

LOS ANGELES COUNTY

DEPARTMENT OF PUBLIC HEALTH

SUBSTANCE ABUSE PREVENTION AND CONTROL



**PREVENTION PROGRAM MANUAL AND
STANDARDS AND PRACTICES
FISCAL YEARS 2011-2014**

ALCOHOL AND OTHER DRUG PREVENTION SERVICES

Environmental Prevention Services

Comprehensive Prevention Services



Preventing Substance
Use, Misuse, & Abuse
Among Children,
Youth & Young Adults
(0-24 Years Old)



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MANUAL SECTIONS FOR SPF STEPS TWO THROUGH FIVE AND RELATED ATTACHMENTS TO BE ADDED BY JUNE 30, 2012.

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH, SUBSTANCE ABUSE PREVENTION AND CONTROL – PREVENTION SERVICES GOALS AND OBJECTIVES

The Los Angeles County Department of Public Health, Substance Abuse Prevention and Control's (SAPC) preliminary assessment determined that the following substances are of highest priority among the youth and young adult populations in the County: alcohol, marijuana, methamphetamine, ecstasy, over-the-counter (OTC) medications, prescription drugs, and inhalants. To address these alcohol and other drug (AOD) problems, SAPC's Alcohol and Other Drug Prevention Services (AODPS) and Adolescent Intervention, Treatment, and Recovery Programs (AITRP) Contractors are required to provide services impacting youth and young adults that focus on addressing the contributing factors of availability and accessibility, and social norms and community conditions, that contribute to AOD use and misuse. These contributing factors are defined as follows:



Availability and Accessibility: The actual and perceived availability and accessibility of AOD can impact consumption patterns beyond the influence of individual characteristics. Therefore, it is important to develop prevention interventions/efforts that not only focus on the individual but also the community.



Availability refers to the physical existence of the substance in the community. Alcohol is available in venues such as licensed outlets, both on-sale (restaurants/bars) and off-sale (grocery/liquor stores); private residences; and public venues such as fairs and sports arenas. Alcohol outlet density is often seen as an indicator of availability in a community. Other legal drugs, such as OTCs and prescriptions are available in venues such as retail outlets (pharmacies, grocery stores) as well as private residences.



Accessibility refers to the ability to get or obtain the substance. In retail settings, access can be restricted by implementing policies and procedures such as checking IDs to ensure patrons are at least 21 years old and by refusing sales to patrons displaying signs of intoxication. In a social setting, such as a private residence, access can be reduced by monitoring alcohol, OTC, and prescription drug supplies; not providing alcohol to those under the age of 21 years; not allowing underage drinking to occur at the residence; and discouraging continued drinking for guests displaying signs of intoxication.

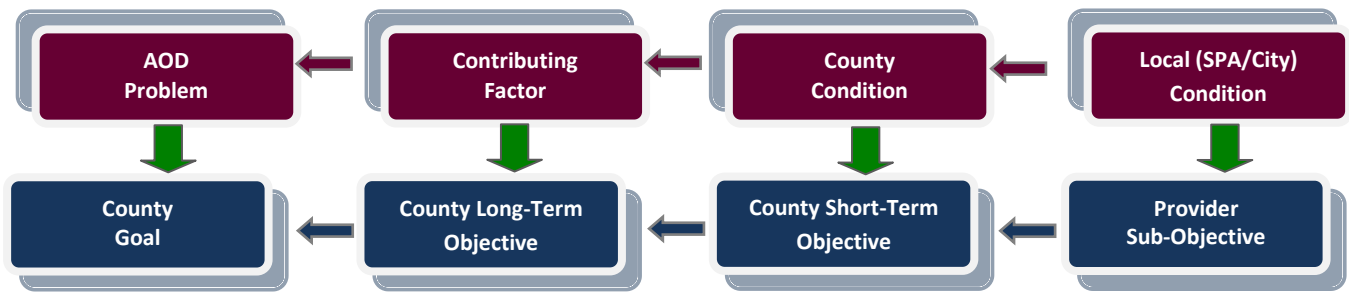


Social Norms and Community Conditions: Families, peers, media, music, movies, advertising, laws, and regulations all play a role in influencing individual beliefs and attitudes about AOD use, and in maintaining or modifying social norms of a community. Social, economic, and environmental conditions also impact health, including AOD use. Interventions designed to influence social norms and community conditions can lead to less favorable attitudes towards AOD use and help create healthier communities.

