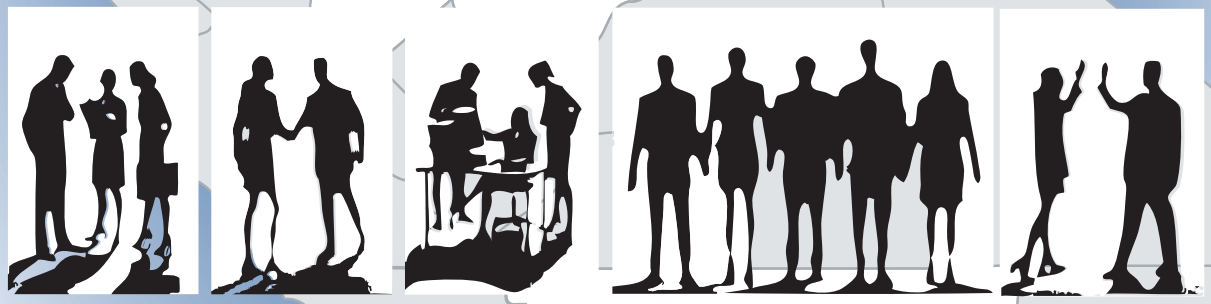
SDFSC Grantee

Learning Community Conference 2007



California's

Safe and Drug-Free Schools and Communities

Governor's Program

Technical Assistance & Training Project

CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS

Managed by The Center for Applied Research Solutions
Funded by The California Department of Alcohol and Drug Programs

Agenda: Day 1

Day One: Tuesday, July 17th , 2007

8:00 to 8:30 **Registration, Networking and Continental Breakfast**
Coordinated by Angela Okamura and Maria Traylor, CARS

8:30 to 9:00 **Welcome and Conference Overview**
Event Hosts: Jane Williams, ADP and Kerrilyn Scott-Nakai, CARS

9:00 to 10:00 **Keynote: No More "Children at Risk": Children at Promise**
The Power of a "Resiliency" Research to Practice Application
Presenter: Mervlyn K. Kitashima

10:00 to 10:15 **BREAK**

10:15 to 12:15 **Concurrent Break-Out Sessions**

Session A: Creating a Continuum of Services: SDFSC Application of the IOM
Facilitated by Jan Ryan

Session B: Nicely Winding Down: Bringing Appropriate Closure for Staff and Participants
Facilitated by Rocco Cheng, Ph.D.

Session C: Make a Wish: The Art of Making Evidence-Based Prevention a Reality
Facilitated by Christina Borbely, Ph.D. with Peer Presentations

12:15 to 1:30 **Lunch, Networking, and Raffle**

1:30 to 2:30 **Effectively Telling Your Story: Strategies for Marketing Your Program for Long-Term Sustainability**
Presenters: Mark Simon and Christina Borbely, Ph.D.

2:30 to 2:45 **BREAK**

2:45 to 4:00 **Creating Compelling and Effective Documents: Executive Summaries and Key Findings Reports**
Facilitated Workgroup Activity and Report Out
Facilitated by Mark Simon and Christina Borbely, Ph.D.

Agenda

Agenda: Day 2

Day Two: Wednesday, July 18th , 2007

8:00 to 8:30 **Registration, Networking and Continental Breakfast**
Coordinated by Angela Okamura and Maria Traylor, CARS

8:30 to 8:45 **Welcome and Overview of the Agenda**
Event Hosts: Jane Williams, ADP and Kerrilyn Scott-Nakai, CARS

8:45 to 9:45 **Keynote: Stand By Me: Planting the Seeds for Future Harvests**
Presenter: Devone Boggan

9:45 to 10:00 **BREAK**

10:00 to 12:00 **Concurrent Break-Out Sessions**

Session A: Creating a Continuum of Services: SDFSC Application of the IOM
Facilitated by Jan Ryan

Session B: Nicely Winding Down: Bringing Appropriate Closure for Staff and Participants
Facilitated by Rocco Cheng, Ph.D.

Session C: Make a Wish: The Art of Making Evidence-Based Prevention a Reality
Facilitated by Christina Borbely, Ph.D. with Peer Presentations

12:00 to 1:15 **Lunch, Networking, and Raffle**

1:15 to 1:45 **Lessons from the Field: Capturing the Years' Successes and Best Practices**
Presenter: Kerrilyn Scott-Nakai

1:45 to 3:15 **Documenting Our Successes: Round Table**
Discussions, Workgroup Activity, and Report Out
Facilitated by Kerrilyn Scott-Nakai, Christina Borbely, Ph.D., Rocco Cheng, Ph.D., Angela De Ra, and Jan Ryan

3:15 to 3:30 **Wrapping-It Up and Raffle**

Plenary Sessions

Day 1: Tuesday, July 17th

Keynote
No More “Children at Risk”: Children at Promise
The Power of a “Resiliency” Research to Practice Application
Presenter: Mervlyn K. Kitashima

Plenary Session
Effectively Telling Your Story: Strategies for Marketing Your Program for Long-Term Sustainability
Presenters: Mark Simon and Christina Borbely, Ph.D.

Plenary Session
Creating Compelling and Effective Documents: Executive Summaries and Key Findings Reports

Day 2: Wednesday, July 18th

Keynote
Stand By Me: Planting the Seeds for Future Harvests
Presenter: Devone Boggan

Plenary Session
Lessons from the Field: Capturing the Years’ Successes and Best Practices
Presenter: Kerrilyn Scott-Nakai

Plenary Session
Documenting Our Successes: Roundtable Discussions, Workgroup Activity, and Report Out
Facilitators: Kerrilyn Scott-Nakai, Christina Borbely, Ph.D., Rocco Cheng, Ph.D., Angela De Ra, and Jan Ryan

Plenary Session
Wrapping-It Up

Plenary

Welcome

Welcome: An Introduction to the 2007 Safe and Drug-Free Schools and Communities Learning Community Conference

Jane Williams
State of California, Department of Alcohol and Drug Programs
Program Services Division, Prevention Services

Jane Williams has been working in the alcohol and other drug field since 1986. She began at the Sacramento County Office of Education working with the California Friday Night Live Program. Her claim to fame is that she is responsible for creating the first Friday Night Live Chapter Handbook and designing the "palm tree" t-shirt. From her humble beginnings in promotional ready-to-wear, she moved to the California Department of Alcohol and Drug Programs as a governmental program analyst where she was involved in numerous prevention programs and campaigns over the years.

Currently, Ms. Williams is the supervisor of the Prevention Program Management section. The unit is responsible for the implementation of county prevention grants including the Safe and Drug Free Schools and Communities and State Incentive Grants.

Ms. Williams has a B.A. in English from the California State University at Sacramento which has served her well in a career that consists of governmental reports, briefs, manuals, press releases, handbooks, brochures, and the occasional holiday newsletter. Jane is passionate about anything having to do with yarn including spinning, weaving and knitting, and was instrumental in establishing an informal prevention policy of crocheting during staff meetings.

Kerrilyn Scott-Nakai
SDFSC TA Project Director
Center for Applied Research Solutions

Kerrilyn Scott-Nakai is a senior Project Director for the Center for Applied Research Solutions and oversees the Safe and Drug Free Schools and Communities Technical Assistance Project. She has over 12 years of progressive experience conducting research and evaluation projects focusing on ATOD and violence prevention services for youth and their families—with an emphasis on school-based programs. Ms. Scott-Nakai has worked at the local, state, and federal levels. She has overseen several local and statewide evaluation projects (including the California Friday Night Live Mentoring Project, the California Youth Council, and the Orange County On Track Tobacco Free Communities Project) and has substantially contributed to the management and design of large-scale multi-site federally funded prevention studies (including Project Youth Connect and the Mentoring and Family Strengthening initiative). Before joining CARS, Ms. Scott-Nakai conducted school safety research as a consultant for the Florida Safe and Drug Free Schools Program and the Florida Safe Learning Environment Data Project (a three-year longitudinal study). During this time, she provided technical assistance and support to SDFSC Coordinators regarding evaluation and measurement issues. Additionally, Ms. Scott-Nakai taught a Theory of Measurement course at the University of Florida for two years.

Keynote

No More "Children at Risk": Children at Promise
The Power of a "Resiliency" Research to Practice Application

Keynote Speaker: Mervlyn K. Kitashima

Abstract: A participant in Emmy Werner's groundbreaking "Kauai Longitudinal Study on Resilience", Ms. Kitashima will share a very personal account of the factors that contributed to her ability to overcome the odds. Emphasis will be on the possibilities, potential and promise possessed by every child, even in the face of adversity.

Objectives:

1. Participants will be introduced to the groundbreaking "resiliency" research that is currently at the core of many prevention and educational programs.
2. Participants will understand the protective factors proven to positively affect children and families at-risk.
3. Participants will understand their role in fostering positive change in children and families at-risk.
4. Participants will begin to view all children as children of promise and potential.

Mervlyn K. Kitashima

Mervlyn is the parent coordinator at the Parents and Alumni Relations Department of the Kamehameha Schools. She has developed parent and family involvement curriculum and training for the State of Hawaii's Department of Education's Parent Community Networking Center Program, Hawaii's parents, teachers and administrators. Mrs. Kitashima has served on the Aloha Council of the Boy Scouts of America, the Governor's Commission on Teacher Morale, as commissioner of the Aloha Region USA Junior Volleyball and many other community and educational organizations. Drawing on her experiences as a teenage mother, mother of seven, grandmother of eight and wife of 34 years, Mrs. Kitashima has traveled widely as a motivating communicator. Her speaking engagements have included institutes and seminars at universities and colleges, state and national conferences on education, prevention, juvenile justice, student assistance and numerous schools, organizations, communities and churches. In 2003 Mervlyn was named the State of Hawaii and the National Mother of the Year .

Plenary Session

Effectively Telling Your Story:
Strategies for Marketing Your Program for Long-Term Sustainability
and
Creating Compelling & Effective Documents:
Executive Summaries and Key Findings Reports

Facilitators: Mark Simon and Christina J. Borbely, Ph.D.

Abstract: Every non-profit organization, public sector project and community improvement initiative begins as a story – an idea conceived by an individual or group, conveyed to others and ultimately put it into action. Every time we seek to communicate something complex, important and powerful we use story. Every time we seek financial contributions from individuals, private entities or government agencies we use story. A story well told plays a critical role in allowing individuals and organizations to bring people together behind a common cause – staff, board, funders, partners, volunteers, clients and stakeholders. Ultimately, story allows large numbers of people to recognize that they are on the same team, that the story of one is the story of all.

Goal: Exploring the concept of story for creatiing materials for funders and stakeholders. Facilitator led activity will provide opportunity to develop program documents.

Objectives:

1. To learn how to identify the intersections between the grantee program's story and the stories of funders and stakeholders.
2. To explore the strengths and pitfalls of several "voices" - the Marketing Executive, the Artist and the Scientist - that may be utilized to tell the organization's story.
3. To create draft story pieces that may become valuable marketing tools, provide the basis for an executive summary to the ADP final report, create funding proposals or other purposes.

Mark Simon is an educator, consultant, writer and storyteller with 15 years of experience in schools, youth development organizations and community development initiatives. Before establishing Storywalkers, Mark was the founding director of Rural Action of Knights Landing and the Knights Landing Family Resource Center. Since 2004, Mark has worked with numerous private and public non-profit organizations across Northern California. Mark has successfully helped small grassroots non-profits as well as large public agencies raise money, clarify vision and articulate key pieces of their story. Whether facilitating a collaborative planning meeting, leading a workshop or drafting a proposal, Mark is attuned to the priorities and values of all involved.

Christina Borbely, Ph.D. is a research consultant at CARS providing technical assistance to California's Safe and Drug Free Schools & Communities grantees. Also a member of the EMT team, Christina coordinates program evaluations for El Dorado County Office of Education and Big Brother Big Sister of the Bay Area. Prior to joining EMT/CARS, Christina was a member of the research staff at Columbia University's National Center for Children and Families. Her work in the field of youth development and prevention programs has been presented at national conferences and published in academic journals. Specifically, Christina has extensive knowledge and experience in program evaluation and improving service delivery by identifying factors that impact today's young people. She is also involved as a volunteer in providing mentoring and developmental support to youth in underserved populations. Christina received her doctoral degree in developmental psychology, with a focus on children and adolescents, from Columbia University.

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Effectively Telling Your Story

Strategies for Marketing Your Program for Long-Term Sustainability

Facilitator: Mark Simon, Storywalkers

The Storywalkers Story

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Our Story is Your Story

- What is built out of story? Where do stories reside?
- Who is your audience and what is their story?
- What is your story and how does it relate to your audience?
- How do you succeed at matching your story to the story of you audience?

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Who Needs to Hear Your Story & Why?

- Audience Inventory
- Prioritization for sustainability
- The story of your audience

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WHO? Audience Inventory

- Active Individual Donors
- Corporate Donors
- Government Grantmakers
- Potential Individual Donors
- Private Foundations
- Agency Staff (In-House)
- Board Members
- Clients
- Community Members
- Constituents
- Faith-Based Community
- Friends & Family Members
- Government Officials
- Media
- Partner Agencies
- Related Sector
- Similar Agencies in Other Regions
- Stakeholders

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What Do You Need to Tell?

- What are the key values of your organization?
- What critical objectives are being achieved?
- What core need is your organization addressing?

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WHAT STORY? Key Values

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- Acceptance of Differences
- Collaboration, Cooperation
- Community and/or Political Involvement
- Confront Difficulty
- Continuous Learning
- Creative Expression
- Equality
- Family
- Healthy Living
- Individual Freedom
- Justice
- Leadership
- Personal Power
- Respect for Nature
- Safety, Protection
- Service to Others, Volunteering

What Are Components of a Story Told Well?

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- In what fashion in the story being told?
- What pieces "collaborate" to make a good story?
- What are key messages from varied perspective?

WHY? Story Venues

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- ☐ Annual Report
- ☐ Final Report
- ☐ Grant Proposals/Reports
- ☐ Press Release
- ☐ Email
- ☐ Newsletters
- ☐ Website
- ☐ Brochures/ Marketing Materials
- ☐ Outside Articles/ Interviews
- ☐ Photos/DVDs
- ☐ Board Meetings
- ☐ Partner/Collaborative Meetings
- ☐ Workshops
- ☐ Conferences
- ☐ Meetings with Donors
- ☐ Fund Raising Events
- ☐ Thank You Letters

Storytelling Perspectives

- Marketing Executive's Story
- Artist's Story
- Scientist's Story

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Marketing Executive's Story

- Clean and tight
- Sizzles, "sexy"
- Formatted well, no typos
- Concise

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Marketing Executive's Story Pitfalls

- "Have I got the car for you..."
- Polish not substance
- Selling something that is not necessarily what is wanted

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Artist's Story

- Values demonstrated
- Qualitative value conveyed
- Connection between teller and audience
- Emotions conveyed or touched upon

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Artist's Story Pitfalls

- Overly flowery or touchy-feely
- Lack of substance
- Over-dependence on qualitative description without substantiation

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Scientist's Story

- Details in place
- Quantitative data including statistics & measurements
- Concrete objectives, outcomes and milestones

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Scientist's Story Pitfalls

- Jargon
- Complicated and/or undecipherable
- No human connection
- Lacks excitement or aliveness

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A Storyteller's Story

- Clear beginning, middle and end
- Includes qualities of Marketing Executive, Artist & Scientist
- A traditional storyline:
  - We set out to do _____
  - We have accomplished _____
  - We experienced the challenge of _____
  - We are currently doing _____
  - We plan to do _____

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A Storyteller's Pitfalls

- Rambling without form
- Focus on going forward without connection to past
- Pieces don't fit together or are out of order

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Telling Your Story:

Creating Compelling & Effective Documents

- Executive Summaries
- Key Findings Reports

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Getting to "Our Story is Your Story"

- Connect to those who do/might hold same values as those within your story
- Who would likely value this story, what priorities they value?
- What values are most central to the last 4-5 years of your work?
- Write your *take-home final exam*

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Revisiting Grantee Profiles

- What was going on back when this document was created?
- Find the Marketing Executive, the Artist and the Scientist.

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Interviewing the Three Voices

How would each of these voices highlight your primary achievements?

- Marketing Executive
- Artist
- Scientist

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Telling Our Story as Your Story

- Why does your story matter?
- Why would others believe that it matters?
- How does your story inform you what needs to be done next?

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Storywalkers

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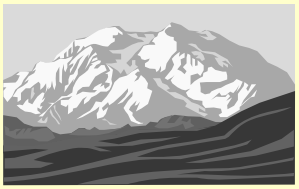

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Effectively Telling Your Story:
Strategies for Marketing Your Program for Long-Term Sustainability

Mark Simon
Principal Consultant, Storywalkers Writing & Consulting

SDFSC Statewide Learning Community Conference
July 17th, 2007

I. Opening
- Introduction
- Overview

II. Getting to "Our Story is Your Story"
- What is built out of story? Where do stories reside?
- Who is your audience and what is their story?
- What is your story and how does it relate to your audience?
- How do you succeed at matching your story to the story of you audience?

III. Who Needs to Hear Your Story and Why?
- Audience Inventory
- Prioritization for sustainability
- The story of your audience

IV. What Do You Need to Tell?
- What are the key values held by your organization?
- What critical objectives are being achieved?
- What core need is your organization addressing?

V. What Are the Components of a Story Told Well?
- In what fashion in the story being told?
- What pieces "collaborate" to make a good story?
- For this one story, what would be the key message from each perspective?
  - The Marketing Executive
  - The Artist
  - The Scientist

VI. Brief Wrap-Up
- Questions
- Insights

Actual Sample Story –
Informal email sent to network of agency friends, supporters & funders upon opening of much awaited playground

November 15, 2002

Dear Friend of Grafton Elementary:

I am writing to share an incredible event that I witnessed this morning. Two weeks ago, crews began to install our playground equipment. A foot of dirt was dug out of the whole area to allow for soft-fall material. Along the way, two large irrigation pipes were broken. For days, the playground has sat installed with bare earth and broken pipes lying beneath – a tease to our students. This week, the pipes were repaired and large piles of soft-fall material were delivered. Yesterday afternoon crews spread the soft-fall across the playground. The only thing left to wait for would be next week's official playground opening.

This morning I arrived for my weekly playground duty. A pack of older boys approached me to ask if the playground was finished. As I affirmed their suspicions, I knew the next question. At that moment, Mr. Nevarez [the principal] arrived and I referred them on to our principal to seek his permission. They, of course, ran up and informed him that I had already given them permission. With a large smile he nodded his head and pointed at the gleaming playground. Those boys ran.

For fifteen incredible minutes Mr. Nevarez and I watched packs of students arrive at school, scream with surprise, drop their backpacks and run for the playground. By 8:00 more than 100 happy children packed the new structure with excitement and delight.

After a few minutes I looked over to see that Maria Martinez, our devoted 3rd grade teacher, parent and Grafton graduate had arrived. As I looked closer I saw that her eyes were filled with tears. It was this woman's 6th grade class, three years ago, who identified themselves as the Extreme Team and began the process of raising money and speaking with government officials to bring this playground. With Maria's help, those same students drafted a letter to businesses last spring which resulted in over $10,000 in playground contributions.

We had no cameras for this event. The press was not here. No one knew that this big moment was coming. As David said, "It is a moment that can not be repeated and can not be taken away." I wish that all of our friends, everyone who has ever supported us, were here to witness. Please know that it was a rare and magical moment and that we are grateful to you for helping to make it happen.

We still have so much work to do. We remain an "under-performing" school. Our high school students have a high drop out rate. Many of our families struggle with poverty level wages and the challenges that are associated. But for this morning, these kids saw that the work of students, parents, teachers and a unified community can make things happen. This playground is a testament to that fact, and we are not relenting.

Next week Grafton Elementary goes on break until the New Year. When we return, this playground will still be here. When we return, we will open the doors to offer services at the new Knights Landing Family Resource Center. When we return, we will come together again with determination to improve student achievement, to support youth in the development of their minds and their whole selves and to provide opportunities for our families to support one another and themselves.

The students at Grafton received an incredible gift this morning, and I believe that it is one of their own making. As we approach the holidays, I hope that you and your family also experience the type of joy that we felt this morning. Thank you for your involvement and support. I approach the New Year with great excitement, holding big dreams of what we now can do together.

Yours kindly,

Mark Simon, Healthy Start Coordinator

Audience Inventory:

Audience	Non Critical Audience	Know Story Well	Know Story Somewhat	Don't Know Story As Well As They Should	Don't Know Story At All
FUNDERS					
Active Individual Donors					
Corporate Donors					
Government Grantmakers					
Potential Individual Donors					
Private Foundations					
OTHER AUDIENCES					
Agency Staff (In-House)					
Board Members					
Clients					
Community Members					
Constituents					
Faith-Based Community					
Friends & Family Members					
Government Officials					
Media					
Partner Agencies					
Related Sector					
Similar Agencies in Other Regions					
Stakeholders					
Other _____ _____					

Notes: _____

_____

_____

_____

_____

_____

Identification of Key Values:

x	Acceptance of Differences		x	Justice	
x	Collaboration, Cooperation		x	Leadership	
x	Community and/or Political Involvement		x	Personal Power	
x	Confront Difficulty		x	Respect for Nature	
x	Continuous Learning		x	Safety, Protection	
x	Creative Expression		x	Service to Others, Volunteering	
x	Equality		x	♦	
x	Family		x	♦	
x	Healthy Living		x	♦	
x	Individual Freedom		x	♦	

- Identify the top five values held by your organization – do your best to number them from 1-5 (1 being the most central value)
- How would someone outside of your organization be aware of your organization's commitment to these values?
  - o
  - o
  - o
- To what degree do staff across your organize know these values, reinforce them with one another and articulate them to stakeholders, clients, community members, donors and partners?

Example of internal integration:	Need for improved integration:
o	o
o	o

Notes: _____

_____

_____

_____

_____

_____

Components of a Story Told Well

Quality	Components	Pitfalls
Marketing Executive	• Story is clean and tight • Story sizzles, may be "sexy" • Formatted well, no typos • Concise	• Used Car Salesman -- "Have I got the car for you..." • Polish in place of substance • Trying to sell something that is not necessarily what your customer wants
Artist	• Organization's values demonstrated • Qualitative value of project conveyed • Connection made between teller and audience • Emotions are conveyed or touched upon	• Overly flowery or touch-feely • Lack of substance • Over-dependence on qualitative description without substantiation
Scientist	• Details in place • Quantitative data including statistics & measurements • Concrete objectives, outcomes and milestones	• Jargon • Complicated and/or undecipherable • No experience of a human connection • Lack of excitement or aliveness
Storyteller (Integrating above qualities)	• Clear beginning, middle and end • Includes qualities of Marketing Executive, Artist & Scientist • Covers the bases of a traditional storyline: - We set out to do _____ - We have accomplished _____ - We experienced the challenge of _____ - We are currently doing _____ - We plan to do _____	• Rambling without form • Focus on going forward without connection to past or what preceded • Pieces of story don't fit together or are out of order

Menu of Story Venues

1. ☐ Annual Report
2. ☐ Grant Proposals/Reports
3. ☐ Press Release
4. ☐ Email
5. ☐ Newsletters
6. ☐ Website
7. ☐ Brochures/Marketing Materials
8. ☐ Outside Articles/Interviews
9. ☐ Photos/DVDs
10. ☐ Board Meetings
11. ☐ Partner/Collaborative Meetings
12. ☐ Workshops/Conferences
13. ☐ Meetings with Donors
14. ☐ Fund Raising Events
15. ☐ Thank You Letters
16. ☐

Notes: _____

_____

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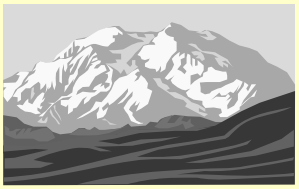

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Creating Compelling & Effective Documents:
Executive Summaries and Key Findings Reports

Mark Simon
Principal Consultant, Storywalkers Writing & Consulting

SDFSC Statewide Learning Community Conference
July 17th, 2007

I. Aiming for "Our Story is Your Story"
- Connect with those who do hold or might hold the same values/priorities as those within your story
- Of the individuals or agencies who would likely value this story, what priorities or areas of need do they tend to value?
- What values are most central to the last 4-5 years of your work?
- Remember that you a writing for a *take-home final exam*
  (You have the opportunity to make this exactly what it needs to be)

II. Revisiting Grantee Profiles
- What was going on back when this document was created?
- RED PENCIL: Where is the Marketing Executive, the Artist and the Scientist?

III. Interviewing the Three Voices – Key Findings Template
- Marketing Executive
- Artist
- Scientist

IV. Arriving at "Our Story is Your Story"
- Why does your story matter?
- Why would others believe that it matters?
- How does your story inform you what needs to be done next?

V. Closing Wrap-Up
- Questions
- Insights
- Adjustments

Story Template

Directions: For each question, generate at least three answers. Your answers may fall into any or all of the three "voices" columns (certain questions lend themselves more to certain voices). When each question has been answered, double-check empty boxes to be sure there is nothing of value to add from that voice.

Core Questions	Marketing Executive	Artist	Scientist
0. GUIDING VALUES **W**hat are your program's distinctive Core Values? (This query is for tone setting, not necessarily content – use as a compass to check if your document is heading in the right direction.)	• • •	• • •	• • •
1. PROBLEM TO BE ADDRESSED **W**hat problem did you set out to address? **H**ow does that problem affect people? **W**hat indicators notify your staff or community of the problem's existence or severity?	• • •	• • •	• • •
2. TARGET AUDIENCE & ROLES **W**ho was the targeted "audience" or service recipient for your project? **W**hat role did service recipients play in determining how to address their needs? **W**hat demographic groups, individuals, agencies or community members were intended to play a role in your project?	• • •	• • •	• • •
3. GOALS & STRATEGIES **W**hat were your project's goals? **W**hat strategies were initially applied to achieve these goals? **H**ow were your strategies adapted along the way to fit your community or to be most effective?	• • •	• • •	• • •

4. ACHIEVEMENTS **W**hat have been the results of your program? **W**hat outcomes were achieved? **I**n what ways is your program unique, innovative or outstanding?	• • •	• • •	• • •
5. INSIGHTS **W**hat wisdom have you gained along the way? **W**hat unexpected circumstances or actions contributed to the success of your program? **W**hat would you do differently if you could?	• • •	• • •	• • •
6. NEXT STEPS **W**here do you hope to go next? **H**ow is your organization uniquely prepared now for something that it couldn't have done (or wouldn't have done) 4-5 years ago?	• • •	• • •	• • •

SDFSC Grantee: San Juan County's Bellingham Youth Program (Sample Document)

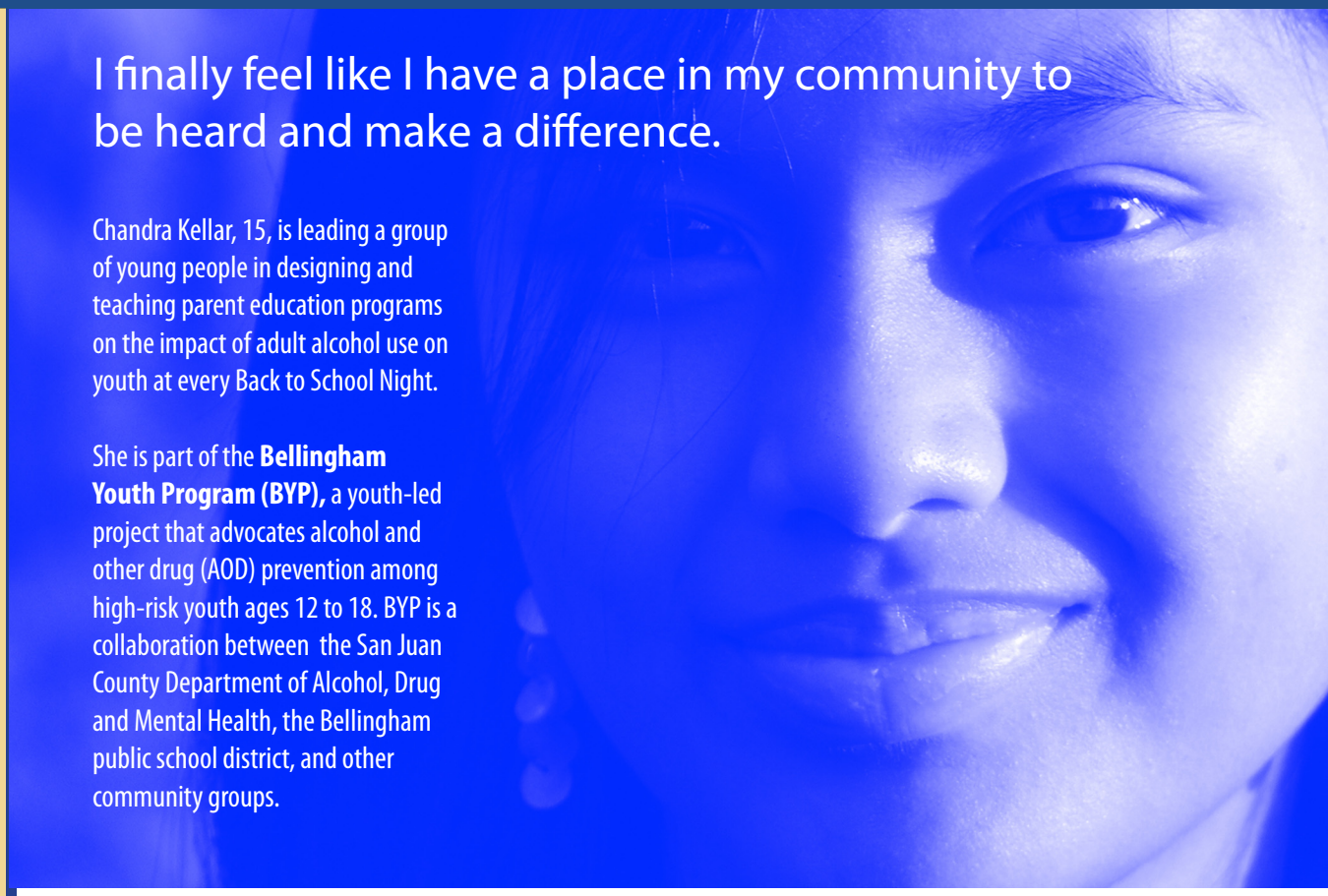
Story Template

Directions: For each question, generate at least three answers. Your answers may fall into any or all of the three "voices" columns (certain questions lend themselves more to certain voices). When each question has been answered, double check empty boxes to be sure there is nothing of value to add from that voice.

