



# Prevention and Reduction of Non-Medical Use of Prescription Drugs Among High School-Age Youth in Massachusetts

## Guidance Document

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Massachusetts Technical Assistance Partnership for Prevention (MasTAPP)

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## ABOUT MASSTAPP

The Massachusetts Technical Assistance Partnership for Prevention (MasTAPP) is funded by the Massachusetts Department of Public Health's Bureau of Substance



Abuse Services (BSAS) to provide technical assistance (TA), build capacity, and offer resources to communities across the Commonwealth who seek to prevent and reduce substance abuse. MasTAPP comprises Education Development Center, Inc., Bay State Community Services, and Partnership for Youth, located in Waltham, Quincy, and Greenfield, Mass., respectively. Working as a statewide team, our TA providers are matched with each community that is home to one or more BSAS-funded programs. Each community benefits from an ongoing relationship with a core TA provider; the provider, in turn, has access to the expertise of both the entire TA team and our consultant pool.

Our TA team members are Kat Allen, Carl Alves, Aubrey Ciol, Tracy Desovich, Amanda Doster, Lauren Gilman, Jessica Koelsch, Gary Langis, Deborah Milbauer, Alejandro Rivera, Ben Spooner, Jack Vondras, and Melissa Ward

Our TA services include the following:

- *Individualized TA:* Each BSAS-funded program is matched with a TA provider, who is the main point of contact for all TA requests. Each TA provider is in touch with coalition coordinators by phone or e-mail weekly and provides one-to-one, in-person tailored TA each month. TA providers are well-versed in the Strategic Prevention Framework process.
- *Expert consultants for in-depth, focused work:* MasTAPP accesses and deploys members of our consultant pool to best meet the specific TA needs of each BSAS-funded community. Our consultant pool comprises professionals with a wide range of expertise and deep knowledge of specific regions and communities across the Commonwealth.
- *Online learning events:* Webinars and other distance-learning events are developed to share information and research and to bring together communities (both BSAS- and non-BSAS-funded) with similar concerns. Our webinars are designed to be useful and engaging, with plenty of opportunity for participation.
- *In-person networking events:* Meetings may be regional or topical; trainings are developed to address the needs of both BSAS- and non-BSAS-funded communities and coalitions around supporting their substance abuse prevention work.
- *Peer-to-peer learning:* TA providers facilitate the sharing of information, both within regions and across the state, among communities and peers (BSAS- and non-BSAS-funded) with issues in common, and help communities form mentoring relationships. Our peer learning conference calls allow communities to network with one another and to share successes and challenges they have faced around a particular topic.
- *Website and monthly e-blast:* Our website serves as a “go to” place for resources and distance-learning opportunities related to substance abuse prevention strategies in Massachusetts. A monthly “e-blast” of upcoming events, recent news, and highlights of

excellent new resources goes out to our mailing list of BSAS- and non-BSAS-funded communities and programs. Our Facebook page provides the latest news, research, and resources around substance misuse prevention, and promotes relevant upcoming local events.

For further information, contact Lauren Gilman, project director, at (617) 618-2308 or [lgilman@edc.org](mailto:lgilman@edc.org), or visit [MassTAPP.edc.org](http://MassTAPP.edc.org).

# PREFACE

This Guidance Document is a resource for municipalities, individuals, organizations, community coalitions, and other groups who are implementing prevention efforts aimed at preventing and reducing the non-medical use of prescription drugs (NMUPD) among high school-age youth in Massachusetts, including those whose efforts are funded by the Massachusetts Department of Public Health’s (DPH) Bureau of Substance Abuse Services (BSAS) and, more specifically, the grantees of the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Partnership for Success (PFS 2015) grant program. This grant is discussed in more detail in section 1.

The PFS 2015 initiative is part of a comprehensive approach to substance misuse and abuse prevention in Massachusetts, which includes the Massachusetts Opioid Abuse Prevention Collaborative (MOAPC) and Massachusetts Substance Abuse Prevention Collaborative (SAPC) grant programs. All initiatives implement evidence-based environmental strategies that can be sustained through local policy, practice, and systems change to prevent and reduce substance misuse and abuse problems in Massachusetts communities. In addition, these initiatives support increases in the number and capacity of Massachusetts communities who are able to effectively address these issues.

Substance misuse is a complex problem that requires comprehensive, coordinated, evidence-based solutions. This Guidance Document is intended to help communities in Massachusetts develop and implement effective, data-informed, and culturally competent strategies that will have a measurable and sustained effect on preventing and reducing NMUPD.

## DEFINITIONS

This document uses several terms that are common to substance misuse and abuse prevention grants in Massachusetts that are funded by BSAS and SAMHSA:

- **Community readiness:** The community’s level of awareness of, interest in, and ability and willingness to support substance misuse and abuse prevention initiatives. More broadly, this connotes readiness for changes in community knowledge, attitudes, motives, policies, and actions. For more detailed information on community readiness, please refer to the Colorado State University’s “Tri-Ethnic Center Community Readiness Handbook”, available online at [http://triethniccenter.colostate.edu/communityReadiness\\_home.htm](http://triethniccenter.colostate.edu/communityReadiness_home.htm).
- **Community resources:** The word *resources* often connotes staff, financial support, and a sound organizational structure. However, prevention resources may also include the following:

<b>BSAS-funded substance abuse prevention in Massachusetts</b>
▪ <i>PFS 2015:</i> \$1.36M annually to 16 high-need communities to address prescription drug misuse and abuse among high school-age youth
▪ <i>MOAPC:</i> \$1.8M annually to 18 lead municipalities, who currently target their efforts to prevent opioid misuse and overdose in more than 90 municipalities across the Commonwealth
▪ <i>SAPC:</i> \$2.9M annually to 26 lead municipalities in 127 communities to prevent substance abuse and underage drinking



- Existing community efforts to address the prevention and reduction of substance misuse and abuse
- Community awareness of those efforts
- Specialized knowledge of prevention research, theory, and practice
- Practical experience working with particular populations
- Knowledge of the ways that local politics and policies help or hinder prevention efforts.
- **Consequences:** The social, economic, and health problems associated with substance misuse and abuse (e.g., increased mortality, morbidity, injury, school dropout, and crime).
- **Consumption patterns:** How people use, misuse, and abuse substances, in terms of the frequency or the amount used. Consumption includes overall consumption, acute or heavy consumption, consumption in risky situations (e.g., while driving), and consumption by high-risk groups (e.g., youth, college students, athletes).
- **Intervening variables:** Factors that have been identified through research as being strongly related to and influencing the occurrence and magnitude of substance misuse and abuse and related risk behaviors and their subsequent consequences. These variables, which include risk and protective factors, guide the selection of prevention strategies.

