of conduct, submit three letters of reference, and pass the IC & RC Certified Prevention Specialist (CPS) exam. Rhode Island, unlike other states, also requires applicants to be currently employed in the prevention field. Once certified, professionals do not have to recertify for two years. Like initial certification, states have similar but not necessarily identical recertification requirements.

Table 6. Certification Requirements

Certification Requirements	CT	MA	ME	NH	RI
Supervised Work Experience	2,000 hours of prevention experience	2,000 hours of prevention experience	2,000 hours of prevention experience	2,000 hours of prevention experience w/ Bachelors; 4,000 hours w/o Bachelors	2,000 hours of prevention experience
Education	100 hours; 50 ATOD specific; 6 hours of ethics; 6 hours problem gambling	120 hours w/ Bachelors; 200 hours w/o Bachelors; 30 ATOD specific; 6 hours of ethics	120 hours; 24 ATOD specific; 6 hours of ethics; 31 hours of SAPST	120 hours w/ Bachelors; 240 hours w/o Bachelor's; 50 ATOD specific; 6 hours of ethics	175 hours; 24 ATOD specific; 6 hours of ethics; 25 hours for each IC & RC domain
Supervised Practicum	120 hours IC & RC six domains; minimum of 10 hours for each	120 hours IC & RC six domains; minimum of 10 hours for each	120 hours IC & RC six domains; minimum of 10 for each	120 hours IC & RC six domains w/ Bachelors; 240 hours w/o Bachelors; minimum of 10 for each	120 hours IC & RC six domains; minimum of 10 for each
Professional References	3: 1 from current supervisor and 2 from professional colleagues	N/A	3	N/A	N/A
IC & RC Exam	Passing Score	Passing Score	Passing Score	Passing Score	Passing Score
Renewal Standards	20 hours of prevention specific education annually	40 hours of prevention specific education bi-annually	40 hours of prevention specific education bi-annually	40 hours of prevention specific education bi-annually	40 hours of prevention specific education bi-annually

According to survey respondents, of those who were not already Certified Prevention Specialists, more than a third (38%) were interested in becoming certified (Figure 5). However, a substantial number of respondents did not perceive certification to be necessary or beneficial for them.

Figure 5. Interest in Becoming Certified Prevention Professional

Most New England states have identified certification as a strength of the prevention workforce. According to interviewees, New England states are using certification as a mechanism for promoting consistency, professionalism, legitimacy, and quality in the field. However, Vermont is still considering adopting an in-state certification program.

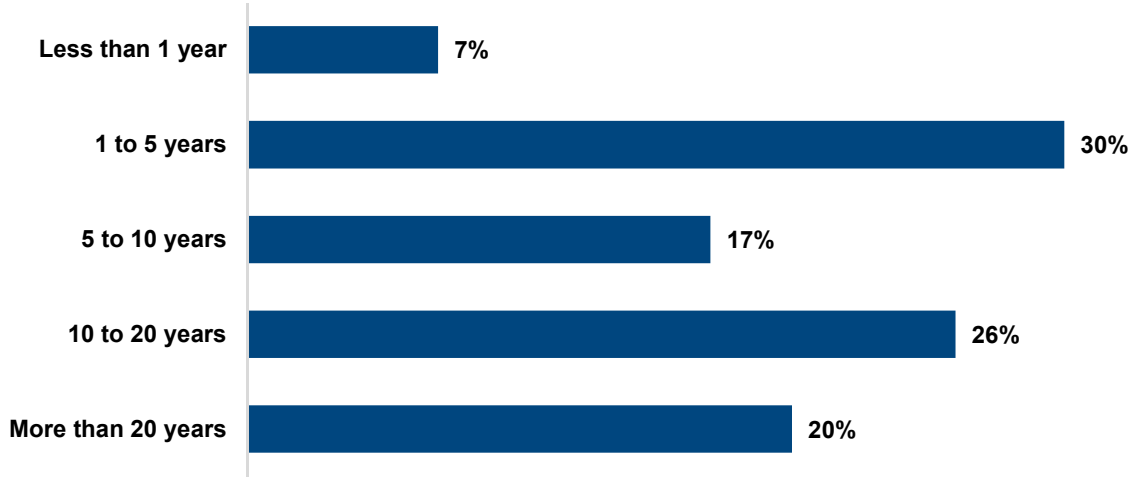
Vermont stakeholders describe the debate around certification as complicated. Interviewees agreed that having quality standards for the field as positive, however; the prevention field is a developing field of study in comparison to treatment and recovery. The workforce is already experiencing high turnover, and many predict a workforce shortage once current prevention professionals retire or leave the field. Vermonters fear that if there are too many barriers to enter the prevention workforce, recruitment of new staff will be even more difficult. Additionally, certification is required for only select employment and neither public nor private organizations have consistently offered much, if any, financial incentive to professionals seeking certification, Rhode Island is one state that has addressed this concern.

Prevention Workforce Skillsets

According to the PCG workforce survey, prevention professionals in New England are working in a variety of employment setting including substance use or community health coalitions (33%), government or state/ local health departments (31%), hospitals or health centers (10%), community or faith-based organizations (7%), treatment or recovery programs (5%), schools (3%), and other (12%).

Most respondents have worked in the prevention field for either more than 10 years (46%) or less than five years (37%). For analysis, PCG classified those with five or fewer years of experience as new professionals and those with 10 or more years as advanced or seasoned professionals (Figure 6).

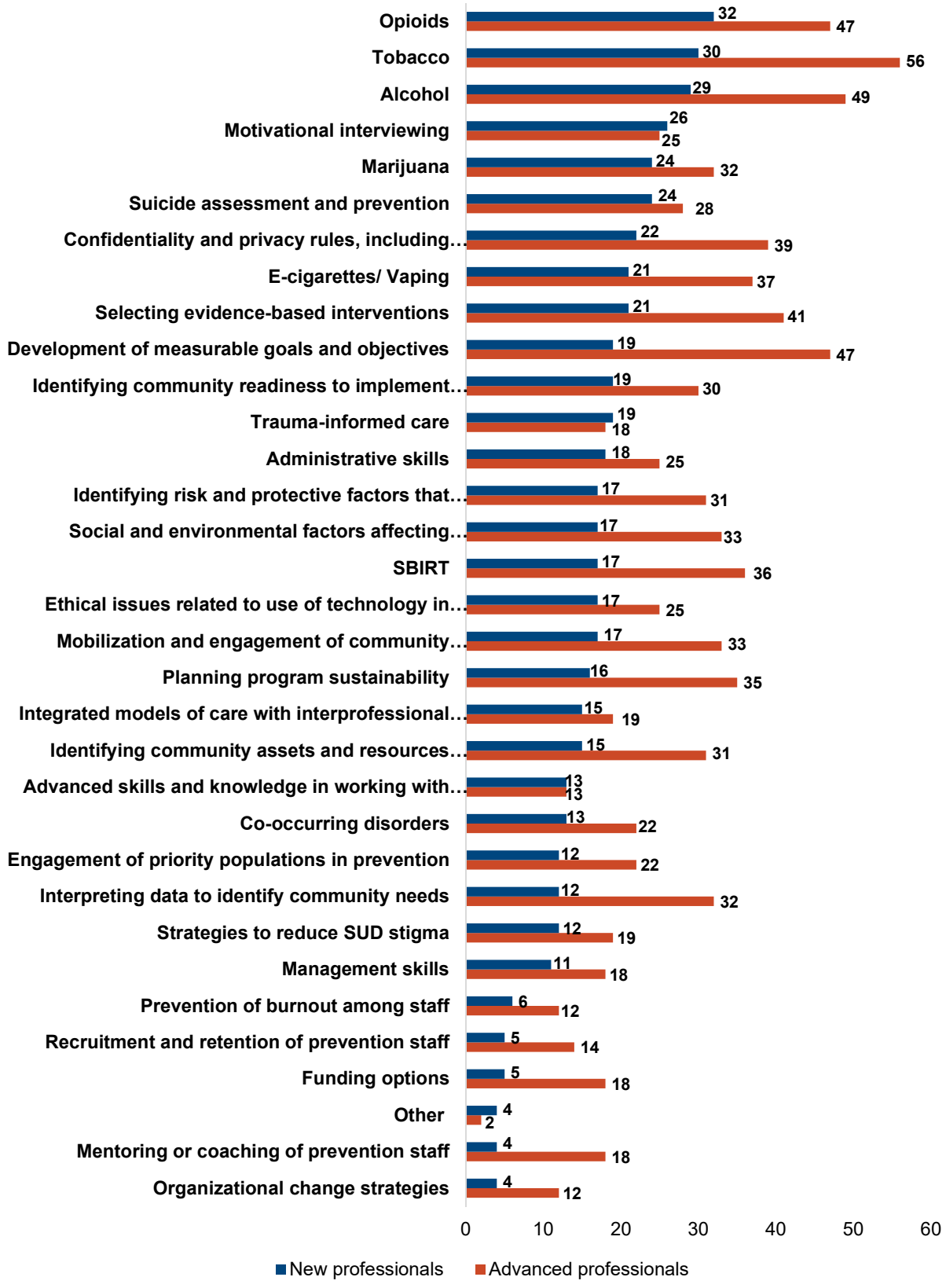
Figure 6. Years Worked in Prevention Field



In general, survey respondents have received a wide variety of training, but there were notable differences in trainings for new and advanced professionals (Figure 7). For example, new professionals reported feeling most adequately trained in basic substance use topics like alcohol, tobacco, and opioids. They reported feeling least adequately trained in interpersonal skill topics, such as organizational change strategies, mentoring/ coaching, funding options, recruitment/ retention of staff, and prevention of staff burnout.

Interestingly, there were similarities in training confidence between new and advanced staff. Both groups felt most adequately trained in basic substance use topics like alcohol, tobacco, and opioids. Similar to new professionals, advanced professionals also felt *least adequately* trained in prevention of staff burnout, organization change strategies, recruitment and retention of staff, and advanced skills and knowledge in working with diverse populations.

Figure 7. Professionals Indicating Adequate Training



New England Workforce Capacity

Reupert suggests that workforce capacity can be conceptualized in five levels.[21] First, on an individual level, people must recognize the importance of prevention and see the benefit of the service. Second, prevention professionals must have the confidence, attitudes, skills, and knowledge to understand prevention needs and provide the required services. Third, community leaders must have the means and opportunity to identify prevention needs and promote development of responses. Fourth, state and community organizations should promote capacity by providing necessary resources and infrastructures that allow the system to work. Finally, the system must be designed with policies and procedures that support the goal of prevention services and the needed interagency collaboration that is required to meet it.

Importance of Prevention

All interviewees recognized the importance of prevention efforts to decrease substance use and misuse and improve general wellbeing. Demonstrated by the consistency and type of training respondents have received, the New England prevention workforce has a high degree of knowledge in substance use topics such as alcohol, tobacco, opioids, and other substances. However, people lack confidence in their soft skills like management, organization change strategies, and strategies for working with diverse populations.

Confidence in Ability to Respond

Many stakeholders commented on political and economic factors that affect public perception, funding, and validation of the field. As the effect of prevention is harder to see and correlate, public and political buy-in has lagged. This is evidenced by the discrepancy in federal and state funding for treatment versus prevention initiatives discussed later in this report.

Further, each state structures its prevention efforts differently. Some have chosen to organize prevention with state-led oversight, some use third-party organizations, and some use a combination. The commonality is the utilization of a grassroots methodology to build traction for prevention efforts and to disseminate strategies throughout New England.

Community Capacity, Resources, and Infrastructure

Every state in New England uses a coalition structure to some degree to promote community stakeholder engagement and operate their prevention coordination through respective departments of health. The oversight, however, for these coalitions vary. Some states have appointment committees or councils to govern community engagement while others rely on outside vendors to do the coordination.

- Connecticut funds 20 coalitions through the block grant and eight communities through the PFS 2015 grant. They provide substance use trainings and support one or two annual events to bring coalitions together

[21] Andrea Reupert (2018) Enhancing workforce capacity in mental health promotion, prevention and early intervention, Advances in Mental Health, 16:1, 1–4, DOI: 10.1080/18387357.2018.1429196

for training and networking. According to interviewees, Connecticut's focus is a grassroots approach – to get into the community, meet people where they are, figure out who the stakeholders are, and to show each community how to use their data to make informed decisions about prevention.

- Maine utilizes an umbrella of Maine Prevention services to divide prevention into five domains: substance use, tobacco use and exposure, youth engagement and empowerment, mass reach health communication, and obesity. The substance use domain funds 20 community organizations through a braided funding model integrating several federal funding initiatives. The Drug Free Communities Support Program grant also supports coalitions engaging community stakeholders. For many rural areas, this coalition model has worked well to give people a venue in which to coalesce where formal supports may not exist.
- Massachusetts funds municipalities across the state to either create or work with an existing coalition. Coalitions, then, must engage community stakeholders and work with at least two neighboring cities or towns. Massachusetts promotes opportunities for coalitions to network and train together on various prevention topics. They also meet with sector representatives, such as media, health, schools, parents, and youth, every other month to solicit feedback and plan events and interventions.
- New Hampshire uses a grassroots approach with seven community coalitions, 13 regional public health networks, and an oversight group comprised of commissioners from various departments to help drive change and influence policy. The state organizes a "community of practice" meeting every other month for all providers funded by the state and some additional providers who are impacted by substance use prevention, like probation and police departments. They also use the governor's task force to convene higher level state agencies for implementation planning.
- Rhode Island has a Prevention Task Force which requires coalitions to have representatives from various sectors, including law enforcement and medical personnel. They have monthly meetings, sponsor trainings and workshops, and reach out to parents and youth.
- Vermont, by contrast to all other states, uses a reverse mechanism for community engagement, as reported by interviewees. Instead of trying to convene all stakeholders at one table, state representatives have made it a point to bring prevention to the stakeholders. They look for common goals, needs of individual communities, and spend much of their time building relationships with the right partners to meet community needs.

While grassroots organizing appears to have many benefits for capacity building, like personalized relationships with communities and specific understanding of unique community needs, the downfall of this approach is that staff turnover can quickly and drastically affect progress in stakeholder relationship-building.

Policies and Procedures Supporting Interagency Collaboration

The last part of Reupert's workforce capacity-building conceptualization requires that systems be designed with policies and procedures that support the goal of prevention services and needed interagency collaboration. At a national level, prevention has become increasingly validated as a necessary substance use field and prevention legislation has begun to gain traction for specific initiatives, such as opioid prevention. However, individually, New England states vary in the degree to which they have supportive policies and procedures for prevention.

For example, Maine, Massachusetts, and Rhode Island operate more formalized interagency platforms to promote collaboration across disciplines. By contrast, Vermont is still evaluating their capacity to adopt a state prevention certification. This is not to say that one system is better than another, but that state-level prevention networks are in various stages of development. Using Reupert's framework, the overall workforce capacity of New England is generally good but commitment, resources, and required financial and political support vary across the region.

Current Workforce Development

According to the Addiction Technology Transfer Center (ATTC) network, low wages, high turnover, a shortage of workers, insufficient professional development and stigma have contributed to a workforce crisis.[22] While the ATTC was referring to treatment professionals, the same could be said of prevention. Without clear educational standards, well-defined career paths, adequate compensation, and the necessary resources for professional development, substance use workforce recruitment is an uphill battle.

All states include workforce development as part of their strategic plans. According to interviewees, states have begun to recognize the importance of workforce recruitment to address shortages, especially as programming expands. One stakeholder said, "Yes, it's part of the strategic plan, but there isn't significant funding. It's just recognized as important." While some plans are more comprehensive than others, the overall need exists.

Prevention Workforce Recruitment Initiatives

Training requirements also vary between and within states. States have struggled to make prevention certification a requirement for providers, but they are beginning to focus on promoting more educational opportunities for the prevention workforce. One stakeholder stated, "It's something we've really started to work on more here. For a large piece of this it has been more traditional degree programs – social work, public health, community development and psychology. There are few programs at the community college or university level that focuses on prevention, but we are working with colleges about expanding that." This topic is also being expanded nationally.

[22] http://www.bettertxoutcomes.org/explore/priorityareas/wfd/overview/crisis.asp

The Society of Prevention Research has tried to fill some of this gap by promoting prevention science in academia via schools of social work, psychology, and public policy. The Society promotes specific standards of knowledge, like knowledge of risk, protective factors, human behavior theories, and multi-method data use, which they consider to be at the core of educating prevention science researchers.[23]

One goal of the PTTC is to promote workforce recruitment in high school and college students. Some states have already begun such initiatives. For example, Massachusetts is working with different sectors, driving recruitment in public health and social work schools, offering capacity trainings, focusing on certification awareness and accessibility, and working with the treatment side of substance use on how to recruit new staff. The University of Maine at Farmington has also created an Addiction Rehabilitation Certificate to drive workforce recruitment to the field of substance use.[24]

Connecticut reported that three years ago the state had used the PFS 2015 grant to hire youth-peer advocates across the states to promote youth involvement and perspectives within community coalitions. They have also used the Healthy Campus Initiative to expose young people in college to prevention careers, and the state's department has partnered with the University of Connecticut to offer prevention internships for social work students.

Other states have hosted prevention conventions at local colleges and used SAMHSA's Center for Substance Abuse Prevention (CSAP) fellowship. Multiple interviewees commented that they would like to see their states establish more formal relationships with colleges and universities to offer course and expertise training in substance use prevention. However, these partnerships have been short-term and slow to form.

Currently, five universities offer a master's degree program in prevention science:

- Harvard University
- Vanderbilt University
- University of Oklahoma
- University of Oregon
- University of Miami

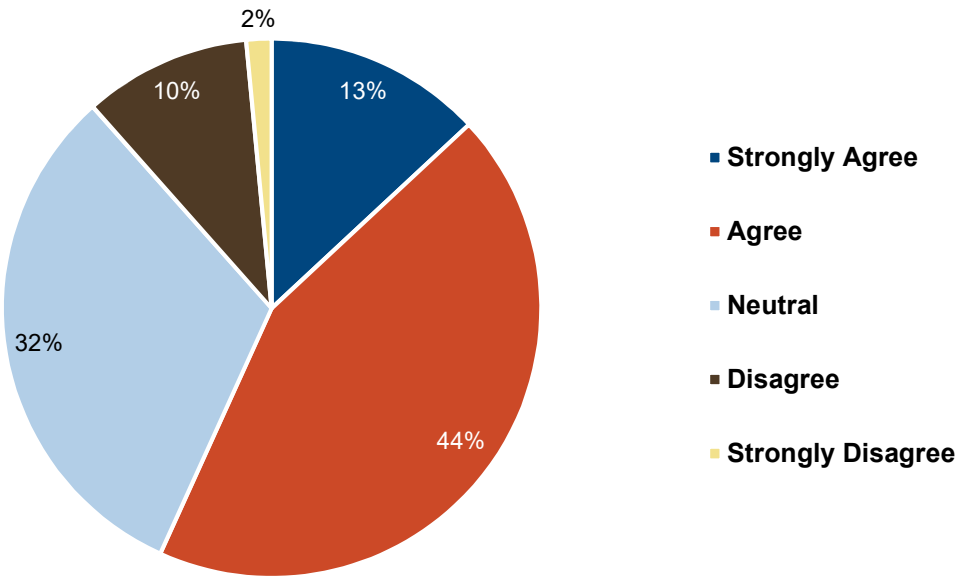
Additionally, Colorado State University offers a Prevention Science Specialization through its Master of Human Development degree. One stakeholder who was interviewed had a Masters of Prevention Science degree. The hope is that with creation of a specialized education track, more young people will be recruited into the prevention field and those recruited will be better educated and trained.

[23] https://www.preventionresearch.org/Society%20for%20Prevention%20Research%20Standards%20of%20Knowledge.pdf

[24] https://www2.umf.maine.edu/inside/2015/11/16/umf-prepares-students-to-combat-substance-abuse-with-new-addiction-certificate/

Workforce diversity and cultural competence/humility have been challenging for many New England States to promote. Over half of survey respondents (57%) did strongly agree or agree that their state promotes diversity and cultural competence in the prevention workforce and nearly a third of respondents were neutral (Figure 8). While there was some variation by state (see state profiles in Appendices C through H), there is nonetheless room for improvement for all states.

Figure 8. Diversity and Cultural Competence in the Workforce



Stakeholders from every state mentioned attempts to promote diversity, since the field is largely made up of white females. One stakeholder summarized the concern saying, "Substance (use) prevention is for a lot of different populations but the workforce looks like one population," a demographic reflected by the prevention professionals who took the workforce survey. In fact, New England states have populations that are 80 percent or more white, non-Hispanic. (See Appendix A for detailed demographic information.) Therefore, it may not be fair to measure New England workforce diversity by only ethnicity or race. Forty-four percent (44%) of survey respondents self-identified as part of a disparate group at some point in their lives. Most common designations were pregnancy (24%) and trauma survivors (18%). Less common but still represented were LGBTQ, homeless, people in the criminal or juvenile justice system, military/ veterans, people with development or physical disabilities, and people with HIV/ AIDS.

Some states have used the SPF model to promote diversity in their prevention structures. Others have chosen to focus efforts for diverse recruitment of young adults/youth in diversity clubs and community organizations. Still others have pushed diversity through community trainings.

Best practices suggest that recruitment and hiring of a diverse workforce requires four elements:[25]

1. Advertising for diversity,
2. Targeting recruitment to underserved populations,
3. On-the-job mentorships and career ladders, and
4. Demonstrating organizational commitment to diversity.

Stakeholder interviewees and survey respondents both suggested that states form relationships with diverse professional organizations and minority-serving institutions, such as colleges, to promote and advertise careers in prevention. Additionally, respondents suggested tapping into the addiction recovery network and recognizing the importance of people with lived experience in prevention work. Some suggested offering better pay, more career development opportunities, financial assistance for relocation, and tuition reimbursement. This financial aspect of recruitment makes sense considering the composition of the current workforce, with 80 percent having a bachelor's degree or higher.

Other ideas offered in best practice include creating a targeted outreach plan for job fairs that serve underrepresented populations; asking existing staff to speak or guest lecture; creating diverse recruiting or hiring teams; personalizing recruitment efforts; and promoting continuous recruitment, not just when there are openings.[26] States should also publicize and increase the ability of career advancement, training, and professional development opportunities. Lastly, organizations and states must integrate elements of diversity, equity, and inclusion and enforce accountability among all staff to show a commitment to diversity.

Training and Technical Assistance

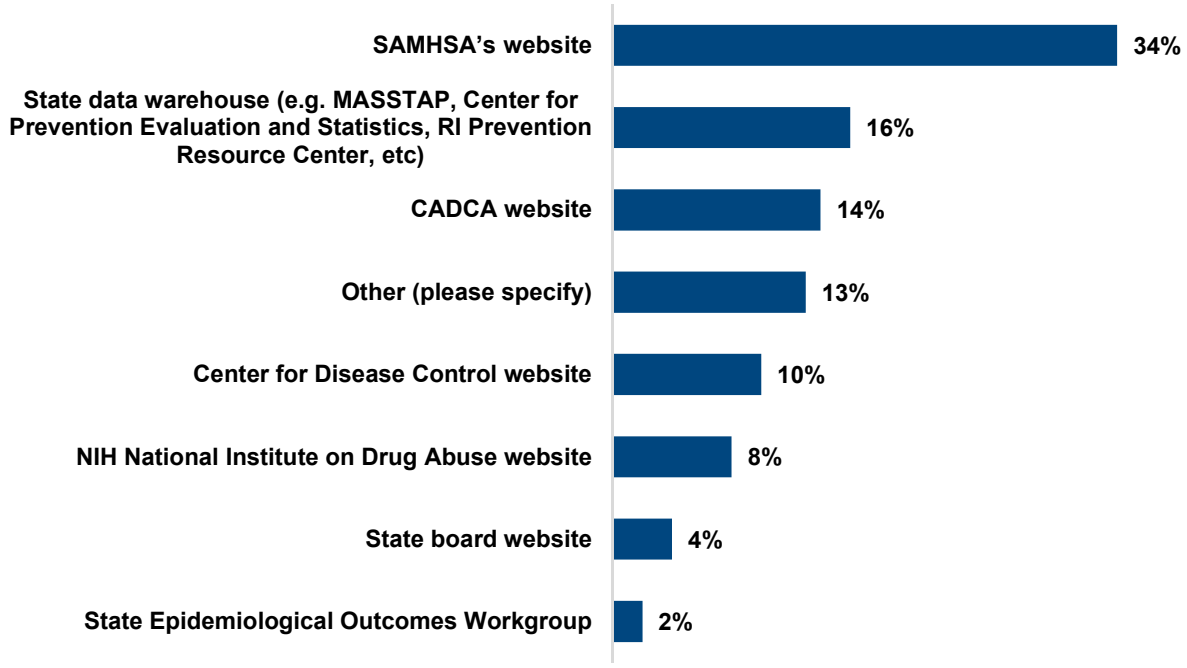
The PTTC is not a replacement of SAMHSA's CAPT platform. It is a new model that will provide broadened access to training and technical assistance to all professionals and stakeholders engaged in prevention. That said, for the purposes of this needs assessment, it is informative to examine the utilization of the prior CAPT platform. More than half (53%) of workforce survey respondents and nearly all stakeholders indicated that they had utilized the CAPT program regularly.

Stakeholders stated that the most helpful features of the program were consultation with experts; accessibility of information; level of responsiveness; access to free quality trainings; the variety of training topics; curriculum development; research and logic model development; onboarding of new employees; and networking opportunities. Rhode Island interviewees recognized the importance of CAPT to developing regional coalitions, trainings and service plans. Vermont interviewees commented on the platform's utility in collaboration and mentorship for professionals not found in any other state organization or agency. Acknowledging the training needs and presentation preferences, this is a barrier the New England PTTC could easily overcome.

[25] https://diversity.berkeley.edu/sites/default/files/recruiting_a_more_diverse_workforce_uhs.pdf
[26] https://diversity.berkeley.edu/sites/default/files/recruiting_a_more_diverse_workforce_uhs.pdf

In terms of current training and technical assistance, at a national level, states have access to National Prevention Network (NPN)[27] and CADCA[28] for information and networking. According to stakeholders, with the dissolution of CAPT in 2017, New England states have fallen back on state-level training and technical assistance organizations. Survey respondents confirmed that the primary go-to source for knowledge, skills, and techniques was SAMHSA's website, followed by state data warehouses (Figure 9).

Figure 9. Go-To Sources for Prevention Knowledge, Skills, and Techniques



[27] https://nasadad.org/npn-4/
[28] https://www.cadca.org/

Table 7 shows the current state training and technical assistance organizations most commonly referenced by survey respondents and interviewees.

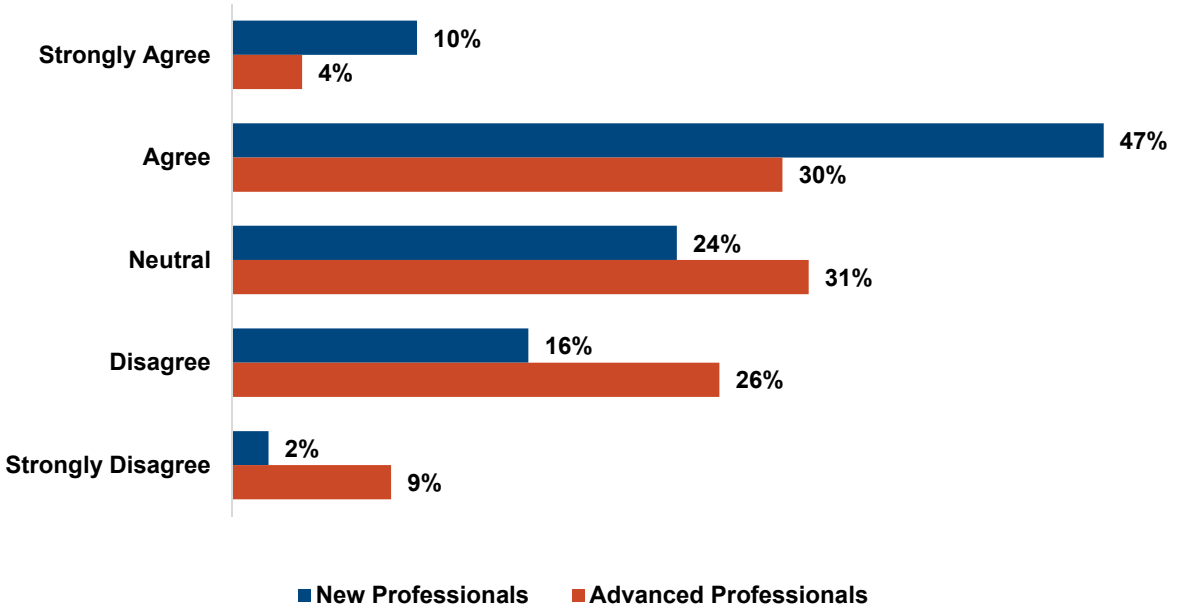
Table 7. State Training and Technical Assistance Organizations

State	Organization
Connecticut	• Connecticut Association for Prevention Professionals (CAPP)[29] • Prevention Training and Technical Assistance Service Center (TTASC)[30] • Connecticut Clearinghouse by Wheeler Clinic[31] • Governor's Prevention Partnership[32]
Maine	• AdCare Educational Institute of Maine, Inc.[33] • Co-Occurring Collaborative Serving Maine (CCSME)[34] • University of New England (UNE)[35]
Massachusetts	• AdCare Educational Institute, Inc.[36] • Massachusetts Technical Assistance Partnership for Prevention (MASSTAP)[37]
New Hampshire	• NH Alcohol & Drug Abuse Counselors Association (NHADACA) and NH Training Institute on Addictive Disorders (NHTIAD)[38]
Rhode Island	• Rhode Island Prevention Resource Center (RIPRC)[39]
Vermont	• Vermont Center for Health and Learning[40] • Vermont Department of Health Prevention Network[41]

More than half (57%) of new professionals (less than five years in the field) and 34 percent of advanced professionals (more than 10 years in the field) agreed or strongly agreed that their state has adequate educational or training opportunities (Figure 10).

