



OREGON
SUBSTANCE
• A B U S E •
PREVENTION
COORDINATOR
MANUAL 2013

OREGON HEALTH AUTHORITY

ADDICTIONS AND MENTAL HEALTH DIVISION

Prevention Coordinator Manual

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OREGON HEALTH AUTHORITY

Addictions and Mental Health Division

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Oregon Department of Education partnered with the Addictions and Mental Health Division’s Prevention Unit to assist with prevention and intervention efforts in Oregon’s schools and communities. Some of the monies from the grant were used to develop, create and print, for dissemination, a Prevention Coordinator’s Manual to assist with collaborative prevention efforts in each of Oregon’s counties and tribal communities.

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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 Unit 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, assisting in community planning, 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

Oregon has a well-established prevention system which is briefly described in this section. In addition, there are many partners in substance abuse and problem gambling prevention programs as well as individuals, both professionally and personally committed to prevention efforts.

- ❖ Oregon Health Authority Addictions and Mental Health Division
- ❖ Prevention funding sources
- ❖ Planning and partnerships



ADDICTIONS & MENTAL HEALTH DIVISION

OVERVIEW

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, evidence-based practice treatments of addictions, pathological gambling, mental illness and emotional disorders.

Prevention programs and services utilize evidenced-based services to prevent the problematic use of addictive substances including tobacco, alcohol, drugs and gambling statewide. Oregon's prevention system promotes the use of SAMHSA and CSAP prevention models including:

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

County-based programs, community-based programs, federally-recognized Tribal programs and statewide contractors provide evidenced-based services to prevent problematic use of alcohol, drugs and gambling. These programs are monitored by the Prevention Unit at Addictions & Mental Health Division of the Oregon Health Authority.

Oregon's health care transformation efforts have resulted in many potential changes to prevention systems and infrastructure. To distinguish community-based prevention efforts, such as those AMH oversees, from those prevention efforts that are more individually based (such as in primary care settings), a systems description was developed in 2012. It is included as an Appendix (See Appendix F).

For more information visit the following Addictions and Mental Health Division web sites: <http://www.oregon.gov/oha/amh/Pages/prevention.aspx> (substance abuse prevention) and <http://www.oregon.gov/oha/amh/Pages/gambling.aspx> (problem gambling prevention). Oregon has an extensive history of offering prevention services. See Appendix A for the highlights of Oregon's prevention history.

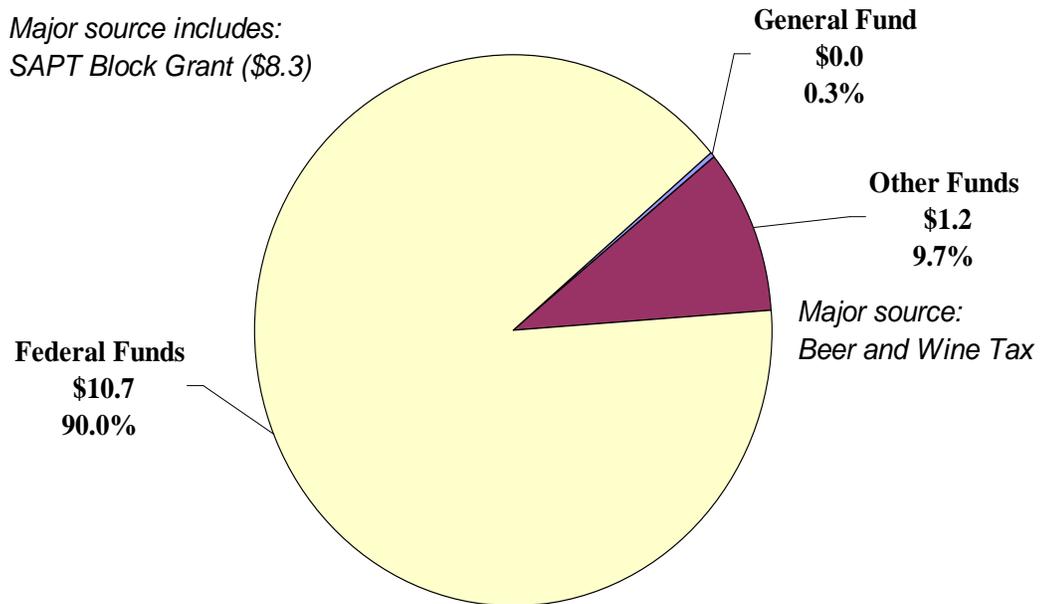
PREVENTION FUNDING SOURCES

The Addictions and Mental Health Division of the Oregon Health Authority receives funding from Beer and Wine Tax, Federal Block Grant, and other Federal Grants. Problem gambling prevention funds come from the state Lottery proceeds. Federal grants contribute to more than two thirds of alcohol and drug abuse prevention funding.

County and tribal allocations are distributed primarily by population, and each is provided with sufficient base funding to employ a minimum half-time prevention coordinator. Base funding provides capacity to meet a minimum level of prevention services at each county and tribe across the state.

2011-13 Legislatively Adopted Budget Prevention Programs by Fund Type \$11.9 Total Funds

(dollars in millions)



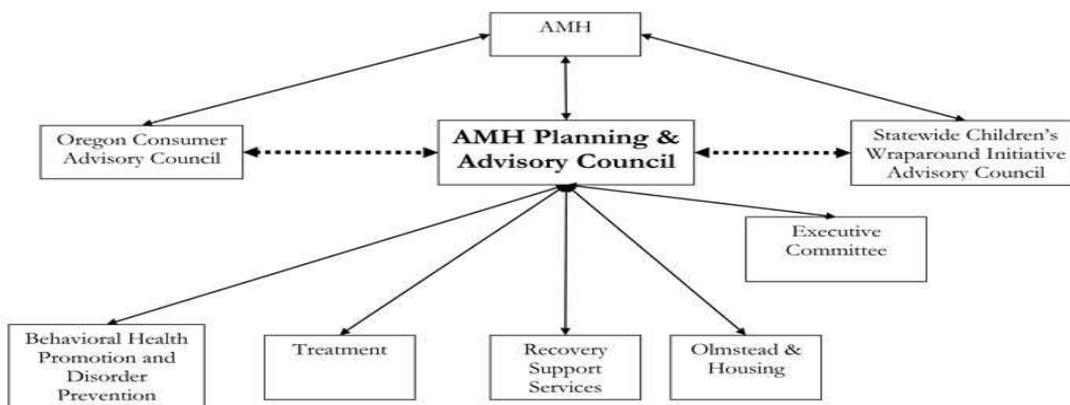
PLANNING AND PARTNERSHIPS

Addictions & Mental Health Planning and Advisory Council (AMHPAC)

Formed in 2012 as part of health care transformation efforts, this newly developed group includes representatives of all major AMH constituencies, including prevention. AMHPAC's role is to:

- Review the Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant application and reports;
- Serve as an advocate for children, youth, young adults and adults with behavioral health disorders;
- Monitor, review and evaluate the allocation and adequacy of addictions and behavioral health services in Oregon; and
- Other advisory actions as might be assigned by the director of AMH.

More details on this group can be found at
<http://www.oregon.gov/oha/amh/Pages/amhpac.aspx>



Alcohol And Drug Policy Commission

The goal of the commission is to improve health and safety, strengthen families, reduce crime and save taxpayer dollars through the effective implementation of a unified, coordinated alcohol and drug prevention and recovery system. The group's goals and objectives, meeting schedules and minutes, and work products can be found at: <http://www.doj.state.or.us/adpc/Pages/index.aspx>

Nine Federally Recognized Tribes

AMH has dedicated staff to serve as liaisons to the Oregon's nine federally recognized tribes. Tribal Liaisons are present for tribal functions to continue building rapport and understanding with Native American communities. The liaisons listen for concerns, answer questions, assist in removing barriers and look for opportunities to improve or services to the tribes. AMH staff solicits assistance and guidance from the liaisons to ensure that cultural considerations and tribal voices are included in planning for substance abuse prevention, addictions and mental health treatment.

Senate Bill 770, passed by the Oregon Legislature in 2001, enacted a Government-to-Government relationship between the State of Oregon and each of the nine Tribal Governments. AMH meets this statute by consulting with the nine tribes on a quarterly basis at the SB 770 Health Services Cluster, participating in an annual Tribal Relations cultural training and communicating with tribal staff on a regular basis.

Federally recognized tribes in Oregon are Sovereign nations, and therefore not required to go through the local community mental health authority to access mental health services off the reservation. Adjustments have been made in the Oregon Administrative Rules (OARs), and contract language has been modified to ensure direct access to treatment and to better meet the cultural needs of Oregon tribes.

In terms of alcohol and drug services, Tribal Governments are not required to have the biennial plan approved by an LADPC (Local Alcohol and Drug Planning Committee). The plans are approved by the Tribal Council, the Tribal Health Department or through an entity authorized by the Tribal Council.

AMH is committed to providing culturally appropriate services to Native Americans in Oregon, and therefore supportive of Tribal Best Practices. Tribal Best Practices are cultural and traditional practices that have been reviewed and approved by a panel of scientific researchers, prevention and treatment practitioners and program managers across the state.

State Epidemiological Outcomes Workgroup

The state is required to have an epidemiological outcomes workgroup to bring systematic, analytical thinking to the causes and consequences of substance use in order to effectively and efficiently utilize prevention resources.

It is the job of the SEOW to propose prevention priorities, make allocation recommendations and promote data-driven decision-making at all stages in the Strategic Prevention Framework. For more information go to:

<http://www.oregon.gov/oha/amh/sew/Pages/index.aspx>

RESOURCES

Prevention Certification

http://www.accbo.com/general_images/pdf_files/prevention.pdf

Community Anti-Drug Coalitions of America CADCA www.cadca.org

Lines for Life (formerly Oregon Partnership) www.oregonpartnership.org

Oregon Tobacco Prevention & Education Program

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

Oregon Problem Gambling Prevention Coordinators Resource Hub

www.problemgamblingprevention.org

SAMHSA's Center for Substance Abuse Prevention www.samhsa.gov

Search Institute's 40 Developmental Assets

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

Behavioral Health Promotion (AMH article)

<http://www.oregon.gov/oha/amh/docs/behavioral-health-promotion-paper.pdf>

Strengthening Families Program 10-14

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

Specific to Schools: [Also See Appendix H]

PBIS Network www.pbis.org

Bullying Prevention www.stopbullying.gov

Cyber-Bullying Prevention www.cyberbullying.us

Bridge' Resources for Safe Schools & Communities www.oregonschoolclimate.org

Oregon Department of Education, Safe & Healthy Schools Resources

<http://www.ode.state.or.us/search/results/?id=107>

National Association of School Psychologists (NASP) <http://www.nasponline.org/>

Resources for Response to Crisis and Trauma

<http://www.oregon.gov/oha/amh/Pages/resources-for-crisis-and-trauma-response.aspx>

Prevention Services

- ❖ Roles and Responsibilities
- ❖ Biennial Implementation Plan
- ❖ Annual Report
- ❖ Certification

Prevention services for counties are part of larger county implementation plans. Counties include prevention plans as part of an overall service delivery package.

Tribal communities are not required to submit a larger plan, but outline their prevention services with tools provided by Addictions and Mental Health Division (AMH).

Oregon Administrative Rules for prevention may be viewed in the Appendices.



ROLES AND RESPONSIBILITIES

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

The following roles and responsibilities describe many of the functions of County and Tribal Prevention Coordinators, AMH Policy & Program Development Unit Prevention Specialists and Statewide Prevention Contractors for programs funded through AMH. AMH prevention programs are primarily funded with the Substance Abuse Prevention & Treatment (SAPT) Block Grant 20% prevention set-aside and Lottery funds within the Division's Flexible Funding Service Element (MHS 37). Funds may also include specifically contracted projects such as Strategic Prevention Framework State Incentive Grant (SPF-SIG) or other funded opportunities.

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

County/Tribal Prevention Coordinators

Management

- Monitor Prevention and other AMH revenues contracted to the county or tribe through financial agreements
- Oversee the implementation of programs funded by AMH
- 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 comprehensive community planning requirements
- Maintain compliance with the Oregon Administrative Rules governing AMH prevention agencies

Planning

- Analyze data for trends in alcohol, tobacco and other drug use and gambling and predictive risk/protective factors
 - Collect and utilize current local data to develop Biennial Implementation Plan (BIP)
-

- Act as liaison with planning groups, including the Commission on Children and Families, Local Alcohol & Drug Planning Committees and Local Public Safety Coordinating Councils

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
- 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

- Monitor county and tribal contracts
- 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 reporting 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
- Facilitate communication across disciplines
- Make available expertise in evaluation for prevention programming

Planning

- Analyze data for trends in alcohol, tobacco and other drug use and gambling and identify 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

- 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
- Work in partnership with AMH, Tribal and County Prevention Coordinators to support and strengthen prevention system.
- Collect data on specific areas of need
- Assist with support for data/evaluation
- Maintain effective standards of prevention practice



COUNTY & TRIBAL IMPLEMENTATION PLANS

As of 2013 and with the initiation of flexible funding, general prevention plans are submitted one specific part of each County's master Biennial Implementation Plan (BIP). The BIP covers a full range of mental health and addiction services, including prevention. Below is the set of guidelines and forms current as of the writing of this manual, but **they are subject to change**. The most current versions should be on the AMH website <http://www.oregon.gov/oha/amh/pages/data/cc-plans/main.aspx>. Prevention information should be included in the following sections of the BIP: System Overview, Community Needs Assessment, Strengths and Areas for Improvement, Current Data and Special Funding Allocation (in the Budget section). The current performance indicator for prevention services is that the county/entity will reach 80% of its approved prevention goals and objectives.

SERVICE DESCRIPTION "A&D 70" REFERS TO FUNDS ALLOCATED FOR PREVENTION (NOW ONLY APPLIES TO TRIBES THAT DO NOT HAVE A MENTAL HEALTH AUTHORITY)

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. Mental Health Promotion has been added to the scope of prevention which is focused on the general public or a whole population. Interventions aim to enhance individuals' ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem,

mastery, well-being, and social inclusion, and strengthen their ability to cope with adversity.

Services are implemented through one or more of the six Center for Substance Abuse Prevention's (CSAP) strategies. Examples of services in each strategy include:

1. Information Dissemination - media campaigns, speaking engagements;
2. Prevention Education - school curricula and parenting education;
3. Alcohol, Tobacco & Other Drugs (ATOD) Free Alternatives - youth leadership, mentoring, and youth led 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, referral to treatment.

Performance Requirements

Agencies, as defined in OAR 415-056-0030, providing A&D 70 Services must comply with OAR 415-056-0000 through 415-056-0030, 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.



SERVICE DESCRIPTION REFERS TO FUNDS ALLOCATED FOR PREVENTION APPLIES TO COUNTIES AND CONFEDERATED TRIBES OF WARM SPRINGS

Service Name: PREVENTION SERVICES

Service ID Code: MHS 37 – Flexible Funding

I. Service Description

Flexible funding is the promotion, prevention, early identification and intervention of conditions that lead to mental health, substance use and addiction disorders. This focus will lead to improved outcomes and enhanced healthcare experiences for individuals as well as reduce overall expenditures.

County shall prioritize persons to be served as outlined in ORS 430.644, federal Mental Health and Substance Abuse Prevention and Treatment grants, and OAR 309-032-1525. County is responsible to establish and maintain a structure for meaningful system design and oversight that includes involvement by individuals and families across all ages that have or are receiving addictions or mental health services.

System design and oversight structure must include:

- A. Planning
- B. Implementation
- C. Monitoring
- D. Evaluation of services and supports
- E. Involvement in activities that focus on:
 - 1. Resource allocation
 - 2. Outcomes
 - 3. Quality improvement
 - 4. Advisory councils

II. Performance Requirements

County shall provide the following Services, subject to availability of funding. Services may be reduced commensurate with reductions in funding by OHA:

- A. Behavioral Health Promotion and Prevention.
 - 1. Behavioral Health Promotion and Prevention is distinct from treatment.
-

2. Behavioral Health Promotion and Prevention is focused on changing common influences on the development of individuals across their lifespan, reducing risk factors and increasing protective factors.
3. Behavioral Health Promotion and Prevention is designed to target universal populations and indicated populations based on risk.
4. Behavioral Health Promotion and Prevention must incorporate the Strategic Planning Framework (SPF). The SPF provides an effective, comprehensive prevention process and a common set of goals to be adopted and integrated at all levels. This process is built upon state and local data assessment, building capacity, development of a comprehensive strategic plan, implementation of evidence-based strategies, and evaluation of work.
5. The SPF takes a public health approach to prevent community problems. The focus is on change for entire populations, collections of individuals who have one or more personal or environmental characteristics in common. Population-based public health considers an entire range of factors that determine health.

B. Outreach (Case Finding), Early Identification and Screening, Assessment and Diagnosis.

1. Outreach: Partner with healthcare providers and other social service partners who provide screening for the presence of behavioral health conditions to facilitate access to appropriate services.
2. Early Identification and Screening: Conduct periodic and systematic methods that identify individuals with behavioral health conditions and potential physical health consequences of behavioral health conditions which consider epidemiological and community factors, as identified in the Biennial Implementation Plan, Exhibit C;

Special Reporting Requirements

Until a new system is in place, Minimum Data Set for Prevention (MDS).

All MHS 37 prevention and 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 prevention 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.

Excerpt from April 11, 2013 Memorandum

To: Community Mental Health Programs

From: Karen Wheeler, M.A, Administrator
Michael N. Morris, M.S., Administrator

Subject: Clarification on the use of some Service Element #37 “Flexible Funds”

Flexible funding allows counties to put resources where they are most needed to serve the unique needs of the people in their communities. These funds can be spent on supports to provide for unique client needs and improve outcomes. However, some of the revenue sources comprising these funds do have specific requirements, and restrictions. Providers must spend the restricted funds as described below, though they are able to augment these services with additional funds, based on community need.

Service Element #37 (SE37), or “Flexible Funds” include service dollars from a variety of funding sources. Four of these sources – Substance Abuse Prevention and Treatment (SAPT) Block Grant, Beer and Wine Taxes, Intoxicated Driver Program Funds and Lottery Funds – require special attention and can only be used for specific purposes as summarized below:

- **SAPT Block Grant**: The prevention portion of SAPT Block Grant funds that each county and tribe receives must be entirely spent on prevention services. The federal regulations require that no less than 20% of the state’s Block Grant allocation be spent on prevention. Because the prevention funds included in SE37 are mostly made up of SAPT Block Grant funds, they must be spent on prevention only. The treatment portion of SAPT block grant funds must be entirely spent on substance abuse treatment services, including non-encounterable wraparound services. (45 C.F.R., 96.135 – Restrictions on expenditure of grant.)
- **Lottery Funds**: Lottery Funds included in SE37 must be used for problem gambling prevention and treatment. Problem Gambling Prevention funds must be spent only on prevention services. Problem Gambling Treatment funds can be spent specifically on treatment services, including non-encounterable wraparound services, or on services that support gambling treatment. (ORS 413.522 – Problem Gambling Treatment Fund).
- **Beer and Wine Taxes**: Beer and Wine Taxes included in SE37 may be used for substance abuse prevention or treatment services. Treatment funds may be used to provide non-encounterable, wraparound services (e.g., secure transportation to and from treatment) (ORS 430.338 – Purposes of laws related to alcoholism).