## ORGANIZATION OF THIS GUIDANCE DOCUMENT

This guidance document may be viewed as having three distinct sections that, altogether, provide the necessary information and resources to assist communities in their efforts to prevent/reduce NMUPD:

- **Section 1: Introduction and Overview** provides information on NMUPD and the PFS 2015 grant program. The first part of the section includes a more in-depth description of the grant while the parts that follow include a description of, national and state consumption patterns of, physical and psychosocial consequences of, and select intervening variables relevant to NMUPD.
- **Section 2: Strategic Prevention Framework** provides guidance on the use of the Strategic Prevention Framework (SPF), a model for implementing and evaluating evidence-based, culturally appropriate, sustainable substance misuse and abuse prevention strategies. Developed by SAMHSA, the SPF is used by BSAS grantees and other communities nationwide to implement interventions addressing substance misuse and abuse.
- **Section 3: Appendices** encompasses a range of tools and resources relevant to the SPF process that are referenced throughout Sections 1 and 2. These include grant-specific, as well as general, resources that communities may use to help plan and implement their prevention/reduction efforts.

# SECTION 1: INTRODUCTION AND OVERVIEW

## PFS 2015 GRANT DESCRIPTION

### Grant Background and Prevention Priority

On September 30, 2015, BSAS was awarded a five-year Strategic Prevention Framework Partnerships for Success 2015 grant (SPF-PFS 2015) from SAMHSA's Center for Substance Abuse Prevention (CSAP). This grant, which was awarded to 22 states (Alaska, Arkansas, Connecticut, Georgia, Indiana, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Mississippi, New Hampshire, New Mexico, North Dakota, South Carolina, Vermont, Virginia, Vermont, Wisconsin, and Wyoming), 9 tribal entities, and Puerto Rico, provides funding between September 30, 2015, and September 29, 2020, for states to address a state-identified prevention priority in communities of high need. States were required to target one or both of the following substance abuse prevention priorities: (1) underage drinking among persons ages 12–20, and/or (2) prescription drug misuse and abuse among persons ages 12–25. States could also choose to target an additional data-driven prevention priority, provided that they also targeted one of the aforementioned issues.

The PFS 2015 grant in Massachusetts will target **prescription drug misuse and abuse among high school-age youth as its sole prevention priority**. This decision was based on the findings from a state epidemiological assessment process and recommendations that appear in several state-level strategic prevention plans.

### Community Selection

As part of the application to SAMHSA/CSAP, states were required to identify communities disproportionately impacted by the state-identified prevention priority. The availability of community-level data on prescription drug misuse and abuse is sporadic in Massachusetts. Existing state surveillance systems (e.g., Massachusetts Youth Risk Behavior Survey [Mass. YRBS], Massachusetts Youth Health Survey [MYHS]) are not designed to provide data that can be disaggregated below the state level. Many communities conduct local health and behavioral health surveys among middle and high school populations, but these data are not complete or consistent enough to support state-level decisions about which communities should be targeted over others. As with the earlier PFS-II grant and the SPF-SIG before that, the most consistent and reliable proxy indicator for assessing need related to prescription drug abuse has been unintentional fatal and non-fatal opioid-related poisoning overdoses. These data help identify communities that are disproportionately affected by this issue and that could benefit the most from earlier *primary prevention programming*.

In preparation for this proposal, a state-level data workgroup examined the absolute number of unintentional fatal and non-fatal opioid-related overdoses over the most recently available three-year period, 2010–2012. The sub-group selected a three-year count of 50 overdoses or

more as an indicator of high need, with the intention of directing resources to the communities with the largest total number of overdoses—and, by inference, the highest ongoing risk of prescription drug misuse. As shown in Table 1, 16 communities in the Commonwealth met this criterion, accounting for more than 6,000 fatal and non-fatal overdose events between 2010 and 2012.

**Table 1. SPF-PFS 2015 Target Communities in Mass. with  $\geq$  50 Fatal or Non-Fatal (Unintentional, Undetermined, and Missing Intent) Opioid-Related Poisoning Overdoses, 2010–2012**

City/Town of Residence	Three-Year Average (2010–2012)	Total Three-Year Count	Population Total (Three-Year)	Average Annual Rate per 100,000	Region
1. Boston	553	1,659	1,887,360	87.9	Boston
2. Worcester	196	588	546,467	107.6	Central
3. New Bedford	152	455	284,647	159.8	Southeast
4. Fall River	149	447	266,270	167.9	Southeast
5. Quincy	125	376	278,021	135.2	Metro West
6. Brockton	109	326	281,693	115.7	Southeast
7. Springfield	130	310	460,521	67.3	Western
8. Lynn	102	305	272,342	112.0	Northeast
9. Lowell	99	297	322,447	92.1	Northeast
10. Weymouth	78	234	162,875	143.7	Metro West
11. Revere	73	218	157,766	138.2	Boston
12. Malden	59	178	179,636	99.1	Northeast
13. Taunton	58	175	167,760	104.3	Southeast
14. Cambridge	54	161	316,723	50.8	Metro West
15. Everett	54	162	126,291	128.3	Northeast
16. Medford	51	153	169,854	90.1	Northeast

### Sub-Recipient Responsibilities

The 16 sub-recipient communities will have five months from the point at which they receive funding to engage in a local comprehensive strategic prevention process using SAMHSA’s Strategic Prevention Framework. This planning process will result in the generation of a strategic plan that includes (1) data demonstrating NMUPD among high school-age youth in the community and an assessment of the intervening variables that appear to be driving use, (2) an assessment of local capacity to address the issue and capacity needs, (3) a data-informed strategy selection process, (4) an implementation plan, and (5) an evaluation plan. Instructions on how to develop this plan and acceptable evidence-based strategies appear in this Guidance Document. For a timeline of deliverables specific to the PFS 2015 grant program, see Appendix 1: PFS 2015 Grant Milestones, Timeline, and Deliverables.