Core Questions	Marketing Executive	Artist	Scientist
0. GUIDING VALUES • **W**hat are your program's distinctive Core Values? (This query is for tone setting, not necessarily content – use as a compass with which to check if your document is heading in the right direction.)	• Youth as Frontrunner • Safe and Drug Free Schools and Communities	• The community is a place for young people to be heard and to make a difference.	• Evidence-based prevention • Environmental Prevention Strategies • Youth Development Framework
1. PROBLEM TO BE ADDRESSED • **W**hat problem did you set out to address? • **H**ow does that problem affect people? • **W**hat are the indicators notifying your staff or community of the problem's existence or severity?	• Alcohol and drug related problems • Communities and young people at risk	• Teen drinking and drug use	• Over 1,000 youth identified to be at risk based on high drop out rates, gang activities, and alcohol and other drug-related crime in the neighborhood
2. TARGET AUDIENCE & ROLES • **W**ho was the targeted "audience" or service recipient for your project? • **W**hat role did service recipients play in determining how to address their needs? • **W**hat demographic groups, individuals, agencies or community members were intended to play a role in your project?	• Tweens and Teens • Youth as prevention leaders	• Young people who are at risk can make a difference.	• Adolescents age 12-18 years at six public high school sites • Youth-driven programming • Partners in the community (San Juan County Department of Alcohol, Drug and Mental Health; the Bellingham School District and other community groups)
3. GOALS & STRATEGIES • **W**hat were your project's goals? • **W**hat strategies were initially applied to achieve these goals? • **H**ow were your strategies adapted along the way to fit your community or to be most effective?	• Youth-led strategies • Increase parents/caregiver awareness on alcohol accessibility at home • Surveying and educating downtown merchants on alcohol advertising • Provide Spanish materials • 40 Developmental Assets	• Engage the Youth. Nurture young hearts and minds • Friday Night Live and Club Live. Promoting self-expression in healthy and creative ways • Multicultural activities. Embracing each individual • Youth Nexus: Shaping Youth Leaders • Teacher Training	• Reduce AOD use by 30% and build a safe and drug-free community by implementing evidence-based environmental strategies in a youth development framework. • Implement model programs • Compare specific environmental factor with other county • Engage external evaluators

4. ACHIEVEMENTS • **W**hat have been the results of your program? • **W**hat outcomes were achieved? • **I**n what ways is your program unique, innovative or outstanding?	• Engaged youth developed a healthier attitude towards AOD use than their peers • Youth Leaders developed a community education campaign • "My Life" Teen Film Festival • 80 teens organized four alcohol-free community parks weekends. • Youth and protest rally deterred alcohol advertising at local fairs. • Thriving Youth, Teens Take Charge	• Youth Leaders developed a community education campaign • Wholesome, happy and engaged children • Working together for the benefit of all	• Youth leaders developed three grant proposals and four formal partnership agreements • Teachers of all six high schools attended the training series on integrating principles of the Search Institute's 40 Developmental Assets into curricula and educational practices • Increased community engagement (80%) and increased civic involvement (60%). Over half of the students felt more connected to school as well.
5. INSIGHTS • What wisdom have you gained along the way? • What unexpected circumstances or actions contributed to the success of the program • What would you do differently if you could?	• Teens are a rich resource • Value diversified funding resources	• Children are our future • Wonderful and supportive staff • Include a community fund drive	• Consistent adult partners are critical • Limited resources for prevention inspired youth to pool resources by building partnerships within the community and other experts. • Improve financial stability
6. NEXT STEPS • Where do you hope to go next? • How is your organization uniquely prepared now for something that it couldn't have done (or wouldn't have done) 4-5 years ago?	• Collaborate with new partners • Leverage program's reputation in community to keep going	• Stay right here and keep doing what we can	• Strategically downscale program to preserve core components • Increased capacity for monitoring program and making improvements

San Juan County



I finally feel like I have a place in my community to be heard and make a difference.

Chandra Kellar, 15, is leading a group of young people in designing and teaching parent education programs on the impact of adult alcohol use on youth at every Back to School Night.

She is part of the **Bellingham Youth Program (BYP),** a youth-led project that advocates alcohol and other drug (AOD) prevention among high-risk youth ages 12 to 18. BYP is a collaboration between the San Juan County Department of Alcohol, Drug and Mental Health, the Bellingham public school district, and other community groups.

The Bellingham Youth Program

MISSION. To build a safe and drug-free community in which youth are valued as assets by implementing evidence-based environmental prevention strategies in a youth development framework.

YOUTH AND COUNTIES SERVED. Over 1,000 students at six public high school sites in San Juan County were engaged. All were identified to be at risk of AOD use based on high drop out rates, gang activities, and alcohol and other drug related crimes in their neighborhoods.

STRATEGIES. BYP integrates existing science-based prevention strategies through the following programs:

Friday Night Live and Club Live Programs. BYP leveraged the success of FNL and CL by conducting a series of youth training on environmental prevention. Youth identified the following prevention priorities: a) increasing parental/ caregiver pledges that address alcohol accessibility in the home, especially during family functions; and c) surveying and educating downtown merchants on alcohol advertising.

Training Youth Leaders through Youth Nexus. 24 youth leaders were trained on organizing community events, grant writing, writing reports and making presentations.

Teacher Training on 40 Developmental Assets. 20 teachers were trained in six high schools on integrating principles of the Search Institute's 40 Developmental Assets into curricula.

In addition to youth-led strategies, BYP also advanced their program evaluation methods. The program selected Del Mar County to compare a specific environmental prevention indicator (i.e. parents' attitudes towards youth alcohol use); and engaged external evaluators .

KEY ACHIEVEMENTS.

Youth Leaders and BYP members developed a community education campaign to promote adolescents as resources and increase awareness about AOD prevention priorities.

- 400 community members attended the teen film festival on "My Life" topics.
- 80 teens organized 4 alcohol-free community parks weekends.
- All six BYP chapters coordinated alcohol-free holiday events for families.
- Youth and family protest rally deterred alcohol advertising at two local fairs.

Outcomes for the distribution of parent pledge exceeded initial expectations. From the original 500 pledges printed, an additional 1,000 were reprinted and distributed on demand.

Youth Leaders developed three grant proposals and four formal partnership agreements to sustain core BYP programming for the next three years.

Teachers of all six high schools attended the training series on integrating principles of the Search Institute's 40 Developmental Assets into curricula and educational practices.

IMPACT OF THE PROJECT.

The majority of BYP members demonstrated increased community engagement (80%) and increased civic involvement (74%). Over half of the students (60%) felt more connected to school as well.

BYP youth reported healthier attitudes towards AOD use than their peers; rates of substance abuse were significantly lower among 9th graders. This indicates that continued programming may shift adolescent AOD norms and behaviors as younger students age with the program.

Survey results indicate an increase in understanding (86%) and use (61%) of youth development principles by educators.

LESSONS LEARNED AND FUTURE DIRECTIONS.

BYP operates in a small urban center within San Juan county. Limited resources for prevention inspired youth to pool resources by building partnerships within the community and with other experts. This resulted in diversified funding sources as well as opportunities to foster cross-generational and cross-sector for program activities.

For more information, please contact:

Gina Garcia, Project Director
San Juan County Department of Alcohol, Drugs and Mental Health
555 Street Drive
Atownlikeyours, CA 95555
Tel (555) 555-1776
Fax (555) 555-5153
ggarcia@email.org

Safe & Drug-Free Schools & Communities
Technical Assistance Project
California's Governor's Program

Celebrate Unity!

For a safe & healthy community

Bellingham Youth Program

THE BIG PICTURE RALLY

Thursday, August 9th
1:30 p.m. – 6:30 p.m.

At the Bellingham Community Park

Please bring all your FAMILY to a day full of
valuable information,
educational activities,
raffle,
food,
music and fun.

Bringing the generations together!

For more information please contact Gina Garcia or Jose Barajas at the BYP office, (555) 555-1776.

¡Celebrar la unidad!

Para una comunidad segura y saludable

Bellingham Youth Program PRESENTA

EL CUADRO COMPLETO MITIN

JUEVES 9 DE AGOSTO
1:30 p.m. – 6:30 p.m.

Bellingham Community Park

Por favor traiga a toda su FAMILIA a esta tarde llena de
informacion valiosa,
rifa,
comida,
musica y diversion.

¡Uniendo las generaciones!

Para mas informacion llame a Gina Garcia o Jose Barajas a la oficina de BYP

(555) 555-1776.

Bellingham Youth Program

P.O. Box 555 Atownlikeyours, CA 95555
(555) 555-1243 (555) 555-6155 FAX
ggarcia@email.org

PRESS RELEASE

To:	Youth Press Enterprise	Fax Number:	555-6565
Attention:	Itsa Goodbet	Phone Number:	555-6566 (home office)
Date:	July 31, 2008		

Event: Bellingham Youth Program: "THE BIG PICTURE RALLY"
Event Location: Bellingham Community Park
Event Date: Thursday, August 9th **Event Time:** 1:30 – 6:30 pm

Bellingham Youth Celebrate Family & Community

On August 9, more than one thousand students from Grafton High will gather at the Bellingham Community Park to celebrate their successes in helping the community build and see ***The Big Picture***. Already on its second year, ***The Big Picture*** continues to raise awareness in Bellingham on the impact of adult alcohol use on teens. It is a youth-led project that pools the community's resources, across generations and sectors, with everyone involved advocating alcohol and drug (AOD) prevention among high-risk youth.

Expect ***The Big Picture*** rally to pull up the stakes with its line-up of performances, speakers, family activities, free resources and interactive information on health and wellbeing. Most of the collaborative activities bridge gaps across ages and groups. Highlights include home-grown musicians such as *The Volpis*, performing original original compositions with emerging youth bands, led by *ShugaCoat* and Blindside. Parents and youth leaders of the Bellingham Youth Program will take center stage with representatives from family resource centers, local businesses, the PTA, and the San Juan County Health Department around to give support. The focus is on topics relevant to youth development, family wellbeing, and community norms, with content available in Spanish translation. The rally will take place from 1:30 to 6:30 pm. All attendees will be entered in a free raffle with prizes from gift certificates to t-shirts. Come prepared for non-stop action with activities for all ages, snacks and music.

Information booths and learning activities will be sponsored by by WestCare Health Clinic, San Juan County Health Department, the Children & Families Commission and CHDC Head Start. Other participating organizations include the San Juan County Family Service Agency – Para La Familia, San Juan Connections, San Juan County WIC, Bellingham County Children & Families Commission, San Juan County Department of Alcohol, Drugs & Mental Health, and Migrant Education.

Among the Bellingham Youth Program's accomplishments over the past year include the teen short film festival "My Life", which drew the participation of hundreds in the community. 80 teens also organized 4 alcohol-free community parks weekends.

Encl: big picture flyer

For more information, contact:
Gina Garcia, Bellingham Youth Program
(555) 555-1776 ggarcia@email.org

Keynote

"Stand By Me": Planting the Seeds for Future Harvests

Keynote Speaker: DeVone L. Boggan

Abstract: While funding will come and go, the true power of prevention lies in the long-term personal commitment of individuals and communities to invest in the future of our youth. Mr. Boggan will bring participants through a powerful and motivational series of real world examples of the difference that prevention services can make in a young person's life. The power of using a strength-based youth development approach will be discussed.

Objectives:

1. Validation of the potential long-term impact of AOD prevention efforts on the lives of young people (and their families and communities)
2. Building on the power of a strength-based/youth development approach
3. Recognizing the value of long-term personal and community commitment to prevention

DeVone Boggan

DeVone Boggan has an extensive background as a provider of technical assistance and training for mentoring and youth development practitioners serving youth traditionally underserved by mentoring programs. He has provided consultation to numerous municipal governments and school districts, assisting in the creation of city-wide violence prevention plans and intervention strategies to address chronic youth violence in urban settings. A graduate of UC Berkeley, he has worked in the public and private sectors in the areas of public policy and administration, organizational design, human resource development, and management. Mr. Boggan's experience, leadership and advocacy efforts in the mentoring arena have placed him in high demand as a youth development policy advocate, organizational development consultant, and trainer. DeVone has served on the Governors State Mentoring Council and as a consultant to the President's National Advisory Council on Violence Against Women and Children. DeVone is the co-author of three publications: Classification of Mentoring Relationship Types, Final Report – Mentoring Service Delivery Systems, and Framework for Mentorology. Before creating dbMENTORS, Inc.™, Mr. Boggan served as Executive Director of The Mentoring Center, a regional provider of technical assistance and training for mentors and mentoring organizations.

Plenary Session

Lessons from the Field:
Capturing the Years' Successes and Best Practices
and
Documenting Our Successes
Round Table Discussions, Workgroup Activity, and Report Out

Facilitators: Christina Borbely, Ph.D., Rocco Cheng, Ph.D., Angela Da Re, Jan Ryan and Kerrilyn Scott-Nakai

Abstract: The gap between research on prevention and practice in prevention has been frequently observed. There is little guarantee that innovative research findings are translated into applicable and feasible implementation strategies. Additionally, science-based programs, rigorously tested in controlled settings, do not necessarily transition to real world settings without challenges. This workshop focuses on identifying the key lessons learned and most successful prevention strategies identified over the course of the 5 year SDFSC initiative. The ultimate goal is to identify best practices which have relevance for advancing the prevention field.

The discussion will center around the following topic areas: using youth as agents of change; finding the balance between fidelity and adaptation; moving towards evidence-based services at the local level; expanding community-based services from universal to selective and indicated; and expanding prevention services to non-traditional settings (i.e. alternative schools and juvenile halls).

- Increased knowledge of common challenges associated with implementing science-based programming in real world settings and potential solutions for adapting services.
- Increased awareness of novel locally developed evidence-based strategies including youth-led environmental prevention efforts.
- Documentation of key lessons learned and best practices from the 5 year initiative.
- Identification of next steps for packaging and disseminating information to the field.

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Lessons From the Field

Capturing the Years' Successes and Best Practices

Kerrilyn Scott-Nakai
Center for Applied Research Solutions (CARS)

Learnings from Real World Application

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- A gap between research on prevention and practice of prevention is frequently observed
- Science-based programs, in controlled settings, do not always neatly transition to real world settings

Session Objectives

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- Identification of common challenges with implementing science-based programming in real world settings and potential solutions for adapting services.
- Identification of novel locally developed evidence-based strategies including youth-led environmental prevention efforts.

Session Objectives

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- Documentation of key lessons learned and best practices from the 5 year initiative.
- Identification of next steps for packaging and disseminating information to the field—"technology transfer".

Session Goal

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- **The ultimate goal is to identify best practices which have relevance for advancing the prevention field.**

Discussion Topics

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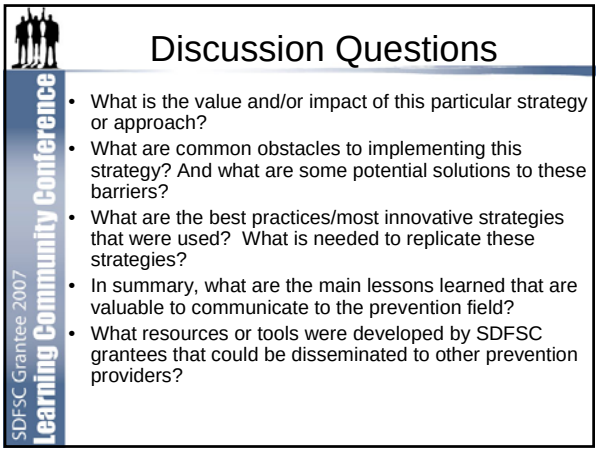
- Engaging youth as agents of change
- Finding the balance between fidelity and adaptation
- Documenting evidence at the local level
- Transitioning from universal to selected and indicated services
- Expanding services to non-traditional settings (i.e. non-traditional schools and juvenile halls)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Discussion Questions
• What is the value and/or impact of this particular strategy or approach?
• What are common obstacles to implementing this strategy? And what are some potential solutions to these barriers?
• What are the best practices/most innovative strategies that were used? What is needed to replicate these strategies?
• In summary, what are the main lessons learned that are valuable to communicate to the prevention field?
• What resources or tools were developed by SDFSC grantees that could be disseminated to other prevention providers?

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Discussion Questions

Thank you in advance for your participation in the 2007 SDFSC TA Learning Community Conference. With the California SDFSC Governor's Program initiative in its fourth and fifth year, the conference is focused on documenting the implementation successes and challenges (and associated learnings) and the impact of the initiative at both the local and statewide level.

Time is allocated on day two for having open discussions regarding the successes and challenges to implementation and to identify the lessons's learned from this initiative. We'd like you to consider these questions in order to prepare for this discussion. We are not asking you to formally prepare information, just to actively reflect on the questions relative to your SDFSC project in order to capitalize more fully on our on-site discussion time together.

1. ***Engaging Youth as Agents of Change***

A considerable portion of the SDFSC Grantees engaged youth in planning and implementing a variety of environmental prevention activities. Traditionally, California has been a leader in employing environmental prevention strategies. The SDFSC initiative offers an opportunity to add to the prevention field's knowledge regarding best practices for youth-led environmental prevention activities. The following questions are geared at beginning to identify the core elements of success in this area.

- ✓ What is the value and/or impact of engaging youth in environmental prevention efforts as compared to traditional environmental prevention approaches?
- ✓ What are the best ways to promote EP activities to young people? What works best for middle school students? What works best for high school students?
- ✓ What are common obstacles to engaging youth in EP activities? And what are some potential solutions to these barriers?
- ✓ What were the most innovative strategies that were used? What is needed to replicate these strategies?
- ✓ In summary, what are the main lessons learned that are valuable to communicate to the prevention field?
- ✓ What resources or tools were developed by SDFSC grantees that could be disseminated to other prevention providers who are beginning to integrate youth-led environmental prevention efforts?

2. *Finding the Balance Between Fidelity and Adaptation*

The gap between research on prevention and practice in prevention has been frequently observed. There is little guarantee that innovative research findings are translated into applicable and feasible implementation strategies. Additionally, science-based programs rigorously tested in controlled settings do not transition to real world settings without challenges. Many of the SDFSC grantees have learned substantial lessons regarding effective strategies for adapting and replicating science-based programs to ensure cultural relevance and applicability at the community level.

- ✓ What is the value and/or impact of adapting services while maintaining fidelity to the original intent of science-based programs/curriculum?
- ✓ What are common obstacles to fidelity/adaptation efforts? And what are some potential solutions to these barriers?
- ✓ What are the best practices/most innovative strategies that were used? What is needed to replicate these strategies?
- ✓ In summary, what are the main lessons learned that are valuable to communicate to the prevention field?
- ✓ What resources or tools were developed by SDFSC grantees that could be disseminated to other prevention providers?

3. *Documenting Evidence at the Local Level*

SDFSC grantees have become very familiar with "picking off the list" of model programs in order to meet science-based funding requirements. However, grantees have also expressed interest and have begun to advance their efforts in documenting the evidence of their own locally developed prevention efforts. A number of SDFSC grantees have learned substantial lessons regarding effective strategies for advancing local prevention programming towards achieving evidence-based criteria which have relevance for future funding initiatives.

- ✓ What is the value and/or impact of progressing local efforts to document evidence of effectiveness more rigorously?
- ✓ What are common obstacles to advancing evaluation and programming efforts? And what are some potential solutions to these barriers?
- ✓ What are the best practices/most innovative strategies that were used? What is needed to replicate these strategies?
- ✓ In summary, what are the main lessons learned that are valuable to communicate to the prevention field?
- ✓ What resources or tools were developed by SDFSC grantees that could be disseminated to other prevention providers?

4. *Transitioning from Universal to Selective and Indicated Services*

Programs or activities funded through the SDFSC Governor's portion are intended to complement and support activities of local educational agencies. The emphasis is on serving at-risk and underserved youth and communities. More specifically, priority was given to programs that ensured the provision of services to: a) Children and youth who are not normally served by State or local educational agencies; or b) populations that need special services or additional resources such as youth in juvenile detention facilities, runaway or homeless children and youth, pregnant and parenting teenagers, and school dropouts. Given this charge, community-based SDFSC prevention providers have made concentrated efforts to target these populations and have learned substantial lessons along the way.

- ✓ What is the value and/or impact of transitioning services to include a focus on selective and indicated populations?
- ✓ What are common obstacles to serving selective and indicated populations? And what are some potential solutions to these barriers?
- ✓ What are the best practices/most innovative strategies that were used? What is needed to replicate these strategies?
- ✓ In summary, what are the main lessons learned that are valuable to communicate to the prevention field?
- ✓ What resources or tools were developed by SDFSC grantees that could be disseminated to other prevention providers?

5. *Expanding Services to Non-Traditional Settings*

A considerable portion of SDFSC grantees expanded traditional school-based services to alternative settings. County day schools, continuation schools, and community schools are the most prevalent alternative sites. A few grantees are also providing services at Juvenile Halls. Fifteen grantees are providing services at other alternative sites such as a housing project, YMCA, family services center, or community center.

- ✓ What is the value and/or impact of expanding services to non-traditional settings?
- ✓ What are common obstacles to providing services in non-traditional settings? And what are some potential solutions to these barriers?
- ✓ What are the best practices/most innovative strategies that were used? What is needed to replicate these strategies?
- ✓ In summary, what are the main lessons learned that are valuable to communicate to the prevention field?
- ✓ What resources or tools were developed by SDFSC grantees that could be disseminated to other prevention providers?

Creating a Continuum of Services: SDFSC Application of the IOM

Facilitator: Jan Ryan

Abstract: Prevention providers work collaboratively every day and expect it of their partners; it is why prevention can do so much with so little. Yet, prevention, treatment, and recovery support services often plan and implement separately. The result is that people have to find the right door to the right service. California Alcohol and Drug Program (ADP) leadership has been on a two-year journey to re-engineer services so that the design reflects the way people approach the services and not only by how they are funded. When prevention, treatment, and recovery support become a comprehensive and integrated continuum of alcohol and other drug services, any door is the right door. Individual and community centered services are more effective, of higher quality, sustainable and culturally competent. The leadership and planning groups envision the system "will have the capacity and resources to facilitate holistic health and promote wellness." Change brings new tools and techniques. This workshop will review the latest tools, techniques, and structures grantees have implemented.

Goals: Develop an understanding of effective strategies for moving towards a continuum of services approach and the relationship of SDFSC services within the IOM framework.

Objectives:

1. Understand goals, objectives, and progress of the Continuum of Service Re-Engineering Approach
2. Understand how the prevention frameworks fit together: Strategic Prevention Framework, Principles of Effectiveness, Institute of Medicine Model, and the CSAP six strategies.
3. Increase knowledge of SDFSC application of IOM and SPF

Jan Ryan

Ms. Ryan has a long history of providing consultation and training services within both the education and prevention fields. Although employed by one district for 28 years, she has been a consultant locally, regionally, state-wide, nationally, and internationally. She recently worked with a collaborative of school partners cooperating closely with the Department of Mental Health Substance Abuse Prevention Services to create the Prevention Education Trust which has become known statewide as one of the most effective uses of the harm reduction funding legislated for primary prevention. In 2002, she co-wrote the largest funded project in the country for the Safe Schools and Healthy Students Initiative. The Connect to Achieve project replicated the Desert Sands Student Assistance Program Model for over 100,000 students in seven school districts. Over the years her career experience have taught her the languages of many systems: schools, prevention providers, law enforcement, mental health, workforce development, community-based agencies and county services. She is often asked to "translate" the complexity of the public school culture to providers in many other systems. Ms. Ryan received her Masters degree from California State University, San Bernardino.

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Creating a Continuum of Services:

SDFSC Application of the IOM

Facilitated by Jan Ryan

Agenda

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I. Leading with the Continuum of Services
II. Fitting the frameworks together
III. Serving the most appropriate individuals and the communities
IV. Stories of learning to love IOM, or at least appreciating it

Your Prevention Setting

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What is your "home base"?

- County ADP office
- County Office of Education
- School District
- School site
- Community site
- Other

Your Prevention Reality and Vision

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What it is now; what you hope for

- with schools
- with community partners
- with ADP colleagues (tx. and recovery)
- With the participants you serve

I. Why

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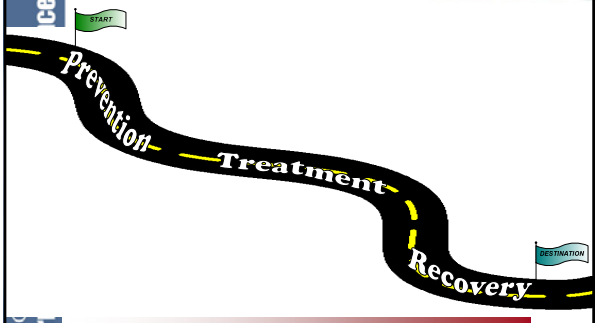
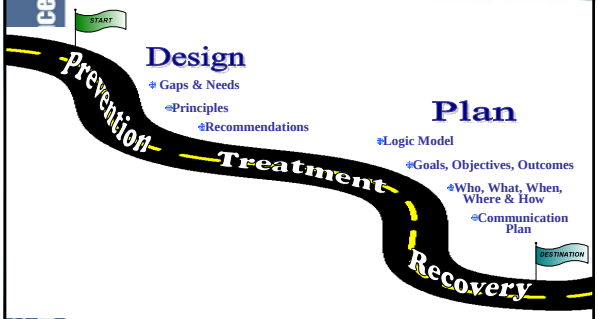
Leading with Continuum of Services

AOD Services Re-Engineering



AOD Services Re-Engineering



Design

- Gaps & Needs
- Principles
- Recommendations

Plan

- Logic Model
- Goals, Objectives, Outcomes
- Who, What, When, Where & How
- Communication Plan

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Continuum of Services

State of California
Department of Alcohol and Drug Programs

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"Our" Destination

- A comprehensive and integrated continuum of alcohol and other drug services.
- The services are effective, high quality, client and community centered, sustainable and culturally competent.
- They have the capacity and resources to facilitate holistic health and promote wellness.

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Desired Outcome

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Ensure that individuals and communities receive

- high quality,
- effective, and
- efficient services

along a service continuum that addresses the potential risk, and the acute and chronic nature of AOD problems.

Using What Strategies

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- Developing a system of services design that is comprehensive, integrated, effective and efficient
- Developing, recruiting and retaining a prepared workforce
- Removing funding barriers, developing resources and establishing policies for system and between systems
- Developing and maintaining a diverse set of community partnerships to ensure critical linkages

Results in What Long Range Outcomes

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- Empowered and prepared individuals, families and communities as active partners to prevent, reduce and manage AOD risks & recovery
- Individuals and communities routinely receive high quality, effective and efficient services along a service continuum that addresses the potential risk, acute and chronic nature of alcohol and other drug problems

II. What

Fitting the Pieces Together

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Prevention Tools

- Principles of Effectiveness (POE)
- Strategic Prevention Framework (SPF)
- Institute of Medicine (IOM) Prevention Populations

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Strategic Prevention Framework

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SPF and POE

- SPF: Assessment
  - POE: incidence data, analysis of data
- SPF: Capacity
  - POE: intended or implied, not specific
- SPF: Planning
  - POE: performance measures
- SPF: Implementation
  - POE: evidence-based program guidelines
- SPF: Evaluation
  - POE: evaluation

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History of IOM

- *1982--Terms used first by Gordon to describe a health consequences model focusing on population and risk*
- *1994—Institute of Medicine full continuum of care model for mental health*
- *2000—CSAP adopts language*
- *2003—CSAP mandates use by states*

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Definition of IOM Prevention Components

Universal Prevention Measures:
- Address the **entire** population.
- Aim is prevent/delay use of ATOD. Deter onset through a variety of community & individuals level approaches

Selected Prevention Measures:
- Targets **subsets** of community settings and/or population considered at risk by virtue of their *membership* in a particular segment.
- Selected Prevention targets the **entire** subgroup regardless of the degree of risk of any targets (settings and/or individuals) in the group.

Indicated Prevention Measures:
- Targets specific settings and/or **individuals** who are exhibiting early signs or consequences of AOD use.

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IOM Prevention Services Populations

Type of Prevention	Definition
Universal	General population
Selected	people who are selected because they have increased risk for developing a problem, though no problem has yet occurred.
Indicated	people who have some sign or symptom of an impending problem, though not yet to a level that requires treatment.

