



OREGON DEPARTMENT OF HUMAN SERVICES

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ADDICTIONS AND MENTAL HEALTH DIVISION

# Prevention Coordinator Manual

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DEPARTMENT OF HUMAN SERVICES

*Addictions and Mental Health Division*

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# INTRODUCTION

Welcome to the prevention community in Oregon. The following information is designed to offer Prevention Coordinators a reference for creating and maintaining community specific prevention programming. The Addictions and Mental Health Division's Prevention Team is available to assist you by providing technical assistance, training and monitoring of your program.

The process of designing a prevention program involves an understanding of layers of governmental systems, individual community needs, resources, and theoretical and evidence-based frameworks which collectively shape a specific a region's prevention efforts. Indeed, a prevention coordinator wears many hats!

Prevention coordinators may find themselves writing grants, teaching parenting classes, coordinating with media, mobilizing communities, conducting research, collecting and entering data, evaluating programs, creating reports, or attending community events to name a few. Whether you are just getting started or a seasoned veteran in the field, it is our hope to provide resources that are helpful.

Please feel free to contact us with your questions.

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## View of Prevention

There are many partners in alcohol and drug abuse prevention programs as well individuals, both professionally and personally committed to prevention efforts. This section will present a view of partners in prevention.

- ❖ Department of Humans Services
- ❖ Prevention funding sources
- ❖ Oregon's Partner Agencies
- ❖ Oregon alcohol and drug abuse prevention history.



# ADDICTIONS AND MENTAL HEALTH DIVISION

## DIVISION OVERVIEW

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The Addictions and Mental Health Division (AMH) assists Oregonians and their families to become independent, healthy and safe by:

- Preventing and reducing the negative effects of Alcohol, other drugs, gambling addiction and mental health disorders; and
- Promoting recovery through culturally competent, trauma informed, integrated, evidenced-based practice treatments of addictions, pathological gambling, mental illness and emotional disorders.

Alcohol and drug abuse prevention utilizes evidenced-based services to prevent the problematic use of addictive substances including tobacco, alcohol, and drugs and gambling statewide. Approximately 47,276 people benefitted from specific preventative services. More than 800,000 Oregonians were exposed to broad-based prevention information.

County Mental Health Programs, federally recognized Tribes and statewide contractors provide evidenced- based services to prevent the problematic use of addictive substances. These programs are monitored by the Prevention Unit which lies within the Addictions and Mental Health Division of Oregon State Department of Human Services.

For information on evidenced practices visit the following Addictions and Mental Health Division web site: <http://www.oregon.gov/DHS/mentalhealth/ebp/practices.shtml>

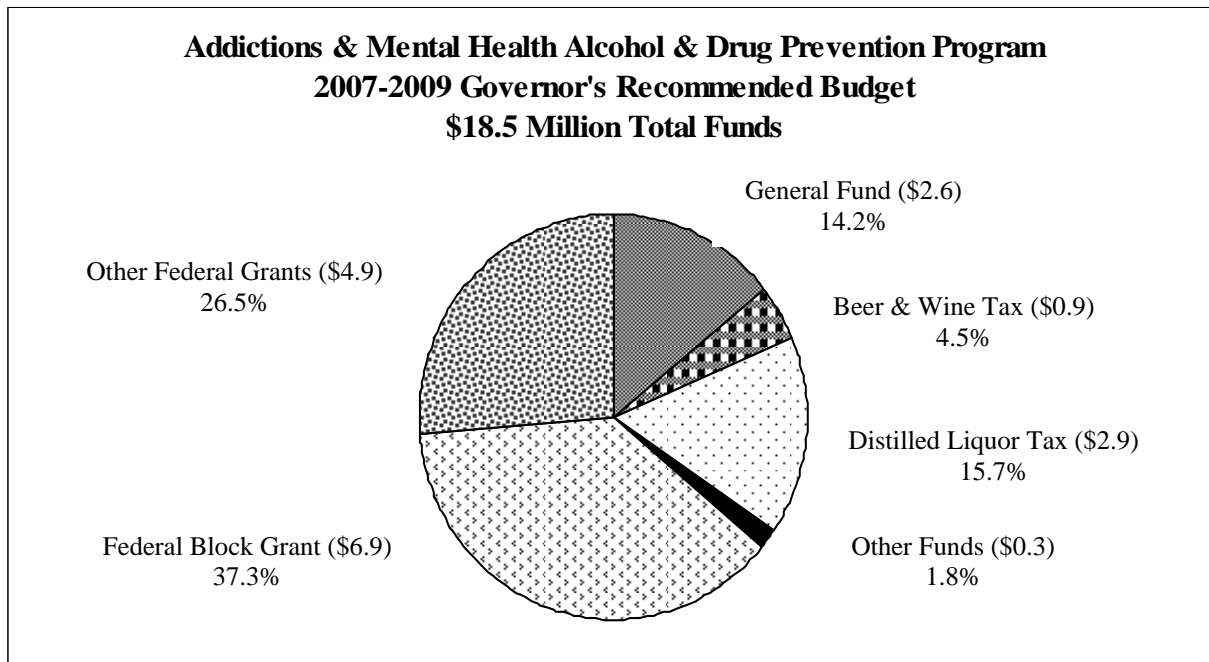


## PREVENTION FUNDING SOURCES

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The Addictions and Mental Health Division of the Oregon Department of Humans Services receives its funding from Oregon's general fund, Beer and Wine Tax, Distilled liquor Tax, Other Funds, Federal Block Grant and other Federal Grants. Federal grants contribute to over two thirds of alcohol and drug abuse prevention

2007-2009 Budget Summaries (ADP)



- \$6.9 million received from Federal Block Grant
- \$4.9 million received from other Federal Grants
- \$2.9 million received from Distilled Liquor Tax
- \$2.6 million General Fund
- \$0.9 million from Beer and Wine Tax
- \$0.3 million from Other Funds

Major Federal Fund (FF) Revenues:

- The Federal Block Grant consists of the Substance Abuse Prevention & Treatment (SAPT) Grant.

The Other Federal Funds include:

- Safe & Drug Free Schools and Communities, (Governor's Portion)
- Enforcing Underage Drinking Laws (EUDL); and
- Enforcing Underage Drinking Laws- Rural Communities Initiative (EUDL)

In addition to SAMHSA, (Substance Abuse and Mental Health Services Administration, [www.samhsa.gov](http://www.samhsa.gov)) and CSAP, (Center for Substance Abuse Prevention [www.csap.samhsa.gov](http://www.csap.samhsa.gov).) The Addictions and Mental Health Division partners with the following agencies by way of Senate Bill 555 passed in the 1999 legislative session.

Oregon Senate Bill 555 in 1999 established a state policy for serving Oregon's children and families, in recognition that addressing the needs, strengths and assets of children necessarily requires addressing the needs, strengths and assets of families and communities, and to direct state agencies to work in partnership with local communities to plan, coordinate and provide programs accordingly.

### **Partner Agencies**

(As identified and passed in SB 555,  
1999 Legislative Session)

Department of Education  
Susan Castillo, Director  
(503) 947-5600  
<http://www.oregon.gov/ode>

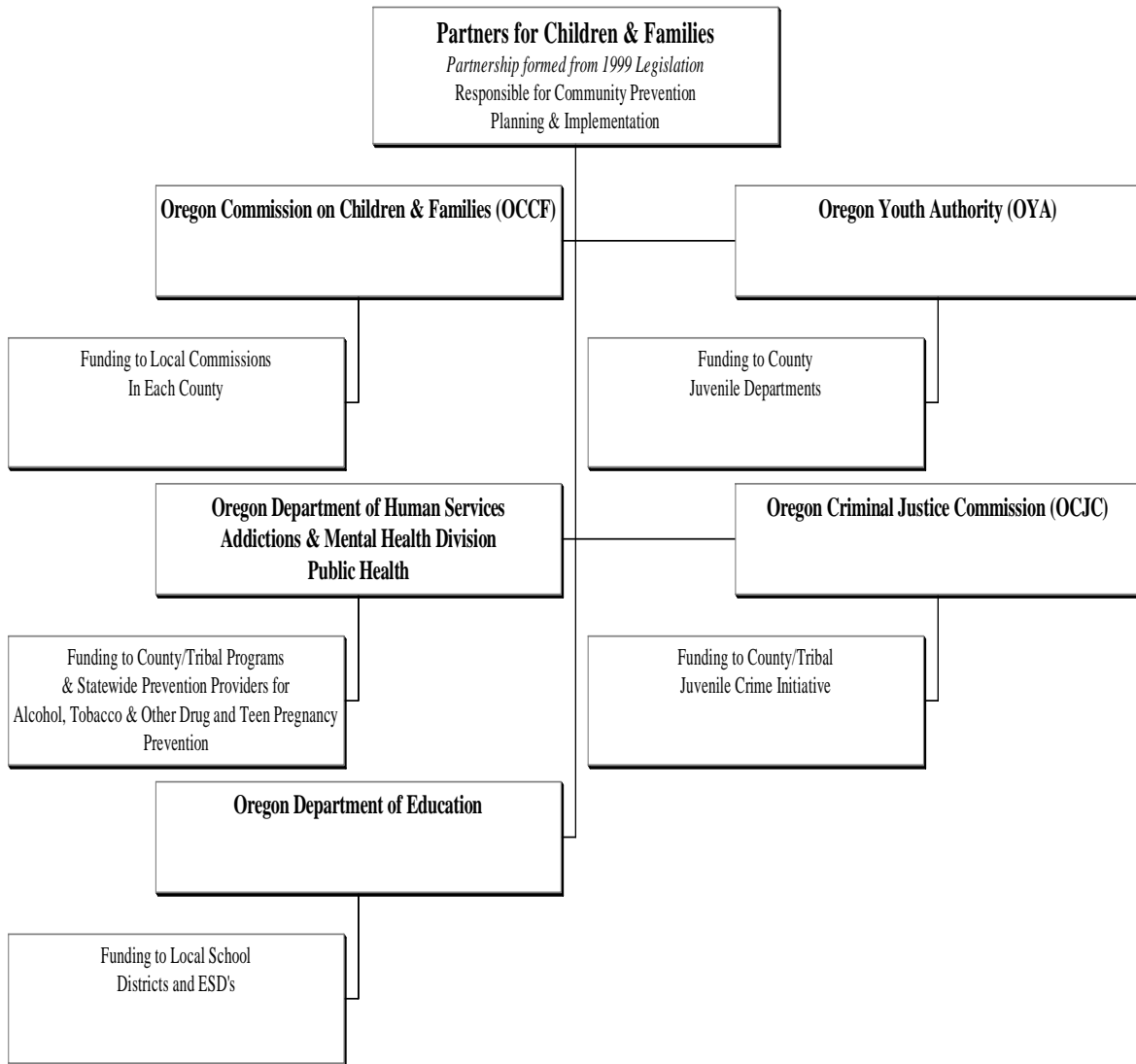
Juvenile Crime Prevention Advisory  
Committee (JCPAC)  
Bobby Green, Chair  
(503) 373-1283  
<http://www.oregon.gov/OCCF/Mission/Progs/progjcp/miprojcp.shtml>

Oregon Commission on Children and  
Families  
Mickey Lansing, Director  
(503) 373-1283  
<http://www.oregon.gov/occf>

Oregon Criminal Justice Commission  
Craig Prins, Executive Director  
(503) 378-4830  
<http://www.oregon.gov/cjc>

Oregon Youth Authority  
Bobby Mink, Interim Director  
(503) 373-7205  
<http://www.oregon.gov/oya>

# Partners for Children & Families



## OREGON PREVENTION HISTORY

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Oregon has an extensive history of offering prevention services. Oregon began a vision to create a prevention system for health and healing. Together we can reflect on the past, do the work of today and continue to manifest the dream for healthy individuals, families and communities in Oregon. The following timeline highlights significant mileposts in Oregon's Alcohol, Tobacco and other drug prevention history:

- 1970's – Towards the latter part of the 70's, 10% of treatment dollars could be used for substance abuse prevention services.
- 1976 – Rick Cady hired as Planner for Drug Program.
- Alcohol and Drug Information Service (ADIS) Library was established and located at the State Hospital Administration Office. Operated by Oregon Drug and Alcohol Information Center.
- 1984 – Steve Gallon oversaw Training and Diversion Program; Carol Brownlow oversaw Prevention within the Office of Alcohol and Drug Abuse Programs (OADAP). They both coordinated the 1<sup>st</sup> Alcohol and Drug Prevention Conference in 1984 held at Kah-Nee-Ta, Logistics coordinated with Caroline M. Cruz, who was coordinating Prevention in Warm Springs. Theme for 1<sup>st</sup> Conference was “Oregon Conference on Prevention of Substance Abuse among Youth”.
- June 1984 – Oregon Student Safety On the Move (OSSOM) was created, located at Oregon State University.
- 1984 – Rick Cady became the Prevention and Diversion Coordinator for OADAP.
- 1984 – Jeff Kushner hired as the State Authority
- 1985 – 1<sup>st</sup> “Just Say No March” held at the State Capitol.
- 1985 – 2<sup>nd</sup> Annual ATOD Prevention Conference on Prevention of Substance Abuse among Youth.

- 1986 – Federal Drug Omnibus bill signed, creating funding for prevention. Drug-Free School Act was enacted.
- 1986 – 1<sup>st</sup> Red Ribbon Campaign held at the State Capitol.
- 1986 – Oregon Student Retention Initiative (SRI) process was enacted to do comprehensive prevention planning.
  - Part – A – Department of Education dollars
  - Part – B – OADAP Prevention dollars
  - Part – C – Adolescent Early Intervention dollars
  - Part – D – Juvenile Justice Dollars
  - Part – E – Teenage Pregnancy dollars
- 1986 – 3<sup>rd</sup> Annual ATOD Prevention Conference: “Branching Out”.
- January 1987 – Larry Didier hired as Prevention Manager for OADAP.
- November 1987 – Oregon Prevention Resource Center (OPRC) was created; Caroline M. Cruz hired as Director.
- 1987 – Western Center for Drug Free Schools was created.
- 1987 – 4<sup>th</sup> Annual ATOD Prevention Conference: “Promising Directions for Prevention”.
- 1988 – First Oregon Teen Leadership Institute conducted by Oregon Student Safety on the Move.
- 1988 – Prevention 101 course developed with V.C. League Consultant firm based out of Oakland California, Caroline Cruz and Larry Didier.
- 1988 – Oregon Prevention Resource Center oversees the Annual Alcohol and Drug Prevention Conference. 5<sup>th</sup> Annual ATOD Prevention Conference: Making it Work in Your Community.
- 1988-89 – William Lofquist – “Discovering the Meaning of Prevention,” was promoted throughout the state.

- 1989 – Drs. David Hawkins and Richard Catalano at University of Washington hire Rick Cady to oversee Oregon Together; it was then transferred to OADAP in 1990. Two-state research grants from The National Institute on Drug Abuse were received by Oregon and Washington. Rick Cady was hired to oversee the Oregon Together (OT) project. Washington State called their initiative Washington Together. Oregon Together was to serve 25 communities under the NIDA grant. Oregon Together had 32 coalitions formed in communities across the state. By 1995 Oregon Together had expanded into 70 communities and by the late 90’s into 75 communities, many receiving CSAP funding for community mobilization efforts. Caroline Cruz was moved to main office (1992) and became an OT and CTC trainer, and Prevention Coordinator. Judy Cushing is hired as OT Assistant Director in 1992.
- 1989 – 6<sup>th</sup> Annual Prevention Conference: “Celebrating Prevention: Strategies for the 90’s”.
- 1989 – Preparing for Drug Free Years (PFDFY) implemented statewide by OPRC, coordinated by Sybil Bullock. Caroline M. Cruz is selected as a PFDFY trainer and becomes a National and Statewide Lead Trainer. Others in the state are selected and trained in PFDFY (Rick Cady, Diane Glass, Gina Mulford and others).
- Early 90’s – “Drugs in the Workplace” for rural areas enacted.
- Early 90’s – Statewide gambling uses OPRC 800 number for gambling issues.
- 1990 – 7<sup>th</sup> Annual ATOD Prevention Conference: Celebrating Prevention: “Teaming to Make a Difference”.
- 1991 – Risk and Protective factors is used as a framework for prevention with Prevention Early Intervention (PE/I) providers.
- 1991 – 8<sup>th</sup> Annual Prevention Conference. Celebrating Prevention: “Bridging the Gaps”.

- 1992 – Five-year Community Partnership grants are awarded in Oregon by Center for Substance Abuse Program (CSAP). (Lincoln County, Lane County, Salem/Keizer, Regional Drug Initiative, and Klamath Tribe).
- 1992 – 9<sup>th</sup> Annual Prevention Conference. Celebrating Prevention: “Shaping Oregon’s Future”.
- 1992 – Oregon Together held a special conference for OT communities that focused on their highest priority risk and protective factors, community laws and norms favorable to ATOD use and family management problems.
- 1993 – Grant from Center for Substance Abuse Prevention (CSAP) started the Six State Consortium to focus on statewide risk/protective factors. (Oregon, Washington, Kansas, Utah, South Carolina, and Maine).
- 1993 - Oregon Partnership formed, incorporated three existing agencies with common objective to help communities across the state prevent substance abuse.
- 1993 – 10<sup>th</sup> Annual Prevention Conference. Celebrating Prevention: “A Decade Together”.
- 1994 – 11<sup>th</sup> Annual Prevention Conference. Celebrating Prevention: “Building Partnerships with the Family”.
- 1994 – Rick Cady leaves OT Project to become Director of Training with Hawkins’ and Catalano’s company, Developmental Research, Inc. Judy Cushing becomes Director of OT and Jeff Ruscoe is hired as Assistant Coordinator of Oregon Together project.
- 1994 Risk and Protective Factor survey initiated in 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup>, grades.
- 1994– Synar Amendment passes, requiring states to reduce teen use of tobacco.
- 1995 – CSAP awards a two-state mentoring grant to Oregon and Washington. The Pacific Northwest Prevention Coalition (PNPC) project includes 9 communities from the state of Oregon and 9 communities from the state of Washington. Judy Cushing leaves OADAP to direct Oregon Partnership. Barbara Groves is named

Project Director of PNPC and Oregon Together. Larry Didier moved to Research and Evaluation Unit and the Prevention Manager position is eliminated.