## Grant Parameters

- This is a primary prevention grant focused on preventing and reducing NMUPD.
- The purpose here is to prevent and reduce *non-medical use* (i.e., primary prevention). This grant is not directly focused on the potential consequences of any or all use (e.g., overdose).
- This grant is not limited to prescription opioids. A community may choose to specifically focus on prescription opioids, but any and all classes of prescription drugs may be targeted.
- The *primary* target population is high school-aged youth – which can be reached both in and/or outside of the school setting. Secondary target populations (e.g., parents, prescribers, etc.) can be served provided that the effects of any services delivered to these groups are likely to have an impact on past 30-day NMUPD among high school-age youth in the community.
- All prevention activities *must* be limited to the funded community—this is *not* a cluster model.

## WHAT IS NMUPD?

There is no single agreed-upon definition of NMUPD in the scientific literature. Terms used to describe this phenomenon include *prescription drug misuse*, *prescription drug abuse or dependence*, and *misuse of prescription psychotherapeutics* (Colliver, Kroutil, Dai, & Gfroerer, 2006; Office of National Drug Control Policy, 2011; Papp, 2010). National health and behavioral health surveys use slightly different definitions:

- SAMHSA’s National Survey on Drug Use and Health (NSDUH) defines NMUPD as the use of a prescription drug without a prescription from a physician or simply for the experience or feeling the drug caused (Center for Behavioral Health Statistics and Quality [CBHSQ], 2015).
- Both Monitoring the Future (Johnston, O’Malley, Miech, Bachman, & Schulenberg, 2016) and the Centers for Disease Control and Prevention’s (CDC) Youth Risk Behaviors Surveillance survey (YRBS) (Kann et al., 2014) define NMUPD as the use of a prescription drug without a doctor’s prescription.

The following definition, which is somewhat broader in scope and doesn’t imply a specific reason for the misuse or pattern of misuse, tends to be more in line with the breadth and intent of current prevention initiatives within the state:

*NMUPD is the intentional or unintentional use of a prescribed medication in a manner that is contrary to directions, regardless of whether a harmful outcome occurs* (Hertz & Knight, 2006).

NMUPD is often broken down into four categories: pain relievers, stimulants, tranquilizers, and sedatives (CBHSQ, 2015):

- *Pain relievers*, also known as opioid analgesics or opioids, are commonly prescribed for the management of acute or chronic pain, including post-surgical pain.
- *Stimulants* are frequently prescribed for attention deficit hyperactivity disorder (ADHD), narcolepsy, or depression that does not respond to typical medication.
- *Tranquilizers* and *sedatives* both fall under the category of central nervous system depressants. These classes of drugs are commonly prescribed for sleep problems (e.g., insomnia), anxiety, panic disorders, and seizure disorders.

Data from the most recent NSDUH indicate that of these four categories, pain relievers (opioids) are the most commonly misused and abused type of prescription drug, far exceeding the misuse and abuse of stimulants, tranquilizers, and sedatives. The term *opioid* designates a class of drugs derived from opium or manufactured synthetically with a chemical structure similar to opium. Heroin is a naturally derived opioid. Other opioids—including oxycodone (OxyContin<sup>®</sup>), morphine, meperidine, methadone, and codeine—are used therapeutically for the management of pain and other conditions. These products may be diverted from pharmaceutical purposes and used illicitly, and they have a high potential for abuse because they create psychological or physical dependence (Hahn, 2011).

**Table 2. Commonly Diverted Medications\***

Narcotic Pain Medications (Schedule II)	Stimulant Medications	Barbiturate Sedatives	Benzodiazepine Tranquilizers
<ul style="list-style-type: none"> <li>• Codeine</li> <li>• Fentanyl (Sublimaze®/ Duragesic®)</li> <li>• Meperidine (Demerol®)</li> <li>• Methadone (Dolophine®)</li> <li>• Hydromorphone (Dilaudid®)</li> <li>• Morphine</li> <li>• Opium</li> <li>• Oxycodone (OxyContin®)</li> </ul>	<ul style="list-style-type: none"> <li>• Adderall®</li> <li>• Dextroamphetamine (Dexedrine®/ Dextrostat®)</li> <li>• Focalin</li> <li>• Methylphenidate (Methylin®/Ritalin®)</li> </ul>	<ul style="list-style-type: none"> <li>• Amobarbital (Amytal®)</li> <li>• Pentobarbital (Nembutal®)</li> <li>• Secobarbital (Seconal®)</li> <li>• Phenobarbital (Luminal®)</li> </ul>	<ul style="list-style-type: none"> <li>• Clonazepam (Klonopin®)</li> <li>• Diazepam (Valium®)</li> <li>• Estazolam (Prosom®)</li> <li>• Flunitrazepam (Rohypnol®)</li> <li>• Lorazepam (Ativan®)</li> <li>• Midazolam (Versed®)</li> <li>• Nitrazepam (Mogadon®)</li> <li>• Oxazepam (Seraz®)</li> <li>• Triazolam (Halcion®)</li> <li>• Temazepam (Restoril®/ Normison®/ Planum®/Tenox®/ Temaze®)</li> <li>• Chlordiazepoxide (Librium®)</li> <li>• Alprazolam (Xanax®)</li> </ul>

\* Trade names are in parentheses.