###

**PREVENTION PLAN DETAIL
TRIBAL 2013-2015 IMPLEMENTATION PLAN
Addictions and Mental Health (AMH) Division
Oregon Health Authority**

Tribe's name:

Prevention Coordinator:

Prevention Supervisor:

Agency Name:

Address:

City/Zip:

Phone:

FAX:

E-mail Address:

Fiscal contact name and e-mail:

Tribal Community Information

<p>1. For purpose of these funds, our Tribal Community is defined as: (Examples: Tribal members, Tribal members and household families)</p>
<p>2. Vision Statement for Prevention Program:</p>
<p>3. Describe Tribal Community and Coalition input in the development of this plan:</p>
<p>4. Describe how your Tribe participates in the 9 Tribes MOU Working Group?</p>

Action Planning Sheets

This action planning sheet is designed to provide a logic model for your prevention program. An Annual report is due August 30th that will measure outcomes and outputs. An example is provided below.

Data Used to Determine Priority Areas	Plan to Address	CSAP Strategy and MDS Service Code	Person(s) Responsible and When	Outcomes and Outputs
<p><u>Example:</u> Adult prescription drug abuse is significantly higher than the state average.</p> <p>Data Sources: 2011-2012 Health Clinic Data Oregon Student Wellness Survey 2010 and 2012</p>	<p>Risk and Protective Factors to be addressed: (See Addendum #1)</p> <p>Policy Creation (See Addendum #2)</p> <p>Example: Work with Tribal Police or Local Police to create a policy for permanent drug take-back containers.</p>	<p>1. Community-Based 2. Environmental Strategy</p> <p>MDS Service Code:</p>	<p>By 11/10/2014, the Prevention Coordinator will facilitate a meeting with Tribal Police, Pharmacy, and the Health Director in order to address the adult prevention drug abuse rates for Tribal Members.</p> <p>By 3/1/2014, the group will have a draft policy to create a permanent drug take-back container at the Health Clinic, under the monitoring of Tribal Police.</p>	<p>Outcome: New policy created for permanent drug take-back container.</p> <p>Outcome: Tribal Pharmacy participates in Prescription Drug Monitoring Program</p> <p>Output: Prevention Coordinator facilitated two meetings with 7 staff attending.</p>

Data Used to Determine Priority Areas	Plan to Address	CSAP Strategy and MDS Service Code	Person(s) Responsible and When	Outcomes and Outputs

Data Used to Determine Priority Areas	Plan to Address	CSAP Strategy and MDS Service Code	Person(s) Responsible and When	Outcomes and Outputs

2013-2015 Itemized Budget

	Element #70 AMH Prevention	SPF-SIG	Other
Personnel (Salary, Benefits, etc.)			
Program Supplies/Materials			
Office Supplies/Mailing/Computer Software, etc.			
Contracts/Consultants			
Other, Please List:			
Total Budget Amount	122,500		

Action Planning Sheets

For evaluation, monthly MDS reports due the 15th of the following month (inputs). Annual report due August 30th measuring (outcomes) educational gain, attitudinal and behavioral changes of the programs you have selected to implement. (MDS does not currently include problem gambling prevention measures)

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.

ACTION PLANNING SHEETS

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

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

ANNUAL REPORTING FOR COUNTIES & TRIBES

Each year AMH requires an annual report of progress towards meeting the goals and objectives of your plan. The results and your successes should be reported on the following forms.

OREGON HEALTH AUTHORITY
Addictions and Mental Health Division

Program Narrative & Successes Report
July 1, 20XX through June 30, 20XX

(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 and Problem Gambling 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.)

OREGON HEALTH AUTHORITY
Addictions and Mental Health Division
-- Demographic Reporting Sheet

Prevention Service

July 1, 20XX through June 30, 20XX

In addition to other requirements as determined by the Oregon Health Authority– Addictions and Mental Health Division (DHS-AMH), this completed form must be submitted electronically to OHA no later than August 15, 20xx.

County/Tribe: _____

Agency: _____

Contact Person: _____

Phone: _____ E-MAIL: _____

*This report covers the months of **July 1, 20xx through June 30, 20xx**. 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 (from MDS)		Ethnicity of Community (from Census)	
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)	. %

SAMPLE REPORTING FORM

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

FISCAL AGREEMENT PREVENTION REPORTING AND OTHER REQUIREMENTS

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 th each year.
MDS Reporting [Will change]	Must be completed by the 15 th day of January, April, July, and October.
Prevention Summit	Held each Spring & Fall.
Ethics Training	6 Hours required to recertify.
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 (Test Prep)	Annually [optional]
Various courses offered throughout year	TBD
Problem gambling prevention conference	Annually
Other reports for special projects including SPF-SIG	TBD

MINIMUM DATA SET FOR PREVENTION

(Note: in the next biennium or two we will be moving to a new system, OWITS, and there will be early notifications, trainings, technical assistance, etc to ensure a smooth transition. The OWITS system is currently being implemented for treatment services only. When we transfer to OWITS, problem gambling prevention will also be included in the data set).

The Minimum Data Set for Prevention 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 the MDS system. Reporting must be completed by the 15th day of the month following the end of each quarter. (April, July, October, January) MDS 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). 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 day, week or month, 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.

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Prevention Minimum Dataset

Site can be found at: <https://mds.hr.state.or.us/>

Welcome to the Prevention Minimum Dataset

Message of the Day for 04/16/2013:

Please note: Have you checked your data to see if you are using an invalid code for recurring services??? Please make sure that the codes you are using are correct! 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:

Login

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

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.

Staff ID		Provider ID		Substate (County Code)		Service Code (S/R)	
_____		_____		_____		S	
Service Type		Service Date (mm/dd/yyyy)		Name of Group (20 characters only)			Unit Count
ST _____							
Service Population:		Attendees: (Male)		Attendees: (Female)		Total Present:	Counts Estimated? (Yes/No)
SP _____							
Attendees by Age: (Totals must equal total number of male and female attendees.)				Attendees by Hispanic Origin (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 _____					
Attendees by Racial Category: (Totals must equal or be greater than total male & female attendees.)				Attendees that selected more than one race:		Attendees by other Demographic Category:	
American Indian/Alaska Native _____		Native Hawaiian or other Pacific Islander _____				Cuban _____ Dominican _____	
Asian _____		White _____				Mexican/Chicano _____ Puerto Rican _____	
Black/African American _____						Other Hispanic/Latino _____	
Primary RP Factor (Required)		Secondary RP Factor (Optional)		IOM Category (Required)		Funding Source (Optional)	
Hrs of Indirect Service (Optional)		Zip Code (Optional)		Evaluation Method (Required)		Evidence-Based Practice (Yes/No) (Required)	

Service Type		Service Date (mm/dd/yyyy)		Name of Group (20 characters only)			Unit Count
ST _____							
Service Population:		Attendees: (Male)		Attendees: (Female)		Total Present:	Counts Estimated? (Yes/No)
SP _____							
Attendees by Age: (Totals must equal total number of male and female attendees.)				Attendees by Hispanic Origin (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 _____					
Attendees by Racial Category: (Totals must equal or be greater than total male & female attendees.)				Attendees that selected more than one race:		Attendees by other Demographic Category:	
American Indian/Alaska Native _____		Native Hawaiian or other Pacific Islander _____				Cuban _____ Dominican _____	
Asian _____		White _____				Mexican/Chicano _____ Puerto Rican _____	
Black/African American _____						Other Hispanic/Latino _____	
Primary RP Factor (Required)		Secondary RP Factor (Optional)		IOM Category (Required)		Funding Source (Optional)	
Hrs of Indirect Service (Optional)		Zip Code (Optional)		Evaluation Method (Required)		Evidence-Based Practice (Yes/No) (Required)	

Prevention MDS 4.1 Data Entry Form – Recurring Services

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

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

CERTIFIED PREVENTION SPECIALIST (CPS)

Prevention Coordinators are required to be certified under the Prevention **OAR** 415-056-0030 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

❖ 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 TM (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's prevention system 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

The Strategic Prevention Framework (SPF) is a public health model that recognizes that effective 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.

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.
 - Within each process, **Cultural Competence** and long-term **Sustainability** are integrated into the processes of the framework.
-

INFORMATION SHEET

SAMHSA's Strategic Prevention Framework At-a-Glance

Step 1: Assessment	Step 2: Capacity	Step 3: Planning	Step 4: Implementation	Step 5: Evaluation
Profile population needs, resources, and readiness to address needs and gaps.	Mobilize and build capacity to address needs.	Develop a comprehensive strategic plan.	Implement evidence-based prevention programs, policies, and practices.	Monitor, evaluate, sustain, and improve or replace those that fail.
Assess Behaviors and Related Problems	Assess Capacity: Resources and Readiness	Prioritize Risk and Protective Factors (Criteria: importance, changeability)	Build Capacity and Mobilize Support	Conduct Process Evaluation
Prioritize Problems (criteria: largest, most severe, getting worse, high in comparison)	Build Capacity: Increase Resources and Improve Readiness	Select Interventions (criteria: effectiveness, conceptual fit, practical fit)	Carry Out Interventions	Conduct Outcome Evaluation
Assess Risk and Protective Factors		Develop a Comprehensive Plan that Aligns with the Logic Model	Balance Fidelity with Necessary Adaptations	Recommend Improvements and Make Mid-Course Corrections
			Monitor, Evaluate, and Adjust	Report Evaluation Results

INSTITUTE OF MEDICINE CONTINUUM OF HEALTH CARE (IOM)

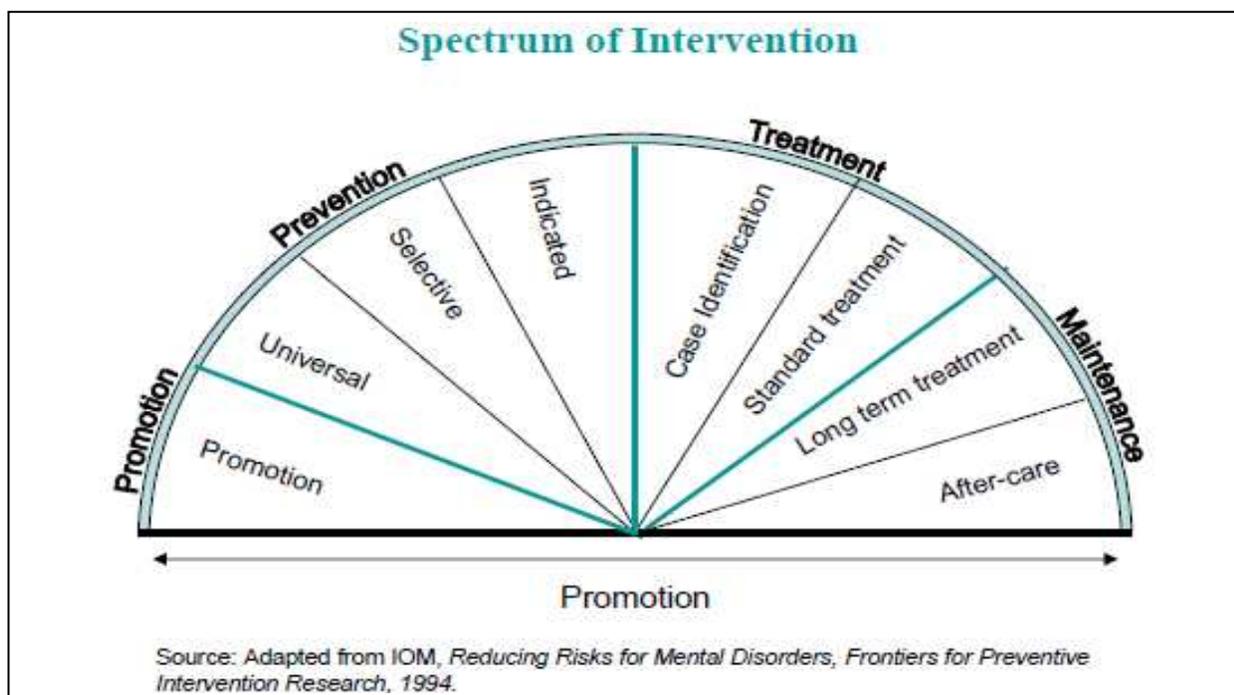
Prevention is one sector of the IOM spectrum of intervention. This chapter will define prevention types in that sector. (See figure 1)

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. 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. IOM Spectrum of Intervention



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 categories describe individuals who have not been diagnosed with a disease.

Mental Health Promotion was adopted in 2007 by SAMHSA and World Health Organization in 2004. Mental health promotion is characterized by a focus on well-being rather than prevention of illness and disorder, although it may also decrease the likelihood of disorder. The National Academy of Sciences defines *Mental Health Promotion* interventions: Usually targeted to the general public or a whole population. Interventions aim to enhance individuals’ ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion, and strengthen their ability to cope with adversity.

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).

A universal service may be 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 more costly indicated interventions to those who most benefit from them.

RISK AND PROTECTIVE FACTORS

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, violence, depression and anxiety. Protective Factors are conditions which are associated with resilience toward substance abuse. Longitudinal research is showing risk factors that have been identified as leading to adolescent problem behavior. While risk factors may predict problem behavior, protective factors buffer the impact and promote positive development of youth strengths. Prevention planning should address both risk and protective factors. Research also indicates that the same set of risk and protective factors guide youth gambling and problem gambling.

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 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.

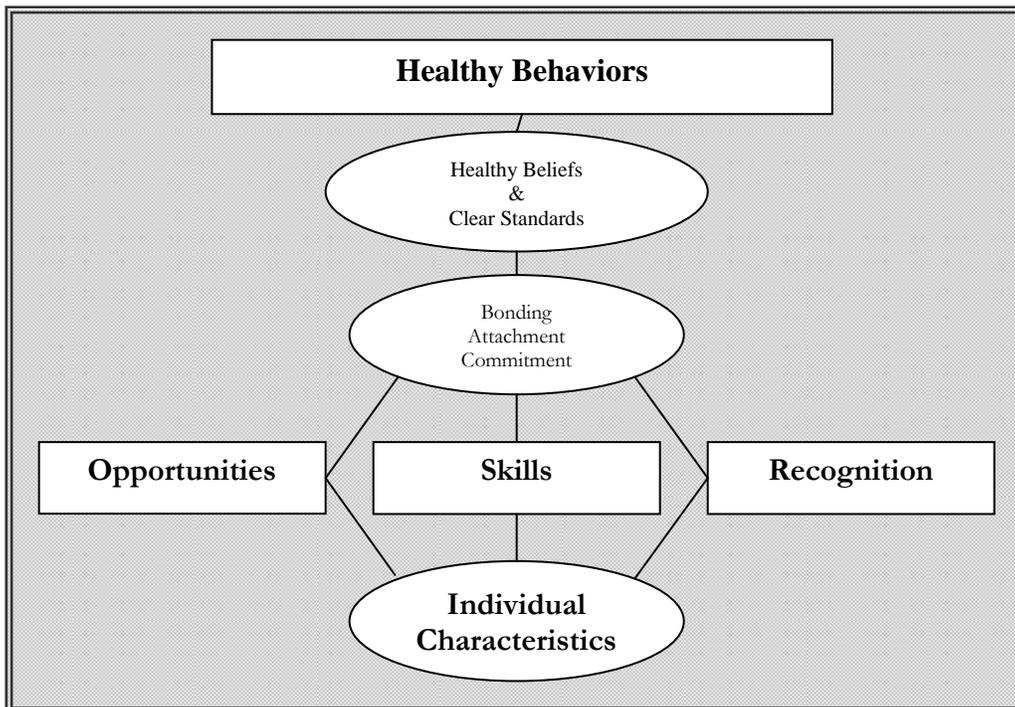
Healthy beliefs and clear standards

People with 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.

SOCIAL DEVELOPMENT STRATEGY



The figure below illustrates the dynamics of the Social Development Strategy



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 substance abuse, delinquency, problem gambling, violence, school dropout, and teen pregnancy. How do we step ahead of the problems with solutions which are far-reaching and lasting?

Risk factors 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. By reducing risks while increasing protection throughout the course of young people's development, problems can be prevented and pro-social growth is promoted.

Research over the past two decades has tried to determine how drug abuse begins and how it progresses. Many factors can add to a person's risk for drug abuse. Risk factors can increase a person's chances for drug abuse, while protective factors can reduce the risk. Please note, however, that most individuals at risk for drug abuse do not start using drugs or become addicted. Also, a risk factor for one person may not be for another.

Risk and protective factors can affect children at different stages of their lives. At each stage, risks occur that can be changed through prevention intervention. Early childhood risks, such as aggressive behavior, can be changed or prevented with family, school, and community interventions that focus on helping children develop appropriate, positive behaviors. If not addressed, negative behaviors can lead to more risks, such as academic failure and social difficulties, which put children at further risk for later drug abuse.

Research-based prevention programs focus on intervening early in a child's development to strengthen protective factors before problem behaviors develop.

The table below describes how risk and protective factors affect people in five domains, or settings, where interventions can take place.

Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Self-Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Anti-drug Use Policies
Poverty	Community	Strong Neighborhood Attachment

Risk factors can influence drug abuse in several ways. The more risks a child is exposed to, the more likely the child will abuse drugs. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the teenage years; just as some protective factors, such as a strong parent-child bond, can have a greater impact on reducing risks during the early years. An important goal of prevention is to change the balance between risk and protective factors so that protective factors outweigh risk factors. NIDA

Risk Factors During Adolescence

Persons	Risk Factors	Protective factors
Individual	Behavioral disengagement coping Negative emotionality Conduct disorder Favorable attitudes toward drugs Rebelliousness Early substance use Antisocial behavior	Positive physical development Emotional self-regulation High self-esteem Good coping skills and problem-solving skills Engagement and connections in two or more of the following contexts: at school, with peers, in athletics, employment, religion, culture
Family	Substance use among parents Lack of adult supervision Poor attachment with parents	Family provides structure, limits, rules, monitoring, and predictability Supportive relationships with family members Clear expectations for behavior and values
School, Peers, Community	School failure Low commitment to school Associating with drug-using peers Not college bound Aggression toward peers Norms (e.g., advertising) favorable toward alcohol use Accessibility/availability	Presence of mentors and support for development of skills and interests Opportunities for engagement within school and community Positive norms Clear expectations for behavior Physical and psychological safety

Risk Factors for Young Adulthoods

Persons	Risk Factors	Protective factors
Individual	Lack of commitment to conventional adult roles Antisocial behavior	Identity exploration in love, work, and world view Subjective sense of adult status Subjective sense of self-sufficiency, making independent decisions, becoming financially independent Future orientation Achievement motivation
Family	Leaving home	Balance of autonomy and relatedness to family Behavioral and emotional autonomy
School, Peers, Community	Not attending college Substance-using peers	Opportunities for exploration in work and school Connectedness to adults outside of family

All tables adapted from O'Connell, M. E., Boat, T., & Warner, K. E. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: The National Academies Press and U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (2009). *Risk and protective factors for mental, emotional, and behavioral disorders across the life cycle*. Retrieved from http://dhss.alaska.gov/dbh/Documents/Prevention/programs/spfsig/pdfs/IOM_Matrix_8%205x11_FINAL.pdf

The following is a summary of research-based risk factors and the problem behaviors they predict (in parentheses). ***A comparison of these as they relate to problem gambling prevention is included in Appendix G .**

COMMUNITY RISK FACTORS

Availability of Drugs (Substance Abuse and *Gambling)

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, *Gambling)

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.