- 1995 – The first county alcohol and drug profiles are created, using student survey and archival data.
- 1995 – 12<sup>th</sup> Annual Prevention Conference. Celebrating Prevention: “Strengthening our Roots for a Healthy Community”.
- 1996 – Oregon Prevention Cookbook created with key elements listed to enable replication of prevention efforts.
- 1996 – Minimum Data Set for Prevention (MDA) piloted with eleven counties.
- 1996 – 13<sup>th</sup> Annual Prevention Conference. Celebrating Prevention: “Prevention Efforts in an Era of Change”.
- 1996 – Jeff Ruscoe named Synar Coordinator for the State.
- 1996 – Jeff Kushner leaves Office of Alcohol and Drug Abuse Programs (OADAP).
- 1997 – Barbara Cimaglio named Director of the Office of Alcohol and Drug Abuse Programs (OADAP).
- 1997 – Interagency Agreement signed by several agencies with the focus on collaboration.
- 1997 – State Incentive Grant awarded to five States, (Oregon, Kansas, Illinois, Kentucky and Vermont). Barbara Groves named as Project Manager for Oregon’s project. This will change how we administer prevention dollars. Caroline M. Cruz named as Project Director for The Pacific Northwest Prevention Coalition (PNPC).
- 1997 – Tobacco Liaison position within OADAP is created, Jeff Ruscoe is named as the liaison with the Health Division’s Tobacco Prevention and Education Program (TPEP).

- 1997 – Western Center for the Application of Prevention Technologies is formed; Kristen Reed is hired as Project Manager and housed in OADAP.
- 1997 – 14<sup>th</sup> Annual Prevention Conference. Celebrating Prevention: Making a Difference – Prevention Works.
- 1997-98 – Strategic planning throughout the state. Community mobilization and parenting are named as the two top priorities for prevention.
- 1998 – Caroline M. Cruz is designated as the Lead Prevention Trainer for the OADAP Prevention Unit.
- 1997-98 – Caroline M. Cruz named as Prevention Chair and forms a task force to pursue Prevention Certification in Oregon through the Addictions Counseling and Certification Board of Oregon (ACCBO).
- 1998 – Prevention Certification Specialist process is adopted by OADAP, utilizing International Certification and Reciprocity Consortium standardized format and processes. Eight prevention professionals take the first certification exam and pass. Caroline M. Cruz, Janet Bubl, Jackie Matlick, Joe Marmo, Diane Glass, Barbara Groves, Tammy Jackson and Julie Dodge.
- 1998 – State planning coalesced into Juvenile Crime Prevention Partnership, (beginning of Senate Bill 555), Barbara Groves named as Liaison with Governors Office part time.
- 1998 – Planning, Evaluation, Research and Technology (PERT), unit established. Gwen Gramms hired as Manger.
- 1998 – OADAP Prevention Unit hires three new Prevention Coordinators. Janet Bubl, Lawrence Piper and Tim Cohea.
- 1998 – 15<sup>th</sup> Annual Prevention Conference. Celebrating Prevention:” A Crucial Step to a Healthy Future”.
- 1999 – OPRC moves to Center for Addiction Resources and Training (CART), OPRC becomes Oregon Prevention Treatment Resource Center (OPTRC).

- 1999 – Minimum Data Set (MDS) fully adopted for all counties and tribes receiving prevention dollars. Institute of Medicine becomes part of the planning process for County/Tribal annual implementation plans.
- 1999 – All OADAP treatment and prevention dollars are required to be directly contracted with County Mental Health Authorities, or directly with Tribes, per Oregon Administrative Rules (OAR). OADAP can no longer have direct contracts with Oregon Together coalitions/communities. Oregon legislature approved general funds for ATOD prevention for the first time in Oregon’s history. Interagency Technical Assistance Teams provided statewide training on Cultural Competency/Gender Specific and Best Practices/Evaluation, Caroline M. Cruz on the training team. Senate Bill 555 approved by the legislature.
- 1999 – Caroline M. Cruz is designated as the Tribal Liaison for OADAP. Joe Marmo hired as Prevention Coordinator, replacing Tim Cohea, Kim Brown hired as Workforce Training Coordinator.
- 1999 – Prevention Training calendar is announced. Sixteenth Annual Prevention Conference: Celebrating Prevention: “Best Practices for the 21<sup>st</sup> Century”.
- 2000 – Pilot project to integrate the Youth Risk Behavior Survey and the Student Drug Youth Survey was initiated.
- 2000 – Parent training’s offered by OADAP, Strengthening Multi-ethnic Families, Parents Who Care and Making Parenting a Pleasure.
- 2000 – Request for Grant Proposals for Enhancing Parenting is announced. \$700,000 is awarded by the state legislature.
- 2000 – First Blue Print Prevention Training is offered in Florence.
- 2000 – 17<sup>th</sup> Annual Prevention Conference: “A Ton of Prevention”.
- 2001 – January - Joe Marmo, one of State Prevention Coordinators goes to D.C. as Deputy Director for CSAP Model Programs Office.

- 2001 – OADAP re-named Office of Mental Health and Addiction Services (OMHAS). A&D Prevention is placed under Barbara Cimaglio and reports directly to Barry Kast, Health Cluster Deputy Director.
- 2001 – Oregon Children’s Plan passed.
- 2001 – Legislative Budget note for OMHAS addresses Fetal Alcohol Syndrome.
- 2001 – First Entry Level Prevention class begins.
- 2001 – All nine Tribes awarded up to \$95,000 for prevention during the 2001-2003 biennium.
- 2001 – No prevention conference held.
- 2002 – A&D Prevention is re-named “Child & Adolescent Health Systems Unit” (CAHSU).
- June 2002 – Rey Agullana hired as Prevention Coordinator, replacing Joe Marmo.
- 2002 – Prevention Conference 2002: “Working Together to Build a Safe & Healthy Oregon”. The conference included agencies from the entire Health Cluster, changing the focus from ATOD to numerous disciplines within the health field.
- December 2002 – Jeff Ruscoe named state coordinator for the Enforcing Underage Drinking Laws (EUDL) program.
- 2003 – CAHSU moved into Office of Mental Health and Addictions Services and becomes the Prevention Unit.
- 2003 – No prevention conference. Oregon Partnership submits a CSAP Conference grant to co-host a Northwest Prevention Conference for 2004.
- 2004 – Prevention Manager Position is brought back and announced in January. Barbara Cimaglio is appointed Prevention Manager. March – Barbara Cimaglio leaves OMHAS.

- 2004 - Prevention Unit operates as a team to handle administrative issues until new manager is hired. Caroline M. Cruz is designated as National Prevention Network state representative and passes it on to Lawrence Piper.
- 2004- The rest of the OMHAS staff moves from the State Hospital Offices located at Bittern Street to the main DHS building.
- 2004 – Karen Wheeler hired as Policy and Program Development Manager, which includes the prevention unit.
- 2004 – Prevention Manager Position eliminated.
- 2004 – Northwest Prevention Conference: “Take the Lead,” hosted by Oregon Partnership, and co-sponsored with OMHAS Prevention Unit.
- 2004 – OMHAS was awarded two five-year CSAP cooperative agreements for Ecstasy and other Club Drug Prevention services grants. The recipients were Oregon Partnership and Washington County.
- 2004 – OMHAS is notified that the five year Ecstasy and other Club Drug Prevention will not be funded for year 3 to 5 due to realignment of SAMHSA’s FY 2006 budget.
- July 2005 – With the beginning of a new biennium, prevention allocations to counties were redistributed based on a population formula. This was made necessary because of the change in how Safe and Drug-Free Schools funding was distributed, moving to a competitive process.
- October 2005 – Oregon received 3-year Enforcing Underage Drinking Laws – Rural Communities Initiative (EUDL-RCI) Discretionary Grant. Three communities, Lake County, Wallowa County and the City of Newport were selected as the targeted rural communities for the grant.
- 2006 – Rey Agullana is named as Synar Coordinator.
- 2006 – CSAP Fellowship awarded to Oregon. Shane Lopez-Johnston was selected for a 1 to 3 year term to be mentored by Caroline M. Cruz.

- 2006 – Oregon received a 3-year CSAP state epidemiological outcomes grant. GERALYN BRENNAN was hired by OMHAS.
- 2006 – OMHAS renamed as Addictions and Mental Health Division AMH. Policy and Program Development Unit remains the same.
- March 2007 – Lawrence Piper leaves the AMH prevention unit and takes a new position with Children, Adults and Families. Caroline M. Cruz is named National Prevention Network state representative. Rey Agullana is named the Safe and Drug Free School state representative.
- July 2007 – The Oregon Legislature approves 1.9 million general fund dollars for suicide prevention (.2M) and parenting prevention (1.5m). Caroline M. Cruz named as lead with Strengthening Families Program 10-14 (SFP 10-14). Twenty-eight proposals were received; 25 counties (Multnomah submitted two) and two tribes. All 28 proposals were awarded funding. Approximately 70 teams are trained statewide to provide training to approximately 1,340 families.
- September 2007 – Oregon, Washington and Alaska co-host The National Prevention Network Conference at the Portland Downtown Hilton for 900 plus participants. Caroline M. Cruz and Lawrence Piper on planning committee.
- October 2007 – Prevention Manager Position announced.
- February 2008 – Rick Cady hired as Prevention Manager.
- April 2008 – Rey Agullana placed on active duty with the Oregon National Guard. Jeff Ruscoe resumes Synar Coordinator Duties, Rick Cady assumes oversight of the Safe & Drug Free Schools funding (Governor's portion), and also assumes the role of Oregon's National Prevention Network State Representative.
- July 28, 2008 – Jill Dale hired as AMH's newest Prevention Specialist.
- June 2008 *Work Drug Free* becomes Oregon Employers Drug Initiative and Work Healthy Oregon.
- November 2008 – Joanne Trzcinski from Oregon State Hospital takes a job rotation position with the Prevention Unit.

- March 2009- Rey Agullana resigns from the prevention unit.
- March 2009 – Shane Lope-Johnson, completes CSAP fellowship with the State of Oregon

## **GOVERNOR’S COUNCIL ON ALCOHOL & DRUG ABUSE PROGRAMS**

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c/o Department of Human Services, Addictions and Mental Health Division  
500 Summer Street NE, E86, Salem, OR 97301-1118  
(503) 945-6003 FAX (503) 378-8467

The Governor's Council on Alcohol and Drug Abuse Programs was created in 1985. Statutes creating the Council and establishing its duties include ORS 430.250, 430.255, and 430.257. These statutes also contain the following legislative policy:

### **Legislative Policy**

- Dependence on alcohol or other drugs is treatable and preventable;
- The Legislative Assembly has a responsibility to the citizens of the state to insure that all related services and resources are provided in an effective and efficient manner; and
- State agencies are accountable to coordinate all related services to the maximum extent possible.

### **Council Duties**

The Council is charged with implementing the legislative policy by:

- Describing the need for prevention and treatment services and strategies, and the method by which state and federal resources shall be prioritized;
- Setting forth principles guiding the purchase of services and strategies from local community providers;
- Identifying outcomes and a method for monitoring those outcomes;
- Identifying consistent standards for measuring prevention and treatment provision/success;

- Outlining a process for providing training and technical assistance to local providers, including special populations;
- Identifying how prevention and treatment link to other services and supports for children and families;
- Assessing the economic and social impact of alcohol and drug abuse on Oregon and report the findings and recommendation to the Governor by January 1<sup>st</sup> of each even-numbered year;
- Reviewing and make recommendations to the Governor on the goals, financing, priorities and a state plan for prevention, intervention and treatment of alcohol and drug abuse problems, which encompasses all appropriate state agencies by January 1<sup>st</sup> of each even-numbered year;
- Reviewing alcohol and drug abuse programs and making recommendations to the Governor on the effectiveness and priorities for improvements of all such prevention and treatment programs for alcohol and drug problems engaged in or financed through state agencies by January 1<sup>st</sup> of each even-numbered year;
- Ensuring that each state agency or other entity responsible for a component of the local coordinated comprehensive plan shall ensure that a biennial evaluation of the plan component is conducted according to a consistent framework:
- Working to ensure broad-based citizen involvement in the planning and execution of the alcohol and drug prevention and treatment plans at both the state and local level;

The Council is also directed by statute to:

- Assessing the economic and social impact of alcohol and drug abuse on the State of Oregon and reporting the findings and recommendations to the Governor by January 1 of each even-numbered year.
- Reviewing and making recommendations to the Governor on the goals, financing, priorities and a state plan for prevention, intervention and treatment of alcohol and drug abuse problems, which encompasses all appropriate state agencies, by January 1 of each even-numbered year.
- Reviewing alcohol and drug abuse programs and making recommendations to the Governor on the effectiveness and priorities for improvements of all such prevention and treatment programs for alcohol and drug problems engaged in or financed through state agencies by January 1 of each even-numbered year.

### **Participating State Agencies**

Some 15 state agencies are specifically charged with the duty of assisting the Council in carrying out these responsibilities.

- The Council looks at the current and proposed efforts of each of the agencies to deal with problems caused by alcohol and other drug misuse and addiction.
- The Council also looks horizontally across all 15 of the agencies for the purpose of identifying gaps in needed services, duplications of services, and opportunities for multi-agency cooperation in less costly or more effective services.
- Taken together, the agencies expend over \$185 million per biennium on alcohol and other drug related problems.

The participating state agencies are:

- Department of Corrections
- Department of Education
- Department of Employment
- Department of Human Services
- Children Adults and Families
- Public Health
- Office of Mental Health and Addiction Services
- Office of Medical Assistance Programs
- Seniors and People with Disabilities
- Oregon Youth Authority
- Department of State Police
- Department of Transportation
- Motor Vehicles Division
- Traffic Safety Division
- State Commission on Children and Families
- Liquor Control Commission

### **Council Membership**

The Council consists of 11 voting members who are appointed by the Governor for terms of four years and two non-voting members, including one member appointed by the House Speaker and one member appointed by the Senate President. Members are eligible for one reappointment. Members must be without conflicting interests and as representative as possible of:

- Geographic regions of the state;
- At-risk populations, including among others, youth, the elderly, minorities and women;
- Knowledgeable professionals, such as pharmacists, physicians, attorneys, and the like who are not necessarily representatives of professional organizations, but who may be recovering;
- Knowledgeable nonprofessionals who may represent advocate groups and who may be recovering; and
- Local advisory groups. Currently there are members from the Juvenile Crime Prevention Advisory Committee (JCPAC) and Oregon State Police that serve on the council in a liaison capacity.

## **Council Awards**

From time to time the Council, in cooperation with the Governor, provides recognition for outstanding efforts to prevent or to deal with the problems caused by alcohol or other drug abuse and addiction. Awards have been made for the efforts of members of the media, of local communities, and of particular individuals. The awards to individuals are made in the name of Thomas R. Dargan, the first chairperson of the Council.

Current council membership is available on this DHS web site.

[http://www.oregon.gov/DHS/addiction/gov\\_council/main](http://www.oregon.gov/DHS/addiction/gov_council/main).

## RESOURCES

Prevention Certification

[http://www.accbo.com/general\\_images/pdf\\_files/prevention.pdf](http://www.accbo.com/general_images/pdf_files/prevention.pdf)

Strengthening Families Program 10-14

Evaluation site: <http://sfp.wsu.edu/Oregon.htm>

To Order Material: <http://www.extension.iastate.edu/sfp/>

Community Anti-Drug Coalitions of America CADCA

[www.cadca.org](http://www.cadca.org)

Oregon Partnership

[www.oregonpartnership.org](http://www.oregonpartnership.org)

Oregon Tobacco Prevention & Education Program

<http://www.oregon.gov/DHS/ph/tobacco/>

Oregon Commission on Children and Families

<http://www.oregon.gov/OCCF/>

Oregon Partners for Children and Families

<http://www.oregonpcf.org/>

Oregon Progress Board

<http://www.oregon.gov/DAS/OPB/>

SAMHSA's Center for Substance Abuse Prevention

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

<http://prevention.samhsa.gov/>

Surgeon General's Call to Action

<http://www.surgeongeneral.gov>

Search Institute's 40 Developmental Assets

<http://www.search-institute.org/system/files/40AssetsList.pdf>

WesternCAPT

<http://captus.samhsa.gov/western/western.cfm>

## Prevention Services

- ❖ Roles and Responsibilities
- ❖ Implementation Plans
- ❖ Annual Reports
- ❖ CPS

Prevention services for counties are part of larger county implementation plans. Counties include prevention plans as part of an overall service delivery package. The following is an excerpt of those requirements.

Tribal communities are not mandated by legislative requirements to provide a larger plan, but outline their services with tools provided by AMH.

The Oregon Administrative Rules for prevention may be viewed in Appendix A.



## **ROLES AND RESPONSIBILITIES**

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- ❖ County and Tribal Prevention Coordinators
- ❖ AMH Prevention Specialists
- ❖ Statewide Prevention Contractors

The following roles and responsibilities describe the functions of County and Tribal Prevention Coordinators, AMH Policy & Program Development Unit Prevention Specialists and Statewide Prevention Contractors for programs administered by AMH. Typically AMH prevention programs are funded with the Substance Abuse Prevention & Treatment (SAPT) Block Grant within the Division's A&D Service Element 70 (SE 70) and may include contracted projects such as Safe and Drug Free Schools, *Strengthening Families 10- 14* Program and the Enforcing Underage Drinking Laws (EUDL) or other funded opportunities.

County and Tribal Prevention Coordinators, AMH Prevention Specialists and statewide contracts have a range of responsibilities. Management, planning, prevention system development and sustainability form core elements of common duties.