Social Norms refer to the expected, approved, and/or established attitudes and behaviors around an issue, in this case AOD use. Social norms can vary based on geography (among nations, states, or cities) and/or membership with a specific group (race/ethnicity, gender, age), and can change over time. Factors such as family attitudes and behaviors, media (movies, music, advertising), and the absence or presence of laws, regulations, and policies, contribute to how individuals perceive and respond to established social norms, and whether they change over time. Decreasing favorable attitudes around experimentation and/or use of AOD can lead to changes in acceptability of use and subsequently community norms.

Community Conditions refer to the social, economic, and environmental factors that influence the health of individuals and communities, in this case AOD use. Addressing the specific environmental and social conditions such as the built environment (deteriorating or dilapidated buildings, unkempt streets or sidewalks, poorly lit areas, availability of parks), social networks/support, and community cohesion that influence AOD availability, accessibility, and community norms can ultimately lead to decreased use and ideally improved health.

The problem areas and contributing factors described above translate to the following goals and objectives:



Goal 1: Decrease underage drinking and binge drinking among youth and young adults in Los Angeles County.

Long-Term Objective 1.1: Reduce availability of and access to alcohol by underage youth.

Short-Term Objectives:

- 1.1.1 Decrease rates of retail access to alcohol by underage youth.
- 1.1.2 Decrease rates of social access to alcohol by underage youth.
- 1.1.3 Decrease the availability of alcohol in the community by underage youth.

Long-Term Objective 1.2: Change social norms that contribute to alcohol use by decreasing favorable attitudes toward underage and binge drinking.

Short-Term Objectives:

- 1.2.1 Increase parent/guardian communication and disapproval of underage alcohol use.
- 1.2.2 Increase recognition of high-risk alcohol use patterns among youth and young adults.
- 1.2.3 Decrease social influences associated with alcohol use among youth and young adults.
- 1.2.4 Reduce exposure to outdoor and in-store alcohol advertising.

Goal 2: Decrease illicit drug use (i.e., marijuana, methamphetamine, ecstasy) among youth and young adults in Los Angeles County.

Long-Term Objective 2.1: Reduce availability of and access to illicit drugs by youth and young adults.

Short-Term Objectives:

- 2.1.1 Decrease rates of access to illicit drugs in homes, parties, and public events.
- 2.1.2 Decrease access to illicit drugs in retail settings.

Long-Term Objective 2.2: Decrease community conditions conducive to illicit drug use.

Short-Term Objectives:

- 2.2.1 Decrease neighborhood tolerance for drug dealing.
- 2.2.2 Decrease prevalence of nuisance locations.

Long-Term Objective 2.3: Change social norms that contribute to substance use by decreasing favorable attitudes toward illicit drug use.

Short-Term Objectives:

- 2.3.1 Increase parent/guardian communication and disapproval of illicit drug use.
- 2.3.2 Decrease social influences associated with illicit drug use among youth and young adults.
- 2.3.3 Reduce exposure to pro-drug products and advertising.

Goal 3: Decrease misuse of legal products (i.e., inhalants, over-the-counter medications, prescription drugs) among youth and young adults in Los Angeles County.

Long-Term Objective 3.1: Reduce availability of and access to legal products that can be misused among youth and young adults.

Short-Term Objectives:

- 3.1.1 Increase retail outlet management of substances that can be misused.
- 3.1.2 Increase adult management of substances in the home that can be misused.

Long-Term Objective 3.2: Change social norms that contribute to substance use by decreasing favorable attitudes toward use of legal products commonly available in the home or retail outlets that can be misused.

Short-Term Objectives:

- 3.2.1 Increase parent/guardian communication and disapproval of OTC, Rx, and inhalant misuse.
- 3.2.2 Decrease social influences associated with misuse of legal products among youth and young adults.

The Comprehensive Community Assessment will guide contractor identification of what County Problems and Contributing Factors are most pressing for their target community, and which County Goals, Long-Term Objectives, Short-Term Objectives, and Provider Sub-Objectives will lead to the greatest change (outcomes). Activities and services should then be selected based on results of the Comprehensive Community Assessment and their ability to directly impact the County Goals and Objectives.