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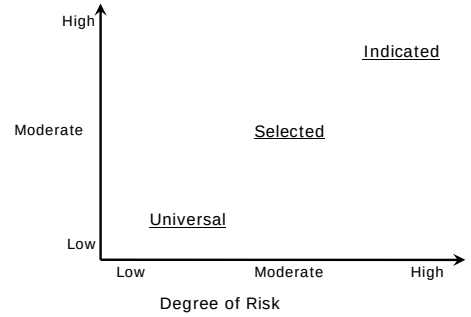
Intensity Versus Degree of Risk



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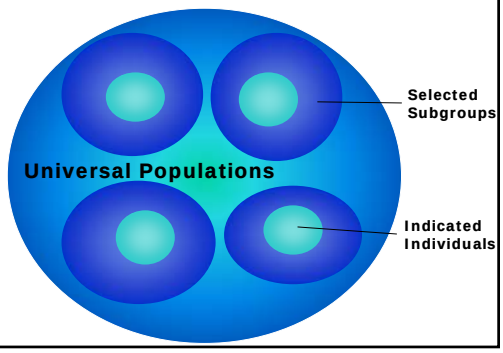
Who Prevention Reaches

Circles within Circles



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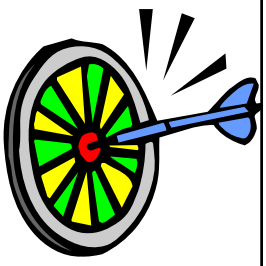
Connecting the tools: ADP

- Dart board: Continuum of Services and SPF:
- Circles: IOM prevention populations: universal, selected and indicated
- Darts: Six Prevention Strategies, Best Practices, Evidence based programs and strategies,
- Score: Cal OMS Prevention, Evaluation of SPF implementation, monitoring of funded partners and participation in collaborative efforts



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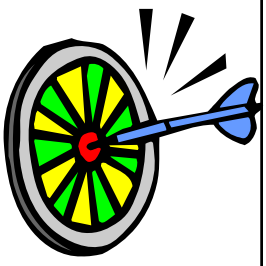
Connecting the Tools: CDE

- Dart board: Title IV, SDFSC SPF:
- Circles: IOM (Universal, Selected and Indicated = smallest)
- Darts: best practices, Evidence based programs and strategies, mandates
- Score: CHKS, UMIRS, Graduation rates, drop out rates, Exit tests



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III. How

III. Serving the Individual and the Community

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IV. When

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Applying IOM Prevention Populations

What IOM Contributes

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- Knowledge about risks
- Causal contributors
- Effective interventions for specific populations
- Different complementary approaches vs. alternatives
- Informed look at outcomes, interventions, and resource requirements

Key Issues

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- Defining the population
- Recruiting participants
- Providing access to the services
- Designing/selecting the appropriate intervention
- Specifying the appropriate outcomes

Universal (Discussion)

- High visibility rallying point for stakeholders
- Strong common sense appeal
- Varied risk (not low risk)
- Attributing behavior change is difficult
- Information impacts people positively and negatively
- Appropriate Outcomes: change social acceptance and supporting awareness

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Universal: characteristics

- Delay or prevent onset of substance abuse
- Target the entire population
- All share the same general risk; individual risk is not assessed
- Participants not recruited
- Lower staff-to-audience ratios
- Require less audience time and effort
- Staff can be from many fields
- Lower per-person costs

• Source: CSAP definitions

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Selected (Discussion)

- Subgroups may share identified risks, but doesn't account for multiple risk factors.
- Recruitment often based on circumstance for convenience, not necessarily accuracy so risk profiles will vary.
- "Vulnerable" population served as a group, not as individuals; intervention is addressing an assumed shared need.
- Seek understanding of their experiences. Clarify yours and their expectations.
- Focus on validating protective factors and skill building that addresses risk factors encountered in risk conditions common to the group.
- When matched with indicated prevention that surfaces accurate needs, selective prevention could have improved outcomes.

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Selected: characteristics

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- **Delay or prevent substance abuse**
- **Selective prevention targets the entire subgroup regardless of their individual risk**
- **The subgroup can be determined by a number of characteristics that significantly increase their risk of substance abuse**
- **Recipients are recruited to participate**
- **Programs address specific subgroup risk factors**
- **Programs run for longer periods of time and usually require more participant's time and effort than do universal programs**
- **Programs require skilled staff**
- **Costs of selective prevention programs are usually greater per person than those of Universal prevention programs**

Indicated (Discussion)

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- Relatively neglected population
- Reasons are institutional: funding
- Less useful as a public statement
- Part of comprehensive plan
- Strategies require skilled practioners
- *One approach: individual prevention is focused on "screening" provided by trained prevention professionals familiar with strength-based approaches. Individuals may be referred to an "assessment" by a tx. Provider to determine if they meet the criteria for treatment services.*

Indicated: characteristics

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- **Targets individuals experiencing early signs of substance abuse and other related problem behaviors, but without a clinical diagnosis**
- **Stems the progression of substance abuse and related disorders**
- **Recipients are individually assessed and recruited into the program**
- **Risk factors and problem behaviors are specifically addressed by the program**
- **Programs can target multiple behaviors simultaneously**
- **Programs are extensive and intensive**
- **Programs require highly skilled staff**
- **Indicated prevention strategies may generally be more expensive on a per-person basis than are universal and selected prevention.**

Sources

- ***CSAP definitions for IOM Prevention Populations***
- ***THE INSTITUTE OF MEDICINE FRAMEWORK AND ITS IMPLICATION FOR THE ADVANCEMENT OF PREVENTION POLICY, PROGRAMS AND PRACTICE By: J. Fred Springer and Joël Phillips (research document in progress)***
- ***ADP Phase II of Continuum of Services Systems Re-engineering ppt. by Michael Cunningham***
- ***Assistance from: Kerrilyn Scott-Nakai, Jim Rothblatt, Bob Alkire, Planning Team from CPI for this SDFSC Conference***

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Our Prevention Experiences

SDFSC grantee experiences

- Serving one population
- Balancing serving all three
- Implementing Project Success
- Using SPF to move towards IOM
- Educating their communities about IOM
- Others?

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Final Reflections

I learned or relearned…

I believe…

I feel…

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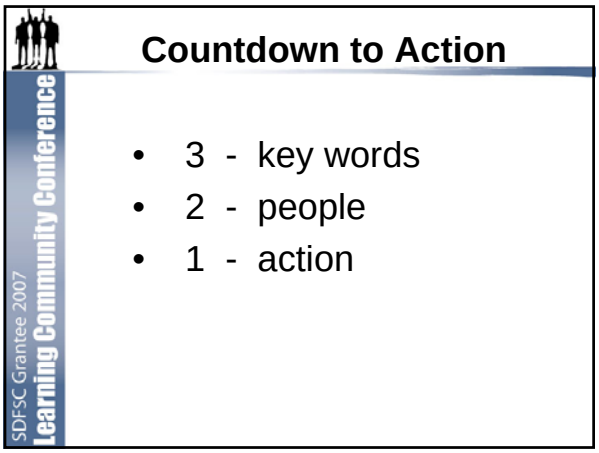
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Learning Community Conference
Countdown to Action
• 3 - key words
• 2 - people
• 1 - action

Continuum of Services System Re-Engineering Task Force

PHASE I REPORT
September 2006

California Department of Alcohol & Drug Programs

Contents

Introduction : a re-engineered california continuum of aod services system

The Department of Alcohol and Drug Programs (ADP) is committed to the development, maintenance, and continuous improvement of a comprehensive and integrated continuum of alcohol and other drug (AOD) services.

Towards that end, in May 2006, ADP established the Continuum of Services System Re-Engineering (COSSR) Task Force to provide recommendations to the department on re-engineering the system of AOD prevention, treatment, and recovery services in California. This is the first step in a process that will guide ADP, working with our stakeholders, in reshaping and repositioning the AOD field in California to insure system accountability, efficiency, and effectiveness, while delivering comprehensive, high quality AOD services.

ADP invited individuals to participate based on their expertise, experience, leadership, and contributions to the AOD field, and reflecting the cultural and geographic diversity of California. The COSSR Task Force included AOD administrators; prevention, treatment, and mental health specialists; Narcotic Treatment Program (NTP) providers; Director's Advisory Committee (DAC) members; policy professionals; and educators. There were representatives from the County Alcohol and Drug Program Administrators Association of California (CADPAAC), the California Association of Alcohol and Drug Program Executives (CAADPE), the California Association of Addiction Recovery Resources (CAARR), the California Association of Alcoholism and Drug Abuse Counselors (CAADAC), and the Friday Night Live Partnership.

The primary tasks of the COSSR Task Force were to: identify gaps and needs in the current system of services; develop core principles to guide the process of re-engineering; and develop a framework for a continuum of services (COS) model for California. Once this was accomplished, the Task Force developed a set of recommendations on re-engineering the AOD system of services in California to ensure that services are effective, high quality, client and community centered, sustainable and culturally competent, and that the AOD system has the capacity and the resources to facilitate holistic health and promote wellness.

The COSSR Task Force is committed to expanding upon and not duplicating prior ADP initiatives to improve system outcomes for clients, their families, and California communities. The recommendations ultimately produced by the COSSR Task Force build upon the work done in previous efforts (System of Care Redesign, Managed Care Policy Advisory Committee, California Treatment Outcomes Project, and California Outcomes Measurement System).

Based on the gaps and needs identified by the Task Force and the adoption of the IOM chronic care model, ADP developed the California Continuum of AOD Services system model. The continuum model reflects the Task Force members' recommendation that intervention must occur at all levels in the continuum and that coordination of services. Coordination of services within the AOD services model and with other service providers is a critical component. Finally, the model acknowledges that recovery services are a necessary and critical component of the AOD system of services in California.

Conceptual framework for re-engineering

Re-engineering a system is defined as a radical transformation of business processes to achieve significant levels of improvement in one or more performance measures through examination, rethinking, redesigning, and implementation. It requires a close examination of assumptions and a willingness to consider new approaches that are systematic and disciplined.

The COS model in California AOD systems is based on the concept that AOD dependence is a chronic illness, which has been defined by the Improving Chronic Illness Care Program as "any condition that requires ongoing adjustments by the affected person and interactions with the health care system." Consistent with that definition AOD dependence should be addressed in a manner similar to other chronic illnesses such as depression, hepatitis C, Human Immuno-deficiency Virus (HIV), and asthma. This is consistent with the 2006 update of the Institute of Medicine's (IOM) Quality Chasm Series which recommends that "substance use disorder treatment move toward building its standards of care, performance measurement and quality, information and cost measures upon a chronic illness model rather than the current, acute illness-based, fragmented and deficient system of health care." The IOM report also noted that substance abuse problems and illnesses are not separate from or unrelated to overall health care and wellness.

Viewing substance dependence as a chronic illness requires a shift in thinking about current systems for addressing these problems and a willingness to examine a new model for delivering services.

Viewing substance dependence as a chronic illness requires a shift in thinking about current systems for addressing these problems and a willingness to examine a new model for delivering services. In 2004, the Institute for Research, Education, and Training (IRETA) facilitated a leadership group to examine the assertion that substance abuse is a chronic illness and to develop "a common vision for the prevention and treatment of substance use disorders." In addition to concurring with the IOM's findings, they established principles of care for development of new systems to treat addiction, including an overarching principle that:

> *the individual (family and community) receiving the right prevention, intervention, and/or treatment and support, at the right level, for the right period of time by the right practitioner, agency or sponsor, every time. . . In this principle will be the assurance of quality, efficiency and accountability to all stakeholders and the assurance that every individual has the best opportunity to achieve wellness and recovery.*

Further, they concluded that “to build a continuum model all parts of the system, including self-care, prevention, intervention and recovery support and management strategies, are complimentary and necessary; and that “wherever the entry point occurs, the continuity of care must be prioritized and supported.”

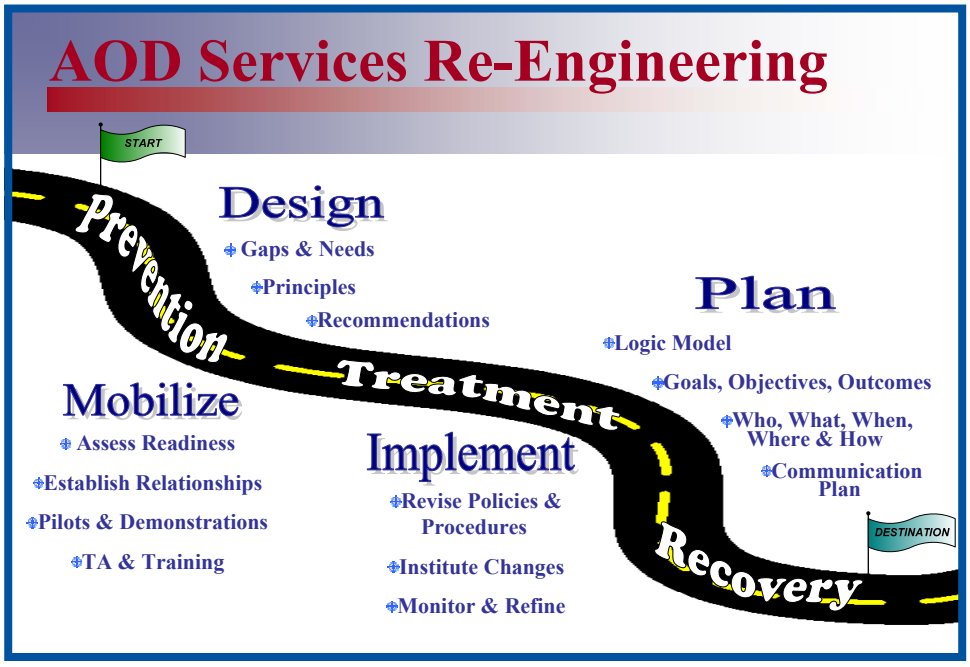
It is ADP’s intention to re-engineer the COS system in California to reflect these principles, as well as others that are identified in this report as critical to providing effective, high quality, and integrated prevention, treatment, and recovery services in California.

Goal of re-engineering the California continuum of services system

The overarching goal of re-engineering the AOD services system is to develop and to maintain a comprehensive statewide prevention, treatment, and recovery system that will prevent, treat, and reduce AOD addictions and related problems and improve the health and safety of the citizens of California.

To accomplish this goal, ADP has established a Continuum of AOD Services Re-Engineering Roadmap to guide the process of services system re-engineering. The system re-engineering goal and road map directly support two of ADP's strategic plan goals, which are to:

- Develop and maintain a comprehensive, integrated statewide prevention, treatment and recovery system.
- Improve quality, capacity and effectiveness of AOD prevention, treatment and recovery services through better use of data, including epidemiological research, and the application of continuous quality improvement practices.



Methodology: designing the continuum

The COSSR Task Force met four times over a six week period. Activities were designed to advance the process of developing recommendations for re-engineering the California AOD system of care. Task Force members were encouraged to develop recommendations that could be easily implemented, as well as those that may require more complex and long-term implementation plans.

The COSSR Task Force members self-selected to participate in a prevention, treatment, or recovery subcommittee; members also worked, at times, in multi-disciplinary groups. Work developed by the small groups was presented and discussed in the Task Force as a whole to allow for continuing input and discussion. Once a set of recommendations based on the work of the subcommittees and multi-disciplinary groups was completed, they were approved by consensus.

Core Principles

The COSSR Task Force established core principles to guide ADP and stakeholders during all phases of the process to re-engineer the COS system in California.

AOD problems are both acute and transient, as well as severe and persistent, and are similar to other chronic conditions.

AOD problems can be successfully prevented, treated and/or managed through comprehensive and integrated prevention, treatment, and recovery services.

The COSSR Task Force members agreed that an effective COS recognizes that AOD problems are both acute and transient, as well as severe and persistent, and are similar to other chronic conditions. Further, problems can be successfully prevented, treated and/or managed through comprehensive and integrated prevention, treatment, and recovery services. Thus, important principles for an effective continuum of AOD services include:

- Services must be strength-based, comprehensive, integrated, and high quality, with demonstrated effectiveness.
- Services must share the following characteristics: accessible, affordable, individual and community-centered, culturally and gender appropriate, and responsive to individual and family needs and differences.
- Delivering quality and effective care requires outcome and data-based planning for California's prevention, treatment, and recovery systems.

- Potential problems can be prevented by reducing risk factors and increasing protective factors in both communities and individuals.
- Transient or non-dependent alcohol or other drug problems can be resolved through acute care, including brief intervention and brief treatment services.
- Recovery from severe and persistent problems can be achieved through continuing and comprehensive AOD treatment and recovery maintenance services.

The Task Force utilized these core principles to develop the recommendations to re-engineer the AOD system of services, and will continue to utilize them in Phase II of the process to develop a plan to implement the recommendations for a COS model in California.

Gaps and needs

In order to develop recommendations for re-engineering the California AOD system of services, the Task Force identified and discussed gaps, needs, and barriers in the current AOD system overall, as well as for prevention, treatment, and recovery. This was not intended as a formal gap analysis nor a needs assessment, but rather the identification of items that, if addressed properly, would enhance or improve the COS in California.

Overall

Numerous barriers interfere with providing the most appropriate services for communities and individual clients, and providing access to a comprehensive array of available services.

Of primary concern to the COSSR Task Force members are the barriers that interfere with providing the most appropriate services for communities and individual clients, and providing access to a comprehensive array of available services. Treatment and recovery client needs, as determined by a qualified AOD professional using a standardized assessment in collaboration with the client, should dictate placement in services and treatment and recovery planning. Instead, services are often determined by available funding and capacity. This also contributes to a severe lack of appropriate and efficient services for family members, including children of individuals in treatment or recovery.

Exacerbating this problem is the lack of coordination, cooperation, and linkages between AOD providers and other state and local systems, particularly criminal justice, primary healthcare, and mental health, that contributes to clients being

under-served. Further, funding is structured in a way that forces compartmentalization or "siloing" of services, adding to the difficulty of prevention participants, treatment clients, and persons in recovery receiving needed services that are outside the AOD system of services.

Finally, stigma continues to undermine effectiveness at all service levels, discouraging individuals from seeking and obtaining services. This, in the long run, can result in a significant increase in costs to the AOD and health care systems, as an individual delays seeking assistance for an AOD problem.

Prevention

Youth face two primary service gaps in the current system: a) there are few options for those whose use and AOD-related behavior problems require indicated prevention services; and, b) there is little youth treatment available for those who are diagnosable by DSM IV as abusers or dependent users. Ideally, to create a seamless transition between prevention and treatment services for adolescents, prevention providers can increase screening and early intervention activities while treatment providers can increase the availability of adolescent brief treatment services.

The COSSR Task Force also noted the lack of consistency in how evidence-based model programs are defined among funding sources, causing difficulties in adopting programs on a large-scale level when working with multiple funders. The requirement for selection of science-based programs creates an artificial gap in services, as customization or adaptation of programs to be culturally appropriate for California results in additional resources and costs. There is a lack of flexibility for innovation due to funding limitations within a given community. Indicated services are more resource intensive and need precise understanding since they blur more readily with treatment. Further, providers may not be experienced in all three categories of prevention services (universal, selective, and indicated).

Finally, special populations and/or communities, such as foster or homeless youth, the elderly, and out-of-school youth tend to be underserved.

Intervention

COSSR Task Force members agreed that, for a variety of reasons, intervention has not been formally identified or funded as a service modality, yet is a vital component of the AOD system.

Intervention should be a bridge from one category of services to another and belongs in all phases of the COS – prevention, treatment, and recovery.

Intervention should be a bridge from one category of services to another and belongs in all phases of the COS – prevention, treatment, and recovery. However, there is a lack of consistency in how intervention is defined in prevention, treatment, and recovery settings. Funding barriers and lack of definitions and service responsibilities often preclude opportunities to intervene with a client with AOD issues or problems.

Treatment

The COSSR Task Force examined the AOD treatment system and identified gaps in current services and for specific populations. In general, there's a need to build capacity to provide client-centered, effective, and comprehensive services and on the system changes that may necessary to insure that client's treatment needs are met. Too often, income and geographic location often dictate what treatment services a client receives. The Task Force identified a number of services that can be critical to the success of individuals while they are in treatment and as they move from treatment to the recovery in the COS. These include: options for post-treatment (sober) housing; financial management and basic living skills; primary health care services; employment services; and integrated co-occurring treatment (mental health and substance abuse).

The Task Force recognized the critical need for treatment services and linkages to services in the criminal justice system. Correctional facilities often lack staff who are trained and professionally certified to identify or properly address individuals with substance abuse problems. There is a gap in services for parolees seeking AOD treatment services or seeking services that will support their sobriety, such as sober living and employment training. Lack of funding limits the number of individuals who can participate in drug court programs.

The continuing decrease in funding and the growing demand for services and improved service effectiveness and accountability is a critical issue.

Capacity is a major issue, and as a result many programs have waiting lists for those wishing to enter treatment. Residential treatment services are unavailable for many who need them, particularly those living in less affluent or rural communities. In some areas, individuals may have to travel long distances to receive services and may be precluded from doing so by lack of transportation options. In addition, there's a significant lack of availability of culturally appropriate treatment services for women, families, and special populations (the elderly, Lesbian-Gay-Bisexual-Transgender, African-Americans, Latinos). There is also an especially acute need for a range of age appropriate adolescent treatment services.

Efficient data and quality assurance systems that ensure accountability across the continuum of AOD services would assist providers in developing evidence-based practices.

A critical issue raised by a member of the California Association of Alcohol and Drug Program Executives (CAADPE) and discussed by the COSSR Task Force as a whole is the continuing decrease in funding and the growing demand for services and improved service effectiveness and accountability. The options for addressing the funding shortfalls are problematic; providers can serve more people by reducing the duration of treatment, reducing the frequency of client contact, or reducing care to a level lower than indicated by clinical assessment. Another option is to shift funds from other programs; however, this results in decreased services to another segment of the population whose needs may be perceived as less critical. These attempts to artificially increase program capacity by reducing standards of care are inconsistent with research findings on what constitutes "best practices" for treating addiction. Task Force members agreed that the best option is to maintain current treatment standards with existing funding priorities and to accept first-come-first-served waiting lists where the demand for services exceeds the currently funded capacity, while providing interim treatment services to individuals on waiting lists.

There is another issue with incorporating evidence-based practices in treatment services and activities. The complexity of an individual's treatment and recovery needs, as well as the variation of treatment methods and philosophies of AOD providers make evidence-based practices difficult to apply consistently to all programs. However, members note that having efficient data and quality assurance systems that ensure accountability across the continuum of AOD services would assist providers in developing evidence-based practices to meet the specific needs of identified target groups.

The COSSR Task Force identified a comprehensive services coordination system as an important need in insuring that clients succeed while in treatment and also post-treatment. A case manager can help insure that a client is receiving services that are necessary and appropriate and can coordinate and link clients to a range of necessary services is critical. This would help to reduce service fragmentation and prevent loss of clients.

There are numerous issues surrounding the lack of integration of diagnosis and treatment of co-occurring disorders; clients with both a substance abuse and mental health problem are often misdiagnosed and, consequently, receive inappropriate treatment. Another barrier to clients receiving appropriate AOD treatment is the availability of narcotic replacement treatment (NRT) in residential recovery settings; this, in part, is due to a lack of agreement in the treatment

community of how and when NRT should be used. This limits the availability of residential and other treatment services for clients who need NRT.

The laws and regulations governing Drug Medi-Cal (DMC) can be barriers to providing effective AOD treatment services. Having staff person-certified as opposed to site-certified DMC would improve access to persons who do not have access to facilities due to rural area residence, disability, or age. Some changes in eligibility requirements would benefit DMC clients in need of AOD services. For example, once children are removed from a parent's custody, that parent may no longer be eligible for DMC.

Recovery

Recovery should be client centered, based on an individual's needs, preferences, experiences, and cultural backgrounds; clients have the right to choose from a range of options and participate in decisions that will effect their lives.

While prevention and treatment have formal and established AOD systems, there is not a similar system in place for clients who have completed treatment and are in the maintenance phase of recovery. There is a lack of consensus in the AOD community of when treatment ends and recovery begins. Recovery is a term that has varied meanings; for example, people may refer to themselves as being in recovery while they are still in a formal treatment program or years after treatment and sobriety. While there is recognition of the strong link between treatment and recovery, there is no such link between recovery and prevention. However, there was consensus that:

1. Recovery is the business of an AOD System and belongs firmly in the continuum;
2. Self-help is an integral part of recovery, along with other culturally-supportive peer help systems, such as 12 Step, Talking Circles and faith-based activities;
3. These services should be available in the recovery part of the COS system: services coordination, relapse prevention, continuing involvement, continuing comprehensive assessments, motivational counseling, recovery maintenance planning, community services linkages, exit planning, family preservation and reunification, child care, housing (sober living, safe housing, permanent housing), drop in services, transportation, peer support and mentoring, education/ life skills training;
4. Recovery should be client centered, based on an individual's needs, preferences, experiences, and cultural backgrounds; clients have the right to choose from a range of options and participate in decisions that will effect their lives; and
5. There is a significant lack of funding for recovery services, especially services that address the needs of families.

Recommendations

The COSSR Task Force developed the following recommendations to begin the process of re-engineering the COS system of AOD Services in California.

Overall System

Policy

- Hold harmless the current service system by insuring that financial and other resources are identified or developed for recommended system changes and improvements that may require additional funding to implement.
- Advocate for parity in insurance and medical plans for AOD services for individuals with AOD problems.
- Advocate for the repeal of the Uniform Policy Provision Law (UPPL) law to allow for identification and documentation of an AOD problem in health care settings, including emergency rooms.
- Identify resources to expand Screening, Brief Intervention, Referral, and Treatment (SBIRT) in all medical settings.

Fiscal

- Reduce the funding restrictions between systems that are barriers to providing individual and community-centered services.
- ADP should identify resources for technical assistance and training needed to implement COSSR Task Force recommendations.
- Provide resources for pilot or demonstration projects for recommended service approaches.
- Advocate for new resources and useful data information systems that document demonstrated outcomes and lead to improved services.

Linkages

- Foster and promote key partnerships, and use a multi-disciplinary approach at the federal, state, and local levels to facilitate effective service linkages and cross-referrals, as well as collaboration to identify and develop resources, while respecting philosophical and bias differences between systems.

- Develop linkages and improve service coordination between Employee Assistance (EAP) programs and AOD service providers.

- Enhance service linkages and cross-discipline coordination within the continuum for family-based services, including services to children with a parent/caretaker in treatment and/or recovery.

- Insure cultural competency in prevention, treatment, and recovery services to address barriers to service, including language barriers.

- Increase consumer input into ADP's process for re-engineering the COS.

- Develop a plan to address the specific services needs of adolescents in prevention, treatment, and recovery.

- Include DUI in the COS as part of treatment; through screening assessment and treatment referral services, DUI services should be a portal to the appropriate services in the continuum.

- Intervention should occur in all phases of the COS system; individuals representing a broad array of systems, disciplines, and settings should be trained to provide AOD prevention screening and referral for AOD treatment assessments (DSM IV criteria) as warranted.

Specific Recommendations

Prevention

- Enhance workforce development opportunities for prevention providers by developing core competencies for prevention and early intervention specialists (e.g., EAP, SAP, SBIRT).

- Encourage participation of parents/caretakers in prevention parenting classes; eliminate current barriers to providing incentives.

- Develop and clarify the definitions of selected and indicated prevention in order to plan for and insure service delivery in compliance with the Block Grant; services delivered through indicated prevention need to be clearly distinguishable from treatment assessments (DSM IV diagnosis) and services.

- Enhance the opportunities for individuals in recovery to participate in local planning and implementation efforts that advance prevention, treatment, and recovery objectives.

- Partner with the medical community to develop strategies to address prescription drug abuse, including continuing education and availability of computer based information.

Treatment

- Expand the availability and affordability of health services, including primary care, dental care, and mental health services, through coordination and linkages for all individuals in treatment and recovery.

- Explore the option of services for opioid-related treatment in residential settings.

- Provide reimbursement for narcotic replacement therapy in medical settings, such as primary care or community care clinics, who are served by physicians, pharmacists, registered nurses, physicians' assistants, and nurse practitioners.

- Use AOD specialists in pre-release planning programs.

- Increase workforce development for criminal justice staff regarding AOD issues through continuing education requirements and as part of peace officer/correctional staff training.

- Ensure jail based AOD treatment, including narcotic replacement therapy.

- Provide AOD specialists to courts and judges to help inform their decisions.

- Work with the Judicial Council and the Administrative Office of the Courts to expand judicial education regarding AOD problems, including addictions.

- Expand the number of dependency drug courts for interaction and linkages between AOD services and the child welfare system.

Recovery

- Advocate for recognition of the importance of recovery in the continuum of services at the Federal, State, and local level.
- Identify available resources and advocate for flexibility in spending public dollars in order to provide sufficient resources for recovery services.
- Insure that Recovery Support Services occur in demonstrated ways in both the treatment and recovery areas of the continuum.
- Eliminate arbitrary and absolute timeframes that limit how and when services can be provided.
- Promote outreach to recovering persons who may benefit from recovery services even if they have no formal treatment program experience.
- Develop recovery-supportive services for youth in schools.
- Insure that clients have the right to choose from a range of options and participate in decisions that will affect their lives to insure that recovery services are client centered and based on an individual's needs, preferences, experiences, and cultural background.
- Recovery planning for individuals in treatment and recovery should be comprehensive and include housing, employment, education, mental health, addiction treatment, spirituality, social networks, family supports and more; this should be provided for, when appropriate, through services and/or coordination and linkage with other systems.
- Develop and implement a model of statewide services coordination for clients in treatment and/or recovery.

Summary

In supporting ADP's Continuum of AOD Services Re-Engineering Roadmap, the COSSR Task Force is advancing California towards a more comprehensive and integrated system reflects and addresses the specific needs of Californians, with an emphasis and focus on integration - linkages between and within modalities.

Re-Engineering the COS system in California is a challenging task that will require the development of a system that: is dynamic and responsive to changes; considers the needs of all people and communities served by the system and addresses their multiple needs; anticipates new groups and new issues; is driven by data and outcomes; and provides for continuous quality improvement. In taking this step, Phase I of the roadmap, California is leading the nation in addressing the need to improve AOD systems through a comprehensive and integrated continuum of AOD services based on chronicity and the need for the availability of continuous care.

ADP will be convening a COSSR Task Force for Phase Two: Implementation Planning, which will review the recommendations and plan the steps for implementation.

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List of Task Force Members

ADP would like to acknowledge the following individuals, who participated in the Continuum of Services System Re-Engineering Task Force and contributed their time and expertise in developing the recommendations to re-engineer California's AOD system of services.