### **County/Tribal Prevention Coordinators**

#### **Management**

- Monitor SE 70 and other AMH revenues contracted to the county or tribe through financial agreements
- Oversee the implementation of programs funded by SE 70 and other AMH funds
- Monitor deliverables and fiscal accountability of county and tribal funds that are subcontracted for delivery of prevention services and oversee performance of the subcontractor
- Assure all prevention services, whether provided directly or by subcontract, are reported in a timely and accurate manner on the Minimum Data Set (MDS) system and through annual reports
- Assure compliance with SB 555 (comprehensive community planning) requirements
- Maintain compliance with the Oregon Administrative Rules governing AMH prevention agencies
- Attend twice yearly statewide gatherings for training and policy updates

## **Planning**

- Analyze data for trends in alcohol, tobacco and other drug use and predictive risk/protective factors
- Collect and utilize current local data to develop a biennial County or Tribal Prevention Implementation Plan
- Act as liaison with planning groups, including the Commission on Children and Families, Local Alcohol & Drug Planning Committees and Local Public Safety Coordinating Councils where appropriate
- Lead and participate in collaborative planning

## **Prevention System Development**

- Develop local system of prevention based on the IOM continuum
- Provide technical assistance to communities, agencies, law enforcement, schools (SDFSC funds and other prevention initiatives within the schools) and subcontractors in prevention program
- Deliver or subcontract to deliver prevention programs
- Provide expertise in evidence-based prevention programming/curricula
- Develop new and/or strengthen existing community coalitions
- Provide expertise in evaluation for prevention programming

## **Sustainability**

- Assist in local funding development
- Act as information and referral resource
- Develop/review and write grant proposals; oversee process
- Develop and promote prevention media & awareness campaigns
- Advocate for local prevention services
- Develop and maintain effective standards of prevention practice

## **AMH Prevention Specialists**

### **Management**

- Oversee county and tribal contracts
- Continually update county and tribal contact list
- Monitor deliverables, stewardship and accountability of contractual agreements
- Develop and train coordinators/partners on reporting mechanisms; provide reports

- Report activities entered into the Minimum Data Set system and other County level reports to Federal, State and Tribal partners
- Maintain compliance with the Oregon Administrative Rules governing AMH prevention services
- Review eligibility to receive letters of approval for prevention agencies
  
- **Prevention System Development**
- Provide foundation and background information for coordinators
- Facilitate system development through collaborative efforts
- Facilitate statewide communication to strengthen prevention efforts
- Collect and provide consistent data to local communities
- Develop and assist with quality improvement mechanisms
- Provide technical assistance to local prevention systems and coalitions
- Provide expertise and technical assistance on evidence-based practices
- Promote best practice and research information to facilitate system development
- Facilitate communication across disciplines
- Reduce barriers to DHS supported systems of care
- Make available expertise in evaluation for prevention programming
- Promote prevention Oregon Prevention community and prevention messages to the public
  
- **Planning**
- Analyze data for trends in alcohol, tobacco and other drug use and predictive risk/protective factors
- Act as liaison with Statewide planning groups
  
- **Sustainability**
- Develop, support and provide training in current prevention technology
- Act as information and referral resource
- Expand competent leadership in the prevention field
- Provide access to and promote statewide prevention media & awareness
- Advocate for prevention services
- Develop and maintain effective standards of prevention practice

## **Statewide Contractors**

- **Management**
- Deliver and be accountable for contracted agreements
- Report activities on the Minimum Data Set system and provide other reports as required in contracts
- Maintain compliance with the Oregon Administrative Rules governing AMH prevention agencies
  
- **Prevention System Development**
- Assist with linkages between prevention systems
- Work in partnership with AMH, Tribal and County Prevention Coordinators to support and strengthen prevention system.
- Promote prevention Oregon Prevention community and prevention messages to the public
  
- **Planning**
- Collect data on specific areas of need
- Assist with support for data/evaluation
  
- **Sustainability**
- Inform/advocate for prevention strategies via website and other media
- Maintain effective standards of prevention practice
- Develop technology transfer mechanisms for overarching systemic areas

## COUNTY & TRIBAL IMPLEMENTATION PLANS

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### 2007-2009 County Prevention Plan Guidelines

*(If you have questions regarding any of the information requested, contact your prevention specialist.)*

1. The County/Tribe must designate a coordinator or contact person who is either funded by A&D #70 dollars, or who is wholly responsible for the development, monitoring, and oversight of the plan. This coordinator/contact person must be able to carry out the responsibilities of a Certified Prevention Specialist (CPS).
2. The County/Tribal coordinator/contact person must agree to attend, and budget for, two Department of Human Services (DHS) sponsored meetings per year for prevention coordinators/contact persons. All meetings will be held in a central location.
3. Counties must continue to maintain and/or support the ongoing development of community coalitions within the County as a major program area.
4. The County/Tribe must insure participation and coordination of the SB 555 planning process and/or Tribal Action Plan. **The Funding Plan must include the priorities and activities/strategies that have been identified in the County's Comprehensive Plan\*, Phase II & Phase III, which includes services to reduce 8<sup>th</sup> grade drug use.** The County's logic model identifies specific strategies and intermediate-level outcomes that will assist you in writing this portion of the plan. The Funding Plan must follow the Planning Principles as adopted by the SB 555 partners.  
\*If you do not have a copy of your County's Comprehensive Plan, contact the Director of the local Commission on Children and Families (CCF).
5. The plan should include a narrative that describes major program areas. These areas include community mobilization, parent education, public awareness about alcohol and other drug issues (with a focus on underage drinking), and other needs identified in the local SB555 Comprehensive Plan. The narrative should list any SAMHSA Model Programs being used. The narrative should also explain how the prevention plan addresses the Comprehensive County Plan and the priorities and logic model information related to ATOD from Phase II and Phase III. Include a description of how the county is addressing cultural and gender specific issues and describe how the County/Tribe is expected to plan for and provide access to ongoing professional development training for prevention staff and providers.

## **SERVICE DESCRIPTION (“A&D 70” REFERS TO THE TITLE OF STATE FUNDS ALLOCATED FOR PREVENTION)**

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Service Name: PREVENTION SERVICES

Service ID Code: A&D 70

### **Service Description:**

Prevention Services (A&D 70) are integrated strategies designed to prevent substance abuse and associated effects, regardless of the age of participants. They are designed to reduce risk factors and increase protective factors associated with substance abuse. A&D 70 Services fall within one of the three prevention elements of the Institute of Medicine (IOM) Continuum of Care. The IOM prevention elements include Universal, Selective, and Indicated Prevention. Universal prevention addresses the entire population with messages and programs aimed at prevention or delaying the use of alcohol, tobacco and other drugs. Selective prevention targets subsets of the total population that are deemed to be at risk for substance abuse by virtue of the membership in a particular population segment. Indicated prevention is designed to prevent the onset of substance abuse in individuals who do not meet criteria for addiction but who are showing early danger signs.

A&D 70 Services are implemented through one or more of the Center for Substance Abuse Prevention’s (CSAP) six strategies. The six strategies with examples of services are 1. Information Dissemination - media campaigns; 2. Prevention Education - school curricula and parenting education; 3. Alcohol, Tobacco & Other Drugs (ATOD) Free Alternatives - youth leadership and community service projects; 4. Community Based Processes - community coalitions (Oregon Together); 5. Environmental/Social Policy - school policies and community laws concerning alcohol, tobacco and other drugs; and 6. Problem Identification and Referral - student assistance programs.

### **Performance Requirements**

Agencies, as defined in OAR 415-056-0005, providing A&D 70 Services must comply with OAR 415-056-0000 through 415-056-0025, and must have a current Letter of Approval issued by the Department of Human Services, Addictions and Mental Health Division (AMH), hereafter known as Division.

Agencies must implement their A&D 70 Services funded through this Agreement in accordance with the Biennial Prevention Plan dated as of July 1, 2007, which is incorporated herein by this reference (the “Plan”). Division financial assistance to the Agency in the subsequent biennium, for A&D 70 Services, will in part depend upon the Agency’s achievement of the outcomes set forth in the Plan. In the event of a conflict or inconsistency between the provisions of the Plan and other provision of this Service Description, the other provisions of this Services Description shall control.

### **Special Reporting Requirements**

Minimum Data Set for Prevention (MDS).

All A&D 70 Services financed in whole or in part with funds provided under this Agreement must be reported in writing by the Agency to the Division on a monthly basis. The reports are due to the Division by the 15th of January, April, July, October. Each report must contain the MDS data for each service reported.

Agency must submit a standardized written annual report to the Division describing the results of A&D 70 Services in achieving the outcomes set forth in the Plan. The report shall document prevention strategies as they relate to decreasing risk factors and increasing protective factors as well as local efforts to implement evidence-based prevention strategies.

### **Financial Assistance Calculation and Disbursement Procedures**

- A. Calculation of Financial Assistance. The funds awarded for A&D 70 Services are intended to be general financial assistance to Agency for A&D 70 Services. Accordingly, the Division will not track delivery of A&D 70 services on a per unit basis so long as Agency delivers A&D 70 Services as part of its CMHP or Tribal Plan. Total Department financial assistance for A&D 70 Services under a particular line of the Financial Assistance Award shall not exceed the total funds awarded for A&D 70 Services as specified on that line.
- B. Disbursement: Division will disburse the funds awarded for A&D 70 Services identified in a particular line of the Financial Assistance Award to Agency as set forth in the Special Condition on that line.
  - 1. Division may, at its discretion, adjust allotments to meet cash flow requirements to ensure continued availability of A&D 70 services.

2. Division may, at its discretion, adjust allotments to reflect changes in the funds awarded for A&D 70 services on that line of the Financial Assistance Award as a result of amendment of the Financial Assistance Award.

3. Division may, at its discretion, suspend allotments pending receipt of complete and accurate Minimum Data Set Prevention data and required reports described in Section III above.

C. Agreement Settlement. Agreement Settlement will be used to verify the inclusion of A&D 70 Services as part of County's CMHP, based on data properly reported to Division through reports required or permitted by this Service Description or an applicable Specialized Service Requirement.

Oregon Administrative Rules (A copy of Oregon Administrative Rules is provided in Appendix A.)



## PREVENTION PLAN DETAIL (FOR COUNTY PLANS)

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- ❖ Reporting Programs
- ❖ Reporting Outputs
- ❖ Reporting Outcomes

### **Developing a plan involves proposing activities and setting goals.**

*Proposed Programs (column 1)* – List each of the programs/activities that are being proposed for the biennium (i.e., Life Skills Training, Parenting for a Positive Future, etc.).

*Program Outputs (column 2)* – List each of the Program Outputs (process objectives) that are being proposed for each of the proposed programs (i.e., Provide 10 sessions of Life Skills Training for a minimum of 150 students each year; Train 250 parents in Parenting for a Positive Future each year.).

*Program Outcomes (column)* – List all the Intermediate-Level Outcomes for each proposed output, noting how the outcome will be measured (i.e., 80% of participants will demonstrate increased knowledge in positive parenting techniques as measured by pre-post tests; 90% of participants will demonstrate a new parenting technique they learned in class, etc.). Designate each outcome as either an educational, attitudinal or behavioral outcome (i.e., 1-A, 3-B, 6-E). Each Program Output must have at least one accompanying Program Outcome. For more information on writing your Intermediate-Level Outcomes, please visit the Oregon Progress Board’s website relating to Performance Measure Guidelines at [www.econ.state.or.us/opb/perfmeas/guidelines.html](http://www.econ.state.or.us/opb/perfmeas/guidelines.html).

Utilize the following worksheets to identify your goals. Keep in mind the county plan, which appears first, is part of a county mental health comprehensive plan. The Tribal programs submit prevention programs independent of an overall comprehensive mental health plan.

## 2007-09 County Prevention Plan

County \_\_\_\_\_

Prevention Coordinator \_\_\_\_\_

*Using the grid below, list all the proposed programs for which the County is requesting funding. Include all the Program Outcomes (process objectives) and Intermediate-Level Outcomes (educational, attitudinal & behavioral objectives) for each of the proposed programs. Outputs and outcomes must be measurable. The following page*

<b>Proposed Programs</b>	<b>Proposed Outputs</b>	<b>Proposed Outcomes</b>

**TRIBAL PREVENTION PLAN**  
**Department of Human Services**  
**Addictions and Mental Health (AMH) Division**

**Cover Sheet**

**Tribe's name:**

**Prevention Coordinator:**

**Agency Name:**

**Address:**

**City/Zip:**

**Phone:**

**FAX:**

**E-mail Address:**

**Fiscal contact name and e-mail:**

**For purpose of these funds, our Tribal Community is defined as:**

**Vision Statement (What do we want our Tribal community to look like 15 to 20 years from now?):**

**What does our data show?**

Which Outcome will you focus on for 2007-09?

- Decrease teen alcohol use (mandatory)       Decrease teen substance use
- Reduce ATOD use during pregnancy       Reduce adult substance abuse
- Increase community engagement

**NAME PROGRAMS YOU WILL BE IMPLEMENTING AND WHY:**  
Program should be culturally, age appropriate and gender specific when appropriate.

1. Under Age Drinking program to decrease teen alcohol use.
2. Back to the Boards program to reduce ATOD use during pregnancy.
3. The Prevention of Fetal Alcohol Spectrum Disorder Program to reduce ATOD during pregnancy.
4. Parenting Programs to decrease teen substance use and reduce adult substance abuse.
5. Meth task Force to increase community engagement

## Action Planning Sheets

**For evaluation, monthly MDS reports due the 15<sup>th</sup> of the following month (inputs). Annual report due August 30<sup>th</sup> measuring (outcomes) educational gain, attitudinal and behavioral changes of the programs you have selected to implement.**

**Example:**

**Long Term Outcomes:** Decrease teen alcohol use, Reduce ATOD use during pregnancy, Reduce adult substance abuse, Decrease teen substance use, Increase community engagement, and Increase protective factors.

**Proposed Programs:** (1) Under Age Drinking program to decrease teen alcohol use. (2) Back to the Boards, a parenting program to reduce ATOD use during pregnancy. (3) The Prevention of Fetal Alcohol Spectrum Disorder Program to reduce ATOD during pregnancy. (4) Shadow substance abuse parent training modules to decrease teen substance use and reduce adult substance abuse. (5) Meth task Force to increase community engagement. (6) Provide a variety of community activities throughout year to increase community engagement and increase protective factors.

CSAP Strategy Information Dissemination	Action	Who	When	Evaluation–Inputs (I) and Outcomes (O)
Information Dissemination				
Strategy	Action	Who	When	Evaluation
Prevention Education				

<b>Strategy</b>	<b>Action</b>	<b>Who</b>	<b>When</b>	<b>Evaluation</b>
Alternative Activities				
<b>Strategy</b>	<b>Action</b>	<b>Who</b>	<b>When</b>	<b>Evaluation</b>
Community-Based				
<b>Strategy</b>	<b>Action</b>	<b>Who</b>	<b>When</b>	<b>Evaluation</b>
Environ./Social Policy				

**2007- 2009 Itemized Budget**

	<b>AD#70 AMH Prevention</b>	<b>AD#70 AMH EUDL*</b>	<b>JCP OPTIONAL</b>	<b>Total Amount of Budget</b>
<b>Personnel (Salary, Benefits, etc.)</b>				
<b>Printing/Photo-copying</b>				
<b>Program Supplies/Materials</b>				
<b>Office Supplies/Mailing/etc.</b>				
<b>Contracts/Consultants</b>				
<b>Computer Software, etc.</b>				
<b>Other: Please List:</b>				
<b>Total Budget Amount</b>	\$100,000	\$5,000	\$25,000	

\* EUDL, Enforcing Underage Drinking Laws, each Tribe will be awarded \$5,000. Needs to be spent by M

## Budget Narrative

(Maximum one page)

**Community:** \_\_\_\_\_

Please explain your budget by providing a brief summary of the programs, activities, tasks, and equipment for which your grant funds will be used. Please be as specific as possible, including such information as personnel expenses, programs and supplies to be purchased, etc. This will give us a better understanding of your budget sheet.

**2007- 2009 Itemized Budget**

	<b>AD#70 AMH Prevention</b>	<b>AD#70 AMH EUDL*</b>	<b>JCP OPTIONAL</b>	<b>Total Amount of Budget</b>
<b>Personnel (Salary, Benefits, etc.)</b>				
<b>Printing/Photo-copying</b>				
<b>Program Supplies/Materials</b>				
<b>Office Supplies/Mailing/etc.</b>				
<b>Contracts/Consultants</b>				
<b>Computer Software, etc.</b>				
<b>Other: Please List:</b>				
<b>Total Budget Amount</b>	\$100,000	\$5,000	\$25,000	

\* EUDL, Enforcing Underage Drinking Laws, each Tribe will be awarded \$5,000. Needs to be spent by May 2009.

## **ANNUAL REPORTING FOR COUNTIES AND TRIBES**

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At the end of each year AMH will ask for an evaluation of your plan. The results and your successes should be reported on the following forms.

### **DEPARTMENT OF HUMAN SERVICES Addictions and Mental Health Division**

**Program Narrative & Successes Report**  
July 1, 200X through June 30, 200X

(Please use this space to report prevention successes for this reporting period and your work with local community coalitions. These “success stories” and coalition activities will be used to highlight prevention services across the state in our Annual Substance Abuse Prevention Report. Examples may include policy changes or enhancements in your community or awards received by prevention programs in your county. You may also include pictures and/or relevant graphics, charts, or graphs. Please indicate whether or not you grant AMH permission to use these items in creating the statewide annual report.)

DEPARTMENT OF HUMAN SERVICES  
Addictions and Mental Health Division  
-- Demographic Reporting Sheet  
Service Element 70  
July 1, 200X through June 30, 200X

In addition to other requirements as determined by the Department of Human Services – Addictions and Mental Health Division (DHS-AMH), this completed form must be submitted electronically to DHS no later than August 15, 2008.

County/Tribe: \_\_\_\_\_

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

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

*This report covers the months of **July 1, 2007 through June 30, 2008**. Complete all sections below as they apply to the group(s) targeted with your prevention efforts (as outlined in your Implementation Plan). Program data can be obtained directly from your Minimum Data Set (MDS) entries.*

1. Total number of participants in the reporting period: \_\_\_\_\_

2. Participant/Attendee Ages. Please note the number in each category:

0-4 yrs.	5 -11 yrs.	12 - 14 yrs.	15 – 17 yrs.	18 – 20 yrs.	21+ yrs.