Furthermore, SAPC’s continued assessment and the data from contracted providers gathered during the first six months of the contract term will help confirm whether the Long-Term and Short-Term Objectives listed above are the most appropriate for Los Angeles County as a whole and whether modifications, additions, or deletions are required based on the assessment results.

AOD Prevention Efforts Examples

As outlined in the AODPS Request for Proposals (RFP), the following are examples of allowable AOD prevention efforts that align with the above frameworks and should lead to impacting SAPC’s Goals and Objectives. While not an exhaustive list, this provides a general framework on the types of AOD prevention activities that are allowable under these AODPS services. Any selected strategy, activity, and/or services must also be evidence based as defined herein.

EXAMPLES OF AOD PREVENTION EFFORTS TO ADDRESS LONG-TERM OBJECTIVES 1.1, 2.1, AND 3.1		
ALCOHOL: UNDERAGE AND BINGE DRINKING	ILLICIT DRUGS: MARIJUANA, METHAMPHETAMINE, ECSTASY	HOUSEHOLD DRUGS OF MISUSE: INHALANTS, PRESCRIPTIONS, OTC
<ul style="list-style-type: none"> • Implement and enforce local ordinances (e.g., social host, deemed approved, conditional use permits, public consumption, zoning) • Restrict availability at events attended by minors • Ensure compliance with minimum age purchase laws • Responsible beverage service training • Restrictions on alcohol density, location, and types of outlets • Collaborative projects with Alcoholic Beverage Control 	<ul style="list-style-type: none"> • Surveillance of high risk public areas • Nuisance abatement • Enforcement of zoning and building codes • Enforcement of marijuana dispensaries regulations • Restrictions on sales of drug paraphernalia • Restrict availability at events attended by minors 	<ul style="list-style-type: none"> • Retailer Education/Training • Mandatory/voluntary restrictions on sales • Compliance with minimum age purchase laws • Restrict availability at events attended by minors

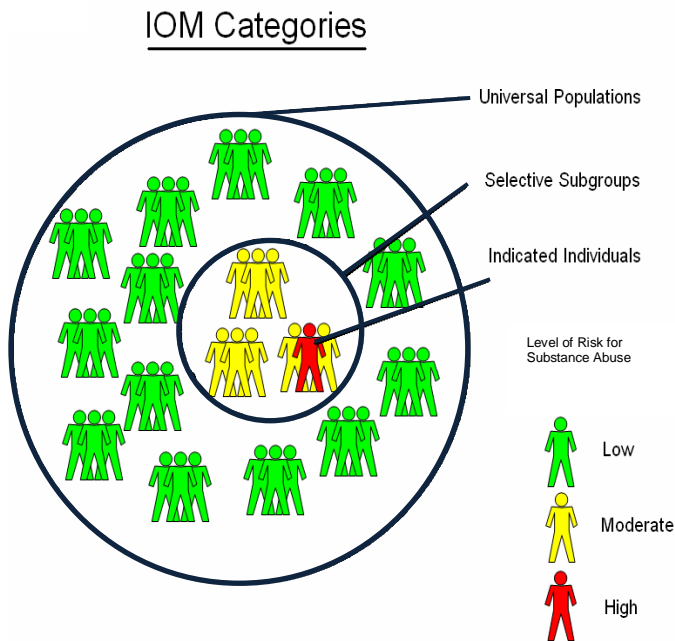
EXAMPLES OF AOD PREVENTION EFFORTS TO ADDRESS LONG-TERM OBJECTIVES 1.2, 2.2, 2.3, AND 3.2		
ALCOHOL: UNDERAGE AND BINGE DRINKING	ILLICIT DRUGS: MARIJUANA, METHAMPHETAMINE, ECSTASY	HOUSEHOLD DRUGS OF MISUSE: INHALANTS, PRESCRIPTIONS, OTC
<ul style="list-style-type: none"> • Restrictions on advertising (e.g., billboards, mass transit, near places where minors frequent) • Restrictions/enforcement on product or sign placement in retail outlets • Appropriate design, maintenance/upkeep of parks, streets, buildings, and other public places • Restrict availability at events attended by minors (e.g., family events, sports, fairs) • Reduced access in the home through proper storage, monitoring, and disposal • Widespread media campaigns (e.g., at the SPA or County level)/media advocacy • NREPP Substance Abuse Prevention Programs/Communities That Care Programs • Develop youth skills/assets counter to AOD use (e.g., peer leadership, life skills, parent bonding) • AOD screening and referral by agency, in schools, detention facilities, and medical offices 		