## NATIONAL AND STATE CONSUMPTION ESTIMATES OF NMUPD

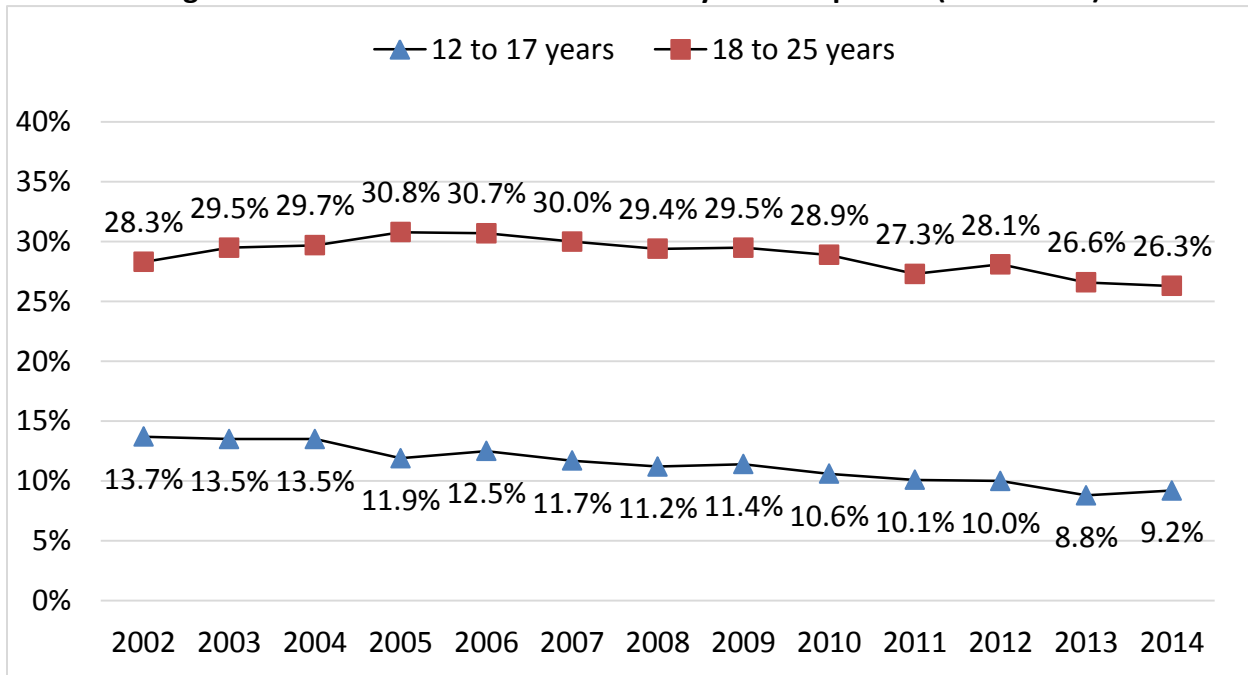
### National Estimates of Lifetime Use

The NSDUH survey provides one of the best population-level snapshots of prescription drug misuse and abuse at the national level among civilian, non-institutionalized individuals 12 years of age or older. The most recent NSDUH results, which cover the 2014 implementation, were released in September 2015. NSDUH asks about four types of prescription drugs (pain relievers, stimulants, tranquilizers, and sedatives). Respondents are asked to report on use without a prescription or use simply for the feeling caused by the drug.

According to 2014 NSDUH estimates, a total of 130.3 million individuals ages 12 and older (49.2% of the civilian, non-institutionalized individuals in the United States age 12 or older) consumed an illicit drug at least once in their lifetime. Among these individuals, 117.2 million (44.2%) reported lifetime use of marijuana, and *54.4 million (20.5%) reported non-medical lifetime use of psychotherapeutics*. Of individuals in the latter group, it is estimated that 36 million people age 12 or older (13.6%) misused pain relievers in their lifetime. In addition, 24.8 million people age 12 or older (9.4%) misused tranquilizers, 22.5 million (8.5%) misused stimulants, 7.8 million (3%) misused sedatives. Within the pain reliever category, it is estimated that 7 million individuals (2.7%) specifically misused OxyContin (SAMHSA, 2015a).

Lifetime non-medical use of psychotherapeutics in 2014 ranged from 9.2% among 12–17 year olds to 26.3% among 18–25 year olds. Non-medical use among 18–25 year olds peaked in 2005 at 30.8%—the 2014 survey marked the lowest reported lifetime use on record among this age group. Similarly, lifetime non-medical use of psychotherapeutics among 12–17 year olds peaked in 2002 at 13.7%. The 2013 survey marked the lowest reported lifetime use among this age group (8.8%). This rebounded in 2014 to 9.2%, but still marked the second lowest rate of reported lifetime misuse in 13 years, as shown in Figure 1 (SAMHSA, 2015a).

**Figure 1. Lifetime Non-Medical Use of Psychotherapeutics (2002–2014)**



Source: NSDUH 2014 (SAMHSA, 2015a).

Additional national data are available from the Monitoring the Future (MTF) survey. Sponsored by the National Institute on Drug Abuse (NIDA), MTF has examined drug, alcohol, and tobacco use among public and private school students in grades 8, 10, and 12 since 1975. The items measuring NMUPD among 8th- and 10th-graders have been deemed to be of questionable validity, so these estimates are only available for 12th-graders. MTF estimates lifetime non-medical use of psychotherapeutics among 12th-graders at 21.2% in 2012, 21.5% in 2013, 19.9% in 2014, and 18.3% in 2015, indicating a downward trend in lifetime use in recent years. Broken down by type of prescription drug, MTF found lifetime use rates among 12th-graders at 10.8% for stimulants, 8.4% for pain relievers, 6.9% for tranquilizers, and 5.9% for sedatives (Johnston et al., 2016).

Estimates from CDC’s YRBS place lifetime NMUPD in 2013 at 17.8% among public and private high school students (grades 9–12) across the country (Kann et al., 2014).