Conflicting messages about alcohol/other drugs from key social institutions are another concern. 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, School Dropout Depression and Anxiety, *Gambling)

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, Violence, *Gambling)

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, School Dropout, *Gambling)

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, Depression and Anxiety, Gambling*)

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, Gambling*)

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, Gambling*)

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, Gambling*)

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 (see Appendix H guide to working with schools)

Academic Failure Beginning in Elementary School (Substance Abuse, Delinquency, Violence, Teen Pregnancy, School Dropout, Depression and Anxiety, Gambling*)

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, School Dropout, Gambling*)

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, School Dropout, Gambling*)

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, Depression and Anxiety, Gambling*)

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, School Dropout, Gambling*)

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, School Dropout, Gambling*)

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, School Dropout, Gambling*)

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, Violence, Gambling*)

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, Violence, Gambling*)

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>							
<i>Risk Factors</i>	Substance Abuse	Delinquency	Teen Pregnancy	School Drop-Out	Violence	Depression & Anxiety	Youth Gambling (emerging research)
<i>Community</i>							
Availability of Drugs/Alcohol (Gambling)	√				√		√
Availability of Firearms		√			√		
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime, (Gambling)	√	√			√		√
Media Portrayals of Violence					√		
Transitions and Mobility	√	√		√	√	√	√
Low Neighborhood Attachment and Community Disorganization	√	√			√		√
Extreme Economic Deprivation	√	√	√	√	√		√
<i>Family</i>							
Family History of the Problem Behavior	√	√	√	√	√	√	√
Family Management Problems	√	√	√	√	√	√	√
Family Conflict	√	√	√	√	√	√	√
Favorable Parental Attitudes and Involvement in the Problem Behavior	√	√			√		√
<i>School</i>							
Academic Failure Beginning in Late Elementary School	√	√	√	√	√	√	√
Lack of Commitment to School	√	√	√	√	√		√
<i>Individual/Peer</i>							
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	√	√			√	√	√

<i>Risk and Protective Factors</i> <i>Validated Archival Indicators at county level only</i>	
<i>Archival Indicators</i>	<i>Community per capita data</i>
Availability	
Alcohol sales outlets	
Tobacco sales outlets	
Transitions and Mobility	
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	
Extreme Economic Deprivation	
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	
Family In cohesion	
Children living away from parents	
Children living in foster care	
Family Conflict	
Divorces	
Domestic Violence arrests	
Parental Involvement in substance use/crime	
Low commitment to school	
Drop outs	
School Age not enrolled	
Early and Persistent Antisocial Behavior	
Substance Abuse	
Delinquency	
Violence	
Academic Failures	
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	
<i>Community Laws and Norms (not validated)</i>	

COMMUNITY ASSESSMENT

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 and gambling. This usually is around the 6th 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 6th, 8th, 11th 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 6th, 8th, 10th and 12th 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 8th and 11th grades. Because 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 that produced the Student Wellness survey. The Oregon Healthy Teen Survey (OHT) from Public Health will be administered in the odd years. The Student Wellness Survey is administered in even 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.

The following links may be useful .

Oregon Student Wellness Survey Data

<http://www.oregon.gov/oha/amh/pages/student-wellness/index.aspx>

Oregon Healthy Teens Data

<http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx>

Oregon Youth Gambling Data

<http://www.oregon.gov/oha/amh/sew/SEOW/Youth%20gambling%20in%20the%20past%2030%20days.pdf>

Mortality

<https://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/leadingcausesofdeath.pdf>

DATA ANALYSIS, SETTING PRIORITIES, TARGETING

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

- Promotion
 - Universal (Entire population)
 - Selective (At risk population)
 - Indicative (showing early danger signs of problem behavior)
-

PREVENTION STRATEGIES AND PRINCIPLES

CSAP PREVENTION STRATEGIES:

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.
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. [Note: Alternative activities alone have not been shown to be effective at preventing substance abuse or gambling.]
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. Community-based efforts-This strategy helps communities 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, law enforcement, counselors, membership and service clubs (Lions, Kiwanis, Elks Clubs)
 5. Problem identification and referral- In this strategy we can work to reverse risky behaviors by applying some of the awareness, alternatives, and skill building tools discussed above.
Ideas: Tobacco Quit Lines, assessment and referral to appropriate services, SBIRT, Help lines
 6. Environmental- This strategy helps communities identify existing laws, attitudes, or social norms around substance abuse and gambling to either enforce, or work at changing them.
-

PREVENTION PRINCIPLES:

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-driven 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 as funding allows.
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.

EFFECTIVE APPROACHES TO SUBSTANCE ABUSE AND PROBLEM GAMBLING PREVENTION

The goal of substance abuse and problem gambling prevention endeavors 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 assembly 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. Much more research has been done on substance abuse than on problem gambling, but it is an emerging field of research and, so far, tends to parallel substance abuse prevention very closely in terms of etiology, intervention methods, prevention frameworks and strategies, etc.

Evidence-based prevention practices are those that research has proved effective. OHA promotes the use of proven practices in addictions and mental health services. The Oregon Legislature directed OHA 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/oha/amh/pages/ebp/main.aspx>

Oregon and State of Washington partnered to put together a searchable database for prevention Evidence Based Practices, Policies, and Programs.

[http://www.theathenaforum.org/learning_library/ebp?keys=&tid_1\[\]=957](http://www.theathenaforum.org/learning_library/ebp?keys=&tid_1[]=957)

An evidence-based practice from any list should not be assumed better than a 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 and produced findings

which are posted at <http://www.oregon.gov/oha/amh/pages/ebp/main.aspx> (scroll down to Native American Population and then to Approved Tribal Programs).

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).

Attention to the school climate and culture in a given school community would be helpful as well. The underlying values, attitudes and beliefs predominantly held in a school community, resulting in the school Climate, directly influences behavior or the culture of a school. A negative school climate, which is typically directly reflective of the community, often results in increased incidents of bullying and harassment, increased abuse of drugs and alcohol, other addictive and at-risk tendencies or behavior, and an increase in the use of expulsion, out of school suspensions, and truancies.

Schools need to survey their teachers, students and staff to assess for school climate. The data or results from these surveys would be used to guide practices and interventions at schools. The implementation of school-wide Positive Behavioral Interventions & Supports (PBIS), which is evidence-based, would provide an excellent foundation for teaching, promoting and reinforcing positive expectations. This program would lay the groundwork or framework for creating a positive school climate and culture. Evidence-based social-emotional learning (SEL) curricula to pinpoint a school's specific needs and further reinforce and promote pro-social behavior would be beneficial as well. Specific evidence-based SEL programs for a school's particular needs can be found on the SAMHSA website.

To promote optimum learning conditions, it is important to create positive school climates and cultures where students feel safe. Positive school climates also result in less behavioral difficulties, substance abuse issues, bullying and harassment, and nullifies students not feeling safe. A positive school climate promotes inclusiveness, effective communication and tolerance, feelings of well-being, optimum learning conditions, better attendance, and increased academic achievement. It supports student's ability to thrive academically and socially.

STRATEGIES THAT HAVE THE BEST OPPORTUNITY FOR POSITIVE BEHAVIOR CHANGE IN ALCOHOL, TOBACCO AND OTHER DRUG USE AND PROBLEM GAMBLING PREVENTION PROGRAMS

(ADAPTED FROM DRUGSTRATEGIES.ORG: MAKING THE GRADE)

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 and gamble.
 2. Facilitate development of personal, social and refusal skills to resist these pressures.
 3. Teach youth that using alcohol, tobacco and other drugs and gambling 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 and problem gambling.
 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

(Excerpt from "Preventing Drug Use Among Children and Adolescents: A Research-Based Guide" by the National Institute for Drug Abuse, 1997, p. i-ii; problem gambling information added, 2013)

These principles can be applied to existing programs or in 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 substance abuse, including the use of tobacco, alcohol, marijuana prescription drugs and inhalants. Other relevant behaviors, such as youth gambling, should also be included in comprehensive approaches.
 - Prevention programs should include skills to resist drugs when offered, strengthen personal commitments against substance 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. A similar approach should be taken with gambling.
 - 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, and gambling, are more effective when accompanied by school and family interventions.
 - Community programs need to strengthen norms against substance use and problem gambling 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, 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 problems 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.
-

Prevention Site Review Protocol

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

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

Agency Approval/Certificate: An agency may operate a substance abuse and/or problem gambling prevention program and may request a Letter of Approval from AMH after review and comment by the community mental health authority and the local alcoholism planning committee or appropriate drug abuse planning committee. Funding from AMH may only occur with an agency approved by the AMH. 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 prevention expenditures and offers support and technical assistance to further prevention efforts and issues Letters of Agreement or LOAs. This site review protocol helps 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/oha/amh/prevention/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.

State of Oregon
Oregon Health Authority– Addictions & Mental Health Division
500 Summer Street NE, E-86 • Salem, Oregon 97301-1118

Prevention Site Review Protocol

This site review protocol is intended to help funded substance abuse and problem gambling prevention 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:	A&D 70 or 37 \$ Lottery \$
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:
	Address of Person Completing this Form:		Fax Number:
		E-Mail Address (of person completing this form)	
5.	Name of Fiscal Agent Contact Person:		Telephone Number:
	Fiscal Agency:		Fax Number:
		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"/>
Policy on substance use by program staff/participants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policy on gambling by program staff/participants	<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...	<u>Yes</u> (Formal/Written)	<u>Yes</u> (Informal)	<u>No</u>
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)*

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	
LOTTERY	
OTHER (Identify Source)	

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.
-

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, CCO's 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)		
Treatment and Recovery Services		

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 survey	Health knowledge, attitudes, and behaviors	Administered to all public middle school 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
Grants Short term, specific initiatives, federal or state government, foundation	<input type="checkbox"/>	<input type="checkbox"/>	
Gifts Restricted or Unrestricted	<input type="checkbox"/>	<input type="checkbox"/>	
Membership Fees	<input type="checkbox"/>	<input type="checkbox"/>	
Underwriting/Sponsorship 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"/>	
Events Fundraising activities and awareness events	<input type="checkbox"/>	<input type="checkbox"/>	
Fee-for-Service Sliding scales dependent upon income	<input type="checkbox"/>	<input type="checkbox"/>	
Sale of Products or Services Products (t-shirts, stickers, cook books, etc.) sold to support programs and services	<input type="checkbox"/>	<input type="checkbox"/>	
Non-Profit Business Affiliate A for-profit business created separate from 501(c)(3) and profit supporting programs and services	<input type="checkbox"/>	<input type="checkbox"/>	
Bequests Money willed to a group	<input type="checkbox"/>	<input type="checkbox"/>	
Endowment Funds Donated funds, may be restricted or unrestricted	<input type="checkbox"/>	<input type="checkbox"/>	
Awards Party applies to competition and receives funding	<input type="checkbox"/>	<input type="checkbox"/>	
Special Taxes Taxes set aside to support a particular program	<input type="checkbox"/>	<input type="checkbox"/>	
Program of Government Local government subsidizes program activities, police department, town funds, Community Development Block Grants	<input type="checkbox"/>	<input type="checkbox"/>	

- 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

19. Please give examples of how you have used Student Wellness Survey data on youth gambling, and how you have infused problem gambling into your substance abuse prevention efforts

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 for substance abuse and problem gambling prevention**
 - 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 completed form to AMH at least one week prior to scheduled site review.

Site Review Forms (completed by AMH Staff during site review)

Site Review Form - Addictions and Mental Health Division
 Application for Approval/Renewal of Substance Abuse & Problem Gambling Prevention Programs
 OAR 415-56-0030 through 415-56-0050

Program:					County:	
Evaluated by:					Date:	
	Exceeds	Compliant	Non-Compliant	N/A		
Areas of Review	Findings					
<u>OAR 415-56-0040 - Administrative Requirements</u>						
Fee Schedules						
1.) If a fee schedule is established and used, it must approximate the actual cost of service delivery, and must assess the cost to the participant for the services in accordance with the participant's ability to pay.	-	-	-	-	-	
Policies and Procedures						
1.) Prevention Provider has established comprehensive written policies and procedures which describe operations and compliance with existing administrative rules.						
2.) At a minimum, written policies and procedures describe the following:						
(a) <i>Mission, vision and values statement</i>						
(b) <i>Organizational Management Chart</i>						
(c) <i>Prevention framework that guides prevention efforts</i>						
(d) <i>Anti-discrimination policy</i>						

(e) Cultural competency plan								
(f) Policy for addressing gender specific services								
(g) Use of substances by program participants and staff								
(h) Gambling by program participants and staff								
(i) Protection and safety of service recipients								
(j) Process for referring individuals who are not appropriate for prevention services to more applicable resources such as emergency and crisis services, detoxification, mental health treatment and other services within the continuum of care.								
Review of Letter of Approval Request								
1.) If this is an initial request for certification, has the request been approved and received comment from the CMHP, tribal authority, LADPC or other applicable review committee?.								
Evidence-Based Practices								
1.) Prevention provider provides services that incorporate evidence-based practices as defined in OAR 415-056-0035								
Printed Materials								
1.) Prevention Provider utilizes program materials that are:								
(a) Written with consideration to the demographic make-up of the program and in culturally competent language.								
(b) Written in the participant's native language								
(c) Reflective of current substance abuse and gambling prevention research and practice								
Agency Reporting								
1.) Prevention Provider reports to the Division on approved standardized format.								
2.) All reporting is done in accordance with federal Confidentiality Regulations (42 CFR Part 2)								

Physical Environment				
1.) Prevention Provider operates the program(s) in facilities that ensure the privacy and safety of participants, where appropriate and necessary.				
Coordination of Activities				
1.) Prevention Provider documents coordination of activities with related community partners.				
<u>OAR 415-056-0045 - Staff Requirements</u>				
1.) The substance abuse and/or problem gambling prevention program is administered by staff in accordance with standards set forth in these rules.				
2.) The Coordinator is qualified by virtue of knowledge, training, experience and skills.				
(a) <i>The Coordinator must be certified by the Addiction Counselor Certification Board of Oregon (ACCBO) as a Certified Prevention Specialist (CPS), or must acquire certification within two years from the date of hire.</i>				
3.) The Coordinator shall be employed greater than .50 FTE to carry out their responsibilities.				
4.) Roles and authorities of the Coordinator include:				
(a) <i>Development, monitoring and oversight of the Prevention Implementation Plan, which shall be in compliance with the requirements set forth by the Division.</i>				
(b) <i>Implementation of the defined strategies.</i>				
(c) <i>Management of the program staff.</i>				
(d) <i>Administration of funds.</i>				
(e) <i>Accountability for the oversight and quality of prevention services.</i>				

<p>(f) Supervision of other staff related to their skill level with the goal of achieving the objectives of the prevention program and assisting staff to increase their knowledge, skills and abilities.</p>				
<p>5.) Program staff providing more than .5 FTE hours of direct prevention services must:</p>				
<p>(a) Have a CPS certification, or must acquire the certification within two years of hire.</p>				
<p>(b) Have a workforce development plan utilized to assure compliance with these rules and to ensure staff has opportunities to advance their prevention knowledge and skills.</p>				
<p>(c) Be culturally competent to serve the identified populations.</p>				
<p>(A) Agencies who contract for the delivery of direct prevention services must insure that the contractors meet the requirements for prevention staff described in these rules.</p>				
<p>6.) The number and responsibilities of teh prevention staff must be sufficient to provide the services required under these rules, for the number of participants the program intends to serve.</p>				
<p><u>OAR 415-056-0050 - Variances</u></p>				
<p>1.) Requirements and standards for requesting and granting variances or exceptions are found in OAR 415-012-0090.</p>				

APPENDIX A

OREGON PREVENTION HISTORY HIGHLIGHTS

(a fuller version of this history is available from AMH Prevention Unit upon request)

- 1970's – Towards the latter part of the 70's, 10% of treatment dollars could be used for substance abuse prevention services.
 - 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 – 1st Alcohol and Drug Prevention Conference held at Kah-Nee-Ta Resort
 - June 1984 – Oregon Student Safety On the Move (OSSOM) created at OSU
 - 1985 – 1st “Just Say No March” held at the State Capitol.
 - 1986 – Federal Drug Omnibus bill signed, creating funding for prevention. Drug-Free School Act was enacted.
 - 1986 – 1st Red Ribbon Campaign held at the State Capitol.
 - 1986 – Oregon Student Retention Initiative (SRI) process was enacted to do comprehensive prevention planning.
 - November 1987 – Oregon Prevention Resource Center (OPRC) opened.
 - 1987 – Western Center for Drug Free Schools was created.
 - 1988 – First Oregon Teen Leadership Institute conducted by OSSOM
 - 1988-89 – “Discovering the Meaning of Prevention,” promoted statewide
 - 1989 – Preparing for Drug Free Years (PFDFY) implemented statewide by OPRC
 - 1990. Oregon Together initiated by NIDA grant. 32 coalitions formed in communities across the state. By the late 90's expanded into 75 communities, many receiving CSAP funding for community mobilization efforts.
 - Early 90's – “Drugs in the Workplace” for rural areas enacted.
 - Early 90's – Statewide gambling program uses OPRC 800 number for gambling issues.
 - 1991 – Risk and Protective factors is used as a framework for prevention with Prevention Early Intervention (PE/I) providers.
 - 1992 – Five-year Community Partnership grants are awarded in Oregon by CSAP. (Lincoln County, Lane County, Salem/Keizer, Regional Drug Initiative, & Klamath Tribe).
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- 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 – CSAP grant started the Six State Consortium to focus on statewide risk/protective factors. (Oregon, Washington, Kansas, Utah, South Carolina and Maine).
 - 1993 - Oregon Partnership formed, incorporating three existing agencies with common objective to help communities across the state prevent substance abuse.
 - 1994 Risk and Protective Factor survey initiated in 6th, 8th, 10th, and 12th 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 Oregon and 9 from Washington.
 - 1995 – The first county alcohol and drug profiles are created, using student survey and archival data.
 - 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.
 - 1997 – State Incentive Grant awarded to five States, (Oregon, Kansas, Illinois, Kentucky and Vermont). This will change how we administer prevention dollars.
 - 1997 – Tobacco Liaison position within OADAP is created.
 - 1997 – Western Center for the Application of Prevention Technologies is formed.
 - 1997-98 – Strategic planning throughout the state. Community mobilization and parenting are named as the two top priorities for prevention.
 - 1997-98 –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, utilizing International Certification and Reciprocity Consortium standardized format and processes.
 - 1998 – State planning coalesced into Juvenile Crime Prevention Partnership, (beginning of Senate Bill 555).
 - 1998 – OADAP Prevention Unit hires three new Prevention Coordinators.
 - 1999 – OPRC moves and becomes Oregon Prevention Treatment Resource Center (OPTRC).
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- 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). 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. Senate Bill 555 approved by the legislature.
 - 1999 – Tribal Liaison position created within OADAP.
 - 2000 – Pilot project to integrate the Youth Risk Behavior Survey and the Student Drug Use 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.
 - 2001 – OADAP re-named Office of Mental Health and Addiction Services (OMHAS).
 - 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 9 Tribes awarded up to \$95,000 for prevention during 01-03 biennium.
 - 2001 – No prevention conference held.
 - 2002 – Prevention Unit is re-named “Child & Adolescent Health Systems Unit” (CAHSU).
 - December 2002 –state coordinator for the Enforcing Underage Drinking Laws (EUDL) program named.
 - 2003 – CAHSU moved into Office of Mental Health and Addictions Services and becomes the Prevention Unit.
 - 2003 – No prevention conference. .
 - 2004- OMHAS Mental Health Unit staff moves from the State Hospital Offices to DHS building.
 - 2004 – Prevention moves to Policy and Program Development Unit
 - 2004 – OMHAS was awarded CSAP cooperative agreements for Ecstasy and other Club Drug Prevention services grants.
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- July 2005 – 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 – CSAP Fellowship awarded to Oregon.
 - 2006 – Oregon received a 3-year CSAP state epidemiological outcomes workgroup grant.
 - 2006 – OMHAS renamed as Addictions and Mental Health Division AMH. Policy and Program Development Unit remains the same.
 - July 2007 – The Oregon Legislature approves 1.9 million general fund dollars for suicide prevention (.2M) and 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 in Portland for over 900 participants.
 - October 2007 – Prevention Manager Position announced.
 - June 2008 *Work Drug Free* becomes *Oregon Employers Drug Initiative* and *Work Healthy Oregon*.
 - 2010 Strategic Prevention Framework initiative begins.
 - 2010 CSAP Fellowship awarded to Oregon.
 - 2011 Problem gambling prevention added to Prevention Unit.
 - 2012 Prevention OAR changed to include problem gambling prevention.
 - 2013 Health Care Transformation process results in flexible funding and creation of CCOs; prevention funds included in flexible funding.
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APPENDICES B – E

OREGON ADMINISTRATIVE RULES

APPENDIX B

OREGON HEALTH AUTHORITY ADDICTIONS AND MENTAL HEALTH DIVISION CHAPTER 415: ADDICTION SERVICES

DIVISION 56

SUBSTANCE ABUSE AND PROBLEM GAMBLING PREVENTION PROGRAMS

415-056-0030

Purpose and Scope

(1) These rules prescribe standards and procedures for substance abuse and problem gambling prevention providers approved by the Addictions and Mental Health Division (AMH). These rules establish standards for community substance abuse and problem gambling prevention and provide that a full continuum of services be available to Oregonians either directly or through written agreements or contracts.