PREVENTION FRAMEWORKS

The Strategic Prevention Framework (SPF), the Institute of Medicine (IOM) population classification system, and the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) Strategies are three distinct frameworks that when combined contribute to the development of comprehensive, culturally competent, and effective prevention services. Use of these frameworks is also required by the California Department of Alcohol and Drug Programs (CA-ADP) and included as part of their required California Outcome Measurement Service for Prevention (CalOMS Pv) web-based reporting system.

Institute of Medicine (IOM) Classification System

The IOM model divides the continuum of services into three parts: prevention, treatment, and maintenance. The prevention classifications are further subdivided into universal, selective, and indicated. The IOM category is assigned by looking at the risk level of the individual or group receiving the service. Federal prevention funding allows for the delivery of services for *universal*, *selective*, and *indicated* populations only and not those who would or do need treatment and recovery services.



Universal - Universal prevention targets the entire population (national, local community, school, and/or neighborhood) with messages and programs aimed at preventing or delaying the (ab)use of AOD. All members of the population share the same general risk for substance (ab)use, although the risk may vary among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk.

Selective - Selective prevention targets subsets of the total population at risk for substance abuse by virtue of their membership in a particular population segment. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not

specifically assessed or identified, and is based solely on a presumption given his or her membership in the at-risk subgroup.

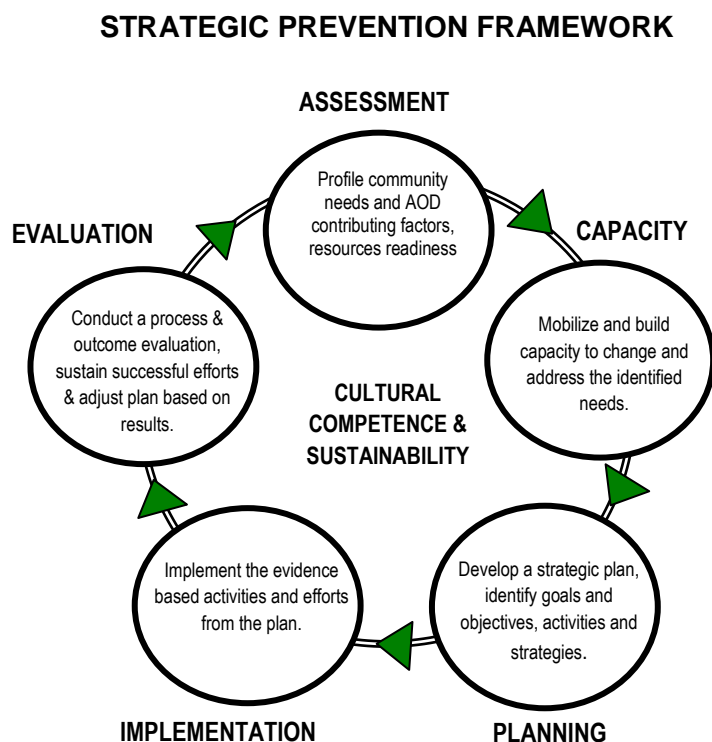
Indicated - Indicated prevention is designed to prevent the onset of substance abuse in individuals who do not meet Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision (DSM-IV-TR) criteria for abuse or dependence, but who are showing early danger signs, such as failing grades and consumption of alcohol and other gateway drugs. The mission of indicated prevention is to identify individuals who are exhibiting potential early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs.

For more information on the IOM categories, see the *Assigning Institute of Medicine Categories Guidelines* document in the *Knowledge Base* module of the CalOMS Pv web-based data system.