### State Estimates of Lifetime Use

At the state level, the MYHS, funded by the DPH, provides selected data on NMUPD. The data points listed below are from the 2013 survey, as the report on the 2015 survey was not available at the writing of this document. The MYHS estimates lifetime NMUPD at 3.9% among Massachusetts middle school students (grades 6–8) and 13.4% among high school students (grades 9–12). At a more detailed level, the MYHS estimates lifetime misuse of prescription narcotics at 1.3% among middle-schoolers and 5.5% among high-schoolers, lifetime misuse of Ritalin or Adderall at 0.8% among middle-schoolers and 5.9% among high-schoolers, and

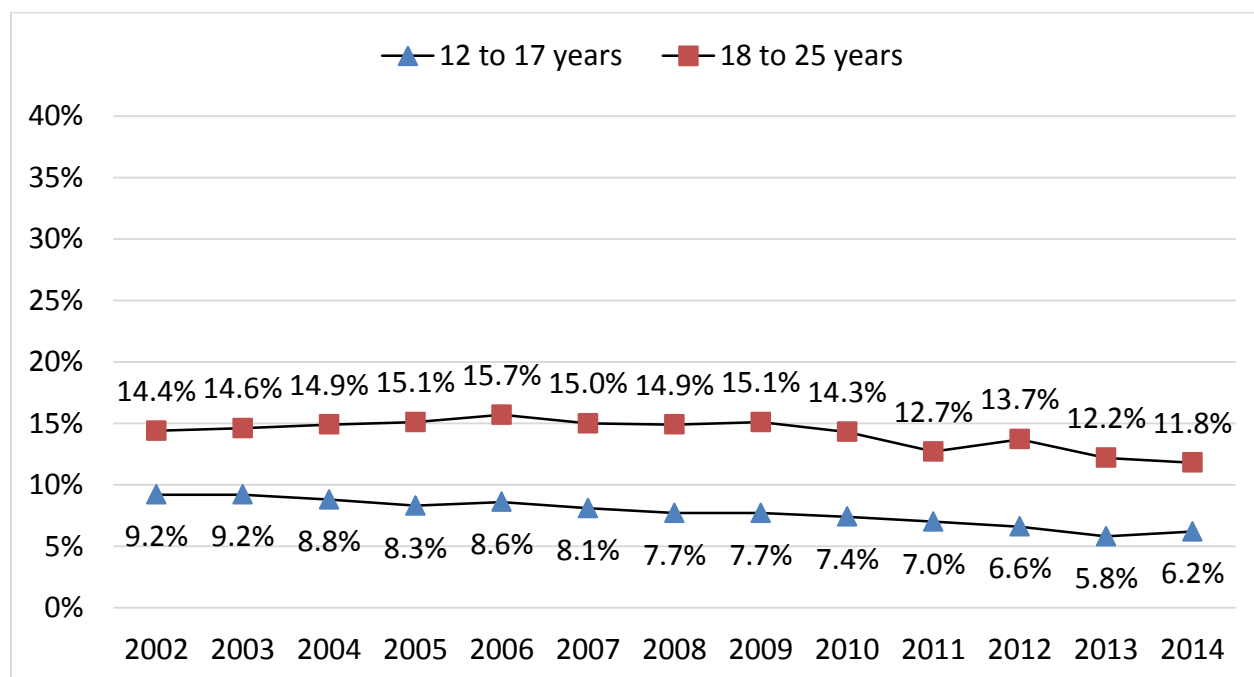


lifetime misuse of other prescription drugs at 2.9% among middle-schoolers and 7.5% among high-schoolers (Mass. DPH, 2014). Changes in the wording of these items between the 2011 and 2013 implementations limit the ability to examine trends in lifetime misuse.

## National Estimates of Past-Year Use

Past-year non-medical use of psychotherapeutics in the 2014 NSDUH ranged from 6.2% among 12–17 year olds to 11.8% among 18–25 year olds. Non-medical use of psychotherapeutics among 18–25 year olds peaked in 2006 at 15.7%; the 2014 survey marked the lowest reported past-year use on record among this age group. Similarly, past-year non-medical use of psychotherapeutics peaked in 2003 among 12–17 year olds at 9.2%, and the 2013 survey marked the lowest reported lifetime use among this age group (5.8%). This rebounded in 2014 to 6.2%, but still marked the second lowest rate of reported past-year misuse in 13 years (SAMHSA, 2015a).

**Figure 2. Past-Year Non-Medical Use of Psychotherapeutics (2002–2014)**



Source: NSDUH 2014 (SAMHSA, 2015a).

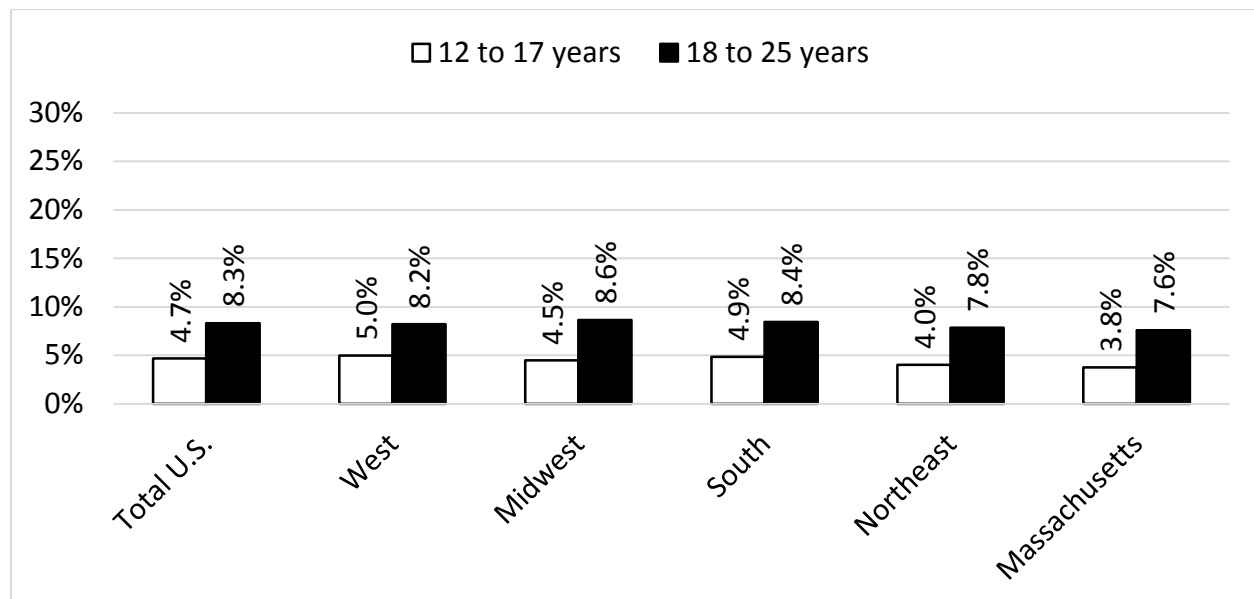
Within NSDUH’s psychotherapeutic category, pain relievers were the most prominent type of prescription drug misused, with past-year misuse rates of 4.7% among 12–17 year olds, and 7.8% among 18–25 year olds, followed by tranquilizers (1.7% among 12–17 year olds; 4.1% among 18–25 year olds), stimulants (1.5% among 12–17 year olds; 3.9% among 18–25 year olds), and sedatives (0.5% among 12–17 year olds; 0.4% among 18–25 year olds). Past-year misuse of OxyContin was 0.7% among 12–17 year olds and 1.2% among 18–25 year olds (SAMHSA, 2015a).