Statutory Authority: ORS 409.410 and 413.042

Statutes Implemented: ORS 430.240 - 430.415

415-056-0035

Definitions

(1) "Approval" means the Letter of Approval issued by the Division to indicate that the substance abuse prevention and/or problem gambling program has been found in compliance with all relevant federal and Oregon laws and Oregon Administrative Rules (OAR).

(2) "Community Mental Health Program (CMHP)" means an entity that is responsible for planning and delivery of services for individuals with substance use disorders or a mental health diagnosis, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(3) "Coordinator" means the designated county or tribal program coordinator hired to oversee prevention services.

(4) "Cultural Competence" means 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) "Deputy Director" means the Deputy Director of AMH.

(6) "Division" means the AMH Division of the Oregon Health Authority.

(7) "Evidenced-Based Practices" (EBP) means practices for which there is consistent scientific evidence that produce positive outcomes. An EBP must meet the criteria set forth by the Division.

(8) "Gender-Specific Services" means services which comprehensively address the needs of a gender group and foster positive gender identity development.

(9) "Letter of Approval" means the "Approval" as defined in 415-056-0035.

(10) "Institute of Medicine Model" means the framework that defines the target groups and activities addressed by various prevention efforts and includes the following:

(a) Promotion: Strategies that typically address the entire population. Strategies are aimed to enhance individuals' ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem, mastery, well-being and social inclusion, and strengthen their ability to cope with adversity;

(b) Universal Prevention: Universal strategies address the entire population with messages and programs aimed at preventing or delaying the substance abuse and/or problem gambling.

(c) Selective Prevention: Selective prevention strategies target subsets of the total population that are deemed to be at-risk for substance abuse or problem gambling by virtue of the membership in a particular population segment; and

(d) Indicated Prevention: Indicated prevention strategies are designed to prevent the onset of substance abuse or problem gambling in individuals who do not meet criteria for addiction but who are showing early danger signs.

(11) "Local Alcohol and Drug Planning Committee" (LADPC), 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) "Minority" means a participant whose cultural, ethnic or racial characteristics constitute a distinct demographic population including but not limited to members of differing cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders or sexual orientations.

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

(14) "Participant" means an individual who receives services under these rules.

(15) "Prevention Provider" means a governmental entity, an organization or federally recognized tribe that undertakes to establish, operate or contract for prevention services.

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

(17) "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 and problem gambling or detrimental effects from occurring. The Center for Substance Abuse Prevention's 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, 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 dissemination strategy;

(c) Alternatives: This strategy provides participation in activities that exclude alcohol and other drugs and gambling. The purpose is to identify and offer healthy activities and to discourage the use of gambling, alcohol and drugs through these activities;

(d) Problem Identification and Referral: This strategy aims at identification of individuals who have indulged in illegal or age-inappropriate use of tobacco or alcohol or gambling and those individuals who have indulged in the first use of illicit drugs in order to assess if the individual's 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; and

(f) Environmental: This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing alcohol and other drug use and gambling by the general population.

(18) "Tribal Authority" means an individual or group identified by the tribe that approves the prevention plan. Examples include a Tribal Council, Health Director or Prevention Supervisor.

415-056-0040

Administrative Requirements

- (1) A prevention provider that contracts directly or indirectly with the Division must comply with all related administrative rules.
 - (2) Subcontracted agencies must be administered by staff in accordance with standards set forth in OAR 309-014-0000 through 0025 and OAR 309-014-0030(3) through 0040.
 - (3) A fee schedule may be established that 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.
 - (4) A prevention provider must establish comprehensive written policies and procedures which describe program operations and compliance with these rules, and shall at minimum address the following:
 - (a) A mission, vision and values statement;
 - (b) An organizational management chart;
 - (c) The prevention framework that guides the program's prevention efforts;
 - (d) An anti-discrimination policy;
 - (e) A cultural competency plan;
 - (f) Gender specific services;
 - (g) The use of substances by program participants and staff during program activities;
 - (h) Gambling by program participants and staff during program activities;
 - (i) The protection and safety of service recipients and
 - (j) A process for referring individuals who are not appropriate for prevention services to more applicable resources such as emergency and crisis services, detoxification, mental health treatment and other services within the continuum of care.
 - (5) A request for certification will be considered by the Division after the CMHP or tribal authority, and the LADPC or other applicable committee has reviewed and commented on the request.
 - (6) Prevention providers must provide services that incorporate evidence based practices as defined in OAR 415-056-0035.
 - (7) Printed materials utilized by the program must be:
-

- (a) Written with consideration to the demographic make-up of the program and in cultural competent language;
- (b) In the participant's native language; and
- (c) Reflective of current substance abuse and gambling prevention research and practice.
- (8) The provider must report to the Division on approved standardized forms. All reporting must be done in accordance with Federal Confidentiality Regulations (42 CFR Part 2).
- (9) The provider must ensure the privacy and safety of participants where appropriate and necessary.

- (10) Providers must document coordination of activities with related community partners.

Statutory Authority: ORS 409.410 and 413.042
Statutes Implemented: ORS 430.240 through ORS 430.415

415-056-0045

Staff Requirements

- (1) The substance abuse and/or problem gambling prevention program must be administered by staff in accordance with standards set forth in these rules.
 - (2) The Coordinator is qualified by virtue of knowledge, training, experience and skills.
 - (a) The Coordinator must be certified by the Addiction Counselor Certification Board of Oregon (ACCBO) as a Certified Prevention Specialist (CPS), or must acquire certification within two years from the date of hire.
 - (3) The Coordinator shall be employed greater than .50 FTE to carry out their responsibilities.
 - (4) Roles and authorities of the Coordinator include:
 - (a) Development, monitoring and oversight of the Prevention Implementation Plan, which shall be in compliance with the requirements set forth by the Division.
 - (b) Implementation of the defined strategies;
 - (c) Management of the program staff;
 - (d) Administration of funds;
 - (e) Accountability for the oversight and quality of prevention services; and
 - (f) Supervision of other staff related to their skill level with the goal of achieving the objectives of the prevention program and assisting staff to increase their knowledge, skills and abilities.
 - (5) Program staff providing more than .5 FTE hours of direct prevention services must:
-

- (a) Have a CPS certification, or must acquire the certification within two years of hire;
 - (b) Have a workforce development plan utilized to assure compliance with these rules and to ensure each staff has opportunities to advance their prevention knowledge and skills; and
 - (c) Be culturally competent to serve the identified populations.
- (A) Agencies who contract for the delivery of direct prevention services must assure that the contractors meet the requirements for prevention staff described in these rules.
- (6) The number and responsibilities of the prevention staff must be sufficient to provide the services required under these rules, for the number of participants the program intends to serve.

Statutory Authority: ORS 409.410 and 413.042

Statutes Implemented: ORS 430.240 through ORS 430.415

415-056-0050

Variations

(1) Requirements and standards for requesting and granting variations or exceptions are found in OAR 415-012-0090.

Statutory Authority: ORS 409.410 and 413.042

Statutes Implemented: ORS 430.240 through ORS 430.415

APPENDIX C

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
 - (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

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.

(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. + }

Passed by Senate April 2, 2001

.....
Secretary of Senate

.....
President of Senate

Passed by House May 11, 2001

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Speaker of House

APPENDIX E REMOVED SB 555 1999



Community Prevention Services - Promoting Healthy Behaviors and Lifestyles

Preventing substance abuse, addictions and problem gambling is fundamental to Oregon's vision for better health, better care and lower costs.

What is Prevention?

The word "prevention" is used a lot. Different types of prevention have different meanings and purposes. Prevention can be categorized in two ways, clinical prevention and community prevention.

Both types of prevention are central to improving health. Clinical and community prevention efforts need to reinforce each other. People need to receive appropriate preventive care in clinical settings and also be supported by community-based resources.

Clinical Prevention (Primary Care)	Community Prevention
Clinical preventive services include those services that are typically performed in a clinical setting and are conducted by a health professional. Preventive interventions include: screening, testing, counseling, immunization, preventive medication and other preventive treatments, such as monitoring blood pressure and weight, asking about tobacco, alcohol and other drug use, providing counseling about risk and health promotion strategies.	Community prevention services -- also known as population-based prevention -- include any kind of planned strategy or group of strategies (including programs, policies, and laws) designed to prevent disease or injury or promote health in a group of people. Examples include problem gambling prevention, underage drinking prevention and worksite wellness programs. These programs are often delivered or facilitated by a Certified Prevention Specialist.

What is new: How Community Prevention could work with Coordinated Care Organizations

A Coordinated Care Organization (CCO) is a network of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid). Coordinated Care Organizations (CCOs) are required to coordinate the delivery of physical health care as well as mental health and chemical dependency services. Community prevention coordinators can offer specific knowledge about their communities' specific demographics and needs. Prevention coordinators can be a key element as a way to improve health, provide better care and lower costs for the approximately 600,000 clients of the Oregon Health Plan.

Important messages to share about Community Prevention

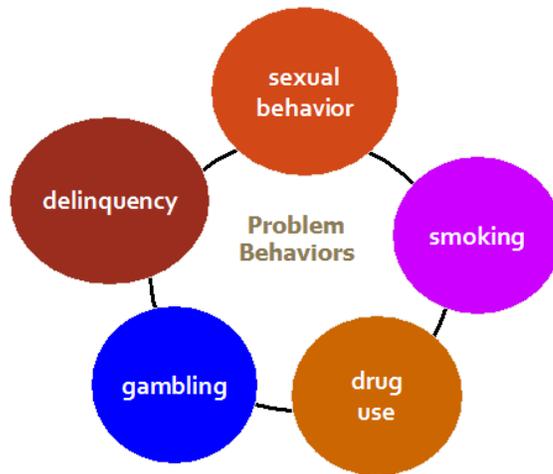
- Across Oregon, County and Tribal Prevention Coordinators play an important role in creating strategies, policies, and programs designed to promote healthy behaviors among an entire community. Coordinators and partners prioritize community prevention needs based on local data. Some of the key health issues include substance abuse, tobacco use, violence, problem gambling and suicide prevention.
- Community prevention includes strategies such as: parent training, school curriculum, cultural best practices, along with wellness programs and screening tools most often coordinated or delivered by a Certified Prevention Specialist.
- Community prevention is about creating healthier communities, in part through community coalitions. Local coalitions are organized groups of concerned citizens and professionals whose efforts encourage prevention and health promotion through awareness campaigns, positive and healthy advertising, and policy development.
- Coordinated community prevention happens best when local data is used to help identify and prioritize community healthy priorities. This is best done utilizing the Strategic Prevention Framework (SPF). SPF is an evidenced-based community planning tool that engages citizens, professionals and coalitions to assess the community help build capacity, create a comprehensive plan, implement the plan with fidelity and evaluate outcomes; while focusing on sustainability and local community culture.

For more information about Coordinated Care Organizations visit
www.health.oregon.gov

APPENDIX G PROBLEM GAMBLING PREVENTION OVERVIEW AND RESEARCH

A “picture” of the framework we support:

Youth gambling should be addressed with other risk behaviors in prevention/education programs



AMH Prevention programs also address problem gambling, particularly among youth. Funds come to DAS from Lottery proceeds and are given to AMH, which is responsible for providing effective prevention and treatment services to all Oregonians.

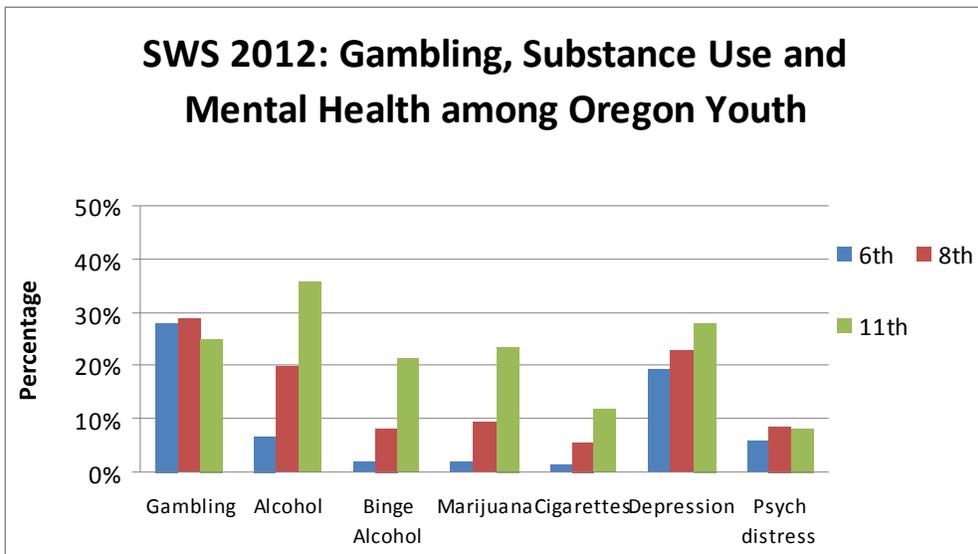
Youth gambling is of concern because of: relatively high participation rates; increasingly easy access to gambling opportunities and ongoing glamorization of it as an easy way to make money; increasing marketing of gambling to youth; youth brain development providing an environment conducive to gambling (risk taking, lack of consideration of consequences, high stimulation, etc.); a lack of overall understanding of and attention to this issue among parents, schools, etc; and because youth develop gambling problems more readily than adults (national data indicate youth problem gambling at about 5% and adult at about 3%). Oregon data tell us that already one youth per classroom has a gambling problem that would meet criteria for further diagnosis, yet it remains off of the radar screen of most people who have, and work with, kids.

Each county receives problem gambling prevention (and treatment) funding of various amounts depending on population and performance. Each county has a part

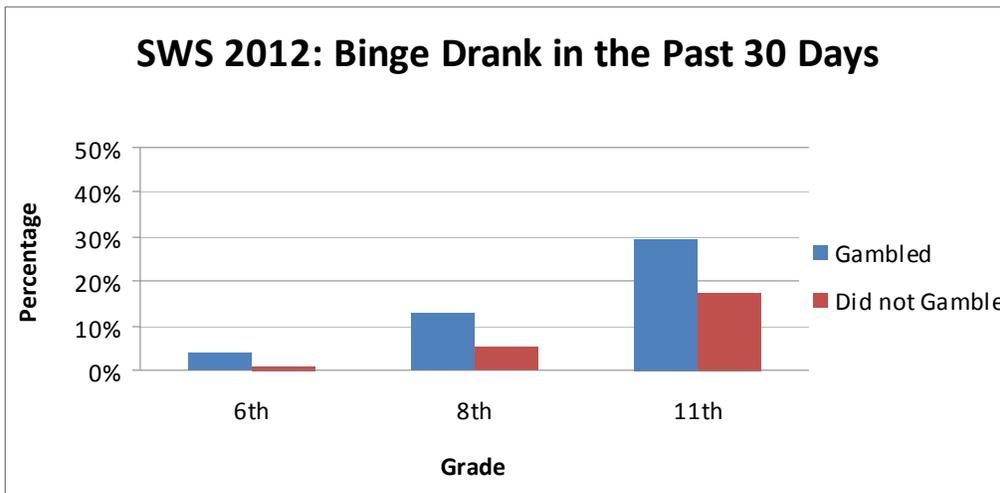
time problem gambling prevention specialist, most of whom are also the substance abuse prevention coordinator.

Because risk and protective factors, as well as prevention strategies are the same for problem gambling prevention as for substance abuse prevention, local programs are encouraged to include problem gambling into their existing prevention programs and to follow SAMHSA’s CSAP 6 prevention strategies as they develop their services. Oregon is a national leader in this regard.

For more information, there is a state-sponsored problem gambling prevention coordinator’s resource hub at www.problemgamblingprevention.org.



Youth who gamble are much more likely to engage in other risk behaviors. which is another reason it needs to be addressed; the graph shown is for binge drinking, but this pattern holds true for smoking, marijuana use, skipping school, getting into fights, etc.



Youth who gamble are much more likely to engage in other risk behaviors. which is another reason it needs to be addressed; the graph shown is for binge drinking, but this pattern holds true for smoking, marijuana use, skipping school, getting into fights, etc.

SECTION I. RISK AND PROTECTIVE FACTORS RELATED TO PROBLEM GAMBLING AND OTHER PROBLEM BEHAVIORS

Research has identified risk factors that contribute toward problem youth behavior, including substance abuse, violence, delinquency, teenage pregnancy, and school dropout (Hawkins & Catalano, 1992). Recent studies in the field of gambling have established that many adolescents who engage in gambling activities are also involved in other problem behaviors (Carlson & Moore, 1998; Vitaro, Ferland, Jacques, & Ladouceur, 1998; Volberg, 1998; Winters, Stinchfield, & Fulkerson, 1993), and research continues to develop that demonstrates the commonalities of risk factors for problem gambling and other problematic behaviors. While studies have not yet clearly demonstrated a link between protective factors and reduced risk for problem gambling, exploratory research suggests such a link exists (Dickson et al., 2002).

The purpose of this section is to equip gambling prevention providers with an improved understanding of the relationships of risk factors between problem gambling and other problem behaviors, and to have a general understanding of how protective factors may be of use in problem gambling prevention program strategies.

Please note that the literature review, particularly with regard to problem behaviors in general, is not exhaustive. Many studies exist in the literature examining various problem behaviors and their hypothesized risk and protective factors. The links shown in this document outline the belief that problem gambling prevention activities may be most effective by addressing common risk and protective factors. Many thanks to Dickson, Derevensky, & Gupta (2002) for providing the gambling prevention community with a compilation of valuable research, much of which follows.

A. COMMUNITY RISK FACTORS

1. Availability

The more available drugs and alcohol are in a community, the higher the risk that drug abuse will occur in that community. Perceived availability of drugs is also associated with increased risk. In schools where children just **perceive** that drugs are more available, a higher rate of drug use occurs.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Accessibility	Jacques et al., 2000; Griffiths, 1995	Greater accessibility found to be related to increased gambling, money spent on gambling, increased numbers of problem gamblers (Dickson et. al., 2002).
ALCOHOL / DRUGS: Access and availability to substances	Brook et al., 1992	The more available substances are, the higher the risk that young people will abuse them. Intervention in later research showed that higher alcohol taxes were found to be related to decreases in consumption and problem drinking consequences (Coate & Grossman, 1988 as cited in Dickson et al., 2002).