3. Number of Male Participants \_\_\_\_\_

Number of Female Participants \_\_\_\_\_

4. Total Population in the County \_\_\_\_\_

5. Estimate the following (percentages):

Ethnicity of Program Participants	Ethnicity of Community
a) White %	a) White %
b) African American %	b) African American %
c) Hispanic %	c) Hispanic %
d) Native American %	d) Native American %
e) Other (indicate) %	e) Other (indicate) %

<u>Agency Phone</u>	<u>Agency Fax</u>	<u>E-Mail:</u>
<b>Proposed Program and All Proposed Outcomes for this Program</b>	<b>Actual Results (Process, Attitudinal, Educational and Behavioral Outcomes)</b>	<b>If proposed results were not achieved, please explain</b>
<u>1-P</u>	<u>1-P</u>	
<u>2-P</u>	<u>2-P</u>	
<u>3-P</u>	<u>3-P</u>	
<u>4-P</u>	<u>4-P</u>	
<u>5-P</u>	<u>5-P</u>	
<u>6-P</u>	<u>6-P</u>	
<u>7-P</u>	<u>7-P</u>	
<u>8-P</u>	<u>8-P</u>	

## FISCAL AGREEMENT PREVENTION REPORTING

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All fiscal agreements require reporting. The following chart gives an outline of the general prevention requirements, including plans, reporting, and meetings.

Implementation Plan	Completed each biennium.
Annual Prevention Report	Due August 15 <sup>th</sup> each year.
MDS Reporting	Must be completed by the 15 <sup>th</sup> day of the January, April, July, and October.
Prevention Summit	Held each Spring & Fall.
Ethics Training	Held annually.
Substance Abuse Prevention Specialist Training (SAPST)	Trainings held annually, or as needed
Tribal/APACSA Quarterly Prevention Summit	March, June, Sept, Dec.
Certified Prevention Specialist Training (Prep)	Annually
Various courses offered throughout year	TBD
SFP10-14	Evaluation forms must be submitted to WSU after each session and booster, and quarterly MDS.
EUDL	Quarterly MDS and when requested.
Other reports for special projects	TBD

## MINIMUM DATA SET FOR PREVENTION

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Minimum Data Set, or MDS for short, is an on line reporting system for prevention services. MDS reporting is a state requirement that provides data for the annual SAPT Block Grant Application and the Oregon State Legislature. This system was developed to enable states, substance abuse agencies, community-based service providers, and others to quantify and compare the numbers and types of primary substance abuse prevention and early intervention services delivered across the United States.

All prevention programs are required to enter their services into this system. Reporting must be completed by the 15<sup>th</sup> day of the month following the end of each quarter. (April, July, October, January) This database is equipped to graph information and illustrate types of services and populations served. Use the forms on the following pages to record your services during the month.

To get started, contact Jeff Ruscoe at 503-945-5901 ([jeff.ruscoe@state.or.us](mailto:jeff.ruscoe@state.or.us)). You will receive a login ID and password and get instructions on how to input data.

Familiarize yourself with the codes for the services you are providing.

Fill out data sheets to collect information about what services were provided and to whom.

Enter the data at the end of the month or at least at the end of the quarter

The database is only as good as the data entered. The AMH Prevention team is happy to help this process to make it an accurate reflection of services. Feel free to contact the team for suggestions, questions, or assistance.

.

# *Prevention Minimum Dataset*

<https://mds.hr.state.or.us/>

Welcome to the Prevention Minimum Dataset

## Message of the Day for 10/21/2009:

Please note: MDS is now running on new in-state servers. Please make a note of the new website URL, and change any shortcuts you have for MDS. If you are experiencing any problems logging onto the system, or have forgotten your Login or Password, please contact Jeff Ruscoe at (503) 945-5901.

## Login

**Login:**

**Password:**

YOUR NAME

Forget your user ID or password?  
Contact Jeff Ruscoe at 503-945-5901 ([jeff.ruscoe@state.or.us](mailto:jeff.ruscoe@state.or.us)).

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Prevention MDS 4.1  
Data Entry Form – Single Services

<b>Service Type</b>	<b>Service Date</b> (mm/dd/yyyy)	<b>Name of Group</b> (20 characters only)			<b>Unit Count</b>
S T ____					
<b>Service Population:</b>	<b>Attendees:</b> (Male)	<b>Attendees:</b> (Female)	<b>Total Present:</b>	<b>Counts Estimated?</b> (Yes/No)	
S P ____					
<b>Attendees by Age:</b> (Totals must equal total number of male and female attendees.)			<b>Attendees by Hispanic Origin</b> (Totals must equal total number of male & female attendees by age.)		
0-4 _____	18-20 _____	Hispanic or Latino _____			
5-11 _____	21-24 _____	Not Hispanic or Latino _____			
12-14 _____	25-44 _____				
15-17 _____	45-64 _____				
65 & Over _____					
<b>Attendees by Racial Category:</b> (Totals must equal or be greater than total male & female attendees.)		<b>Attendees that selected more than one race:</b>	<b>Attendees by other Demographic Category:</b>		
American Indian/Alaska Native _____	Native Hawaiian _____		Cuban _____	Dominican _____	
Asian _____	other Pacific Island _____		Mexican/Chicano _____	Puerto Rican _____	
Black/African American _____	White _____			Other Hispanic/Latino _____	
<b>Primary RP Factor</b> (Required)	<b>Secondary RP Factor</b> (Optional)	<b>IOM Category</b> (Required)	<b>Funding Source</b> (Optional)	<b>Hrs of Direct Service</b> (Optional)	
<b>Hrs of Indirect Service</b> (Optional)	<b>Zip Code</b> (Optional)	<b>Evaluation Method</b> (Required)	<b>Evidence-Based Practice</b> (Yes/No) (Required)	<b>Local Data</b> (Optional)	

Prevention MDS 4.1  
Data Entry Form – Reoccurring Services

	<b>Service Date</b> (mm/dd/yyyy)	<b>Name of Group</b> (20 characters only)			<b>Unit Count</b>
S T ____					
Service Population:	<b>Attendees:</b> (Male)	<b>Attendees:</b> (Female)	<b>Total Present:</b>	<b>Counts Estimated?</b> (Yes/No)	
S P ____					
<b>Attendees by Age:</b> (Totals must equal total number of male and female attendees.)			<b>Attendees by Hispanic Origin</b> (Totals must equal total number of male & female attendees by age.)		
0-4 _____	18-20 _____	Hispanic or Latino _____ Not Hispanic or Latino _____			
5-11 _____	21-24 _____				
12-14 _____	25-44 _____				
15-17 _____	45-64 _____				
65 & Over _____					
<b>Attendees by Racial Category:</b> (Totals must equal or be greater than total male & female attendees.)			<b>Attendees that selected more than one race:</b>	<b>Attendees by other Demographic Category:</b>	
American Indian/Alaska Native _____	Native Hawaiian or other Pacific Islander _____	Cuban _____ Dominican _____			
Asian _____	White _____	Mexican/Chicano _____ Puerto Rican _____			
Black/African American _____		Other Hispanic/Latino _____			
<b>Primary RIP Factor</b> (Required)	<b>Secondary RIP Factor</b> (Optional)	<b>IOM Category</b> (Required)	<b>Funding Source</b> (Optional)	<b>Hrs of Direct Service</b> (Optional)	
<b>Hrs of Indirect Service</b> (Optional)	<b>Zip Code</b> (Optional)	<b>Evaluation Method</b> (Required)	<b>Evidence-Based Practice</b> (Yes/No) (Required)	<b>Local Data</b> (Optional)	

## **CERTIFIED PREVENTION SPECIALIST (CPS)**

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Prevention Coordinators are required to be certified under the Prevention OAR which is intended to advance the professional quality of the prevention field.

Certified Prevention Specialists receive their accreditation through the Addiction Counselor Certification Board of Oregon. **For application and test information:** [http://www.accbo.com/general\\_images/pdf\\_files/prevention.pdf](http://www.accbo.com/general_images/pdf_files/prevention.pdf)

❖ 150 Prevention Education Hours

All education hours must be accredited or approved by a recognized/approved accreditation body. Education hours must include the topical areas of:

ATOD Pharmacology, Risk Protective Factors, ATOD Prevention and General Prevention

❖ 2,000 Supervised Experience Hours in the Prevention Domains™ (c. ICRC/AODA)

❖ 120 Hours of Experiential Learning and Evaluation by a Qualified Prevention Supervisor

❖ Letter of Verification

Verifying a minimum of 2 years of sobriety time for those who are recovering from chemical dependence.

❖ Ethics Agreement (*signed and dated*)

❖ National Criminal History Check

❖ ICRC Prevention Specialist Certification Exam

Passing score on the CPS professional psychometric national certification examination from the International Certification Reciprocity Consortium

## Oregon's Strategic Prevention Framework

Oregon prevention policy promotes the use of prevention models outlined by The Substance Abuse and Mental Health Services Administration (SAMHSA) and The Center for Substance Abuse Prevention (CSAP). This chapter will provide an overview of key models utilized in designing comprehensive alcohol and drug abuse prevention plans.

- ❖ Strategic Prevention Framework
- ❖ Institute of Medicine Framework
- ❖ Risk and Protective Factors/Assessment
- ❖ Prevention Strategies and Principles

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### SAMHSA'S STRATEGIC PREVENTION FRAMEWORK

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The Strategic Prevention Framework (SPF) is a public health model that recognizes that effective substance abuse prevention involves strategies that address the whole community. These involve broad strategies such as laws and policy, and targeted strategies such as parenting classes or educating youth.

The following diagram outlines the processes.

## SAMHSA'S STRATEGIC PREVENTION FRAMEWORK

Supports Accountability, Capacity, and Effectiveness



- **Assessment:** Collect Data to define problems.
- **Capacity:** Mobilize and/or build capacity within a geographic area to address needs.
- **Planning:** Develop comprehensive strategic plan that includes policies, programs, and practices creating a logical, data driven plan to address problems identified in assessment.
- **Implementation:** Implement evidence-based prevention programs, policies, and practices.
- **Evaluation:** Measure the impact of the SPF and its implemented programs, policies, and practices.

## INFORMATION SHEET

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### SAMHSA's Strategic Prevention Framework At-a-Glance

Step 1	Step 2	Step 3	Step 4	Step 5
<b>Profile population needs, resources, and readiness to address needs and gaps.</b>	<b>Mobilize and build capacity to address needs.</b>	<b>Develop a comprehensive strategic plan.</b>	<b>Implement evidence-based prevention programs, policies, and practices.</b>	<b>Monitor, evaluate, sustain, and improve or replace those that fail.</b>
Conduct a needs assessment.	Create and maintain partnerships.	Select policies, programs, and practices to implement.	Develop action plans for implementing policies, programs, and practices.	Collect and analyze evaluation data.
Assess your community's readiness for prevention.	Convene key stakeholders, coalitions, and service providers to plan and implement Steps 3 and 4.	Develop logic model and evaluation plan.	Implement policies, programs, and practices.	Write evaluation report.
Develop clear, concise, and data-driven problem statements.	Plan and implement strategies to improve your community's readiness.	Create a comprehensive strategic plan, including strategic goals, objectives, and performance targets.	Implement strategic plan.	Recommend quality improvements based on evaluation data.
Assess organizational, fiscal, and leadership capacity.	Mobilize financial and organizational resources.			
Assess resources and service gaps.				

## INSTITUTE OF MEDICINE FRAMEWORK (IOM)

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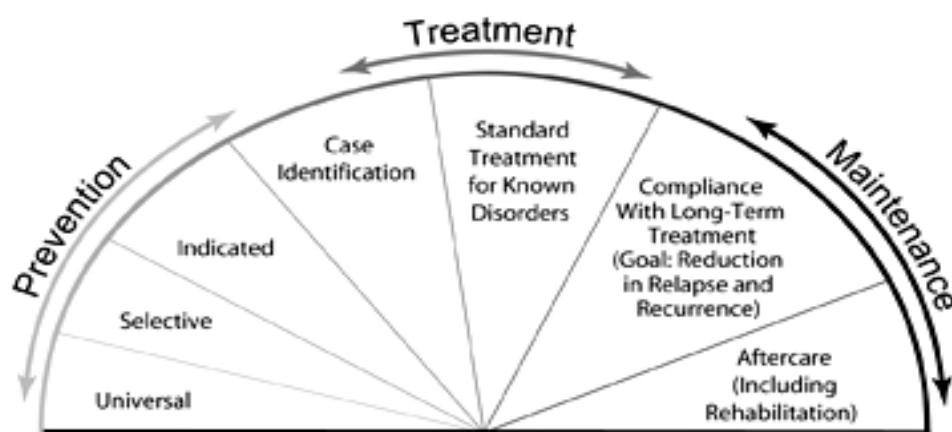
Prevention is one sector of the Continuum of Health Care. This chapter will define prevention types in that sector. (See figure 1)

### *The Continuum of Health Care Model According to the Institute of Medicine*

When dealing with substance use and other behavioral disorders in clinical settings, the levels of prevention are less distinct than with physical illnesses. The tasks of identifying risk factors and detecting early stage disease are usually accomplished by patient or family interview. Initial management of both risk and early stage disease is often conducted via patient and family counseling by the primary care provider. Thus, the continuum of the health care model is more practical than the public health model when dealing with preventive behavioral health services.

The continuum of health care model is drawn from a 1994 report of the Institute of Medicine (IOM) (Mrazek & Haggerty, eds., 1994), as originally proposed by Gordon (1983). It differs from the public health model in that it covers the full range of preventive, treatment, and maintenance services. There are three types of preventive services in the IOM model—universal, selective, and indicated. These do not correspond to the primary, secondary, and tertiary services in the public health model. Screening and follow-up preventive behavioral services correspond to secondary prevention within the public health model. Other preventive behavioral services, including most community-based services, correspond to primary or tertiary prevention.

Figure 1. Continuum of Health Care



Source: Reprinted with permission from Reducing Risks for Mental Disorders. Copyright 1994 by the National Academy of Sciences, Courtesy of the National Academy Press, Washington, DC.

In the IOM model, a “universal” preventive measure is an intervention that is applicable to or useful for everyone in the general population, such as all enrollees in a managed care organization. A “selective” preventive measure is desirable only when an individual is a member of a subgroup with above-average risk. An “indicated” preventive measure applies to persons who are found to manifest a risk factor that puts them at high risk (Mrazek & Haggerty, eds., 1994). All these categories describe individuals who have not been diagnosed with a disease.

Universal interventions, on a per-client basis, are relatively inexpensive services offered to the entire population of a life stage group. They are conducted as a primary prevention or screening to identify sub-populations and individuals who need more intensive screening, preventive, or therapeutic services. A clinical example would be the provision of prenatal care as a universal service for all pregnant women. A behavioral health example would be the use of a simple screening protocol to identify depression in all adult patients at all primary care visits.

Selective interventions are more intensive services offered to subpopulations identified as having more risk factors than the general population, based on their age, gender, genetic history, condition, or situation. For example, more intensive breast cancer screening is provided for women with a family history of breast cancer. A behavioral health example would be offering smoking cessation programming to all smokers.

Indicated interventions are based on higher probability of developing a disease. They provide an intensive level of service to persons at extremely high risk or who already show asymptomatic, clinical, or demonstrable abnormality, but do not meet diagnostic criteria levels yet. Case management and intensive in-home assessment, health education, and counseling are examples of indicated interventions (Mrazek & Haggerty, eds., 1994).

Sometimes a universal service is a screening procedure provided to all, or a primary prevention procedure such as vaccinations for children. The selective service involves diagnostic procedures to confirm or deny a diagnosis, and the indicated service involves much more intensive, individualized services for those at highest risk.

The efficacy and cost-efficiency of preventive services depend on the entire array of universal, selective, and indicated service components. They also depend on the ability of the health care system to target and limit the more costly indicated interventions to those who could most benefit from them.

## **RISK AND PROTECTIVE FACTORS**

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Risk and Protective Factor Theory is based on the work of J. David Hawkins, PhD., and Richard F. Catalano, PhD. Risk factors are those conditions which put someone at risk for substance abuse, delinquency, school dropout, teen pregnancy and suicide. Protective Factors are conditions which are associated with resilience toward substance abuse. Research has shown that the following twenty risk factors have been identified as leading to adolescent problem behavior. While risk factors can predict problem behavior, protective factors buffer the impact and promote positive development of youth strengths. Prevention planning should address both risk and protective factors.

### **PROTECTIVE FACTORS**

Protective factors are conditions that buffer young people from the negative consequences of exposure to risks by either reducing the impact of the risk or changing the way a person responds to the risk. Consequently, enhancing protective factors can reduce the likelihood of problem behaviors arising.

Some youngsters who are exposed to multiple risk factors do not become substance abusers, juvenile delinquents, school dropouts, or teen parents. Balancing the risk factors are protective factors--aspects of people's lives that counter or buffer risk. Research has identified protective factors that fall into three basic categories: individual characteristics, bonding, and healthy beliefs and clear standards.

#### **Individual Characteristics**

Research has identified four individual characteristics as protective factors. These are characteristics children are born with and are difficult to change: gender, a resilient temperament, a positive social orientation, and intelligence. Intelligence, however, does not protect against substance abuse.

#### **Bonding**

Positive bonding makes up for many other disadvantages caused by other risk factors or environmental characteristics. Children who are attached to positive families, friends, school, and community, and who are committed to achieving the goals valued by these groups are less likely to develop problems in adolescence. Studies of successful children who live in high risk neighborhoods or situations indicate that strong bonds with a caregiver can keep children from getting into trouble.

To build bonding, three conditions are necessary: opportunities, skills, and recognition. Children must be provided with opportunities to contribute to their community, family, peers, and school. The challenge is to provide children with meaningful opportunities that help them feel responsible and significant.

Children must be taught the skills necessary to effectively take advantage of the opportunity they are provided. If they don't have the necessary skills to be successful, they experience frustration and/or failure. Children must also be recognized and acknowledged for their efforts. This gives them the incentive to contribute and reinforces their skillful performance.

The Search Institute's 40 Assets Model is grounded in research in youth development, resiliency and prevention. The developmental assets represent the relationships, opportunities and personal qualities that young people need to avoid risks and to thrive.

There is a relationship between the Social Developmental Model and the Developmental Assets. It has been characterized as unzipping the Social Development Model and you will find the 40 assets arrayed around protective factors. The two models work in harmony and are not diametrically opposed.