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Regional Trainer for Orange, Riverside and
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Jonathan Graham, Drug Court
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Department of Alcohol and Drug Programs
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Marty A. Jessup, PhD, RN, CNS
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Department of Family Health Care Nursing
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Ellen M. Johnson, MA, Behavioral Health
Director Sacramento Native American
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Linda Jue
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Bosseba Kong, MSW, LCSW
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Executive Director
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Thomas Metcalf, LCSW, Program Manager
Sutter-Yuba Mental Health Services

David Mineta, Associate Director
Asian American Recovery Services

David Monti, Assistant Deputy Director
Department of Alcohol and Drug Programs
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Carol Nottley, Chair
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Aging Constituent Committee

Terry O'Brien, Chief
Kaiser Permanente Chemical Dependency Recovery Program

Patrick Ogawa, Director
Los Angeles County Alcohol and Drug Program Administration

Lori Phelps, Psy.D, CATC
California Association for AOD Educators

Roger Riott, Sober Living Consultant
California Association of Addition Recovery Resources

Terry Robinson, Executive Director
Alcohol and Drug Policy Institute

Kerrilyn Scott-Nakai
Center for Applied Research Solutions

Albert Senella, Director
Tarzana Treatment Center

Naomi Smith, Director
Ujima Family Recovery Services, East

Laura Solis, Program Administrator
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Morgan Staines, Chief Counsel
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Shirin Vakharia, Acting Administrator
Napa County HHS Agency AOD Programs

Barbara Weiss, Analyst
Department of Alcohol and Drug Programs
Program Services Division

Joan Zweben PhD, Program Director
14th Street Clinic
East Bay Community Recovery Project

Break-Out Sessions

Concurrent Break-Out Sessions

Session A

Creating a Continuum of Services: SDFSC Application of the IOM
Facilitator: Jan Ryan

Session B

Nicely Winding Down: Bringing Appropriate Closure for Staff and Participants
Facilitator: Rocco Cheng, Ph.D.

Session C

Make a Wish: The Art of Making Evidence-Based Prevention a Reality
Facilitator: Christina Borbely, Ph.D. with Peer Presentations

Break-Out

Breakout Session

Nicely Winding Down: Bringing Appropriate Closure for Staff and Participants

Facilitator: C. Rocco Cheng, Ph.D.

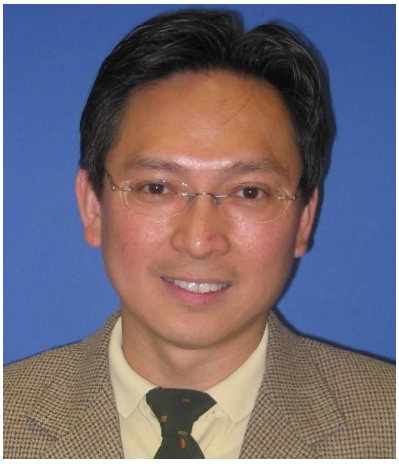
Abstract: When program funding inevitably comes to an end, staff often respond to their impending unemployment with survival and loss issues. Hence, it is important that as managers, we recognize the various needs of staff and address their termination process properly. It is important for supervisors to empower and encourage the team to continue their excellent work, recognize the contributions they've made and continue to stay focused on their priorities. As prevention services end, it is also important to bring appropriate closure and/or service transition for participants. This workshop will provide an opportunity for participants to reflect on their past experiences and feelings toward termination. We will also discuss self-care and how the same principles can be applied to program participants to have adequate termination. The facilitator will review theories regarding attachment and loss. An opportunity to experience and discuss termination will be provided as we share our own journey and create a ritual to saying good-bye.

Goals: Facilitated presentation, discussion and experiential workshop on the topic of staff and participant termination and transition due to loss of program funding.

Objectives:

1. Review factors affecting personal feelings about termination.
2. Examine self-care techniques as staff and/or managers in the termination process.
3. Learn appropriate and effective ways to assist program participants during service transition/ termination process.

Rocco Cheng, Ph.D.



Dr. Cheng has been a licensed clinical psychologist since 1995. He has been working in Asian Pacific Family Center since 1994 as a crisis counselor, team leader, project coordinator, and program director. He has been directing several prevention projects in the APFC. Currently, he functions as a program director responsible for the APFC satellite office in City of Industry. In a recently completed parenting project, he led a team with only one FTE position yet trained over 1,000 Chinese parents who attended series of parenting classes ranging from 8 to 13 weeks. He has implemented and completed 8 federal substance abuse prevention and youth violence prevention projects since 1995. Presently, he is directing a substance abuse and HIV prevention project, a parenting program, and a gang education program. Dr. Cheng has also taught at CSPP and has been a consultant/grant reviewer for Substance Abuse and Mental Health Services Agency (SMHSA) since 1999.

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Nicely Winding Down: Bringing Appropriate Closure for Staff and Participants

C. Rocco Cheng, Ph.D.

2007 SDFSC Statewide Learning Community Conference
July 17-18, 2007
San Jose, CA

It All Began With These…

- Reflection activity
  - What are a few initial thoughts, reasons, and/or goals for joining the program?

Keeping Up the Momentum

- Staff as an analogy of tools in helping others
- Dealing with changes and termination
- Importance of soul searching in this phase
- The need to support staff in order to continue supporting participants

What's Loss Got to Do With It?

- Whose loss is it anyway?
- Personal relevance to loss and good-bye
  - End of the employment
  - End of the relationship
  - Unfinished business
- Anticipated loss
- Multiple losses
  - Phases of life
  - Other losses

How Does it Affect Us?

- Physiological aspect
- Cognitive aspect
- Behavioral aspect
- Relational aspect
- Emotional aspect

- Am I insane?
  - Common reactions to uncommon situations

Attachment Theory

- Harry Frederick Harlow (1905 – 1981)
  - American Psychologist experiments on rhesus monkeys
  - Surrogate mothers
    - Wire mesh vs. Terry cloth

- John Bowlby (1907 – 1990)
  - British developmental psychologist
  - Attachment: secure, avoidant, ambivalent

Kubler-Ross Model

- Elisabeth Kubler-Ross (1926 – 2004)
- Swiss-born psychiatrist
- "On Death and Dying"
- Five stages of grief:
  - Denial and isolation: it can't be happening
  - Anger: how dare you do this to me
  - Bargaining: just let me live to see my son graduate
  - Depression: I'm so sad, why bother with anything
  - Acceptance: I know that I will be in a better place

The Importance of Meaning & Hope

- Victor Frankl (1905 – 1997)
  - Austrian neurologist and psychiatrist
  - Holocaust survivor
  - "Men's Search for Meaning"
  - Logotherapy

Gift Giving: Good-bye

- The dreadful good-bye
- Why can good-bye be good?
- Emotional corrective experience
- Give students a gift of good good-bye: expected and unexpected termination

Saying Good-bye

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(worksheet)

- What is your worse fear/concern?
  - .
  - .
  - .
- What would be ideal?
  - .
  - .
  - .

Saying Good-bye (cont.)

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(worksheet)

- What do you anticipate for the last day?
- What would you like to see?
- What if it does not happen?

Planning for Termination/Transition of Services

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- Get staff and participants involved
  - Assess their needs and get their perspective
    - Transition and transfer of services
    - Proper referral and walking through
  - Modeling planning and problem solving by not avoiding it
  - The need to create a ritual
    - Putting it in context
    - Celebration
  - Working with “unaffected” individuals

Planning for Termination of Services (II)

- Review the work together
  - How things have changed: highlight the landmarks and memorable moments
  - The good
    - Remind them their strengths and celebrate achievements
  - The bad
    - Help them reframe
  - The others….

Appropriate Closure

- Picture the day of last meeting
- Create a ritual
  - What are some helpful rituals?
- Transitional objects
- Anticipate and plan
  - What do you anticipate?
  - Would you like to see?
  - What if it does not happen?

Thinking About the Future

- Plan for the future
  - What it would be like without the regular activity?
  - What it would be like without activity?
  - What to do with the time?
  - What to do when challenges are encountered?

Appropriate Boundaries

- Taking care of staff and participants' emotional needs
  - Honoring the need while observing the boundary
  - When it is hard….
    - He who shall not be named
  - Faith and trust that they can carry on

The Last Service Session

- The last day/time together
  - If you have planned…
  - If you have not planned…
  - When people refuse to say good-bye
  - When people appears to be unaffected

Follow-Up Contact

- Contact after termination
  - When initiated by participants
  - When initiated by staff
    - What's the criteria
  - Promise, promise

Transition of Relationships

- Change of relationship

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Q/A

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Closing Circle and Unity Clap

- What do we wish for in this difficult time?

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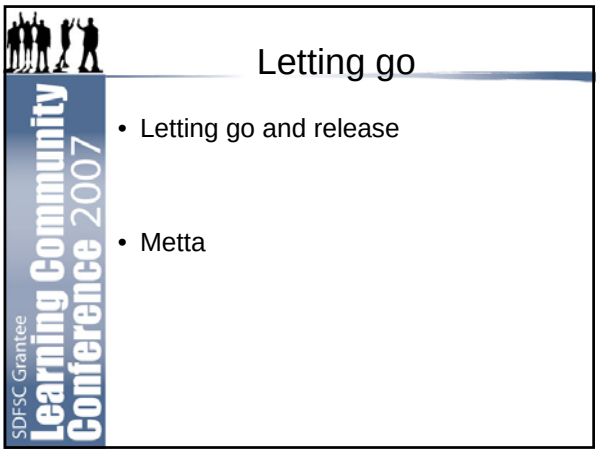
Letting go
• Letting go and release
• Metta
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Wishes Do Come True:
The Art of Making Science-based Prevention a Reality

Facilitator: Christina J. Borbely, Ph.D.

Abstract: If wishes were horses, you'd have a stable. If science-based prevention seems like wishful thinking, then saddle up! This session provides an overview of real life, practical applications of that slippery theoretical concept - evidence-based prevention. By now we are familiar with programs proven effective by science or strategies grounded in research. How does that translate to service provider reality: Picking off a list? Curriculum out of a box? Sure. But there are other and more innovative ways to practice science-based prevention that makes sense in your community and for your team's resources. There are new approaches in the field rooted in making science-based prevention relevant and achievable. We will review hot-off-the-presses CSAP recommendations for selecting science-based programming, learn from the experience of prevention providers, and gain insight through discussion with experts (you!). Participants will be able to identify and articulate the science-based prevention they already practice and take away new strategies and tips for real-world application. Yeehaw!

Goals: Review, discussion and peer presentations of real-world implementations of science-based prevention programming.

Objectives:

1. Increase knowledge regarding latest CSAP guidelines for selecting, designing, and implementing evidence-based services.
2. Explore options for building evidence to support locally designed prevention efforts.
3. Learn from other grantees regarding their own experiences in documenting evidence of effectiveness of their local program efforts.

Christina Borbely

Christina Borbely, Ph.D. is a research consultant at CARS providing technical assistance to California's Safe and Drug Free Schools & Communities grantees. Also a member of the EMT team, Christina coordinates program evaluations for El Dorado County Office of Education and Big Brother Big Sister of the Bay Area. Prior to joining EMT/CARS, Christina was a member of the research staff at Columbia University's National Center for Children and Families. Her work in the field of youth development and prevention programs has been presented at national conferences and published in academic journals. Specifically, Christina has extensive knowledge and experience in program evaluation and improving service delivery by identifying factors that impact today's young people. She is also involved as a volunteer in providing mentoring and developmental support to youth in underserved populations. Christina received her doctoral degree in developmental psychology, with a focus on children and adolescents, from Columbia University (2004).

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Wishes Do Come True

The Art of Making Science-based Prevention a Reality

Facilitator: Christina J. Borbely, Ph.D.

Adapted from: USDHHS, SAMHSA, (2007) *Identifying & Selecting Evidence-based Interventions.*

Taking Hold of the Reins

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Evidence-based Prevention

- Where We've Been
- Where We Are
- Where We're Going

Reality Check

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- Conceptual fit to the logic model:
  Is it relevant?
- Practical fit to the community's needs and resources:
  Is it appropriate?
- Strength of evidence:
  Is it effective?

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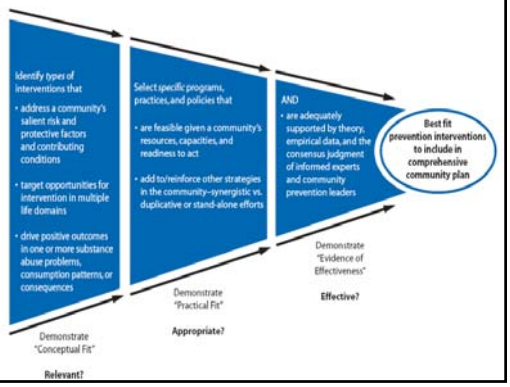
Figure 3. Process Description: Selecting Best Fit Prevention Interventions



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Is It Relevant?

- *If the prevention program, policy, or practice doesn't address the underlying risk and protective factors/conditions that contribute to the problem, then the intervention is unlikely to be effective in changing the substance abuse problem or behavior.*

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Concept Check

Meaningful community needs & resource assessment

- Does the intervention directly address the identified priority population & needs?

Logic model

- Is the intervention a conceptual fit with the logic model? The theory of change?

Data-driven decision-making

- What type of intervention is warranted given the available community needs and resource data?

Is It Appropriate?

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If the prevention program, policy, or practice doesn't fit the community's

- *capacity,*
- *resources,*
- *or readiness to act,*

then the community is unlikely to implement the intervention effectively

Utility Check

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Appropriate for the priority population.

- Has the intervention been implemented successfully with the same or a similar population?
- Are the population differences likely to compromise the results?

Delivered in a setting similar to the one planned by the community.

- In what ways is the context different?
- Are the differences likely to compromise the intervention's effectiveness?

Culturally appropriate.

- Did members of the culturally identified group participate in developing it?
- Were intervention materials adapted to the culturally identified group?

Are implementation materials (e.g., manuals, procedures) available to guide intervention implementation?

- Are training and technical assistance available to support implementation?
- Are monitoring or evaluation tools available to help track implementation quality?

Feasibility Check

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- Culturally feasible, given the values of the community?
- Politically feasible, given the local power structure and priorities?
- Match with mission, vision, and culture?
- Administratively feasible, given the policies and procedures?
- Technically feasible, given staff capabilities and time commitments and program resources?
- Financially feasible, given the estimated costs of implementation (including costs for purchase of implementation materials and specialized training or technical assistance)?

The Nature of Evidence

…is continuous

Strength of evidence is determined by:

- **Rigor of the study design**
- **Rigor and appropriateness of methods** used to collect and analyze the data
- The extent to which **findings can be generalized** to similar populations and settings.

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Identifying "Evidence-based" Prevention

- Included on Federal Lists or Registries of evidence-based interventions;
- Reported (with positive effects) in peer-reviewed journals; or
- Documented effectiveness based on the three new guidelines for evidence.

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Evidence of Effectiveness Guidelines

Credible and persuasive evidence for community-based interventions require certain characteristics.

There are 3 guidelines for assessing evidence *all of which must be met to demonstrate "documented effectiveness"*

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Guideline 1

Proven Theory

- The intervention is based on a solid theory or theoretical perspective that has been validated by research;

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Guideline 2

Convergence of Proof

- The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness; and

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Guideline 3

Expert Consensus

- The intervention is judged by a consensus among informed experts to be effective based on a combination of theory, research and practice experience.“ Informed experts” may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

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Truth ≠ Self-Evident: Prove It

- Document similarity in theory, content, and structure to interventions that are considered evidence-based by scientific standards.
- Document use by the community through multiple iterations, and data collected indicating its effectiveness.
- Documentation with content comparable to evidence usually addressed in peer-reviewed journal articles.

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Truth ≠ Self-Evident: Prove It

- Document established theory that has been tested and empirically supported in multiple studies.
- Document basis in published principles of prevention
- Describe and explain how the intervention is rooted in the indigenous culture and tradition.

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Round Up

- What Are You Doing?
  - What Works?
- What Doesn't Work?

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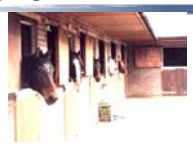
Happy Trails



- Regularly document proof of evidence-based practices
- Systematically review the relevance & appropriateness of prevention programming
- Think creatively about how to integrate science into practice
- Learn from concrete examples

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Peer Presenter

Peer Presenter

Butte County

Peer Presenter

Marin County

Peer Presenter

Peer Presenter

San Mateo County

Stay Safe Youth Coalition

The Stay Safe Youth Coalition or SSYC (pronounced “sick”) is a unified and committed group of young people, passionate and motivated about creating positive changes within the community through Action, Education, and Leadership. Young leaders of SSYC come from the school based Stay Safe prevention programs at Terra Nova, Oceana, Westmoor, and Jefferson high schools within the Jefferson Union High School District of Daly City and Pacifica. In partnership with adult allies from Asian American Recovery Services, Inc (AARS) and Youth Leadership Institute (YLI), SSYC focuses all their efforts on environmental prevention addressing local alcohol, tobacco and other drug issues impacting youth.

AARS San Mateo Youth Services 1115 Mission Road. South San Francisco, Ca 94080
Phone: 650.243.4850 Fax: 650.243.4851
www.AARS-inc.org

Stay Safe Youth Coalition

The Stay Safe Youth Coalition
is a unified and committed group of young people, passionate and motivated about creating positive changes within the community through
Action, Education, and Leadership.

About the Stay Safe Youth Coalition (SSYC)

Young leaders recruited from Oceana, Terra Nova, Westmoor, and Jefferson High Schools formed SSYC to create change and mobilize around issues regarding Alcohol, Tobacco, and other Drugs (ATOD) in the Daly City and Pacifica community. Prior to its inception in March 2005, students from the Stay Safe groups of Asian American Recovery Services (AARS) partnered up with the Youth Leadership Institute (YLI) and surveyed 1000 teens in the Jefferson Union High School District (JUHSD) about what leads teens to use drugs and alcohol, how they get them, and where most of the influences to use drugs and alcohol come from. Since then SSYC and its youth led movement unified its efforts to create projects that have lasting and positive effects in our community.

Tobacco Retail Licensing (TRL) Campaign

SSYC is committed to reducing tobacco use among all Teens, especially focusing on preventing youth access to tobacco. Currently, SSYC is working to adopt a policy, which would require all tobacco merchants to purchase a license in order to sell tobacco products in Daly City. A tobacco retail license would entail enforcement of tobacco laws, especially those that prevent youth access to tobacco products. SSYC collected data about the problem in their local community by implementing public opinion surveys and youth tobacco purchase surveys. In collaboration with YLI, members of SSYC are being trained so that they have the skills and knowledge to lead, design, and implement this policy project.

Other Projects:

Conceived from the startling results of a youth access survey the group implemented throughout the JUHSD in 2004-2005, youth members hosted the "The SSYC Truth" press conference to disclose the *sick truth* about teen access to alcohol, tobacco, and other drugs. Findings that were released included the fact that stores were only carding *consistently 25% of the time.* This successful event united the Mayors of Daly City and Pacifica, Trustees of the Jefferson Union High School District, and other prominent figures of the community to support SSYC in educating the community about the "sick truth". SSYC has also worked on a number of other projects including "The Smoke Free Movies Campaign", a global effort to get tobacco smoking out of Hollywood movies. In addition the group has been videotaping all of their projects in hopes to making educational films for young people and the community at large.

SSYC is a project of Asian American Recovery Services, Inc. in partnership with the Youth Leadership Institute, West Ed, and the Jefferson Union High School District. Funding is made possible by the San Mateo County Alcohol and Other Drug Services.

ASIAN AMERICAN RECOVERY SERVICES, INC.

AARS San Mateo Youth Services 1115 Mission Road. South San Francisco, Ca 94080
Phone: 650.243.4850 Fax: 650.243.4851
www.AARS-inc.org

The Mission of Asian American Recovery Services
is to decrease the incidence and impact of substance abuse in the
Asian and Pacific Islander communities of the greater San Francisco Bay Area counties.

About Asian American Recovery Services, Inc (AARS)

AARS was established in 1985 by the community-wide, grassroots efforts of the Asian American Substance Abuse Task Force, in response to rising substance abuse rates among San Francisco's Asian and Pacific Islander population.

Created as a culturally responsive alternative to existing treatment programs that offered little or no programming specific to Asians with substance abuse problems, AARS continues to adapt and change to meet the rapidly growing and diverse needs of the Asian and Pacific Islander communities in the Bay Area.Today, AARS is the largest agency in the nation providing substance abuse programs targeting the diverse Asian and Pacific Islander Communities.

About San Mateo County AARS Youth Services Programs:

Located in South San Francisco, AARS Youth Services provides one the most comprehensive and diverse spectrum of programs in the county. A continuum of services aimed at reaching young people and their families are offered through *Prevention*, *Intervention*, *Treatment* and *Family* programs.

Treatment / Intervention

Treatment programs include *Project Oasis* which is an outpatient treatment program geared toward youth who are on probation or referred by the Juvenile Probation Department, and *Project Reconnect* which is a brief intervention/treatment program for any youth who may be struggling with substance abuse issues.

Family

Family Oasis is a family-based counseling program working with youth who have substance abuse problems. The program uses a specially designed approach called "Brief Strategic Family Therapy" (BSFT) which brings family members into the counseling process. Family Oasis treats youth with risk factors for substance abuse, including behavioral and emotional problems, violence, early drug use, and family conflict.

Prevention / Youth Development

STAY Safe, which stands for *Supportive Transitions for All Youth to be Safe* is a unique blending of different prevention strategies beginning in the eighth grade. Not only are youth exposed to leadership activities including those that involve *Environmental Prevention* efforts such as the *Stay Safe Youth Coalition*, they are also given opportunities to mentor or be mentored through the *STAY Safe Program*. In addition, weekly after school *Life Skills* groups and in-school *Support* groups are provided throughout the school year where youth learn skills such as communication, team building, and goal-setting, as well as addressing issues related to drugs, relationships, and family. Currently, over 150 youth participate in *STAY Safe* Programs in the *Jefferson School District* and the *Jefferson Union High School District.*

San Mateo County AARS Youth Services
1115 Mission Road. • South San Francisco, CA 94080 • TEL: 650.243.4850• FAX: 650.243.4851

Stop Youth Access to Tobacco! Campaign

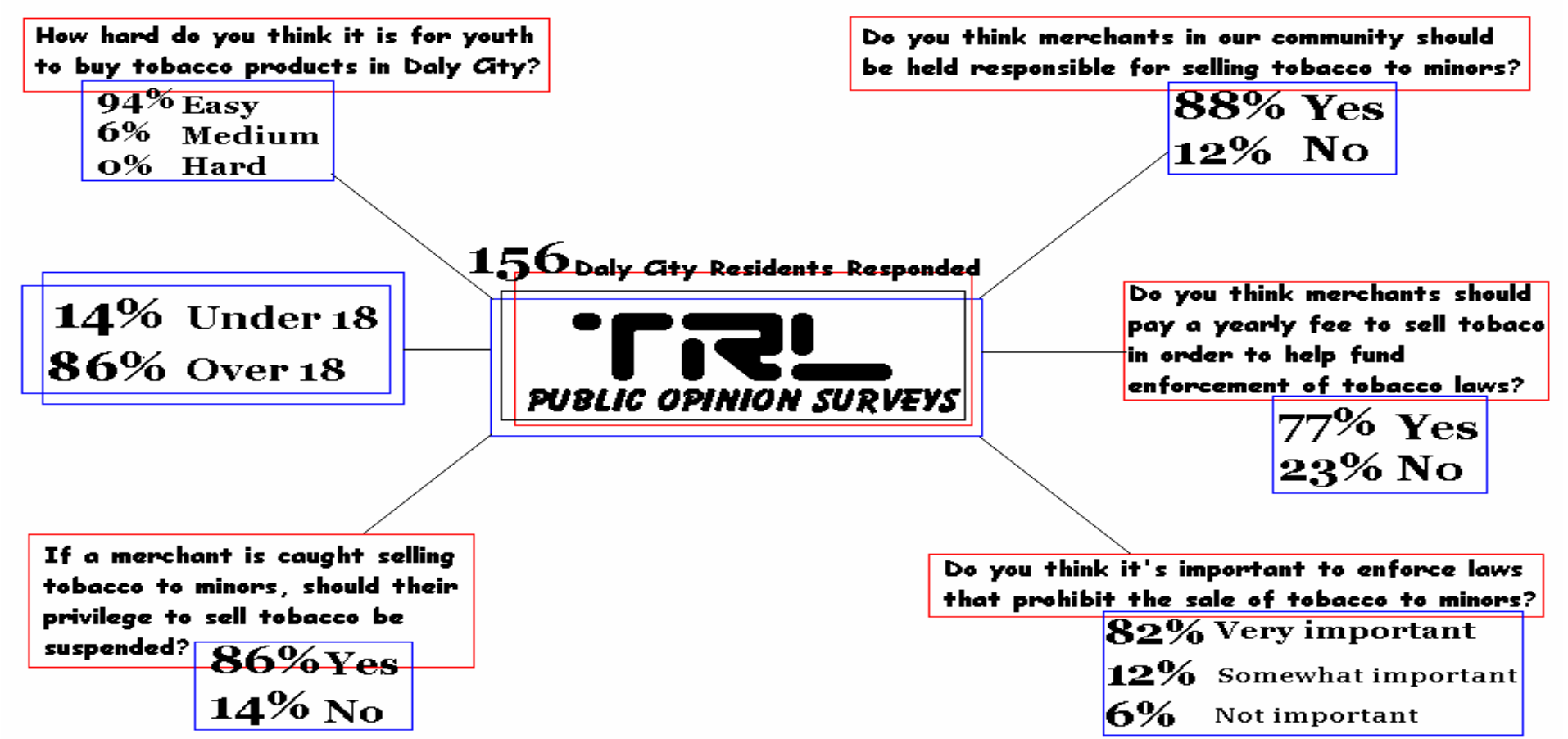
The Stay Safe Youth Coalition is trying to get a tobacco retail license ordinance adopted in the City of Daly City. Tobacco retail licenses have been shown to be an effective way to reduce rates of youth access to tobacco. For the last 100 years, it has been unlawful to sell tobacco products to youth 18 and under. Currently, approximately **one out of four stores in Daly City sell cigarettes to youth!** By supporting the campaign efforts, you are supporting a tobacco free environment for all youth in Daly City.

Data Collection

The following report contains results from two surveys conducted by the youth in SSYC. Youth Purchase Surveys were implemented in October of 2006. After training and strict protocols, youth under the age of 18 walked into stores and attempted to purchase cigarettes. The second survey, the Public Opinion Survey, was implemented in July of 2006. In this survey residents of Daly City were asked several questions regarding their opinions about tobacco laws, the responsibility of tobacco merchants, and youth access to tobacco. Coalition members spent a week interviewing residents at various 'popular spots' in Daly City including Albertson's, Blockbuster, Westlake Area, Century 20 Movie Theatres, Daly City BART, and the Serramonte area. Please read this report and help support our campaign.

Stay Safe Youth Coalition

Public Opinion Survey Results



Asian American Recovery Services, Inc.

yli Youth Leadership Institute

Stay Safe Youth Coalition

Youth Purchase Survey Results

Youth Purchases	Number of stores	Number of buys	Youth purchase Rate
October 2006	38	10	24.5%

Key Findings

- Approximately 1 in 4 stores (24.5%) sell tobacco to minors.
- 94% of the Daly City residents think it is easy for youth to buy tobacco products in Daly City.
- 86% of residents think that merchants should have their selling privileges suspended if they are caught selling to minors
- 82% of Daly City residents think that it is VERY important to enforce laws that prohibit the sale of tobacco to minors.
- 77% of residents think that merchants should pay a yearly fee to sell tobacco to help pay for enforcing tobacco laws.

Contact Info

To learn more about our efforts, or to become involved, please call:

Etan Zaitsu
Asian American Recovery Services
Stay Safe Program Supervisor
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Amanda Cue
Sr. Director of Prevention
Youth Leadership Institute
SMC Tobacco Coalition Co-Chair
www.yli.org
(650) 347-4963

ASIAN AMERICAN RECOVERY SERVICES, INC.

YOUTH LEADERSHIP INSTITUTE

Stay Safe Youth Coalition

STOP TOBACCO SALES TO YOUTH!
THE FACTS…

A Youth-Led Campaign by the Stay Safe Youth Coalition

Youth smoking rates and youth access to tobacco products are a problem, in California and in Daly City.

- 15.4% of high school students in California smoke, and the middle school smoking rate is 6.7% [i]
- An estimated 14% of Daly City youth reported smoking cigarettes in the past month.[ii]
- In a 2004 survey by the Stay Safe Youth Coalition, 24% of current smokers report they most often get tobacco from buying it at store.[iii]
- 90% of current adult smokers tried their first cigarette by the age of 18 and the average age at which smokers try their first cigarette is 14.5.[iv]
- 38,100 kids under 18 became new, regular smokers each year in California.[v]
- Tobacco products killed more than 43,000 Californians in 1999.[vi]
- In 2006, the illegal tobacco sales rate in California increased to 13%. [vii]
- A recent 2006 survey by Stay Safe Youth Coalition found that one in four stores (25%) illegally sold tobacco to minors – double that of the state.[viii]

Adopting a tobacco retail license is a good solution.

- Tobacco retail licenses have been shown to be an effective way to reduce rates of youth access to tobacco.[ix] [x] [xi]
- 80% of California adults think that a license should be required to sell tobacco.[xii]
- 3 of 4 teenagers shop at a convenience store at least once a week.[xiii]
- Tobacco companies spend more of their marketing dollars on the retail outlet than on any other advertising venue.[xiv]
- The current license in San Mateo County is great first step. However, to make it effective, cities need to strengthen the ordinance.
- This license would not only be a way to ensure that youth access laws are enforced, but also other tobacco control laws as well.
- Enforcement of tobacco sales laws enhances their efficacy both by directly deterring violators and by sending a message to the public that Daly City and community leadership believes that the policies are important.