[29] https://www.cappct.org/ct-sam
[30] https://preventiontrainingcenter.org/
[31] https://www.ctclearinghouse.org/
[32] https://www.preventionworksct.org/
[33] https://adcareme.org/
[34] https://www.ccsme.org/
[35] https://www.une.edu/research/centers/center-excellence-health-innovation/maine-substance-use-prevention-service
[36] https://adcare.com/
[37] http://masstapp.edc.org/
[38] https://www.nhadaca.org/Training-Events
[39] https://www.riprc.org/
[40] https://healthandlearning.org/
[41] https://www.healthvermont.gov/

Figure 10. Adequate Educational or Training Opportunities



Interestingly, more advanced professionals compared to new professionals felt that they had access to career development opportunities that matched their career goals (Figure 11). There is obviously a substantial opportunity for the New England PTTC to fill a void and provide training and technical assistance to all prevention professionals.

Figure 11. Access to Career Development Opportunities

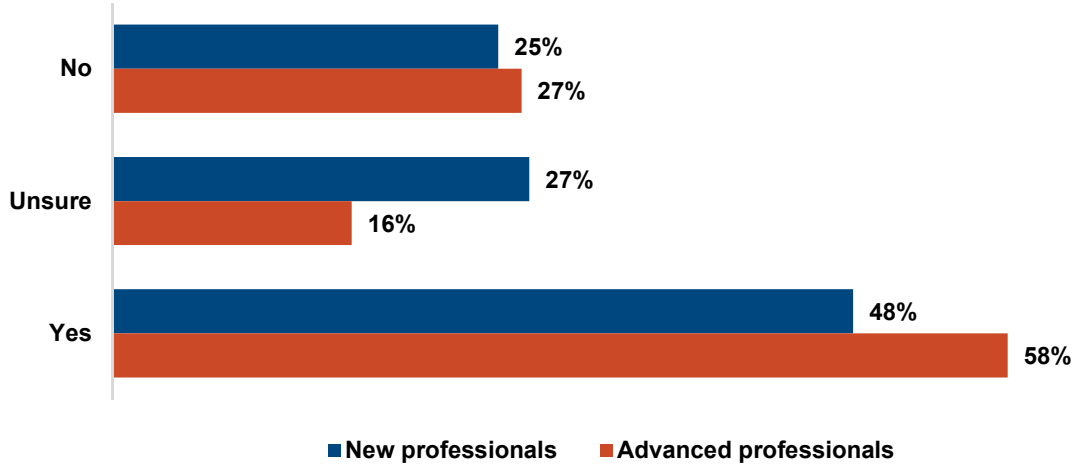


Table 8 reflects the topics wanted by more than half of survey respondents. Topics vary in terms of hard (*e.g.,* funding options) and soft or interpersonal (*e.g.,* organizational change strategies) skill-building. While every state had a slightly different prioritized list, strategies to reduce substance use disorder *stigma* fell among the top three topics in five out of six states and advanced skills and knowledge in working with diverse populations fell among the top 12 in each state.

Table 8. Requested Training Topics

Topics of Interest	Percent Wanting More Training
Advanced skills and knowledge in working with diverse populations	67%
Strategies to reduce SUD stigma	65%
Social and environmental factors affecting substance use prevention	63%
Co-occurring disorders	60%
Engagement of priority populations in prevention	59%
Planning program sustainability	58%
Suicide assessment and prevention	56%
Trauma-informed care	56%
Interpreting data to identify community needs	55%
E-cigarettes/ Vaping	55%
Ethical issues related to use of technology in delivering client/patient services	55%
Management skills	55%
Marijuana	55%
Funding options	54%
Integrated models of care with interprofessional teams	54%
Identifying risk and protective factors that impact disparate populations	54%
Mobilization and engagement of community stakeholders	53%
Identifying community readiness to implement prevention interventions	53%
Organizational change strategies	51%
Administrative skills	50%

Stakeholder interviewees also specifically requested more training for:

- The use of media in prevention,
- Understanding youth and teen behavior in terms of substance use,
- Prevention for elementary-age youth,
- Effective prevention promotion tactics,
- Interception between primary prevention and overdose prevention,
- Cultural diversity,
- Clinical skills,
- Understanding and using data in prevention efforts, and
- Prevention science.

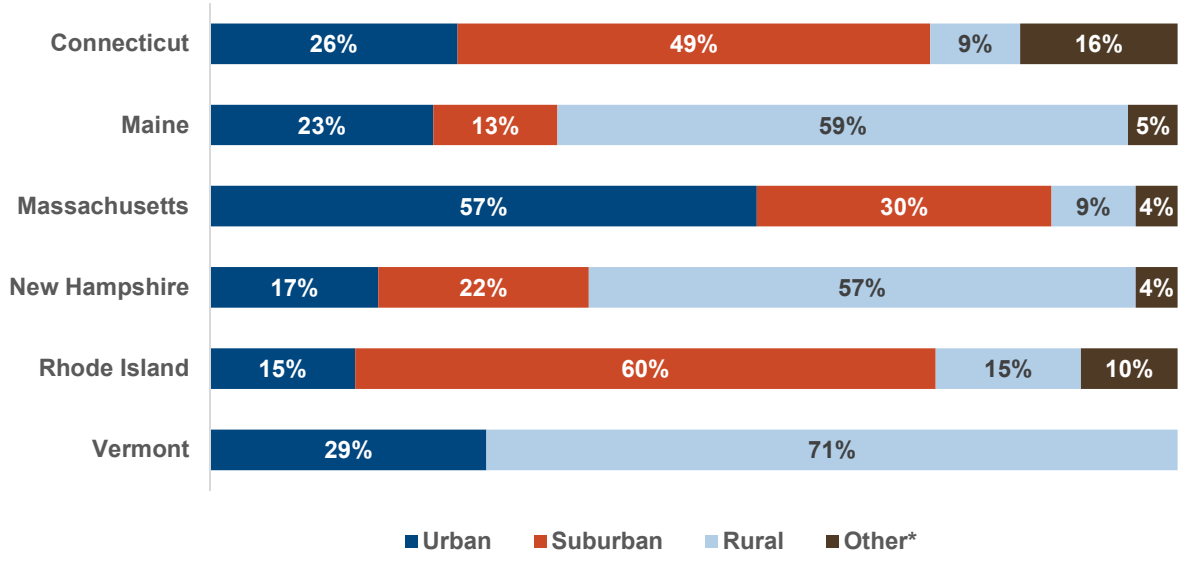
Interviewees often commented that advanced ethics training was an ongoing issue for recertification, not that people lacked knowledge of professional ethics, but that infrequent course offerings made the certification requirement difficult to meet. This sentiment was echoed by survey respondents who also commented on the difficulty of finding courses to meet certification requirements.

The nature of the topics should influence the way training and technical assistance are provided. Most topics can be classified as *soft skills* in which people are trained to interact more effectively with others, unlike *hard skills*, that are more easily quantifiable. Interpersonal skills programming needs to allow interaction among participants.

The modality of training and technical assistance provided to different communities is as equally important as topic content. According to the United States Census Bureau, Massachusetts has the largest state population of the New England states with nearly seven million people and Vermont has the smallest with just over a half million. New England is traditionally conceptualized as rural countryside with urban pockets, some states more than others. For example, while Maine has a few larger cities, it also has the lowest population per square mile (43.1), which means that there are large tracts of rural areas where access to and availability of most services, including those targeting substance use treatment and prevention, are very limited. Rhode Island, by contrast, has one of the smallest state populations, but the densest population per square mile (1018.1). Thus, access to and availability of services are better, in general, for the state.

The employment settings of survey respondents, Figure 12, reflects these demographics. Maine and New Hampshire have the most people working in rural areas whereas Massachusetts has the most in urban; Rhode Island and Connecticut stand out for their suburban settings. The contrasts are great and will need to be considered in the planning of training and technical assistance, both for content and training modality.

Figure 12. Employment Setting by State

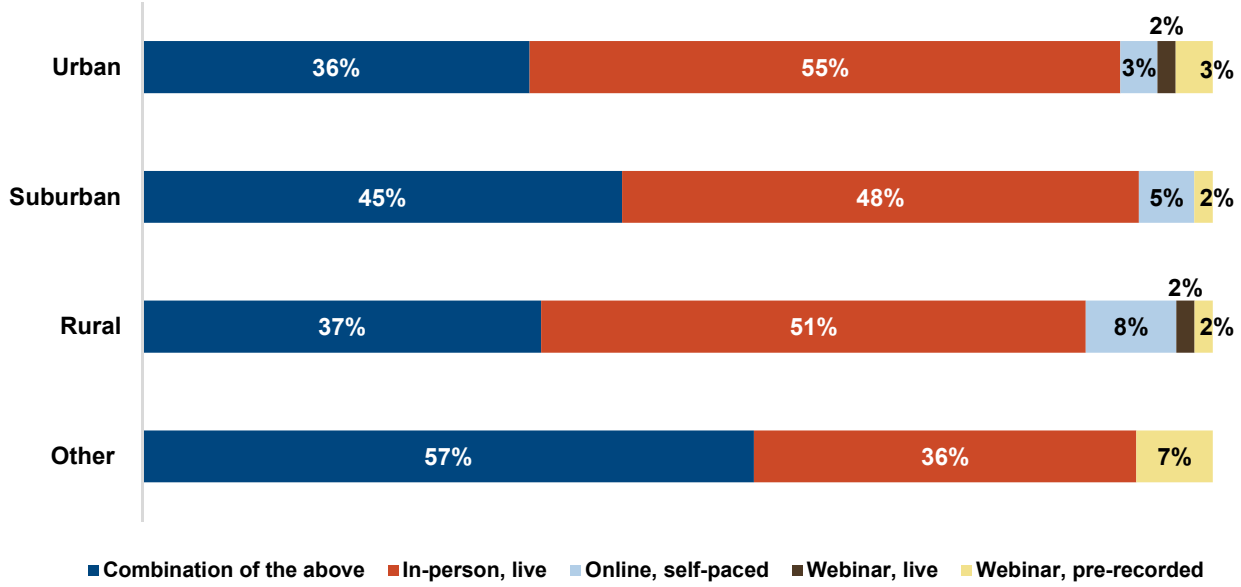


* Those indicating other as employment setting included people working statewide or in a combination of settings.

For example, more than half of all respondents (53%) preferred to receive in-person training, and those working in urban areas were more likely to request training this way compared to respondents working in urban and suburban areas. A substantial portion

(39%) of all respondents also indicated that a combination of learning styles was preferred; however, those working in suburban areas (excluding work settings classified as other) were the most likely to request this modality. Additionally, 12 percent of professionals working in rural areas, more than suburban or urban workers, also requested online or webinar-based training. See Figure 13 for learning style preferences by people in various work settings.

Figure 13. Workforce Respondent Learning Style Preference



In sum, stakeholders report that future efforts to regionalize training and technical assistance should consider more advanced course offerings for seasoned professionals, especially around management and other soft skills; better coordination of training offerings among various providers to decrease duplication; more opportunities for in-person training, self-paced learning, and recorded webinars; better marketing of available resources; and opportunities for collaboration of professionals within and across state lines.

Data and Prevention Science

The prevention field has developed a range of programs, policies, and systems which have been empirically proven to support health and prevent substance misuse. These are referred to as evidence-based. Data and prevention science are critical to well-founded, effective prevention practice. This section describes the use of the SPF framework (detailed in the Methodology section on page 7) in the review of evidence-based practices, data clearinghouses, and specialized training for the prevention workforce.

SAMHSA dollars provided for prevention funding through Block Grants require the use of the SPF model, and it is the most common framework that is used across New England. The workforce survey asked prevention professionals to rate their confidence in their

ability to implement SAMHSA's SPF model. The largest gaps in confidence were related to cultural competence and health disparities (effective integration and interaction with diverse populations) and sustainability (funding stream development). There were also gaps in confidence for evaluation (ensuring accuracy in results, developing quality improvement plans, and communicating results). Multiple stakeholders also noted in interviews that their capacity for data collection and analysis as a major weakness. Interviewees stated that they would like additional trainings on how to utilize data to inform practice and how to best present that data to various audiences.

Recognizing that multiple approaches are needed to properly serve the community, other prevention strategies utilized are listed by state in Table 9.

Table 9. Additional Prevention Strategies

State	Prevention Strategies
Connecticut	• NIAAA 3-in-1 Framework • Environmental strategies • Public education and awareness
Maine	• Principles of Effectiveness • Data driven environmental strategies • Integrated Behavioral Health approach • Social-Ecological Model • Primary Prevention • CSAP 6
Massachusetts	• Environmental strategies • School trainings • *Ad Hoc* evidence-based workgroup
New Hampshire	• Primary Prevention • Continuum of Care Models
Rhode Island	• Life Span Framework • Population Health Model • Integrated Behavioral Health infrastructure • CSAP strategies • Environmental strategies • Early Identification Referral
Vermont	• Vermont Prevention Model – Ecological strategies • Public Health Promotion Model • Environmental strategies

All prevention efforts must be based on evidence-based practices for states to continue receiving federal funds. Survey respondents reported education, information dissemination, and community-based processes as the most commonly used evidence-based strategies. However, environmental strategies, alternative activities, and problem identification and referral were also utilized.

- **Information dissemination** provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, misuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.

- **Education** builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.

- **Alternatives** provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities;

- **Problem identification and referral** aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco or alcohol and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.

- **Community-based process** provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

- **Environmental strategies** establish or change written and unwritten community standards, codes, and attitudes. Its intent is to influence the general population's use of alcohol and other drugs.

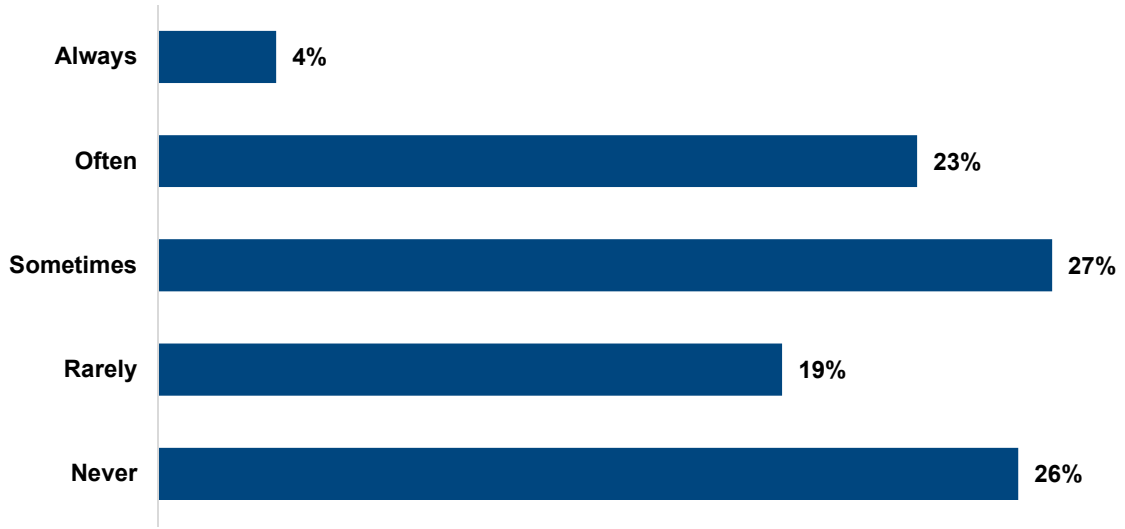
Further, prevention specialists are required to collect data and have access to the most current training and evidence-based practices. Some state task forces and organizations are reportedly better at it than others. A major barrier to accessing current literature on evidence-based practices and prevention science has been SAMHSA's suspension of

the National Registry of Evidence-Based Programs and Practices (NREPP) in January of 2018.[42]

NREPP has since been replaced by the Evidence-Based Practices Resource Center (EPBRC). According to SAMHSA, the new center aims to "provide communities, clinicians, policy-makers and others in the field with the information and tools they need to incorporate evidence-based practices into their communities or clinical settings."[43] However, interviewees noted that the new EPBRC policy lab is not updated frequently, and new materials have not been made available since April of 2019.

In terms of substance use data, every state in New England participates in a Statewide Epidemiological Outcomes Workgroup (SEOW). However, capacity and the degree to which professionals use the SEOW varies among the states, with overall results shown in Figure 14. For example, Connecticut's SEOW meets quarterly, while New Hampshire's meets every other week. Massachusetts' SEOW meets to plan/assess new prevention models and as other needs arise. Maine's SEOW also operates as the state's Prevention Clearinghouse for data. More than half of survey respondents use SEOW data to inform their prevention practices. However, the degree to which the group is used varies among the states with those in Massachusetts and New Hampshire making less use than elsewhere.

Figure 14. Consultation with State Epidemiological Outcomes Workgroup (SEOW)



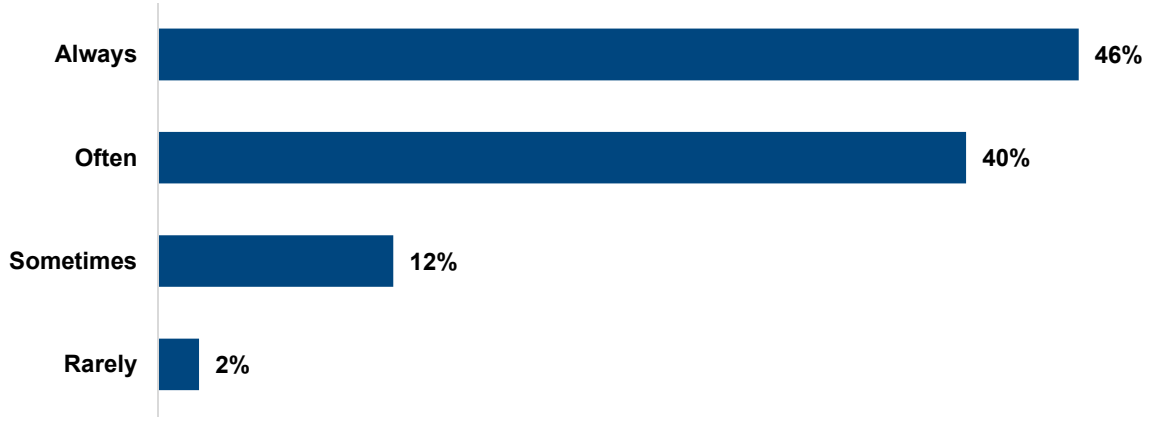
Connecticut and New Hampshire have adopted their own structured prevention clearinghouses for substance use data, while other states still struggle with statewide data sharing and availability. For example, prevention professionals from Massachusetts expressed that data sharing is difficult because there is no centralized system. Another

[42] https://preventionpluswellness.com/blogs/news/providing-evidence-based-substance-use-prevention-in-a-post-nrepp-shutdown-era
[43] https://www.samhsa.gov/ebp-resource-center

stated, “we use data but it’s really hard to come by. It’s been challenging to get good data on opioid use if you rely on the state – we don’t get timely data that is useful. We also need more qualitative data collection.” These sentiments were echoed by stakeholders in other states. Databases have to be built at the local level by coalition leaders, many whom don’t have extensive training in data collection and analysis practices, and who also have limited resources to hire an epidemiologist.

While data sharing can be difficult, there was still a very strong positive response about how often stakeholders use data to inform their prevention work (Figure 15). Almost all interviewees and survey respondents use data as much as they can to inform their prevention work.

Figure 15. Degree to Which Data Informs Prevention Work



Prevention Messaging and Funding

Two major factors that have impacted prevention services are the media campaigns that are used to spread prevention messaging and the funding available to provide services. Historically, money had to be spent to spread messages about substance use prevention through media campaigns. However, with the advent of social media this is no longer the case. The changing landscape of substance use prevention and the advent of social media have altered the way that prevention messaging is distributed to youth, parents, and the general public. Social media campaigns have become increasingly more popular to spread messages because they are effective and free, allowing prevention funds to be utilized in other areas. Furthermore, additional federal dollars are being allocated towards funding substance use prevention as evidence of its effectiveness has become more concrete. We know more now about how effective, evidence-based prevention practices can curtail substance use as a lot more research has been done over the last decade and a half.

Current Prevention Campaigns

Stakeholders report that while many states are still grappling with complications of legalizing medical marijuana, the looming opioid crisis, and increasing cocaine usage, prevention efforts have largely continued to target alcohol and prescription medication.

Stakeholders explain that while prominent issues such as opioid use and overdose deaths get a lot of media attention, underage alcohol use is still the most prevalent issue which requires considerable attention and funding. This is because the majority of the prevention work that is being done is centered around primary prevention and deterring underage use of substances.

Nearly all states have media campaigns targeting underage drinking and/or non-medical prescription drug use. There are also multiple national substance use prevention media campaigns including the Above the Influence (ATI) drug and alcohol prevention campaign, It Only Takes a Little to Lose A Lot – Rx Awareness Campaign and The National Youth Anti-Drug Media Campaign.

The ATI drug and alcohol prevention campaign was first introduced in 2005 by the Partnership for Drug-Free Kids and the Office of National Drug Control Policy (ONDCP). "The insightful strategic messages offered by the ATI campaign take a different approach toward teens, reinforcing the fact that they value themselves and their aspirations above the debilitating and self-destructive influence of drugs. Over time, this has proven far more effective that the more traditional, negative anti-drug messages that today's teens largely ignore."[44]

The Partnership for Drug-Free Kids recently decided to continue funding the campaign but is reducing costs by concentrating on digital and social media messaging instead of television advertisements. To foster participation at the community level, the ATI campaign has partnered with over 40 youth-serving organizations in over 20 communities across the country to provide technical assistance and training to over 500 community organizations through conferences and webinars with the objectives of[45]:

- Actively engaging youth at the local level to allow them to inform and inspire the campaign;
- Providing local youth-serving organizations with the recognized, national platform to further their specific goals and initiatives; and
- Providing localized advertising – including posters and bus shelter ads featuring artwork created by teens and customized banners in 1,150 high schools – across all of the 20+ partner communities to generate additional awareness.

It Only Takes A Little to Lose A Lot – Rx Awareness Campaign tells the real stories of people whose lives were torn apart by prescription opioids. Its goal is to increase awareness that prescription opioids can be addictive and dangerous. The campaign also strives to decrease the number of individuals who use opioids recreationally or overuses them. State and local health departments and community organizations can also take part

[44] https://drugfree.org/learn/drug-and-alcohol-news/teen-targeted-substance-abuse-prevention-campaign-focuses-on-digital-social-media/
[45] https://obamawhitehouse.archives.gov/ondcp/ondcp-fact-sheets/above-the-influence-ATI

in the Rx Awareness campaign and use the tested campaign materials and resources to launch campaigns, support local prevention activities, and raise awareness about the risks of prescription opioids.[46]

The National Youth Anti-Drug Media campaign was developed in 1997 by ONDCP after receiving funding for a large-scale paid media campaign to educate and enable youth to reject illegal drugs. The campaign was developed from solid scientific evidence and implemented in collaboration with the Partnership for a Drug-Free America and other non-profit, public and private sector organizations. The campaign addresses a range of issues including demand reduction, reduction of drug-related crime and violence, and reduction of drug-related health and social costs. Its goal is to educate and enable America's youth to reject illicit drugs, including preventing drug use and encouraging occasional users to discontinue use.[47]

In addition to national campaigns, SAMHSA hosts a National Prevention Week every May dedicated to increase public awareness of, and action around, mental health and substance use disorders. Each year communities and organizations across the country come together to raise awareness about the importance of substance use prevention.

All six states in New England utilize media campaigns.

- **Connecticut** has a statewide media campaigns to promote prevention efforts and bring together key stakeholders called *Change the Script*.
- **Maine** promotes several prevention campaigns, primarily addressing underage drinking and marijuana use. Prevention strategies target youth and adults and seek to educate as well as influence behavior. Examples of prevention campaigns include: *Parents Who Host, Lose the Most; Project Sticker Shock; Student Intervention and Reintegration Program (SIRP); Eyes Open for ME*; *Be a Hero; Positive Influence*; and *You are the Target*.
- **Massachusetts** has statewide and local media campaigns to promote prevention efforts and bring together key stakeholders. Examples include: *Make the Right Call; Talk, They Hear You; Stop Addiction Before It Starts; My Choice Matters;* and *Rethink the Drinks.*
- **New Hampshire** promotes multiple prevention campaigns, primarily targeting binge drinking, drinking while pregnant, and opioid addiction. Examples include: *Today is for Me; Anyone. Anytime.;* and *Binge Free in 603.*
- **Rhode Island** also employs media campaigns to spread prevention messages. These include: *Count It, Lock It, Drop It; Hidden in Plain Sight;* and *Four Legs to Stand On*.
- **Vermont** utilizes the SPF prevention model to target youth and adults and seeks to educate and influence behavior. It promotes several campaigns,

[46] https://www.cdc.gov/rxawareness/about/index.html
[47] https://www.ncjrs.gov/pdffiles1/ondcp/171694.pdf

focusing primarily on underage drinking, binge drinking, and non-medical prescription drug use. Examples include: *eCheckup to Go*; *ParentUp*; *Most Dangerous Leftover*; and *Do Your Part*. More information on each of these campaigns can be found in the State Profile Appendices C through H.

SAMHSA states, "communication through mass media is a powerful tool for reaching substance use prevention audiences and achieving prevention goals. Traditional media channels include television, radio, newspapers, magazines, movies, and music. Along with traditional print and broadcast channels, emerging social media and networking tools such as podcasts, blogs, and popular sites like Facebook, Twitter, YouTube, and Instagram help shape views and values."[48]

Social networking sites are free and a great way to promote prevention messages through ambassadors, advocates, and champions who can help spread the word for you and measure results. Social networking allows one-to-one communication and connects personally with each and every user. Users are collecting information based on what they want, which means a deeper engagement with the message via interactivity. Leveraging media and social media outlets can serve several purposes, including[49]:

- Building support for prevention activities;
- Delivering prevention messages to target audiences; and
- Generating public support for policies and laws related to substance use

Media and social networking activities can strengthen prevention strategies and make people more aware of aims, activities, messages, and results. Combining media outreach activities with other prevention efforts can help change knowledge, attitudes, and beliefs regarding substance use. A successful marketing strategy under the new media model leverages a variety of tools, and an interactive, collaborative approach that will help to reach target audiences and achieve objectives.

Funding for Prevention

State prevention agencies have faced challenges in obtaining adequate funding partly due to the fact that prevention is defined in various ways. One stakeholder stated, "my sense is that there is a lot more money going towards treatment and recovery than prevention; prevention gets slighted and gets defined in a siloed way – it needs to be defined more holistically." Another concern regarding prevention funding is that it is difficult to measure outcomes as primary prevention is

> On some level, there is always some sort of political impact. It doesn't matter which party is in office. Whenever there is a change in administration, those of us who rely on grant funding always cross our fingers that our work can continue.".
>
> *– Stakeholder*

[48] https://store.samhsa.gov/system/files/sma10-4120.pdf
[49] https://store.samhsa.gov/system/files/sma10-4120.pdf

often hard to see, requiring many years to observe effects.

Most prevention funding throughout New England comes from federal block grants and other federally funded discretionary grants (Table 10). Prevention specialists from all six states expressed concern that there were very little, if any, state dollars going into prevention. Prevention specialists worry about job security and what would happen if they lost their federal grant dollars.

- Connecticut receives much of its prevention funding through SAMHSA block grants and other federal sources. State representatives expressed that there is a limited amount of state dollars spent on prevention work.
- Maine state officials have worked hard to increase education about the importance and necessity of prevention services. They report that this education has resulted in making the field more visible and increasing state-portion funding; however, most prevention funding is still federally sourced.
- Massachusetts receives most of its prevention funding through SAMHSA block grants and other federal sources. State representatives expressed that there is currently no amount of state dollars being spent on prevention work. Furthermore, Massachusetts spends about 20 percent of its annual Block Grant funding on prevention versus treatment.
- According to stakeholders, political support for prevention in New Hampshire has been hit or miss especially since 2010 when prevention services essentially were hollowed out forcing some organizations out of business.
- Rhode Island state officials have increased efforts to promote the necessity of prevention education and services. They report that this education, coupled with increased federal dollars, has resulted in making the field more relevant.
- According to the state's strategic plan, Vermont has various state and federal funding sources for prevention services. In 2016, community-based prevention grants were joint initiatives between the Division of Alcohol and Drug Abuse Programs (ADAP) and the Tobacco Control Program to reduce health-care costs by creating of healthy communities.50 However, prevention stakeholders report that nearly all (98%) of prevention efforts in Vermont are federally funded with the balance coming from private organizations/grants.

The largest federal grant that all six states utilize is the Substance Abuse Prevention and Treatment Block Grant (SABG). SABG provides funds for all 50 states and jurisdictions. Its objectives are to help plan, implement, and evaluate activities that prevent and treat substance use disorders.

[50] http://www.healthvermont.gov/sites/default/files/documents/2017/01/ADAP_Prevention%20Program%20Overview.pdf

According to SAMHSA, the SABG program targets the following populations and service areas:

- Pregnant women and women with dependent children
- Intravenous drug users
- Tuberculosis services
- Early intervention services for HIV/AIDS
- Primary prevention services

As it is difficult to parse out what portion of SABG funding is spent on treatment versus prevention, SAMHSA requires that grantees spend no less than 20 percent of their SABG allotment on primary prevention strategies[51]. These strategies are directed at individuals not identified to need treatment. Grantees must develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse.