### **Healthy beliefs and clear standards**

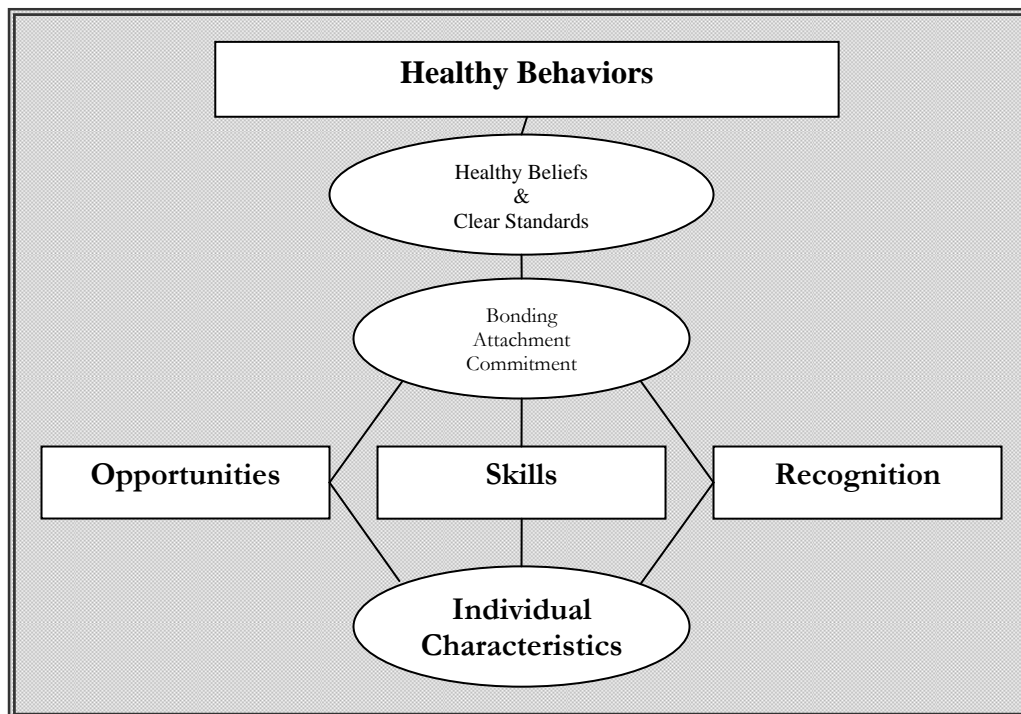
The people to whom youth are bonded need to have clear, positive standards for behavior. The content of these standards is what protects young people. When parents, teachers, and communities set clear standards for children's behavior, when they are widely and consistently supported, and when the consequences for not following the standards are consistent, young people are more likely to follow the standards.

## **S O C I A L   D E V E L O P M E N T   M O D E L**

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The figure below illustrates the dynamics of protective factors



## **What Does It Mean for Community Prevention Planning?**

All across our country, adults concerned about the healthy development of young people are searching for answers to the behavior problems of alcohol and other drug abuse, delinquency, violence, school dropout, and teen pregnancy. How do we step ahead of the problems with solutions which are far-reaching and lasting?

Research has shown there are a number of risk factors that increase the chances of adolescents developing health and behavior problems. Equally important is the evidence that certain protective factors can help shield youngsters from problems. If we can reduce risks while increasing protection throughout the course of young people's development, we can prevent these problems and promote healthy, pro-social growth.

The following is a summary of the research-based risk factors and the problem behaviors they predict (in parentheses).

### **COMMUNITY RISK FACTORS**

#### **Availability of Drugs** (Substance Abuse)

The more available drugs are in a community, the higher the risk that young people will abuse drugs in the community. Perceived availability of drugs is also associated with risk. In schools where children just think that drugs are more available, a higher rate of drug use occurs.

#### **Availability of Firearms** (Delinquency and Violence)

Firearm availability and firearm homicide have increased together since the late 1950s. If a gun is present in the home, it is much more likely to be used against a relative or friend than an intruder or stranger. Also, when a firearm is used in a crime or assault instead of another weapon or no weapon, the outcome is much more likely to be fatal. While a few studies report no association between firearm availability and violence, more studies show a positive relationship. Given the lethality of firearms, the increase in the likelihood of conflict escalating into homicide when guns are present and the strong association between availability of guns and homicide rates, firearm availability is included as a risk factor.

#### **Community laws and norms favorable toward drug use, firearms, and crime** (Substance Abuse, Delinquency and Violence)

Community norms - the attitudes and policies a community holds about drug use and crime - are communicated in a variety of ways: through laws and written policies,

through informal social practices, and through the expectations parents and other members of the community have of young people.

One example of the community law affecting drug use is the taxation of alcoholic beverages. Higher rates of taxation decrease the rate of alcohol use at every level of use.

When laws, tax rates, and community standards are favorable toward substance use or crime, or even if they are just unclear, children are at higher risk.

Another concern is conflicting messages about alcohol/other drugs from key social institutions. An example of conflicting messages about substance abuse can be found in the acceptance of alcohol use as a social activity within the community. The "Beer Gardens," popular at street fairs and community festivals frequented by young people, are in contrast to the "Just Say No" messages that schools and parents may be promoting. These conflicting messages make it difficult for children to decide which norms to follow.

Laws regulating the sale of firearms have had little effect on violent crime and those effects usually diminish after the law has been in effect for multiple years. In addition, laws regulating the penalties for violating licensing laws or using a firearm in the commission of a crime, have also been related to reduction in the amount of violent crime, especially involving firearms. A number of studies suggest the small and diminishing effect is due to two factors: the availability of firearms from other jurisdictions without legal prohibitions on sales or illegal access, and community norms which include lack of proactive monitoring or enforcement of the laws.

### **Media Portrayal of Violence** (Violence)

The effect of media violence on the behavior of viewers (especially young viewers) has been debated for over three decades. Research over that time period has shown a clear correlation between media violence and the development of aggressive and violent behavior. Exposure to media violence appears to impact children in several ways. First, children learn from watching actors model violent behavior, as well as learning violent problem-solving strategies. Second, media violence appears to alter children's attitudes and sensitivity to violence.

### **Transitions and Mobility** (Substance Abuse, Delinquency, and School Dropout Depression and Anxiety)

Even normal school transitions predict increases in problem behaviors. When children move from elementary school to middle school or from middle school to high school, significant increases in the rate of drug use, school misbehavior, and

delinquency result. When communities are characterized by frequent non-scheduled transition rates, there is an increase in problem behaviors.

Communities with high rates of mobility appear to be linked to an increased risk of drug and crime problems. The more often people in a community move, the greater the risk of both criminal behavior and drug-related problems in families. While some people find buffers against the negative effects of mobility by making connections in new communities, others are less likely to have the resources to deal with the effects of frequent moves and are more likely to have problems.

### **Low Neighborhood Attachment and Community Disorganization** (Substance Abuse, Delinquency, and Violence)

Higher rates of drug problems, juvenile delinquency, and violence occur in communities or neighborhoods where people have little attachment to the community, where the rates of vandalism are high, and where there is low surveillance of public places. These conditions are not limited to low income neighborhoods; they can also be found in wealthier neighborhoods.

The less homogeneous a community is in terms of race, class, and religion, the less connected its residents may feel to the overall community, and the more difficult it is to establish clear community goals and identity. The challenge of creating neighborhood attachment and organization is greater in these neighborhoods.

Perhaps the most significant issue affecting community attachment is whether residents feel they can make a difference in their lives.

If the key players in the neighborhood--such as merchants, teachers, police, human and social services personnel--live outside the neighborhood, residents' sense of commitment will be less. Lower rates of voter participation and parental involvement in schools also indicate lower attachment to the community.

### **Extreme Economic Deprivation** (Substance Abuse, Delinquency, Violence, Teen Pregnancy, and School Dropout)

Children who live in deteriorating and crime-ridden neighborhoods characterized by extreme poverty are more likely to develop problems with delinquency, teen pregnancy, school dropout, and violence. Children who live in these areas--and have behavior and adjustment problems early in life--are also more likely to have problems with drugs later on.

## **FAMILY RISK FACTORS**

### **Family History of the Problem Behavior** (Substance Abuse, Delinquency, Teen Pregnancy, School Dropout, and Depression and Anxiety)

If children are raised in a family with a history of addiction to alcohol or other drugs, the risk of having alcohol and other drug problems themselves increases. If children are born or raised in a family with a history of criminal activity, the risk of juvenile delinquency increases. Similarly, children who are raised by a teenage mother are more likely to be teen parents, and children of dropouts are more likely to drop out of school themselves.

**Family Management Problems** (Substance Abuse, Delinquency, Violence, Teen Pregnancy, School Dropout, Depression and Anxiety)

The risk factor has been shown to increase the risk of drug abuse, delinquency, teen pregnancy, school dropout, and violence. Poor family management practices include lack of clear expectations for behavior, failure of parents to monitor their children (knowing where they are and who they are with), and excessively severe or inconsistent punishment.

**Family Conflict** (Substance Abuse, Delinquency, Violence, Teen Pregnancy, School Dropout, Anxiety and Depression)

Persistent, serious conflict between primary caregivers or between caregivers and children appears to enhance risk for children raised in these families. Conflict between family members appears to be more important than family structure. Whether the family is headed by two biological parents, a single parent, or some other primary caregiver, children raised in families high in conflict appear to be at risk for all of the problem behaviors. For example, domestic violence in a family increases the likelihood that young people will engage in delinquent behaviors and substance abuse, as well as become pregnant or drop out of school.

**Parental Attitudes and Involvement in Drug Use, Crime, and Violence**  
(Substance Abuse, Violence and Delinquency)

Parental attitudes and behavior toward drugs, crime, and violence influence the attitudes and behavior of their children. Parental approval of young people's moderate drinking, even under parental supervision, increases the risk of the young person using marijuana. Similarly, children of parents who excuse their children for breaking the law are more likely to develop problems with juvenile delinquency. In families where parents display violent behavior towards those outside the family, there is an increase in the risk that a child will become violent.

Further, in families where parents involve children in their own drug or alcohol behavior - for example, asking the child to light the parent's cigarette or get the parent a beer from the refrigerator - there is an increased likelihood that their children will become drug abusers in adolescence.

## **SCHOOL RISK FACTORS**

**Academic Failure Beginning in Elementary School** (Substance Abuse, Delinquency, Violence, Teen Pregnancy, School Dropout, Depression and Anxiety)  
Beginning in the late elementary grades, academic failure increases the risk of drug abuse, delinquency, violence, pregnancy, and school dropout. Children fail for many reasons. It appears that the experience or failure--not necessarily ability--increases the risk of problem behaviors.

This is particularly troubling because, in many school districts, African American, Native American, and Hispanic students have disproportionately higher rates of academic failure compared to white students. Consequently, school improvement and reducing academic failure are particularly important prevention strategies for communities of color.

**Lack of Commitment to School** (Substance Abuse, Delinquency, Teen Pregnancy, and School Dropout)

Low commitment to school means the young person has ceased to see the role of student as a viable one. Young people who have lost this commitment to school are at higher risk for substance abuse, delinquency, teen pregnancy, and school dropout.

In many communities of color, education is seen as a "way out," similar to the way early immigrants viewed education. Other subgroups in the same community may view education and school as a form of negative acculturation. In essence, if you get education, you have "sold out" to the majority culture. Young people who adopt this view are likely to be at higher risk for health and problem behaviors.

## **INDIVIDUAL/PEER RISK FACTORS**

**Alienation/Rebelliousness** (Substance Abuse, Delinquency, and School Dropout)  
Young people, who feel they are not part of society, are not bound by rules, don't believe in trying to be successful or responsible, or who take an active rebellious stance toward society, are at higher risk of drug abuse, delinquency, and school dropout.

Alienation and rebelliousness may be an especially significant risk for young people of color. Children who are consistently discriminated against may respond by removing themselves from the dominant culture and rebelling against it. On the other hand, many communities of color are experiencing significant cultural change due to integration. The conflicting emotions about family and friends working, socializing or

marrying outside of the culture, may well interfere with a young person's development of a clear and positive racial identity.

**Early and Persistent Antisocial Behavior** (Substance Abuse, Delinquency, Violence, School Dropout, Teen Pregnancy, and Depression and Anxiety)

Boys who are aggressive in grades K-3 are at higher risk of substance abuse and juvenile delinquency. However, aggressive behavior very early in childhood does not appear to increase risk. When a boy's aggressive behavior in the early grades is combined with isolation or withdrawal, there is an even greater risk of problems in adolescence. This increased risk also applies to aggressive behavior combined with hyperactivity or attention deficit disorder.

This risk factor also includes persistent antisocial behavior in early adolescence, like misbehaving in school, skipping school, and getting into fights with other children. Young people, both girls and boys, who engage in these behaviors during early adolescence, are at increased risk for drug abuse, juvenile delinquency, violence, school dropout, and teen pregnancy.

**Friends Who Engage in the Problem Behavior** (Substance Abuse, Delinquency, Violence, Teen Pregnancy, and School Dropout)

Young people who associate with peers who engage in problem behavior - delinquency, substance abuse, violent activity, sexual activity, or school dropout - are much more likely to engage in the same problem behavior. This is one of the most consistent predictors that research has identified. Even when young people come from well-managed families and do not experience other risk factors, just hanging out with friends who engage in the problem behavior greatly increases the child's risk of that problem. However, young people who experience a low number of risk factors are less likely to associate with friends who are involved in the problem behavior.

**Favorable Attitudes Toward the Problem Behavior** (Substance Abuse, Delinquency, Teen Pregnancy, and School Dropout)

During the elementary school years, children usually express anti-drug, anti-crime, and pro-social attitudes. They have difficulty imagining why people use drugs, commit crimes, and drop out of school. However, in middle school, as others they know participate in such activities, their attitudes often shift toward greater acceptance of these behaviors. This acceptance places them at higher risk.

**Early Initiation of the Problem Behavior** (Substance Abuse, Delinquency, Violence, Teen Pregnancy, and School Dropout)

The earlier young people begin using drugs, committing crimes, engaging in violent activity, dropping out of school, and becoming sexually active, the greater the

likelihood that they will have problems with these behaviors later on. For example, research shows that young people who initiate drug use before the age of 15 are at twice the risk of having drug problems as those who wait until after the age of 19.

**Gang Involvement** (Substance Abuse, Delinquency, and Violence)

Research has shown that children who have delinquent friends are more likely to use alcohol or other drugs and to engage in delinquent or violent behavior than children who do not have delinquent friends. But the influence of gang involvement on alcohol and other drug use, delinquency and violence exceeds the influence of delinquent friends on these problem behaviors. Gang members are even more likely than children who have delinquent friends to use alcohol or other drugs and to engage in delinquent or violent behavior.

**Constitutional Factors** (Substance Abuse, Delinquency, and Violence) Constitutional factors are factors that may have a biological or physiological basis. These factors are often seen in young people with behaviors such as sensation-seeking, low harm-avoidance, and lack of impulse control. These factors appear to increase the risk of young people abusing drugs, engaging in delinquent behavior, and/or committing violent acts.

<i>Risk Factors for Adolescent Problem Behavior</i>	Substance Abuse	Delinquency	Teen Pregnancy	School Drop-Out	Violence	Depression & Anxiety
<b><i>Risk Factors</i></b>						
<b><i>Community</i></b>						
Availability of Drugs	√				√	
Availability of Firearms		√			√	
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	√	√			√	
Media Portrayals of Violence					√	
Transitions and Mobility	√	√		√	√	√
Low Neighborhood Attachment and Community Disorganization	√	√			√	
Extreme Economic Deprivation	√	√	√	√	√	
<b><i>Family</i></b>						
Family History of the Problem Behavior	√	√	√	√	√	√
Family Management Problems	√	√	√	√	√	√
Family Conflict	√	√	√	√	√	√
Favorable Parental Attitudes and Involvement in the Problem Behavior	√	√			√	
<b><i>School</i></b>						
Academic Failure Beginning in Late Elementary School	√	√	√	√	√	√
Lack of Commitment to School	√	√	√	√	√	
<b><i>Individual/Peer</i></b>						
Early and Persistent Antisocial Behavior	√	√	√	√	√	√
Rebelliousness	√	√		√	√	
Friends Who Engage in the Problem Behavior	√	√	√	√	√	
Gang Involvement	√	√			√	
Favorable Attitudes Toward the Problem Behavior	√	√	√	√	√	
Early Initiation of the Problem Behavior	√	√	√	√	√	
Constitutional Factors	√	√			√	√

<b><i>Risk and Protective Factors</i></b> <b><i>Validated Archival Indicators at county level only</i></b>	
<b><i>Archival Indicators</i></b>	<b><i>Community per capita data</i></b>
<b>Availability</b>	
Alcohol sales outlets	
Tobacco sales outlets	
<b>Transitions and Mobility</b>	
New home construction	
Households in rental properties	
Net migration	
Low Neighborhood Attachment/ Community Disorganization	
Population voting in elections	
Prisoners in state and local correctional systems	
<b>Extreme Economic Deprivation</b>	
Unemployment	
Free and reduced lunch program	
Aid to families with dependent children	
Food stamp recipients	
Adults without high school diploma	
Single-parent family households	
Family history of substance abuse	
Teen Pregnancy	
<b>Family In cohesion</b>	
Children living away from parents	
Children living in foster care	
<b>Family Conflict</b>	
Divorces	
Domestic Violence arrests	
<b>Parental Involvement in substance use/crime</b>	
<b>Low commitment to school</b>	
Drop outs	
School Age not enrolled	
<b>Early and Persistent Antisocial Behavior</b>	
Substance Abuse	
Delinquency	
Violence	
<b>Academic Failures</b>	
Alienation/rebelliousness	
Friends who engage in risk behavior	

<i>Protective Factors</i>	<i>Survey Data</i>
Family Attachment	
Family Opportunities for pro-social behavior	
Family rewards for pro-social involvement	
Community pro-social involvement	
Community rewards pro-social involvement	
School Opportunities for pro-social	
School Rewards	
Religiosity	
Social skills	
Belief in The Moral Order	
<b><i>Community Laws and Norms (not validated)</i></b>	

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## COMMUNITY ASSESSMENT

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A key activity for a community tribe and county is to routinely assess the levels of risk and protective factors by using the most reliable methods possible. This allows a community, tribe or county to use data to drive decision rather than hunches or subjective opinion and to set priorities for the community and county. The most reliable and valid method for assessing risk and protective factors is survey students with an instrument that has been specifically designed for that purpose. Ideally the survey will be administered to students prior to the typical age of initiation of use of alcohol, tobacco and other drugs. This usually is around the 6<sup>th</sup> grade. To establish trends and a picture of the progression of risk and protective factors it is recommended that the survey be administered in the 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup> and if possible 12<sup>th</sup> grades. Since the survey is a population based survey verses and individual survey, there is no need to administer the survey annually. It is recommended that the survey be administered every other year.