A strong tobacco retail license in Daly City is important.

- A license is a way to ensure that merchants are held accountable for selling to minors and is supported by a majority of residents in our community. A recent public opinion survey done by SSYC, found that 86% of Daly City residents surveyed felt that merchants who sold tobacco products to minors should have their license to sell tobacco suspended.[xv] 77 % thought at yearly fees should be added to pay for enforcement.
- We want to make sure it is strong by:
    - Renewing the license annually, which would allow lists of current retailers to be up-to-date and could be used to educate merchants about laws and regulations pertaining to tobacco sales to minors. An annual renewal also creates a level playing field by ensuring that all retailers are equally eligible for enforcement visits.
    - Providing meaningful suspensions and fines for violations of the license. This type of penalty for violating tobacco control laws would create a significant economic deterrent effect to retailers.

  - Requiring a fee sufficient to pay for ongoing administration, enforcement and prosecution of the license.
- The license is not meant to punish the law-abiding merchants that are not selling to minors. Instead, it is our intent to level the playing field for all merchants, so that no merchant is inappropriately profiting from sales to minors.
- We hope that by adopting a tobacco retail license in Daly City, we will send a strong message to retailers and others in our community that we will not tolerate tobacco use by young people or sales by merchants to youth. We must work together to protect the health and safety of young people in Daly City.

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[i] National Youth Tobacco Survey, 2004
[ii] California Healthy Kids Survey, 2005; Jefferson Union High School District.
[iii] Stay Safe Youth Coalition, YLI Youth Access Survey, Jefferson Union High School District, 2004.
[iv] U.S. Department of Health & Human Services. Et al., Preventing Tobacco Use Among Young People: A Report of the Surgeon General 67 (1994)
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[vii] California Department of Health & Human Services, Tobacco Control Section, Youth Tobacco Purchase Survey 2005.
[viii] Stay Safe Youth Coalition Youth Purchase Survey Results, 2006, Daly City.
[ix] Forster JL, Wolfson M. Youth access to tobacco: Policies and politics. Annual Review of Public Health. 1998; 19:203-235.
[x] Stead LF and Lancaster T. A systematic review of interventions for prevention tobacco sales to minors. Tobacco Control. 2000, 9:169-176.
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[xii] Harder+ Company Community Research. American Lung Association of California Key Opinion Leader Survey Year One Report. June 2000.
[xiii] POPAI, The Point of Purchase Advertising Industry Fact Book. 1992, Point of Purchase Advertising Institute: Englewwod, NJ.
[xiv] Federal Trade Commission, Report to Congress for 1997, Pursuant to the federal cigarette labeling and advertising act. Washington D.C.: Federal Trade Commission, 1999.
[xiv] Stay Safe Youth Coalition Public Opinion Survey, 2006. Daly City.

The Stay Safe Youth Coalition has been working to reduce youth access to tobacco in Daly City by advocating for a strong tobacco retail license in partnership with the Youth Leadership Institute and San Mateo County Tobacco Education Coalition.

For more information or to learn more about the Stay Safe Youth Coalition and Asian American Recovery Services efforts, please contact Etan Zaitsu, Program Supervisor for Stay Safe Programs at ezaitsu@aars-inc.org or (650) 756-323. To learn more about Youth Leadership Institute or the Tobacco Education Coalition, contact Amanda Cue, Sr. Director of Prevention - San Mateo County, at acue@yli.org or (650) 347-4963.

This project is funded in part by San Mateo County Health Department Tobacco Prevention Program and the San Mateo County Alcohol and Drug Services.

ASIAN AMERICAN RECOVERY SERVICES, INC.

YOUTH LEADERSHIP INSTITUTE

Stay Safe
Youth Coalition

Tobacco Retail License Questions and Answers

1. What is a Tobacco Retail License?

A tobacco retail license (TRL) is a local license merchants need to sell tobacco products in their store, paying a yearly fee in order to sell tobacco. When merchants are caught violating tobacco laws, the stores are fined could potentially have their license suspended. Money from fees and fines go to support resources for enforcement and administration of the license through regular compliance checks.

2. Why Should Businesses Have a Tobacco Retail License?

Merchants should have to have a license to sell a deadly product like tobacco. You currently need a license to sell alcohol, food, mattresses, and to own a dog, but not tobacco. Tobacco retail licenses throughout the state have been a proven strategy to reduce youth access to tobacco, and thus lowering youth smoking rates. Renewing the license annually, would allow lists of current retailers to be up-to-date, accurate and could be used to contact merchants for education about laws and regulations pertaining to tobacco sales to minors and ALL tobacco laws.

3. Isn't there already a state tobacco license?

There is a statewide law, AB 71, requiring all businesses to obtain a license by paying a one-time fee of $100. There is no enforcement to AB 71 and it was designed to reduce tobacco smuggling, not youth access to tobacco.

4. Isn't selling tobacco to minors already against the law? How does this differ?

Yes, Penal Code 308A states that it is illegal to sell tobacco to minors. Currently, there are no resources for law enforcement to enforce this law in addition to their many community needs and priorities. A tobacco retail license would provide resources for law enforcement to enforce ALL tobacco laws including mobile sales, single sales, STAKE Act signage, etc. Under a license, violations are cited against the license holder, and not the clerk, as PC308 currently states.

5. Do we really need a new law?

Yes! Currently there is no local law or ordinance that provides resources for law enforcement to enforce youth access to tobacco laws. A tobacco retail license also incorporates license suspensions, not just fines, for violating tobacco laws. Youth access to tobacco is best controlled by local jurisdictions.

6. How much would a license fee cost?

The fee is determined by the number of merchants in a community and the enforcement costs to perform a specified number of compliance checks each year. Requiring a fee sufficient to pay for ongoing administration, enforcement and prosecution of the license is ideal. On average in California, effective local licenses are between $100 to $350 per year.

7. What happens when merchants are caught selling tobacco to minors under a tobacco retail license?

The stores would be cited and fined with a potential license suspension. The suspension time and fine amount would depend if the violation was the first, second or third violation within a year or specified time period. Providing meaningful suspensions and fines for violations of the license would create a significant economic deterrent effect to retailers.

Please join us in our efforts!

The Stay Safe Youth Coalition is a group of high school students in Daly City and Pacifica who are dedicated to voicing the concerns of young people and making a difference in their communities. In partnership with Youth Leadership Institute and the San Mateo County Tobacco Education Coalition, the Stay Safe Youth Coalition has been working to reduce youth access to tobacco in Daly City by advocating for a strong tobacco retail license.

To learn more about our efforts, or to become involved, please call:

Etan Zaitsu
Asian American Recovery Services
Stay Safe Program Supervisor
www.aars-inc.org
(650) 243-4850

Amanda Cue
Sr. Director of Prevention
Youth Leadership Institute
SMC Tobacco Coalition Co-Chair
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ASIAN AMERICAN RECOVERY SERVICES, INC.

San Mateo County united healthy tobacco free community Tobacco Education COALITION

yli YOUTH LEADERSHIP INSTITUTE

SAN MATEO COUNTY Friday Night live PARTNERSHIP

The CENTER FOR TOBACCO POLICY & ORGANIZING

AMERICAN LUNG ASSOCIATION. of California

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Tobacco Retailer Licensing Is Effective

September 2006

Several years ago tobacco control advocates in California launched a new effort to end illegal sales of tobacco to minors. The strategy was to pass strong local tobacco retailer licensing ordinances. Seventeen communities have passed strong ordinances so far, and more are on the way. What distinguishes these new ordinances from earlier, weaker versions is licensing fees high enough to fund strong enforcement programs. Currently, strong local licensing ordinances around California have fees between $200-300 per retailer.

Enough time has now passed for some of these communities to have implemented their licensing program and to evaluate the effectiveness of the program in deterring sales of tobacco to minors. The results overwhelmingly demonstrate that tobacco retailer licensing with strong enforcement provisions is effective. Rates of illegal tobacco sales to minors have decreased in California communities which have passed strong tobacco retailer licensing ordinances. In many communities, the reductions are quite dramatic.

Previous laws were unsuccessful because the fees were not set high enough to fund an effective enforcement program that included compliance checks. In addition, punishments in previous laws were not significant enough to serve as a deterrent. Strong licensing ordinances include financial deterrents through fines and penalties that include the suspension and revocation of the license. To learn more about drafting an effective tobacco retailer licensing ordinance contact Randy Kline at the Technical Assistance Legal Center (TALC) at 510-444-8252 or rkline@phi.org.

YOUTH TOBACCO SALES DECLINE IN COMMUNITIES WITH STRONG TOBACCO RETAIL LICENSING LAWS

Berkeley
$300 annual fee
Adopted December 2002
Rates dropped from 38% to 5.8%

Contra Costa County
$160 annual fee
Adopted January 2003
Rates dropped from 37% to 7%

Elk Grove
$270 annual fee
Adopted September 2004
Rates dropped from 17% to 10%

Pasadena
$135 annual fee
Adopted January 2004
Rates dropped from 19% to 5%

City of Sacramento
$300 annual fee
Adopted March 2004
Rates dropped from 27% to 7%

Sacramento County
$287 annual fee
Adopted May 2004
Rates dropped from 20.6% to 10.6%

City of San Luis Obispo
$255 annual fee
Adopted August 2003
Rates dropped from 17% to 2%

* Pre- and post- rates of illegal tobacco sales to minors were determined by youth purchase surveys administered by local agencies. (For more information, contact the local tobacco control program.)

Stay Safe Youth Coalition

Stop Youth Access to Tobacco! Campaign

The following is a statement of endorsement for adopting a tobacco retail license ordinance in the City of Daly City. Tobacco retail licenses have been shown to be an effective way to reduce rates of youth access to tobacco. For the last 100 years, it has been unlawful to sell tobacco products to youth 18 and under. Currently, approximately one out of four stores (25%) in Daly City are selling cigarettes to youth! By supporting the campaign efforts, you are supporting a tobacco free environment to all youth in the City of Daly City. To show your support, please sign the endorsement form below:

ENDORSEMENT FORM

_____ _____

Name of Organization or Group Telephone

_____

Address, City, Zip Code

_____ _____

Fax Email

The above-mentioned organization wishes to support the effort of the Stay Safe Youth Coalition (SSYC) Stop Youth Access to Tobacco! Campaign in the City of Daly City by endorsing the following: 1) **adopting** the tobacco retail license ordinance in Daly City; 2) ensuring annual license fees are sufficient to provide enforcement of the ordinance.

Further, our organization wishes to support the Campaign efforts by undertaking the following actions (check all that apply):

_____ 1. Endorse the efforts of the Campaign for a complete stop of tobacco sales to youth!

_____ 2. The Campaign has the permission to use our name as an endorser

_____ 3. We will communicate with our membership about reasons to support the Tobacco Retail License in Daly City

_____ 4. We will provide spokespersons, youths, and other concerned parties for press conferences, community forums, and other related campaign activities upon request and when the issue is compatible with the concerns of our organization

_____ 5. Other:

_____

Signature Title Date

For more information or to learn more about the Stay Safe Youth Coalition, please contact: Etan Zaitsu, Project Supervisor of Prevention at 650-243-4850 or ezaitsu@aars-inc.org. This project is in collaboration with the **Youth Leadership Institute (YLI)**, an organization that works with youth and adults to build communities that invest in youth. This project is funded by the San Mateo County Alcohol and Drug Services and San Mateo County Tobacco Prevention Program.

Daly City · Colma
Brisbane · Pacifica
South San Francisco
San Bruno · Millbrae
Burlingame · Hillsborough

MONDAY
MARCH 12, 2007

The Examiner
PENINSULA

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Since 1865

CARDINAL MEN MAKE THE CUT

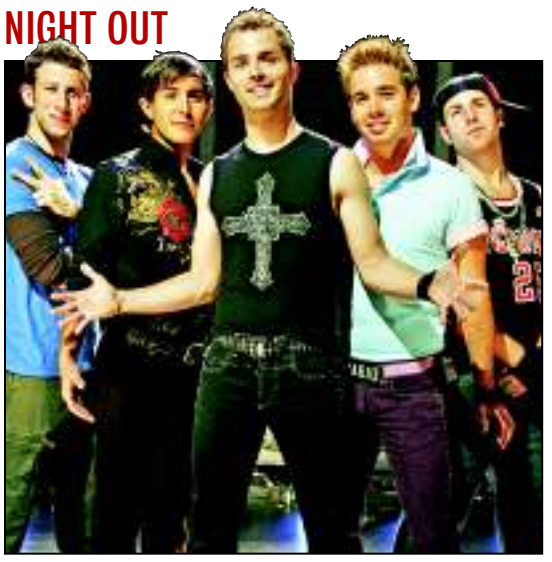
Stanford squeaks into tourney; check out the full bracket inside » PAGE 38

WINE AND WOMEN

Female-judged competition in North Bay heats up » PAGE 14

LOCAL: END OF PAPER AIRLINE TICKETS? » PAGE 3

NIGHT OUT



Boy band spoof rocks Orpheum

New musical "Altar Boyz" makes its way to San Francisco with a built-in fan base. » Page 19

NIGHT IN

Meeting displays the future of video games

Video game conference at Moscone Center showcases latest in technology. » Page 18

Daly City kids join forces to fight smoking

Group seeks county tobacco retail-licensing fee » Page 4

SCOOP!

Salma Hayek's low-key romance

Actress and "Ugly Betty" producer is pregnant, to wed Frenchman. » Page 20

COMING TUESDAY!
Warriors face Mavs at Oracle

Millbrae 69° 50° Mostly sunny skies and warm conditions » Page 37

HEART OF THE PENINSULA

COMPETING TALENT Samantha Oliveira sings her rendition of the song "On My Own" from "Les Misérables" as part of the pageant competition for Miss Redwood City, held at Sequoia High School. Among the judges were representatives from the Miss California and Miss America pageants. — Juan Carlos Pometta Betancourt/Special to The Examiner

Tell us who is doing positive things: peninsula@examiner.com

WHAT'S MAKING NEWS TODAY

12th annual Law Enforcement symposium

Retrofit on GG bridge approach discussed «

SFSU faculty votes whether to go on strike

Caltrain celebrates at baby bullet station

YOU MAKE THE NEWS **E-mail us your news, photos, tips, sightings and events.** Newstips@examiner.com

Talks about retrofits for the bridge.

BAY AREA NEWS

OAKLAND

Woman fatally shot while on her way to church

A woman was fatally shot while on her way to church in Oakland on Sunday morning, Oakland police Sgt. Jim Rullamas said.

The shooting was reported at 7:42 a.m. outside the Acts Full Gospel Church of God in Christ at 1034 66th Ave.

The victim, a woman about 40 years old, was believed to have been heading to the church when she was shot, Rullamas said. Worship service was scheduled to begin at 8 a.m., according to the church's online schedule.

Father arrested in 3-month-old son's death

A father who told police his 3-month-old son died after being dropped in the bathtub has been jailed after an autopsy showed the infant's injuries resulted from a beating, not a fall, authorities said.

Fernando Loughlin, 32, was arrested Saturday on suspicion of murder in the death of his son, Julian Loughlin, authorities said.

SAN JOSE

Three displaced, two injured in morning house fire

Two adults were injured when a fire tore through part of an East San Jose home Sunday morning, a San Jose Fire Department spokesman said.

The fire was first reported at the single-story residence at 2342 Barlow Ave. at 11:08 a.m., according to Capt. Steve Alvarado.

Fire units arrived minutes later and reported seeing flames and heavy smoke coming from the house's windows, Alvarado said.

Approximately 30 firefighters were able to quickly contain the blaze, which was declared under control at 11:37 a.m., according to Alvarado.

HAYWARD

Man loses control of car, dies in roll-over crash

Police are investigating the cause of a Saturday evening crash that claimed the life of one man when he lost control of his car and landed upside down after uprooting three trees.

At around 9:42 p.m., witnesses at a Starbucks said they saw what looked like a chase or a race, as two vehicles sped west on a parkway, weaving around slower traffic.

— Wire reports

Daly City youth work to snuff out smoking

Teens join in effort to get tobacco licensing fees instituted in the city

By David Smith
Staff Writer

DALY CITY — Every time she sees her father smoking, 15-year-old Jill de Leon tells him he's going to die.

The Oceana High School freshman from Daly City is part of a youth movement in northern San Mateo County pushing a tobacco retail-licensing fee in the county's largest city in an effort to stymie underage smoking.

"It's the only way I know how to get through to him," said de Leon, a member of the Stay Safe Youth Coalition of Asian-American Recovery Services, a nonprofit program for prevention, treatment and recovery.

Their effort has received support from the Jefferson Union High School District, but Daly City officials are looking into how such a fee has been enforced in cities and counties that have adopted the ordinance.

Tobacco-selling businesses in Colma, Daly City, East Palo Alto, Millbrae, Redwood City, San Carlos and San Mateo all must pay a $35 fee already, but that's orchestrated through the county and rarely enforced, youth officials said. By strengthening the ordinance and increasing the fee, funds for strong enforcement could be generated, advocates said.

While Daly City officials recognize and agree with the cause — implementing a licensing fee on retailers selling tobacco products to cut down on kids buying cigarettes and other products — they don't want to take on an obligation they can't enforce, police Chief Gary McClane said, at a March 5 study session.

At the session, Mayor Maggie Gomez asked city staff to look at how other cities and counties have implemented a several hundred-dollar fee for retailers.

The idea goes over in the business world like a lead balloon because if enforcement is questionable, why should some businesses pay it when others can't or won't, said Marian Mann, the former president of the now-defunct Daly City Mission Merchants Association.

"Many, many, many of the businesses would support it if it were totally enforceable," Mann said. "When you look it, there's so many ways to get around it."

City staff will look at tobacco retail-licensing fees in Berkeley, Contra Costa County, Elk Grove, the city and county of Sacramento, San Luis Obispo and Pasadena. According to statistics provided by the Center for Tobacco Policy and Organizing, Berkeley's rate of illegal tobacco sales dropped 32.2 percent to 5.8 percent after it adopted a $300 annual fee per business in 2002.

"We're not saying 'no' to it, but we're looking into what programs they have," Gomez said. "It's a good idea but at the same time it's labor intensive and costly."

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A coalition of youths, a high school district and police is pushing for a tobacco retail-licensing fee in the county.— Juan Carlos Pometta Betancourt/Special to The Examiner

San Mateo officials weigh benefits of Kaiser center project

Residents, city have concerns over added traffic problems

By Jason Goldman-Hall
Staff Writer

SAN MATEO — San Mateo Planning officials and residents are wondering whether the increased traffic from a proposed medical center near Bay Meadows will outweigh the community benefit of filling a lot that has sat vacant for years.

Kaiser Permanente hopes to house 22 care providers and other services in the proposed three-story 64,300 medical center on a 4.2 acre lot at the corner of Franklin Parkway and Saratoga Drive. The center would have a two-level parking garage with 207 parking spaces on site.

"Just by not having that empty lot with a fence there it's going to be an improvement," said San Mateo/Glendale Village Neighborhood Association President Greg Grialou. "But whatever goes in there is going to create a traffic nightmare."

Even with the current empty lot, traffic is heavy and fast in that area, in a square also bordered by East Hillsdale Boulevard and U.S. Highway 101. The addition of pedestrian overpasses to provide a safe route for visitors over the busy streets or on-site amenities to cut down on the amount of traffic into the parking garage could alleviate some of the concern.

The Planning Commission is scheduled to discuss the project Tuesday for the first time since Nov. 14. Among other changes made to the proposal since then, Associate Planner Kenneth Chin said the building and its parking lot have switched positions on the lot. The medical center is now on the southern half of the lot.

"The Planning Commission was looking for something to relate to the [planned] police station across the street. Having the parking garage across from it wasn't the right fit," Chin said.

Kaiser spokesman Carl Sonkin said the health care provider didn't mind making the changes so they could build at a location north of Redwood City to serve their 40,000 county members.

Kaiser is not the first group to attempt to build on the site. In 2002, Westin Hotels began planning to build a hotel on the site, but a market downturn ended that plan. In late 2005, planning officials put the brakes on a proposed 190 multi-family unit housing project after deeming the location inappropriate for housing.

While San Mateo will benefit from sales and property taxes collected from a medical center, it loses between $500,000 and almost $1.5 million in revenues that would have come in through the site's original hotel plan.

To meet the city's expectations for green construction, Kaiser is planning to use bioswales — plots of dirt and vegetation to filter runoff — and photovoltaic solar panels on the side rather than roof of the building.

Depending on the commission's reaction to the new plan, Chin said the item could be back for approval three months from Tuesday, but he stressed that more discussions and revisions were likely on the project.

jgoldman@examiner.com

Peer Presenter

Peer Presenter

Santa Clara County

Peer Presenter

Peer Presenter

Solano County

IOM Policy Paper (Working Draft)

THE INSTITUTE OF MEDICINE FRAMEWORK AND ITS IMPLICATION FOR THE ADVANCEMENT OF PREVENTION POLICY, PROGRAMS AND PRACTICE

By: J. Fred Springer
Joël Phillips

CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS

THE INSTITUTE OF MEDICINE FRAMEWORK AND ITS IMPLICATION FOR THE ADVANCEMENT OF PREVENTION POLICY, PROGRAMS AND PRACTICE

By: J. Fred Springer
Joël Phillips

ABSTRACT

The Institute of Medicine (IOM) categorization of prevention into universal, selective and indicated populations has been widely adopted in the prevention field, yet the terms are not precisely or uniformly applied in practice. In this paper, the strong potential for the IOM categories to bring a unifying framework to currently fragmented strategies and practices in prevention is furthered by carefully identifying the underlying implications of these population categories for identifying and recruiting participants, selecting interventions that are effective, anticipating attainable positive outcomes and avoiding potential unintended influences. Systematically applied, the IOM framework can be a valuable tool for creating a conceptually unified and evidence-based continuum of prevention services.

INTRODUCTION

Prevention is an encompassing policy concern in public health. As applied to substance abuse, prevention can be defined broadly as policies, programs and practices designed to reduce the incidence and prevalence of alcohol and other drug abuse and consequent health, behavioral and social problems. Prevention services focus on a broad population -- persons who have not yet experienced serious negative consequences, or inflicted serious social harms, associated with abuse of substances. Like so many policy purposes, prevention objectives have broad appeal. However, to provide clear guidance for policy, program and practice design and implementation, the broad prevention concept requires clear logical and empirical definition. Paradoxically, the very popularity of a broad policy term in public debate can obfuscate critical distinctions and limitations because stakeholders invoke the term to serve preferred policy objectives. As pithily stated two decades ago, "(p)revention is a concept in vogue. As a result, the term is, at best, ill-defined and misused" (Seidman, 1987, emphasis added).

In the past two decades the prevention field has progressed and matured. Evidence-based knowledge concerning the prevention of substance abuse has grown, producing greater understanding of the factors that contribute to the initiation and growth of alcohol, tobacco and other drug use at individual, family, school and community levels. Importantly, knowledge about evidence-based practices and programs that are effective for different populations has also grown significantly. However, knowledge about what works is based on evaluation results produced largely through studies of individual programs diverse in approach, specific objectives and participants. Knowledge of factors contributing to substance abuse and associated problems is fragmented, as is evidence concerning effective prevention policies, programs and practices.

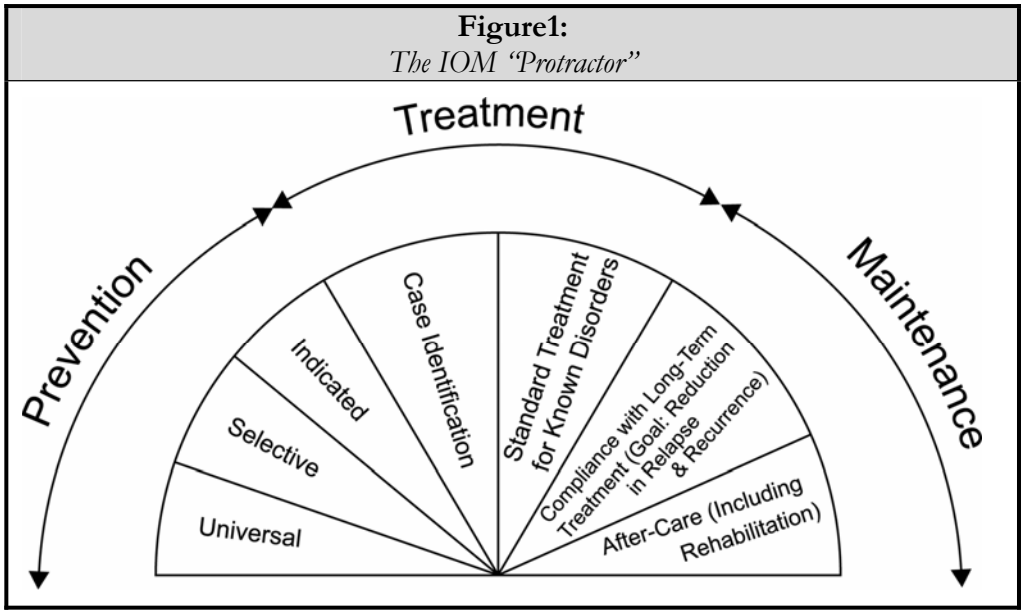
In summary, the prevention field has not yet matured to the point of developing an overall theoretical framework that relates knowledge about risk for substance abuse, causal contributors to substance abuse and effective intervention. Different approaches are often posed as alternatives rather than complements, and prevention policy makers and practitioners experience confusion concerning the selection and application of evidence-based practices. An encompassing framework that facilitates systematic comparison of outcomes, interventions, and resource requirements is essential to meet the growing desire for informed planning, evidence-based policy and practice, and monetary accountability in the prevention field.

This article expounds the Institute of Medicine continuum of health services as a promising framework to integrate the prevention field. The IOM framework places prevention in a graded continuum of care that distinguishes between prevention, treatment and maintenance, and shows their interrelation. It also distinguishes between three levels of prevention services according to the risk levels of the target populations. The IOM framework has been visibly adopted in prevention policy language, but its implications for policy and practice have not been fully developed or explored in detail. Seidman's (1987) observation from two decades earlier remains applicable – as the IOM categories have come into vogue, their application has been loosely defined, and sometimes contentious. In this article, the premises of the original formulation of the IOM framework are reviewed, and limitations of its current application are discussed. To clarify the utility of the IOM categories for meeting the need for a unifying conceptual framework in prevention, the definition of populations, recruiting of participants, identification of appropriate interventions, and specification of appropriate outcomes are discussed within universal, selective and indicated prevention categories.

BACKGROUND: ORIGINS AND PREMISES OF THE IOM FRAMEWORK

In 1994, the Institute of Medicine recognized the need for a framework for health planning that went beyond the distinction between primary (prevention), secondary (intervention), and tertiary (treatment) phases then in use. The Institute commissioned development of the framework summarized in the IOM "protractor" (Figure 1). The framework was adapted from the universal, selective and indicated service population categories defined by Gordon (1987). The protractor depicts a graded series of need and service from the prevention of health or behavioral health problems, through the treatment of a chronic condition, to the maintenance of a managed healthy status. This continuum of care model has several advantages over the older primary, secondary, tertiary conceptualization. First, intervention phases defined as prevention, treatment and maintenance are descriptive of the different service needs that occur in each phase. Second, distinctions between each of the three phases are more clearly identifiable than in the old categories that assumed clear distinctions in disease progression. For example, in the IOM framework treatment begins only when case identification (diagnosis) is achieved. With respect to substance abuse, prevention can be concretely defined as all services provided prior to a specific diagnosis of abuse or dependence – treatment comes after. Third, the IOM framework provides additional phased distinctions in activities within prevention, treatment and maintenance.

Figure1:
The IOM "Protractor"



The prevention arc is divided into universal, selected, and indicated prevention activities. While Gordon's work focused on physical health his ideas were received as particularly suitable for planning prevention of behavioral health problems such as substance abuse, mental health, eating disorders, obesity, problem gambling, and their associated mix of personal and social harms. These behavioral health problems all have multiple individual and environmental risks as precursors. The risk and protective factor framework had gained great currency because it was readily demonstrated and had intuitive appeal (Hawkins et al, 1986; Hawkins et al, 1992). The development of substance abuse and other behavioral health problems is characterized by complex relations between these multiple risks and the progression of the diagnosable disease state (e.g., substance dependence).

In contrast to the earlier focus on disease etiology, Gordon's (1987) focus on risk was based in epidemiology which "… regards the individual as a 'black box,' and collects data only on the outwardly observable forces that influence the individual and the state(s) of health or disease that follow."

This paradigm fits nicely with the growing empirical focus on risk factors as a way of focusing preventive interventions for substance abuse, and it provides a systematic conceptual framework for developing evidence-based knowledge on matching intervention to participants at progressive degrees of risk.

Current Applications of IOM in Substance Abuse Prevention

When the Institute of Medicine endorsed its new framework for a continuum of care, the committee noted that its application to behavioral health "is not straightforward" (Mrazek & Haggerty, 1994). Primary issues included the need for a clear definition of the distinction between prevention and treatment, the relation between prevention of behavioral health disorders and promotion of wellness, and the clear identification of actions (interventions) appropriate to each population. Notwithstanding these caveats, the IOM categories have been adopted in the language of prevention planners, policy makers and funding agencies. The three categories are widely used to classify target populations, intervention strategies, and specific interventions. With respect to substance abuse and mental health prevention, Robinson et al (2004) adapted typical definitions (Kennedy, 1999).

1. Universal preventive interventions: Addresses general public or a segment of the entire population with average probability of developing a disorder, risk, or condition.

2. Selective preventive interventions: Serves specific sub-populations whose risk of a disorder is significantly higher than average, either imminently or over a lifetime.