Table 10. New England SAMHSA Funding Sources[52]

Funding Source	Substance Use Treatment	Substance Use Prevention	Mental Health	Total
Substance Abuse Prevention and Treatment Block Grant (SABG)	—	—	—	$87,650,315
SAMHSA – Discretionary Funding	$172,088,071	$25,045,002	$55,075,252	$242,454,142
Community Mental Health Services Block Grant	—	—	$30,564,264	$48,564,264

Over $87 million for substance use prevention and treatment in New England comes from the SABG. Other federal grants that are utilized by all six New England states are the Drug Free Communities (DFC) grant from the Offices of National Drug Control Policy (ONDCP) and several grants from SAMHSA, such as Community Mental Health Services Block Grants (MHBG), State Opioid Response (SOR) grants, the Strategic Prevention Framework Partnerships for Success grant (SPF-PFS), and Drug Free Communities Support Programs grants. Additional discretionary funding is also made available by SAMHSA for substance use treatment, prevention, and mental health.

The MHBG's objective is to support the grantees in carrying out plans for providing comprehensive community mental health services. Grantees can be flexible in the use of funds for both new and unique programs to supplement their current activities. SAMHSA's

[51] https://www.samhsa.gov/grants/block-grants/sabg
[52] https://www.samhsa.gov/grants-awards-by-state/CT/2018

Center for Mental Health Services (CMHS) also provides recipients with technical assistance to support evidence-based practices.

The SOR grant program aims to address the opioid crisis by increasing access to medication-assisted treatment (MAT) using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment needs, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorders (OUD). Grantees are required to use epidemiological data to demonstrate the critical gaps in availability of treatment for OUD's in geographic, demographic and service level terms; utilize evidence based implementation strategies to identify which system design models will most rapidly and adequately address the gaps in their systems of care; deliver evidence-based treatment interventions that include medication(s) FDA-approved specifically for the treatment of OUD, and psychosocial interventions; report progress toward increasing availability of medication-assisted treatment for OUD; and, reduce opioid-related overdose deaths.[53]

The purpose of the SPF-PFS grant program is to address one of the top substance use prevention priorities: underage drinking among persons age nine to 20. All New England states utilize their SPF-PFS funding differently and more information can be found about each state's use of the grant in Appendices C through H. States and tribes may also use grant funds to target up to two additional, data driven prevention priorities such as marijuana or tobacco use by individuals nine and above.

The SPF-PFS program is designed to ensure that prevention strategies and messages reach the populations most impacted by substance use. The program extends current established cross-agency and community-level partnerships by connecting prevention programming to social services and community service providers. This includes working with populations disproportionately impacted by the consequences of substance use; *i.e.,* children entering foster care, transitional youth, and individuals that support persons with substance use issues (women, families, parents, caregivers, and young adults).[54]

All six states have community-based coalitions funded directly by DFC SAMHSA.[55] According to SAMHSA, the DFC Support Program has two goals:[56]

1. Establish and strengthen collaboration among communities, public and private non-profit agencies, as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance use among youth; and
2. Reduce substance use among youth and, over time, reduce misuse among adults by addressing the factors in a community that increase the risk of substance use and promoting the factors that minimize the risk of misuse.

[53] https://www.samhsa.gov/grants/grant-announcements/ti-18-015
[54] https://www.samhsa.gov/newsroom/press-announcements/201805231100
[55] https://www.whitehouse.gov/wp-content/uploads/2018/08/DFC-New-Grant-Award-Recipients.pdf
[56] https://www.samhsa.gov/grants/grant-announcements/sp-19-005

Prevention Workforce Needs and Gaps

As prevention services is a developing field of study compared to treatment and recovery, the sophistication of prevention structures, workforces, policies, and practices vary. States have taken similar, but unique approaches to obtaining the same goals and objectives. Each has its strengths and weaknesses.

The six issues outlined below were found in the assessment as potential barriers and opportunities for the New England PTTC to positively influence prevention services.

Differing Definitions of Prevention

States across New England all define prevention a little differently. There are also differences within states based on the stakeholder. SAMHSA states that, "communities vary greatly in the specific problems they face, the groups affected by those problems, and the events that rouse people to take action. In addition to having different problems and priorities, some communities have more resources and experience with locally based prevention activities than others."[57]

Some of the difficulties associated with not having a concrete definition for prevention is that it is difficult for state level policy makers to really understand what prevention is. One interviewee stated, "leaders who are making decisions don't really understand what prevention is—they think they're putting money into it but they're not." Aside from funding concerns related to defining prevention, another difficulty stakeholders face is how to promote prevention within their communities in a meaningful way. Furthermore, communities all have varying needs when it comes to prevention, making it even more difficult to develop a succinct definition across states and the region.

Additionally, because of the lack of a singular definition of prevention, stakeholders struggle with defining their professional role and the scope of their work. Many expressed that it can be difficult to tell where prevention ends and where harm reduction and treatment begins. In a way this silos prevention work and often makes it a backdrop in the substance use services continuum. It also makes it difficult to measure the success of prevention work as there is no concrete way to measure effectiveness, especially without a clear description of the role it plays in the continuum.

Nonetheless, SAMHSA asserts that, "substance use prevention strategies are driven by the needs and urgency of communities throughout the US. Success is more likely when action is based on sound procedures, the best available information, and a long-range view."[58] Essential qualities for prevention strategy requires accountability, capacity and effectiveness. Prevention should be treated as a continuum; it ranges from deterring diseases and behaviors that foster them to slowing the onset and severity of illnesses when they do arise.

[57] https://store.samhsa.gov/system/files/sma10-4120.pdf
[58] https://store.samhsa.gov/system/files/sma10-4120.pdf

Systems of prevention services work better than isolated efforts. The best prevention results come from partnerships. Without teamwork, even the most determined prevention efforts can fall short of their goals. Some states across New England, like Rhode Island, have started to expand on these partnerships by creating regional networks for coalitions. However, states could use assistance in breaking down the silos that exist between prevention, treatment, harm reduction, recovery, and mental health.

The National Institute on Drug Abuse (NIDA) developed a list of 16 prevention principles that states can utilize to better promote positive prevention practices. These principles are centered around risk and protective factors, prevention planning and prevention program delivery which are underlying focuses of SAMHSA's SPF Framework. The PTTC should help prevention providers across New England implement these principles into their prevention framework to better define their roles. These principles include:

1. Prevention programs should enhance protective factors and reverse or reduce risk factors.
2. Prevention programs should address all forms of drug misuse, alone or in combination, including the underage use of legal drugs (*e.g.,* tobacco or alcohol); the use of illegal drugs (*e.g.,* marijuana or heroin); and the inappropriate use of legally obtained substances (*e.g.,* inhalants), prescription medications, or over-the-counter drugs.
3. Prevention programs should address the type of drug misuse problems in the local community, target modifiable risk factors, and strengthen identified protective factors.
4. Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.[59]

Other principles are centered around prevention planning relating to family programs, school programs and community programs. These include:

1. Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance misuse; and training in drug education and information.
2. Prevention programs can be designed to intervene as early as preschool to address risk factors for drug use, such as aggressive behavior, poor social skills, and academic difficulties.
3. Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug use, such as early aggression, academic failure, and school dropout.

[59] https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents-in-brief/prevention-principles

Education should focus on the following skills:

   a. self-control;
   b. emotional awareness;
   c. communication;
   d. social problem-solving; and
   e. academic support, especially in reading

4. Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills:
   a. study habits and academic support;
   b. communication;
   c. peer relationships;
   d. self-efficacy and assertiveness;
   e. drug resistance skills;
   f. reinforcement of anti-drug attitudes; and
   g. strengthening of personal commitments against drug use.
5. Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community.
6. Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.
7. Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting.

The last five principles in the NIDA framework are centered around prevention program delivery. These include:

1. When communities adapt programs to match their needs, community norms, or differing cultural requirements, they should retain core elements of the original research-based intervention which include:
   a. Structure (how the program is organized and constructed);
   b. Content (the information, skills, and strategies of the program); and
   c. Delivery (how the program is adapted, implemented, and evaluated).

2. Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school.
3. Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster students' positive behavior, achievement, academic motivation, and school bonding.
4. Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug misuse and reinforcing skills.
5. Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to $10 in treatment for alcohol or other substance misuse can be seen.

Limited Prevention Workforce Development

In addition to difficulty defining what substance use prevention is, states struggle with who should be included as primary stakeholders in the workforce and who constitutes prevention providers. About 40 percent (40%) of survey respondents considered substance use prevention specialist as their primary profession. Other professions included behavioral health, coalition director/leader, youth/social services, social worker, health educator, and public or business administrator, among others.

Furthermore, principal employment settings included not just substance use prevention coalitions but also government, non-profit agencies, state/local health departments, community health coalitions, and CAP agencies, among others. All these different stakeholders are doing prevention work in some capacity or another, which can make it difficult for states to define the workforce objectively. The PTTC should work closely with states to help them more accurately characterize who is working in the prevention field.

Interviewees were split on whether treatment, recovery, and mental health stakeholders should be included in PTTC collaboration, less so in Connecticut and Maine. One interviewee stated, "true prevention takes a community coalition approach and needs to be grassroots partnerships between different stakeholder groups." Interviewees in Massachusetts, New Hampshire and Vermont were more unsure about whether additional stakeholders should be included, while those in Rhode Island were predominately unsupportive of the notion.

> The field of prevention needs to be completely restructured. At the very least you should be aware of the common ground between treatment and recovery and then be ready to advise them on opportunities that might reveal themselves.
>
> *– Interviewee*

As diversifying the prevention workforce is a goal of SAMHSA, states across New England will have to come up with inventive ways to do so. Due to the demographic makeup of New England, which is comprised of individuals who are older and less racially/ethnically diverse than the rest of the United States it can be a challenge to recruit younger, more racially/ethnically diverse individuals into the field, especially in Maine, New Hampshire and Vermont.

It may be beneficial for states to broaden how they define diversity outside of race/ethnicity. For example, the prevention workforce is filled predominately with women, thus states could focus on recruiting more men. States can also look at including more individuals from health disparate populations. Adding more professionals with lived experience to the field could potentially be a positive workforce development strategy, as these individuals have a personal understanding of the drastic impacts of substance use.

Changing Landscape of Prevention Work and Mental Health Care

The field of substance use prevention and treatment is constantly changing and evolving. Social issues and concerns, and policy changes are impacting the way states view prevention and the work that is expected from providers. Some of these include marijuana legalization; alternative forms of tobacco use and vaping; the opioid epidemic; higher rates of drug use among baby boomers than previous cohorts; and the promotion of mental health and the intersection of health disparate population and drug use. These changes pose interesting challenges for prevention providers across New England.

Medical marijuana is legal in all six states and adult-use marijuana is legal in Maine, Massachusetts and Vermont. The legalization of marijuana has a social impact beyond substance use prevention. Specifically, states are grappling with the implications of legalization relating to DMV/driving laws and other public health outcomes associated with use. Prevention providers expressed a desire to begin working more closely with

Department of Transportation (DOT) and Highway Safety officials to assure that marijuana users do not drive under the influence.

Primary prevention specialists expressed concern about how to incorporate driving under the influence of marijuana education into driver's education courses for high school students. The New England PTTC may want to consider working with DOT and Highway Safety agencies to come up with a training curriculum that can be disseminated to prevention specialists and driver's education instructors. An additional concern that states grapple with, is how to effectively assess a marijuana users' level of intoxication. The New England PTTC should consider providing educational resources and literature about how other states across the country that have legalized marijuana have updated driving laws as they relate to marijuana use.

Vaping is another emerging concern for prevention providers. Vaping apparatus' can be used to smoke both tobacco and marijuana products. These devices make it easier for youth to hide their drug and tobacco use from their parents/caregivers and makes it easier to engage in these activities in school. Vaping products are heavily marketed towards youth – companies like Juul sell fruity flavored tobacco cartridges that are especially intriguing to children. The vaping landscape is changing as we write, with new prohibitions on products and access being introduced daily. Prevention providers want more literature on vaping and technical assistance on how to develop media campaigns targeted towards parents and youth about the dangers of vaping.

An additional concern for vaping is that illegal, unregulated cartridges are being sold making people sick or even causing death. Over 500 people have been hospitalized in the last six months and at least nine deaths have occurred.[60] Some states have banned vaping for some or all of the population both for these health concerns and the absence of FDA approval.

The opioid epidemic and increased federal funding to curtail it has created additional needs for prevention providers, but in an unexpected way. Traditionally, their work in primary prevention has focused on youth. Many interviewees expressed that opioids are not the main concern for youth, and very few youths engage in any related opioid use. Instead, underage alcohol, marijuana, and tobacco/vaping use are their substances of choice.

Federal dollars are being funneled to states for opioid prevention which requires expanding the role of prevention providers beyond primary prevention. However, one interviewee expressed, "it's [overdose prevention] not really prevention, it's really more harm reduction." Another proclaimed, "The influx of opioid dollars in the state is driving a lot of prevention and shaping a prevention focus. It used to be we had limited resources and now we have so many resources coming in from different partners, so we have to work together strategically. Opioid funding is a challenge because we are being tasked

[60] https://www.vox.com/science-and-health/2019/9/3/20847219/vaping-health-risks-2019-lung-damage-death

with putting the money to use but also making programs sustainable and opioid use seems to be the flavor of the day, so how do we build something with sustainable capacity beyond the opioid crisis?"

Battling the opioid epidemic requires prevention providers to move beyond their typical engagement with youth. A slightly older population, 18- to 25-year-olds, are far more likely to misuse opioids. The New England PTTC should consider ways to provide training and technical assistance on how prevention providers can best serve this population. Additionally, new research shows higher rates of drug use among baby boomers than previous cohorts, which is another area prevention providers are hoping to address.

As the need for prevention has become more prominent, providers have come to look at solutions more holistically. This has involved shifting practices from traditional, educational strategies to a more public and mental health approach. Additionally, scientific evidence shows that there are links between substance use and misuse and mental health disorders. These links are likely to be more prevalent in certain health disparate populations, such as the LGBTQ community and military veterans. Youth risk factors also have disproportionate impact on youth who have experienced abuse or foster care or who have parents with substance use disorders. Prevention providers and coalition leaders require more information on how to effectively reach these population within their communities. They also want literature on how to promote prevention from a mental health lens. Better collaboration among prevention and mental health providers would be beneficial.

Limited Funding and Grants

Additional federal block grant dollars and collaboration with mental health agencies and providers have changed the funding structure of prevention work in New England. However, prevention providers fear that state level policy makers do not understand prevention intrinsically. One interviewee stated, "Prevention is something people never see in the media outlet – there is a need for training for state leaders and government as well as local leaders." This makes getting state level funding approved increasingly difficult and forces coalitions to rely on federal block grants.

Another interviewee was hesitant to promote the prevention field to high school and college students due to a lack of job security prompted by unguaranteed funding streams. The use of grants, whether state or federal, to fund coalitions is unreliable because coalitions are not guaranteed to win bids to receive them. While state funding can also be unreliable, with budget alterations made every year and a half, many interviewees expressed that they wished their policy makers would invest state funds in substance use prevention.

The New England PTTC may consider providing training courses or hosting a conference for state leaders and policy makers demonstrating the advantages of funding prevention which states can use themselves. Additionally, the New England PTTC may consider identifying smaller grant opportunities, including private sources, that can be made

available on the website.

Restrictions in Evidence-Based Practices and Data Collection

Prevention providers who are receiving federal block grant dollars and other federal funds from PFS and DFC grants are required to use evidence-based practices and collect data on the work that they are doing. Many perceived this an area of weakness. Some stakeholders struggled with how evidence-based is defined, especially since NREPP has been disabled. Others voiced concern with their capacity for data collection and insufficient knowledge in conducting effective evaluations.

Data collection is something that all six states in New England have struggled with, particularly disaggregating data past a county level, if that. Additionally, some school districts have chosen not to disseminate the YRBS, making it harder for coalitions to see data about their particular communities. The New England PTTC should consider providing regional coalitions assistance in creating community profiles as well as data analysis trainings.

Misaligned Training and Technical Assistance

All of these factors – defining prevention practices; prevention workforce development; the changing landscape of prevention work and mental health care; funding and grants; and evidence-based practices and data collection – have impacted the training and TA needs of prevention providers across New England. Most stakeholders think there is adequate training for beginners, but that advanced topics are severely lacking. This includes access to online, self-paced ethics and advanced ethics coursework as it is a requirement for certification and re-certification.

Over half of survey respondents from Connecticut, Massachusetts, and Vermont said they would like to receive more advanced trainings on program planning and sustainability; over half of survey respondents in Maine want more training and TA on funding options; and over half of survey respondents from New Hampshire and Rhode Island would like additional training on both. Of all respondents, 81 percent would like to learn more about funding options; 32 percent of respondents shared the same sentiment about planning and program sustainability. Some of the largest gaps in confidence relate to sustainability and funding stream development. Interviewees shared that they felt the least well trained in how to sustain coalition capacity, and grant writing to increase capacity and funding.

Another looming training concern was cultural competency. Interviewees in all six states struggle with cultural competency within the workforce, some more than others. They also want help with how to engage with health disparate populations, and people with co-occurring disorders; suicide assessment and prevention; advanced skills and knowledge in working with diverse populations; and identifying risk and protective factors that impact disparate populations.

Stakeholders across New England recommended that future technical assistance/training opportunities should:

- Provide advanced trainings;
- Collaborate with other communities and states;
- Provide multiple modalities of training;
- Create frequent training opportunities;
- Pay attention to what constitutes effective evidence-based prevention policies and practices;
- Expand training and bringing prevention into other sectors;
- Consider new ways to tie prevention efforts to public health initiatives;
- Move away from content and focusing on skills and application of knowledge to practice; and
- Develop a prevention system of care to legitimize the field and increase efficiency.

Stakeholders across New England would like more information on:

- How to effectively communicate prevention to the general public and outside stakeholders;
- How to develop a public health focus on prevention;
- How to develop community capacity and readiness for change;
- How to effectively recruit and retain individuals in the workforce, especially from diverse populations;
- How to build an evidence-based curriculum;
- How to engage health disparate populations;
- How to effectively engage with and work with the youth and young adult populations;
- How to collect, analyze and disseminate data; and
- How to manage coalitions, including budget management and grant writing training.

Recommendations

Despite different approaches and philosophies across states and stakeholders, prevention professionals expressed a genuine need for the New England PTTC. Substance use prevention is complicated and requires a fine balance between the use of evidence-based strategies, prescribed requirements, and creativity for outreach and problem-solving. Analysis of the needs and gaps, stakeholder interviews, workforce survey, and literature review yielded several recommendations. They are described below.

Promote a Consistent Definition of Prevention

It cannot be understated that defining prevention in a way that offers clear guidance to the roles of states and professionals has several challenges. However, this assessment offers that New England stakeholders start with a common definition. PCG suggests the following:

> *Prevention is a strategy or set of strategies for creating protective factors and conditions that promote individual and community health while reducing risk factors that have a substantial impact on well-being. Proactively addressing these factors via evidence-based education, programs, policies, and practices can help prevent substance misuse and have an impact on related topics such as mental health and violence.*

Using this as a basis of discussion, stakeholders can further operationalize and define target populations, strategies, and prevention partners. Having a complete definition will help states more clearly collaborate with each other and the appropriate strategic partners, request funding, track data, provide training and education to the workforce, and develop comprehensive programs, policies, and practices.

Partner with State-level Prevention Training and Technical Assistance Agencies

The needs of the New England prevention workforce are complex, with several agencies (state and national) currently engaged in providing some level of training and technical assistance. The New England PTTC should seek to partner with current providers to avoid duplication of training and services, increase workforce reach, and maximize funding sources to meet as many needs as possible.

In addition to offering regional trainings and technical assistance, the New England PTTC could assist training and technical assistance partners in the development of specific trainings to meet the needs of the workforce, such as interpersonal skill trainings on cultural competence/ humility and how to work with diverse populations. The extended reach of training and technical assistance may also allow for more ability to coordinate and contract with local schools in less centralized areas to provide in-person trainings and other prevention events.

Expand Repository of Data and Prevention Resources

The national PTTC Network has already begun to create a repository of resources for the prevention workforce. The New England PTTC should continue to support development of this repository with specific focus on state and federal policy changes and development of curriculum around emerging issues such as marijuana legalization and vaping.

Additionally, several stakeholders interviewed for this assessment were unaware that such a resource now exists. The New England PTTC should work to promote and publicize this resource among stakeholders.

Standardize Prevention Data Collection

While states collect similar data about substance use and the prevention workforce, they are not identical; thus, it can be difficult for prevention professionals, researchers, or the general public to know if apples to apples comparisons can be made. This impacts not only informed decisions about prevention services but also the ability to demonstrate change over time and program impact. The creation of standardized prevention data collection could allow for baselines metrics to be calculated between and among states not only for substance use but also for workforce strengths, gaps, and needs.

Create Networking Platform for Professionals Across New England

Several stakeholders identified a lack of collaborative opportunities for prevention professionals. As conferences and trainings are largely the places where people network, opportunities are limited for professionals who cannot afford to travel or who have inter-state travel restrictions.

The New England PTTC is primed to support a collaborative platform for prevention professionals. The organization should seek to develop a comprehensive platform that includes but is not exclusive to an annual strategic planning meeting with each state NPN representative and other driving agents, routinized conference or web-based calls with high-level facilitation so that professionals can discuss specific issues/ needs, financial support for prevention agencies to send representatives to key prevention conferences, and a web-based discussion forum.

Online System to Track Certification Progress

Currently, each state independently tracks prevention board certifications, but there is no single source for national certification. It is also not currently possible to identify or track professionals who are in the process of becoming certified. Thus, the transfer process of professional certification between states can be cumbersome and the recruitment of prevention professionals is operating in a vacuum without knowing which geographic areas are most in need.

Creation of a system to track certification on a larger scale will enable more effective recruitment and decrease barriers for service provision of professionals working across state borders.

Appendices

Appendix A: New England Demographics

State-Level Demographics

Rurality, cultural diversity, and age of the workforce are three initiatives noted in the SAMHSA collaborative agreement. Table 11 examines how each plays a role in the substance use prevention workforce within New England.

Table 11. State Demographics[61]

	CT	ME	MA	NH	RI	VT
State population	3.5 mil	1.3 mil	6.9 mil	1.3 mil	1.0 mil	626,299
Population per square mile	738.1	43.1	839.4	147.0	1018.1	67.9
Population Race						
White	80%	95%	81%	94%	84%	95%
African American	12%	2%	9%	2%	8%	1%
American Indian	1%	1%	1%	0%	1%	0%
Asian	5%	1%	7%	3%	4%	2%
Hispanic	16%	2%	12%	4%	16%	2%
Population 65 years +	17%	21%	17%	18%	17%	19%

New England state populations are largely white, non-Hispanic. However, Connecticut, Massachusetts, and Rhode Island report more diverse populations than Maine, New Hampshire, and Vermont. While workforce diversity is important, it is also important that the workforce reflect the population it serves. Therefore, it does not seem unreasonable that the surveyed New England prevention workforce includes mostly white, non-Hispanic people.

The population of the New England states is also older than the national average. On average, 16 percent of people in the US are 65 years and older; however, New England populations in this older age group range between 17 and 21 percent of the states' respective populations.

[61] https://www.census.gov/quickfacts/

Prevention Workforce Survey Demographics

Table 12. Workforce Survey Demographics

Demographics	CT	ME	MA	NH	RI	VT	Overall
Sex							
Female	84%	79%	84%	96%	75%	86%	**84%**
Male	16%	21%	16%	4%	25%	14%	**16%**
Race							
White	93%	95%	78%	79%	90%	87%	**87%**
African American	5%	–	6%	–	–	7%	**3%**
American Indian	2%	3%	2%	–	–	–	**1%**
Asian	–	–	2%	3%	5%	–	**2%**
Alaskan Native	–	–	2%	3%	–	–	**1%**
Other	–	3%	6%	3%	–	7%	**3%**
Hispanic	–	–	6%	10%	5%	–	**3%**
Age							
18 to 25 years	7%	–	10%	8%	11%	–	**6%**
26 to 35 years	30%	23%	20%	17%	11%	29%	**21%**
36 to 49 years	28%	28%	41%	33%	26%	36%	**32%**
50 + years	35%	50%	29%	42%	53%	36%	**41%**
Highest Degree Earned							
High school diploma	–	–	–	–	5%	7%	**2%**
Some college	2%	10%	6%	13%	5%	7%	**7%**
Associate's	2%	7%	2%	4%	5%	–	**3%**
Bachelor's	28%	24%	33%	33%	10%	36%	**27%**
Some graduate school	–	–	2%	–	–	–	**–**
Master's	65%	55%	53%	50%	55%	43%	**53%**
Doctoral or equivalent	2%	5%	4%	–	20%	7%	**6%**
Years Spent in Prevention Field							
Less than 1	5%	7%	4%	4%	15%	7%	**7%**
1 to 5 years	21%	24%	37%	30%	35%	43%	**32%**
5 to 10 years	16%	17%	20%	13%	15%	14%	**16%**
10 to 20 years	35%	20%	28%	26%	15%	36%	**27%**
More than 20 years	23%	32%	11%	26%	20%	–	**19%**
Disparate Population							
Pregnant women	19%	17%	18%	30%	22%	23%	**22%**
Trauma survivors	19%	13%	18%	15%	6%	12%	**14%**
Unemployed	8%	8%	11%	4%	17%	19%	**11%**
LGBT	8%	9%	7%	11%	28%	4%	**11%**
People in the criminal justice system	4%	9%	8%	4%	6%	8%	**6%**
Homeless	8%	6%	8%	11%	0%	4%	**6%**

Demographics	CT	ME	MA	NH	RI	VT	Overall
Military and veterans	0%	9%	4%	4%	6%	12%	**6%**
People with developmental disabilities	4%	8%	4%	4%	0%	8%	**4%**
People in the juvenile justice system	4%	3%	6%	4%	0%	0%	**3%**
People with physical disabilities	4%	5%	2%	7%	0%	0%	**3%**
People with HIV or AIDS	0%	5%	4%	0%	0%	4%	**2%**

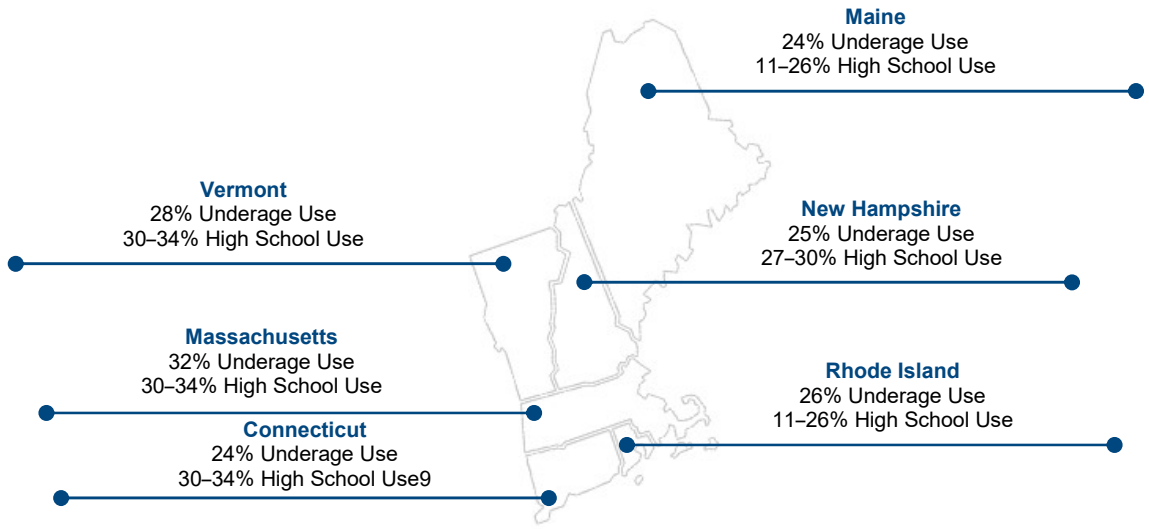
New England's prevention workforce includes a disproportionate number of women. States and the PTTC may want to consider how they can recruit more men into the workforce. Additionally, over 50 percent of both Maine and Rhode Island's prevention workforces are 50 years of age or older, nearing or at the age of retirement. Both states will likely require assistance in recruiting additional staff as the role of prevention continues to expand. Furthermore, half of Rhode Island's prevention workforce are beginners in the field, with less than five years' experience, so retention may be an additional concern.

Appendix B: Scope of Substance Use in New England

Since states vary in the ways they measure substance use, this needs assessment employs two, national data sets for comparisons, the National Survey on Drug Use and Health (NSDUH) and the Youth Risk Behavior Survey (YRBS).

The National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control cite the legal drinking age in the US as 21. According to the NSDUH, approximately one-quarter of 12 to 20-year-olds have consumed alcohol. According to YRBS,[62] approximately one-third of Connecticut, Massachusetts, Vermont, and New Hampshire high school students report current alcohol use. Maine and Rhode Island students report somewhat lower rates of use, between 11 and 26 percent. This means that up to a third of young people in New England have illegally consumed alcohol.