In 1994, as part of the University of Washington seven state diffusion project, AMH administered the Communities That Care Youth Survey (CTCYS) to 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> graders. In 2000 the decision was made to combine the CDC Youth Risk Behavior Survey and the CTC survey and to administer it in the 8<sup>th</sup> and 11<sup>th</sup> grades.

Since the merged survey was too large for students to complete, the survey had to be administered every year. The findings ‘rolled up’ into a report for the biennia. Unfortunately the level of sensitivity in measuring the risk and protective factors was lost. In 2009 AMH initiated a revision to the Oregon Healthy Teens survey by infusing an increased number of items that measured the risk and protective factors, expanded the number of schools who administered the survey and would be administered on even number years. The revised OHT will be referred to as the OHT – R&P Survey. The OHT from Public Health, the YRBS, will be administered on the odd years.

In the absence of a student survey, communities and counties can utilize archival data. Archival data is only reliable and valid at the county level and can not be disaggregated to the community level. Archival data measures only nine of the risk factors and none of the protective factors whereas the OHT – R&P will measure twenty-three risk and protective factors.

The following links may be useful.

Oregon Healthy Teens Data

<http://www.dhs.state.or.us/dhs/ph/chs/youthsurvey/ohtdata.shtml>

Region Specific Data

<http://www.oregon.gov/DHS/addiction/ad/main.shtml>

Mortality

<http://www.oregon.gov/DHS/addiction/ad/mortality-alc-drugs-overview.pdf>

Alcohol Cigarette and Marijuana use

<http://www.oregon.gov/DHS/addiction/ad/youth-overview.pdf>

Center for Health Statistics Adult Survey

<http://www.dhs.state.or.us/dhs/ph/chs/brfs/07/brfsqu07.shtml>

Center for Health Statistics, Vital Health

<http://www.dhs.state.or.us/dhs/ph/chs/data/ytd/ytd.shtml>

# DATA ANALYSIS, SETTING PRIORITIES, TARGETING

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## Data Analysis

After data has been collected through archival or survey means, analysis begins.

- At glance, what stands out? Highs? Lows? Lack of data?
- How does this data compare? Are there trends? How does data compare with other communities at the local, state or national level?
- Are there correlations?
- Are there relationships between risk factors and incidents and prevalence?
- Does additional data need to be determined?

## Prioritizing

After analyzing data, determine which risk and protective factors will be addressed.

Are there risk and protective factors which have no data indicators?

- If no, collect data.
- Which are the prevalent risk factors?
- Which protective factors should be addressed?
- Limit the task to 3 risk and protective factors?

What are other community resources doing to address the identified risk and protective factors? Is it effective? Is the program involving youth? Can the program be improved?

## Targeting Populations

Determine the population that will be addressed

- Universal (Entire population)
- Selective (At risk population)
- Indicative (showing early danger signs of substance abuse)

## PREVENTION STRATEGIES AND PRINCIPLES

### CSAP PREVENTION STRATEGIES:

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1. Information dissemination-This step provides knowledge and increases awareness of the problem and its effects in your community. This strategy is often a one-way communication from the source to the audience with little interaction. [Note: Information dissemination alone has not been shown to be effective at preventing substance abuse.]  
**Ideas: brochures, posters, handouts, or lectures**
2. Education-Builds skills through a structured learning process. Facilitators and participants focus on decision-making and resistance skills, coping with stress, problem solving, and interpersonal communication. [Note: Alternative activities alone have not been shown to be effective at preventing substance abuse.]  
**Ideas: role-playing, goal setting, skits and plays, or games, Parenting programs such as Strengthening Families Program.**
3. Alternatives-Provides an opportunity to engage in activities other than drinking alcohol and other drugs.  
**Ideas: after-school sports, art or language classes held at a church or other community center, boys and girls clubs or groups, volunteer opportunities such as visiting an assisted living center**
4. Problem identification and referral- In this step we can work to reverse behavior by applying some of the awareness, alternatives, and skill building tools discussed above.  
**Ideas: Tobacco Quit**
5. Community-based efforts-This strategy helps communities at-large identify where there may be a gap in needs AND where there are community strengths such as existing programs or activities. This strategy is critical in helping with prevention efforts because it helps develop grass-roots involvement in capacity building efforts and includes all community members.  
**Ideas: forming coalitions or task forces with members from churches or community groups, school board members, membership clubs (Zonta, Knights of Columbus, etc.)**
6. Environmental- This strategy helps communities identify existing laws, attitudes, or social norms around substance abuse and either enforce, or work at changing them.

## PREVENTION PRINCIPLES:

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1. **Evidence-based practices**-These are programs and activities that scientific study has shown to produce predictable outcomes under certain conditions. These programs should be used whenever possible, however, when innovative programs are needed, they should be informed by scientific research, theory, and evaluation.
2. **Accountability**-Programs will be responsible to and respectful of the community at large by building trust and forwarding the public mission. Programs will be community-based and involve community members at all phases of development, including providing information in a format accessible by general populations\*.
3. **Data-based planning and programming**- Collecting data and using data to inform policies and programs is a form of accountability. It should drive planning, allocation of funds, and decision-making at all levels. The evaluation, collection and distribution of consistent data are a foundation of the public health practice.
4. **Collaboration**-Federal, state, and local stakeholders must work together to achieve shared outcomes. In addition, practices will encourage opportunities for all cultures, races, genders, and special needs individuals to participate in all phases of program development.
5. **Capacity building and support**-The state will provide an outlet for training, technical assistance, and other prevention resources according to the level available.
6. **Equitable resource distribution**-Funding and resources will be equitably distributed.

These principles should guide program development and help inform prevention strategies. Promoting diversity and engaging all cultures, races, socioeconomic classes, genders, and special needs individuals is essential in developing effective prevention efforts.

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## **EFFECTIVE APPROACHES TO SUBSTANCE ABUSE PREVENTION**

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The goal of alcohol and drug abuse prevention is to make a positive impact on individual, family, and community behavior. The existing prevention knowledge base, founded on research and principles of effectiveness, should guide prevention strategies applied by agencies and communities to address this issue.

The prevention field has learned from past mistakes. Over the years, well-intended strategies have been applied and proven to have no positive impact on reducing drug use and abuse (e.g., scared straight, fear arousal, moral approaches and one time assemblies) programs that focused on building self-esteem. It must be ensured that strategies implemented have the greatest potential to prevent and impact this destructive behavior pattern. Strategies most likely to have a positive impact on behavior change are well known and documented in the research.

Evidence-based prevention practices are those that research has proved effective. DHS is adopting proven practices in addictions and mental health services. The Oregon Legislature directed DHS and four other state agencies to spend increasing shares of public dollars on evidence-based services, culminating in 75 percent by the 2009-11 budget period. Approved practices, which have undergone independent review, can be found on the following web site.

<http://www.oregon.gov/DHS/mentalhealth/ebp/sb267summary.pdf>

AMH does not believe that an evidence-based practice from AMH list should be assumed to be better than culturally validated practice unless the assumption is supported by scientific evidence. Because scientific evidence for imposing practices on native American providers is lacking, AMH concludes that we need a different framework. A Tribal Native American Stakeholder best practice work group was formed. This group did create a Tribal Best Practice validation process. These practices will soon be posted on the Evidence Based Practice web site above along with a procedure for submitting practices for review.

One way to implement prevention strategies in schools is through comprehensive school health education. Effective health education curricula employs practices that are grounded in research and focus on skill development such as accessing information (quit lines, how to help a friend), advocacy (advocating for your own health and the health of others), analyzing influences (positive and negative influences

of media, peers, family, self) and interpersonal communication skills (refusal skills, negotiation skills).

**STRATEGIES THAT HAVE THE BEST  
OPPORTUNITY FOR POSITIVE BEHAVIOR  
CHANGE IN ALCOHOL, TOBACCO AND OTHER  
DRUG USE PREVENTION PROGRAMS  
(DRUGSTRATEGIES.ORG: MAKING THE GRADE)**

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1. Help students recognize internal pressures such as wanting to belong to the group and external pressures like peer attitudes and advertising that influence them to use alcohol, tobacco and other drugs.
2. Facilitate development of personal, social and refusal skills to resist these pressures.
3. Teach youth that using alcohol, tobacco and other drugs is not the norm among teenagers, thereby correcting the misconception that "everyone is doing it" and promoting positive norms through constructive role models.
4. Provide developmentally appropriate material and activities including information about the short-term effects and long-term consequences of alcohol, tobacco and other drugs.
5. Use interactive teaching techniques, such as role-plays, discussions, brainstorming and cooperative learning.
6. Cover necessary prevention elements in at least eight well-designed sessions a year (with a minimum of three to five booster sessions in one or more succeeding years).
7. Actively involve the family and the community so that prevention strategies are reinforced across settings.
8. Include teacher training and support in order to assure that curricula are delivered as intended.
9. Provide material that is easy for teachers to implement and culturally relevant for students.

## PREVENTION PRINCIPLES FOR CHILDREN AND ADOLESCENTS

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These principles can be applied to either existing programs or for designing innovative programs.

- Prevention programs should be designed to enhance protective factors and decrease or address risk factors.
- Prevention programs should target all forms of drug abuse, including the use of tobacco, alcohol, marijuana and inhalants.
- Prevention programs should include skills to resist drugs when offered, strengthen personal commitments against drug use and increase social competency (e.g., in communications, peer relationships, self-efficacy and assertiveness), in conjunction with reinforcement of attitudes against drug use.
- Prevention programs for adolescents should include interactive methods, such as peer discussion groups, rather than didactic teaching techniques alone.
- Prevention programs should include a parent or caregiver component that reinforces what the children are learning -- such as facts about drugs and their harmful effects -- and that opens opportunities for family discussions about use of legal and illegal substances and family policies about their use.
- Prevention programs should be long-term, over the school career with repeat interventions to reinforce the original prevention goals. For example, school-based efforts directed at elementary and middle school students should include booster sessions to help with critical transitions from middle to high school.
- Family-focused prevention efforts have a greater impact than strategies that focus on parents only or children only.
- Community programs that include media campaigns and policy changes, such as new regulations that restrict access to alcohol, tobacco, or other drugs, are more effective when accompanied by school and family interventions.
- Community programs need to strengthen norms against drug use in all drug abuse prevention settings, including the family, the school, and the community.
- Schools offer opportunities to reach all populations and also serve as important settings for specific subpopulations at risk for drug abuse, such as children with behavior problems or learning disabilities and those who are potential dropouts.
- Prevention programming should be adapted to address the specific nature of the drug abuse problem in the local community.

- The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.
- Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive.
- Effective prevention programs are cost-effective. Every dollar spent on prevention, can save 4 to 5 dollars in costs for treatment and counseling.

*(Excerpt from "Preventing Drug Use Among Children and Adolescents: A Research-Based Guide" by the National Institute for Drug Abuse, 1997, p. i-ii)*

## Prevention Site Review Protocol

*This chapter will explain letters of approval and outline the prevention site review protocol.*

In order to operate a substance abuse prevention program that is funded by the State of Oregon, a Letter of Approval is required.

**Agency Approval/Certificate:** An agency may operate a substance abuse prevention program and may request a Letter of Approval from the Division after review and comment by the community mental health authority and the local alcoholism planning committee or appropriate drug abuse planning committee. Funding from the Division may only occur with an agency approved by the Division. A federally recognized Tribal entity may operate a substance abuse prevention program and may request Letter of Approval from the Division after review and comment by their tribal authority.

To maintain standards, the AMH Policy and Program Development Unit monitors the state expenditures and offers support and technical assistance to further prevention efforts and issues Letters of Agreement or LOAs. This site review protocol is intended to help funded programs prepare for the site review as well allow AMH staff the opportunity to review your program before they arrive. Please complete the following information and return it to AMH at least one week before your scheduled site review. The site review protocol that each coordinator is required to complete is available on-line.

<http://www.oregon.gov/DHS/addiction/prev-manual/site-review-protocol.pdf>

Please feel free to extract information from your agency's annual report or implementation plan to complete this form. The first document compiles information about your program to ensure that it meets a standard. The second document will be completed by reviewers after the site review has taken place.

## Prevention Site Review Protocol

This site review protocol is intended to help funded programs prepare for the site review and allow AMH staff the opportunity to review your program before they arrive. Please complete the following information and return it to AMH at least one week before your scheduled site review. Please feel free to extract information from your annual report or implementation plan to help complete this form.

PART A: Agency and Program Information			
<i>Administrative information about your agency and AMH-funded programs.</i>			
1.	Period Covered by this Site Review: ____/____/____ to ____/____/____	Date(s) of Site Review: ____/____/____ to ____/____/____	
2.	Agency (Legal name and address of organization):		Program ID Number:
	FEIN:	Funding Amount this biennium:	\$
3.	Communities Served Under this Program (write in):		
4.	Name of Person Completing this Form:		Title of Person Completing this Form:
	Agency of Person Completing this Form:	Telephone Number:	Fax Number:

	Address of Person Completing this Form:	E-Mail Address (of person completing this form)	
5.	Name of Fiscal Agent Contact Person:	Telephone Number:	Fax Number:
	Fiscal Agency:	E-Mail Address (of fiscal agency contact):	
6.	Date form Completed ____/____/____		

## PART B: Agency Capacity and Project Administration

The information requested in this section addresses your agency's operational structure and resources. It will be used to assess your agency's ability and readiness to implement the funded program(s).

### WRITTEN POLICIES AND PROCEDURES

1. **Indicate whether your agency has each of the following. Be prepared to share or discuss anything marked "Yes" with your AMH Site Reviewer.** (*Check one box on each line*).

Does the agency have...?	<u>Yes</u> (Formal/Written)	<u>Yes</u> (Informal)	<u>No</u>
Prevention framework to guide efforts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current mission/vision/values statement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Organizational
management chart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-discrimination policy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural competency plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policy for addressing gender specific services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### STAFFING

2. **Indicate whether your agency has each of the following. Be prepared to share or discuss anything marked "Yes" with your AMH Site reviewer.** (*Check one box on each line*).

Does the agency have...?	<b><u>Yes</u></b> (Formal/Written)	<b><u>Yes</u></b> (Informal)	<b><u>No</u></b>
Current and accurate job descriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff orientation process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional training and development plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff certification plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff recruitment and retention policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. **How many adult staff are employed by your agency in total AND on the project(s) funded by AMH under review during this site review? Please answer *both* in terms of the actual number of staff members as well as the number of full-time employees (FTE's) that they represent. For example, if you have 4 full-time staff members and 3 half-time staff, you have 7 staff members representing 5.5 FTE staff. (write in answers to all items)**

- a) **All Agency Staff** (including AMH-funded project and administrative staff):
- b) **AMH-Funded Project Staff Only:**            *Number of staff members equivalent to FTE.*
- c) **Number of Volunteers** assigned to the AMH-funded projects:
- d) **Total Volunteer Hours Per Week** (if applicable):

4. **In the table below, list all staff members on the project(s) funded by AMH under review during this site review. Provide (1) each individual's name, (2) their project position, (3) the number of hours that they work per week on this project, (4) their project responsibilities, and (5) a description of any other work that they do for your agency. Attach another sheet or continue on the back if you need more room.**

Name	Project Position	Project Hours Per Week	Project Responsibilities	Other Agency Work

5. **Have there been any changes, additions, or vacancies during the period covered by this site review in staffing on the AMH-funded project(s)? (check one)**

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Yes       No

**If “Yes”, describe the staff changes/additions/vacancies, the reason for these conditions, and the way in which your agency handled or plan to handle these conditions.**

## REFERRAL AND ANCILLARY SERVICES

6. **Check the appropriate box for the type of services your agency provides. (check all that apply)**

Universal       Selective       Indicated       Other: \_\_\_\_\_

7. **What, if any, other similar prevention programs does your agency have and what are the funding sources?**

SOURCE	FOCUS/OBJECTIVES
FEDERAL	
STATE	

8. **Describe your agency’s referral processes. Please include information about processes used *both* for referring clients into your programs and out of your agency for services not provided by your agency.**

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9. **List the agencies with which your AMH-funded project has formal or informal collaborative agreements (e.g., agreements to share resources, refer clients, etc.).** List the names of the agencies and provide a brief description of the agreement and any results of these collaborations. A *formal* agreement is written and sanctioned by your agency leadership. An *informal* agreement is understood by both agencies but not formalized. *Please attach another sheet if you need more room.*

Type of Collaborating Agency	Names of Agencies	Description of Agreement and Results of Collaboration
Business Community		
Faith Community (e.g., Clergy)		
Grassroots Community Organizations (e.g., Neighborhood Associations)		
Health Care Sector (e.g., Physicians, Hospitals)		
Law Enforcement		
Local Government (e.g., Town or City Government)		
Local Media (e.g., Newspaper, Radio, TV)		
Non-Governmental Health/Social Service Providers (e.g., Family Services)		
Schools		
Volunteer Service Organizations (e.g., Lions Club, Rotary)		
Youth Services Agencies (e.g., YMCA, Boys/Girls Club)		

## RECORD KEEPING AND FILE VERIFICATION

10. **Indicate whether your agency has up-to-date, *formal/written* records of each of the following for the AMH-funded project(s) under review during this site review. Be prepared to share anything marked “Yes” with your AMH Site Reviewer. Provide explanation for anything marked “Not Applicable.”** (*check one box on each line*)

Do you have formal/written records of...?	Yes	No	Not Applicable	If “Not Applicable,” explain why:
Insurance and legal forms pertinent to the program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Agreements with subcontractors for professional services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Agreements with other agencies/organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Program activities/interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Program meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Program curricula materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Program participants (number, demographics, participation level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Program publicity/media coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Evaluation plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Evaluation activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Study participant consent forms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Institutional Review Board (IRB) proceedings (review to guarantee protection of human subjects)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Background checks/clearances for staff and/or volunteers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## PART C: Project Information

### EVALUATION

11. **Who is primarily responsible for the evaluation of your project (i.e., tracking its progress)?**
- Project Staff Person (write in name) \_\_\_\_\_
- Contracted Evaluator (write in name) \_\_\_\_\_
- Other (write in name) \_\_\_\_\_
- No Evaluator/Evaluation (please explain) \_\_\_\_\_
12. **Briefly describe how you are tracking the progress and impact of your project(s). Include a description of your (a) process evaluation activities (is the project implemented as planned – description of materials and activities) and (b) outcome evaluation activities (what impact does the project have – assessment of achievements and effects).**
- a) **How are you tracking your process evaluation activities?** (Examples of process evaluation activities include tracking the number of program participants or number of people served, tracking whether program sessions are implemented as planned, keeping formal records of meetings, etc.)
- b) **How are you tracking your outcome evaluation activities?** (Examples of outcome evaluation activities include tracking changes in participant knowledge and attitudes as a result of the program, assessing improvement in quality of services as a result of the program, etc.)
13. **Identify any evaluation instruments you have utilized during the period covered by this site review: (1) describe the instrument; (2) describe what it is intended to measure; and (3) explain how and when it was administered during this reporting period. Be prepared to share these instruments during the site review. See the sample below for guidance.**

Description of Instrument	Intended to Measure	How and When Utilized
Middle school student	Health knowledge,	Administered to all public middle school

survey	attitudes, and behaviors	students at the beginning and end of the school year.