3. Indicated preventive interventions: Addresses identified individuals who have minimal but detectable signs or symptoms suggesting a disorder

This definition applies the categories to "interventions", implying that the IOM framework is a classification of different types of interventions. This assumption is widely accepted in current uses of IOM. For example, a recent and widely disseminated training program (WCAPT, 2005) directs prevention planners to "identify what type of strategy you need to employ: universal, selective or indicated." (emphasis added) In another example, programs that have received model status within SAMHSA's National Registry of Effective and Proven Programs (NREPP) are organized by IOM category. However, there are no formal criteria for determining to which category a given intervention should be assigned, so the designation is self-assigned by intervention developers. In still another example, prevention programs (WCAPT, 2005) are assigned to multiple categories (e.g., one program may be listed as universal and selective, or as selective and indicated). The lack of criteria for assignment of policies, programs or practices to IOM categories seriously limits the usefulness of the labels for guiding selection and implementation of appropriate interventions.

The uncertainty of definition means that IOM categories are subject to varying interpretation. For example, NIDA clearly states that indicated programs are preventative and serve populations "who do not meet DSM-IV criteria for addiction, but who are showing early danger signs." However, the Office of Substance Abuse Services in Virginia has interpreted indicated services to be outside of prevention, and has clearly stated that "SAPT prevention set-aside funds may not be used to support Indicated prevention programs" (Guidance Bulletin No. 2003-03). Other states face opposition to funding indicated prevention because it may overlap with programs funded with treatment dollars. As long as definitions are not standardized, operationalized and disseminated, the real world interpretation of IOM categories remain variable and potentially contentious. The full opportunity for advancing prevention understanding and applications will not be realized.

Thus, the fundamental issue in current application of the IOM categories is the need for systematic clarification of terms for operational definitions to be used in criteria for real world application (e.g., how does one define specific populations and actually recruit participants), and for clarity in the implications of these categories for intervention design and implementation (e.g., what are the criteria for determining whether a program is appropriate for a given population).

Currently, the most widely applied criterion for identifying universal, selective and indicated interventions is simply the type of population to which an intervention has been delivered. Thus, a universal intervention is one delivered to a universal population – with no independent criteria for whether it is suitable for this population. A failure to clarify will allow confusion to continue, and will eventually lead the field to move on to yet another conceptual framework without realizing the significant contribution that the IOM model can bring to policy, practice and research in prevention.

PROMISE AND FUTURE DEVELOPMENT OF THE IOM FRAMEWORK

The IOM framework provides a fertile conceptual base for advancing thinking about the continuum of prevention activities. It guides the conceptualization of fitting participant needs with intervention design and implementation. To date, however, this promise has not been realized. The purpose of this section is to begin to explore the major implications of the universal, selective and indicated categories for concrete issues related to: a) defining populations, b) recruiting prevention participants and providing access to interventions; c) designing and selecting appropriate interventions; and, d) identifying appropriate outcomes.

- Defining the Population. The IOM framework identifies categories of populations that are defined broadly by assumptions concerning their risk for substance abuse. If the potential of the framework for guiding prevention planning and implementation is to be more fully realized, it is important to clearly identify and define universal, selective and indicated populations, and to relate them to recruitment and intervention design.

- Recruiting Participants and Providing Access to Service. Once population criteria are identified, intervention implementers must develop procedures for accessing the population and recruiting appropriate participants. This is a key implementation issue that must be addressed if the IOM framework is to fulfill its basic purpose of matching participants to interventions.

- Designing and Selecting Appropriate Interventions. Prevention interventions are currently assigned to IOM categories largely because of the populations to which they have been delivered. Clarifying how and why specific characteristics of policies, programs and practices are more appropriate to specific IOM categories will be a major step in improving the utility of the framework for decision making.

- Specifying Appropriate Outcomes. One of the complexities of prevention research is identifying outcomes that are appropriate for a particular intervention and population. One issue is identifying outcomes that are achievable within time frames that are short enough to provide meaningful feedback to program planners, funders and implementers. The IOM framework provides a potentially useful format for identifying useful outcomes for different population categories and interventions.

Clarifying the meaning and implications of the IOM categories in these ways is an important step in making the IOM framework more useful to practitioners. The following discussion provides a systematic assessment of these questions, which have gone largely unexamined in applications of the IOM framework, to date.

Universal Prevention

Universal substance abuse prevention has become highly visible in schools and communities. Public information campaigns sponsored by governmental agencies, and even the alcohol industry itself, caution the public around the safety, legal and health dangers of substance abuse. School children receive ever-increasing exposure to a range of substance use prevention in the classroom, beginning in the elementary years and progressing through high school. Other policy and social campaigns are aimed at community environments with the intent of reducing access to substances that may promote problem use, or of altering behaviors and traditions that may be accepting or supportive of problematic substance use. Unlike other IOM categories, in universal prevention recipients are not targeted by explicit criteria that would differentiate them by their relative risk for future development of substance abuse. The following discussion articulates some of the typically unexamined implications of this broad definition.

Universal Population Definition

Because they are not selected according to risk characteristics, universal populations are commonly characterized as "low" or "average" in risk. Closer consideration of the universal category leads to two important elaborations of this characterization. First, the assumption of "average risk" is less important than the fact that risk is not specifically known, and that it may be highly variable. Universal populations often include both very low risk and very high risk members. This means that the impact of a universal intervention may vary significantly across sub-populations. It may even be positive for some subgroups and negative for others. This is a critical potential issue in universal prevention that is typically not considered. It is more accurate to characterize the risk in universal populations as "unknown" and "variable" than as "average," or certainly, than as "low."

Second, even though risk is not explicitly considered in defining universal populations, these populations are delimited. There are multiple options in criteria for sub-setting a population, such as accessibility, or life stage (e.g., adolescence) or ethnic community. For example, the following four criteria (or circumstances) commonly define universal populations.

- Geography may define a community population (e.g., state, city, neighborhood).
- Demographics define many sub-populations that receive universal interventions (e.g., age, ethnic/cultural membership, gender).
- Setting is an important definer of sub-populations. School is the most pervasive setting in which focused universal prevention is delivered, but workplaces and communities are other examples. The unique thing about setting as a definition is that it creates a specific structural environment within which the population interacts.
- Relevance is a less obvious definer of universal populations. Universal messages may be delivered broadly, but be relevant only to a sub-population that is defined by a circumstance that makes the message relevant to them, but not to others in the population. For example, messages concerning designated drivers are relevant only to those who are potential drivers in circumstances in which alcohol is involved.

Although these criteria for defining universal populations are typically implicit or determined by convenience and opportunity, they still have important implications for intervention strategy and effectiveness. First, the way that a universal population is defined may shape the opportunities and requirements for effective interventions. For example, the effectiveness and efficiency of a particular prevention message will depend on the proportion of the receiving audience to which it is relevant. Second, it is possible that the same criteria that define a universal population when applied with no consideration of relative risk, may define a selective population if the criteria is used because of a demonstrated relation to risk. For example, a school may be a universal population when served because of criteria unrelated to specific assessment of risk (e.g., a state requirement); but be a selective population when identified according to specific risk criteria (e.g., community disorganization, poverty). More careful attention to the actual make-up of universal populations and to the circumstances that actually define their scope is important to making decisions about universal policies, programs and practices in actual applications.

Universal Recruitment of Participants and Access to Interventions

Formal recruitment is not typically an issue with universal interventions since all members of the defined population are participants, by definition, though consent may be necessary in some cases. However, lack of attention or the ability to avoid participation is a major access issue. Many interventions (e.g., many public information messages) will not reach all members of the population, and lack of attention may impact receipt of a message. Information campaigns that require participants to actively access information (e.g., pick up and read brochures) are examples of one extreme in which universal availability will be strongly filtered by self-selection. At the other extreme, school prevention programs are an example of limited opportunity for self-selection. The degree of potential self-selection has important implications for understanding who the meaningful intervention participants may be, and as noted below, the ability to self-select can improve relevance of the message. Making the message available to a universal population does not equate to receipt of the message, or desired behaviors.

Culture is an example of unintended selection issues that must be considered in universal prevention programs. Research has shown that cultural sensitivity has a large impact on the degree to which participants perceive prevention messages to be meaningful and relevant (Chipungu et al, 2000; Springer et al, 2004). Incorporating cultural meaning into heterogeneous messages, particularly those aimed at individual behavioral change, is important to achieving equal access.

Designing and Selecting Universal Services and Approaches

The appropriateness of the design or selection of a universal policy, program or practice should be justified by a plausible explanation of why planned activities will produce desired outcomes. The IOM framework can help classify different universal interventions according to the general mechanism through which the intervention is expected to impact behavior. Table 1 provides a set of examples of universal interventions that are arrayed along continuum of change approaches ranging from controlling negative behaviors to promoting positive behaviors, and with interventions aimed at promoting awareness of risks or protective behaviors in between. The display also distinguishes between universal interventions in which there will be low or high opportunity for self-selection into or out of the intervention.

Table 1: *Cautions in Applying Universal Policies, Programs and Practices*		
	Low Opportunity for Self-selection	High Opportunity for Self-selection
Control Behavior/ Opportunity for Risk	E.G., environmental policies such as price increases, marketing controls, school policies such as zero tolerance • *Potential for unintended consequences for low risk members* • *Low effectiveness for most relevant sub-population*	E.G., environmental policies such as use ordinances, nuisance location enforcement • *Limited scope of impact* • *Displacement rather than reduction of problem*
Promote Awareness of Risk	E.G., school-based education • *Iatrogenic effects* • *Potentially low behavioral impact* • *High opportunity cost*	E.G., media campaigns concerning health, legal, social risk • *Iatrogenic effects* • *Potentially low behavioral impact*
Promote Awareness of Protection	E.G., school-based social norms programs • *Potentially low behavioral impact*	E.G., media campaigns promoting positive actions such as designated drivers • *Potentially low behavioral impact*
Promote Protective Skills/ Protective Opportunities	E.G., full school reform programs, school-based behavioral skills programs, positive youth development programs	E.G., comprehensive community health and wellness programs, positive youth development • *Does not reach high risk/high need youth*

The top of this continuum references universal policies, programs and practices aimed at putting constraints on behavior, and that would be categorized as "environmental" in the current language of prevention. These policies, such as price increases, enforcement policies, public use ordinances, or zero tolerance policies in schools are designed to constrain access and increase sanctions to deter substance abuse. Most of these policies have low opportunities for self-selection by targeted populations, although some, such as campaigns to close or constrain nuisance bars or other locations, can be avoided by individual users. In selecting these policies when there is low opportunity for self-selection, there are important considerations that follow directly from the fact that universal populations are heterogeneous. These policies may have significant unintended consequences for low risk components of the population. For example, non-problem drinkers may be more sensitive to price than problem drinkers, and price increases may compel them to forego social drinking. Conversely, price increases may not impact use rates for dependent or high risk drinkers. Another area of concern with setting-based universal approaches that emphasize punitive control (e.g. zero tolerance school policies) is that they actually work counter to the school connectedness that has been shown to be a consistent positive contributor to reduced substance use and other positive youth outcomes (Drug Policy Alliance, 2005; Sambrano et al, 2005; Sale et al, 2002). Control-oriented environmental policy that can be avoided by problem users may result in the well known phenomenon of problem displacement rather than net reduction – problem users and their hot spots are simply moved from one location to another.

Universal programs aimed at increasing awareness of risk and awareness of protective skills or opportunities are in the center of the continuum in Table 1. These approaches are similar in assumptions about effects on behavior, but differ in encouraging avoidance or adoption. For example, a media program emphasizing legal consequences of drinking and driving increases awareness of risk, and a "designated driver" campaign emphasizes protective behavior. These approaches include programs such as school prevention curricula and public media campaigns. In simple application, they reflect a theory of change commonly summarized as the KAB theory, standing for knowledge-attitudes-behavior. It is assumed that improved knowledge will lead to changed attitudes and that this will lead to altered behavior.

Research has demonstrated that this assumption is invalid if behavioral change is the direct intended outcome. Nonetheless, information intended to build awareness is a big part of universal prevention interventions, and while it does not have a strong direct relation to behavioral change, it may play a critical part in complex understandings of the change process. For example, awareness messages may play a role in creating receptiveness for behavior change, and have a viable role in the early stages of theories of change such as the transtheoretic model (Prochaska, J. et al, 1994). Properly formulated, messages may help move recipients in need of change from pre-contemplative, or contemplative stages toward actual behavior change.

Universal awareness messages, particularly those delivered community-wide, may also be relevant to theories of change that focus on capacity building, or community attitudinal, behavioral and policy norms, as contextual conditions important to changing substance use and associated problems. Universal messages may contribute to the readiness of a community to undertake prevention, and be a motivator to support more direct influences on behavior (e.g. policy change). The major point is that universal prevention mechanisms must be assessed with a clear understanding of their realistic outcome objectives within a well developed plan for achieving longer term goals.

Studies of universal interventions focusing on education and awareness have raised evidence-based concern about the potential iatrogenic effects of universal interventions, particularly for youth. A recent study of an ONDCP national media campaign identified a potential harmful impact on the initiation of substance use for pre-teens and adolescent females (NIDA, 2006). Studies of informational programs concerning substances have raised concerns about potential increases in experimentation by young participants (NIDA, 2006). The implication is that heightened awareness for youth in the experimental ages may actually increase the motivation to initiate use.

Universal interventions designed to promote protective behavioral skills and provide opportunity for positive behaviors are at the bottom of the continuum in Table 1. These strategies are consistent with prevention planners who argue that universal prevention should focus on physical and behavioral health promotion more than on specific strategies of prevention. In universal prevention for youth, this perspective is often articulated through positive youth development strategies. These strategies focus on promotion of protective factors, positive alternative activities, and creation of opportunities for development of these skills through interacting in a positive social environment. Advocates of this position argue that the theories of change, the empirical evidence, issues of population heterogeneity, and issues of equity all support making promotion—particularly positive youth development—the focus of universal prevention. A particularly promising approach is full school reforms that restructure school disciplinary policy, governance and classroom procedure to emphasize guided opportunities for positive youth development (Schaps & Solomon, 2003). This positive promotion approach is less prone to iatrogenic effects, unintended consequences for low risk participants, or to self-selected non-participation by high risk targets than are the universal interventions that are higher on the continuum. These approaches also focus more clearly on evidence-based practices that have been shown to positively impact behavior.

Appropriate Universal Outcomes

The typical approach to specifying outcomes for substance use prevention initiatives, including universal initiatives, is to focus on behavioral indicators of incidence and prevalence of use of different substances. A primary issue with respect to outcomes for universal interventions concerns the reasons that use, itself, is considered problematic; this, of course, will vary by substance. Reduction in average use across whole populations may be reasonable outcome indicator for substances that are deemed to be illegal, or that have egregious health consequences.

However, when the concern is primarily with associated consequences related to the degree of use (e.g., car crashes, sclerosis, school failure, etc.), or the circumstances of use (e.g., recreational accidents), the applicability of average use as a primary outcome is questionable. More focused measures of harm may be necessary.

Universal interventions focusing on education, awareness or health risk messages often use measures of attitude as an outcome indicator. Indeed, some of the initial model prevention programs in NREP achieved model status based on demonstrated change in attitudes related to substance use, or health and other risks associated with use. Research has demonstrated that intervention-induced attitude change is not related to behavioral change, and interventions that produce positive attitude change do not produce behavioral change (SAMHSA, 2002). Awareness outcomes such as attitude change, increased knowledge, or modification of belief may show progress toward early stages in theories of change, but they should not be used as surrogates for behavioral change.

The above discussion raises clear concerns with respect to the adequacy of indicators of substance use or substance use attitudes as the primary measures of outcome for many universal interventions. For interventions focused on harms that are attributable to specific patterns of use in sub-populations (e.g. car crashes), the better measures would be those that are sensitive to the ultimate outcome of interest. Average use measures, for instance, will reflect reductions in legal drinking that are not associated with the ultimate outcome. For universal interventions that are intended to strengthen awareness or motivation to initiate more specific prevention activities, the appropriate measures would be those associated with increases in readiness or capacity.

Discussion

Universal prevention is widely applied, and provides highly visible rallying points for stakeholders who desire to make a public statement against substance use and the harms it brings to youth, families and society. Universal prevention has a strong common sense appeal and a history of association with the reduction of tobacco use in this country. However, tobacco use is a special case of substance use in that it is legal, widespread, and has serious and relatively uniform health risks for smokers. This brief review of issues related to universal prevention for other substances demonstrates the complexity of that concept, and indicates the potential utility of conceptually unpacking the term “universal prevention.”

This family of interventions is distinct from the selective and indicated categories because need as indicated by risk or symptoms is not considered in determining who will receive services. The distinguishing characteristic of these populations is not low risk, but varied risk. This variance in risk of recipients contributes to many challenges in assessing the impact of universal interventions that are designed to control (prevent or reduce) specific negative behaviors. Studies of universal interventions aimed at increasing awareness have raised concerns that informational interventions may actually stimulate curiosity and experimentation, especially in relatively low risk, young population members.

The diversity of universal interventions requires careful distinctions between differing approaches within this category. Application of universal interventions will require identifying strategies based on appropriate expectations of change within comprehensive approaches, such as changing social acceptance and supporting awareness that will increase readiness and capacity to implement more direct prevention activities. Approaches that promote positive skills and provide environments supporting positive opportunities are strong candidates for appropriate universal prevention.

Selective Prevention

The selective category is the most direct application of Gordon's insight that known risks for developing the health condition can help preventive interventions. In fact, the selective category is the only one of the three in which risk is explicitly applied as a criterion for selecting participants into interventions. Using shared risk factors as indicators of need is expected to have three major advantages for applicable groups. First, it should simplify identification and recruitment processes, as there is no need to conduct individual diagnoses. Second, it should help design services so that they are efficiently delivered to persons with similar prevention needs. Third, it should help develop evidence-based interventions that are more effective because they can be designed and tested for participants with shared intervention needs. Many of the cautions that issue from the diverse risk profiles of universal populations will disappear in well-defined selective populations.

In prevention, the conceptualization of selective populations is consistent with the growth of the risk framework for understanding the initiation and progression of substance abuse, particularly among young people. This risk framework has widespread credence and research support in prevention, and it supports the proposition that identifiable risk factors have a substantial relation to the probability of developing substance abuse. The great and valuable insight involved in identifying selective programming as a meaningful category for service planning and design is that there is no doubt that some individuals who share certain attributes/circumstances are at greater risk for developing behavioral health problems than others, and that these differences in risk can be identified before the disease conditions begin to manifest. Risk factors have become a predominant framework for thinking about who should receive more intensive (selective) prevention services. It is less clear that practical ways of using the risk concept to help design and deliver more efficient and effective prevention services have been successfully developed and applied. In this section, the current use of the selective category is reviewed, and directions for improving its utility in prevention planning and implementation are suggested.

Defining the Selective Target Population

The potential value of the selective prevention category lies in the way that populations are defined. A review of the application of the selective category to population definition reveals a gap between the research-based conceptualization of its applicability and the practical realities of identifying discrete populations with shared prevention needs. For example, in discussing the application of Gordon's distinctions to behavioral health, Silburn (1999) identifies the fact that the potential utility of the ability to identify selective populations depends on "… knowing something about the magnitude of various risks for a condition (relative risks) and … the proportion of the population …" that shares the risk. In application, these are demanding criteria. The risk factor research on substance abuse is typically not sufficient to precisely specify risk factors by degree of contribution to the health condition, by threshold levels of risk, or by prevalence of specific risks in the population. Measurement error is endemic to many risk factor indicators, and their relation to substance use is probabilistic. Analyses of the relation between common risk factors and measures of substance use among youth typically reveal that the increase in probability of substance use associated with individual risks is relatively small (Skager and Austin, 2004). Multivariate analyses combining multiple risks demonstrate higher increases in the probability of substance abuse, but this information becomes less practical for precisely defining populations in need of prevention service.

The challenges of precisely defining selective populations are compounded by the fact that risk factors for substance abuse have been identified in a number of categories. At the simplest level, they have been defined as internal (e.g. social-emotional, self-regulation, oppositional, attitudes, perceptions) or external risk in the youth's environment. These external risks may inhere in a variety of social contexts such as friends, family, school, community and society, or in circumstances such as divorce, job loss, or transitional age of emancipation for foster youth. Closely examined, identifying risk in each of these domains has different implications for selecting an intervention. For example, community level risk cannot be removed through an intervention aimed at individual internal states, but it can be used to identify people who may need help in developing "resilient" individual characteristics that will help them thrive in a high risk environment.

Fundamentally, the knowledge that multiple risk factors have a complex, probabilistic relation to substance use is of limited practical value in making real world decisions about who should be actually targeted in a particular selective intervention. Similarly, interrelated risk factors, as identified in research based largely on correlations, do not provide clear direction concerning the most effective policies, programs and practices in specific applications. Too frequently, profiles of a population (e.g., a school) indicate multiple risk conditions that warrant a "high risk" categorization.

This was almost universally the case across the 48 sites in the Center for Substance Abuse Prevention's National Cross-Site Evaluation of High Risk Youth Programs. In this study, location in a low income community was the dominant shared characteristic for populations, while a variety of other factors were also predictably present. These multiple factors did provide a rationale for identification as "selective," but the interventions themselves were diverse, and were not driven specifically by intervention strategy based on specific risk. A profile of correlated risk factors simply does not provide specific guidance for specialized selective interventions.

In practice, prevention planners make decisions based on available information that can be used to easily identify higher risk youth. Common ways of identifying youth for selective programs are to focus on youth who are in high risk circumstances – troubled homes, communities experiencing social disorganization and/or poverty, or schools that are characterized by low performance or social disorganization. It is these naturally occurring high risk circumstances that are visible and accessible, and the presence of multiple risks in these circumstances that confirms, rather than guides, the appropriateness of targeting these youth as participants in selective prevention. Clearly identifying, naming, and understanding these naturally occurring selective populations is an under-explored and promising approach to defining selective populations.

Recent work in applying selective prevention has introduced the term "vulnerable populations" (Burkart, G., 2005; Springer, 2006). Examples of vulnerable populations for which interventions have or can be developed include the following:

- Homeless youth
- Young offenders
- Foster youth
- School drop-outs
- Regular participants at dance clubs
- Students experiencing academic failure

Prevention practitioners often want to serve these sorts of populations, which certainly fit the selective category. However, the professional discussion of selected prevention has not focused on how these vulnerable populations provide opportunities for definition, recruitment of participants and service access. Nor has research or professional discussion explored the ways in which the vulnerable population concept may help guide the selection of specifically tailored interventions for prevention. The next sections will elaborate the advantages of focusing on identifiable vulnerable populations as the target of selective prevention.

Recruitment of Participants and Access to Selective Services

A primary advantage of focusing on vulnerable populations is that they already exist and are clearly identifiable. Recruitment and access to many existing programs depends on finding participants that share one of multiple risks in a larger population, or on applying a category that is so inclusive that it results in very diverse risk profiles. The "high risk" label is an example of the latter. Methods of "finding" participants who meet the selective populations are often dependent on membership in broad and heterogeneous groups, such as membership in an economically disadvantaged community. Or they may use evaluative processes such as referral based on personal experience with the referred participant, typically as a parent or a teacher. These referrals are often based on relatively loose criteria related to perceived need, and are prone to bias and selection error. For example, "acting out" has been identified as an overrepresented criterion in teacher-driven referral processes.

The multiplicity of risk factors available for recruitment purposes is a double-edged sword. On the one hand, youth at higher risk for substance use for some reason can be readily identified using a variety of information. On the other hand, the probabilistic correlation of risk to harm, the lack of specific knowledge about the relation of single indicators to substance use, and lack of strong clustering of specific risks in many selective programs means that the potential power of selective programming to identify participants with similar need, and to guide effective intervention design, is not realized.

A focus on existing vulnerable populations can greatly increase the similarity of risk and need among program participants and provide guidance related to need and opportunity for effective intervention. For example, vulnerable populations are typically tied to a particular setting. Foster youth can be accessed in the foster care system, young offenders can be accessed through the juvenile justice system, and regular club participants can be recruited through the clubs. Outreach and recruitment processes can be tailored to the natural setting in which the vulnerable population can be accessed. Criteria for referral or publicizing opportunities can be incorporated into intake or case management procedures in foster care, the criminal justice system, or in the counseling offices of schools. Another advantage of focusing on vulnerable populations is the ability to identify opportunities for effective intervention. This includes both the ability to identify commonly occurring negative outcomes for this population, specifying the role and prevalence of substance abuse in the population, and identifying opportunities for creating support and opportunity for prevention activities (e.g., training in the foster parent system to support foster youth). These important implications of recruiting will be elaborated in the following section on intervention design.

In recruiting vulnerable populations, practitioners must take care in carefully selecting their intervention services. The risk literature tells us the following: a) that vulnerable populations are not homogeneous, i.e., it can not be assumed that all participants have the same needs; and b) risk research demonstrates co-occurring problems, but less is known about causation.

Designing and Selecting Selective Services

Key questions in designing interventions for selective populations include: a) How should selective interventions be different from universal, and why?, and, b) What are the important differences in services that will meet the needs of different selective groups and what is the basis for these differences? Some universal strategies such as media campaigns are clearly distinct from selective strategies, though this is not always the case. As noted in earlier sections, interventions offered to selective populations, in school-based programs for example, are often identical to those used for universal populations. The following discussion explores what is known about content in effective selective interventions with the intent to differentiate them more clearly from universal interventions.

First, selective programs will emphasize direct services to populations, typically in smaller groups than are associated with universal applications. For programs that serve youth in school settings, students who are perceived to be at elevated risk are served outside the normal classroom in smaller groups.

Research gives some guidance on those factors that make selective programs effective. A first requirement of effectiveness for prevention programs serving selective populations is a relatively high level of service intensity, as measured by the amount of program contact time per week. Researchers for CSAP's National Cross-site Evaluation of High Risk Youth Programs found that programs averaging more than four hours of contact per week were more effective in achieving substance abuse prevention outcomes than those with less contact (Springer et al, 2004). Selective program designers should plan for more intensity than involved with universal programs.

CSAP's National HRY Evaluation also produced conclusions about the content and mode of delivery that is effective in programming for selective programs. Those programs that: a) included a focus on protective behavioral skills rather than information; b) relied minimally on didactic instruction; c) used group tasks involving cooperation and building connections to the group; and, d) incorporated exercises involving reflective learning were more effective in reducing substance use relative to comparison groups (Springer et al, 2004). The first two of these characteristics are similar to those that research has associated with more effective universal in-school programs that promote protective behaviors. While the line between principles of effectiveness for selective programs is not a step change from the more similar types of universal programming, research is demonstrating important and consistent differences in emphasis that appear to apply across vulnerable populations. This growing research also demonstrates that the characteristics of effective prevention for selective populations require more time per week and more loosely structured activity that can typically be accomplished in classroom programs. Selective programs for youth work best in after-school or community-based settings.

Beyond selecting programs that are appropriate for higher risk populations, generally, program designers must determine whether the particular risks that define their participants have implications for how services should be designed and delivered. The first consideration is the alignment of risk domains, the focus of the intervention, and the design of services. A focus on vulnerable populations has great potential for helping to align prevention services to the particular cluster of need and service opportunity that characterizes a specific vulnerable group. This potential follows from the fact that vulnerable populations exist prior to the intervention.

They are not groups of youth that are created through a selection process based on multiple, discreet risks. As depicted in Table 2, vulnerable populations can be described according to features important to designing preventive interventions, and close consideration of these characteristics can provide a guide to tailoring selective interventions to specific groups of participants. Table 2 is an overview example. Each of these vulnerable populations would require closer consideration of needs and opportunities in a local planning environment, but the general utility of this planning focus is evident.

Table 2:
Vulnerable Youth Populations and Parameters of Selective Intervention Design

Vulnerable Populations	Setting	Substance Abuse	Priority Service Needs	Intervention Support
Foster Youth	Foster care system	High risk, important intervention	Improved stability, home support, individual needs may vary	Potential continuity of service through the foster care system, potential focus for collaboration with system involved providers, basis for family training
Young Offenders	Juvenile justice system	High risk, important intervention	Cognitive-behavioral skills, positive opportunities, academic /vocational support	Potential supportive supervision through the CJS, potential collaboration with involved services
Low Achievers	School system	Unknown, medium, ancillary	Cognitive-behavioral skills, academic/ vocational support	School system cooperation is important to focus on this group, and to help focus program need
Club Goers	Clubs	High risk, important intervention	Harm reduction awareness, positive opportunities	Non-organized setting emphasizes need for outreach, appealing awareness information, positive alternatives
Homeless Youth	Shelters, CJS contact, Street	High risk, important intervention	Harm reduction awareness/ support, positive alternatives, supportive shelter, re-integration assistance	Non-organized setting emphasizes need for outreach, appealing awareness information, supportive and accepting alternatives, counseling and group opportunities
School Drop Outs	Community, difficult access	Unknown, high, ancillary	Positive alternatives, vocational/ academic support, cognitive-behavioral skills	Non-organized setting emphasizes need for outreach, appealing awareness information, supportive and accepting alternatives, counseling and group opportunities

The display in Table 2 demonstrates how identification of an example vulnerable population can help guide consideration of important planning issues. Understanding the setting provides guidance concerning recruitment and access, potential collaborators, and opportunities for effective intervention. The need and opportunity to focus on skills and continuity of foster families, or the utility of criminal justice mechanisms (such as juvenile drug courts) to provide supervised support, are examples. Focusing on these existing populations also allows specification of the priority negative outcomes experienced by these vulnerable youth, and assessment of the degree to which substance use is a known contributor, or an ancillary concern, with respect to these priority negative outcomes.

Cultural differences provide an important example of the need for tailoring prevention in selective applications. Research has shown that cultural content increases participants' perceptions that services are meaningful (Chipungu et al, 2000) and some programs that fully incorporate cultural content into the intervention design have been found to be more effective in achieving outcomes for participants than programs that do not incorporate that content (Springer et al, 2005).