2. Community laws and norms favorable toward drug use

Community norms--the attitudes and policies a community holds in relation to drug use, violence 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. When laws, tax rates, and community standards are favorable toward substance abuse, violence or crime, or even when they are just unclear, young people are at higher risk.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Lack of community awareness	Gupta & Derevensky, 1996; Wood & Griffiths, 1998, 2000	Parents and family members are not aware of the dangers inherent in children regularly engaging in gambling activities; educators are not aware of the prevalence of children gambling on a regular basis (Dickson et al., 2002).
GAMBLING: Social acceptance	Stinchfield & Winters, 1998	Gambling is heavily advertised and readily available to youth.
GAMBLING: Media; television lottery ads	Carlson & Moore, 1998	Youth who are more aware of lottery advertising are more likely to play the lottery.
ALCOHOL: Absence of legal enforcement of underage drinking	Maddahian et al., 1988; Gottfredson, 1988; Laughery et al., 1993	Availability of affected use of alcohol and illegal drugs. Later research showed that, by increasing the price of beer, frequent youth drinking was reduced (Coate & Grossman, 1988 as cited in Dickson et al., 2002).
ALCOHOL: Media; drinking an acceptable social behavior	Coler & Chassin, 1999; Johnston et al., 1991; Atkin et al., 1984)	Socialization specific to alcohol related to moderate alcohol use; more exposure to media campaigns promoting alcohol among teens reporting higher drinking levels. Later research of sensation-targeted public ads warning of dangers of drug use and other drinking behaviors reduced participation in high-risk behaviors (Palmgreen et al., 1995 as cited in Dickson et al., 2002).

3. Transitions and Mobility

Communities that are characterized by high rates of mobility appear to be linked to an increased risk of drug and crime problems. The more people in a community move, the greater is the risk of both criminal behavior and drug-related problems in families. 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 dropout, and anti-social behavior may occur.

While a relationship may exist between transition and mobility issues and problem gambling behaviors, no specific findings were encountered in the review of literature.

4. Low Neighborhood Attachment and Community Disorganization

Higher rates of drug problems, delinquency and violence and higher rates of drug trafficking 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 more affluent neighborhoods. Neighborhood disorganization makes it more difficult for schools, churches, and families to promote prosocial values and norms.

While a relationship may exist between low neighborhood attachment / community disorganization issues and problem gambling behaviors, no specific findings were encountered in the review of literature.

5. Extreme Economic Deprivation

Children who live in deteriorating neighborhoods characterized by extreme poverty, poor living conditions and high unemployment are more likely to develop problems with delinquency, teen pregnancy and school dropout or to engage in violence toward others during adolescence and adulthood.

Children who live in these areas and have behavior or adjustment problems early in life, are also more likely to have problems with drugs later on. While a relationship may exist between extreme economic deprivation issues and problem gambling behaviors, no specific findings were encountered in the review of literature.

B. FAMILY RISK FACTORS

1. Family History of Problem Behavior

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

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Family history of addiction, illegal activity	Browne & Brown, 1993; Firsher, 1993; Griffiths, 1995; Gupta & Derevensky, 1998a; Ide-Smith & Lea, 1988; Wood & Griffiths, 1998; Wynne et al., 1996	Pathological gamblers are more likely to have parents with an addiction or involvement in illegal activity. Researchers recommended targeting interventions in children whose parents or siblings are gamblers or problem gamblers (Dickson et al., 2002).
ALCOHOL/ DRUGS: Family history of substance abuse	Merikangas et al., 1998 (as cited in Dickson et al., 2002)	A powerful predictor of substance abuse. Later researched showed that residential intervention and prevention program involving distancing from drug using parents significantly decreased AOD use and delayed onset of initial substance use (Brounstein et al., 1999; Ficaro, 1999). Targeted community-based prevention/intervention approaches to children of users/abusers successfully decreased substance use (Horn, 1998; Johnson et al., 1996; Strader et al., 2000). Additionally, training high-risk parents in alcohol and drug issues demonstrated gains in levels of knowledge and beliefs about AOD (Horn, 1998; Johnson et al., 1996; Strader et al., 2000).

2. Family Management Problems

Poor family management practices are defined as having a lack of clear expectations for behavior, failure of parents to supervise and monitor their children (knowing where they are and with whom), and excessively severe, harsh or inconsistent punishment. Children exposed to these poor family management practices are at higher risk of developing health and behavior problems.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Lack of parental knowledge	Ladouceur et al., 1998 (as cited in Dickson et al., 2002)	Lack of parental knowledge about adolescent problem gambling. Researchers recommended that youth problem gambling prevention programs should include information for parents.
ALCOHOL/ DRUGS: Poor family management practices	Baumrind, 1983; Chassin et al., 1996 (as cited in Dickson et al., 2002)	Impact of parental alcoholism mediated by parent's stress and monitoring of child; permissiveness related to children's drug use. Researchers recommended facilitating social support by providing family support groups; teaching family management skills to parents.
ALCOHOL/ DRUGS: Poor family management practices	Peterson et al., 1994; Windle et al., 1996 (as cited in Dickson et al., 2002)	Failure to monitor children; inconsistent parenting practices and/or harsh discipline. Researchers recommended school-based prevention program incorporating home activities.
ALCOHOL/ DRUGS: Poor family management practices	Reilly, 1979 (as cited in Dickson et al., 2002)	Negative communication patterns, unrealistic expectations, unclear and inconsistent behavior limits. Later research of targeting high-risk homes with education and support activities showed prosocial changes in attitudes and perceived refusal skills in youth (St. Pierre et al., 1997; St. Pierre & Kaltreider, 1997, as cited in Dickson et al., 2002).

3. Family Conflict

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.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Competitive home environment	Hypothesized link	Hypothesized link that highly competitive home situations pose a risk factor for later problem gambling behavior.
DRUGS: Deviant behavior among family members	Norco et al., 1996 (as cited in Dickson et al., 2002)	Increases likelihood of narcotic addiction. Researchers recommended group counseling aimed at correcting misperceptions about normative substance use.
ALCOHOL: Family conflict and disruption	Colder & Chassin, 1999; Nurco et al., 1996; Neddle et al., 1990 (as cited in Dickson et al., 2002)	High family conflict is associated with problem alcohol use. Later research of programs targeting families with pre-schoolers showed increases in communication, problem-solving, reasoning skills in children (Fritz et al., 1995; Miller-Heyl et al., 1998)

4. Parental Attitudes and Involvement in Problem Behavior

Parental attitudes and behavior toward drugs, crime and violence influence the attitudes and behavior of their children. Children of parents who approve of or excuse their children for breaking the law are more likely to develop problems with juvenile delinquency. Children whose parents engage in violent behavior inside or outside the home are at greater risk for exhibiting violent behavior.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Family attitudes and involvement	Gupta & Derevensky, 1997; Carlson & Moore, 1998	Pathological gamblers and youth in general report early gambling in the home and with family members; siblings appear to be the predominant influence. Youth are significantly more likely to gamble, and gamble more often, if one or both of their parents gamble. Researchers recommended the development of prevention programs targeting elementary and middle school youth.
GAMBLING: Lack of parental objection to youth gambling	Ladouceur & Mireault, 1988	Most parents acknowledge their youth gamble and do not object.
DRUGS: Number of members abusing substances in household	Ahmend et al., 1984 (as cited in Dickson et al., 2002)	Increases children's use and intentions to use substances.
ALCOHOL / DRUGS: Involving children in parental alcohol or drug-abusing behaviors	Ahmend et al., 1984; Sullivan & Farrell, 1999 (as cited in Dickson et al., 2002)	Modeling of substance abuse increases likelihood of children's use and intentions to use substances. Research of residential intervention program showed decreased use of ATOD (Brounstein et al., 1999; Kumpfer et al., 1996).
DRUGS: Parental attitudes	Barnes & Welte, 1986 (as cited in Dickson et al., 2002)	Permissive parental attitudes toward children's drug use predicted alcohol use among 7 th -12 th graders. Researchers recommended fostering of health-wise attitudes in young children in school prevention programs.

C. SCHOOL RISK FACTORS

1. Early and Persistent Anti-Social Behavior

Boys who are aggressive in grades K-3 or who have trouble controlling their impulses are at higher risk for substance abuse, delinquency and violent behavior. 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 also applies to aggressive behavior combined with hyperactivity or attention deficit disorder.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Poor impulse control	Vitaro, Arseneault, & Tremblay, 1999; Zimmerman et al., 1985 (as cited in Dickson et al., 2002)	Predictive links between impulsivity and problem gambling.
GAMBLING/ DRUGS/ CRIMINAL BEHAVIOR: Poor impulse control	Carlton & Manowitz, 1992; Raine, 1993 (as cited in Vitaro, Brendgen, Ladouceur, & Tremblay, 2001)	Links between impulsivity and gambling, substance use, or criminal behavior.
ALCOHOL / DRUGS: Poor Impulse control	Colder & Chassin, 1997 (as cited in Dickson et al., 2002)	Impulsivity moderated the effects of positive affectivity on both alcohol use and alcohol-related impairment.
ALCOHOL / DRUGS: Poor Impulse control	Cloninger et al., 1988 (as cited in Dickson et al., 2002)	Impulsiveness in childhood predicts frequent marijuana use at age 18.
DRUGS: High sensation seeking	Cloninger et al., 1988 (as cited in Dickson et al., 2002)	High sensation seeking predictive of early drug initiation. Researchers recommended education and life skills program targeting economically disadvantaged, high-sensation-seeking youth; finding showed significant pretest differences between high and low sensation (Clayton et al., 1991; Harrington & Donohew, 1997).

2. Academic Failure Beginning in Elementary School

Beginning in the late elementary grades, academic failure increases the risk of drug abuse, delinquency, violence, teen pregnancy and school dropout. Children fail for many reasons, but it appears that the *experience* of failure itself, not necessarily ability, increases the risk of problem behaviors.

PROBLEM BEHAVIOR/ Risk	Research	Findings
DRUGS: Poor school performance		Predictive of early substance initiation.
DRUGS: Poor school performance	Eggert et al., 1994; Gottfredson, 1986; Kumpfer et al., 1991	School responsiveness to student needs is related to substance abuse. Peer tutors and use of school for after-hours enrichment and parent education. Decreased substance abuse and delinquency; improved grades.

3. Lack of Commitment to School

The child 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 problem behaviors. While a relationship may exist between transition and mobility issues and problem gambling behaviors, no specific findings were encountered in the review of literature.

D. INDIVIDUAL / PEER RISK FACTORS

1. Alienation / Rebelliousness

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 drop-out.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING/ATOD: Delinquency and persistent problem behaviors	Ladouceur et al., 1994; Maden et al., 1992; Omnifacts, 1993; Stinchfield, 2000; (as cited in Dickson et al., 2002); Winters, Stinchfield, & Fulkerson, 1993	Adolescent problem gamblers engage in other addictive behaviors (ATOD), and often have a history of delinquency.
DRUGS: Persistent delinquency	Loeber et al., 1999 (as cited in Dickson et al., 2002)	Associated with persistent juvenile substance use between 7-18 years.

2. Friends Involved in the Problem Behavior

Young people who associate with peers who engage in a problem behavior--delinquency, substance abuse, violent activity, sexual activity or dropping out of school--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 spending time with friends who engage in problem behaviors greatly increases the risk of that problem developing.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Peers influence gambling behaviors	Browne & Brown, 1994; Fisher, 1995; Griffiths, 1990; Powell, 2003	Youth imitate peers' gambling behaviors; 44% of adolescents reported initiating gambling behavior because their friends were involved (Griffiths, 1990). Gambling considered a 'rite of passage' into adulthood.
DRUGS: Reinforcement by drug-abusing peers	Dishion, Capaldi, Spracklen, & Li, 1995; Kandel, 1986	Increased risk for ATOD use. Researchers recommended teaching social pressures resistance skills.

3. Favorable attitudes toward the problem behavior

During the elementary school years, children usually express anti-drug, anti-crime and pro-social attitudes and 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.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Attitudes favorable to problem gambling	Derevensky, Gupta, & Emond, 1995; Wood & Griffiths, 2001 (as cited in Dickson et al., 2002)	As children get older their fear of being caught in a gambling activity decreases; adolescent attitudes and behavior toward gambling predict adulthood attitudes and behavior. Researchers recommended fostering social norms opposing childhood gambling experiences (Dickson et al., 2002).

4. Early initiation of the problem behavior

This is an issue that has been raised in many prevention arenas involving youth. The strength of the appropriate use model is that it is a risk reduction strategy based in the reality that a majority of high school students are already involved in some gambling activity. The strength of the zero tolerance or abstinence model is that other prevention efforts, most notably nicotine use prevention, have found that postponing age of onset of an addictive or otherwise harmful behavior is indeed preventative in that it lowers risk of unhealthy involvement in the activity. Although the authors do not know if this has been studied for gambling, it is probably a safe assumption that raising the age of onset for teen gambling, like with alcohol or sexual activity, will indeed lower the risk of harmful involvement in gambling.

PROBLEM BEHAVIOR/ Risk	Research	Findings
GAMBLING: Early win; early onset of gambling experiences	Griffiths, 1995; Gupta & Derevensky, 1997, 1998a; Wallisch, 1995; Winters et al., 1993	Early onset predicts higher risk for problem gambling behavior; early win predicts later problem gambling behavior.
DRUGS: Early and persistent problem behaviors in multiple settings	Younoszai et al., 1999 (as cited in Dickson et al., 2002)	Increases likelihood for later substance abuse.
DRUGS: Prior drug use	Sullivan & Farrell, 1999 (as cited in Dickson et al., 2002)	Predicts substance use.
ALCOHOL: Early initiation of alcohol use (ages 10-11, 11-12)	Hawkins et al., 1997 (as cited in Dickson et al., 2002)	Younger age of alcohol initiation strongly related to higher levels of alcohol misuse at age 17-18.
ATOD: Early initiation (prior to 15-16 years)	Dishion et al., 1999; Fleming et al., 1982	The earlier the initiation, the greater the frequency of usage affects found for ATOD.

5. Constitutional Factors

Constitutional factors are aspects 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, committing violent acts, and/or engaging in problem gambling behavior.

PROBLEM BEHAVIOR/Risk	Research	Findings
GAMBLING: Biochemical factors	Gupta & Derevensky, 1998a	Increased physiological resting state; increased sensation seeking; more likely to be excited and aroused during gambling.
GAMBLING: Gender	Carlson & Moore, 1998; Derevensky, Gupta, & Della Cioppa, 1996; Griffiths, 1989; Gupta & Derevensky, 1998a; Jacobs, 2000; Ladouceur, Dubé, & Bujold, 1994; Powell, 2003; Stinchfield, 2000; Volberg, 1994, 1997, 1998; Wallisch, 1993; Wynne et al., 1996	Gambling is more popular among males; males are more likely to gamble and do so more frequently. Males make higher gross wagers and have higher gross winnings, suggesting they are greater risk takers.
GAMBLING: Depression	Gupta & Derevensky, 1998a, 1998b	Adolescent problem gamblers have higher rates of depression.
GAMBLING: Suicide attempts	Gupta & Derevensky, 1998a; Ladouceur et al., 1994; Lesieur, Cross, Frank et al., 1991	Adolescents with gambling problems report higher suicide ideation and attempts.

GAMBLING: Poor coping skills	Margret et al., 1999; Nower et al., 2000 (as cited in Dickson et al., 2002)	Adolescents with problem gambling have poor general coping skills.
ALCOHOL: Genetic; male at increased risk for alcohol abuse	Chassin et al., 1996; Chassin et al., 1991 (as cited in Dickson et al., 2002)	Males at increased risk for alcohol abuse.
ALCOHOL: Poor psychological functioning	Coler & Chassin, 1999 (as cited in Dickson et al., 2002)	Associated with problem use of alcohol.
DRUGS: Early physical or sexual abuse during childhood	Downs & Harrison, 1998 (as cited in Dickson et al., 2002)	A positive association found between child abuse and substance abuse problems later in life.
DRUGS: Trauma and aversive life events	Clark et al., 1997 (as cited in Dickson et al., 2002)	Mediate between temperament, genetic risk, and substance abuse disorder outcomes.

E. POTENTIAL PROTECTIVE FACTORS

Youth that are exposed to a number of risk factors are at high risk for problem behaviors. However, research has shown that, when there are positive factors in place, problem behaviors can be prevented by these buffering, or protective, factors

Research to date has mainly examined protective factors as related to substance abuse and violence issues. The following table is provided to illustrate research, and is not exhaustive. Many thanks to Dickson, Derevensky, and Gupta (2002) for their groundwork in this area.

PROBLEM BEHAVIOR/ Protective factor	Research	Findings
DRUGS: Self-confidence and well-being	Brounstein et al., 1999; Ficaró, 1999	Decreases the likelihood of participating in multiple problem behaviors. Self-esteem building as part of prevention and intervention programs has shown improvement in well-being, reactions to drug-involving situations and attitudes toward school (numerous studies); impact on decreasing substance abuse among adolescents who have experienced mental health problems, including attempted suicide (Dickson et al., 2002).
DRUGS: Strong parental bonding	Bell et al., 2000; Brook et al., 1986; Resnick et al., 1997 (as cited in Dickson et al., 2002)	Strong parental bonding mitigates initial use or abuse of substances.
DRUGS: Positive involvement	Jenkins, 1987; Resnick et al., 1997 (as cited in Dickson et al., 2002)	Attachment and involvement in school, attendance in extracurricular activities protect against substance abuse.

<p>DRUGS: Strong ethnic identity</p>	<p>Brook et al., 1998 (as cited in Dickson et al., 2002)</p>	<p>Offset risks, enhance protective factors from the ecology, family, personality, and peer domains lessening drug use. Targeted interventions to immigrant families and at-risk cultural groups have demonstrated an increased willingness among families to discuss substance abuse and move toward empowerment (Hernandez & Lucero, 1996 as cited in Dickson et al., 2002).</p>
<p>DRUGS: Anti-drug attitudes</p>	<p>Zastowny et al., 1993 (as cited in Dickson et al., 2002)</p>	<p>A strong predictor of adolescent healthy substance use. A 'values-rich' literature-based reading and language art program demonstrated success in decreasing substance abuse prevalence rates and increasing students' sense of school community (Battistich et al., 1996; Solomon et al, 2000, as cited in Dickson et al., 2002).</p>
<p>DRUGS: School anti-drug policies</p>		<p>Printing media to support community organizing and youth action initiatives and communicating healthy norms about underage drinking is believed to be effective in reducing underage drug use and delaying initial onset of drug use.</p>

DRUGS: School anti-drug policies	Felner et al., 1993 (as cited in Dickson et al., 2002)	Schools that discourage substance use are associated with positive student outcomes. Increased use of treatment facilities by students; increased referrals by staff (DiCicco et al., 1984 as cited in Dickson et al., 2002).
ALCOHOL: Late onset of drunkenness	Thomas et al., 2000 (as cited in Dickson et al., 2002)	Later onset diminished future levels of alcohol misuse and sexual risk-taking.
ALCOHOL: Parental monitoring	Thomas et al., 2000 (as cited in Dickson et al., 2002)	Parental monitoring mitigated later levels of alcohol misuse.
DRUGS: Perceived parental support	Frauenglass, et al., 1997 (as cited in Dickson et al., 2002)	High levels of perceived support from family is negatively associated with drug use among Hispanic adolescents.
VIOLENCE/ SEXUALITY/ DRUGS: School bonding	Resnick et al., 1997 (as cited in Dickson et al., 2002)	Protective factor for physical and emotional health, violence, substance abuse, and sexuality in grades 7-12.
ALCOHOL/ MARIJUANA: Positive involvement	(Battistich et al., 1996; Pettit et al., 1997; Solomon et al., 2000, as cited in Dickson et al., 2002)	Teaching and problem-solving approach to discipline and classroom management; students have regular opportunities to contribute. Students reported having stronger sense of community in their school; preventative effects on alcohol and marijuana.
VIOLENCE/ DRUGS: Bonding; community participation in organized groups	Elder at al., 2000 (as cited in Dickson et al., 2002)	Participation in community groups contributes to the development of leadership, sense of community, helping others, and provides alternative activities to drug use.