## SUSTAINABILITY

14. Identify any additional resources that you have obtained to enhance your AMH-funded projects (check one box on each line)

	Yes	No	→ If “Yes” explain funding obtained
<b>Grants</b> Short term, specific initiatives, federal or state government, foundation	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Gifts</b> Restricted or Unrestricted	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Membership</b> Fees	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Underwriting/Sponsorship</b> Businesses, Chambers of Commerce, rotary Clubs, Masons, Animal Clubs (Elks, Lions, etc.) may sponsor or underwrite specific programs & services	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Events</b> Fundraising activities and awareness events	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Fee-for-Service</b> Sliding scales dependent upon income	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Sale of Products or Services</b> Products (t-shirts, stickers, cook books, etc.) sold to support programs and services	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Non-Profit Business Affiliate</b> A for-profit business created separate from 501(c)(3) and profit supporting programs and services	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Bequests</b> Money willed to a group	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Endowment Funds</b> Donated funds, may be restricted or unrestricted	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Awards</b> Party applies to competition and receives funding	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Special Taxes</b> Taxes set aside to support a particular program	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Program of Government</b>	<input type="checkbox"/>	<input type="checkbox"/>	

Local government subsidizes program activities, police department, town funds, Community Development Block Grants			
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**15. Describe your plans for continuing the work (e.g., what program components will remain). Please describe any efforts you have made or will make to institutionalize your program in the community.**

**PART D: Project Successes, Challenges, and Changes**  
 Your experiences in implementing your project.

**16. Describe the significant project successes or accomplishments during the period covered by this site review *and* any efforts that you made to promote these successes within your community to potential funders, etc. (e.g., media coverage). This includes successes/accomplishments related to program implementation, evaluation, staffing, or other issues.**

**17. Describe the significant challenges to your project that you encountered during the period covered by this site review *and* how you addressed these issues. This includes challenges related to program implementation, evaluation, staffing, or other issues.**

**18. Describe any significant changes made to your project during the period covered by this site review. This includes changes related to program implementation, evaluation, or other issues.**

Implementation Changes

Evaluation Changes

Other Changes

### **PART E: Technical Assistance Needs**

Assistance that AMH can provide to assist your project.

19. In terms of project management, what technical assistance needs (if any) does your project have? This may include assistance with fiscal or administrative issues such as record keeping, staff management, policies and procedures development, etc.
20. In terms of project implementation, what technical assistance needs (if any) does your project have? This may include assistance with strategic planning, staff training, recruitment, etc.
21. In terms of evaluation, what technical assistance needs (if any) does your project have? This may include assistance in locating an evaluator, conducting needs assessments, reporting data, MDS reporting, etc.
22. What (if any) other technical assistance needs does your project have?

### **PART F: Additional Information for AMH**

23. Is there anything else that you would like to share with AMH or discuss during the upcoming site review?

### **PART G: Records Review**

**Be prepared to share the following materials with AMH during the site review.** *(You do not have to fill in any information in this section.)*

1. **AMH-funded project materials**
    - a) Curricula materials (e.g., manuals, videos).
-

- b) Evaluation instruments (e.g., surveys, and interview questions, curriculum fidelity checklists).
- c) Evaluation reports (e.g., report on results from a student survey, needs assessment summary).
- d) Other supporting materials (e.g., tracking of project participants, description of program components).

**2. Agency materials identified in “Part B: Agency Capacity and Administrative Project Management”**

- a) *Written Policies and Procedures* – Prevention framework to guide efforts; Current mission/vision/values statement; Organizational management chart; Anti-discrimination policy.
- b) *Staffing Materials* – Current and accurate job descriptions; Staff orientation process; Professional training and development plans; Staff certification plans.
- c) *Record Keeping and File Verification* – Insurance and legal forms pertinent to the program; Agreements with subcontractors for professional services; Agreements with other provider agencies; Program activities/interventions; Program meetings; Program curricula materials; Program participants (number, description, participation); Program publicity/media coverage; Evaluation plan; Evaluation activities; Study participant consent forms; Institutional Review board (IRB) proceedings; Police clearances for staff and/or volunteers

**Thank you for completing this information.**

**Please return your completed for to AMH *at least one week prior* to your site review.**

# Site Review Protocol (completed by site reviewers)

<b>Program:</b> _____		<b>County:</b> _____			
<b>Evaluated by:</b> _____		<b>Date:</b> _____			
	<b>Exceeds</b>	<b>Compliant</b>	<b>Non-Compliant</b>	<b>N/A</b>	<b>FINDINGS</b>
<b><u>OAR 514 -56-010 General requirements</u></b>					
<b>Agency Approval</b>					
(1) Prevention Plan submitted for review & comment to the Mental Health Director and the local alcohol & drug abuse planning committee					
<b>Printed Materials</b>					
1) Agency staff have established and maintained materials appropriate and pertinent to the program.					
2) Materials utilized are culturally relevant to the demographics of the area.					
3) Materials are reviewed by an external advisory group on a biennial basis.					
	<b>Exceeds</b>	<b>Compliant</b>	<b>Non-Compliant</b>	<b>N/A</b>	<b>FINDINGS</b>
<b><u>Program Reporting</u></b>					
1) The program has provided regular reports as required by AMH on standardized forms.					
2) All reporting is done in accordance with federal					

Confidentiality Regulations (42 CFR Part 2).

**Physical Environment**

1) When appropriate programs are provided in facilities which ensure the privacy of the participants.

**OAR 415-56-015 Letter of Approval**

1) The program meets the relevant standards set forth in OAR 309-14-000 through 309-14-040 General Administrative Standards (except 309-14-030, fee policy & quality assurance).

**Program Planning & Development**

1) The program has conducted a thorough community needs assessment which clearly identifies target population and resources.

2) Program utilizes risk/protective framework, Institute of Medicine model, and Science based practices for program planning and development.

	Exceeds	Compliant	Non-Compliant	N/A	<b>FINDINGS</b>
--	---------	-----------	---------------	-----	-----------------

3) Program uses a collaborative planning process with other prevention efforts e.g. community coalitions, Commission on Families & Children, schools, churches etc.

4). Plan includes philosophy of program, basis for strategies implemented, including research support, and complete description of program activities.

**Evaluation**

1) Program has developed outcome measurements for each prevention strategy that define and measure process, educational, attitudinal, and behavioral objectives.

2) Program reports evaluation outcomes on standardized AMH forms.

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<p><b><u>OAR 415-56-020 Administration</u></b></p> <p>1) The program Director is qualified by virtue of knowledge, training, experience, and skills to manage the program.</p> <p>2) program has a written referral policy and process to refer individuals not appropriate for the agency services or needing additional services. These include: a. Written affiliation agreements with community referral sources.</p>					
	Exceeds	Compliant	Non-Compliant	N/A	FINDINGS
3) Staff of the program show evidence concerning coordination with other related community agencies.					
4) Staff of the program have written procedures for referral to emergency and crisis services.					
5) Staff of the program have written policies and procedures defining who is eligible to participate.					
6) If appropriate, a fee schedule is established basing fees on the participant's ability to pay.					
<p><b>Staff requirements</b></p> <p>1) Accountability for the management and quality of service reside with the program director.</p>					
2) Supervision and consultation related to their skill level are available to all staff.					
3) Staff demonstrate competency in prevention through a combination of experience & training.					
4) Roles, functions, competencies and skills required by staff are set forth in position descriptions.					
5) The size and responsibilities of the staff shall be sufficient to provide the services.					

# APPENDIX A AMH ASSIGNMENTS

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## State Prevention Specialist Tribal/County Assignments

<b>Caroline</b>		<b>Jeff</b>		<b>Jill</b>	
APACSA		Benton		Coos	
Baker		Clackamas		Curry	
Burns Paiute		Clatsop		Douglas	
CLUSI Tribe		Columbia		Gilliam	
Coquille Tribe		Grant		Hood River	
Cow Creek		Harney		Jackson	
Crook		Lake		Josephine	
Deschutes		Lincoln		Lane	
Grand Ronde		Linn		Morrow	
Jefferson		Malheur		Multnomah	
Klamath County		Marion		Wasco	
Klamath Tribe		Polk		Washington	
Siletz Tribe		Sherman		Wheeler	
Umatilla County		Tillamook		Yamhill	
Umatilla Tribe		Oregon Nurses Association			
Union		Associated Oregon Industries			
Wallowa					
Warm Springs					
<b>Total Contracts</b>		<b>Total Contracts</b>		<b>Total Contracts</b>	
18		15		14	
<b>Rick Cady</b>					
Oregon Partnership					

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**APPENDICES B - E**

**OREGON ADMINISTRATIVE RULES**



# APPENDIX B

Department Of Human Services, Addiction Services

## Division 56

### Standards For Approval Of Substance Abuse Prevention Programs

#### 415-056-0000

##### Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for operating substance abuse prevention agencies approved by the Division. These rules establish standards for community substance abuse prevention and provide that a full continuum of substance abuse prevention services be available to Oregonians either directly or through written agreements or contracts.

(2) Statutory Authority. These rules are authorized by [ORS 409.410](#) and carry out the provisions of [ORS 430.240](#) through 430.415.

Stat. Auth.: [ORS 409.410](#)

Stats. Implemented: [ORS 430.240](#) - [ORS 430.415](#)

#### 415-056-0005

##### Definitions

Definitions. As used in these rules:

(1) "Assistant Director" means the Assistant Director, Addictions and Mental Health Division of the Department of Human Services.

(2) "Agency" means any organization, association, or federally recognized tribal entity that undertakes to establish and operate an Alcohol and/or Substance Abuse Prevention Program. Agency does not include individuals or community coalitions that implement substance abuse prevention services or strategies.

(3) "Approval/Certificate" means the Letter of Approval issued by the Division to indicate that the substance abuse prevention agency has been found to be in compliance with all relevant administrative rules.

(4) "Cultural Competence" Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

(5) "Evidenced-Based Practices" (EBP) are practices for which there is consistent scientific evidence that they produce positive outcomes. An EBP meets the following criteria:

- (a) Has been studied, using appropriate scientific methodology;
  - (b) Has been replicated in more than one geographic or practice setting, with consistent results;
  - (c) Has been recognized in scientific journals by one or more published articles;
  - (d) Documents standards that outline the parameters of the practice or strategy; and
  - (e) Produces specific outcomes.
-

(6) "Gender-Specific Services" comprehensively address the needs of a gender group and foster positive gender identity development. They intentionally allow gender to affect and guide the services that are responsive to the unique developmental issues and needs of the females and males receiving them.

(7) "Minority" means a participant who's cultural, ethnic, or racial characteristics constitute a distinct demographic population living within a larger society, including, but not limited to members of differing cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, or sexual orientations.

(8) "Minority Program" means a program that is designed to meet the unique prevention needs of a minority group and that provides services to persons belonging to a minority population as defined in these rules.

(9) "Division" means the Addictions and Mental Health Division of the Department of Human Services.

(10) Institute of Medicine Model: This framework defines the types of activities and target groups addressed by various prevention efforts:

(a) Universal Prevention:

Universal strategies address the entire population with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco and other drugs.

(b) Selective Prevention:

Selective prevention strategies target subsets of the total population that are deemed to be at-risk for substance abuse by virtue of the membership in a particular population segment.

(c) Indicated Prevention:

Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet criteria for addiction but who are showing early danger signs.

(11) "Local Alcoholism Planning Committee" means a committee appointed or designated by a board of county commissioners. The committee identifies needs and establishes priorities for substance abuse prevention, treatment, and recovery services in the county. Members of the committee must be representative of the geographic area and include a number of minority members to reasonably reflect the proportion of need for minority services in the community.

(12) "Participant" means a person receiving services under these rules.

(13) "Population-based Prevention Program" means a program consisting of planned activities designed to impact individuals and/or groups of any age with a potential for developing alcohol and/or other drug-related problems but who have not yet developed significant problems. Such strategies inhibit or delay the onset of problems related to an individual's use of alcohol and other drugs.

(14) "Prevention Service" means an integrated combination of strategies designed to prevent substance abuse and associated effects regardless of the age of participants.

(15) "Strategy" means activities targeted to a specific population or the larger community that are designed to be implemented before the onset of problems as a means to prevent substance abuse or detrimental effects from occurring.

(a) The six primary prevention strategies are defined below:

(A) Information Dissemination – This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals,

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families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

- (B) Education – This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.
- (C) Alternatives – This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities, and to discourage the use of alcohol and drugs through these activities.
- (D) Problem Identification and Referral – This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education.
- (E) Community – Based Processes – This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based or industry led, grassroots, empowerment models using action planning and collaborative systems planning.
- (F) Environmental – This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

Stat. Auth.: [ORS 409.410](#)

Stats. Implemented: [ORS 430.240](#) - [ORS 430.415](#)

#### **415-056-0010**

##### **Administrative Requirements for Prevention Providers.**

(1) Administrative Rules: A prevention agency that contracts directly or indirectly with the Division must comply with the contracting rules of the Division, including, but not limited to:

- (a) OAR 309-013-0120 to 309-013-0220 (Audit Guidelines);
- (b) OAR 309-013-0075 to 13-0105 (Fraud and Embezzlement);
- (c) OAR 309-014-0000 to 14-0040 (Administrative Standards);

(2) Policies and Procedures: A prevention agency must establish comprehensive written policies and procedures stating that services will be available and accessible and that no person will be denied service or discriminated against on the basis of sex, race, color, creed, sexual orientation, disability, or age in compliance with local, state and federal laws. Written policies and procedures must describe agency operations and compliance with these rules, including but not limited to:

- (a) Prevention framework to guide efforts
- (b) Current mission/vision/values statement
- (c) Organizational management chart
- (d) Anti-discrimination policy
- (e) Cultural competency plan
- (f) Policy for addressing gender specific services
- (g) Use of substances by program participants
- (h) Protection and safety of service recipients

(3) Monitoring of Sub-Contractors: If the Agency sub-contracts prevention services, it will ensure compliance with all administrative requirements referenced in these rules.

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(4) Agency Approval/Certificate. An agency may operate a substance abuse prevention program and may request a Letter of Approval from the Division after review and comment by the community mental health authority and the local alcoholism planning committee or appropriate drug abuse planning committee. Funding from the Division may only occur with an agency approved by the Division. A federally recognized Tribal entity may operate a substance abuse prevention program and may request a Letter of Approval from the Division after review and comment by their tribal authority.

(5) Standards for Evidenced-Based Practices. As is appropriate, prevention providers must implement programs and provide services that incorporate Evidence Based Practices, as defined in OAR 415-056-0005.

(6) Printed Materials. The agency must establish and maintain materials pertaining to the program. Materials developed for participants must be in the participants' native language. The agency personnel must demonstrate the relevancy of materials transmitted to participants. The agency must consider materials utilized for cultural relevancy and demographic or professional background of participants. Materials must reflect current substance abuse prevention research and practice.

(7) Agency Reporting. The agency must report to the Division on approved standardized forms. All reporting must be done in accordance with Federal Confidentiality Regulations (**42 CFR Part 2**).

(8) Physical Environment. Agency must operate the program in facilities that ensure the privacy and safety of participants where appropriate and necessary.

[Publication: The Publication(s) referred to or incorporated by reference in this rule are available from the agency.]

Stat. Auth.: [ORS 409.410](#)

Stats. Implemented: [ORS 430.240](#) - [ORS 430.415](#)

## **415-056-0015**

### **Letter of Approval Applications**

In order to receive a Letter of Approval from the Division under the process set forth in OAR 415-012-0000 to 415-012-0090, a substance abuse prevention agency must meet the standards set forth in the rule, those provisions set forth in OAR 309-014-0000 through 309-014-0040 that are relevant and any other administrative rules applicable to the agency. A Letter of Approval issued to a substance abuse prevention agency under these administrative rules may be effective for up to three years from the date of issue and may be renewed or revoked by the Division in the manner set forth in OAR 415-012-0000 to 415-012-0090. An agency seeking approval under these rules must establish to the satisfaction of the Division that the following have been accomplished:

- (1) Community Needs Assessment:
    - (a) Need for substance abuse prevention services -- A Division approved process used to determine need;
    - (b) Process used to determine appropriate prevention strategy to meet assessed needs and assessment of other current resources to meet assessed needs; and
    - (c) Access to resources to implement strategy and ongoing technical assistance during program implementation.
  - (2) Identification of target population:
    - (a) Susceptibility to substance abuse;
    - (b) Size;
    - (c) Accessibility;
    - (d) Process for isolating target group; and
    - (e) Selection criteria or other identifying characteristics.
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- (3) Written information relating to the delivery of services:
  - (a) Philosophy of program;
  - (b) Prevention strategy to be implemented and objectives to be met;
  - (c) Research supporting use of strategy with the identified population;
  - (d) Program activities and informational content (to include number of contact hours, characteristics of people receiving services, setting, and other relevant factors; and
  - (e) Tools used by the agency to measure fidelity to the strategy applied to the selected population.
- (4) Evaluation of the impact of strategy:
  - (a) Knowledge to be gained and/or behavior to be changed;
  - (b) Relationship of behavior change to substance abuse prevention;
  - (c) The evaluation shall include:
    - (A) A mechanism to record the amount and type of services provided; and
    - (B) Records of attendance of participants.
  - (d) Where appropriate, the following must be included:
    - (A) Pre-and post-tests or other inquiries at the time a service is delivered to indicate knowledge gained by participants;
    - (B) Measures of community and participant satisfaction with services received;
    - (C) Behavior change measurement instruments; and
    - (D) Other methods of measurement.