Figure 16. Alcohol Use by State



Medical marijuana is legal in all New England states, though the legal age of use varies among the states. Adults over the age of 18 in Connecticut and Vermont may use medical marijuana, but adults must be 21 in Maine, Massachusetts, New Hampshire, and Rhode Island.[63] Adult-use marijuana is also legal for adults over the age of 21 in Maine, Massachusetts, and Vermont. However, it is not legal in Connecticut, New Hampshire, and Rhode Island.[64]

[62] The YRBS is usually conducted during the spring of odd-numbered years (9th and 11th grade) which means that not every grade is being surveyed every year. States can also opt out or implement their own youth surveys. Therefore, when the YRBS reports results, they generally offer ranges for substance use to include confidence intervals around median scores.
[63] https://www.marijuanadoctors.com/blog/medical-marijuana-age-requirement/
[64] https://en.wikipedia.org/wiki/Minors_and_the_legality_of_cannabis#cite_note-the_marijuana_legalization_movement_in_the_states-5

YRBS data suggests that between a fifth and a quarter of high school students currently use marijuana, which is illegal regardless of state. Further, NSDUH reports increased rates of use for 18- to 25-year-olds, to about a third.

Table 13. Marijuana Use by State

	CT	ME	MA	NH	RI	VT
High School Students Who Currently Use Marijuana[65]	19% – 21%	19% – 21%	21% – 27%	21% – 27%	19% – 21%	21% – 27%
Marijuana use in past month (18-25)[66]	30%	34%	30%	29%	32%	39%
Marijuana use in past month (18+)[67]	11%	16%	14%	13%	16%	19%
High School Students Who Currently Use an Electronic Vapor Product[68]	–	14% –17%	17% – 26%	17% – 26%	17% – 26%	12% – 14%

The advent of electronic cigarettes and vaping products has muddied prevention efforts as it is more difficult to determine what substance is being consumed. The federal legal age to purchase or smoke tobacco is 18. However, the national Campaign for Tobacco Free-Kids has pushed to raise the legal age in several states, including Connecticut, Maine, Massachusetts, and Vermont to 21.[69] Regardless of substance type, according to YRBS, approximately 12 to 26 percent of New England high school students have used an electronic vapor product. Connecticut did not report this information for the YRBS.

Several New England states have also targeted prescription drug misuse in their prevention efforts. YRBS reports that, generally, between eight and 11 percent of high school students reported using non-medical prescription drugs, which is illegal at any age. However, YRBS data were not available for Massachusetts or New Hampshire.

[65] US Dept. of Health and Human Services, Centers for Disease Control and Prevention (2017) National Youth Risk Behavior Survey [PowerPoint slides]. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

[66] https://pdas.samhsa.gov/saes/state

[67] https://pdas.samhsa.gov/saes/state

[68] US Dept. of Health and Human Services, Centers for Disease Control and Prevention (2017) National Youth Risk Behavior Survey [PowerPoint slides]. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

[69] https://www.tobaccofreekids.org/assets/content/what_we_do/state_local_issues/sales_21/states_localities_MLSA_21.pdf

Appendix C: Connecticut State Profile

Connecticut is home to approximately 3.6 million people with an average of 738.1 people per square mile according to the Census Bureau.[70] Thus, Connecticut is the third most densely populated New England state, behind Rhode Island and Massachusetts, respectively.

The population is 80 percent White; 16.5 percent Hispanic or Latino; 12 percent African American; and five percent Asian, making it racially and ethnically diverse. Seventeen percent of the population is over 65, which is slightly higher than the national average. These three facts (rurality, race/ethnicity, and age) present unique opportunities for the diverse workforce recruitment of Connecticut, an aim of SAMHSA and the PTTC.

Prevention Defined

According to Connecticut's Department of Mental Health and Addiction Services (DMHAS), prevention is defined as "creating conditions that promote good health. It is achieved by reducing those factors that are known to cause illness and problem behaviors and encouraging those factors that buffer individuals and promote good health."[71] The goal of prevention is to "promote the overall health and wellness of individuals and communities by preventing or delaying substance use."[72] Connecticut's prevention services comprise six key strategies including, information dissemination; education; alternative activities; strengthening communities; promoting positive values; and, identifying and referring individuals to services. The mission of prevention is to "build a system approach to strengthen local capacity and to support local empowerment in meeting the needs of their communities and implementing prevention programs."[73]

Structure of Prevention Services

The Connecticut DMHAS established five distinct regions for behavioral health services. Prevention services within these regions are comprised of nine components: Prevention Infrastructure (four Statewide Resource Links that support prevention services statewide); Connecticut's Strategic Framework Coalition Initiative; 156 Local Prevention Councils; Tobacco Prevention and Enforcement Initiatives; five Regional Behavioral Health Action Organizations; the *Partnerships for Success 2015* Initiative; and the Connecticut Youth Suicide Prevention Initiative. Past initiatives also include the *Safe Schools Healthy Students* Initiative and the *Now is the Time Healthy Transitions: CT STRONG* program.

[70] https://www.census.gov/quickfacts/
[71] https://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendium.pdf
[72] https://www.ct.gov/dmhas/cwp/view.asp?a=2912&Q=335152&dmhasNav=|
[73] https://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendium.pdf

Connecticut DMHAS' Prevention and Health Promotion Division is "strategically aligned with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Network (SPF)" and work is guided by the SPF five steps model.[74] Connecticut is also comprised of two state advisory councils including the Connecticut Alcohol and Drug Policy Council (ADPC) and the Connecticut Suicide Advisory Board.

Prevention Funding

According to the state's Prevention and Health Promotion Division Compendium, Connecticut has various state and federal funding sources for prevention services, including:

Table 14. Connecticut - Prevention Funding Sources

Prevention Funding Sources[75]
1. SAMHSA Center for Mental Health Services
2. SAMHSA Center for Substance Abuse Prevention Partnerships for Success 2015 Grants
3. SAMHSA Substance Abuse Prevention and Treatment Block Grant (SABG)
4. SAMHSA Drug Free Communities Grants
5. State Drug Assets Forfeiture Revolving Account
6. State Pretrial Alcohol Education Services
7. Social Services Block Grant
8. Federal Food and Drug Administration
9. State Tobacco and Health Trust Fund
10. Other Grant Funds (Courage to Speak Foundation; The Specialized Crisis Intervention Teams Grant; Safe Schools/Healthy Student Grant

Connecticut receives much of its prevention funding through SAMHSA block grants and other federal sources. State representatives expressed that there is a limited amount of state dollars spent on prevention work.

Table 15. Connecticut SAMHSA Funding Sources[76]

Funding Source	Substance Use Treatment	Substance Use Prevention	Mental Health	Total
Substance Abuse Prevention and Treatment Block Grant (SABG)	–	–	–	$18,479,143
SAMHSA - Discretionary Funding	$22,767,834	$4,311,787	$15,534,999	$42,614,620
Community Mental Health Services Block Grant	–	–	$7,304,951	$7,304,951

Information on the percentage of the block grants being spent on substance use prevention was unavailable. However, focusing on discretionary funding, it looks as more than half of the funding Connecticut receives is spent on treatment versus prevention.

[74] https://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendium.pdf
[75] https://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendium.pdf
[76] https://www.samhsa.gov/grants-awards-by-state/CT/2018

Scope of Prevention Work

Connecticut's Prevention and Health Promotion services and programs fall into three categories: universal, selected, and indicated. The comprehensive system is aligned with SAMHSA's Center for Substance Abuse Prevention's (CSAP) concepts of performance management which includes, management and organization; program infrastructure; planning, needs assessment, resource allocation, and data collection; coordination with other agencies; and, quality assurance and improvement.[77]

Connecticut believes all policy, funding, training, and communication decisions should be supported by evidence-based strategies. DMHAS uses the SPF model and has implemented a statewide data driven needs assessment process, spearheaded by the State Epidemiological Outcomes Workgroup (SEOW).[78] The SEOW also created a data portal to easily share data among key stakeholders. Some SEOW Data Resources include: the Connecticut Crash Data Repository (CTCDR); the Connecticut Data Collaborative; the Connecticut School Health Survey; the Connecticut Open Data Initiative and Portal; the Drug Enforcement Administration; the Behavioral Risk Factor Surveillance System (BRFSS); and, the National Survey on Drug Use and Health (NSDUH).[79]

DMHAS prevention programs are organized into five categories: Statewide Resource Links and Behavioral Health Action Organizations; community and evidence-based substance use and misuse prevention projects; community and evidence-based suicide prevention and school-based efforts; programs aimed at reducing access of tobacco products to underage youth; and programs that support youth and adults ages five to 25.

There is a growing understanding about the importance of interagency coordination in prevention efforts and some of the key stakeholders in Connecticut include: provider agencies; parents and youth; law enforcement; legislators; schools; state agencies; and, the public sector.[80] Connecticut also has a statewide media campaign to promote prevention efforts and align key stakeholders.

- **Change the Script** statewide public awareness campaign to help communities deal with the prescription drug and opioid misuse crisis.[81]

State Prevention Workforce

Connecticut's strategy of using a system's approach to strengthen local capacity in prevention necessitates that multiple professional specialties work collaboratively. Stakeholders estimate that there are approximately 100 people doing primary prevention work in Connecticut, but many more are working in tandem with these professionals.

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[77] https://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendium.pdf
[78] https://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendium.pdf
[79] http://preventionportal.ctdata.org/resources.html
[80] https://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendium.pdf
[81] https://www.ct.gov/dmhas/cwp/view.asp?a=2912&q=600280

Workforce Survey

Using existing prevention workforce surveys from the IC & RC, as well as those conducted in Connecticut, Maine, Massachusetts, and Rhode Island, PCG developed a refined, web-based workforce survey which was disseminated in late July 2019. PCG used a snowball sampling method to disseminate the survey, wherein prevention leadership and stakeholder interviewees helped PCG in emailing the survey to their respective listservs.

The resulting workforce sample included 209 total stakeholders from various levels of prevention, comprising state level policy makers, prevention administrators, and prevention field staff, from all six states. A total of 44 people responded from Connecticut.

State Board Certifications

The Connecticut Certification Board (CCB) supports the International Certification & Reciprocity Consortium (IC & RC) Certified Prevention Specialist (CPS) certification,[82] identifying 44 certified prevention professionals in Connecticut. The state offers reciprocity certification via a transfer of IC & RC credentials to those who are fully certified with the IC & RC and CCB.[83]

To become a Certified Prevention Specialist in Connecticut, applicants must have[84]:

- 2,000 hours of supervised prevention experience across the domains;
- 100 hours of prevention specific education, including 50 hours of ATOD specific education, six hours specific to prevention ethics, and six hours specific to problem gambling;
- 120 hours of supervised practicum specific to the six IC & RC prevention domains with a minimum of 10 hours in each domain;
- Three positive professional references with one from a current or most recent supervisor and two from professional colleagues (preferably CCB credentialed); and
- a passing score on the IC & RC prevention specialist exam.

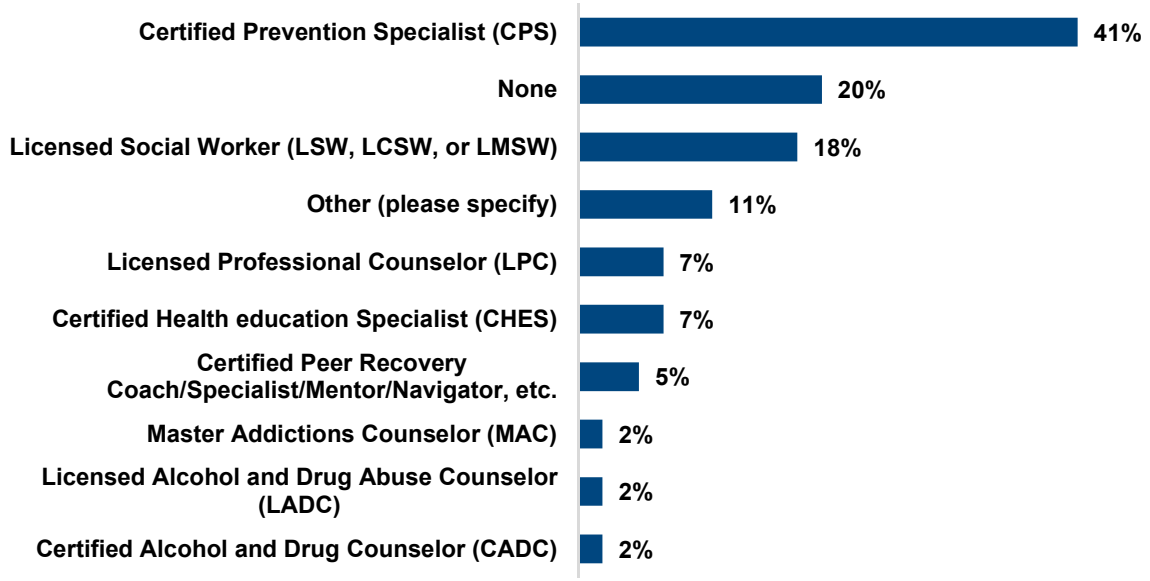
To become a certified CPS, candidates must demonstrate they have completed the appropriate education, training, and supervised experience relevant to the performance domains. The exam tests candidate's knowledge in each of SAMHSA's six domains: planning and evaluation, prevention education and service delivery, communication, community organization, public policy and environmental change, and professional growth and responsibility.[85]

[82] https://www.ctcertboard.org/
[83] https://www.ctcertboard.org/reciprocity-transfer-of-ic-rc-credentials
[84] https://www.ctcertboard.org/files/pdfs/CPS%20Application.pdf
[85] https://www.ctcertboard.org/files/pdfs/CPS%20Application.pdf

Annual re-certification requires twenty hours of documented, prevention specific continuing education.

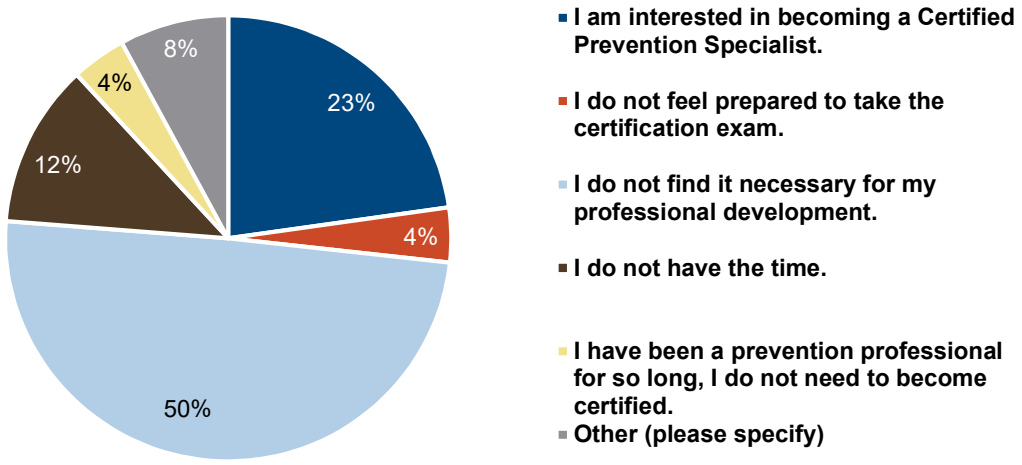
Prevention certification is not a requirement to work in the field. The PCG workforce survey showed that approximately 41 percent of respondents were CPS certified while 20 percent had no certification or licensure. When other certifications and licensures are considered, it appears a large portion of Connecticut's prevention workforce understands the value in obtaining their certification.

Figure 17. Connecticut - Professional Certifications and Licensures



Of those who were not certified, half did not find certification necessary for their professional development. Many of those were employed in prevention adjacent fields, like research, social work, or the medical field. Of respondents who chose "other," they indicated that they were very close to becoming certified with very few classes left or were just waiting to take the exam.

Figure 18. Connecticut - Feelings About Becoming Certified Prevention Specialist



Connecticut's Strategic Plan

The Prevention and Health Promotion Division of DMHAS uses state policy plans and recommendations, individual agencies' strategic plans and SAMHSA goals to guide the strategic plan for prevention. It focuses on four main themes: quality of care management; improved service system; workforce and organizational effectiveness; and resource base. The broad outcome for the strategic plan is to quantifiably decrease substance use, misuse, suicide, and suicide attempt rates across the state.[86]

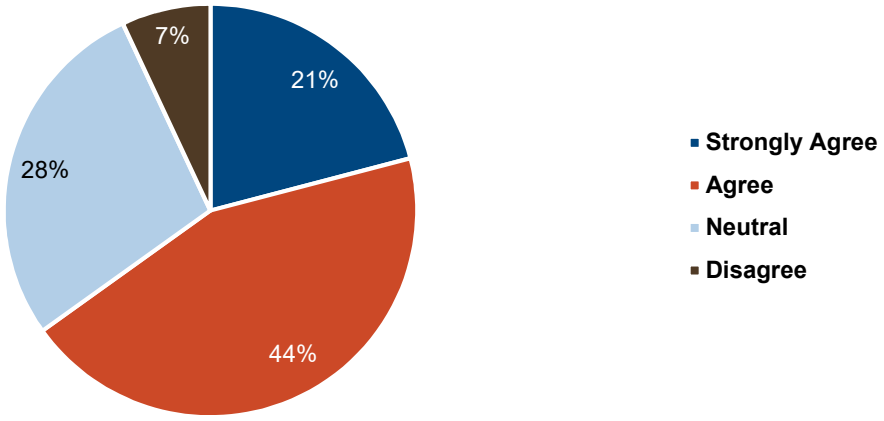
The goals of the four main themes are:[87]

- **Quality of Care Management:** Continue to provide a quality care management system to achieve defined goals, services outcomes and the improvement of the integrated DHMAS health care system.
- **Improved Service System:** Maintain a broad array of programs and practices that are data informed and will respond to changing needs as the prevention system grows.
- **Workforce and Organizational Effectiveness:** Increase workforce capacity to provide culturally competent and integrated services to persons whose needs are challenging or not well met.
- **Resource Base:** Increase funding to fulfill unmet needs; support prevention service and management goals; and, leverage TA from state and national experts and agencies.

[86] https://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendium.pdf
[87] https://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendium.pdf

Part of the state's strategic plan aims to increase workforce capacity around cultural competency. According to the PCG workforce survey, 65 percent of respondents agreed or strongly agreed Connecticut was actively working to promote diversity in the workforce. However, more than a quarter of respondents were neutral on this topic. This suggests that Connecticut is moving in the right direction but could use more support from organizations like the New England PTTC in these endeavors.

Figure 19. Connecticut - State Promotes Diversity in the Workforce

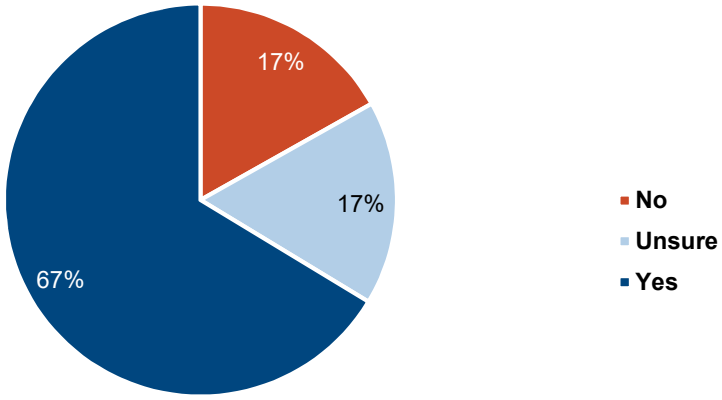


Current Training Availability

Connecticut has a multitude of platforms that provide prevention education and training. The state has the Prevention Training and Technical Assistance Service Center (TTASC), the Governor's Prevention Partnership, the Connecticut Clearinghouse by Wheeler Clinic, and the Connecticut Association of Prevention Professionals (CAPP) which both provide in person trainings and technical assistance on various prevention work topics. DMHAS has also provided prevention trainings and seminars that are typically hosted by the state's National Prevention Network (NPN) representative. Prevention professionals are also able to receive free online training from the Community Anti-Drug Coalitions of America (CADCA) website.

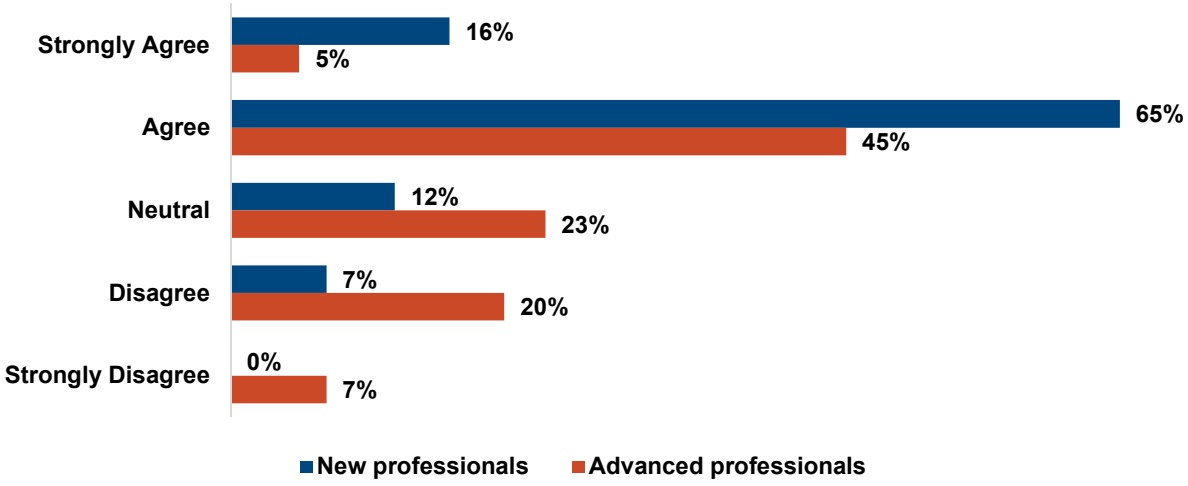
Despite having access to a variety of training sources, a third of prevention professionals who responded to the workforce survey stated that they did not have access to career development opportunities that matched their career goals or were not sure if they did.

Figure 20. Connecticut – Access to Career Development Opportunities



When asked specifically about adequate educational or training opportunities for new professionals (with five or fewer years of experience) and advanced professionals (with 10 or more years of experience), the gaps became clearer. Respondents were more likely to indicate there was more adequate training for new professionals than for those who are more seasoned. This finding aligns with stakeholder interviews which suggested that many New England states are lacking sufficient training options for advanced professionals, especially around core knowledge areas, like prevention ethics.

Figure 21. Connecticut - Availability of Training and Education



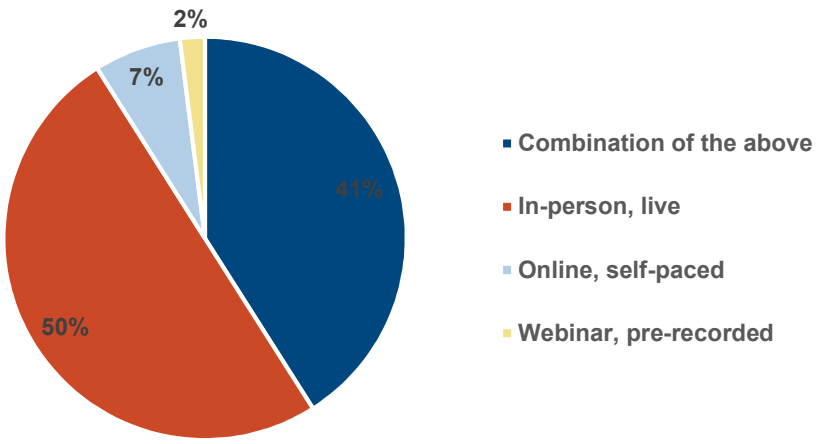
More than half of survey respondents from Connecticut requested the following topics for training and education.

Table 16. Connecticut - Most Requested Training Topics

Topics of Interest	Percent Wanting More Training
Strategies to reduce SUD stigma	70%
Co-occurring disorders	70%
Funding options	68%
Social and environmental factors affecting substance use prevention	64%
Planning program sustainability	61%
Interpreting data to identify community needs	59%
Engagement of priority populations in prevention	57%
Mobilization and engagement of community stakeholders	55%
E-cigarettes/ Vaping	55%
Identifying community readiness to implement prevention interventions	52%
Integrated models of care with interprofessional teams	52%
Advanced skills and knowledge in working with diverse populations	52%
Suicide assessment and prevention	52%
Identifying risk and protective factors that impact disparate populations	52%
Ethical issues related to use of technology in delivering client/patient services	52%
Identifying community assets and resources (human, fiscal, and organizational)	52%
Motivational interviewing	52%
Management skills	50%
SBIRT	50%
Organizational change strategies	50%

They also noted some preferences in training modality. While half of respondents have a clear preference for in-person training, a substantial portion (41%) would like a combination of training offerings.

Figure 22. Connecticut - Training Modality Preference



Gaps and Needs

Recommendations offered by stakeholders to improve future technical assistance/ training opportunities include:

- Providing advanced level in-person trainings;
- Working with practitioners at the local level;
- Collaborating with other communities and states;
- Providing a variety of in person, online, and webinar trainings;
- Marketing specific availability of different course offerings; and
- Delivering on-boarding training options for new employees in the field.

Stakeholders would also like more information on:

- A public health focus of prevention;
- Community capacity and readiness for change;
- Management training;
- Effective recruitment;
- Data capacity training; and
- Communicating prevention to the general public and outside stakeholders.

Appendix D: Maine State Profile

Maine is home to 1.3 million people with an average of 43.1 people per square mile according to the Census Bureau.[88] Maine is the most rural of the six New England states. The population is also primarily white (95%) with only one to two percent identifying as African American, American Indian, Asian, or Hispanic. More than 20 percent of the population is over the age of 65, higher than any of the other New England states and greater than the national average of 16 percent. While workforce diversity is a goal for SAMHSA and the New England PTTC, if the Maine prevention workforce were reflective of the population it serves, diversity would be limited regardless unless male to female diversity were considered.

Prevention Defined

According to the Maine Center for Disease Control and Prevention (CDC), prevention is defined as "the active, assertive process of creating conditions that promote well-being."[89] The state's goal for prevention services is to prevent and reduce "substance abuse and mental illness and related problems by providing leadership, education and support to communities and institutions" to help Mainers avoid personal and societal costs, like loss of productivity and health, crime, family disintegration, loss of employment, failure in school, domestic violence, and child abuse .[90]

Structure of Prevention Services

The state has structured services using SAMHSA's Strategic Prevention Framework model to improve the capacity to deliver prevention services and to fund evidence-based prevention services using data to identify areas of need.[91] As such, the Maine CDC and community partners have formed a collaborative, Maine Prevention Services, to target obesity, tobacco and substance use across the state. The idea is that Maine Prevention Services, Drug Free Community Coalitions, communities, consumers and a variety of organizations in the state, work together to provide funding, technical assistance and training to educate Mainers with the understanding that wellness is a core component of prevention. Stakeholders recognize that no one strategy will be effective in reaching all populations so organizations should be encouraged to use a variety of approaches.

The Maine CDC divides prevention services into five domains under the umbrella of Maine Prevention Services: substance use, tobacco use and exposure, youth engagement and empowerment, mass reach health communication, and obesity. The substance use prevention domain is led by the University of New England (UNE) and works with "20 community organizations statewide to prevent youth from using alcohol or marijuana, or misusing prescription drugs. This work is done in partnership with schools, law enforcement, community agencies and health care providers among others."[92] The Maine CDC also contracts with other providers, outside of UNE, to implement substance

[88] https://www.census.gov/quickfacts/
[89] https://digitalmaine.com/osamhs_docs/1/
[90] https://www.maine.gov/dhhs/mecdc/population-health/prevention/
[91] https://www.maine.gov/dhhs/mecdc/population-health/prevention/community/index.htm
[92] https://www.maine.gov/dhhs/mecdc/population-health/prevention/maine-prevention-services.shtml

used prevention interventions.

Prevention Funding

According to the state's strategic plan, Maine has various state and federal funding sources for prevention services, including:

Table 17. Maine - Prevention Funding Sources

Prevention Funding Sources[93]
1. State of Maine General Fund
2. State of Maine Fund for a Healthy Maine
3. Substance Abuse Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG)
4. SAMHSA Drug Free Communities Grants
5. SAMHSA Partnerships for Success Grants
6. SAMHSA Strategic Prevention Framework for Prescription Drugs (SPF RX)

Maine state officials have worked hard to increase education about the importance and necessity of prevention services. They report that this education has resulted in making the field more visible and increasing state-portion funding in Maine; however, most prevention funding is still federally sourced.

Table 18. Maine SAMHSA Funding Sources[94]

Funding Source	Substance Use Treatment	Substance Use Prevention	Mental Health	Total
Substance Abuse Prevention and Treatment Block Grant (SABG)	–	–	–	$7,233,530
SAMHSA - Discretionary Funding	$8,432,654	$3,611,756	$2,490,159	$14,534,569
Community Mental Health Services Block Grant	–	–	$2,888,999	$2,888,999

Information on the percentage of block grant monies being spent on substance use prevention or related services was unavailable. Focusing on discretionary funding received, it looks as though more than twice as much funding is spent on treatment than prevention in Maine.

Scope of Prevention Work

Maine Prevention Services view substance use in a larger environmental context and believe in using limited, evidence-based strategies to provide structure, quality, and consistency in state prevention practices. They use environmental prevention strategies including policy, enforcement, education, communications and collaboration to complement traditional prevention strategies.