MTF estimates past-year non-medical use of psychotherapeutics among 12th-graders at 14.8% in 2012, 15% in 2013, 13.9% in 2014, and 12.9% in 2015, indicating a downward trend in past-year use in recent years. Broken down by type of prescription drug, MTF found past-year use rates among 12th-graders at 7.7% for stimulants, 5.4% for pain relievers, 4.7% for tranquilizers, and 3.6% for sedatives. Sub-divided even further, MTF estimates past-year misuse among 12th-graders at 7.5% for Adderall, 2% for Ritalin, 4.4% for Vicodin, and 3.7% for OxyContin (Johnston et al., 2016).

### State Estimates of Past-Year Use

Limited data on past-year misuse of prescription drugs at the state level are available from NSDUH, which aggregates two years of data together. The 2013 and 2014 pooled estimate from NSDUH indicates that 3.8% of individuals 12–17 years of age and 7.6% of individuals 18–25 years of age in Massachusetts misused prescription pain relievers in the past year. The estimate for Massachusetts is slightly lower than the rest of the Northeast in past-year misuse of prescription pain relievers, and the estimate for the Northeast region is lower than for other regions of the country (SAMHSA, 2015b).

**Figure 3. Past-Year Non-Medical Use of Pain Relievers (2013 and 2014)**



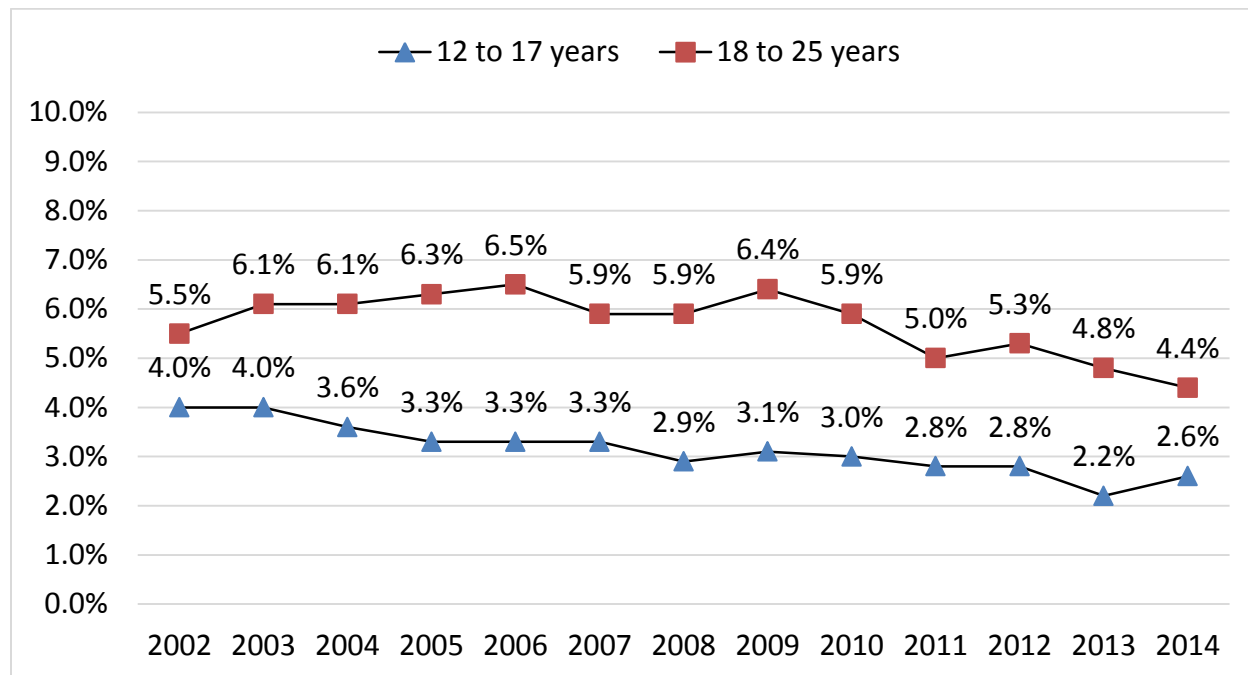
Source: NSDUH 2013 and 2014 (SAMHSA, 2015b).

### National Estimates of Current Use

Past-month non-medical use of psychotherapeutics in the 2014 NSDUH ranged from 2.6% among 12–17 year olds to 4.4% among 18–25 year olds. Non-medical use among 18–25 year olds peaked in 2006 at 6.5% and has been lower than that rate in each successive year—the 2014 survey marked the lowest reported use on record among this age group. Similarly, non-medical use of psychotherapeutics peaked in 2002 and 2003 among 12–17 year olds at 4.0% and has been lower than that rate in each successive year. The 2013 survey marked the lowest

reported use among this age group (2.2%). This rebounded in 2014 to 2.6%, but still marked the second lowest rate of reported misuse in 13 years (SAMHSA, 2015a).

**Figure 4. Past-Month Non-Medical Use of Psychotherapeutics (2002–2014)**



Source: NSDUH 2014 (SAMHSA, 2015a).

Within the psychotherapeutic category, pain relievers were the most prominent type of prescription drug misused, with past-month misuse rates among 12–17 year olds of 1.9%, and among 18–25 year olds of 2.8%, followed by stimulants (0.7% among 12–17 year olds; 1.2% among 18–25 year olds), tranquilizers (0.4% among 12–17 year olds; 1.2% among 18–25 year olds), and sedatives (0.2% among both 12–17 year olds and 18–25 year olds). Past-month misuse of OxyContin was 0.1% among 12–17 year olds and 0.3% among 18–25 year olds (SAMHSA, 2015a). Past-month misuse of pain relievers was second only to marijuana among the specific illicit drugs measured by the survey (CBHSQ, 2015).