Stat. Auth.: [ORS 409.410](#)

Stats. Implemented: [ORS 430.240](#) - [ORS 430.415](#)

#### **415-056-0020**

##### **Administration**

- (1) Administration of Program. The substance abuse prevention agency must be administered by staff in accordance with standards set forth in OAR 309-014-0000 through 309-014-0040 which relate to subcontract agencies except 309-014-0030(1) and (2) (Fee Policy and Quality Assurance).
  - (2) Qualifications of Director. A program director must be designated who is qualified by virtue of knowledge, training, experience, and skills, to perform the defined services, implement the defined strategies, and administer requested funds if appropriate. The program director must manage the program and be accountable for the quality of service provided.
  - (3) Referral. As part of the written program, a written policy must exist establishing a referral process to be used to refer individuals not appropriate for the agency services to appropriate agencies or services.
  - (4) Coordination. Staff of the program must show evidence concerning coordination of activities with other related community agencies. (i.e., schools, parent groups, juvenile services department, alcohol and drug abuse treatment agencies).
  - (5) Crisis Procedures. Staff of the agency must, if deemed appropriate, have written procedures for referral to emergency and crisis services, including procedures for referring participants to detoxification, crisis intervention and other elements in the continuum of care.
  - (6) Staff:
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- (a) Accountability. Accountability for the management and quality of service of the substance abuse prevention agency must reside with the Agency director;
- (b) Supervision. Supervision and consultation must be available to all staff related to their skill level with the objective of achieving the objectives of the program and assisting staff to increase their skills;
- (c) Qualification. The County or Tribal designated coordinator or contact person who is wholly responsible for developing, monitoring, and overseeing the substance abuse prevention plan, must be qualified by demonstrated competency in substance abuse prevention techniques through experience and training as specified in these rules. The roles, functions, competencies, and skills required of staff must include the following:
  - (A) 2,000 hours of Substance abuse Prevention related experience.
  - (B) 150 Education hours in the following "Prevention" specific topics:
    - (i) 20 hours minimum in Substance Abuse Education (i.e. drug 101, alcohol 101, marijuana, methamphetamine, inhalants, hallucinogens, opiates);
    - (ii) 50 hours minimum Substance Abuse Prevention Education Curricula, 10 hours minimum Risk & Protective Factor Education, Assets & Resiliency;
    - (iii) 70 hours general prevention topics which include: Delinquency, Teen pregnancy, school dropout, violence prevention, sexually transmitted diseases, Positive Youth Development, Cultural Competence; and
    - (iv) Must demonstrate competency by completing and passing certification exam.
- (d) Personnel methods must be utilized to assure that the requirements are met and a staff development program instituted to maintain and upgrade staff skills.
- (e) Staff of Prevention programs who do not hold a certificate that meets the Prevention Specialist criteria must make application within six months of the effective date of this rule and achieve the Certified Prevention Specialist Credential within (24) months of the application date.
- (f) New Hires: New hires need not hold the Certified Prevention Specialist Credential but those who do not must make application within (12) months of employment and receive the Certified Prevention Specialist Credential within (24) months of the application date.
- (g) Staffing Pattern. The number and responsibilities of the agency staff must be sufficient to provide the services required under these rules for the number of participants the agency intends to serve. Agency staff must be culturally competent to serve identified populations.

(7) Fee Schedule. A fee schedule may be established, if appropriate, which approximates actual cost of service delivery. The fee schedule must assess the cost to the participant for the service in accordance with the participant's ability to pay.

Stat. Auth.: [ORS 409.410](#)

Stats. Implemented: [ORS 430.240](#) - [ORS 430.415](#)

#### **415-056-0025**

##### **Variances**

A variance from these rules may be granted to an agency in the following manner:

- (1) An agency requesting a variance must submit, in writing, through the community mental health authority to the Division:
    - (a) The section of the rule from which the variance is sought;
    - (b) The reason for the proposed variance;
    - (c) The alternative practice proposed;
    - (d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and
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(e) Signed documentation from the local mental health authority indicating its position on the proposed variance.

(2) The Division shall approve or deny the request for variance.

(3) The Division shall notify the community mental health authority of the decision. The community mental health authority will forward the decision and reasons therefore to the program requesting the variance. This notice must be given to the program within 30 days of receipt of the request by the Division.

(4) Appeal of the denial of a variance request must be made to the Assistant Director, whose decision shall be final.

(5) A variance granted by the Division must be attached to, and become part of, the contract for that year.

Stat. Auth.: [ORS 409.410](#)

Stats. Implemented: [ORS 430.240](#) - [ORS 430.415](#)

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## APPENDIX C

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### Senate Bill 267 Summary

SECTION 5, 6, and 7. (1) For the biennium beginning July 1, 2005 (section 5)/ July 1, 2007 (section 6), the Department of Corrections, the Oregon Youth Authority, the State Commission on Children and Families, that part of the Department of Human Services that deals with mental health and addiction issues and the Oregon Criminal Justice Commission shall spend at least 25 percent (section 5)/ 50 percent (section 6)/ 75 percent (section 7) of state moneys that each agency receives for programs on evidence-based programs.

(2) Each agency shall submit a report containing:

- (a) An assessment of each program on which the agency expends funds, including but not limited to whether the program is an evidence-based program;
- (b) The percentage of state moneys the agency receives for programs that is being expended on evidence-based programs;
- (c) The percentage of federal and other moneys the agency receives for

programs that is being expended on evidence-based programs; and

(d) A description of the efforts the agency is making to meet the requirements of subsection (1) of this section and sections 6 (1) and 7 (1) of this 2003 Act.

(3) The agencies shall submit the reports required by subsection (2) of this section no later than September 30, 2006 (section 5)/ September 30, 2008 (section 6)/ September 30 of each even numbered year (section 7), to the interim legislative committee dealing with judicial matters.

(4) If an agency, during the biennium beginning July 1, 2005 (section 5)/ July 1, 2007 (section 6), spends more than 75 percent (section 5)/ 50 percent (section 6) of the state moneys that the agency receives for programs on programs that are not evidence based, the Legislative Assembly shall consider the agency's failure to meet the requirement of subsection (1) of this section in making appropriations to the agency for the following biennium.

(5) Each agency may adopt rules necessary to carry out the provisions of this section, including but not limited to rules defining a reasonable period of time for purposes of determining cost effectiveness

### **Definition of Terms:**

1. "Cost effective" means that cost savings realized over a reasonable period of time are greater than costs.

2. "Evidence-based program" means a program that:

(a) Incorporates significant and relevant practices based on scientifically based research; and

(b) Is cost effective.

3. (A) "Program" means a treatment or intervention program or service that is intended to:

(a) Reduce the propensity of a person to commit crimes;

(b) Improve the mental health of a person with the result of reducing the likelihood that the person

will commit a crime or need emergency mental health services; or

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(c) Reduce the propensity of a person who is less than 18 years of age to engage in antisocial behavior with the result of reducing the likelihood that the person will become a juvenile offender.

(B) “Program” does not include:

(a) An educational program or service that an agency is required to provide to meet educational requirements imposed by state law; or

(b) A program that provides basic medical services.

4. “Scientifically based research” means research that obtains reliable and valid knowledge by:

(a) Employing systematic, empirical methods that draw on observation or experiment;

(b) Involving rigorous data analyses that are adequate to test the stated hypotheses and justify the general conclusions drawn; and

(c) Relying on measurements or observational methods that provide reliable and valid data across evaluators and observers, across multiple measurements and observations and across studies by the same or different investigators

For a complete copy of Chapter 669, SB 267 visit:

<http://www.leg.state.or.us/orlaws/sess0600.dir/0669ses.htm>

# APPENDIX D

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71st OREGON LEGISLATIVE ASSEMBLY--2001 Regular Session

Enrolled

Senate Bill 770

Sponsored by Senators BROWN, CLARNO; Senators CASTILLO, CORCORAN, DECKERT, FERRIOLI, GORDLY, MESSERLE, METSGER, NELSON, SHIELDS, STARR, TROW, Representatives GARDNER, KNOPP, KRIEGER, MONNES ANDERSON, NOLAN, ROSENBAUM, G SMITH, VERGER, V WALKER, WESTLUND (at the request of Commission on Indian Services)

CHAPTER.....

AN ACT

Relating to government-to-government relations between the State of Oregon and American Indian tribes in Oregon.

Be It Enacted by the People of the State of Oregon:

SECTION 1. {+ As used in sections 1 to 4 of this 2001 Act:

(1) 'State agency' has the meaning given that term in ORS 358.635.

(2) 'Tribe' means a federally recognized Indian tribe in Oregon. + }

SECTION 2. {+ (1) A state agency shall develop and implement a policy that:

(a) Identifies individuals in the state agency who are responsible for developing and implementing programs of the state agency that affect tribes.

(b) Establishes a process to identify the programs of the state agency that affect tribes.

(c) Promotes communication between the state agency and tribes.

(d) Promotes positive government-to-government relations between the state and tribes.

(e) Establishes a method for notifying employees of the state agency of the provisions of sections 1 to 4 of this 2001 Act and the policy the state agency adopts under this section.

(2) In the process of identifying and developing the programs of the state agency that affect tribes, a state agency shall include representatives designated by the tribes.

(3) A state agency shall make a reasonable effort to cooperate with tribes in the development and implementation of programs of the state agency that affect tribes, including the use of agreements authorized by ORS 190.110. + }

SECTION 3. {+ (1) At least once a year, the Oregon Department of Administrative Services, in consultation with the Commission on Indian Services, shall provide training to state agency managers and employees who have regular communication with tribes on the legal status of tribes, the legal rights of members of tribes and issues of concern to tribes.

(2) Once a year, the Governor shall convene a meeting at which representatives of state agencies and tribes may work together to achieve mutual goals.

Enrolled Senate Bill 770 (SB 770-INTRO)

Page 1

(3) No later than December 15 of every year, a state agency shall submit a report to the Governor and to the Commission on Indian Services on the activities of the state agency under sections 1 to 4 of this 2001 Act. The report shall include:

(a) The policy the state agency adopted under section 2 of this 2001 Act.

(b) The names of the individuals in the state agency who are responsible for developing and implementing programs of the state agency that affect tribes.

(c) The process the state agency established to identify the programs of the state agency that affect tribes.

(d) The efforts of the state agency to promote communication between the state agency and tribes and government-to-government relations between the state and tribes.

(e) A description of the training required by subsection (1) of this section.

(f) The method the state agency established for notifying employees of the state agency of the provisions of sections 1 to 4 of this 2001 Act and the policy the state agency adopts under section 2 of this 2001 Act. + }

SECTION 4. {+ Nothing in sections 1 to 4 of this 2001 Act  
creates a right of action against a state agency or a right of  
review of an action of a state agency. + }

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Passed by Senate April 2, 2001

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Secretary of Senate

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President of Senate

Passed by House May 11, 2001

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Speaker of House

# APPENDIX E

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70th OREGON LEGISLATIVE ASSEMBLY--1999 Regular Session

NOTE: Matter within { + braces and plus signs + } in an amended section is new. Matter within { - braces and minus signs - } is existing law to be omitted. New sections are within {+ braces and plus signs + } .

LC 553

## Senate Bill 555

Sponsored by Senator YIH; Senators BEYER, BROWN, BURDICK, CASTILLO, CORCORAN, COURTNEY, DERFLER, DUNCAN, FERRIOLI, FISHER, GEORGE, GORDLY, LIM, METSGER, NELSON, QUTUB, SHANNON, SHIELDS, STARR, TARNO, TIMMS, TROW, WILDE, Representatives BECK, BUTLER, CLOSE, KROPF, LEONARD, LEWIS, LOKAN, MESSERLE, MINNIS, MORRISETTE, PATRIDGE, ROSS, SCHRADER, SHETTERLY, STARR, THOMPSON, WELSH

### SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Requires that youth taken into custody for possession of firearm or dangerous weapon in public building may not be released until mental health and sociological evaluation is conducted. Requires that court make release decision. Requires youth, parent or guardian to pay cost of evaluation.

### A BILL FOR AN ACT

Relating to juveniles; amending ORS 419C.100, 419C.103 and 419C.145.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 419C.100 is amended to read:

419C.100. The person taking the youth into custody under ORS 419C.080 and 419C.088 shall release the youth to the custody of the youth's parent, guardian or other responsible person in this state, except in the following cases:

- (1) { - Where - } { + When + } the court has issued a warrant of arrest against the youth.
  - (2) { - Where - } { + When + } the person taking the youth into custody has probable cause to believe that the welfare of the youth or others may be immediately endangered by the release of the youth.
  - { + (3) When the youth has been taken into custody for possessing a firearm or dangerous weapon in a public building as defined in ORS 166.360. + }
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SECTION 2. ORS 419C.103 is amended to read:

419C.103. (1) If a youth taken into custody is not released as provided in ORS 419C.100 and the juvenile court for the county has not established the alternative procedure authorized in subsection (4) of this section, the person taking the youth into custody shall, without unnecessary delay, do one of the following:

(a) Take the youth before the court or a person appointed by the court to effect disposition under ORS 419C.109 and 419C.136.

(b) Take the youth to a place of detention or shelter care or a public or private agency designated by the court and as soon as possible thereafter notify the court that the youth has been taken into custody.

{ + (c) Take the youth before the court if the youth has been taken into custody for possessing a firearm or dangerous weapon in a public building as defined in ORS 166.360. + }

(2) { - Where - } { + When + } a youth residing in some other county is taken into custody { + , + } the youth may be:

(a) Released to the youth's parent, guardian or other responsible person in this state as provided in ORS 419C.100

{ - . - } { + ; or + }

(b) Delivered to a peace officer or juvenile counselor in the county in which the youth resides, if such delivery can be made without unnecessary delay. In such event, the person to whom the youth is delivered shall assume custody of the youth and shall proceed as provided in this chapter.

(3) { - Where - } { + When + } a youth is released or delivered as provided in subsection (2) of this section, the jurisdiction of the juvenile court of the county in which the youth resides shall attach from the time the youth is taken into custody.

(4) The juvenile court may establish, as an alternative to the provisions of subsection (1) { + (a) and (b) + } of this section, that if a youth taken into custody is not released as provided in ORS 419C.100, procedures shall be followed that comply with the following:

(a) The person taking the youth into custody may communicate, by telecommunications or otherwise, with the person appointed by the court to effect disposition under ORS 419C.109.

(b) After interviewing the person taking the youth into custody and obtaining such other information as is considered necessary, the person appointed by the court under ORS 419C.109 to effect disposition may exercise the authority granted under that section and shall, in such case, direct that the person taking the youth into custody release the youth or deliver the youth in accordance with such direction.

(c) The person taking the youth into custody shall comply with the direction of the person appointed by the court to effect disposition.

SECTION 3. ORS 419C.145 is amended to read:

419C.145. (1) A youth may be held or placed in detention before adjudication on the merits if one or more of the following circumstances exists:

(a) The youth is a fugitive from another jurisdiction;

(b) The youth is alleged to be within the jurisdiction of the

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court under ORS 419C.005, by having committed or attempted to commit an offense which, if committed by an adult, would be chargeable as:

(A) A crime involving infliction of physical injury to another person; or

(B) Any felony crime;

(c) The youth has willfully failed to appear at one or more juvenile court proceedings by having disobeyed a proper summons, citation or subpoena;

(d) The youth is currently on probation imposed as a consequence of the youth previously having been found to be within the jurisdiction of the court under ORS 419C.005, and there is probable cause to believe the youth has violated one or more of the conditions of that probation;

(e) The youth is subject to conditions of release pending or following adjudication of a petition alleging that the youth is within the jurisdiction of the court pursuant to ORS 419C.005 and there is probable cause to believe the youth has violated a condition of release; or

(f) The youth is alleged to be in possession of a firearm in violation of ORS 166.250.

(2) A youth detained under subsection (1) of this section must be released to the custody of a parent or other responsible person, released upon the youth's own recognizance or placed in shelter care unless the court or its authorized representative finds that there is probable cause to believe that the youth may be detained under subsection (1) of this section, and that one or more of the following circumstances are present:

(a) No means less restrictive of the youth's liberty gives reasonable assurance that the youth will attend the adjudicative hearing; or

(b) The youth's behavior endangers the physical welfare of the youth or another person, or endangers the community.

(3) When a youth is ordered held or placed in detention, the court or its authorized representative shall state in writing the basis for its detention decision and a finding that it is contrary to the welfare of the youth and community for the youth to be released to the custody of the youth's parent or some other responsible adult. The youth shall have the opportunity to rebut evidence received by the court and to present evidence at the hearing.

(4) In determining whether release is appropriate under subsection (2) of this section, the court or its authorized representative shall consider the following:

(a) The nature and extent of the youth's family relationships and the youth's relationships with other responsible adults in the community;

(b) The youth's previous record of referrals to juvenile court and recent demonstrable conduct;

(c) The youth's past and present residence;

(d) The youth's education status and school attendance record;

(e) The youth's past and present employment;

(f) The youth's previous record regarding appearance in court;

(g) The nature of the charges against the youth and any

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mitigating or aggravating factors; { - and - }

(h) Any other facts relevant to the likelihood of the youth's appearance in court or likelihood that the youth will comply with the law and other conditions of release { + ; and

(i) The results of any mental health and sociological evaluation required by subsection (5) of this section + }.

{ + (5) Before determining whether release is appropriate under subsection (2) of this section for a youth who is before the court for possessing a firearm or dangerous weapon in a public building as defined in ORS 166.360, the court shall order a mental health and sociological evaluation that may include, but need not be limited to, a review of the youth's emotional state, background, lifestyle and family situation. Except in cases of extreme hardship, the court shall require the youth, parent or guardian of the estate to pay the costs of the evaluation. + }

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