[93] https://digitalmaine.com/osamhs_docs/1/
[94] https://www.samhsa.gov/grants-awards-by-state/ME/2018

Maine Prevention Services collaborates with the State Epidemiological Outcomes Workgroup to digest and disseminate key data sources, like the Maine Integrated Youth Health Survey, National Survey on Drug Use and Health, Behavioral Risk Factor Surveillance System, and the Youth Risk Behavior Surveillance System.[95]

The Maine CDC currently promotes several prevention campaigns, primarily about underage drinking and marijuana use. Prevention strategies target youth and adults and seek to educate, as well as influence behavior. Examples of prevention campaigns include:

- **Parents Who Host, Lose the Most** is a nationwide campaign adopted locally to educate parents about the health and safety risks of serving alcohol to minors and increase their awareness and compliance with underage drinking laws.[96]
- **Project Sticker Shock** targets adults who may buy or supply alcohol to underage drinkers. According to the CDC website, this project aims to be a partnership between youth, retailers, parents, community members, prevention professionals, and law enforcement with the goal of educating the population and raising public awareness.[97]
- **Student Intervention and Reintegration Program (SIRP)** uses the Prime for Life intervention to influence behaviors using research-based persuasion protocol to target at risk youth ages 13-18 who are considered at-risk if they are experimenting with or are otherwise using alcohol or other drugs.
- **Eyes Open for ME** is aimed at educating patients, prescribers, and community members on misuse of prescription medication.[98]
- **You are the Target** is a youth tobacco prevention campaign targeted toward youth, parent, and known influencers. It uses digital media and disruptive messaging to counteract tobacco advertisements.[99]
- **Be a Hero** promotes the importance of building strong relationships with children and educates adults on engagement to prevent risky behaviors later in life.[100]
- **Positive Influence** empowers youth to celebrate self-expression and making smart choices by dispelling myths around peer substance use.[101]

Interviewees report that while considerable focus has been placed on prescription drug misuse and opioids; alcohol, marijuana, tobacco, and vaping are more prevalent problems for the state.

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[95] https://digitalmaine.com/cgi/viewcontent.cgi?article=1001&context=osamhs_docs
[96] https://www.maine.gov/dhhs/mecdc/population-health/prevention/adult/PWHguide2012.pdf
[97] https://www.maine.gov/dhhs/mecdc/population-health/prevention/youth/index.htm
[98] https://www.eyesopenforme.org/
[99] http://youarethetarget.com/
[100] https://bemyherotoday.com/
[101] https://leadthewaymaine.com/

Table 19. Substance Use in Maine

Substance	Percent of Use
Underage Alcohol use in past month (12-20)[102]	24%
High School Students Who Currently Drink Alcohol[103]	11% – 26%
Marijuana use in past month (18-25)[102]	34%
High School Students Who Currently Use Marijuana[103]	19% - 21%
Cigarette use in the past month (18-25) [102]	28%
High School Students Who Currently Use an Electronic Vapor Product[103]	14% - 17%
Heroin use in the past year (18+)[102]	0.55%
Prescription medication misuse in the past year (18+)[102]	4.04%

Based on information from NSDUH and YRBS, data suggests a quarter of 12- to 20-year-olds have engaged in illegal, underage drinking within the past month; more than a third of 18- to 25-year-old Mainers have used marijuana in the past month; and nearly a third of 18- to 25-year-olds have smoked cigarettes in the past month. In comparison, less than one percent of Maine adults have used heroin, and approximately four percent have misused prescription medication in the past year.

State Prevention Workforce

As Maine takes a broad approach to defining prevention, many professionals work collaboratively with prevention specialists. There are two primary groups of prevention professionals in Maine, coalitions that are subrecipients through UNE and Drug Free Communities grantees. Approximately 100 people are employed in primary prevention, excluding coalition members. Secondarily, a number of mental health, medical professionals, and community health educators do prevention work.

Workforce Survey

Using existing prevention workforce surveys from the IC & RC, as well as those conducted in Connecticut, Maine, Massachusetts, and Rhode Island, PCG developed a refined, web-based workforce survey which was disseminated in late July 2019. PCG used a snowball sampling method to disseminate the survey, wherein prevention leadership and stakeholder interviewees helped PCG in emailing the survey to their respective listservs.

The resulting workforce sample included 209 total stakeholders from various levels of prevention, comprising state level policy makers, prevention administrators, and

[102] https://pdas.samhsa.gov/saes/state
[103] US Dept. of Health and Human Services, Centers for Disease Control and Prevention (2017) National Youth Risk Behavior Survey [PowerPoint slides]. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

prevention field staff, from all six states. A total of 45 people responded from Maine.

State Board Certifications

The Maine Prevention Certification Board supports the IC & RC Certified Prevention Specialist certification,[104] identifying approximately 70 certified prevention professionals in Maine. The state also supports a Provisional Prevention Specialist certification, which does not require an exam for entry-level workers. However, this certification is not reciprocal in any other state and is meant for use while professionals work toward the Certified Prevention Specialist certification.

To become a Certified Prevention Specialist (CPS) in Maine, applicants must:[105]

- Have at least 2,000 documented hours of prevention-related experience in the IC & RC Prevention Performance Domains. Of those 2,000 documented hours, a minimum of 120 hours of supervision is required, with at least 10 hours in each domain. A minimum of 500 (25%) of the required 2,000 hours must be specific to alcohol, tobacco, or other drugs (ATOD) prevention.
- Have at least 120 hours of documented education/training, according to the following breakdown:
    - 24 hours must be related to ATOD, 6 hours to Prevention Ethics, and 31 hours (26 in-person and 5 online) must be obtained through the "Substance Abuse Prevention Skills Training" (SAPST) or MPCB-approved SAPST equivalent*. The remaining "other hours" of education/training must be related to the 6 IC & RC Prevention Domains.
- Pass a Prevention Specialist Examination administered by IC & RC.
- Sign an Agreement to Abide by the Code of Ethical Standards Form.
- Submit three professional references.

Re-certification requires forty hours of documented continuing education, including six hours from an approved Prevention Ethics Training every two years.

> Certification is a bar we are setting. There's no career ladder so we lose people.
>
> *– Stakeholder*

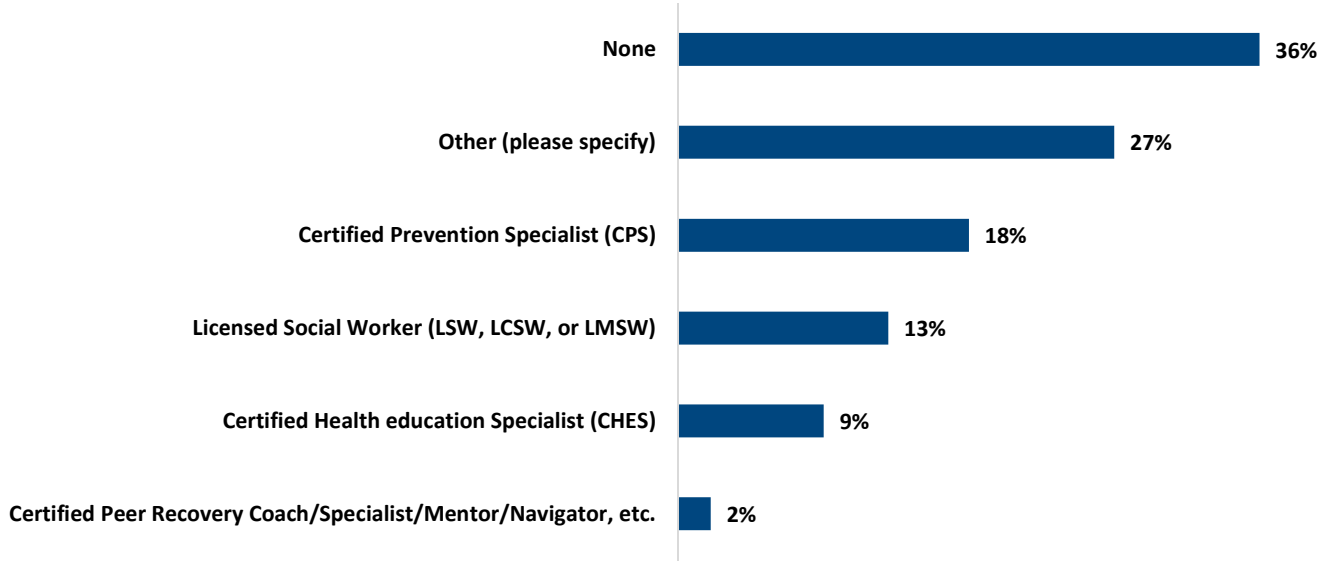
According to interviewees, prevention certification is required only for professionals funded under the Substance Use Prevention Services contract; however, it is encouraged for all prevention professionals. Stakeholders reported that certification lends a level of credibility, promotes a strategic performance model, and creates a baseline consistency of knowledge in the

[104] https://mainepreventioncertification.org/
[105] IC & RC certification board CPS requirements matrix. Updated October 2018.

field, but there are some barriers: inadequate number of basic courses to fulfill the requirement and a lack of qualified trainers. It is difficult to promote certification in rural areas due to spotty internet access to take online courses and distances needed to travel to attend training. Most notably, there isn't a clear path for career advancement, making it hard to retain professionals in the field.

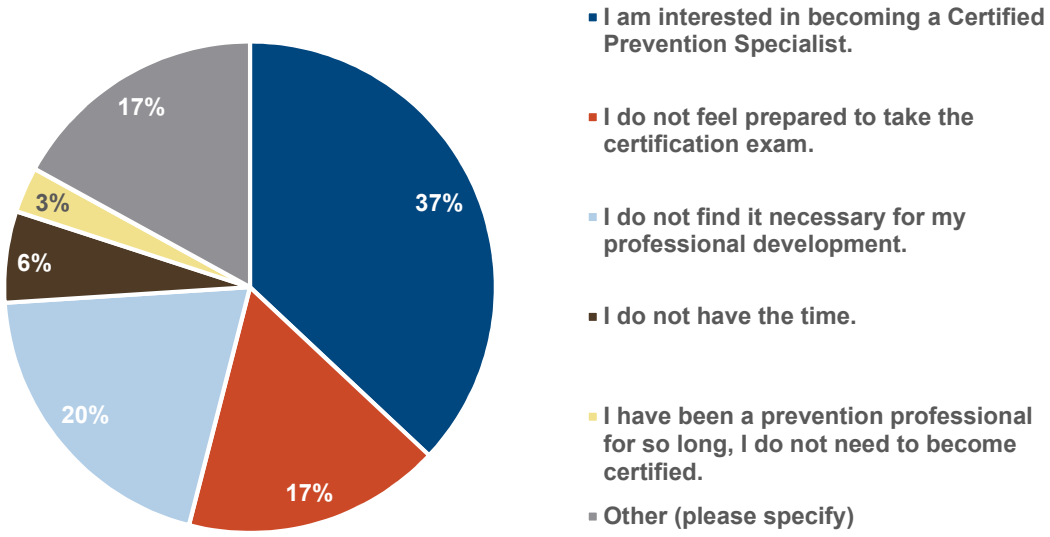
Despite stakeholders having very positive comments about CPS certification, the PCG workforce survey showed that less than a fifth (18%) of respondents were CPS certified and more than a third (36%) had no certification or licensure.

Figure 23. Maine – Professional Certifications and Licensures



Of those not certified, nearly two-thirds indicated that they did not find it necessary to become certified, didn't feel prepared to take the exam, or didn't have time. They were more likely to be employed in prevention-adjacent fields such as research, social work, or the medical field.

Figure 24. Maine - Feelings About Becoming Certified Prevention Specialist



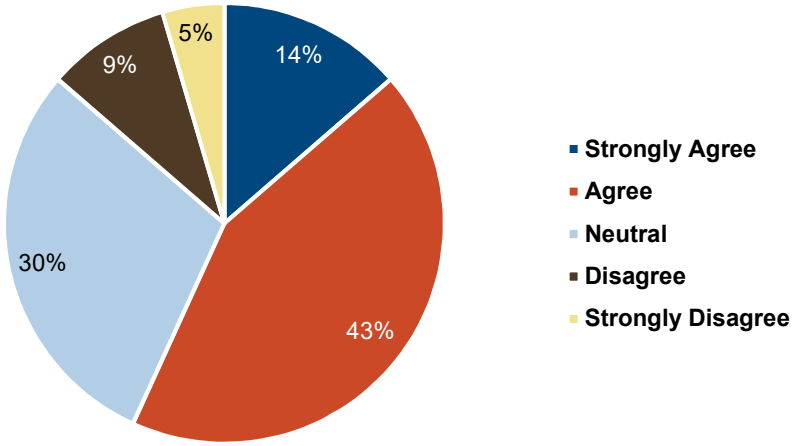
Maine's Strategic Plan

The goals for Maine's strategic plan of 2013 through 2018 were based on recommendations from an evaluation of Maine's SPF Grant.[106] The plan focused on addressing substance use in priority populations (underage and young adults, 18 to 25 years) via increasing infrastructure and workforce development. The plan specified the implementation of a statewide prevention certification system for Maine based on IC & RC standards. Additionally, the plan sought to assure prevention specialists have access to training on evidence-based practices, cultural competency, policies/practices, use of data, and importance of program evaluation. A new strategic plan for 2019 is currently unavailable.

More than half (57%) of survey respondents felt that the state promotes diversity and cultural competence in the workforce; however, a substantial portion were neutral on the subject. This is another opportunity for the New England PTTC to assist Maine in training and education about workforce diversity.

[106] https://www.maine.gov/dhhs/samhs/osa/pubs/prev/2012/StrategicPrevPlan.pdf

Figure 25. Maine - State Promotes Diversity in the Workforce

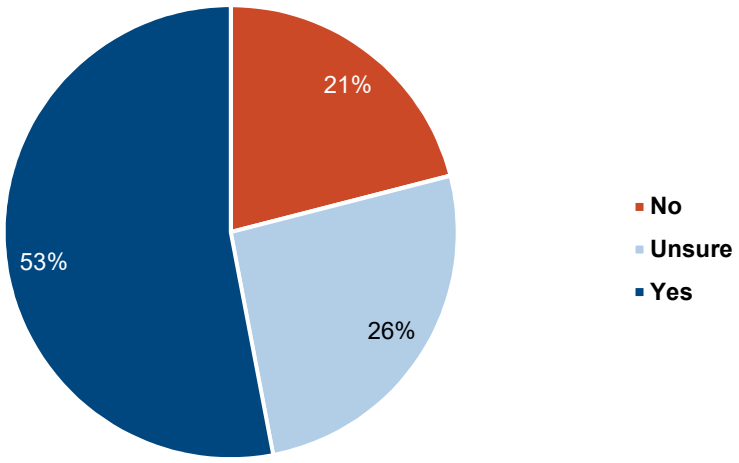


Current Training Availability

Maine promotes four platforms for prevention education and training. AdCare and CCSME supports in person and/or long-distance learning on various substance use and mental health topics. UNE provides training and technical assistance to the 21 community organizations with which they work via webinars and grantee meetings. The Maine CDC hosts an annual Prevention Providers Conference and Prevention Professionals Day. Prevention professionals are also able to receive free online training from the CADAC website.

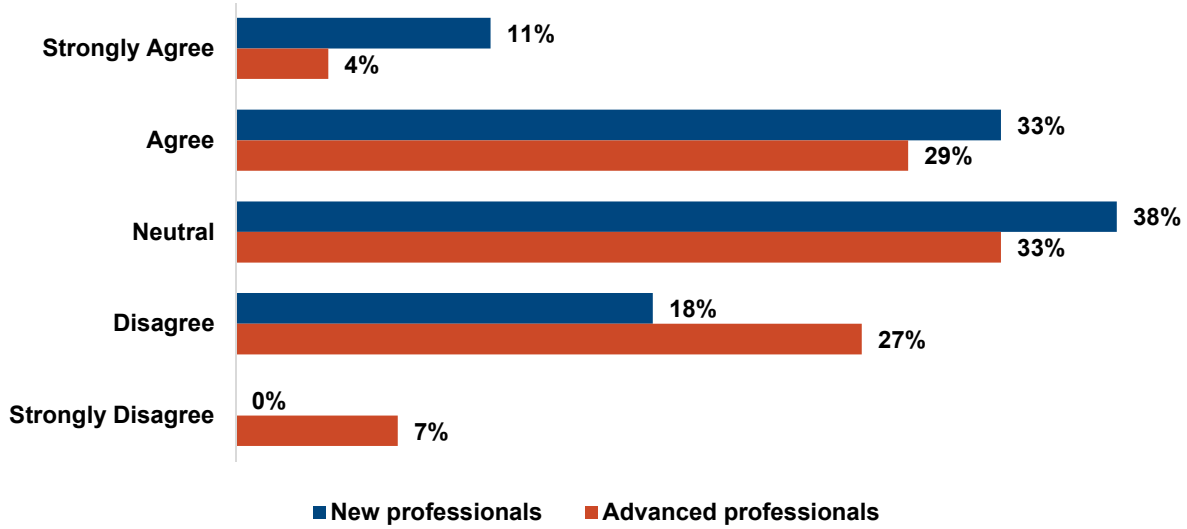
Despite having access to many sources of information, nearly half of workforce survey respondents indicated that they felt unsure about having, or did not have, access to career development and training opportunities that matched their career goals.

Figure 26. Maine - Access to Career Development Opportunities



Survey respondents reported more adequate availability of training and education opportunities for new professionals (with five or fewer years of experience) over advanced professionals (with 10 or more years of experience). This finding aligns with stakeholder interviews which suggested that many New England states are lacking sufficient training options for advanced professionals, especially about core knowledge areas, like prevention ethics.

Figure 27. Maine - Availability of Training and Education



More than half of Maine survey respondents requested more information on the following training topics.

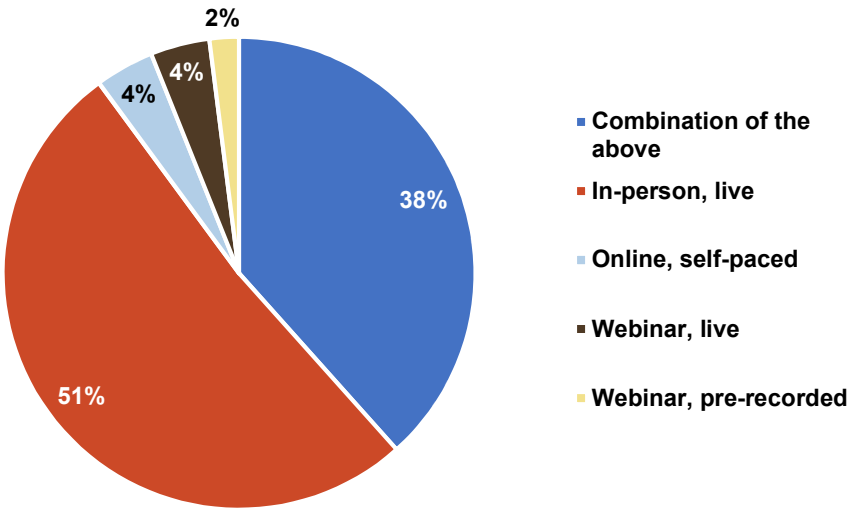
Table 20. Maine - Most Requested Training Topic

Topics of Interest	Percent Wanting More Training
Social and environmental factors affecting substance use prevention	73%
Opioids	73%
Strategies to reduce SUD stigma	71%
Marijuana	71%
Advanced skills and knowledge in working with diverse populations	69%
Trauma-informed care	67%
Management skills	64%
Selecting evidence-based interventions	64%
Engagement of priority populations in prevention	62%
E-cigarettes/ Vaping	62%
Suicide assessment and prevention	60%
Identifying risk and protective factors that impact disparate populations	60%
Interpreting data to identify community needs	58%
Identifying community assets and resources (human, fiscal, and organizational)	58%
SBIRT	58%
Co-occurring disorders	56%

Integrated models of care with interprofessional teams	56%
Ethical issues related to use of technology in delivering client/patient services	56%
Planning program sustainability	53%
Mobilization and engagement of community stakeholders	53%
Mentoring or coaching of prevention staff	53%
Tobacco	53%
Alcohol	53%
Funding options	51%
Identifying community readiness to implement prevention interventions	51%

Maine workforce survey respondents (51%) indicated a clear preference for in-person training but over a third (38%) would also like a combination of training offerings. Despite being the most rural and sparsely populated of all New England states, only a small percentage (10%) of respondents requested strictly online or web-based training. Even rural respondents reported a preference for in-person training.

Figure 28. Maine - Training Modality Preference



Gaps and Needs

Stakeholders were optimistic about a new technical assistance and training platform and had several suggestions for function and program offerings. They recommended that any future technical assistance/training opportunities should:

- Develop advanced level prevention professional trainings, especially for ethics
- Collaborate with states to coordinate and promote existing trainings to reduce duplication
- Offer a self-paced, open enrollment style of learning

- Create routine, frequent opportunities for professionals to network between states, regions, and nationally

Stakeholders would also like more information on:

- How to build an evidence-based curriculum
- Retention of prevention staff
- Supervisory, management courses
- How to engage health disparate populations, like LGBTQ, veterans, and the uninsured
- Innovative ways to approach alcohol, vaping, opioids, and marijuana
- How to engage and work with youth

Appendix E: Massachusetts State Profile

Massachusetts is home to approximately 6.9 million people with an average of 839 people per square mile according to the Census Bureau.[107] Massachusetts is the second most densely populated New England state, behind Rhode Island. The population is 81 percent white; 12 percent Hispanic or Latino; nine percent African American; and seven percent Asian, making it racially and ethnically more diverse than other New England states. At the same time, 16.5 percent of the population is over 65, which is comparable to the national average. These three facts (rurality, race/ethnicity, and age) present unique opportunities for the diverse workforce recruitment of Massachusetts, an aim of SAMHSA and the PTTC.

Prevention Defined

According to representatives from the Massachusetts Bureau of Substance Addiction Services (BSAS), the prevention mission can be stated as:

> *"We empower communities using a public health approach to promote and support healthy decisions around substance use among youth."*

Massachusetts has several goals and strategies to support this mission. Specifically, BSAS strives to:

- Build local capacity to address the factors that cause substance use disorders and support the people that they impact,
- Coordinate with municipalities or counties on effective prevention efforts through targeted approaches informed by local data,
- Increase data sharing and collection to inform prevention efforts,
- Increase coordination of prevention effort through local/regional partnerships,
- Adopt a thoughtful data driven approach to preventing substance use issues,
- Promote and implement evidence-based universal approaches to prevent substance use issues among youth
- Adopt of strategies aimed at preventing and reducing community problems related to alcohol and other drugs that have also shown an impact on rates of substance misuse,
- Sustain prevention efforts through changes in local policy, practice, and systems,
- Change the overall context within which substance use disorders occur and the approach communities have taken to address the factors that contribute to these issues, and
- Improve the ability of BSAS-funded programs to quantify their prevention efforts through increased capacity and support for evaluation.

[107] https://www.census.gov/quickfacts/fact/table/RI,MA,CT,US/PST045218

Structure of Prevention Services

Massachusetts prevention programs are categorized broadly as universal, selective, and indicated, based on the target population. Universal programs reach the general population; selective programs target subsets of those at risk; and, indicated programs are for those who are already experimenting with alcohol, tobacco, and other drugs or showing signs of risk behavior.[108] Prevention programs in Massachusetts either employ environmental strategies, to reach large populations, or serve smaller groups. All programs must be evidence based and adhere to SAMHSA's Strategic Prevention Framework.

The primary models used in Massachusetts are:

1. Substance Abuse Prevention Collaborative Grant (SAPC) Grant
   Lead Programs (Grantees): 28 (26 municipalities and 2 counties - Barnstable County and Dukes County)
   Cluster Communities (Formal Partnership): 117
   Total Reach: 143

2. Massachusetts Opioid Abuse Prevention Collaborative (MOAPC) Grant
   Lead Programs (Grantees): 19 (17 municipalities and 2 counties - Barnstable County and Berkshire County)
   Cluster Communities (Formal Partnership): 99
   Total Reach: 116

3. SAMHSA - Partnerships for Success 2015 (PFS 2015) Discretionary Grant
   Lead Programs (Grantees): 16
   Cluster Communities (Formal Partnership): N/A
   Total Reach: 16

Massachusetts estimates that their total reach is approximately 173 cities and towns.

In order to provide information on evidence-based principles to the Commonwealth, BSAS offers a Public Information Initiative. The goal is to prevent and decrease alcohol, inhalant, and other substance use across the lifespan. This aim is accomplished using electronic and social media, print, web-based and public relations initiatives.[109] These media are developed for health and educational organizations, retailers, parents, youth, older adults, and those who serve them.

Communities that assess their needs and are committed to faithful implementation and data collection may be offered training in evidence-based programs such as the PAX Good Behavior Game, LifeSkills® Training, and/or other options.

[108] https://www.mass.gov/files/documents/2016/07/wj/workforce-dev-strategic-plan.pdf
[109] https://massclearinghouse.ehs.state.ma.us/

Prevention Funding

Massachusetts receives most of its prevention funding through SAMHSA block grants and other federal sources. State representatives expressed that there is limited amount of state dollars being spent on prevention work and this is done through Legislature earmarks for particular programs. Furthermore, Massachusetts spends about 20 percent of its annual Block Grant funding on prevention. According to the state's Prevention Programs Directory and Strategic plan, Massachusetts has various other federal funding sources, like the SAMHSA Drug Free Communities Grants, but grantees report to their federal funders rather than the state.

Table 21. Massachusetts SAMHSA Funding Sources[110]

Funding Source	Substance Use Treatment	Substance Use Prevention	Mental Health	Total
Substance Abuse Prevention and Treatment Block Grant (SABG)	–	$8,965,749	–	$39,769,105
SAMHSA - Discretionary Funding	$64,508,415	$1,648,178	$23,885,737	$97,765,265
Community Mental Health Services Block Grant	–	–	$13,764,503	$31,764,503

Scope of Prevention Work

Prevention services in Massachusetts work primarily through grants to municipalities that organize and energize multiple systems in the community. Most of the grantees engage a cluster of communities in their area and use the SAMHSA Strategic Prevention Framework (assessment, capacity building, planning, implementing evidence-based approaches, and evaluation). Community efforts of the coalitions often focus on availability, community norms, and regulations related to alcohol, tobacco, and other drugs. Some utilized strategies include policy change and implementation, strengthening enforcement, education, health communication, and supporting evidence-based programs.

Massachusetts also has a statewide epidemiological workgroup. The group meets to plan/assess new prevention models and as other needs arise. Some of the data that the state utilizes include Youth Risk Behavior Survey (YRBS), Brief Community Survey (BSAS), and the DPH Data Warehouse. County and local programs may use the Communities that Care model (a risk and protective factors survey), School Discipline data, Law Enforcement data, Court data, and/or Youth Health Assessments.

Further, Massachusetts has statewide and local media campaigns to promote prevention

[110] Dollar amounts in this table related to substance use treatment and mental health are derived from the SAMHSA website at https://www.samhsa.gov/grants-awards-by-state/MA/2018. However, updated dollar amounts for substance use prevention were provided by the Massachusetts Bureau of Substance Addiction Services.

efforts and bring together key stakeholders. Examples include:

- **Make the Right Call**, a public information campaign that promotes opioid overdose prevention by educating on the signs of overdose, training on how to use Narcan, and urging people to carry Naloxone (Narcan) in case of emergency.[111]
- **Talk, They Hear You**, a national underage drinking prevention campaign funded by SAMHSA that reauthorizes a highly visible adult-oriented media campaign to encourage parents to discuss the risks of underage drinking with their children. The campaign encourages parents to post to social media to build a collective conversation about underage drinking prevention using the #WeTalked hashtag. Any organization who has received a Sober Truth on Prevention (STOP) Underage Drinking grant from the Community Anti-Drug Coalitions of America (CADCA) is required to promote the "Talk, They Hear You" campaign locally.[112]
- **Stop Addiction Before It Starts**, offers a message to parents "You want to protect your kids from the harsh realities of life, but addiction can happen to anyone. It's important to make sure they understand how dangerous these drugs can be and how quickly addiction can happen. You can talk to your kids at a level that's right for their age." The campaign also empowers parents to safeguard their youth from unneeded opioid prescriptions; keep the necessary medicine out of youth's reach; and dispose of them in the safest way.[113]
- **My Choice Matters**, a social norming campaign that works with a coordinated system of prevention, intervention, treatment and recovery partners so that Cape Cod communities are happy, healthy, safe and thriving.[114]
- **Rethink the Drinks,** a campaign developed by one of the SAPC funded programs that aims to education communities about the legal and health risks of underage drinking and provides tools that support youth in building assets and resiliency.[115]

State Prevention Workforce

Each state defines its prevention workforce a little differently. Some include Drug-Free Community recipients and coalitions, where others include only primary prevention workers or staff specifically funded by federal grants. Massachusetts stakeholders estimate that there are approximately 300 people working in prevention. This includes all funded agencies whose work includes substance use prevention and individuals who

[111] https://patch.com/massachusetts/newton/make-right-call-new-campaign-stresses-need-quick-action-overdose-cases-0
[112] https://www.samhsa.gov/underage-drinking/about
[113] https://www.mass.gov/protect-your-kids-from-prescription-drug-misuse
[114] https://www.mychoicematters.net/my-choice-matters-tool-kit/
[115] https://rethinkthedrinks.com/

work for community coalitions receiving SAMHSA block grant funding.

Workforce Survey

Using existing prevention workforce surveys from the IC & RC, as well as those conducted in Connecticut, Maine, Massachusetts, and Rhode Island, PCG developed a refined, web-based workforce survey which was disseminated in late July 2019. PCG used a snowball sampling method to disseminate the survey, wherein prevention leadership and stakeholder interviewees helped PCG in emailing the survey to their respective listservs.

The resulting workforce sample included 209 total stakeholders from various levels of prevention, comprising state level policy makers, prevention administrators, and prevention field staff, from all six states. A total of 52 people responded from Massachusetts.

State Board Certifications

The Massachusetts Board of Substance Abuse Counselor Certification supports the IC & RC Certified Prevention Specialist certification.[116] According to the Massachusetts state certification board, there are 38 certified prevention professionals in Massachusetts. The state offers Reciprocity certification via a transfer of IC & RC credentials to individuals who are fully certified with the IC & RC.