MTF estimates past-month non-medical use of psychotherapeutics among 12th-graders at 7% in both 2012 and 2013, 6.4% in 2014, and 5.9% in 2015, indicating a downward trend in past-month use in recent years. Broken down by type of prescription drug, MTF found past-year use rates among 12th-graders at 3.2% for stimulants, 2.1% for pain relievers, 2% for tranquilizers, and 1.7% for sedatives (Johnston et al., 2016).

## State Estimates of Current Use

At the state level, the MYHS estimated in 2013 that 2% of middle school students and 3% of high school students engaged in NMUPD in the past 30 days (Mass. DPH, 2014).

### Initiation of Use

In 2014, 2.1 million individuals age 12 or older initiated NMUPD. Among those ages 12–17, there were 641,000 initiates (2.6% of this age group). Similarly, among those ages 18–25, there were 884,000 new initiates (2.5% of this age group). Among individuals who initiated use prior to turning 21 years of age, the average age of onset was 16.6 years, with minor variation by type of psychotherapeutic (SAMHSA, 2015a). In a longitudinal study of adolescents from grade 10 through age 20, the majority (69.5%) of participants who used prescription drugs non-medically reported starting use in high school (Catalano, White, Fleming, & Haggerty, 2011). Figure 5 provides more detail on age at initiation of use per type of drug.

**Figure 5. Mean Age at First Use Among Individuals Who Initiated Prior to Age 21 (2014)**



Source: NSDUH 2014 (SAMHSA, 2015a).

## Summary of Consumption Data

A snapshot of available surveillance data from the NSDUH, MTF, YRBS, and MYHS surveys appears in Table 3. It is important to note that estimates from these different instruments are not directly comparable. The methodology, year of implementation, age/grade of focus, and specific questions vary from instrument to instrument. The important point here is that the different instruments tend to identify similar patterns in use over time and to produce similar

prevalence estimates when the age/grade groups do overlap. It is also important to take into account that NSDUH estimates suggest that NMUPD is lower in the Northeast than in other regions of the country, so the national estimates may over-estimate the level of use that would be observed locally in Massachusetts (SAMHSA, 2015b).

**Table 3. Summary of NMUPD Consumption Data**

Source	Scope	Year	Age/Grade	Timeframe	Any Rx Drugs	Pain Relievers	OxyContin	Tranquilizers	Stimulants	Sedatives
NSDUH	National	2014	12–17 years	Lifetime	9.2%	7.3%	1.0%	-	-	-
NSDUH	National	2014	12–17 years	Past year	6.2%	4.7%	0.7%	1.7%	1.5%	0.5%
NSDUH	State (Mass.)	2014	12–17 years	Past year	-	3.8%	-	-	-	-
NSDUH	National	2014	12–17 years	Past month	2.6%	1.9%	0.1%	0.4%	0.7%	0.2%
NSDUH	National	2014	18–25 years	Lifetime	26.3%	20.2%	5.1%	-	-	-
NSDUH	National	2014	18–25 years	Past year	11.8%	7.8%	1.2%	4.1%	3.9%	0.4%
NSDUH	State (Mass.)	2014	18–25 years	Past year	-	7.6%	-	-	-	-
NSDUH	National	2014	18-25 years	Past month	4.4%	2.8%	0.3%	1.2%	1.2%	0.2%
MTF	National	2015	12th grade	Lifetime	18.3%	8.4%	-	6.9%	10.8%	5.9%
MTF	National	2015	12th grade	Past year	12.9%	5.4%	3.7%	4.7%	7.7%	3.6%
MTF	National	2015	12th grade	Past month	5.9%	2.1%	-	2.0%	3.2%	1.7%
YRBS	National	2013	Grade 9-12	Lifetime	17.8%	-	-	-	-	-
MYHS	State (Mass.)	2013	Grade 6-8	Lifetime	3.9%	1.3%	-	-	-	-
MYHS	State (Mass.)	2013	Grade 6-8	Past month	2.0%	-	-	-	-	-
MYHS	State (Mass.)	2013	Grade 9-12	Lifetime	13.4%	5.5%	-	-	-	-
MYHS	State (Mass.)	2013	Grade 9-12	Past month	3.0%	-	-	-	-	-

## PHYSICAL CONSEQUENCES OF NMUPD

### Acute Side Effects of Medication and Withdrawal Symptoms

Prescription drugs all have potential acute side effects that range from mild symptoms to more severe reactions that can lead to significant morbidity and, potentially, death. Effects vary by the type of medication misused:

- Common acute side effects of opioid prescription drugs include nausea, sedation or drowsiness, depressed respiration, euphoria, dysphoria, constipation, and itching. Termination of or reduction in opioid use can lead to withdrawal symptoms, including restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps, and involuntary leg movements (Manchikanti & Singh, 2008; National Institute on Drug Abuse [NIDA], 2011).
- Side effects of central nervous system (CNS) depressants (e.g., sedatives, tranquilizers) include increased drowsiness or sedation. CNS depressants can slow heart rate and respiration when combined with prescription pain medications, some types of over-the-counter cold or allergy medications, or alcohol. Rapid discontinuation of sedatives or tranquilizers can lead to seizures, some of which can be life-threatening (NIDA, 2011).
- Effects of stimulant medications include increases in alertness, attention, and energy; physiological effects also include elevated heart rate and blood pressure, increased respiration, suppressed appetite, and sleep deprivation. Frequent use of stimulants during a short period of time can lead to feelings of hostility or paranoia. Large doses can lead to irregular heartbeat and high body temperature, as well as the potential for heart failure or seizures. Stimulant withdrawal symptoms can include fatigue, depression, and disrupted sleep cycles (NIDA, 2011).

Other adverse consequences associated with regular NMUPD over a long period of time include hormonal and immune system effects, physiological dependence, and increased sensitivity to pain, all of which can lead to an increase in physical disability (Manchikanti & Singh, 2008).