Strategic Prevention Framework (SPF)

The SPF is a five step planning process that guides the development of prevention services. Central to all steps is ensuring that efforts are culturally and linguistically competent, and sustainable. By addressing each of these steps, the prevention services should address the actual needs of the target community(ies) and population(s), enhance protective factors and reduce risk factors, build community capacity and collaboration, develop goals and measurable objectives, and emphasize evaluation to ensure the program achieves the intended outcomes. The following is a brief description of each SPF step.

Step 1 Assessment – The assessment involves collecting data on the target community(ies) including describing the demographic characteristics of the population, common risk and protective factors that contribute to AOD use, and can include any individual, family, school, community, peer, or environmental impact/needs. It should address existing community resources and identify service gaps as well as readiness to address the AOD issue(s) through leadership, policies, and services. Cultural competence and community relevance should also be addressed.



Step 2 Capacity – This step involves mobilizing the target community(ies) to identify and address local AOD issue(s) and strengthen the community’s capacity to respond effectively to the identified needs. Essential to this process is involving key stakeholders, local leaders (both elected officials and natural leaders), service providers etc. in the planning, implementation, and evaluation processes. Developing and/or participating on local coalition(s) is needed to ensure a participatory and community-driven process.

Step 3 Planning – This step involves using the information gathered in the assessment to develop a data-driven strategic plan that logically addresses the AOD issues and contributing factors within the target community(ies) through evidence-based policies, programs, and practices. Goals, measurable objectives, and evidence-based strategies and activities will be identified.

Step 4 Implementation – This step involves developing a detailed Work Plan that includes specific timelines for key activities, and putting the plan developed in Step 3 into action. Additional research, acquisition of materials, training, etc., to support the plan will occur here. Formulation of the process and outcome evaluation will also begin in Step 4.

Step 5 Evaluation – This step involves conducting the process and outcome evaluation. The results of a well-planned and developed evaluation will determine if the objectives were met, identify areas of improvement, and determine fidelity to the plan. Based on the results, other SPF steps may need to be revisited to ensure continued effectiveness of the prevention services.

Cultural Competency and Sustainability – These concepts must be integrated within each SPF Step. *Cultural Competency* is as a set of behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable effective work in cross-cultural situations. Such programming respects and is responsive to the health beliefs, practices, and cultural and linguistic needs of diverse individuals and is more likely to bring about positive change. *Sustainability* is the multiple factors that contribute to program success over the long-term including continued community support and engagement, stable infrastructure, and available resources and training.

Center for Substance Abuse Prevention (CSAP) Strategies and Activities

The SAMHSA CSAP has classified common prevention activities into six major categories termed “strategies.” These CSAP strategies, and the associated activities, are basic definitions that broadly describe the most frequent types of efforts for each term. An effective prevention program should be knowledgeable of these strategies and activities, but base the program design on how to comprehensively address the actual needs of the target community(ies) through evidence-based interventions and services with the proven ability to achieve the desired results.

Environmental Strategy - focuses on establishing or changing community standards, codes, and attitudes thereby influencing incidence and prevalence of alcohol and other drug use within the community. The strategy depends on engaging a broad base of community partners, focuses on places and specific problems, and emphasizes public policy.

Community-Based Process Strategy - focuses on enhancing the capacity of the community to address AOD issues through organizing, planning, collaboration, coalition building, and networking.

Information Dissemination Strategy - focuses on improving awareness and knowledge of the effects of AOD issues on communities and families through “one-way” communication with the audience such as speaking engagements, health fairs, and distribution of print materials.

Problem Identification and Referral Strategy – focuses on identifying individuals who have infrequently used or experimented with AOD who could change their behavior through education. The intention of the screening must be to determine the need for indicated prevention services and not treatment need.

Education Strategy – focuses on “two-way” communication between the facilitator and participants, and aims to improve life/social skills such as decision making, refusal skills, and critical analysis.

Alternative Strategy – focuses on redirecting individuals from potentially problematic situations and AOD use by providing constructive and healthy events/activities.

For more information on the CSAP strategies and associated activities see the *Knowledge Base* module of the CalOMS Pv web-based data system.