To become a Certified Prevention Specialist in Massachusetts, applicants must:[117]

- Live in Massachusetts at least 51 percent of the time.
- Complete all approved trainings within the last 10 years.
- Have 120 hours of documented education/training for anyone with a bachelor's degree, or higher; 200 hours for anyone with less than a bachelor's degree. 50 of those hours must be ATOD specific and six hours must include ethics training.
- Have 2,000 hours of documented, supervised alcohol, tobacco, and other drug use prevention specific work experience. It is recommended supervision be done by a Certified Prevention Specialist.
- Have 120 hours with a minimum of 10 hours in each of the CPS domains: planning and evaluation; prevention education and service delivery; communication; community organization; public policy and environmental change; and, professional growth and responsibility.
- Have a Code of Ethics signature.
- Have a passing score on the IC & RC PS exam.

Massachusetts encourages prevention specialists to be recertified every two years.

[116] https://www.mbsacc.com/
[117] https://docs.wixstatic.com/ugd/d5f6ac_db218b3354d2477c98352acd68d58df2.pdf

Recertification requirements include 30 contact hours of approved continuing education specific to prevention, the completion of the recertification application and fee payment.

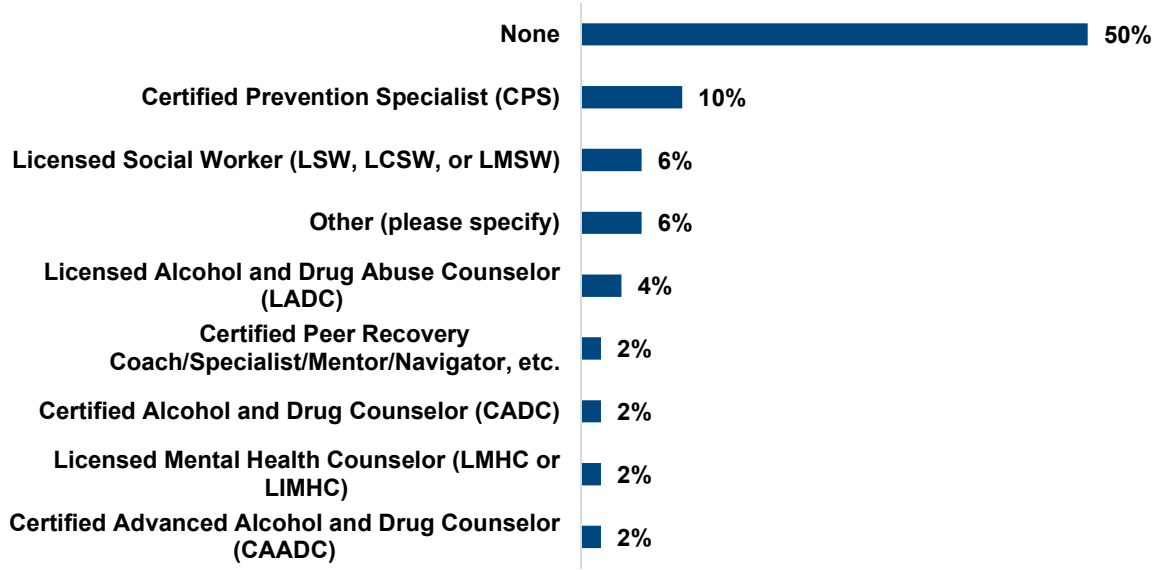
To become certified as a prevention specialist in Massachusetts, individuals must have a certain number of professional development training hours in specific education disciplines which include prevention ethics; cultural competence; mental health; gambling; HIV/AIDS and hepatitis C; Violence Prevention; Alcohol, tobacco, and other drugs categories; prevention practice and theory categories; and, electives.[118] Required professional development hours for anyone with a bachelor's degree or higher are 120 and 200 hours for those with less than a bachelor's degree.[119]

Until about a year and a half ago, Massachusetts required BSAS Prevention Providers to complete prevention certification (CPS) within two years. Recently, BSAS extended this timeline in order to strengthen its training infrastructure. BSAS continued to offer trainings and funding for national conferenced (one of which they organized in Boston) to enable providers to fulfill many of the CPS requirements. According to BSAS representatives, the bureau is currently expanding its training calendar and offering at least one training per month. BSAS continues to co-fund and offer scholarships for a four-day New England Summer School.[120]

BSAS funded programs may decide to make certification a requirement for employment, but this is not currently a state requirement. The PCG workforce survey showed that approximately 10 percent (10%) of respondents were CPS certified and half had no certification or licensure.

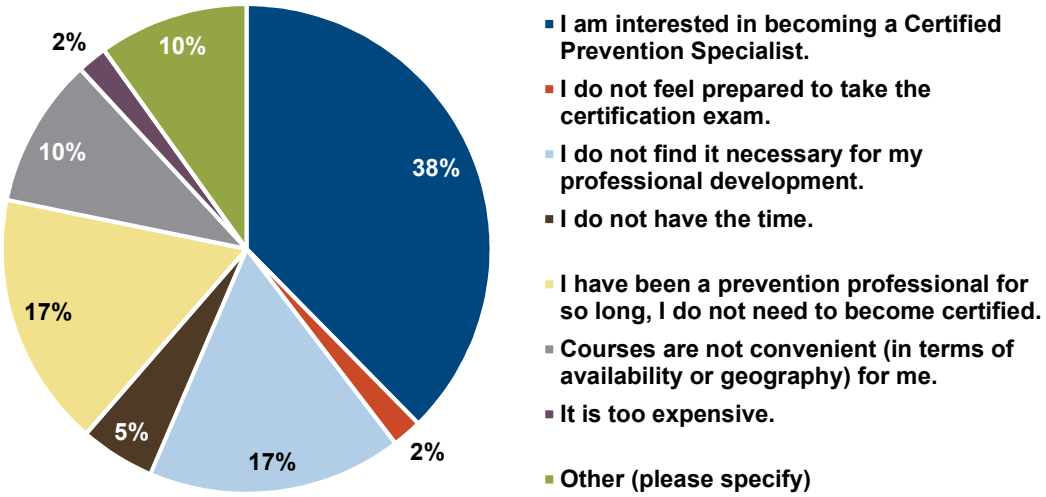
[118] https://docs.wixstatic.com/ugd/d5f6ac_db218b3354d2477c98352acd68d58df2.pdf
[119] https://www.mbsacc.com/cps
[120] https://newengland.adcare-educational.org/

Figure 29. Massachusetts - Professional Certifications and Licensures



Of those who were not certified, more than a third (38%) were interested in becoming certified, while another third felt it was unnecessary for their profession. The remaining respondents generally indicated that they did not have the time, money, or training needed for the CPS exam.

Figure 30. Massachusetts - Feelings About Becoming Certified Prevention Specialist



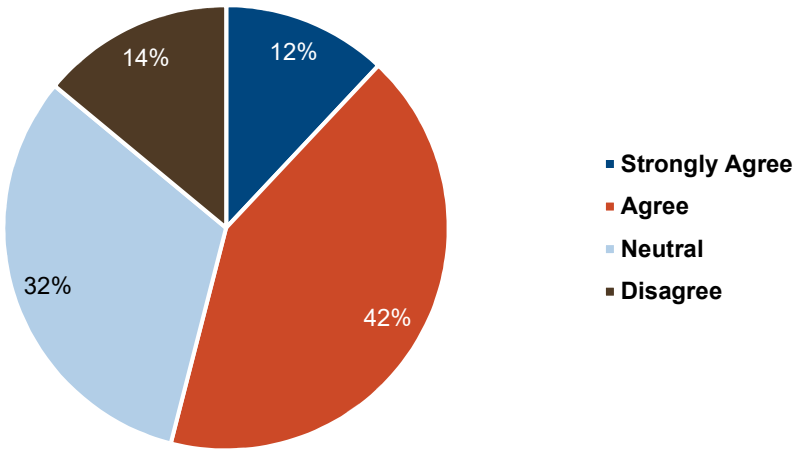
Massachusetts' Strategic Plan for Workforce Development

Massachusetts developed a Workforce Development Strategic Planning Stakeholder Advisory group in 2007 to address the recruitment and retention needs of the substance use workforce. Working group meetings consisting of consumers, providers, regulators,

professors, and researchers commenced to develop recommendations and strategies for addressing workforce development issues in the substance use and addiction field. The Vision developed throughout this process is a workforce that is "capable, caring, connected to the community, energized by their job, and compensated appropriately."[121] The recommendations in the strategic plan center around four key elements: collaborative effort; supporting continuous learning and quality improvement; increasing the value and reward of work in the field; and direct technical assistance for programs in recruitment and retention practices.

According to over half (53%) of Massachusetts workforce survey respondents, their state was promoting diversity and cultural competence/ humility in the workforce. There remains opportunity for the New England PTTC to assist the state in development of this strategic initiative.

Figure 31. Massachusetts - State Promotes Diversity in the Workforce



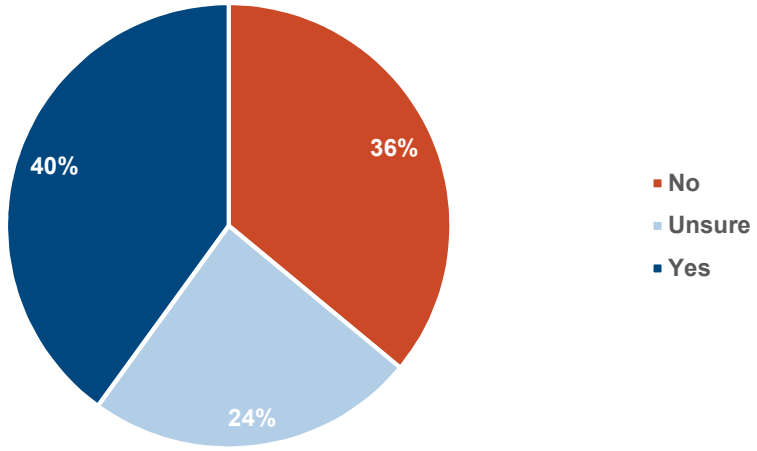
Current Training Availability

Massachusetts has many different organizations that provide substance use prevention training and technical assistance to the workforce. AdCare Massachusetts provides in-person workshops, webinars, and evidence-based certifications. AdCare also hosts the annual Best Practices and New England Summer School of Addiction Studies. Additional online and in-person trainings, regional meetings, and technical assistance are offered by the Education Development Center, and CADCA. BSAS organizes beginning and advanced levels of training in several CPS required trainings (*e.g.* ethics, cultural competence, etc.) Independent agencies, such as the SPIFFY Coalition in Western MA offer county and local technical assistance.[122] The Department of Public Health BSAS gathers and submits the required documentation so that the in-person and on-line workshops meet the certification guidelines and grant participants CPS credits.

[121] https://www.mass.gov/files/documents/2016/07/wj/workforce-dev-strategic-plan.pdf
[122] https://www.collaborative.org/services/healthy-families-and-communities/spiffy-coalition.

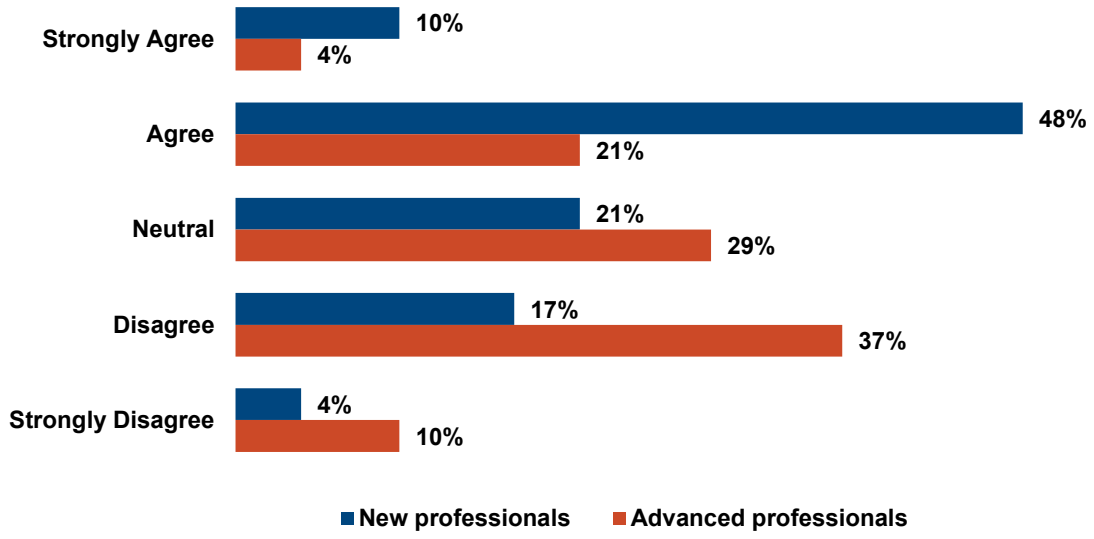
Despite these many sources of information, according to workforce survey respondents, only 40 percent feel they have access to career development opportunities that match their career goals.

Figure 32. Massachusetts - Access to Career Development Opportunities



More than half (58%) agreed or strongly agreed that there were adequate training opportunities for new prevention professionals (with five or fewer years of experience). To the contrary, only 24 percent felt similarly about training opportunities for advanced professionals (with 10 or more years of experience). There is clearly an opportunity for improvement in education and training for more seasoned professionals in Massachusetts.

Figure 33. Massachusetts - Availability of Training and Education



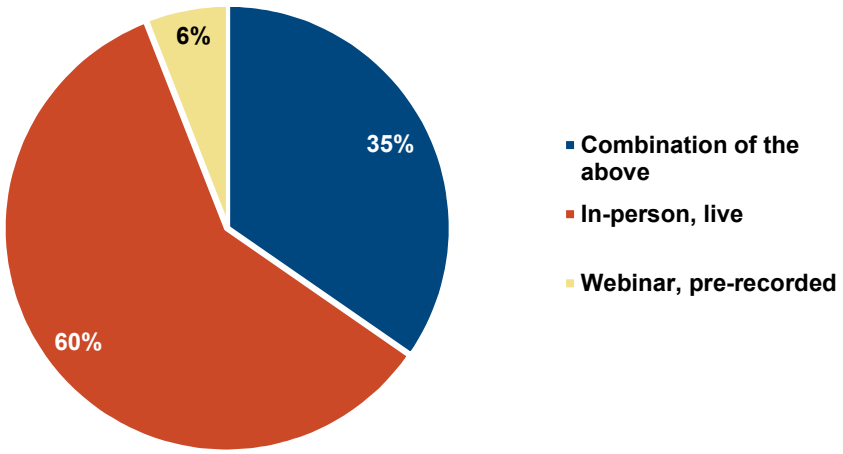
More than half of survey respondents requested the following educational and training topics.

Table 22. Massachusetts - Most Requested Training Topics

Topics of Interest	Percent Wanting More Training
Advanced skills and knowledge in working with diverse populations	75%
Planning program sustainability	62%
Strategies to reduce SUD stigma	56%
Co-occurring disorders	56%
Ethical issues related to use of technology in delivering client/patient services	56%
Organizational change strategies	56%
Interpreting data to identify community needs	54%
Suicide assessment and prevention	54%
Administrative skills	54%
Mobilization and engagement of community stakeholders	52%
Identifying community readiness to implement prevention interventions	52%
Management skills	52%
Trauma-informed care	52%
Confidentiality and privacy rules, including HIPAA and 42 CFR Part 2	52%
Social and environmental factors affecting substance use prevention	50%
E-cigarettes/ Vaping	50%
Integrated models of care with interprofessional teams	50%
Development of measurable goals and objectives	50%

People indicated a clear preference for in-person training (60%), but over a third (35%) would also like a combination of training offerings.

Figure 34. Massachusetts - Training Modality Preference



Gaps and Needs

Stakeholders recommended that any future technical assistance/ training opportunities should be:

- Paying attention to what constitutes effective prevention policies and practices;
- Addressing substance use beyond primary prevention of youth;
- Expanding and bringing prevention into other sectors;
- Providing training for state level leaders in government and well as local leaders;
- Organizing and presented across different areas of the state

Stakeholders would also like more information on:

- Understanding health disparities and promoting health and racial/ethnic equity;
- Retaining staff, capacity building, and sustainability, and website design;
- Additional grant and funding resources and grant writing training;
- Analysis and evaluation;
- Diversifying advisory and executive boards;
- Motivational interviewing, train the trainer, and marketing trainings

Appendix F: New Hampshire State Profile

New Hampshire is home to approximately 1.3 million people with an average of 147 people per square mile according to the Census Bureau.[123] It is the third least densely populated state in New England, following Vermont and Maine.

The population is also primarily white (94%) with two and three percent identifying African American or Asian descent, respectively. Four percent of the population is also Hispanic. Additionally, about 18 percent of the population is over the age of 65, slightly more than the national average of 16 percent. The rurality of the state, a limited racial and ethnic diversity, and an aging population are noted barriers to creating a diverse workforce in New Hampshire, an aim of SAMHSA and the PTTC.

Prevention Defined

According to the New Hampshire Department of Health and Human Services (DHHS), of the Bureau of Drug & Alcohol Services (BDAS) Prevention Services Unit, prevention is defined as a strategy "to reduce the misuse of alcohol and other drugs across the lifespan through the implementation of effective programs, practices and policies."[124] BDAS' goal is to prevent onset, reduce substance misuse, and reduce the negative consequences of substance misuse for individuals, families, and communities across all age groups.

Structure of Prevention Services

DHHS utilizes a continuum of care model which includes health promotion, prevention, early identification and intervention, and treatment and recovery supports to address substance use.[125] It divides prevention services for New Hampshire into 13 Regional Public Health Networks (RPHN) which encompass local health departments, law enforcement, healthcare providers, social services agencies, fire departments, emergency medical services, behavioral health groups, faith communities, advocacy groups, and local government/ community leaders. DHHS, in turn, provides funding to the RPHNs for substance use prevention.

Specifically, BDAS funds one full-time Substance Misuse Prevention (SMP) coordinator in each RPHN. Coordinators are generally responsible for collaborating with Continuum of Care Facilitators, attending Public Health Advisory Committee (PHAC) meetings, and presenting information about prevention-specific data to the PHAC as well as participating on the PHAC Prevention Leadership Team.[126]

The state has structured services using SAMHSA's Strategic Prevention Framework model. According to stakeholder interviews, in addition to RPHNs, New Hampshire utilizes seven coalitions and Drug Free Community programs across the state to work at

[123] https://www.census.gov/quickfacts/
[124] http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/FINAL-Gov-Comm-1_16_19rev.pdf
[125] https://www.dhhs.nh.gov/dcbcs/bdas/documents/coc-assests-gap.pdf
[126] https://www.dhhs.nh.gov/dcbcs/bdas/documents/smp-prevention-manual.pdf

a grassroots level to build local buy-in and support.

BDAS was awarded the Partnerships for Success Grant 2015 "to leverage the state's existing prevention system structures and resources to impact substance use among high need populations in identified communities to reduce: 1) underage drinking among persons aged 12 to 20; and 2) prescription drug misuse among persons aged 12 to 25."[127]

Prevention Funding

According to stakeholders, political support for prevention in New Hampshire has been limited. For example, prevention-directed services were cut in 2010 and essentially hollowed out. Without funding, some organizations were forced out of business.

Around 2015, the state recognized a new importance in prevention and began to dedicate funding again. However, stakeholders report that the state has been slow to catch up. There are still more resources around treatment and recovery and disparities among behavioral health and prevention services.

New Hampshire is one of a handful of states that do not collect income tax; thus, funding for social programming in general is limited.[128] According to the state's strategic plan, New Hampshire receives limited prevention funding from the state; most comes from federal sources.

Table 23. New Hampshire - Prevention Funding Sources

Prevention Funding Sources[129]	
1.	New Hampshire Governor's Commission on Alcohol and Drug Abuse Alcohol Sales Fund
2.	New Hampshire Charitable Foundation (NHCF)
3.	Substance Abuse Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG)
4.	Partnerships for a Drug Free New Hampshire | SAMHSA Grants - direct to grantees (Drug Free Community Coalitions)
5.	SAMHSA Partnership for Success (PFS)

New Hampshire receives considerable funding from SAMSHA for substance use programming. Stakeholders stated that the proportion of funds being spent on prevention versus treatment has increased in recent years. A chief complaint remains that prevention does not get funding at the local level, so sustainability is hard. Unlike treatment where it is easy to show effectiveness and change, prevention struggles to demonstrate influence.

[127] https://www.dhhs.nh.gov/dcbcs/bdas/prevention.htm
[128] Includes New Hampshire, Alaska, Florida, Nevada, South Dakota, Tennessee, Texas, Washington, and Wyoming. https://www.kiplinger.com/slideshow/taxes/T054-S001-states-that-don-t-tax-income/index.html
[129] https://www.dhhs.nh.gov/dcbcs/bdas/documents/smp-prevention-manual.pdf

The state recognizes the relationship between mental health and substance use and the importance of addressing co-occurring disorders; however, a 2016 report indicated that there is still much to do in this area.[130] SAMHSA funds the community mental health block grant for New Hampshire, but there does not appear to be a clear organization between mental health and prevention professionals.

Table 24. New Hampshire SAMHSA Funding Sources[131]

Funding Source	Substance Use Treatment	Substance Use Prevention	Mental Health	Total
Substance Abuse Prevention and Treatment Block Grant (SABG)	$4,163,559	$2,721,544	$348,427	$7,233,530
SAMHSA - Discretionary Funding	$29,173,700	$2,382,581	$5,631,025	$37,187,307
Community Mental Health Services Block Grant	–	–	$2,598,638	$2,598,638

Information on the percentage of the block grants being spent on substance use prevention or related services was unavailable. As with other New England states, substantially more discretionary funding is devoted to treatment; in New Hampshire, $15 for every $1 spent on prevention services is spent on treatment services.

Scope of Prevention Work

Interviewees stated that opioid use, alcohol consumption, prescription misuse, marijuana use, and vaping are the biggest priorities for New Hampshire with a substantial portion of funding dedicated to opioids. The New Hampshire DHHS believes strongly in utilizing evidence-based practices and prevention science, but data collection has not been without challenges.

New Hampshire collaborates with the State Epidemiological Outcomes Workgroup housed at John Snow, Inc. (JSI) to collect and monitor key data sources, like law enforcement, the National Survey on Drug Use and Health (NSDUH) and the Youth Risk Behavior Survey (YRBS) surveys. However, a state bill was passed in 2013 which prohibits surveys from being administered in schools, except for the YRBS. This has limited the amount data which can be collected about substance use among youth.

New Hampshire currently promotes multiple prevention campaigns, primarily targeting binge drinking, drinking while pregnant, and opioid addiction. Examples of campaigns include:

- **Today is for Me** seeks to educate pregnant woman on the importance of alcohol abstinence during pregnancy.[132]

[130] https://www.dhhs.nh.gov/dcbcs/bdas/documents/coc-assests-gap.pdf
[131] https://www.samhsa.gov/grants-awards-by-state/NH/2018
[132] https://todayisfor.me/

- **Anyone. Anytime.** is designed in response to the opioid crisis in NH.[133] It is run via Doorway NH and targeted toward anyone seeking help with or information about drug and alcohol issues. The goal of the campaign is to decrease addiction stigma, educate the community, and connect people with treatment and recovery resources.
- **Binge Free in 603** is a web-based campaign targeting young adults at risk of binge drinking. The campaign seeks to educate the community in ways to prevent binge drinking and drinking to excess.[134]

State Prevention Workforce

Each state defines its prevention workforce a little differently. Some include Drug-Free Community recipients and coalitions, whereas others include only primary prevention workers or staff specifically funded by federal grants. New Hampshire stakeholders estimate that there are more than 90 pertinent vendors, each with one to three staff doing prevention work in the state.

Workforce Survey

Using existing prevention workforce surveys from the IC & RC, as well as those conducted in Connecticut, Maine, Massachusetts, and Rhode Island, PCG developed a refined, web-based workforce survey which was disseminated in late July 2019. PCG used a snowball sampling method to disseminate the survey, wherein prevention leadership and stakeholder interviewees helped PCG in emailing the survey to their respective listservs.

The resulting workforce sample included 209 total stakeholders from various levels of prevention, comprising state level policy makers, prevention administrators, and prevention field staff, from all six states. A total of 26 people responded from New Hampshire.

State Board Certifications

The New Hampshire Prevention Certification Board supports the IC & RC Certified Prevention Specialist certification,[135] with approximately 65 certified prevention professionals in New Hampshire.

To become a Certified Prevention Specialist in New Hampshire, applicants must:[136]

- Complete a minimum of 2,000 documented hours of alcohol, tobacco, and other drug (ATOD) related experience in the International Certification Reciprocity Prevention Performance Domains;

[133] https://anyoneanytimenh.org/
[134] https://bingefree603.org/binge-free-603/
[135] http://nhpreventcert.org/
[136] IC & RC certification board CPS requirements matrix. Updated October 2018.

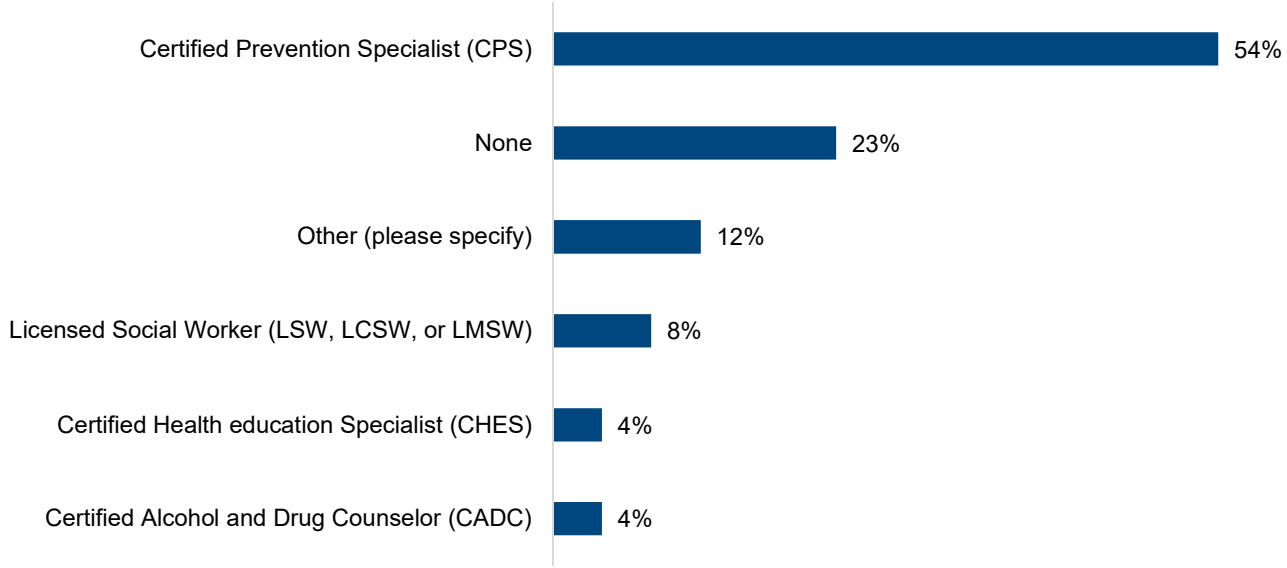
- Have a bachelor's degree from an accredited institution (or complete waiver packet which has alternative educational requirements);
- Complete a minimum of 120 hours of education related to the six Performance Domains with a minimum of 50 hours specific to ATOD use prevention, including six hours of NH Prevention Certification Board-approved Prevention
- Complete the ethics training within the year prior to an applicant applying for certification;
- Have a minimum of 120 hours of supervised practical experience, with a minimum of 10 hours in each Performance Domain;
- Obtain three Letters of Reference;
- Complete the IC & RC Prevention Specialist examination; and,
- Sign and notarize the Code of Ethical Standards.

Re-certification is required every two years. To be eligible, applicants must have at least 40 hours of continuing education, including 34 hours in the six Performance Domains and an additional 6 hours from an approved ethics training.

According to the state certification board, prevention certification is required for some state contracts but not everyone who works in prevention is required to be certified in New Hampshire. Generally, interviewees had positive things to say about the state certification program. Specifically, they remarked that it is a good program, which has a fairly low barrier in terms of time and cost in relation to the substantial legitimacy it adds to the field. The only major drawback to the certification programming was the lack of timely course availability. A couple of stakeholders stated that some courses are offered only every other year.

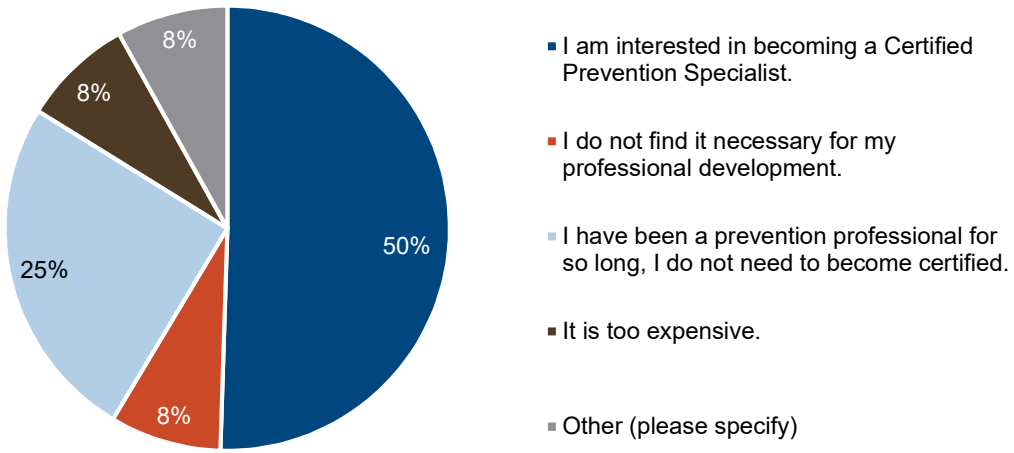
More than half of the survey respondents (54%) were CPS certified while 23 percent had no certification or licensure. This suggests that a large portion of New Hampshire's prevention professionals see value in obtaining some type of certification or licensure, even if not specifically CPS certified.