<p>VIOLENCE/ DRUGS: Bonding; community participation in organized groups</p>	<p>Jessor, 1993 (as cited in Dickson et al., 2002)</p>	<p>Draw adolescents into more conventional behaviors associated with school, church, or community and protect against substance abuse.</p>
<p>ATOD: Delayed onset of initial use</p>	<p>Grant & Dawson, 1997, 1998 (as cited in Dickson et al., 2002)</p>	<p>Each year of delayed alcohol use decreased the odds of lifelong dependence and lifelong use. Prevention programs that have encouraged healthy attitudes and drug education before initiation of substance use have successfully delayed first ATOD, in addition to less ATOD use reported in general.</p>
<p>ATOD: Social competence</p>	<p>Botvin, Eng, & Williams 1980; Botvin & Eng, 1982; Botvin G., Baker, Botvin E., Filazolla, Millman, 1984</p>	<p>Life-skills/social skills training (see Section III of this guide) has demonstrated decreased levels of tobacco, alcohol, and marijuana use; better school adjustment.</p>

SECTION II. PROMISING PROBLEM GAMBLING PREVENTION PROGRAMS

Ready-made gambling prevention programs may be useful to prevention providers for integrating gambling prevention programs into their existing efforts. To date, no best or promising practices exist for gambling prevention strategies. This document is provided to assist gambling prevention and treatment providers who wish to provide gambling prevention efforts in their regions. The programs listed in this section may not have formal evaluations or research backgrounds, yet are included as they have either been in use for some time and/or are widely recognized gambling prevention programs.

1. For reference, the hypothesized risk and protective factors addressed by the programs are included under the description of each program; these factors are assumed by the authors and are based on program curricula and descriptions.

ADOLESCENT COMPULSIVE GAMBLING PREVENTION PROGRAM: WANNA BET?

Source:North American Training Institute, a division of the Minnesota Council on Compulsive Gambling, Inc.

Program description and format

“The North American Training Institute has designed and field-tested this interdisciplinary curriculum to discourage underage gambling through improved critical thinking and problem solving” (North American Training Institute website, www.nati.org). Curriculum includes an educator's guide, an 11-minute video, “Andy's Story”, a Wanna Bet? Resource Guide, overhead transparencies, plus a bibliography and resource list. This easy-to-use curriculum also includes a Gambling Fact Sheet, a Brief History of Gambling, and a Parent Letter, all of which are copy ready. Wanna Bet? Magazine is an interactive online publication designed by teens for teens.

Risk factor(s) assumed to be addressed: Early initiation of gambling behavior
Community laws and norms favorable toward gambling
Lack of parental knowledge
Lack of parental objection

Protective factor(s) assumed to be addressed: Skills
Healthy beliefs and clear standards

Parental monitoring

CSAP strategies: Education

Type of IOM approach: Universal

Populations appropriate for this promising program: 5th-8th grade students

Availability / More information: www.nati.org

ALL BETS OFF

Source: Missouri Alliance to Curb Problem Gambling (Alliance) and the Second Chance Foundation (Jefferson City, MO).

Program description and format:

This one-hour “informative interactive workshop” addresses the intertwined nature of addictions and how similar the risk factors, symptoms and consequences are across the spectrum of addictive behaviors. *All Bets Off* addresses gambling as a potential addiction, presents facts about addictions and seeks to raise awareness of some of the resources available for individuals with an addiction in their family.

Program Objectives:

- To educate youth about the dangers and risk factors of addictions, including gambling.
- To raise awareness among educators and parents about the dangers of addictions, including gambling.
- To raise awareness of the help line phone number and the availability of free treatment.

Risk factor(s) assumed to be addressed: Availability Favorable attitudes toward the problem behavior

Family attitudes and involvement Lack of parental knowledge

Protective factor(s) assumed to be addressed: Skills Healthy beliefs and clear standards

CSAP strategies: Information dissemination

Type of IOM approach: Universal

Populations appropriate for this promising program: Targeted toward 8th-9th grade students.

Availability / More information: Telephone: 573-526-7467

Email: mstephens@mail.state.mo.us or perezs@molottery.com

FACING THE ODDS: THE MATHEMATICS OF GAMBLING AND OTHER RISKS

Source: Harvard Medical School Division on Addictions and the Massachusetts Council on Compulsive Gambling.

Program description:

Facing the Odds: The Mathematics of Gambling and Other Risks is a middle-school curriculum on probability, statistics and mathematics. The curriculum was designed to enhance students' critical thinking ability, number sense and knowledge of mathematics of gambling so that they can develop rational views about gambling and make their own informed choices when confronted with gambling opportunities. The aim of this project is to: (1) make mathematics more meaningful by increasing its relevance to the daily lives of students; (2) develop students' critical thinking skills, allowing them to make decisions and choices

about gambling activities based on mathematical reasoning; and, as a by-product, (3) delay the onset or diminish the level of participation in gambling activities.

Evaluation: Developers provide evaluation mechanisms to measure its effectiveness and use in schools across the United States.

Risk factor(s) assumed to be addressed: Poor impulse control

Protective factor(s) assumed to be addressed: Healthy beliefs and clear standards
Skills

Delayed onset of initial use

CSAP strategies: Education

Type of IOM approach: Universal

Populations appropriate for this promising program: Middle school math students

Availability / More information:

http://www.hms.harvard.edu/doa/main_frame.htm

The curriculum can be downloaded by registering at:

<http://www.hms.harvard.edu/doa/html/registrationform.htm>

GAMBLING: REDUCING THE RISKS

Source: Saskatchewan Health, CAN

Program Description and Format:

The program provides teachers and students with information regarding gambling, teaches students about the risks associated with gambling, presents strategies that reduce the risks, and supports skill development that allows students to make healthy choices about gambling. Resource materials consist of the following: a program manual for teachers that provides instructional strategies and teaching notes; topic-related activities for group discussion; a videotape with short, open-ended clips for discussion after group viewings; and information on accessing helping resources. The program guidebook provides comprehensive information on youth as a high-risk target group, including specific information on:

- Reasons people gamble
 - Definitions and descriptions of various types of gambling
 - Signs of problem gambling in young people
 - Consequences of problem gambling age restrictions for gambling
 - Impact of problem gambling on families
-

Prevention of problem gambling concepts and strategies are presented at each grade level from 6 to 9. Information is progressive, with each of the 7th, through 9th grades' curriculum built upon the lessons of the previous year.

Each grade level has three Foundational and Learning Objectives:

(1) Extend Knowledge Base - Students understand that gambling involves both economic and social risks.

(2) Making Informed Decisions - Students determine and evaluate the risks involved in various gambling activities and explore and identify alternatives to high-risk behavior.

(3) Carry Out an Action Plan - Students participate in actions that reinforce decisions to reduce the risks of gambling.

Each grade explores a focus topic:

Grade 6 "Affirm Standards" - How a youth's family perceives gambling and the family's standards concerning gambling.

Grade 7 "Commit Self" - How youth relate to gambling on a personal level, including spending money on gambling and decision-making regarding current and future involvement in gambling.

Grade 8 "Support Peers" - The effects of gambling on youth and symptoms of problem gambling are identified to support peers in making responsible decisions regarding gambling.

Grade 9 "Promote Health" - Information on the social and economic impact of gambling in the community.

Risk factor(s) assumed to be addressed: Community laws and norms favorable toward gambling

Accessibility Early initiation of gambling behavior Peer influence

Protective factor(s) assumed to be addressed: Healthy beliefs and clear standards Skills

Delayed initial onset of gambling

CSAP strategies: Information dissemination Education

Type of strategy: Universal

Populations appropriate for this promising program: Grades 6 through 9; program designed to supplement middle-level health education curricula.

Research / evaluation of program: The program was pilot-tested, with a proportionate distribution of rural and urban school locations and male and female students. Gambling: Reducing the Risks was distributed in May of 1999 to over 1,000 Saskatchewan schools. No specific program evaluation results described.

Availability / More information: Leanne Fischer, Program Consultant.

Saskatchewan Health, 3475 Albert Street, Regina, Saskatchewan, Canada S4S 6X6. Telephone: 306-787-4094.

IMPROVING YOUR ODDS

Source:Minnesota Institute of Public Health

Program Description:

Improving Your Odds is a six-section curriculum designed to help youth acquire the knowledge and skills necessary to make choices about whether, when, and how much to gamble. Risks and benefits of gambling are examined. Activities are included to help students learn how to recognize a gambling problem, how to talk with someone that may have a problem, and how to find help. The materials in the curriculum are designed to be integrated into teachers' regular curriculum to complement other efforts, and the program can be completed in 4-10 hours.

Risk factor(s) assumed to be addressed: Early initiation of gambling behavior
Poor impulse control

Attitudes favorable toward gambling

Protective factor(s) assumed to be addressed: Healthy beliefs and clear standards Skills

CSAP strategies: Education

Type of IOM approach: Universal

Populations appropriate for this promising program: Middle school students

Availability / More Information: Additional information about the program is available on the Minnesota Institute of Public Health's website:

<http://www.miph.org/gambling/>

PLAYING FOR KEEPS

Source:Alberta Alcohol and Drug Abuse Commission (AADAC)

Program description:

The topics discussed are definitions of gambling and problem gambling, signs of problem gambling, and the people problem gambling affects. The curriculum includes instructor notes, colored overheads, activities, and a quiz. This program provides a kit for a 60-minute presentation for use in schools or youth groups.

Risk factor(s) assumed to be addressed: Early initiation of gambling behavior
Friends who engage in gambling behavior

Protective factor(s) assumed to be addressed: Delayed onset of problem behavior Skills

Healthy beliefs and clear standards

CSAP strategies: Information dissemination Education

Type of IOM approach: Universal

Populations appropriate for this promising program: High school students

Availability / More information: More information about curriculum is available via the Alberta Alcohol and Drug Abuse Commission (AADAC) website:

<http://corp.aadac.com/gambling/index.asp>

YMCA YOUTH GAMBLING PROJECT

Source:YMCA Youth Gambling Project (YGP)

Program description:

(From the 17th National Conference on Problem Gambling): The goal of the YMCA Youth Gambling Project (YGP) is to reduce the harm associated with gambling...the program takes a proactive approach, believing that prevention programs are essential to improving individual health and personal development, and creating healthier communities.

Risk factor(s) assumed to be addressed: Availability Favorable attitudes toward use

Friends who engage in gambling behavior Family conflict, management problems Parental attitudes and involvement Community laws and norms favorable toward use

Protective factor(s) assumed to be addressed: Skills Healthy beliefs and clear standards

CSAP strategies: Information dissemination Education

Type of IOM approach: Universal

Populations appropriate for this promising program: Youth ages 8 to 24 years old

Parents Teachers Professionals

Availability / More information: YMCA Youth Gambling Project 42 Charles Street East, Toronto, Ontario M4Y 1T4 Canada Email: jim.milligan@ymca.net

YOU FIGURE IT OUT, PROBLEM GAMBLING TODAY

KNOW THE ODDS

Source:Know the Odds, Inc.

Program description:

This program is directed to target problem gambling as a health issue and educates students to give them the necessary information to empower them to protect themselves against the harmful effects of problem gambling. Students are taught about the nature of gambling, and not how to gamble. The materials are gambling neutral and avoid normalizing gambling by teaching "responsible gambling." The materials represent the distilled essence of what students need to know in order to preserve their quality of life - compressed into two 45-minute sessions. The kit comprises video, software and notes and is suitable for use in secondary schools. The software is designed to teach students the basic concept of the law of averages by having them see it in action. The purpose of the kit is to educate students to prevent them becoming problem gamblers, and understand problem gambling in others.

Risk factor(s) assumed to be addressed: Poor impulse control

Protective factor(s) assumed to be addressed: Healthy beliefs and clear standards
Skills

CSAP strategies: Information dissemination Education

Type of IOM approach: Universal

Populations appropriate for this promising program: High school students

Availability / More information: www.knowodds.org

SECTION III. INTEGRATING GAMBLING PREVENTION EFFORTS WITH EXISTING BEST AND PROMISING PRACTICES FOR SUBSTANCE ABUSE PREVENTION

This section is provided to assist gambling prevention providers to integrate gambling prevention efforts with recognized best and promising practices for substance abuse prevention (refer to Best and Promising Practices for Substance Abuse Prevention, 3rd Ed.). Each best and promising practice program summary in this section lists a “hypothesized common risk factor to problem gambling addressed.” These hypothesized common risk factors have been described in greater detail in Section I of this resource guide. **Add-on curriculum pieces for Lifeskills, Strengthening Families, Project Northland and Girls Circle were developed in 2013 by prevention coordinators. Copies are available from the state problem gambling prevention coordinator.**

Knowledge of existing evidence-based programs combined with an appreciation of common risk and protective factors between problem gambling and other problem behaviors may increase a program developer’s effectiveness and efficiency in designing strategy-specific interventions and/or population-specific interventions. As an example, if a prevention professional wished to provide education about gambling that addressed favorable attitudes toward “use” targeting early adolescents, that provider might seek more information about the evidence-based “All Stars Program” or “Life Skills Training Program.”

BEST PRACTICES

ALL STARS PROGRAM

Hypothesized common risk factor to problem gambling addressed: Favorable attitudes toward (drug) use

CSAP strategies: Information dissemination Education

Type of strategy: Universal

Populations appropriate for this best practice: Early adolescents between the ages of 10 and 15

For more information: www.tanglewood.net

CASASTART

Hypothesized common risk factor to problem gambling addressed:

Availability (of drugs)

Persistent antisocial behavior Friends who engage in problem behavior

CSAP strategies: Alternative Problem identification and referral Community-based processes

Environmental

Type of strategy: Selective, indicated

Populations appropriate for this best practice: Youth (ages 8-13) in urban neighborhoods; African American, Latino youth

For more information: lmurray@casacolumbia.org

COMMUNITIES THAT CARE

Hypothesized common risk factor to problem gambling addressed: Community laws and norms favorable (toward drug use, firearms and crime)

CSAP strategies: Community-based processes

Type of strategy: Universal

Populations appropriate for this best practice: Not specified

For more information: www.channing-bete.com

COUNTER-ADVERTISING (Tobacco specific; concept might be used to address problem gambling)

Hypothesized common risk factor to problem gambling addressed:

Community laws and norms favorable Favorable attitudes (toward drugs)

CSAP strategies: Environmental

Type of strategy: Universal

Populations appropriate for this best practice: Not specified

For more information: <http://ncadi.samhsa.gov>

CREATING LASTING CONNECTIONS

Hypothesized common risk factor to problem gambling addressed: Family conflict, management problems, Parental attitudes and involvement Early first use

CSAP strategies: Information dissemination Education Problem ID & referral
Community-based processes

Type of strategy: Selective

Populations appropriate for this best practice: 11- to 15-year-old youth and their parents / guardians

For more information: www.copes.org

FAMILIES AND STUDENTS TOGETHER (FAST)

Hypothesized common risk factor to problem gambling addressed: Family management problems

Favorable parental attitudes

CSAP strategies: Information dissemination Education, Problem ID & referral

Type of strategy: Selective

Populations appropriate for this best practice: Early childhood, elementary and middle school youth; rural, medium-sized, and urban communities; various ethno cultural backgrounds

For more information: <http://www.wcer.wisc.edu/FAST>

LIFE SKILLS TRAINING PROGRAM

Hypothesized common risk factor to problem gambling addressed: Favorable attitudes (toward DHS drug use)

Friends who use

CSAP strategies: Information dissemination Education

Type of strategy: Universal

Populations appropriate for this best practice: 6-8th grade or 7-9th grade youth; Caucasian, African American, Latino youth

For more information: www.lifeskillstraining.com

MULTI-COMPONENT SCHOOL-LINKED COMMUNITY APPROACHES

Hypothesized common risk factor to problem gambling addressed:

Community laws and norms favorable Favorable attitudes (toward drug use)

Parental attitudes favorable

CSAP strategies: Information dissemination, Education, Community-based

Type of strategy: Universal

Populations appropriate for this best practice: Not specific

For more information: <http://ncadi.samhsa.gov>

NICASA PARENT PROJECT

Hypothesized common risk factor to problem gambling addressed: Family management problems

Parental attitudes favorable

CSAP strategies: Education

Type of strategy: Universal

Populations appropriate for this best practice: Early childhood, elementary, middle school, and high school youth; parents of young children; single parents

For more information: <http://www.strengtheningfamilies.org/index.html>

PREPARING FOR THE DRUG FREE YEARS

Hypothesized common risk factor to problem gambling addressed: Family management, conflict

Favorable attitudes toward use Parental attitudes and involvement Friends who use Early initiation

CSAP strategies: Information dissemination Education

Type of strategy: Universal

Populations appropriate for this best practice: Parents of children in grades 4-8; various ethno cultural backgrounds

For more information: www.channing-bete.com

PROJECT ALERT

Hypothesized common risk factor to problem gambling addressed: Early first use

CSAP strategies: Education

Type of strategy: Universal

Populations appropriate for this best practice: 6th grade or 7-8th grade students
Minority students

Various socioeconomic settings

For more information: www.projectalert.best.org

PROJECT NORTHLAND

Hypothesized common risk factor to problem gambling addressed: Friends who use Favorable attitudes toward use Early initiation Availability

Community laws and norms favorable

CSAP strategies: Information dissemination Education Alternatives
Environmental

Type of strategy: Universal

Populations appropriate for this best practice: Not specified

For more information: www.hazelden.org

PROJECT STAR

Hypothesized common risk factor to problem gambling addressed:

Availability

Community laws and norms Friends who use Favorable attitudes toward use

CSAP strategies: Information dissemination Community-based processes

Environmental

Type of strategy: Universal

Populations appropriate for this best practice: Middle school youth, parents, and community at large

For more information: www.colorado.edu/cspv/blueprints

PROJECT TOWARDS NO DRUG ABUSE

Hypothesized common risk factor to problem gambling addressed: Favorable attitudes toward use

CSAP strategies: Education

Type of strategy: Selective, indicated

Populations appropriate for this best practice: High school youth at high risk
Alternative high school students Various ethno cultural backgrounds

PROJECT TOWARDS NO TOBACCO USE

Hypothesized common risk factor to problem gambling addressed: Early initiation

CSAP strategies: Information dissemination Education

Type of strategy: Universal

Populations appropriate for this best practice: 7th grade students Various ethno cultural backgrounds

For more information:

RECONNECTING YOUTH PROGRAM

Hypothesized common risk factor to problem gambling addressed: Friends involved

Persistent antisocial behavior

CSAP strategies: Education Problem identification and referral

Type of strategy: Indicated

Populations appropriate for this best practice: Students in 6-12th grade who show signs of poor school achievement and potential for dropping out