In practice, providers do recognize that the specific risks that characterize their selective participant population may require special attention, but there is little explicit programmatic guidance through model programs or other mechanisms for exactly what the important risk distinctions and appropriate responses might be. There are many plausible considerations. Participants who are at risk primarily because of individual characteristics may benefit more from programs that focus fundamentally on their individual skills, or, in some instances, more from therapeutic programs. Youth who initiate use out of a propensity to risk-taking or pleasure-seeking, for instance, may require quite different interventions than those who use out of social insecurity. Participants with risks that inhere largely in the environment may benefit primarily from programs that create opportunity for them to participate and achieve in more positive environments. The close analysis of prevention needs and opportunities within vulnerable populations is a potentially strong tool that can help prevention planners adapt evidence-based policies, programs and practices to specific selective applications.

Appropriate Selective Outcomes

Current practice in evaluation or performance monitoring for selective programs is very similar to that for universal programs. Outcome measurement focuses on substance use type, prevalence, frequency and amount. These indicators are more appropriate, informative and useful for selective intervention than for universal because selected populations are more likely to already have initiated use and are further along a presumed trajectory of risk for abuse. In universal programs, it is often difficult to assess the success of the program in slowing initiation or reducing progression of use because of low base rates and small normative increments. For selective programs, the relevant variance in substance use is higher and actual reductions in use are identified in many programs (SAMHSA, 2002).

In addition, programs often measure change in risk or protective factors. While risk is the basis for recruitment to selective programs, reduction of risk is often not an appropriate outcome indicator. For example, if participants are selected into a youth program on the basis of community disorganization, poverty, family problems, or even school performance, there is probably little opportunity for the program to directly and significantly change those conditions. The alternative is to identify protective factors that will equip participants to cope more effectively with those risk conditions. These protective factors are appropriate and useful outcome indicators of selective programs if those programs have clearly articulated expectations of change that specify how the protective factors address the risk and how the actions of the program are expected to produce the protective factors. In the large sense, this logic is widely expounded by prevention professionals in the language of resilience and protection. However, in the practice of specifying protective factors as outcomes, the lack of clearly articulated expectations for particular selective populations reduces both: a) the validity of the indicators with respect to informing practice, and b) the probability of finding a positive result. Research has shown that when multiple risk and protective factors are measured in focused selective interventions, the observed positive change is greater for indicators of the factors most directly addressed in the intervention (Springer, Wright & McCall, 1992). The stronger the theory of change (logically and empirically) that specifies protective factors as both: a) a plausible outcome of the intervention, and b) a mediator of substance abuse, the more valid and useful that outcome is for evaluating or monitoring the performance of selective programs. Focusing on vulnerable populations and understanding their experience before specifying outcomes and designing interventions will contribute to both achieving outcomes and measuring intervention success.

Discussion

Selective interventions are delivered to populations that share identified risks for substance use. The premise of the original construction of the IOM concept is that the higher level of shared risk is an indicator of need for greater service. In the health setting it was assumed that the higher level of risk was sufficient to indicate the nature of the necessary service without diagnosis of the internal etiology of the disease condition in individual cases – the individual could be treated as a black box. The very large number of risk factors identified concerning the epidemiology of substance use, the fact that these risks can be categorized in a number of different domains, the low correlations between risks and substance abuse, and the questionable attribution of cause for many of these risk factors makes the application of selective logic to substance abuse prevention more complex.

Recruitment of selective program participants is often based on widely shared factors such as residence in a disorganized, high risk community or on loose procedures such as teacher referral. The result is that many selective populations are quite heterogeneous with respect to their specific risk profiles. The ability to meet the specific needs of members of selective populations, particularly those that have distinctive patterns of risk, is often not part of the program. Further research and guidance to practice regarding appropriate screening and recruitment and concerning the specific practices that are more effective for selective populations and particular risk groups is needed. Increased attention to vulnerable populations will contribute to meeting these needs.

INDICATED PREVENTION

Indicated prevention serves the individual screened for early problems associated with substance abuse. These “signs or symptoms” may be related to substance abuse behaviors themselves, or to problems that are associated with substance use. Formally, the distinction between these “minimal but detectable” signs and a clear cut need for substance abuse treatment is that they are insufficient to warrant a DSM-IV diagnosis of dependence.

Providing prevention services to indicated participants is arguably the most neglected service area among the three IOM categories. The reasons are several. First, indicated prevention services are at a point on the IOM protractor that has a long history of professional and institutional tension. Developing a smooth integration and continuum of service from prevention to treatment has been difficult in the behavioral health field. Funding of these portions of the service continuum has come in separate, categorical streams, and competition for funds within the prevention field has tended to limit funding of indicated populations, which are often identified as in need of treatment. The field of substance abuse services is in a long debate about how prevention and treatment should be integrated. Indicated prevention is a critical part of that discussion.

Second, indicated prevention is relatively demanding to deliver. Indicated services often combine individual and small group delivery, involve specific investigations of particular behaviors and issues, and require at least partial involvement of trained therapists. Recruitment, packaging of the right services and cost can be barriers. Nonetheless, indicated services are a critical stage in the continuum of care. At the border of diagnosable dependence, indicated services offer the highest probability of getting services to those who will experience the greatest individual harm, and create the greatest social harm, as a result of substance abuse.

Defining the Indicated Participant Criteria

Similar to selective populations, indicated populations will be defined by characteristics of individuals. In practice, the emphasis on shared characteristics for selective populations and individual characteristics for indicated populations reflects a relative difference. To some extent, participants in indicated prevention interventions must share some characteristics, at least within categories. In concrete terms, the population definition issues for indicated interventions include a) the explicit definition of the types of criteria that are used for selection, and b) the nature and strength of that relation to substance abuse.

Definitions of indicated populations vary from those "specific individuals with known, identified risk factors that place them at higher than average risk for developing a problem or disorder…" (State of Rhode Island, 2005) to definitions that specify the population should display "detectable signs or symptoms suggesting a disorder…" (Robinson et al, 2004). There are important similarities in these definitions. First, there is clarity that the condition to be prevented is progression to a diagnosable "disorder." For substance abuse prevention, that means a DSM-IV diagnosis of dependence or abuse. Put differently, indicated prevention is not designed to prevent initiation or use – it is designed to prevent dependence and associated harms. Second, it is clear that the defining indicators will have an established correlation with substance abuse that is stronger than what is typically found for indicators that suffice for selective populations. Third, it implies the need and use of a 'screening' instrument, protocol or procedure, or some type of formal screening, to identify individuals at risk.

Other factors are less clear. Some definitions specify that "risk" for indicated populations includes co-occurring problems, which may include school failure, justice system involvement, health or mental health problems, violence or aggression, or direct consumption issues such as binge drinking or substance use violations. In addition to being more strongly correlated with harm, these indicators are different than those for selective programs because they are all individual factors – family, peer or community level indicators are not adequate for identifying indicated participants.

Recruiting Participants and Providing Access to Indicated Services.

Recruiting indicated program participants requires an individualized screening process. The purpose of the recruitment process is to identify those individuals who are in need of focused and relatively intensive interventions to prevent progression to dependence and/or to severe harm. There are three major potential avenues of recruitment.

First, self-referral is an option for many indicated programs. Members of indicated populations may already be experiencing negative personal consequences such as black outs, disapproval of friends or family, criminal justice involvement, regret, depression, or guilt. Outreach information letting them know that help is available may be enough encouragement for some potential participants to self-refer. Second, referrals may be made by teachers, counselors, administrators, parents, or even peers (e.g. co-workers). Outreach criteria may be provided as guides to secondary referral. Third, other initial screening processes may be used, such as automatic referrals for students involved in violence, substance possession or other relevant infractions. In the work place, alcohol use on the job or chronic absenteeism may be criteria for further screening.

Indicated programs will typically require additional diagnostic assessment after an initial positive screen. Brief screening and diagnostic instruments are important tools for indicated programs to ensure that high need participants are recruited.

The demands of recruitment for indicated populations limit the environment in which indicated programs operate. The recruitment process is typically contained in an institutional setting such as a school, a work place, the criminal justice system, or a health or behavioral health provider. The institutional setting provides the focused involvement necessary for effective outreach, referral based on behavior, motivation to participate, and the ability to facilitate participation in relatively intensive interventions.

Indicated populations can be defined narrowly based on a single criteria (e.g. threshold rates or patterns of substance use), a narrowly focused cluster of indicators (e.g. behavioral, criminal justice, or other indicators directly related to substance use), or a broader set of indicators focusing on multiple, or more loosely related problems (e.g. substance use, acting out and violence, school failure, date rape). The decision about how widely to screen in a particular setting has very important implications for service and evaluation. When an indicated program is put in place in a particular setting, there is a motivation to use it to meet a broad range of serious issues that are experienced by members of the setting. Furthermore, since membership in indicated populations may be relatively rare in many settings, a broad recruitment net may be necessary to meet capacity. It follows that multi-problem screening into indicated programs is typical in settings where rates are low and multiple issues are of high concern (e.g. schools). In settings where populations may be larger and specific problems of substance use are more prevalent (e.g. some work places), more focused criteria for identifying indicated populations may be appropriate.

Designing and Selecting Indicated Services and Approaches

In contrast to universal and selective prevention, there are relatively few models for indicated prevention policies, programs and practices. The most common forms of indicated prevention are student assistance programs (SAPs) in secondary education schools and institutions of higher education, employee assistance programs (EAPs) in places of employment, and juvenile diversion programs and community placement programs for juveniles. These programs typically use a mix of facilitated group sessions, individual services, and a variety of support services and resources. Facilitated group sessions include skills development, discussion and support groups. Individual sessions are often provided through integrated services in which counselors or therapists are brought into the program to meet specific needs. Referral to external agencies is another way of providing needed services.

One issue in providing indicated prevention through assistance programs or other mechanisms is how to adequately intervene for the multiple, relatively serious issues that may bring an individual into the program. While substance abuse may be highly related to the associated problems that youth bring into a program, it is not necessarily the root problem – it may be a symptom of another problem, or a co-occurring problem issuing from another root cause. When individuals are being admitted to the program because of serious co-occurring problems, it is important to ensure that appropriate services are available that are relevant to each of the conditions that may produce serious negative consequences for participants. Thus, indicated programs that serve many specific indicated problems undertake the responsibility to serve multiple problems. The link between recruitment criteria and services is critical when those criteria are for serious symptoms or conditions that present high risk for impending harm. The role of group services for diverse participants in indicated programs is another central issue for designing indicated programs. In existing indicated programs, group processes are often used to promote reflective learning situations similar to those found to be effective for selective programs.

Specifying Appropriate Outcomes

Outcomes for indicated interventions should differ from those of universal and selected programs in important ways. First, outcomes of interest concerning substance use should include reduction of use where necessary, and particularly, reduction of use of particularly harmful or problem substances such as binge drinking or illicit drug use which carries risk for criminal justice involvement. While these kinds of outcomes are low rate among universal and many selective populations, indicated populations are partly selected on the basis of high probability of these heavy use patterns. They are central to performance monitoring or evaluation in indicated programs.

Second, the indicated programs should include outcome indicators of the serious co-occurring or individually occurring problems that are indicated through the multiple criteria that are part of the screening process. While the rationale for universal programs is diffuse, including general objectives of positive youth development, the rationale for the more intensive and expensive services provided in indicated programs is specifically that it will prevent the progression of specific negative behaviors and the specific negative consequences.

Discussion

Indicated interventions are the last stop for prevention services to individuals who are close to the threshold of the development of a "disease" condition. In the relatively more determinant world of physical health, this may mean the early manifestations of the symptoms of a progressive disease. For substance abuse this may mean experiencing some of the behavioral or consequence symptoms that are part of a DSM-IV diagnosis. It may also mean experiencing harms that are associated with substance use in the larger population. One issue in application of indicated logic to substance use is that the association of individual serious issues in a larger population does not mean that they are associated in the persons that participate in the indicated program.

Indicated interventions are a relatively neglected component of prevention. The reasons are partly institutional since indicated prevention is at the margin of services that may be eligible for different funding pools (prevention or treatment). Indicated prevention may also be less useful as a public statement against substance use by school administrators or community decision makers. Although assistance programs have had strong support from some stakeholders, there is not a lot of attention to systematically developing and testing different approaches to delivering these services.

WORKING WITH THE IOM FRAMEWORK: SEPARATING HUBRIS AND OPPORTUNITY

The ultimate value of the IOM categories is the provision of an encompassing and analytically useful framework that helps prevention policy makers and practitioners relate our growing knowledge about substance abuse epidemiology, etiology and preventive interventions to the practical issues of service delivery, including cost, effectiveness and decisions about who should be served in what ways. The framework is important in several ways.

First, it provides a context for understanding the complexity of the overall prevention enterprise, making it clear that no one strategy or approach can effectively address the manifold contextual and individual factors that produce substance abuse and its related harms. For example, short of clear empirical confirmation, arguments that one "school" or "approach" to prevention should replace others is a reflection of stakeholder hubris or self-interest.

On the other hand, the logical rigor that comes with categorizing programs according to careful analysis of who and what is being impacted, closely examining the delivery of the service, and articulating expectations of change, provides a strong basis for thinking through what "makes sense" in a given action context, even when empirical evidence is weak. Evidence-based practice benefits greatly from the conceptual and analytic side of scientific inquiry even when definitive data is not available. It would, for instance, guide decision makers in realizing that a low rate problem, such as meth use among youth, will not be substantially impacted by a media campaign. Indeed, clear thinking is often a superior guide to weakly conducted empirical investigation. The IOM framework provides a strong resource for clear thinking.

Second, the inherent logic of the relation between specific interventions and specific populations and outcomes clearly demonstrates that different interventions address different portions of a complex social and behavioral set of issues. No one intervention point is sufficient to addressing the full range of issues, and because the components are linked probabilistically, no one set of factors determines the others. For example, the IOM framework provides a way of thinking about and categorizing "environmental" versus "direct service" policies that clearly demonstrates that they are complements rather than mutually exclusive alternatives. They address different populations with different theories of change. Local action or ordinances that focus on closing or controlling "problem establishments," for example, have the objective of changing opportunities to use alcohol publicly, not to change individual behavior. Specifying the nature and appropriate outcomes of different interventions within the IOM framework will clarify how they are complementary. In sum, the IOM model helps show that different categories of service do not necessarily compete, but are complementary components towards creating a system of prevention that includes both building the capacity to design, implement and support prevention activities with development of positive orientations and behaviors; and the reduction of substance abuse, and/or reduction of specific harms related to use.

Third, the IOM framework can be useful in thinking through the details of intervention design and implementation. Because it structures the specification of relations between an intervention, the characteristics of the population, and the intended outcomes, the IOM framework can greatly enhance articulation of the logic of an intervention. By providing a perspective that helps clarify the relation between real world circumstances and prevention concepts and practices, the IOM framework holds promise for furthering the application of research-based knowledge to prevention practice. Focusing on known vulnerable populations to design selective policies, programs and practices is a prime example.

In summary, the IOM framework has great potential for helping to strengthen substance abuse prevention. Carefully applied, it can be a valuable aid to thinking through the design of interventions, to selecting from existing interventions to meet a particular set of requirements or objectives, and to identifying the necessity for and design of comprehensive projects that meet a complex set of needs with multiple, complementary interventions. The IOM framework is also a useful lens through which to observe existing research findings and methods, to enrich their interpretation, and to plan future investigations that build on past findings and fill important gaps. Less positive, the review highlights the current underutilization, and even misapplication, of the IOM insights. Categories are often simplistically defined and used as tallying points for advocacy, rather than careful and considered decision making. Labels are used to market particular programs or approaches with little evidence that they are most appropriate for those approaches. And, most important, many of the important issues that are raised by the careful assessment of programs and activities within each category are not seriously addressed. The greatest danger is that the failure to use the model to its full advantage will contribute to undervaluing its potential contributions, and eventually to its premature abandonment. Hopefully, this review may help identify the promise of serious and in depth application of IOM insights for substance abuse prevention.

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Resources

Resources

Resource

CSAP Evidence-Based Document

Identifying and Selecting Evidence-Based Interventions

Guidance Document for the Strategic Prevention Framework State Incentive Grant Program

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Executive Summary

The purpose of this guidance is to assist State and community planners in applying the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Strategic Prevention Framework (SPF) to identify and select evidence-based interventions that address local needs and reduce substance abuse problems.

Section I. Summarizes the five steps of SAMHSA's SPF and sets the stage for selecting evidence-based interventions to include in a comprehensive strategic plan.

Section II. Focuses on two analytic tasks included under the SPF: assessing local needs, resources, and readiness to act; and developing a community logic model. Explains the importance of these tasks in community planning to identify the best evidence-based interventions for specific local needs.

Section III. Details how prevention planners can apply the community logic model to determine the conceptual fit or relevance of prevention strategies that hold the greatest potential for affecting a substance abuse problem. Also discusses how to examine candidate interventions from the perspective of practical fit or appropriateness for local circumstances, contexts, and populations.

Section IV. Discusses the importance of strength of evidence in determining whether specific interventions work. Presents the three definitions of "evidence-based" status provided under the SPF SIG Program and the challenges of using each one to select prevention interventions. The three definitions of "evidence-based" status are as follows:

- Inclusion in a Federal List or Registry of evidence-based interventions;
- Being reported (with positive effects) in a peer-reviewed journal; or
- Documentation of effectiveness based on the guidelines listed below.

During 2005, SAMHSA/Center for Substance Abuse Prevention (CSAP) convened an Expert Workgroup to develop recommendations for evidence-based programming and guidelines to define documented effectiveness under the SPF SIG Program. Based on the recommendations of the Expert Workgroup, SAMHSA/CSAP recommends three guidelines for evidence—*all of which need to be demonstrated*—to document the effectiveness of complex or innovative interventions developed locally for a specific population and context. Taken together, the evidence guidelines for documented effectiveness are the following:

Guideline 1: The intervention is based on a solid theory or theoretical perspective that has been validated by research;

Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness; and

Guideline 3: The intervention is judged by a consensus among informed experts to be effective based on a combination of theory, research and practice experience." Informed experts" may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

Section V. Summarizes the process of working through three considerations that determine the best fit of interventions to include in comprehensive prevention plans:

- Conceptual fit to the logic model: Is it relevant?
- Practical fit to the community's needs and resources: Is it appropriate?
- Strength of evidence: Is it effective?

Section VI. Discusses the respective roles and expectations for SAMHSA/CSAP and SPF SIG States and their subrecipient communities, jurisdictions, and federally recognized tribes and tribal organizations to ensure the identification and selection of best fit evidence-based prevention interventions for each community.

I. Introduction

A. Background and Context

The Substance Abuse and Mental Health Services Administration (SAMHSA) envisions "a life in the community for everyone" and has as its mission "building resilience and facilitating recovery." SAMHSA strives to achieve its mission through programs supported by three goals: accountability, capacity, and effectiveness. The Center for Substance Abuse Prevention (CSAP) helps to create healthy communities. SAMHSA/CSAP helps States to provide resources and assistance to communities so that communities, in turn, can prevent and reduce substance abuse and related problems. SAMHSA/CSAP also provides training, technical assistance, and funds to strengthen the State prevention systems that serve local communities. SAMHSA/CSAP works with States to identify programs, policies, and practices that are known to be effective in preventing and reducing substance abuse and related problems.

All of SAMHSA's mission and goals are driven by strategic planning to align, manage, and account for priority programs and issues across the three Centers. Chief among SAMHSA's priorities is the Strategic Prevention Framework (SPF)—a five-step planning process to guide the work of States and communities in their prevention activities.

Step 1. *Assess population needs (nature of the substance abuse problem, where it occurs, whom it affects, how it is manifested), the resources required to address the problem, and the readiness to act;*

Step 2. *Build capacity at State and community levels to address needs and problems identified in Step 1;*

Step 3. *Develop a comprehensive strategic plan. At the community level, the comprehensive plan articulates a vision for organizing specific prevention programs, policies, and practices to address substance abuse problems locally;*

Step 4. *Implement the evidence-based programs, practices, and policies identified in Step 3; and*

Step 5. *Monitor implementation, evaluate effectiveness, sustain effective activities, and improve or replace those that fail.*

Throughout all five steps, implementers of the SPF must address issues of cultural competence and sustainability. Cultural competence is important for eliminating disparities in services and programs offered to people of diverse racial, ethnic, and linguistic backgrounds, gender and sexual orientations, and those with disabilities. Cultural competence will improve the effectiveness of programs, policies, and practices selected for targeted populations.

Sustainability of outcomes is a goal established at the outset and addressed throughout each step of the SPF. Prevention planners at both State and local levels need to build systems and institutionalize the practices that will sustain prevention outcomes over time, beyond the life of any specific program.

Under the SPF State Incentive Grant (SIG) Program, prevention planners are specifically required to select and implement evidence-based interventions. SAMHSA/CSAP recognized that this requirement necessitates the availability of a broad array of evidence-based interventions and, further, must allow prevention planners the flexibility to decide which options best fit their local circumstances. To assist the field in meeting this requirement, SAMHSA/CSAP convened an Expert Workgroup during 2005 to develop recommendations and guidelines for selecting evidence-based interventions under the SPF SIG Program.

The Expert Workgroup was composed of nationally-recognized substance abuse prevention experts from a wide spectrum of academic backgrounds and theoretical research perspectives. The guidance presented in this document is grounded in the thinking and recommendations of the SAMHSA/CSAP Expert Workgroup.

B. Purpose of the Guidance

This guidance is directed to prevention planners working through SPF Steps 3 and 4 and to help them successfully select and implement evidence-based interventions. The guidance lays out an analytic process with a few key concepts to apply in selecting interventions that are conceptually and practically fitting and effective.

II. SPF Implications for Community Planning to Identify and Select Evidence-Based Interventions

A. Local Needs and Resource Assessment: Key Data Tool to Guide Community Planning

Prevention experts agree that substance abuse problems are usually best addressed locally—at the community level—because they are manifested locally. Yet some prevention approaches may be most effective when implemented on a larger scale, perhaps through a statewide change in laws (e.g., change in the alcohol index for driving under the influence). Experts also agree that substance abuse problems are among the most difficult social problems to prevent or reduce. Substance abuse problems require comprehensive solutions—a variety of intervention approaches directed to multiple opportunities.

The challenge of selecting the optimal mix of strategies is complicated by the limited availability of public resources on evidence-based interventions. In practice, practitioners seeking to reduce substance abuse problems will need to put together their own mix of interventions. The mix of interventions will need to fit the capacity, resources, and readiness of the community and its participating organizations. Some interventions in the comprehensive plan will demonstrate evidence of effectiveness using scientific standards and research methodologies, while others will demonstrate effectiveness based on less standardized or customized assessment. An optimal mix of strategies will combine *complementary and synergistic interventions* drawn from different resources and based on different types of evidence.

The needs and resource assessments in Step 1 will guide development of the comprehensive plan, from profiling the problem/population and the underlying factors/conditions that contribute to the problem, to checking the appropriateness of prevention strategies to include in the plan. *It is crucial to use local data and information to identify effective strategies that fit local capacity, resources, and readiness. However, finding local data is often difficult. Creative approaches to data sources, including the use of proxy measures and information gleaned through focus groups, may be necessary.*

B. The Community Logic Model: Key Conceptual Tool for Community Planning

The community logic model reflects the planning that needs to take place to generate community level change. Building the logic model begins with careful identification or mapping of the local substance abuse problem (and associated patterns of substance use and consequences) to the factors that contribute to them. *Developing the logic model starts with defining the substance abuse problem, not choosing the solutions, that is, the programs, practices, or policies already decided upon by States or communities.*

Since comprehensive plans combine a variety of strategies, it is important to understand the relationships between these problems and the factors or conditions that contribute to them. Few substance abuse problems are amenable to change through direct influence or attack. Rather, they are influenced *indirectly* through underlying factors that contribute to the problem and its initiation, escalation, and adverse consequences.

These factors include the following:

- *Risk and protective factors* that present themselves across the course of human development and make individuals and groups either more or less prone to substance abuse in certain social contexts.
- *Contributing conditions* implicated in the development of the problems and consequences associated with substance abuse. Examples may include specific local policies and practices, community realities, or population shifts.

Identifying risk and protective factors is central to determining the most promising strategies—programs, practices and policies—for addressing a substance abuse problem and its initiation, progression, frequency/quantity of use, and consequences of use.

Linking the substance abuse problem to the underlying factors, and ultimately to potentially effective prevention strategies, requires analysis and a conceptual tool. The logic model in Figure 1 serves as the *conceptual tool* to map the substance abuse phenomenon and the factors that drive it.

Figure 1. Community Logic Model, Outcomes-Based Prevention

Logic models lay out the community substance abuse problem and the key markers leading to that problem. They represent systematic plans for attacking local problems within a specific context. The community logic model makes explicit the rationale for selecting programs, policies, and practices to address the community's substance abuse problem. Used in this way, the logic model *becomes an important conceptual tool for planning a comprehensive and potentially effective prevention effort.*

Examples of Community Logic Models

The sample community-level logic models in Figures 1A and 1B illustrate the relationships between an identified substance abuse problem or consequence and the salient risk and protective factors/conditions that contribute to the problem. Each risk and protective factor/condition, in turn, highlights an *opportunity—or potential point of entry—for interventions* that can lead to positive outcomes in the targeted problem.

While different communities may show similar substance abuse problems, the underlying factors that contribute most to them will likely vary from community to community. Communities will tailor the logic model to fit their particular needs, capacities, and readiness to act.

Figure 1A. Community Logic Model for Preventing Alcohol-Involved Traffic Crashes (15- to 24-year-olds)

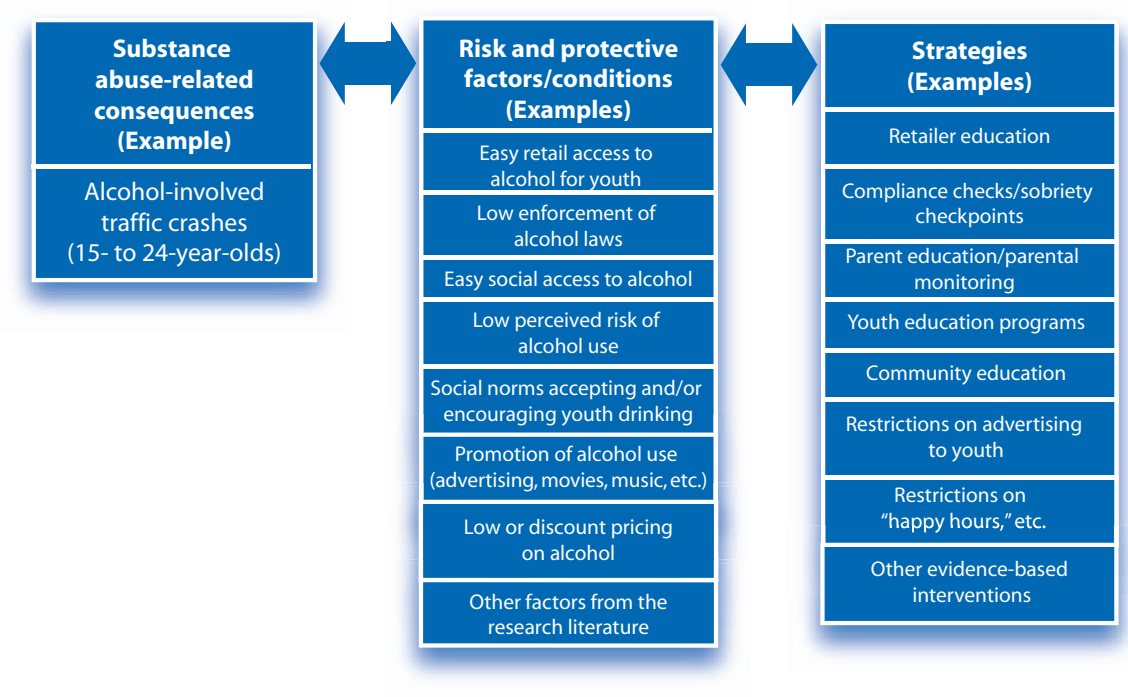
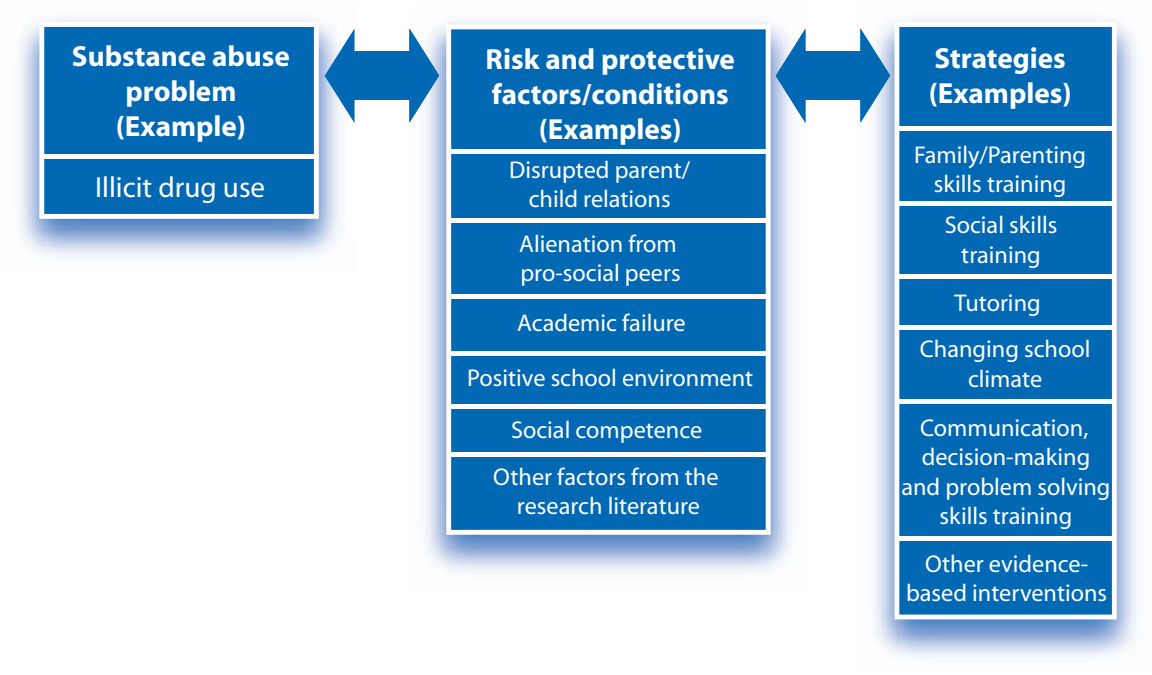


Figure 1B. Community Logic Model for Preventing Illicit Drug Use



III. Using the Community Logic Model and Assessment Information to Identify Best Fit Interventions

A. Establishing Conceptual Fit: Is It Relevant?

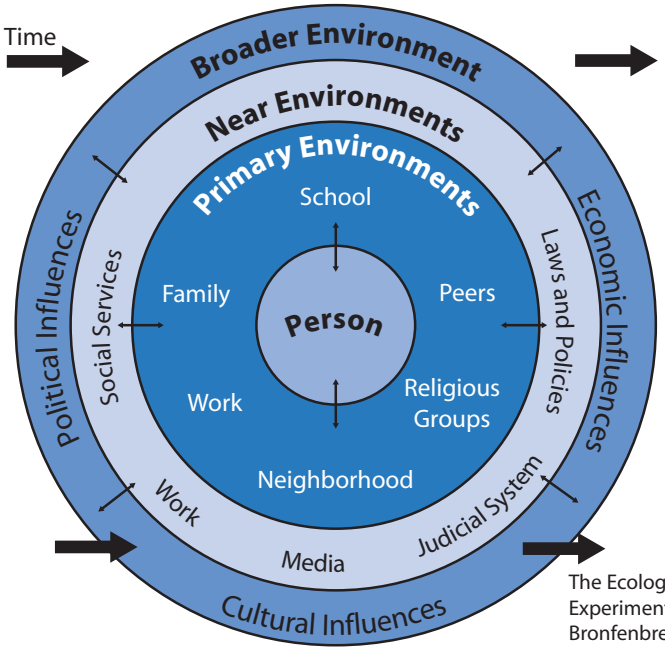
Relevance: If the prevention program, policy, or practice doesn't address the underlying risk and protective factors/conditions that contribute to the problem, then the intervention is unlikely to be effective in changing the substance abuse problem or behavior.