Evidence-Based Practices (EBP) Requirements

AODPS Contractors must select AOD prevention services, activities, and/or programs that have been adequately substantiated by evidence/research to impact community and/or individual level AOD use and related outcomes. For the purpose of this contract, evidence-based practices (EBP) are defined as follows:

- 1) Evidence-based programs or curricula categorized under substance abuse prevention on the National Registry of Evidence-based Programs and Practices (NREPP) [<http://nrepp.samhsa.gov>] or Communities That Care Prevention Strategies Guide [<http://ncadi.samhsa.gov/features/ctc/resources.aspx>];
- 2) Substantiated AOD environmental strategies such as those described in the RAND Preventing Underage Drinking Technical Report [<http://www.rand.org/health/feature/gto/>] or the Centers for Disease Control and Prevention Community Guide [<http://www.thecommunityguide.org/alcohol/index.html>]; or
- 3) Where the program or curricula is not a recognized best practice/model program (as described in one and two above), the AODPS Contractor must provide SAPC with the evaluation or research results conducted by an evaluator independent to substantiate program effectiveness and the ability of the program/curricula to achieve the intended outcomes and receive approval prior to implementation.

Overall, AODPS Contracts must demonstrate that selected AOD prevention effort(s) align with the County SAPC’s Goals and Objectives while addressing the problem areas and contributing factors identified during the Comprehensive Community Assessment (SPF Step 1), that they are culturally appropriate and relevant, and are supported by research/evidence to achieve the desired outcome(s).

GUIDING PRINCIPLES FOR PREVENTION

The Los Angeles County SAPC Prevention System of Services is based on the following nationally accepted and research-based guiding principles of effective AOD prevention programs¹:

1. Prevention fosters safe and healthy environments for individuals, families, and communities.

To create safe and healthy environments, prevention must reduce adverse personal, social, health, and economic consequences by addressing problematic AOD availability, manufacture, distribution, promotion, sales, and use.

By prevention providers leveraging resources, prevention programs will achieve the greatest impact.

2. The entire community shares responsibility for prevention.

All sectors, including youth, must challenge their AOD standards, norms, and values to continually improve the quality of life within the community.

“Community” includes organizations; institutions; ethnic and racial communities; tribal communities and governments; and faith communities.

Community also includes associations/affinity with groups based on age, social status, occupation, professional, and geographic boundaries.

3. Prevention engages individuals, organizations, and groups at all levels of the prevention system.

This includes those who work directly, as well as indirectly, in the prevention system who share a common goal of AOD prevention such as medical professionals, hospitals, teachers, employers, and religious organizations.

4. Prevention utilizes the full range of cultural and ethnic wealth within communities.

By employing ethnic and cultural experience and leadership within a community, prevention can reduce problematic availability, manufacturing, distribution, promotion, sales, and use of AOD.

5. Effective prevention programs are thoughtfully planned and delivered.

To create successful prevention programs, one must use data to assess the needs; prioritize and commit to the purpose; establish actions and measurements; use proven prevention actions; evaluate measured results to improve prevention outcomes; and use a competent proficient and properly trained workforce.

PREVENTION STANDARDS AND PRACTICES: PURPOSE AND IMPLEMENTATION

The purpose for the Prevention Program Manual and Standards and Practices (cited as Prevention Standards and Practices in the AODPS Exhibit and hereafter Prevention Manual) is to provide additional detail on contractual requirements outlined in the AODPS Exhibit and provide policies and procedures associated with these requirements. The Prevention Manual is considered an attachment to the contract, therefore by extension all requirements described herein are also considered contractual requirements and will included as part of SAPC audits.

This Prevention Manual is consistent with the federal SAMHSA SPF planning process, the CA-ADP CalOMS Pv reporting system, and the IOM classification system as well as other accepted and effective prevention practices. The intent is not only to clarify expectations of the AODPS contract but also contribute to the overall ability of the Prevention System of Services to effectively implement services and achieve stated goals, objectives, and outcomes.

Although differences may exist among individual programs, the Prevention Manual intends to ensure that all prevention programs share a common understanding of the AODPS contract requirements and a common set of program principles and practices. The Prevention Manual will be updated and modified over the course of the contract term to refine contract expectations and adjust to advances in the prevention field, including any changes to the Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements. Any updates to this Manual will be provided to AODPS contractors in writing and will automatically become a part of this document and that referenced in the Exhibit.

¹ California Department of Alcohol and Drug Programs, Prevention Strategic Plan, October 2002.