For more information: www.nesonline.com

RETAILER-DIRECTED INTERVENTIONS (Tobacco Specific)

Hypothesized common risk factor to problem gambling addressed:

Availability Community laws and norms

CSAP strategies: Environmental

Type of strategy: Universal

Populations appropriate for this best practice: Not specified

For more information:

SMART LEADERS

Hypothesized common risk factor to problem gambling addressed: Friends who use Favorable attitudes toward use

CSAP strategies: Information dissemination Education

Type of strategy: Universal

Populations appropriate for this best practice: 14-17 years old; various ethno cultural backgrounds

For more information: www.bgca.org

STOP TEENAGE ADDICTION TO TOBACCO

Hypothesized common risk factor to problem gambling addressed:

Community laws and norms favorable Availability

CSAP strategies: Environmental

Type of strategy: Universal

Populations appropriate for this best practice: Youth, law enforcement, vendors, and other community groups

For more information:

STRENGTHENING FAMILIES PROGRAM

Hypothesized common risk factor to problem gambling addressed: Family history of substance abuse

Family management problems Favorable parental attitudes and involvement in problem behavior

Early & persistent antisocial behavior

CSAP strategies: Information dissemination Prevention education Problem identification & referral

Type of strategy: Indicated Selective Universal

Populations appropriate for this best practice: Children 6-11 years old, various ethnic groups, children with conduct problems

For more information: <http://www.strengtheningfamiliesprogram.org/>

TOBACCO-FREE ENVIRONMENT POLICIES

Hypothesized common risk factor to problem gambling addressed:

Community laws and norms favorable toward use

CSAP strategies: Environmental

Type of strategy: Universal

Populations appropriate for this best practice: Not specified

For more information:

<h2>PROMISING PRACTICES</h2>

BI-CULTURAL COMPETENCE SKILLS APPROACH

Hypothesized common risk factor to problem gambling addressed: Friends who engage in problem behavior Favorable attitudes toward behavior

CSAP strategies: Education

Type of strategy: Universal

Populations appropriate for this best practice: Native American

For more information:

FAITH-BASED PREVENTION MODEL

Hypothesized common risk factor to problem gambling addressed: Friends who use

CSAP strategies: Information, education, alternatives

Type of strategy: Universal

Populations appropriate for this best practice: Rural, church members, African Americans

For more information: _

GROWING HEALTHY

Hypothesized common risk factor to problem gambling addressed: Early initiation

Favorable attitudes toward use

CSAP strategies: Information dissemination, education

Type of strategy: Universal

Populations appropriate for this best practice: K-6th grade students

For more information: www.nche.org

TEENAGE HEALTH TEACHING MODULES

Hypothesized common risk factor to problem gambling addressed: Favorable attitudes toward use

CSAP strategies: Education, information dissemination

Type of strategy: Universal

Populations appropriate for this best practice: Middle, & high school students

APPENDIX H

A Practical Guide for Working with Schools A Practical Guide for Working with Schools

School funding and resources are becoming increasingly limited due to budget cuts. As a result, funding, staffing and materials for various initiatives are in place and then go away. Sometimes the coming and going of initiatives and programs are a reality in the public schools, and the current financial constraints that public schools are confronted with is making it more of a challenge to maintain programs outside of the immediate and perceived academic realm.

As you know, the Safe and Drug Free funding (Title IV) has been eliminated since the beginning of the 2011-12 school year. Subsequently, state agencies have been asked to make a concerted effort to collaborate and work together for the purpose of continuing to provide the essential services that our communities and schools need.

The Oregon Health Authority (OHA) and the Oregon Department of Education (ODE) have been collaborating on a plan to link county based prevention coordinators with their school based counterparts and school communities. The plan includes developing a practical guide designed to help you share your expertise with our schools/partners and their students in a practical, comprehensive and effective manner.

This insert is divided into the following sections:

- I. Questions for Guidance: Why should I work with schools? +
 - II. Know Your Audience
 - III. Don't call us, we'll call you
 - IV. What is PBIS? Why it is important?
 - V. A Friend on the Inside: Working with the PBIS Coach, and PBIS at present
 - VI. Bully-Proofing Schools and Promoting Non-Violence
 - VII. Drug-Free Schools
 - VIII. School Climate and School Culture
 - IX. Positive Community Norms – “The Science of the Positive”
 - X. Your very own virtual Toolkit
 - XI. Commonly Asked Questions
-

I. Questions for Guidance

a) Why should I work with schools?

Schools in our various communities do not work in a vacuum. The school climate and culture are a direct reflection of its community and vice-versa. We need to work together to fully understand the attitudes, beliefs, norms and values that underlie the behavior members of the community adhere to and exhibit, respectively, so that we could intervene appropriately with the student body in our schools and be consistent in our prevention efforts and approach with students and families.

b) What do you want to achieve?

Prevention is the goal. We are seeking to create school and community environments free from drugs, alcohol and violence amongst our youth. We will seek to develop, implement and/or sustain already existing school-wide positive behavior and prevention strategies that are being used in our schools.

c) What can you offer schools?

You offer Partnership, Outreach, Presentations, and your Presence (POPP) in schools. Your presence includes face-to-face interactions and your role as consultant to the school, along with providing brochures and your contact information. State-wide program initiatives and your knowledge of and access to evidence-based programs and information would be very helpful as well.

d) What approaches you might use?

Provide brochures designed to highlight our prevention efforts, which includes the Prevention Coordinator's contact information for a particular school/district. Provide in-class and/or school assembly presentations. Provide individual consultation and/or counseling as needed, and be available for face to face meetings, email exchange, and/or telephone contacts. Assist staff and students on how to teach *and/or implement various prevention methods themselves*.

e) What resources (including people and expertise) do you have at your disposal?

The Prevention Coordination manual to guide the process, along with the support of the ODE and other state agencies involved with the project. In the schools, Positive Behavioral Interventions & Supports (PBIS) coaches, counselors, child development specialists, behavior specialists, and school psychologists could be available to assist in your efforts. These folks would be able to be your school-based counterpart and directly assist with your efforts. They further could identify other staff and/or students to assist in the prevention efforts as well. Principals and Vice Principals could also be of assistance.

f) What time commitment can you afford to make?

Flexibility would be best depending on the individual school district, school building and your community's needs. If you could be available as needed, at least by telephone and email, this would be most helpful. Face to face contact would be best, although given your schedule, include specific times when you could be and are available. Furthermore, providing a calendar, in coordination with the school administration, of when you could offer presentations to staff, parents and students would be very helpful.

II. Know Your Audience

Administrators

Superintendent –

This role may vary somewhat depending upon the person who holds the position and their particular areas of expertise and interest. The superintendent is the Chief Executive Officer (CEO) of the school district who ultimately has the final say in decisions made for the school district, in accordance with the school board and its policies and procedures. The superintendent is also in charge of school-community relations. The Superintendent is typically tasked with keeping the district budget balanced, minimizing layoffs, and increasing student achievement every year. While the Superintendent has the final say on decisions for the school district, s/he will often delegate decisions needed to be made about curriculum and programs to other district office and/or school building administrators.

Director of Curriculum and Instruction -

This person is primarily given the responsibility of looking at academic data to determine the success of the instructional programs that are being used across the district. S/he also monitors the drop-out rate and percentage of students requiring special education services. Large districts will sometimes break this role down by grade, but not necessarily given current budgeting trends and funding reductions. You might have one Director of Curriculum and Instruction for the whole district, although sometimes you will find someone in this role for the elementary school/s, and another one for the middle and high schools (secondary level). They are often involved in purchasing programs for district adoption.

Principal -

Many responsibilities come with this job. The principal is responsible for individual school building operations. They are in charge of the overall academic instruction delivered, along with supervision of staff. They further are in charge of regulating behavior, setting the tone, including making the necessary adjustments, for the climate and culture within the school. The principal is further in charge of public relations for the immediate school community, while serving as liaison between the parents and teachers.

Vice Principal -

These folks assist the Principal with his/her duties, and often are primarily responsible for handling student behavior and school discipline, and/or assist the Principal with addressing these issues. These folks might serve on the PBIS teams, Student Service Teams (SST) and other school-based committees. The Assistant Principal would be a good person to enlist for support of our prevention efforts. They are directly involved, as mentioned above, with school discipline and the incidents, locations, times, etc. when students exhibit problem behavior.

Classroom Teachers -

The classroom teacher is in charge of his/her individual classroom. With budget cuts and diminishing resources, time for instruction is getting significantly impacted and scarce. Less time for planning lessons and grading

papers are becoming more of a reality for teachers who are currently operating with fewer resources. The rise in behavior difficulties due to diminished resources further impacts and interferes with maximizing instructional time. Furthermore, teachers are being held increasingly more accountable for student achievement, which adds to the stress they are currently under to provide the best instruction and support to our students in the midst of diminished resources and associated difficulties. The latter is extremely stressful for teachers because student success and achievement is actually impacted by multiple variables, many of which are outside the teacher's control, no matter how competent a teacher might be, including psycho-social, familial and ecological circumstances.

Instructional Assistants & Support Staff –

Instructional Assistants assist the classroom teachers with student instruction and with supporting behavior. These folks are typically interacting and working with the students during both formal (i.e. - structured classroom times) and informal times (i.e. - recess, lunch...). The instructional assistants often times are able to provide excellent insight into the school's climate, individual student's needs, and how to best assist with difficulties.

The School Board –

These citizens are responsible for overseeing the policies and procedures of the school district. They typically work directly with the Superintendent, in conjunction with human resources and other top managers, to ensure that the district is functioning optimally for our students while remaining in compliance with the law and needs of the community.

Parents –

Parents are a critical partner to the process. It is their children, our students, who we want to serve, educate and protect. Consistency between what students are exposed to at school and in the home is crucial to our programs' successes, and their impact on outcomes and sustainability. Direct involvement with parents and engaging them as a partner in our prevention efforts will be critical to the success of our programs and interventions.

In **summation**, once you understand your audience - their needs, perspectives, cultural influences, attitudes, beliefs, values, norms, and interests – you can better assist them and share what you have to offer. Your level of involvement and focus will vary depending on your community and its participants. Focusing on the behavior and expectations taught and modeled by adults to our students will be important for the implementation of any prevention efforts, as well as determine the level of success and positive outcomes and lasting change throughout the system.

The core mission of schools is to provide youth/students with a quality and equitable education, including the provision of a rich and diverse academic repertoire, along with creating and providing an environment that is safe, positive and conducive to learning.

School administrators and teachers are getting increasingly busy with their jobs due to the reductions in funding, staffing and resources. Educators have also seen and experienced many well intentioned programs, initiatives, approaches and methodologies, depending on their tenure or years in the system, come and go. To obtain “buy-in”, you must be well-prepared, sound and grounded in your approach, and would be most successful if you link your work to student achievement.

The research from University authorities around the country, including Osher’s work, and promoted through the United States Department of Education (USDE), indicates that students who receive their schooling in an environment where they feel safe, will be more successful academically. Learning and achievement levels are increased and positively impacted by schools who provide clear expectations for student behavior, and that are culturally responsive in their instructional and disciplinary practices. Teach students positive social-emotional skills and encouraging positive relationships are as essential as using evidence-based academic curricula. The perception that we need to focus only on providing sound, rigorous and relevant academic instruction because of limited resources needs to be challenged, respectfully, by communicating that evidence-based Social-Emotional Learning (SEL) programs are needed as well to directly impact ability to learn and to improve academic success and achievement. Research provided by Durlak, et.al., 2011, found that “SEL programs delivered by classroom teachers and other school staff showed students making *significant gains in academic performance.*” The Positive Behavioral Interventions &

Support (PBIS) research has supported the same for over a decade at present (www.pbis.org)

III. Don't call us, we'll call you

Since you are serving as a “consultant” for the school and not a school employee, it is imperative to respect the school’s wishes, boundaries, and thoughts or ideas on the direction they want to take the school to encourage prevention and develop a positive school environment and climate. You are there to offer your expertise in the prevention of substance abuse and violence in our schools. It is important to maintain ‘your presence’ as the Prevention Coordinator, along with providing resources, support, information and guidance when asked.

IV. What is Positive Behavioral Interventions & Support (PBIS)? Why it is important?

PBIS is a practice *of teaching behavioral expectations and implementing school-wide behavior support systems that allow students to focus on instruction and be successful in school.* "...[PBIS] can be described as a data-driven, team-based framework or approach for establishing a continuum of effective behavioral practices and systems that (a) prevent the development or worsening of problem behavior and (b) encourage the teaching and reinforcement of pro-social expectations and behavior across all environments for all students by all staff (Sugai, Simonsen, & Horner, 2008)."

PBIS is very important because it addresses laying a foundation to positively influence school-wide climate and culture by teaching students basic rules or expectations. These expectations are positively stated, few in number (3-5 general expectations), simple and clear. The typical rules or expectations would include: “Being Respectful”, “Being Responsible”, and “Being Safe.” Students are directly taught these expectations at the school-wide or “universal” level, and are engaged at school by abiding with them. PBIS employs a three-tiered approach, and a school-wide PBIS universal system (tier one) implemented with integrity yields 85% or more students complying and abiding with the expectations. PBIS also employs systems to address social-emotional concerns and/or those students requiring more to comply with expectations (tier two), as well as tertiary methods of interventions (tier three) for those with more intensive behavioral issues or needs.

The system and interventions are applied by a team process and data-driven approach. Continual monitoring and focus on data to identify areas of need in the school environment are paramount and necessary to assist schools with defusing and remedying areas of concern. Individual students in need are also readily identifiable and measures taken to address those students' needs are more easily achieved with the use of PBIS methods and its systems.

Working with School and District PBIS Coaches:

In 2010-2011, almost half of all the schools in Oregon use the School-Wide Information System (SWIS) database, and are therefore highly likely to have at least one PBIS coach in the district. Sometimes it is the office secretary who collates the discipline data and enters it into the SWIS. It is recommended that each building have a PBIS team that meets on a regular basis (at least once per month). The percentage of schools that were using SWIS during the 2010-11 school year includes the following:

Elementary = 43%

Middle = 37%

High = 41%

More recent data revealed that 61% of Oregon's schools in general are implementing school-wide PBIS.

Why work with a PBIS Coach?

- This person has the training, understanding, experience and expertise to help staff implement the PBIS program with integrity. They are typically considered to be the building/district behavior expert by their colleagues.
 - The PBIS coach is involved, along with the PBIS team, with interpreting school and/or district behavior data and presenting it to stakeholders.
 - They are often viewed as the resource with whom to consult about prevention programs for unacceptable or problem behavior in the schools.
 - They are encouraged to attend state level PBIS training conferences that are offered twice a year in Oregon, during which OHA staff would be invited to offer training strands and provide an opportunity to network.
-

How to work with a PBIS Coach and School District -

- Contact the school district office and find out if there is a district level and/or a building level PBIS coach. Request their contact information if one is identified, and contact them to discuss your mission.
- Contact the building principal where you will be working by email or telephone, and set up a meeting. Introduce yourself and state your mission and what you would like to offer the school.
- Topics of discussion might include the following: *What are the areas of need at the school? What are the concerns? Are there individual students of particular grave concerns? How you could help?*
- Some other questions to ask and information to gather include:

-Does the school use PBIS and do they have a PBIS team that meets regularly?

-Offer to attend one of the PBIS meetings and come ready to suggest community based services that might benefit the student/s and their families.

-Interview other staff members around the school about school climate, student behavior, discipline and instruction.

-Observe the environment – are there pro-social posters on the wall?, are students' work displayed?, what are the messages being given?

V. A Friend on the Inside: Working with the PBIS Coach

As the Prevention Coordinator, connecting with the PBIS coach and/or the facilitator of the PBIS team would be an invaluable asset to you, and could be your segue into the school to address our prevention efforts with students. The PBIS coach or team facilitator could typically be the building administrator, a teacher, an instructional assistant, counselor, behavior specialist, or school psychologist. If the school with which you work does not have a PBIS coach or system in place, connecting with one of the above listed staff members and/or the SST would be useful.

The PBIS coaches' survey from this fall, 2011 revealed the following at present:

- *1/3 of the PBIS coaches who responded across the state have 3-5 years' experience, and another 1/3 have 6-10 years of PBIS coaching experience, approximately 20 staff each respectively.*
-

- *Most of the coaches are spending at least 1-5 hours per week on PBIS coaching and providing support to the schools.*
 - *Half of the districts in Oregon are from rural communities; the other half – urban.*
 - *Most PBIS coaches will be continuing with PBIS work this school year, 2011-12.*
 - *Most PBIS coaches work at the district-level, with about 1/5 of them coaching and providing support at the school building level. Most of the PBIS coaching at the school building level is in the elementary schools. Secondary interventions with PBIS needs more support. 10 respondents reported providing coaching at the early childhood level.*
 - *Half of the school districts with PBIS designate .1 to .25 FTE on PBIS coaching, an increase of 15% from last year. About 1/5 of the schools with PBIS designate a full-time PBIS coach.*
 - *Half of the districts meet monthly as a team and review their School-wide Information Systems (SWIS) to make data-driven decisions for prevention and intervention. The rest of the schools meet either bi-monthly or every 6 weeks.*
 - *Most of the PBIS coaches are presenting their data, successes and efforts to school boards, school administrators, and building level staff at least 1-2 times per year.*
 - *Most PBIS schools are using other SEL programs and curricula in their schools.*
 - *At least ½ of the PBIS coaches reporting have not heard of the Student Wellness and Oregon Healthy Teens surveys and/or do not know how to access the information. Only 13 out of the 60 respondents indicated they use the survey data to make decisions regarding prevention efforts in their schools.*
 - *Prevention needs for bullying, drop-out rates, and social skills programming were rated as a high priority. Classroom management and suicide and depression prevention needs were expressed at a medium to high level. Substance abuse prevention needs were also expressed, although were equally scattered amongst the low, medium and high levels of concern by respondents.*
 - *Most PBIS coaches regularly attend the state-wide training programs offered twice per year.*
 - *Common themes expressed that are currently impeding the PBIS efforts in schools include funding issues, budgetary constraints, lack of resources, time constraints, lack of available time, competing demands, extra duties due to staff and funding cuts, and staff turnover.*
-

More recent data suggests that 61% of Oregon's public schools are currently implementing school-wide PBIS systems.

VI. Bully-Proofing Schools and Promoting Non-Violence

Bullying, harassment, intimidation, whether verbal, physical, sexual, occurring face to face or via electronic devices, is never acceptable behavior. Traditionally, "bullying" is defined as victimization by a peer that occurred at school, and including making fun of someone, calling them names, or insulting them; spreading rumors; threatening with harm; pushing, shoving, tripping, or spitting upon; forcing others to do something they did not want to do; excluding others from activities; or destroying their property are also forms of "traditional bullying." "Electronic bullying" or "cyber-bullying" is victimization by a peer that occurred anywhere via electronic means, including the Internet, e-mail, instant messaging, text messaging, online gaming, and online communities. The latter is becoming a great concern and complicates the bullying problem because it can occur from anywhere, off school grounds, monitoring is limited, anonymity is possible, and the bullying is broadcasted to the public or a lot more people.