The community logic model can be used to guide the identification and selection of types of programs, practices, and policies for substance abuse prevention that are relevant for a particular community. Community logic models are tailored to reflect and meet the unique circumstances of a particular community. SAMHSA/CSAP expects SPF SIG States to develop an epidemiological profile and create an initial generic logic model. In turn, each community participating in the program will tailor the generic logic model to its needs.

Because substance abuse problems are complex, multiple factors and conditions will be implicated, some more strongly than others. Communities are encouraged to identify a comprehensive set of interventions directed to their most significant risk and protective factors/conditions and targeted to multiple points of entry. Figure 2 illustrates the Human Environmental Framework, one tool available to guide thinking about multiple points of entry for interventions directed to risk and protective factors across the life span and across social environments, and defining points of entry for interventions in different life sectors.

The community logic model can be used to check the conceptual fit of interventions to include in the comprehensive community plan. The logic model screens for the most appropriate types of interventions for a particular community.

Figure 2. Human Environmental Framework



The Ecology of Human Development: Experiments by Nature and Design, Bronfenbrenner, Urie, 1979, Harvard University Press, Cambridge, Mass.

This figure depicts social environments or spheres of influence in concentric circles that flare outward, moving progressively away from direct influence on the individual toward increasingly indirect influence, and advancing over time. A comprehensive intervention plan should identify a mix or layering of interventions that target salient risk and protective factors in multiple contexts across the life span.

B. Establishing Practical Fit: Is It Appropriate?

Appropriateness: If the prevention program, policy, or practice doesn't fit the community's capacity, resources, or readiness to act, then the community is unlikely to implement the intervention effectively.

A second important concept in selecting prevention interventions is practical fit with the capacity, resources, and readiness of the community itself and the organizations responsible for implementing interventions. Practical fit is assessed through a series of utility and feasibility checks that grow out of the needs/resource assessment and capacity-building activities conducted in SPF Steps 1 and 2.

SAMHSA/CSAP encourages practitioners to use their community assessment findings to judge the appropriateness of specific programs, policies, and practices deemed relevant to the factors

and conditions specified in the community logic model. Below is a list of utility and feasibility checks to consider in selecting prevention strategies.

Utility and Feasibility Checks

Utility Checks

- Is the intervention appropriate for the population identified in the community needs assessment and community logic model? Has the intervention been implemented successfully with the same or a similar population? Are the population differences likely to compromise the results?
- Is the intervention delivered in a setting similar to the one planned by the community? In what ways is the context different? Are the differences likely to compromise the intervention's effectiveness?
- Is the intervention culturally appropriate? Did members of the culturally identified group participate in developing it? Were intervention materials adapted to the culturally identified group?
- Are implementation materials (e.g., manuals, procedures) available to guide intervention implementation? Are training and technical assistance available to support implementation? Are monitoring or evaluation tools available to help track implementation quality?

Feasibility Checks

- Is the intervention culturally feasible, given the values of the community?
- Is the intervention politically feasible, given the local power structure and priorities of the implementing organization? Does the intervention match the mission, vision, and culture of the implementing organization?
- Is the intervention administratively feasible, given the policies and procedures of the implementing organization?
- Is the intervention technically feasible, given staff capabilities and time commitments and program resources?
- Is the intervention financially feasible, given the estimated costs of implementation (including costs for purchase of implementation materials and specialized training or technical assistance)?

Each of the points in the checklist warrants thoughtful consideration among those involved in planning, implementing, and evaluating the prevention strategies in the comprehensive community plan.

IV. Using Public Resources/Review Processes to Identify Evidence-Based Interventions and Determine Their Evidence Status

Evidence-Based Interventions and Evidence Status

Experts in the field agree that the *nature of evidence is continuous*. The strength of evidence or "evidence status" of tested interventions will fall somewhere along a continuum from weak to strong. Strength of evidence is traditionally assessed using established scientific standards and criteria for applying these standards. Strength of evidence comprises three major elements:

- Rigor of the study design (e.g., use of appropriate comparison and control groups; time series design).
- Rigor and appropriateness of the methods used to collect and analyze the data (e.g., whether data were collected in an unbiased manner and the statistical tests were appropriate).

  These two elements directly affect the inferences that can be drawn about cause and effect—the degree to which the results obtained from an evaluation can be attributed to the intervention exclusively, rather than to other factors.
- The extent to which findings can be generalized to similar populations and settings. This element refers to the likelihood that the same findings will be obtained if the intervention is repeated in similar circumstances.

Strong evidence means that the intervention "works"—that it generates a pattern of positive outcomes attributed to the intervention itself, and that it reliably produces the same pattern of positive outcomes for certain populations under certain conditions.

Experts agree that evidence becomes "stronger" with replication and field testing in various circumstances. *However, experts do not agree on a specific minimum threshold of evidence* or cutoff point below which evidence should be considered insufficient. Nor do they agree whether little evidence is equivalent to no evidence at all. Even evidence from multiple studies may still be judged insufficient to resolve all doubts about the likely effectiveness of an intervention designed for a different population or situation.

This discussion takes us to the role of professional judgment and the application of critical thinking skills to determine overall best fit of interventions to include in a comprehensive community plan. Strength of evidence is critical to selecting interventions that are likely to work, but it is not the sole consideration. Keep in mind two practical criteria:

1. Out of two interventions, choose the one for which there is stronger evidence of effectiveness, if the intervention is similar, equivalent, and equally well-matched to the community's unique circumstances.

2. Reserve selecting an intervention with little or weak evidence of effectiveness for situations in which other interventions with stronger evidence do not fit local circumstances.

SPF Definitions of Evidence-Based Status

The SPF SIG Program specifically requires implementation of evidence-based interventions. Evidence-based interventions are defined in the SPF SIG Program by inclusion under one or more of three public resources/review mechanisms that rate, make judgments, or provide information about the strength of evidence supporting specific interventions. These definitions or resource mechanisms are as follows:

- Included on Federal Lists or Registries of evidence-based interventions;
- Reported (with positive effects) in peer-reviewed journals; or
- Documented effectiveness based on the three new guidelines for evidence.

Each of the three definitions helps identify evidence-based interventions and each presents its own advantages and challenges.

Regardless of the resource or review process, consumers must be prepared to think critically about the adequacy of evidence for interventions deemed relevant (conceptual fit) in the logic model and appropriate (practical fit) for real-world implementation.

A. Using Federal Lists or Registries

Federal Lists or Federal Registries are readily accessible and easy-to-use public resources. Historically, most Federal Lists or Registries are limited in scope since they are geared to interventions most amenable to assessment using traditional research designs and methodologies for evaluation. These interventions typically share certain characteristics:

- Discrete in scope;
- Guided by curricula or manuals;
- Implemented in defined settings or organized contexts; and
- Focused primarily on individuals, families, or defined settings.

Advantages

Federal Lists and Registries—

- Provide concise descriptions of discrete interventions;
- Provide documented ratings of strength of evidence measured against defined and generally accepted standards for scientific research;
- Present a variety of practical information, formatted and categorized for easy access, and potentially useful to implementers; and
- Offer "one-stop" convenience for those seeking quick information on certain types of interventions.

Challenges

Federal Lists and Registries—

- Include a limited number of interventions. Not all those eligible choose to apply. Also, the availability of funding may limit the number of interventions that can be reviewed and included in a Registry at any given time;
- Include the types of interventions most easily evaluated using traditional scientific standards and research methodologies. Historically, this has resulted in an overrepresentation of school-based and individual-focused interventions and an underrepresentation of environmental and community-based interventions;
- Use review criteria that emphasize the importance of internal validity (attribution of results to the intervention only) over external validity (ability to generalize to other populations, contexts, and real-world situations); and
- Confer misleading "global effectiveness labels" based on arbitrary cutoff points along an evidence continuum (sometimes with minuscule differences between those included in a particular category and those excluded) and often overgeneralize outcomes not measured in the study.

SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) is a decision support system designed to help stakeholders (including States and community-based organizations) select interventions. The NREPP reflects current thinking that States and communities are best positioned to decide what is most appropriate for their needs.

Scheduled to be up and running early in calendar year 2007, SAMHSA's new NREPP will be available to local prevention providers and decision makers seeking to identify interventions that produce specific community outcomes. Reconceptualized as a decision-support tool, the new NREPP

represents a significant policy accommodation by SAMHSA on behalf of decision makers needing a more diverse set of options to address broader community problems.

Key points about NREPP are as follows:

- NREPP is a voluntary rating and classification system designed to provide the public with reliable information on the scientific basis and practicality of interventions that prevent and/or treat mental and substance use disorders.
- Outside experts will review and rate interventions on two dimensions: strength of evidence and dissemination capability. Strength of evidence is defined and assessed on six criteria; readiness for dissemination is defined and assessed on three criteria. Each criterion will be numerically rated on an ordinal scale ranging from zero to four.
- For all interventions reviewed, detailed descriptive information and the overall average rating score on each dimension (regardless of the rating score) will be included and posted on the NREPP Web site. Average scores achieved on each rating criterion within each dimension will also be available on the NREPP Web site (www.nrepp.samhsa.gov).
- NREPP allows a broader range of evaluation research designs to be eligible for review, including single group pre/posttest design without comparison or control data. However, to encourage the submission of interventions likely to receive strong reviews (i.e., those that demonstrate strength of evidence), NREPP establishes three minimum or threshold requirements that must be met:

1. The intervention demonstrates one or more positive changes (outcomes) in mental health and/or substance use behavior among individuals, communities, or populations;
2. Intervention results have been published in a peer-reviewed publication or documented in a comprehensive evaluation report; and
3. Documentation (e.g., manuals, process guides, tools, training materials) of the intervention and its proper implementation is available to the public to facilitate dissemination.

In addition to the threshold evidence requirements, NREPP will award "priority review points" for quality of study design and for outcomes in designated content areas. Priority points increase the potential for qualifying applications to be selected for review. Interventions will receive one priority point if they have been evaluated using a quasi-experimental or experimental study design, including a pre/post design with comparison or control group, or longitudinal/time series design with a minimum of three data points, one of which must be a baseline assessment.

B. Using Peer-Reviewed Journals

Peer-reviewed journals present findings about what works and what does not. The burden for determining the applicability and credibility of the findings falls on the reader.

Advantages

Peer-reviewed journals—

- Preview new and emerging prevention strategies; highlight a program, practice, or local policy initiative for further follow-up directly with the intervention developer/implementer;
- Report and summarize meta-analyses and other types of complex analyses (e.g., core components) that examine effectiveness across interventions or intervention components; and
- Present detailed findings and analyses that illuminate whether or not and how an intervention works.

Challenges

Peer-reviewed journals—

- Leave it to the reader to assess the credibility of evidence presented and its relevance and applicability to the community;
- Describe in limited detail the activities and implementation issues pertinent to dissemination; and
- Emphasize the importance of internal validity (attribution of results to the intervention) over external validity (generalizability to different populations and contexts).

Assessing Elements of Evidence Reported in Peer-Reviewed Journals

Using the primary research literature to identify potential prevention interventions requires critical assessment of the quality of the research presented and the conceptual model on which it is based. Listed below are key elements addressed in most peer-reviewed journal articles along with some question probes. Critical consumers of information presented in peer-reviewed journals should be prepared to read each article at least twice.

- *Background on the intervention evaluated in the study*. Does the article adequately set the stage for the study and describe why the study was undertaken? Does it adequately describe the intervention? The characteristics of the populations involved in the study? The context or setting of the intervention? How closely does the objective of the study reflect the needs of your community?

- *A defined conceptual model that includes definitions and measures of intermediate and long-term outcomes*. Does the article describe the theory base of the intervention and link the theory to expectations about the way the program works and specific outcomes expected? Does the article describe the connection of theory to intervention approach and activities, and to expected outcomes, in sufficient detail to guide your implementation?

- *A well-described study population that includes baseline or "pre" measurement of the study population and comparison or control groups included in the study*. Does the article describe the characteristics of the study population and comparison/control groups? How well does the study population match your local target group? How are they similar or different?

- *Overall quality of study design and data collection methods*. Does the overall study design adequately rule out competing explanations for the findings? Did the data collection methods account for participant attrition? Missing data? Data collector bias and selection bias? Did the study methodology use a combination of strategies to measure the same outcome using different sources (converging evidence)? Is the overall study design sufficiently robust to show that the intervention worked?

- *Analytic plan and presentation of the findings*. Does the analytic plan address the questions posed in the study? Does the article report and clearly describe findings/outcomes and do they track with what was expected?

- *A summary and discussion of the findings*. Does the discussion draw inferences and conclusions that are appropriate and grounded in the findings and strength of the overall study design?

C. Using Guidelines for Documented Evidence of Effectiveness

Some *complex interventions*, which usually include innovations developed locally, look different from most of those in Federal Lists and Registries. Because complex interventions exhibit qualities different from those of discrete and manualized interventions, they may require customized assessment. Complex interventions may exhibit certain characteristics that make them difficult to evaluate and measure:

- A multifaceted approach with interacting components;

- Inclusive outreach across populations and settings—targeting heterogeneous groups of participants, spanning a range of settings, and extending across multiple levels of organization;

- A philosophy that values adaptation in response to unique community needs and opportunities;

- Reliance on the involvement of committed individuals who provide informal services that go beyond those planned; and
- A flexible intervention design that responds readily to unpredictable and changing community circumstances.

SPF SIG Program Guidelines for Documented Effectiveness

The SAMHSA/CSAP Expert Workgroup recommended taking a broad view toward judging the adequacy of evidence for complex interventions. It recommended using different types or streams of evidence, drawing from traditional research-designed evaluation studies as well as accumulated local empirical data, established theory, professional experience, and indigenous local knowledge and practitioner experience.

Central to the Expert Workgroup's recommendations is the concept of blending—combining multiple streams of evidence to support an optimal mix of interventions to include in a comprehensive community plan.

The Expert Workgroup recognized that evidence provided as support for community-based interventions must reflect certain characteristics to be credible and persuasive. These characteristics are captured in three guidelines for evidence *all of which must be met to demonstrate "documented effectiveness" under the SPF SIG Program:*

Guideline 1: The intervention is based on a solid theory or theoretical perspective that has been validated by research;

Guideline 2: The intervention is supported by a documented body of knowledge—a converging accumulation of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness; and

Guideline 3: The intervention is judged by a consensus among informed experts to be effective based on a combination of theory, research, and practice experience. Informed experts may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

These guidelines are intended to expand the array of interventions available to prevention planners; they are considered supplements, not replacements, for traditional scientific standards in Federal evidence-rating systems or peer-reviewed journals.

Communities are encouraged to use as many types of documentation as possible to justify selecting a particular complex, evidence-based intervention.

Notice that these guidelines do not specify a minimum threshold level of evidence of effectiveness. They rely instead on professional judgment to determine the adequacy of evidence to meet these three guidelines when considered in the broader context of the comprehensive community plan.

Advantages

Guidelines for documented evidence of effectiveness—

- Enable State and community planners to diversify the portfolio of strategies incorporated in a comprehensive plan; ensure flexibility for those making programming decisions;
- Empower State and community planners to select or develop innovative, complex interventions to meet the needs of individual communities;
- Create the potential for using culturally based evidence as well as traditional evidence to support local decisions; and
- Authorize State and community planners to exercise professional judgment in deciding the potential contribution of unique intervention components in the comprehensive plan.

Challenges

Guidelines for documented evidence of effectiveness—

- Place substantial responsibility on prevention planners for intervention selection decisions. The guidelines are new and are neither simple nor simplistic; and
- Require prevention planners to think critically about the evidence provided to support the inclusion of a particular intervention in the community's comprehensive plan.

Examples of Evidence to Support Documented Effectiveness

Several types of evidence may be used to support documented effectiveness as defined under the SPF SIG Program. Documentation is important to justify the inclusion of a particular intervention in a comprehensive community plan. Prevention planners are encouraged to provide as many types of documentation as are appropriate and feasible in order to provide strong justification of documented effectiveness. The following are types of documented evidence that may be used to demonstrate documented effectiveness:

- Documentation that clarifies and explains how the intervention is similar in theory, content, and structure to interventions that are considered evidence-based by scientific standards.
- Documentation that the intervention has been used by the community through multiple iterations, and data collected indicating its effectiveness.
- Documentation that indicates how the proposed intervention adequately addresses elements of evidence usually addressed in peer-reviewed journal articles. These elements may include the nature and quality of the evaluation research design; the consistency of findings across multiple studies; and the nature and quality of the data collection methods, including attention to missing data and possible sources of bias.

- Documentation that explains how the proposed intervention is based on an established theory that has been tested and empirically supported in multiple studies. This documentation should include an intervention-specific logic model that details how the proposed intervention applies and incorporates the established theory.
- Documentation that explains how the proposed intervention is based on published principles of prevention. This documentation should provide references for the principles cited and should explain how the proposed intervention incorporates and applies these principles.
- Documentation that describes and explains how the intervention is rooted in the indigenous culture and tradition.

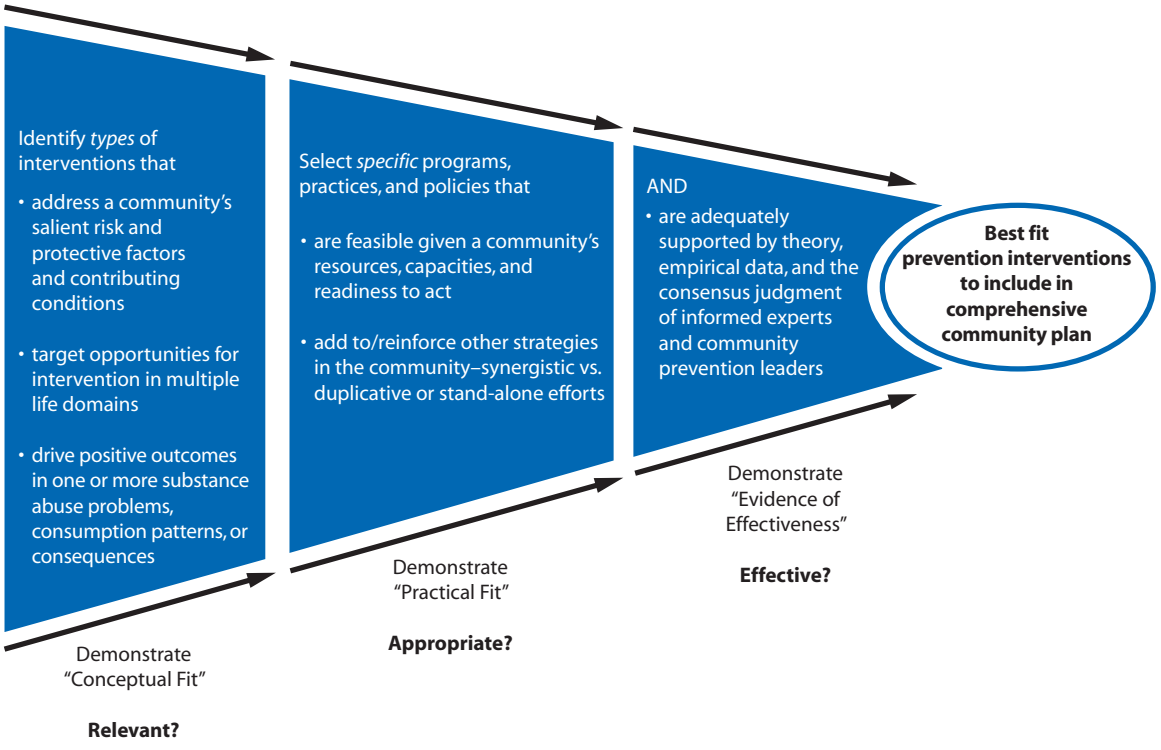
V. Summary Process Description: Selecting Best Fit Prevention Interventions

The process described here is rooted in the work conducted by local communities during SPF Steps 1 and 2. It begins with a community logic model to map the local substance abuse picture and draws from the findings of local needs and resource assessment. Prevention planners apply the logic model and assessment findings in a process of thinking critically and systematically about three considerations that determine best fit interventions to include in a comprehensive plan:

- Conceptual fit with the community's logic model (is it relevant?);
- Practical fit with the community's needs, resources, and readiness to act (is it appropriate?); and
- Evidence of effectiveness (is it effective?).

Figure 3 depicts the process for thinking through these key considerations.

Figure 3. Process Description: Selecting Best Fit Prevention Interventions



VI. SPF SIG Program Guidance: Roles and Expectations

Collaboration and partnership across all levels—Federal, State, and community or local grantee—are essential for successful and flexible implementation of the guidance in this document. The guidance details an analytic process and a few key concepts—*what needs to be done* to think through the selection of best fit evidence-based prevention interventions. *How this is accomplished* will be determined by States and jurisdictions and will vary from one to another. SAMHSA/CSAP's technical assistance providers are available to work with States and jurisdictions to apply the process and concepts detailed in the guidance.

A. Federal Role

SAMHSA/CSAP will provide leadership and technical assistance to States and jurisdictions and will work with them to strengthen prevention systems in order to improve substance use outcomes and achieve targeted community change.

Expectations

- SAMHSA/CSAP will partner with States to develop and implement a plan that facilitates application of the guidance.
- SAMHSA/CSAP, with its technical assistance providers, will work with States to develop their system capacities to support communities in selecting interventions. To this end, SAMHSA/CSAP has directed its five regional Centers for the Application of Prevention Technologies (CAPTs) to allocate substantial technical assistance resources for States to apply the concepts in this guidance. At the request of States, CAPTs will conduct workshops and activities to help States work with communities to identify and select suitable and effective evidence-based interventions.

B. State/Jurisdiction Role

The role of the States and jurisdictions is to provide capacity-building activities, tools, and resources to communities to foster the development of sound community prevention systems and prevention strategies.

Expectations

- SAMHSA/CSAP expects States funded under the SPF SIG Program to strengthen their infrastructure and capacity to assist communities in identifying and selecting evidence-based interventions for their comprehensive plans. To accomplish this, SAMHSA/CSAP expects States to establish a mechanism (e.g., technical expert panel) to assure accountability for: reviewing comprehensive community plans and the justification for interventions included in the plan; identifying issues and problematic intervention selections; and targeting technical assistance to work with communities to improve and strengthen their community plans.

In thinking about the implications of this guidance, States may want to consider the questions below:

How might your State engage informed experts, including community leaders, in applying the concepts in the guidance for funding comprehensive community plans (programs, practices, and policies) selected by your communities?

How might your State communicate its policies regarding funding and implementation of evidence-based programs, practices, and policies to community coalitions and organizations and other key stakeholders?

- SAMHSA/CSAP expects States, with their technical assistance providers, to work closely with communities in identifying and selecting evidence-based interventions. SAMHSA/CSAP and its technical assistance providers will work directly with States on this task.
- SAMHSA/CSAP expects States to develop capacities to assist communities on all key SPF topics, including assessing needs and resources; using data to detail the substance abuse problem and underlying factors and conditions; building a community logic model; and examining intervention options for relevance and appropriateness.

C. Community Role

The role of SPF SIG subrecipient communities is to develop a comprehensive and strategic community prevention plan based on local needs and resource assessment. Following the steps of the SPF, communities use the findings from these activities to develop a logic model specific to the community and its substance abuse problem. Each community logic model reflects and maps the local substance abuse phenomenon. An effective logic model may serve as the primary tool to guide the selection of evidence-based programs, practices, and policies to include in a comprehensive plan.

Expectations

- SAMHSA/CSAP expects communities to partner with the State and its technical assistance providers, who in turn will partner with SAMHSA/CSAP and CSAP's technical assistance providers.

Concluding Comments

As in all steps of SAMHSA's Strategic Prevention Framework, the application of critical thinking skills is vital to selecting programs, practices, and policies to include in a comprehensive strategic plan. Those selected must be relevant, appropriate, and effective to meet community needs and address the community substance abuse problem. SAMHSA/CSAP and its technical assistance providers welcome the opportunity to partner with SPF SIG States, jurisdictions, and federally recognized tribes and tribal organizations through technical assistance workshops and "science to service" learning communities to think through the selection of best fit evidence-based prevention interventions.

GLOSSARY

Best fit interventions	Interventions that are relevant to the community logic model (i.e., directed to the risk and protective factors most at play in a community) and appropriate to the community's needs, resources, and readiness to act.
Community logic model	A graphic depiction or map of the relationships between the local substance abuse problem, the risk/protective factors and conditions that contribute to it, and the interventions known to be effective in altering those underlying factors and conditions.
Conceptual fit	The degree to which an intervention targets the risk and protective factors that contribute to or influence the identified community substance abuse problem.
Documented effectiveness	Defined under the SPF SIG Program by guidelines for evidence to demonstrate intervention effectiveness. These guidelines include grounding in solid theory, a positive empirical track record, and the consensus judgment of informed experts and community prevention leaders.
Epidemiological profile	A summary and characterization of the consumption (use) patterns and consequences of the abuse of alcohol, tobacco, marijuana, heroin, cocaine, methamphetamines, inhalants, prescription drugs, or other substances. The epidemiological profile identifies the sources of data on consumption patterns as well as the indicators used to identify consequences (e.g., morbidity and mortality). It should provide a concise, clear picture of the burden of substance abuse in the State using tables, graphs, and words as appropriate to communicate this burden to a wide range of stakeholders.
Evidence-based interventions	Interventions based on a strong theory or conceptual framework that comprise activities grounded in that theory or framework and that produce empirically verifiable positive outcomes when well implemented.
Evidence-based status—SPF SIG program	Defined by inclusion through one or more of three public resources or review processes that make judgments and provide information about the strength of evidence for intervention selections:

	• Included on Federal Lists or Registries of evidence-based interventions; • Reported (with positive outcomes) in peer-reviewed journals; or • Documented effectiveness based on guidelines developed by SAMHSA/CSAP.
Evidence status or strength of evidence	Refers to the continuum of evidence quality which ranges from weak to strong. Strong evidence means that the positive outcomes assessed are attributable to the intervention rather than extraneous events and that the intervention reliably produces the same pattern of positive outcomes in similar populations and contexts. Strong evidence means that the intervention works.
External validity	The extent to which evaluation outcomes will be achieved in populations, settings, and timeframes beyond those involved in the study; the likelihood that the same pattern of outcomes will be obtained when the intervention is implemented with similar populations and in similar contexts.
Internal validity	The extent to which the reported outcomes can be unambiguously attributed to the intervention rather than to other competing events or extraneous factors.
Interventions	Interventions encompass programs, practices, policies, and strategies that affect individuals, groups of individuals, or entire communities.
Outcomes-based prevention	An approach to prevention planning that begins with a solid understanding of a substance abuse problem, progresses to identify and analyze factors/conditions that contribute to the problem, and finally matches intervention approaches to these factors/conditions ultimately leading to changes in the identified problem, i.e., behavioral outcomes.
Practical fit	The degree to which an intervention meets the resources and capacities of the community and coincides with or matches the community's readiness to take action.
Protective factors	Conditions for an individual, group, or community that decrease the likelihood of substance abuse problems and buffer the risks of substance abuse.
Risk factors	Conditions for an individual, group, or community that increase the likelihood of a substance abuse problem.

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SMA-4205