Figure 35. New Hampshire - Professional Certifications and Licensures



Of those who were not certified, half were interested in becoming certified and approximately a third did not feel it was necessary for their profession. The remaining portion of respondents indicated other barriers to certification, like cost.

Figure 36. New Hampshire - Feelings About Becoming Certified Prevention Specialist



New Hampshire's Strategic Plan

The Governor's Commission Plan for 2017 through 2020 has six priority areas for improving the efficiency and effectiveness of systems to support substance use prevention and strategies to address specific age groups.

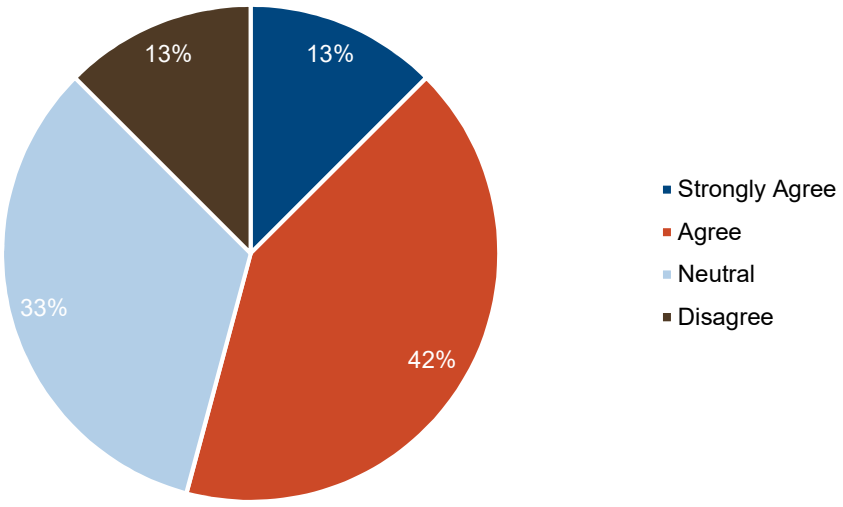
Priority Areas[137]

1. Improve systems to support the efficiency and effectiveness of substance misuse prevention.
2. Early childhood (0-5 years)
3. Children and youth (6-17 years)
4. Emerging and young adults (18-24 years)
5. Adults (18-54 years)
6. Older adults (55+ years)

In addition to providing appropriate education and messaging to specific age groups, part of the strategy for implementing these recommendations are creating ways to identify and promote education and training standards for prevention professionals. Specifically, the plan promotes credentialing of professionals and collaborating with key stakeholders like Family Resource Centers, the NH Charitable Trust, and state leadership teams, to identify and promote training opportunities.

While cultural competence and workforce diversity are not explicitly mentioned in context to the state's strategic plan, more than half of survey respondents (55%) indicated that New Hampshire promoted both.

Figure 37. New Hampshire - State Promotes Diversity in the Workforce



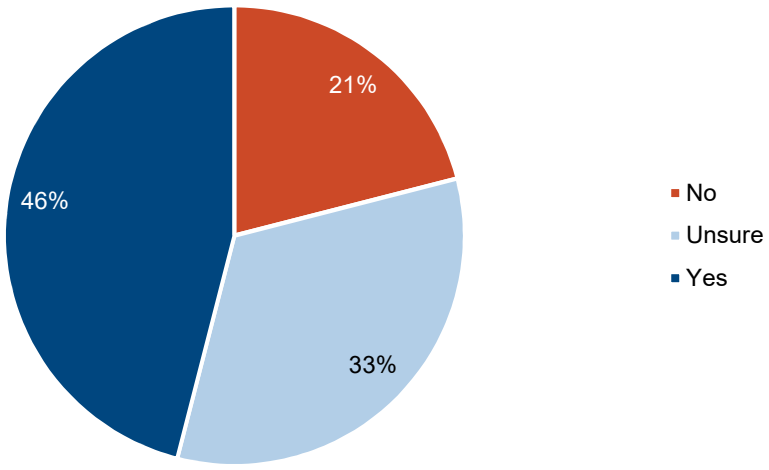
[137] http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/Prevention-Task-Force-State-Plan-Recommendations-FINAL.pdf

Current Training Availability

DHHS and NH Charitable Foundation (NHCF) co-founded the New Hampshire Center for Excellence which supports evaluation and technical assistance across the state through the NH Training Institute on Addictive Disorders (NHTIAD).[138] Stakeholders report that current training is limited for new professionals (with five or fewer years of experience) and advanced professionals (with 10 or more years of experience). There are a lot of webinars available through New Hampshire Alcohol & Drug Abuse Counselors Association (NHDACA), but they are not always targeted toward different audiences. There are some conference opportunities as well, but those appear to be more limited.

Despite various training and information sources, less than half (46%) of respondents indicated they had access to career development opportunities that matched their career goals.

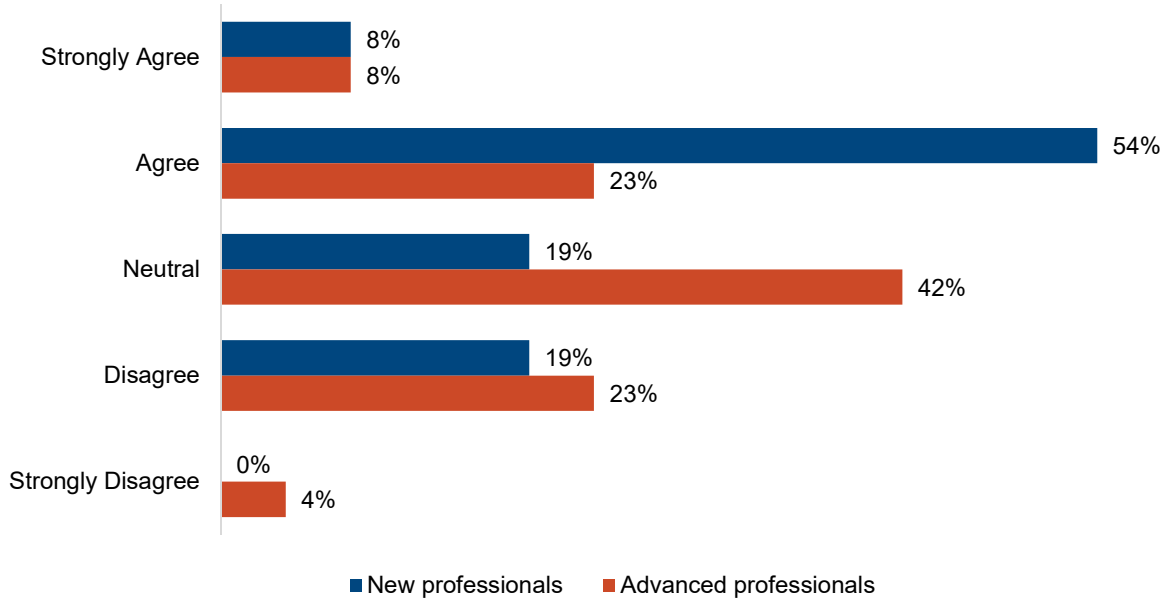
Figure 38. New Hampshire – Access to Career Development Opportunities



The lack of training availability was more apparent for advanced professionals than new professionals. While 62 percent of survey respondents agreed or strongly agreed that New Hampshire has adequate training opportunities for new professionals, only 31 percent reported adequate options for more seasoned professionals.

[138] https://nhcenterforexcellence.org/nh-training-institute/

Figure 39. New Hampshire - Availability of Training and Education



More than half of New Hampshire survey respondents requested training in the following areas.

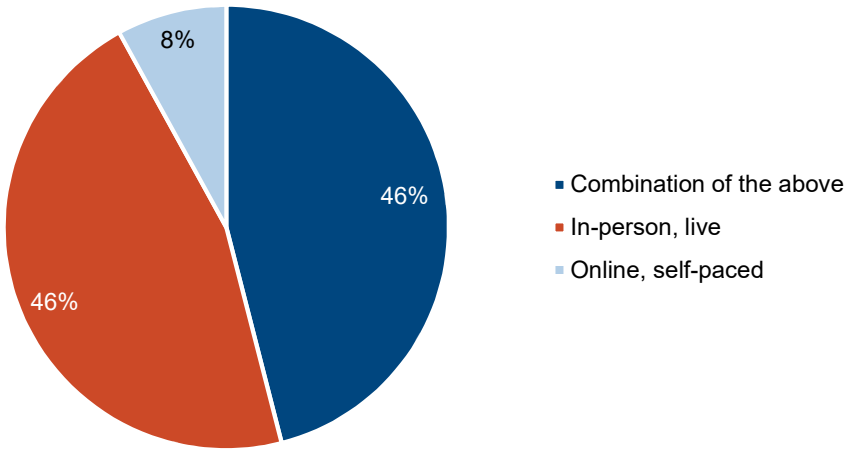
Table 25. New Hampshire - Most Requested Training Topics

Topics of Interest	Percent Wanting More Training
Advanced skills and knowledge in working with diverse populations	73%
Strategies to reduce SUD stigma	69%
Social and environmental factors affecting substance use prevention	69%
Co-occurring disorders	65%
Engagement of priority populations in prevention	65%
E-cigarettes/ Vaping	65%
Integrated models of care with interprofessional teams	65%
Recruitment and retention of prevention staff	65%
Ethical issues related to use of technology in delivering client/patient services	62%
Organizational change strategies	62%
Administrative skills	62%
Planning program sustainability	58%
Identifying community readiness to implement prevention interventions	58%
Trauma-informed care	58%
Marijuana	58%
Prevention of burnout among staff	58%
Funding options	54%
Identifying community assets and resources (human, fiscal, and organizational)	54%
Management skills	54%
Mentoring or coaching of prevention staff	54%
Selecting evidence-based interventions	54%
Opioids	54%

Alcohol	54%
Interpreting data to identify community needs	50%
Identifying risk and protective factors that impact disparate populations	50%
Motivational interviewing	50%

Survey respondents indicated an identical preference for in-person and combination trainings (46%). Very few (8%) indicated a preference solely for online training.

Figure 40. New Hampshire - Training Modality Preference



Gaps and Needs

Stakeholders suggested that future technical assistance/ training opportunities should:

- Consider new ways to tie prevention efforts to public health initiatives to maximize impact and sustainability
- Create opportunities for more advanced trainings for professionals who have been in the field a while
- Create mentorship and collaboration opportunities between neighboring states
- Have increased availability for certification required courses

Stakeholders would also like more information on:

- Workforce strategies to engage the LGBTQ community and other underserved populations, like veterans, older adults, and new Americans
- How to conduct program evaluations
- How to interpret and use data
- Logic model development

Appendix G: Rhode Island State Profile

Rhode Island is home to approximately one million people with an average of one thousand people per square mile according to the Census Bureau.[139] Rhode Island is the most densely populated state in New England.

Rhode Island is approximately 84 percent white; 16 percent Hispanic or Latino; 8 percent African American; and, 4 percent Asian, making it relatively ethnically diverse. Additionally, 17 percent of the population is over 65, which is slightly greater than the national average. These three facts (rurality, race/ethnicity, and age) present unique opportunities for the diverse workforce recruitment of Rhode Island, an aim of SAMHSA and the PTTC.

Prevention Defined

According to Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals' (BHDDH) Strategic Plan for Substance Use Prevention 2016-2019, the primary goals and strategies of prevention are 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."[140] BHDDH focuses on priority populations and activities, including substance use and misuse prevention, mental health promotion, violence prevention, and tobacco control to promote health and mental wellness. BHDDH also implements a population health model by integrating prevention and mental health promotion across behavioral health systems.[141] The model aims to improve the health of the entire population and to reduce health inequities among population groups.

Structure of Prevention Services

By focusing on the integration of prevention and mental health promotion across Rhode Island's behavioral health system, BHDDH has developed a stronger infrastructure to leverage efficiencies and opportunities for increased coordination, collaboration, and sustainability. BHDDH utilizes the Strategic Prevention Framework developed by SAMHSA. "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 in Rhode Island at the state and community levels."[142]
There are several components of Rhode Island's prevention infrastructure that play an important and distinct role in the substance use prevention system. These include:[143]

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[139] https://www.census.gov/quickfacts/fact/table/RI,MA,CT,US/PST045218
[140] http://www.bhddh.ri.gov/substance_use/pdf/BHDDH%20Final%20Prevention%20Strategic%20Plan%204-12-16.pdf
[141] http://www.bhddh.ri.gov/substance_use/pdf/BHDDH%20Final%20Prevention%20Strategic%20Plan%204-12-16.pdf
[142] http://www.bhddh.ri.gov/substance_use/pdf/BHDDH%20Final%20Prevention%20Strategic%20Plan%204-12-16.pdf
[143] http://www.bhddh.ri.gov/substance_use/pdf/BHDDH%20Final%20Prevention%20Strategic%20Plan%204-12-16.pdf

- Rhode Island's Governor's Council on Behavioral Health, who reviews and evaluates mental health and substance use and misuse needs and problems; the Prevention Advisory Committee, who provides recommendations to the Governor's Council.
- The Rhode Island Prevention Resource Center (RIPRC), which is a centralized training and technical assistance resource for Rhode Island substance use prevention providers.
- The Rhode Island State Epidemiological Outcomes Workgroup (SEOW), who guides institutionalized data-driven planning and decision making relevant to substance misuse and mental illness.
- The Rhode Island Student Assistance Services (RISAS), who provides school and community-based substance use prevention and early intervention to Rhode Island schools and communities.
- The Rhode Island Certification Board, who defines the baseline for all prevention credentials that are offered for CPS certification.
- The Substance Use and Mental Health Leadership Council of Rhode Island (SUMHLC), which is a nonprofit membership organization funded through the treatment set aside within the Substance Abuse Block Grant.

In 2016, Rhode Island rolled out a new prevention service delivery model that regionalized services. It has seven regional prevention coalitions that oversee 34 municipal coalitions across the state.[144] Regional providers are also responsible for overseeing 18 Partnerships for Success (PFS) grantees and seven State Opioid Response (SOR) grantees. Rhode Island has also developed Health Equity Zones (HEZ's) for areas that need additional assistance due to health disparity conditions. According to BHDDH's Strategic Plan for Substance Abuse Prevention, "It is of paramount importance to the State that providers and stakeholders identify the gaps and make the necessary changes to work towards creating greater behavioral health equity in the State."[145]

Prevention Funding

According to the state's National Prevention Network (NPN) Representative, Rhode Island has various federal funding sources for prevention services, including:

Table 26. Rhode Island - Prevention Funding Sources

Prevention Funding Sources[146]	
1.	SAMHSA Center for Substance Abuse Prevention Partnerships for Success 2018 Grant
2.	Substance Abuse Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG)
3.	State Opioid Response Dollars (SOR) Grants
4.	SAMHSA Drug Free Communities Grants

[144] https://1jhpx52ed2l72zja983tp5xl-wpengine.netdna-ssl.com/wp-content/uploads/2019/04/RIPRC-Prevention-Providers-List_8.12.19.pdf
[145] http://www.bhddh.ri.gov/substance_use/pdf/BHDDH%20Final%20Prevention%20Strategic%20Plan%204-12-16.pdf
[146] http://www.bhddh.ri.gov/sections/block_grant.php

Rhode Island state officials have placed an increased effort on the promotion of education about the importance and necessity of prevention services. They report that this education, coupled with increased federal dollars, has resulted in making the field more relevant.

Table 27. Rhode Island SAMHSA Funding Sources147

Funding Source	Substance Use Treatment	Substance Use Prevention	Mental Health	Total
Substance Abuse Prevention and Treatment Block Grant (SABG)	–	–	–	$7,864,276
SAMHSA - Discretionary Funding	$35,324,144	$4,357,145	$5,397,039	$35,324,144
Community Mental Health Services Block Grant	–	–	$2,645,828	$2,645,828

While most or all of prevention funding comes from federal services, Rhode Island's NPN did note that the proportion they spend on prevention versus treatment is 48 to 52, respectively, although this is not reflected in the budget data reported by state representatives. The increase in spending going toward prevention versus treatment has increased only within the last two years. This is much more than is required by the federal block grants to be spent on prevention services, and more than any other New England states allocate towards prevention efforts.

Scope of Prevention Work

BHDDH utilizes a life span framework across the Institute of Medicine (IOM) care continuum focusing on priority population and activities, including but not limited to substance use prevention, mental health promotion, violence prevention, and tobacco control to promote health and mental wellness in Rhode Island. "The life span (courses, or stages) framework helps to explain health and disease patterns, particularly health disparities, across populations over time."[148]

BHDDH has promoted ongoing 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.

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

[147] https://www.samhsa.gov/grants-awards-by-state/RI2018
[148]http://www.bhddh.ri.gov/substance_use/pdf/BHDDH%20Final%20Prevention%20Strategic%20Plan%204-12-16.pdf

abuse."[149] The state also utilizes its SEOW to collect, analyze and disseminate data through annual State Epidemiological Profile Reports. Some of the data sources collected include:[150]

- Annual Homelessness Assessment Report (AHAR);
- Behavioral Risk Factor Surveillance System (BRFSS);
- Bureau of Labor Statistics (BLS);
- Fatality Analysis Reporting System (FARS);
- Pregnancy Risk Assessment Monitoring System (PRAMS);
- National Survey on Children's Health (NSCH);
- National Survey on Drug Use and Health (NSDUH);
- National Vital Statistics System (NVSS);
- The Rhode Island Department of Children Youth and Families (RI DYCF);
- Rhode Island Kids Count;
- School Health Profiles;
- Uniform Crime Reports (UCR);
- United States Census; and,
- Youth Risk Behavior Survey (YRBS)

Rhode Island also utilizes media campaigns to spread the message of its prevention efforts. These include:

- **Count It, Lock It, Drop It** Opioid prevention campaign that encourages people to count their pills every two weeks, lock up medications and store them in places others would not think to look, and drop off unused/expired medication to proper disposal sites.

- **Hidden in Plain Sight** Prevention campaign focused on helping parents identify signs of youth drug and alcohol use.

- **Four Legs to Stand On** Media campaign that exposes the secrecy that shrouds the topic of addiction. Opening up to this problem and highlighting the importance of support and family are the goal and the hope.

State Prevention Workforce

Rhode Island's focus on multiple levels of prevention (substance use, mental health, violence) necessitates a collaborative effort to meet this goal. Stakeholders estimate that there are approximately 75 people doing primary prevention work in Rhode Island, but there are more in secondary prevention fields.

[149] http://www.bhddh.ri.gov/substance_use/pdf/BHDDH%20Final%20Prevention%20Strategic%20Plan%204-12-16.pdf
[150] http://www.riprc.org/wp-content/uploads/2016/04/2015_RI_State_Epi_Profile_Final_2-2016_rev.1.pdf

Workforce Survey

Using existing prevention workforce surveys from the IC & RC, as well as those conducted in Connecticut, Maine, Massachusetts, and Rhode Island, PCG developed a refined, web-based workforce survey which was disseminated in late July 2019. PCG used a snowball sampling method to disseminate the survey, wherein prevention leadership and stakeholder interviewees helped PCG in emailing the survey to their respective listservs.

The resulting workforce sample included 209 total stakeholders from various levels of prevention, comprising state level policy makers, prevention administrators, and prevention field staff, from all six states. A total of 22 people responded from Rhode Island.

State Board Certifications

The Rhode Island Certification Board supports the IC & RC Certified Prevention Specialist certification;[151] currently there are 21 certified prevention professionals. Rhode Island offers three stages of prevention certification, which include: Associate Prevention Specialist (APS); Certified Prevention Specialist (CPS); and, Advanced Certified Prevention Specialist (ACPS). "The certification process encompasses education and training in six domains provided by the IC & RC as well as work experience in the field of substance abuse prevention."[152] Rhode Island does offer reciprocity to and from other states for certified prevention specialist certification.

To become a Certified Prevention Specialist in Rhode Island, requirements include:[153]

- One year (2000 hours) of paid or volunteer prevention work experience. Employment must have been gained within the last five years.
- Employment in a prevention position at the time the application is submitted.
- High school diploma/GED.
- 175 hours of education relevant to domains, of which 24 are Alcohol, Tobacco, and Other Drugs (ATOD) specific, minimum of 25 in each domain, and six hours in ethics.
- 120 hours with a minimum of 10 hours in each domain.
- Pass the IC & RC Examination for Prevention Specialists

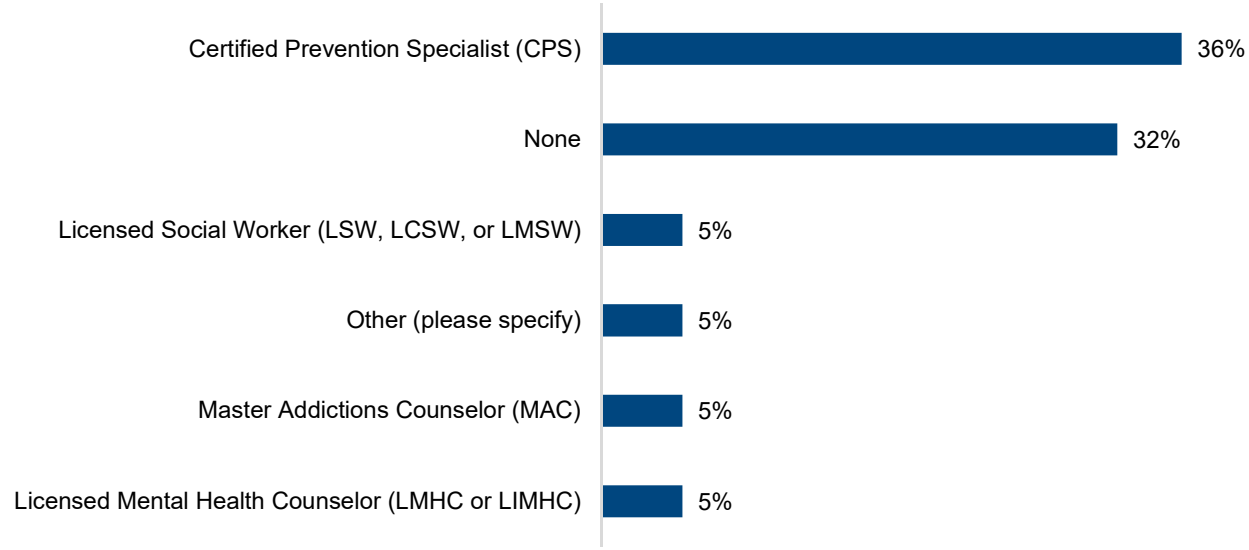
To become a certified CPS, a candidate must demonstrate he or she has completed appropriate education, training, and supervised experience relevant to the performance domains. The exam tests each candidate's knowledge in six domains: planning and evaluation; prevention education and service delivery; communication; community organization; public policy and environmental change; and professional growth and responsibility.

[151] https://www.ricertboard.org/
[152] http://www.bhddh.ri.gov/substance_use/professional_prevention.php
[153] https://www.ricertboard.org/sites/default/files/applications/RICBCPSApplication_0.pdf

According to municipal coalition leaders and the state's NPN, prevention certification is required within one year of employment in the prevention field. To assist individuals in passing the IC & RC exam the Rhode Island Prevention Resource Center (RIPRC) developed *The Rhode Island Prevention Certification Guide: A Study Guide to Certification*. The resource was sponsored by BHDDH and implemented by JSI Research & Training Institute, Inc. The resource has been shared all over New England and nationally as a study aid to assist prevention professionals in preparing for the IC & RC Certification Exam.[154]

According to the PCG workforce survey, more than a third of respondents (36%) were CPS certified and another third (32%) had no certification or licensure.

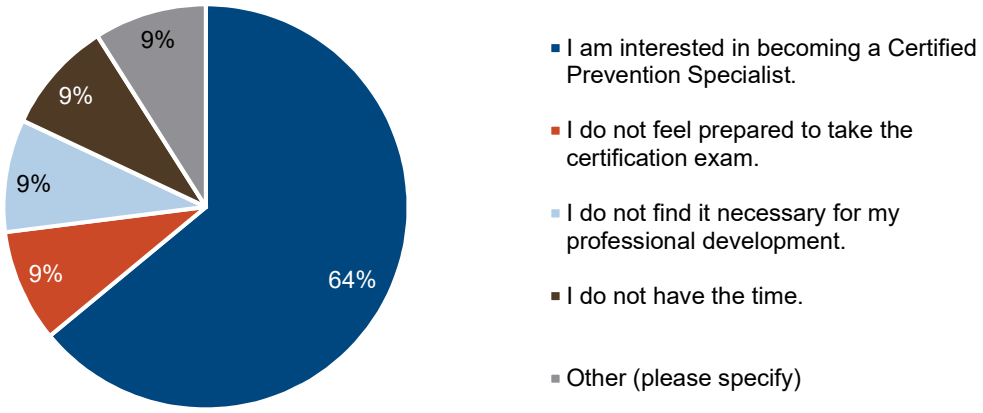
Figure 41. Rhode Island - Professional Certifications and Licensures



Of those who were not CPS certified, most (64%) were interested in becoming certified, 27 percent identified various barriers, like time and exam preparation, and only 9 percent indicated that they didn't feel certification was necessary for their profession.

154 https://www.internationalcredentialing.org/resources/Documents/PreventionCertificationStudyGuide.pdf

Figure 42. Rhode Island - Feelings About Becoming Certified Prevention Specialist



Rhode Island's Strategic Plan

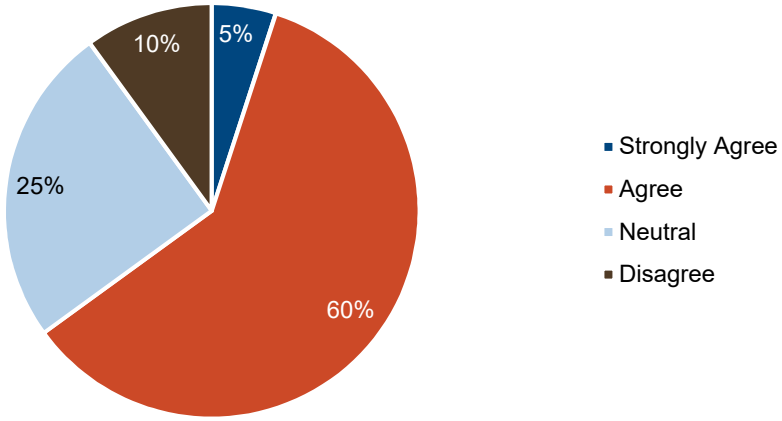
The goals for Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals' (BHDDH) Strategic Plan for Substance Use Prevention 2016-2019 were based on the SEOW's Substance Use and Mental Health in Rhode Island (2015) State Epidemiological Profile. "The plan reflects 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."[155]

The aim of Rhode Island's strategic 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; and, create an integrated prevention service delivery system which incorporates a broader behavioral health approach. The steps of the Strategic Prevention Framework require Rhode Island and its communities to systematically:[156] 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.

Since workforce capacity is a large part of Rhode Island's strategic plan, it is unsurprising that 65 percent (65%) of survey respondents agreed or strongly agreed that the state promotes diversity and cultural competence in the workforce.

[155] http://www.bhddh.ri.gov/substance_use/pdf/BHDDH%20Final%20Prevention%20Strategic%20Plan%204-12-16.pdf
[156] http://www.bhddh.ri.gov/substance_use/pdf/BHDDH%20Final%20Prevention%20Strategic%20Plan%204-12-16.pdf

Figure 43. Rhode Island - State Promotes Diversity in the Workforce

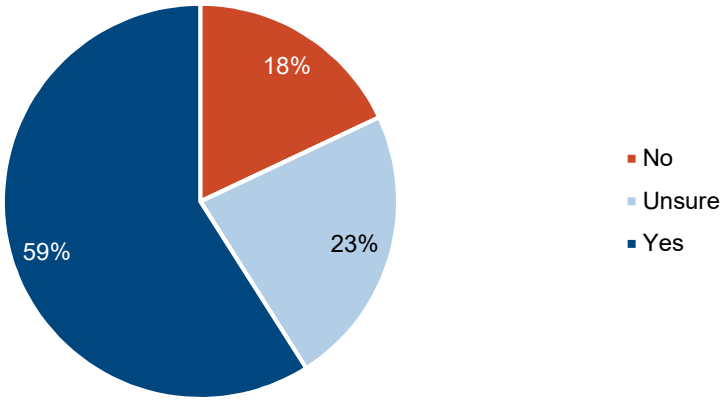


Current Training Availability

Rhode Island has multiple organizations which provide substance use prevention training and technical assistance. The Rhode Island Prevention Resource Center provides in person trainings and seminars, and technical assistance to prevention providers, as well as offers different community engagement events for parents and other interested stakeholders. The Substance Use and Mental Health Leadership Council of RI (SUMHLC) and the John Snow Inc. Research and Training Institute, Inc. also offer additional e-learning and in person trainings throughout Rhode Island. BHDDH also organizes several different seminars for prevention providers throughout the year.

Despite various sources of information, 41 percent of survey respondents were unsure or said they did not have access to career development opportunities that match their career goals.