According to the National Center for Education Statistics (NCES) in 2009, at <http://nces.ed.gov/pubs2012/2012314.pdf>, the following is a summary of the findings on victimization, crime and bullying amongst our students:

- About 2.8 percent of students' ages 12 through 18 reported being victims of theft, 1.4 percent of students reported a violent victimization, and 0.3 percent of students reported a serious violent victimization.
- A larger percentage of males were victims of any crime at school (4.6 percent) than were females (3.2 percent).
- Higher percentages of students who reported any criminal victimization at school reported they were also the targets of traditional (63.5 percent) and electronic/cyber (19.8 percent) bullying than were student non-victims (26.6 percent and 5.5 percent, respectively).
- The percentage of student victims of violent crimes who reported being afraid of attack or harm at school (22.7 percent) was higher than that of student non-victims of violent crime (3.9 percent).

Recent findings from the Oregon Healthy Teens (OHT) survey, 2011, found that 37% of 8th graders reported getting harassed within the past thirty days,

and 28% of the 11th graders reported the same.

The U.S. Department of Education, Office for Civil Rights, 2011, identified the following potential detrimental effects associated with bullying:

- Lowered academic achievement and aspirations
- Increased anxiety
- Loss of self-esteem and confidence
- Depression and post-traumatic stress
- General deterioration in physical health
- Self-harm and suicidal thinking
- Feelings of alienation in the school environment, such as fear of other children
- Absenteeism from school

“Bullying negatively affects the atmosphere of a school and disrupts the learning environment.” Bullying is very likely the symptom of an underlying school climate issue. The above ill-effects from bullying could also lead to an increase in drug and alcohol abuse. It is our duty as an entire school community to create an inviting and healthy school environment and climate where students feel like they belong and are safe. Prevention Coordinators need to collaborate and work together with school administrators, teachers and school staff, parents, and students alike to stop bullying in the school and community.

Bullies, victims, bystanders, and non-participants who witness the bullying all require various forms of intervention. Excellent resources to address bullying can be found at www.stopbullying.gov and at www.cyberbullying.us A clearinghouse of resources website addressing bullying, cyber-bullying, substance abuse, violence prevention and crisis can be accessed at www.oregonschoolclimate.org

VII. Drug-Free Schools

Below are some statistics on current substance abuse issues among our students. While the use of many forms of drugs is decreasing amongst our youth, alcohol consumption continues to be the most widely abused substance amongst our youth, along with marijuana use and more lately, the abuse of

over the counter and prescription medications, which we need to address in our prevention efforts. Young teenagers can be directed to “the cool spot”, an interactive website at <http://www.thecoolspot.gov> to learn more about alcohol abuse issues.

The following has been reported by the National Center for Chronic Disease Prevention and Health Promotion, reference <http://www.cdc.gov/HealthyYouth/alcoholdrug/index.htm>

“Current alcohol use among high school students remained steady from 1991 to 1999 and then decreased from 50% in 1999 to 42% in 2009. In 2009, 24% of high school students reported episodic heavy or binge drinking. 10% of high school students reported driving a car or another vehicle during the past 30 days when they had been drinking alcohol. In addition, 28% of students reported riding in a car or other vehicle during the past 30 days driven by someone who had been drinking alcohol. Alcohol is used more than tobacco and other illicit drugs amongst students/teenagers, although **national statistics suggest 83% of our high school students are not drinking alcohol**. Also, according to another report, less than 7% of students *13 years old and younger* reported using alcohol within the past 30 days. **93% of our young teenagers are not drinking alcohol**. The most recent OHT survey, 2011, found that 91% of our 8th graders are not engaging in excessive drinking and 79% of 11th graders are not engaged in binge drinking. The perception of usage amongst teens is higher than the actual percentage or number, which is a risk variable. Prevention Coordinators need to teach the actual facts about a particular school districts’ students’ involvement with drinking.

Marijuana is the most commonly used illicit drug among youth in the United States.

Current marijuana use decreased from 27% in 1999 to 21% in 2009. Current cocaine use increased from 2% in 1991 to 4% in 2001 and then decreased from 2001 (4%) to 2009 (3%). Inhalant use decreased from 20% in 1995 to 12% in 2003 and then remained steady from 2003 (12%) to 2009 (12%). Use of ecstasy among high school students decreased from 11% in 2003 to 7% in 2009. Use of methamphetamines was steady from 1999 (9%) to 2001 (10%) and then decreased to 4% in 2009. Heroin use did not change from 1999 (2%) to 2009 (2%). Hallucinogenic drug use decreased from 13% in 2001 to

8% in 2007 and then remained steady from 2007 (8%) to 2009 (8%). The OHT, 2011, revealed that 89% and 79% of 8th and 11th graders, respectively, are not smoking marijuana. Again, the perception of students smoking marijuana is distorted and much higher, which needs to be addressed and challenged to reduce the risk of teens engaging in this risky behavior. The same applies for tobacco use as well; most students do not smoke cigarettes or chew tobacco, although the perception of use is higher.

Prescription medications most commonly abused by youth include pain relievers, tranquilizers, stimulants, and depressants. In 2009, 20% of U.S. high school students had taken a prescription drug, such as Oxycontin, Percocet, Vicodin, Adderall, Ritalin, or Xanax, without a doctor's prescription. Teens also reported misusing OTC cough and cold medications, containing the cough suppressant dextromethorphan (DXM), to get high. Prescription and OTC medications are widely available, free or inexpensive, and falsely believed to be safer than illicit drugs. Misuse of prescription and OTC medications can cause serious health effects, addiction, and death.”

VIII. School Climate and School Culture

“*School climate* is created by the attitudes, beliefs, values, and norms that underlie the instructional practices, the level of academic achievement, [social-emotional health and success at the school], and the overall operation of a school.” The community in which a school resides is reflective of the attitudes, beliefs, values and norms held by the adults in the community who teach and work in the school as well. School climate is driven by how well and how fairly the adults in a school create, implement, model and enforce these particular attitudes, beliefs, values, and norms to which they adhere. “The product of good school climate is a strong school culture. *School culture* is the behavior exhibited by the adults.” It is “the way we do that here”, or “the way we don't do that here”, which underlies the core values, beliefs, attitudes, routines and procedures of the individuals in a school community (Saufler, 2005).

School climate is established by the actions of the adults and sets the "tone or feel" of the school. School culture is how students and staff behave in the context of the climate created by the adults. A "positive school culture" and a "negative school culture" will yield different academic and social-emotional outcomes, no matter what the stated rules, values, expectations and norms, and no matter what programs you implement. Furthermore, relationships and the quality of them are at the heart of school culture. It is important to employ evidence-based academic instruction with rigor and relevance, while simultaneously promoting relationships and an atmosphere of safety to promote optimum learning conditions.

The keys to school climate are "*Engagement – Safety – Environment*" (Osher, 2011). *Engagement* refers to the following:

- *Relationships*: [the quality and promotion of positive relationships amongst *school staff and students, students and students, staff and staff, parent/student, parent/staff.*] Do students/staff get along with each other, look out for each other.
- *-Respect*: treating each other with respect and support that are modeled and the norm.
- *-Participation*: positive and active involvement between the parents and the schools, the community and the schools.

Safety refers to the following:

- *Emotional*: students' perceptions of how safe they are and how comfortable they are at their school; [feeling intimidated, bullied and harassed or not.]
- *Physical*: [students are safe or not; are they subjected to physical assault, hitting and physical abuse or not.] Do students feel safe in various settings – classroom, hallways, outside of school, bathroom, etc.?
- *Substance Abuse*: how prevalent is drug and alcohol abuse amongst the students. [What is the perception about substance abuse in the school and is it accurate or not?]. (Note: an actual or perceived high rate of substance abuse negatively impacts school climate).

Environment refers to the following:

- *Physical*: lay out and appearance of the environment; [what is on the walls? – (i.e. student work, pro-social messages...); are staff inviting, positive, healthy?; is the environment & classrooms conducive to learning and promoting interpersonal relationships?]
-

- Academic: challenging curricula [that incorporates the **3 R's** - **Rigor, Relevance** and fosters **Relationships**.]
- Wellness: “the feel”, general atmosphere or attitude of the building. [School climate to School culture.]
- Discipline: [is there a School-Wide Positive Discipline system in place or not?]

Therefore, it is important to know your community and school’s climate. It is important to understand the direct inter-relationship that climate has with culture, and the influence it has on students and the staff with whom you will be working. Focus your efforts on joining with a school, establishing rapport, and working to instill a healthy, positive and safe-minded climate. Using and promoting supportive evidence-based instructional modalities, both academic and social-emotional learning programs, are important, as well as the establishment of a PBIS or school-wide positive discipline system. Keep in mind that your efforts could be for naught if a positive school climate and culture are not promoted and established first. A PBIS system implemented with fidelity will establish the positive framework needed to promote a positive school climate.

For any system to work effectively, adults must be genuine, positive, and “practice what they preach.” It is imperative to attune yourself to the school climate and culture – its environment, the school personnel attitudes and beliefs, community values and norms, behaviors, relationships amongst staff, amongst students, amongst staff and parents, the health, tone or feel of the school, and the perception of safety at the school. The climate and culture will dictate how you need to proceed with your prevention efforts.

IX. Positive Community Norms – “The Science of the Positive”

The Positive Community Norms (PCN) approach or model is driven by social theory and a social-ecological approach in conjunction with “The Science of the Positive.” Social marketing and media to promote dialogue amongst constituents, while creating and sending positive messages in our prevention methods versus resorting to scare tactics and negative messages and/or inadvertent reinforcement of undesired behavior are utilized. PCN further employs integrating the ‘spirit’ or energy surrounding why we do what we do, with the “science” or evidence-based practices to support our efforts and validate our results, while guiding our continued “actions” and methods of intervening for prevention. The focus is on the promotion of leadership,

communication, and the integration of prevention efforts in communities using sound, positive and evidence-based methods that are focused and directed on initiating lasting change. It further employs a comprehensive approach to improving and transforming the health, safety and culture of a community by focusing on all with whom we work, including individuals, families, schools and workplaces, community-wide membership, and society as a whole.

The Oregon Health Authority has contracted with the PCN institute for five years, through 2016, to assist with prevention efforts for youth and alcohol abuse. There are seven core principles driving the prevention efforts through “the Science of the Positive” that we seek to embrace in our efforts. These core principals include the following:

1. Be Positive – considered to our “natural state” and is experienced by us through “hope, acceptance, love and forgiveness”, as opposed to living in fear.
2. Be Present – experiencing life in “the now” as opposed to dwelling on the past or too much in the future.
3. Be Perceptive – established through focused attention and effort, and by using science to counter misperception that distorts reality and creates negative perceptions.
4. Be Purposeful – aligning our intentions with positive change and transformation efforts.
5. Be Perfected – understanding we are “works in progress”; having the courage to acknowledge our imperfections, while working towards wholeness and for our community.
6. Be Proactive – choosing where we place our attention; noticing/observing our reactions rather than just reacting to things, so we can choose better how to respond to circumstances.
7. Be Passionate – making life meaningful; “directing the energy of self-transformation into an act of serving others” and promoting the transformation of a community.

The PCN and “Science of the Positive” model blends very well with the school-wide PBIS approach used in our public schools. The model addresses universal prevention needs through social media and advertisement. It also focuses on providing secondary and individual interventions as needed, emulating the three-tiered model employed by PBIS. Through teaching, modeling, and promoting positive expectations and outcomes, the impact of

our prevention efforts in schools and on the community as a whole could be transformational.

X. Your very own virtual sandbox/toolkit

a. www.oregonschoolclimate.org

XI. Commonly Asked Questions

Why would teachers, school staff or educators want to have a Prevention Coordinator offering a program in their school?

- Educators who are pressured by legislation to improve the academic performance of their students might welcome programs that could boost achievement (by 11 percentile points some SEL programs research reported!)
- Offering something of value to their students and helping in the teaching of the same would be helpful and take some of the pressure off the teacher to now have to implement something else.

What would be the best way to introducing our prevention program/s in the schools?

- Most multi-component SEL and prevention programs that were more extensive and helpful involved parent participation. They require careful planning and integration to attain proper implementation. Having parents involved in the process for consistency between the school and home is essential for behavior change and would greatly assist in the promotion of a healthier community.
- Programs which had multiple components did not fare as well as programs that were entirely school based and taught by a school staff member. The Prevention Coordinator would want to focus on training school staff to eventually teach the program to our students. Involving students in teaching the program or parts of it could be useful as well.

Why might students experience significant academic gains, as supported by the research noted above, when participating in a program that teaches SEL?

- Students who are more self-aware and confident, which is promoted by SEL, about their learning capacities try harder and persist in the face of challenges (Aronson, 2002).
- Students who receive SEL tend to set high academic goals, have self-discipline, are self-motivated, manage their stress and better organize their approach to work, learn more and get better grades (Duckworth & Seligman, 2005; Elliot & Dweck, 2005).
- Students who use problem-solving skills, promoted by SEL, to overcome obstacles and make responsible decisions about studying and completing homework do better academically (Zins & Elias, 2006).
- SEL programs improve self-esteem and assist with making 'inclusion' a reality in schools, which in turn, promotes safe and healthy environments in schools (Mah, 2009).
- Students' feeling safer in school is the most important variable to improved academic achievement; perception of a safe school even had a greater positive impact on student achievement than providing challenging curricula alone (Osher, 2011).

Why might students have greater academic gains when the SEL program is delivered by a classroom teacher or other school staff?

- Peer and adult norms in the given school that convey high expectations and support for academic success are already in place.
- Caring teacher-student relationships that foster commitment and bonding at school are already established.
- Engaging teaching approaches, such as a positive behavior support program, proactive classroom management and cooperative learning, are developed and maintained.
- Safe and orderly environments that encourage and reinforce positive classroom behavior have already been established.

How does SEL contribute to students' immediate and long-term behavior changes?

- Improved student social-emotional competence
 - A more positive school environment
 - Consistent and positive teacher practices and expectations
 - Improved and positive student-teacher relationships
 - Improved student-student relationships; more tolerant and inclusive behavior
-

*Special Circumstances

What to do when education budgets are tight and layoffs abound: Getting your foot in the door now, or being ready for next year?

With budgets cut and resulting layoffs, the remaining school staff and personnel are being charged with taking on more responsibilities and multiple roles. Due to this occurrence, anything you could do as a Prevention Coordinator to assist folks with their jobs, assist with reducing school behavioral problems, and with increasing academic success and achievement would be welcome.

Can the ESD play a role?

Absolutely! The Education Service Districts (ESDs) around the state employ and provide specialists and special programs and educators to support the schools. These specialists, which could include school psychologists, behavioral specialists, consulting teachers, PBIS coaches and coordinators, are assets for the schools and their partnership is becoming increasingly needed. Other specialists provided to the schools from the ESDs could include speech and language pathologists, physical therapists and occupational therapists. It would be beneficial to get to know the ESD personnel that are stationed in your schools. They could assist you with your prevention efforts at the school and serve as another connection or resource between you and the students and school staff.

What role can the district or school website play?

The district website could be employed to announce your presence and role at the school, as well as to publish the calendar of prevention events, presentations, etc. It further is intended to provide a well of resources for students, staff and parents to reinforce and support your prevention efforts. Other applications might include posting your presentations and any data associated with the need for a Prevention Coordinator. Any data possibly collected or used about the effectiveness of the prevention programs could be another venue for the website, as well as pairing and comparing the data with school's achievement data to assess the impact of your interventions and efforts.

It would be very helpful to use the printed materials that were provided to you and to schools by the ODE. These will help explain why you are there and what it is you as the Prevention Coordinators have to offer. Since they are published by the ODE you will have more credibility with educators if you have these in your pocket. Highlight the fact that you are advocating for the same prevention programs that ODE recommends and you have staff that is able to provide training programs to school-based personnel so that they can provide the instruction directly to students.

In summation, use this resource to guide you in your interactions with school and district personnel. In it you will find detailed descriptions of the evidence based prevention programs that are recommended for schools. This list was finalized using multiple processes. Updates will be made in the future as that data becomes available. The current programs listed were compiled by frequent meetings between ODE staff and OHA staff, a survey that went to every prevention coordinator in Oregon, several focus groups held after the PC Summit in 2011, reference to the “Safe and Sound: An Educational Guide to Evidence-Based Social-Emotional Learning Programs”, http://casel.org/wp-content/uploads/1A_Safe_Sound-rev-2.pdf and a few one-on-one meetings with individual prevention coordinators.

The website will have a “request for more information” form for educators to fill out if they would like to know more about a particular prevention program and/or the services that you provide. This will be routed directly to the appropriate county prevention coordinator giving you the information that you need in order to respond to their request.

Use this site to check for any new grant opportunities. We intend to provide an opportunity to sign up for email alerts when new grants are posted on the site.

Furthermore, consult the data received and published from the OHT and the Oregon Student Wellness Survey (SWS). The OHT is administered every odd year and the SWS administered every even year. Check for your school districts participation in these surveys and use the data to assist with prevention and intervention efforts.

Problem gambling addendum: Most school curricula do not address youth gambling, yet it is a common risky behavior. It is included in the health education standards for middle school, which is the time when most youth start to gamble. Introducing schools to the issue is important and the health education standards, ready-to-use curricula and educational materials, data and resources specifically addressing schools and youth gambling is available at <http://problemgamblingprevention.org/population/educators/>

APPENDIX I

SHARED RISK AND PROTECTIVE FACTORS

In 2012, SAMHSA's Center for the Application of Prevention Technologies (CAPT) reviewed literature concerning risk and protective factors for substance abuse and mental health disorders. Existing research and data suggest that there are number of common or *shared* risk and protective factors throughout life that impact both substance abuse and mental health outcomes. The tables below highlight some of these shared risk and protective factors.

Examples of Protective Factors for Both Substance Abuse and Mental Health

Individual

- Health promotion
- Preventative health care/ screening
- Self-esteem
- Religiosity/spirituality
- Stable/steady employment
- Part-time employment for youth, older adults
- Stable housing

Family

- Parental encouragement
- Parental support and bonding
- Positive involvement with children and reinforcement of desirable behaviors
- Frequent contact with other relatives
- Access to mentors
- Social support

Community (school/work)

- Participation in social activities
 - Participation in religious/spiritual activities
 - Volunteering
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Examples of Risk Factors for Both Substance Abuse and Mental Health

Individual

- Chronic pain
- Traumatic brain injury
- HIV/AIDS
- Prenatal alcohol exposure
- Illness/poor physical health
- Impaired health for older adults
- Poor self-esteem
- Aggression/hostility to peers
- Alienation
- Difficult temperament
- Rebelliousness
- High stress
- Insecure attachment
- Grief/death of a loved one
- Job loss
- Unemployment
- Retirement
- Poverty
- Low household income/financial problems
- Residential instability
- Shelterless/homeless

Family

- Adverse childhood experiences (psychological abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, household member w/ substance use disorder and/or mental illness, incarcerated household member, divorced parents, witnessed domestic violence)
- Family conflict
- Family dysfunction and disruption
- Harsh discipline
- Inconsistent parenting
- Lack of discipline
- Low parental warmth
- Parental hostility
- Low parental support
- Maternal inattention
- Critical, unsupportive partner/spouse
- Significant other with substance use, mental health, or co-occurring disorder
- Abused by a sexual partner
- Physical abuse
- Sexual abuse/rape
- Spousal divorce
- Bullying
- Association with deviant peers
- Peer rejection
- Poor peer relationships
- Lack of social support
- Social isolation/deprivation

Community (school/work)

- Chronic community disorganization and stress (crime, economy)
 - Acute community stressful events (school shooting, severe tornado)
 - Exposure to violence (witness violent crime, gangs, wars)
 - Poor grades/ achievement
 - Problems/difficulties in school
 - School transition
 - Truancy
 - Problems at work
 - Military (active duty, combat exposure, redeployment)
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