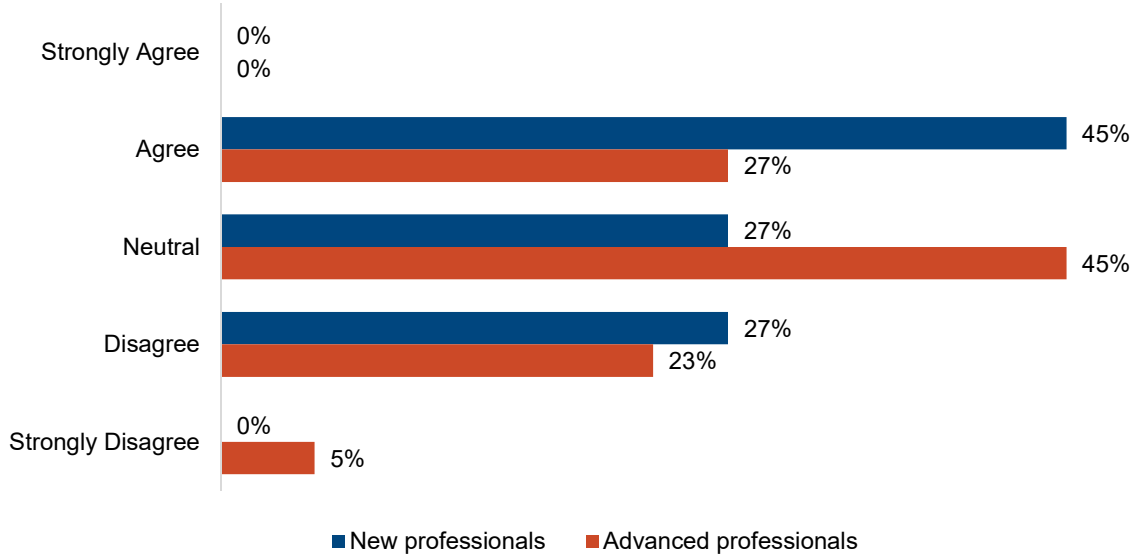
Figure 44. Rhode Island - Access to Career Development Opportunities



Survey respondents further indicted that there was more adequate training availability for

new professionals (with five or fewer years of experience) than for more advanced professionals (with 10 or more years of experience).

Figure 45. Rhode Island - Availability of Training and Education



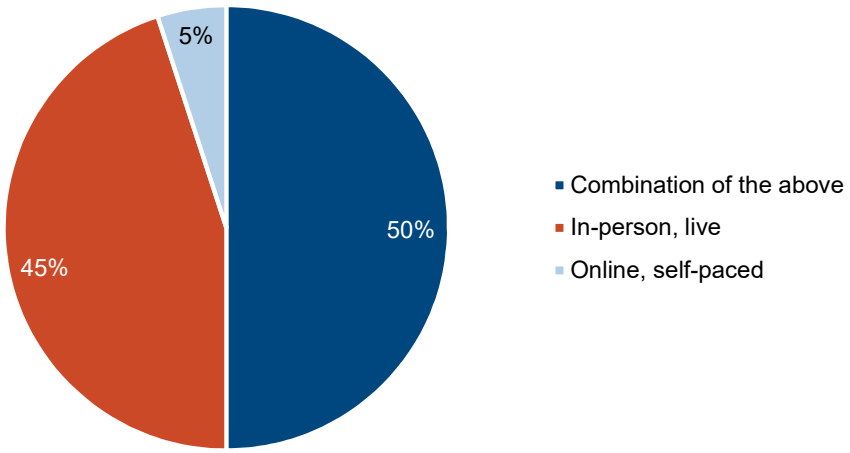
More than half of Rhode Island survey respondents requested training in the following areas.

Table 28. Rhode Island - Most Requested Training Topics

Topics of Interest	Percent Wanting More Training
Strategies to reduce SUD stigma	68%
Engagement of priority populations in prevention	68%
Co-occurring disorders	64%
Advanced skills and knowledge in working with diverse populations	64%
Suicide assessment and prevention	64%
Social and environmental factors affecting substance use prevention	59%
Identifying risk and protective factors that impact disparate populations	59%
Funding options	55%
Planning program sustainability	55%
Marijuana	55%
Selecting evidence-based interventions	55%
Interpreting data to identify community needs	50%
Trauma-informed care	50%
Confidentiality and privacy rules, including HIPAA and 42 CFR Part 2	50%

While Rhode Island survey respondents indicated a preference for training that combines online and in-person modalities, many also indicated a strict preference for in-person only trainings (45%). Few (5%) indicated a preference for solely online courses.

Figure 46. Rhode Island - Training Modality Preference



Gaps and Needs

Stakeholders recommended that any future technical assistance/ training opportunities should be:

- Defining what constitutes evidence-based practices
- Providing resources on how to end the stigma surrounding mental health in communities
- Moving away from content and focusing on skills and application of knowledge to practice
- Supporting new and innovative prevention solutions and providing new information
- Offering online and self-paced Ethics and Advanced Ethics, and Onboarding trainings
- Providing in person Train the Trainer for SPF Model trainings

Stakeholders would also like more information on:

- Effective data collection strategies and engaging external stakeholders, like school superintendents, on the importance of the YRBS and RPFS
- Budget management, and staff and coalition sustainability
- Cultural competency and health equity approaches to prevention
- Thinking about service delivery differently and fostering valuable community connections
- What other local and regional coalitions, and NE states are doing
- Tobacco use and mental health, and chronic disease information related to substance use

Appendix H: Vermont State Profile

Vermont is home to approximately 626,000 people with an average of 67.9 people per square mile according to the Census Bureau.[157] It is the second least densely populated state in New England, following Maine.

The population is also primarily white (95%) with one and two percent reporting African American or Asian descent, respectively. Approximately two percent of the population is also Hispanic. Additionally, about 19 percent of the population is over the age of 65, which makes Vermont the second oldest state in New England (behind only Maine). Like several other states, vast rural areas, limited racial and ethnic diversity, and an aging population present challenges to creating a diverse workforce in Vermont, an aim of SAMHSA and the PTTC.

Prevention Defined

The Vermont Department of Health has an Alcohol and Drug Abuse Program Division which includes prevention, intervention, treatment, and recovery. Prevention is defined as programs that "support communities to grow in wellness and health."[158] The state's goal of prevention services is to prevent substance misuse and reduce risks that contribute to alcohol, tobacco and other drug use and promotes protective factors to support healthy lifestyles and communities.[159]

Structure of Prevention Services

Vermont funds twelve Regional Prevention Consultants across the state to provide technical assistance to agencies, organizations, and individuals about community organizing, program planning, presentations and training, community grant information and guidance, and general information and referral. The goal of the prevention consultant system is to improve local capacity to carry out effective substance use prevention efforts.[160]

Additionally, Vermont has 20 substance use coalitions who also support stakeholder engagement more directly via summer camps, school projects, hospital outreach.
The state has structured prevention services using the Vermont Prevention Model, which is based on the ecological perspective on health promotion and planning to affect prevention efforts at each of the following levels: state, community, school, family, and individual environments.[161] All federally funded programs are required to use evidence-based practices, which are mostly environmental with some individual-based interventions.

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[157] https://www.census.gov/quickfacts/
[158] https://www.healthvermont.gov/alcohol-drug-abuse/programs-services/prevention-programs
[159] https://www.healthvermont.gov/alcohol-drug-abuse/programs-services/how-prevention-works
[160] http://www.healthvermont.gov/sites/default/files/documents/2017/01/ADAP_Prevention%20Program%20Overview.pdf
[161] http://www.healthvermont.gov/sites/default/files/documents/2017/01/ADAP_Prevention%20Program%20Overview.pdf

Figure 47. Vermont Prevention Model

In addition to the Vermont Prevention Model, all substance use prevention programs and activities are identified through the Strategic Prevention Framework (SPF). The SPF utilizes a public health planning model that begins with a data driven assessment of the needs, followed by the building of, or mobilizing capacity and readiness, development of a plan, implementation and evaluation throughout the process.

Figure 48. SPF Model

Prevention Funding

According to the state's strategic plan, Vermont has various state and federal funding sources for prevention services. In 2016, community-based prevention grants were joint initiatives between the Division of Alcohol and Drug Abuse Programs (ADAP) and the Tobacco Control Program to reduce health-care costs by creating of healthy communities.[162] However, prevention stakeholders report that nearly all (98%) prevention efforts in Vermont are federally funded with a small amount coming from private

162 http://www.healthvermont.gov/sites/default/files/documents/2017/01/ADAP_Prevention%20Program%20Overview.pdf

organizations/ grants.

Table 29. Vermont - Prevention Funding Sources

Prevention Funding Sources[163]
1. Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG)
2. SAMHSA Partnerships for Success (PFS)
3. SAMHSA Regional Prevention Partnerships
4. SAMHSA Center for Substance Abuse Prevention (CSAP) Prevention Fellowship Program
5. Vermont School-based Substance Abuse Services Grant
6. State Opioid Response Grant (SOR)
7. SAMHSA Drug Free Communities Grants

Vermont receives considerable funding from SAMSHA for substance use programming. Over the last 15 years they have consistently spent much more than the allocated 20% of the Block Grant on prevention. Treatment efforts, however, are still funded much more extensively than prevention.

One stakeholder mentioned the connection between prevention and mental health, recognizing the relationships between co-occurring mental health and substance use issues. While some collaboration is beginning, limitations to these partnerships arise when funding streams do not promote them. More sophistication is needed to weave these systems together as neither prevention nor mental health professionals are particularly well trained in how to deal with the other.

Table 30. Vermont SAMHSA Funding Sources164

Funding Source	Substance Use Treatment	Substance Use Prevention	Mental Health	Total
Substance Abuse Prevention and Treatment Block Grant (SABG)	–	–	–	$6,725,555
SAMHSA - Discretionary Funding	$11,881,324	$1,010,620	$2,136,293	$15,028,237
Community Mental Health Services Block Grant	–	–	$1,361,345	$1,361,345

Scope of Prevention Work

Vermont recognizes that no one approach to prevention works for everyone. Stakeholders report utilizing SAMSHA's six strategies for prevention as outlined in the Focus on Prevention 2017 publication to engage and educate the public[165]: information

163 http://www.healthvermont.gov/sites/default/files/documents/2017/01/ADAP_Prevention%20Program%20Overview.pdf

164 https://www.samhsa.gov/grants-awards-by-state/VT/2018

165 https://store.samhsa.gov/system/files/sma10-4120.pdf

dissemination; prevention education; positive alternatives; environmental strategies; community-based processes; and identification of problems, and referral to services,

Vermont recently hired a new chair for the State Epidemiological Outcomes Workgroup (SEOW). It uses the SEOW to meet bi-weekly and run statewide substance use data every other year on key data sources like the National Survey on Drug Use and Health (NSDUH) and the Youth Risk Behavior Survey (YRBS) surveys. Stakeholders also reported collecting their own data using Drug Free Communities grant money, However, nearly all interviewees reported limitations on the ability to find and access current and local data. Stakeholders also mentioned that finding data on specific topics, like vaping, can be challenging.

Vermont utilizes the SPF prevention model to target youth and adults and seek to educate as well as influence behavior. The Vermont Department of Health promotes several prevention campaigns, primarily about underage drinking, binge drinking, and non-medical prescription drug use. Examples of prevention campaigns include:

- **eCheckup to Go** works with colleges to target specific populations of high-risk drinking and tailors programming to the college.[166]
- **ParentUp** is a web-based campaign to educate parents on how to talk to teens about marijuana and other substance use.[167]
- **Most Dangerous Leftover** program is an educational campaign for safe prescription drug disposal targeted toward all Vermont adults.[168]
- **Do Your Part** asks Vermonters to properly store medications in lock boxes or locked cabinets and use state provided drop off locations or mail centers to dispose of unused medication.[169]

Many stakeholders suggested that there is a misalignment of funding and substance use priorities. Specifically, there is more funding for opioids and prescription drug use than marijuana, tobacco, and binge/ underage drinking. However, the latter three are much more prevalent issues in Vermont.

[166] https://www.c4tbh.org/program-review/alcohol-echeckup-go/
[167] https://parentupvt.org/
[168] https://www.healthvermont.gov/file/most-dangerous-leftovers-0
[169] https://www.rutlandherald.com/features/weekend_magazine/health-talk-do-your-part/article_61760b71-b569-5c68-9aef-8f2e4e26c45c.html

Table 31. Substance Use in Vermont

Substance	Percent of Use
Underage Alcohol use in past month (12-20)[170]	28%
High School Students Who Currently Drink Alcohol[171]	30% - 34%
Marijuana use in past month (18-25)[172]	39%
High School Students Who Currently Use Marijuana[173]	21% - 27%
Cigarette use in the past month (18-25)[174]	33%
High School Students Who Currently Use an Electronic Vapor Product[175]	12% - 14%
Heroin use in the past year (18+)[176]	0.51%
Prescription medication misuse in the past year (18+)[177]	4.35%

Based on information from NSDUH and YRBS, data suggests nearly a third of 12- to 20-year-olds have engaged in illegal, underage drinking within the past month; more than a third of 18- to 25-year-old Vermonters have used marijuana in the past month; and a third of 18- to 25-year-olds have smoked cigarettes in the past month. In comparison, less than one percent of Vermont adults have used heroin and less than five percent have misused prescription medication in the past year.

While exact proportions of what is spent on different substance use topics was unavailable, stakeholders state and NSDUH and YRBS data agree that prevention funding should primarily target marijuana use, tobacco use, and underage drinking. However, stakeholder report that funding for these topics is a balancing act. As opioid use has been highly sensationalized, and Vermont's economy relies largely on tourism dollars related to brewing and distilling, this has resulted in a cultural conflict.

[170] https://pdas.samhsa.gov/saes/state
[171] US Dept. of Health and Human Services, Centers for Disease Control and Prevention (2017) National Youth Risk Behavior Survey [PowerPoint slides]. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/results.htm
[172] https://pdas.samhsa.gov/saes/state
[173] US Dept. of Health and Human Services, Centers for Disease Control and Prevention (2017) National Youth Risk Behavior Survey [PowerPoint slides]. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/results.htm
[174] https://pdas.samhsa.gov/saes/state
[175] US Dept. of Health and Human Services, Centers for Disease Control and Prevention (2017) National Youth Risk Behavior Survey [PowerPoint slides]. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/results.htm
[176] https://pdas.samhsa.gov/saes/state
[177] https://pdas.samhsa.gov/saes/state

State Prevention Workforce

Each state defines its prevention workforce a little differently. Some include Drug-Free Community recipients and coalitions, whereas others include only primary prevention workers or staff specifically funded by federal grants. Vermont stakeholders estimate that there are 65 student assistance programs, 12 regional prevention consultants and 20 coalitions with approximately two or three staff each working in prevention. If Boys & Girls Club staff, teachers, and school nurses are included, there are perhaps a couple thousand people working at various levels of prevention across the state.

Workforce Survey

Using existing prevention workforce surveys from the IC & RC, as well as those conducted in Connecticut, Maine, Massachusetts, and Rhode Island, PCG developed a refined, web-based workforce survey which was disseminated in late July 2019. PCG used a snowball sampling method to disseminate the survey, wherein prevention leadership and stakeholder interviewees helped PCG in emailing the survey to their respective listservs.

The resulting workforce sample included 209 total stakeholders from various levels of prevention, comprising state level policy makers, prevention administrators, and prevention field staff, from all six states. A total of 15 people responded from Vermont.

State Board Certifications

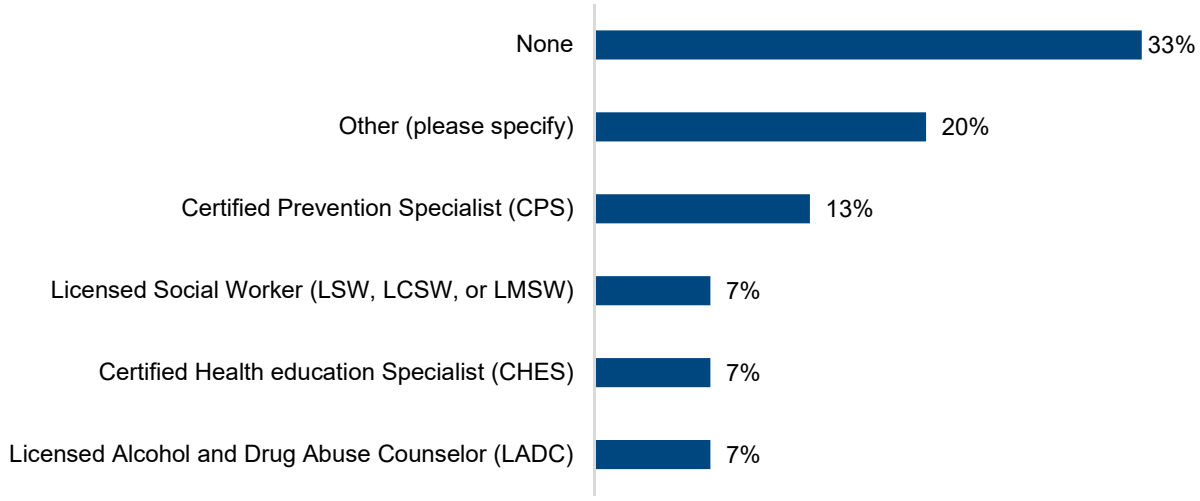
The Vermont Office of Professional Regulation does not currently support a certification specifically for prevention professionals.[178] Instead, the state offers certifications for drug and alcohol counselors and treatment professionals and has a reciprocal relationship with surrounding New England states to recognize certifications achieved in other states.

According to state officials, Vermont is considering the development of a prevention certification; however, the state is still weighing the cost and benefit of this offering. The primary argument against pursing prevention certification, according to the Department of Health, is that agencies in Vermont do not necessarily want to pay providers more for certification, so the public demand has not been strong.

Approximately 13 percent of the survey respondents were CPS certified and a third (33%) had no certification or licensure.

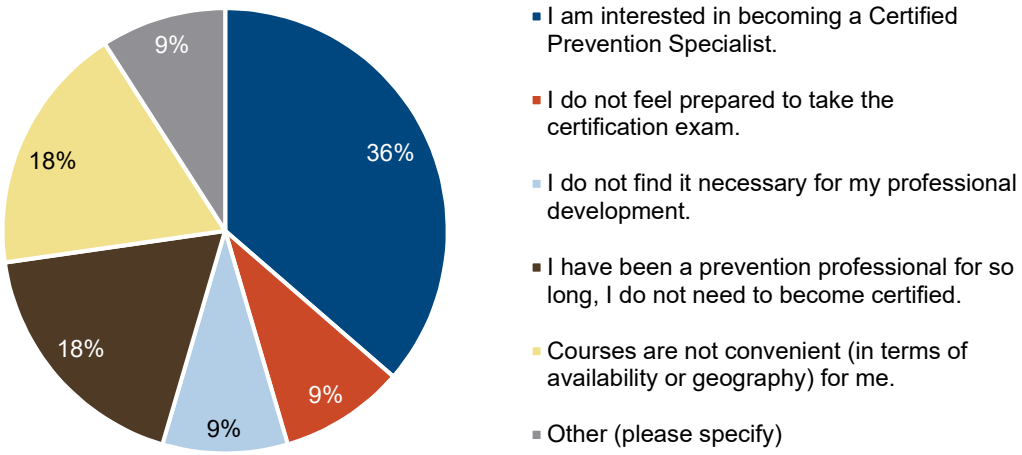
[178] https://www.sec.state.vt.us/professional-regulation.aspx

Figure 49. Vermont - Professional Certifications and Licensures



Of the survey respondents who were not certified, more than a third (36%) expressed interest in becoming certified. About one quarter (27%) indicated barriers to certification, like convenience of training, and 36 percent reported that they did not find certification necessary for their profession.

Figure 50. Vermont - Feelings About Becoming Certified Prevention Specialist



Vermont's Strategic Plan

The Vermont Department of Health strategic plan was informed by the strategic plan for the Agency of Human Services and is based on evidence-based practices and partnerships between local providers and community-based organizations. The plan for 2017 through 2020 has six goals:[179]

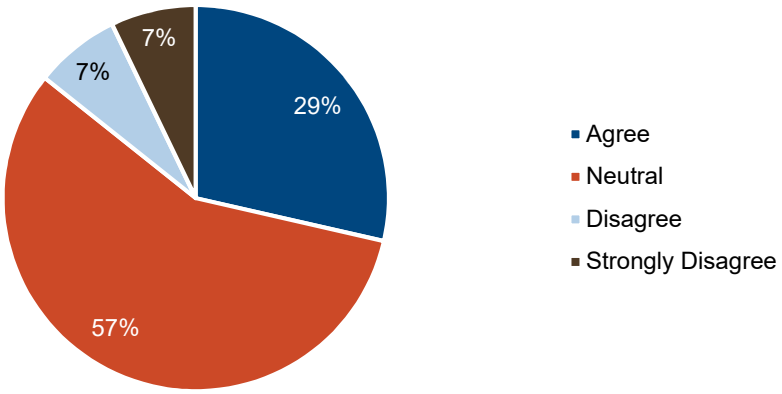
[179] https://www.healthvermont.gov/sites/default/files/documents/2017/02/ADAP_Strategic_Plan.pdf

1. Effective and integrated public health;
2. Communities with the capacity to respond to public health need;
3. Internal systems that provide for consistent and responsive support;
4. Competent and valued workforce that is supported in promoting the public's health;
5. Public health system that is understood and valued by Vermonters; and
6. Health for all Vermonters.

Not only does Vermont's strategic plan to address substance use seek to increase education and access of services/treatment for the public, but a large portion of the plan focuses on recruitment and training of a quality workforce, including prevention professionals. Part of the strategy for responding to public health needs is to strengthen regional capacity by funding communities and schools through the Regional Prevention Partnerships grant, School-based Substance Abuse Services grant, and the Prevention Consultant system. The strategic plan also seeks to increase the quality of prevention practitioners by promoting certification through the IC & RC by providing training in competency areas (Substance Abuse Prevention Skills, American Society of Addiction Medicine, co-occurring disorders, motivational interviewing, trauma-informed care, Standards and Linguistically Appropriate Services, and recovery coaching) and educating practitioners about certification resources. The plan further promotes the incorporation of an orientation process across program areas for new hires to expose them to best practices in operational and performance management, prevention, treatment, and recovery. Additionally, the state seeks to promote substance use services to disparate populations through the use of National Standards for Culturally and Linguistically Appropriate Services and cultural brokers throughout the state.

Despite intentional focus of the state's strategic plan on promotion of workforce diversity, most survey respondents were neutral when asked if their state promotes diversity and cultural competence in the workforce. Less than a third (29%) agreed and zero percent strongly agreed that it did.

Figure 51. Vermont - State Promotes Diversity in the Workforce

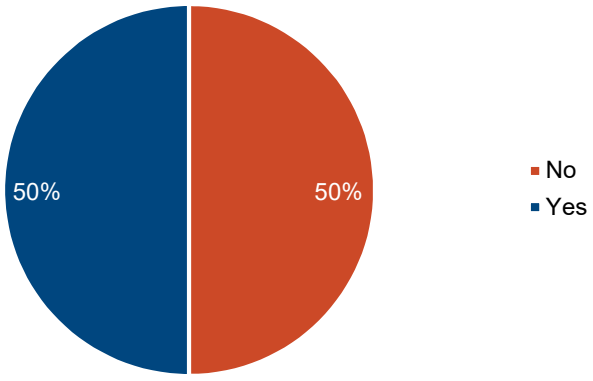


Current Training Availability

State-level interviewees report that in addition to utilizing previously available CAPT training, the state has invested over $60,000 through the PFS grant over the last five years in statewide training and hosts five in-person trainings each year. Although the trainings are paid for and targeted to PFS grantees, trainings are open to all prevention professionals for free.

To the contrary, some survey respondents and some stakeholders report limited educational opportunities for prevention professionals in Vermont. Vermonters mentioned annual SAPST training, an annual tobacco prevention training, one or two local alcohol and drug use conferences, and some opportunities for technical assistance from nonprofits. They indicated that prevention professionals are usually forced to look for out-of-state trainings like the Community Anti-Drug Coalitions of America (CADCA) conference. It was also reported that coalitions will sometimes bring in outside consultants for their communities.

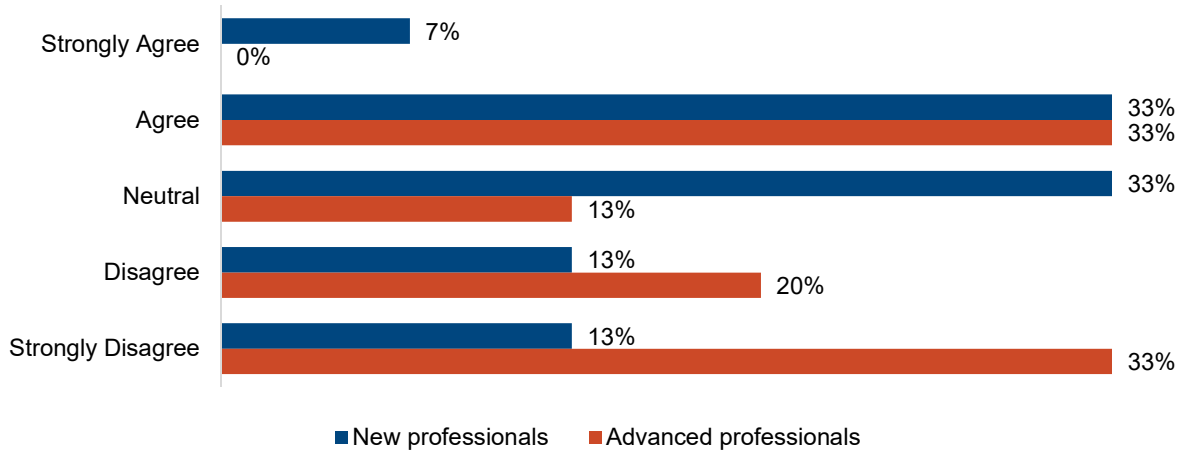
Figure 52. Vermont - Access to Career Development Opportunities



Despite many sources of information, only half of survey respondents indicated that they had access to career development opportunities that match their career goals.

Less than half of respondents strongly agreed or agreed that there was adequate training available for new professionals (with five or fewer years of experience) or advanced professionals (with 10 or more years of experience), but there were generally more opportunities for new professionals.

Figure 53. Vermont - Availability of Training and Education



More than half of survey respondents requested training on the following topics.

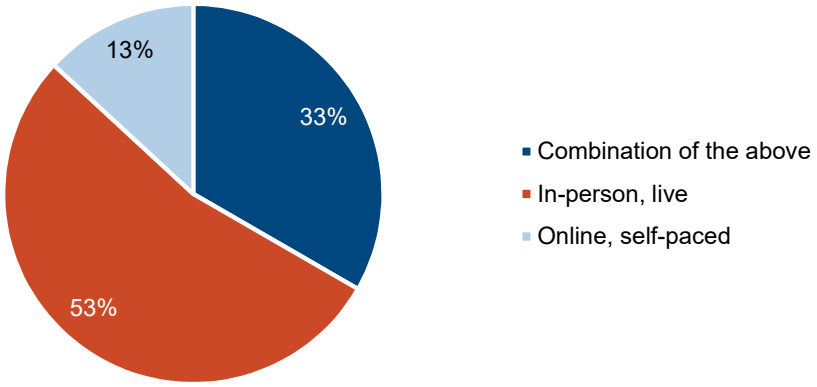
Table 32. Vermont - Most Requested Training Topics

Topics of Interest	Percent Wanting More Training
Mobilization and engagement of community stakeholders	80%
Management skills	80%
Engagement of priority populations in prevention	73%
E-cigarettes/ Vaping	73%
Identifying community readiness to implement prevention interventions	73%
Integrated models of care with interprofessional teams	73%
Marijuana	73%
Social and environmental factors affecting substance use prevention	67%
Advanced skills and knowledge in working with diverse populations	67%
Suicide assessment and prevention	67%
Identifying risk and protective factors that impact disparate populations	67%
Ethical issues related to use of technology in delivering client/patient services	67%
Identifying community assets and resources (human, fiscal, and organizational)	67%
Trauma-informed care	67%
Confidentiality and privacy rules, including HIPAA and 42 CFR Part 2	67%
Planning program sustainability	60%
Interpreting data to identify community needs	60%
Selecting evidence-based interventions	60%

Tobacco	60%
Development of measurable goals and objectives	53%
Opioids	53%
Alcohol	53%

While there was a clear preference among Vermont survey respondents for in-person training (53%), a substantial portion (33%) also requested a combination of training modalities.

Figure 54. Vermont - Training Modality Preference



Gaps and Needs

Stakeholders, while generally excited about the prospect of a technical assistance and training platform, suggested the PTTC might increase the publicity and visibility of the program so that all prevention professionals are aware of the resource. The consensus was that the program is and will be useful, if it can become better known as a resource.

Based on their experience, stakeholders further suggested that any future technical assistance/ training opportunities should:

- Consider ways to better meet the dynamic needs of regions in terms of topic and mode of service delivery
- Create opportunities for collaboration and mentorship between states
- Work to develop a prevention system of care, like the existing treatment system of care in Vermont, to legitimize the field and increase the efficiency
- Obtain experts to conduct specific trainings, instead of relying solely on in-house staff.
- Collaborate with state training organizations to coordinate trainings and reduce duplication

Stakeholders would also like more information on:

- Prevention basics (communication training, sustainability, how to apply for a grant)
- The effects of marijuana legalization

- How to talk to youth about prevention as a career
- Professional development (time management, how to be a first-time supervisor, working with difficult people)
- Sustaining prevention for the future
- How to create braided funding streams with mental health services
- How to interpret and use data to support prevention efforts

In addition, to PTTC offerings, Vermont has also pledged to offer PFS trainings in December 2019 around grant writing, a statewide conference around marijuana legalization in April 2020, and has held annual trainings around data use and interpretation.