### Dependence

NMUPD is associated with a greater likelihood of developing dependence (Blanco et al., 2007; Colliver et al., 2006; McCabe, West, Morales, Cranford, & Boyd, 2007), particularly for adolescents who begin use early. Opioid analgesics, which are in the pain reliever category of prescription drugs, are more likely to lead to dependence. National survey data suggest that adolescent females may be at greater risk of dependence on prescription drugs compared to their male counterparts. There are several hypothesized reasons for this difference, including potentially greater pharmacologic sensitivity in females, and that females are more likely to be prescribed medications, thus giving them greater access to prescription drugs (Cotto et al., 2010).

## Increased Risk of Overdose, Injury, and Death

It is well-documented that NMUPD, particularly misuse of narcotic pain relievers, is associated with an increase in the number of emergency department (ED) visits. Between 1972 and 2011, the Drug Abuse Warning Network (DAWN) tracked drug-related ED visits in the United States. Though the DAWN surveillance system is in the process of being replaced by the National Hospital Care Survey, SAMHSA's Center for Behavioral Health Statistics and Quality continues to analyze the DAWN dataset through 2011. In the final year of DAWN, 1,244,872 ED visits involved NMUPD, 366,181 (29%) of which involved narcotic pain relievers—mostly oxycodone (12.1%), hydrocodone (6.6%), and methadone (5.4%). This constituted an increase of 117% (from 168,379 to 366,181) between 2005 and 2011, although there was evidence of a stabilization in trend between 2008 and 2011 (Crane, 2015).

CDC and the Commonwealth of Massachusetts have each launched websites devoted to tracking drug-related overdose deaths.<sup>1</sup> According to the CDC, drug overdose was the leading cause of injury death in 2013, resulting in 43,982 fatalities nationwide. Among young adults and adults (ages 25–64), deaths from drug overdose exceeded the number of deaths from motor vehicle fatalities. Breaking down these numbers a little further, roughly half the drug overdose deaths in 2013 (52%) were related to prescription drugs (22,767 cases). Within this group, almost three-quarters (71%) involved opioid pain relievers, and one-third (31%) involved benzodiazepines. The CDC estimates that 44 people die each day as a result of prescription opioid overdose. Among this sub-group, those most likely to experience a fatality were between the ages of 25 and 54, non-Hispanic whites, and male (CDC, 2015).

Within Massachusetts, DPH confirmed 1,099 opioid overdose fatalities in 2014 of unintentional or undetermined intent and estimates an additional 61–89 cases once unresolved cases have been finalized. Based on the confirmed cases alone, this constitutes a 65% increase over the number of opioid overdose fatalities observed in 2012 (n = 668). During 2014, the unintentional and undetermined intent opioid overdose death rate (including heroin deaths) was estimated at 17.4 people per 100,000 (Mass. DPH, 2016). This constitutes a 228% increase from the observed death rate in 2000 (5.3 per 100,000) and a 28% increase from the observed death rate in 2013 (13.6 per 100,000). On a year-to-year basis, the death rate has increased in 9 of the past 14 years, with small reversals in 2002, 2004, 2007, 2008, and 2010. The death rate has increased every year since 2010, which is the longest period of uninterrupted growth since 2000.

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<sup>1</sup> These sites can be accessed at [www.cdc.gov/drugoverdose](http://www.cdc.gov/drugoverdose) and <http://www.mass.gov/eohhs/gov/departments/dph/stop-addiction/state-without-stigma/>.



**Table 4. Rate of Opioid Overdose Deaths (Unintentional and Undetermined Intent) in Massachusetts (2000–2014)**

<b>Year</b>	<b>Crude Rate per 100,000 Residents</b>	<b>Percent Change from Previous Year</b>	<b>Percent Change from 2000</b>
2000	5.3	-	-
2001	7.3	37.7%	37.7%
2002	6.7	- 8.2%	26.4%
2003	8.6	28.4%	62.3%
2004	7.1	- 17.4%	34.0%
2005	8.2	15.5%	54.7%
2006	9.6	17.1%	81.1%
2007	9.5	- 1.0%	79.2%
2008	8.6	- 9.5%	62.3%
2009	9.1	5.8%	71.7%
2010	8.0	- 12.1%	50.9%
2011	9.2	15.0%	73.6%
2012	10.1	9.8%	90.6%
2013	13.6	34.7%	156.6%
2014	17.4	27.9%	228.3%

Source: Mass. DPH (2016).

## PSYCHOSOCIAL CONSEQUENCES OF NMUPD

### Association with Psychiatric Conditions

NMUPD is associated with increased risk of developing psychiatric and other medical conditions (Hernandez & Nelson, 2010; Strassels, 2009), including depression, anxiety, ADHD, and mania:

- Hall, Howard, and McCabe (2010) found that among a sample of 723 adolescents in residential care for antisocial behavior, those who reported high levels of anxiety and depression also reported significantly greater amounts of sedative/anxiolytic misuse compared to adolescents who did not report high levels of anxiety and depression.
- Several studies have demonstrated a link between major depressive disorder and greater rates of NMUPD (Havens, Young, & Havens, 2011; Manchikanti & Singh, 2008; Schepis & Krishnan-Sarin, 2008; Subramaniam & Stitzer, 2009); however, it is unknown if this indicates a directional relationship or whether another factor might account for both conditions.
- Research has found an association between illicit drug use and increased risk of suicide; however, suicide risk has not been directly linked with NMUPD (Bohnert, Roeder & Ilgen, 2010).
- A study of treatment-seeking, opiate-dependent adolescents found that prescription drug opioid users reported higher rates of ADHD and manic episodes than did adolescent heroin users. Both groups of adolescents reported high scores on a measure of depression (Subramaniam & Stitzer, 2009).

Additional research is needed to determine whether certain classes of prescription drugs are related to different types of psychiatric or other medical conditions.

### Delinquency and/or Violent Behavior

Several studies have demonstrated a link between violent or delinquent behavior and NMUPD (Catalano et al., 2011; Hall et al., 2010; Harrell & Broman, 2009; McCauley et al., 2010; Sung, Richter, Vaughan, Johnson, & Thom, 2005). The direction of the relationship (e.g., whether NMUPD leads to increased violent or delinquent behavior, or whether delinquent behavior leads to future NMUPD) has not been established. However, in a longitudinal study of adolescents assessed from grade 10 to age 20, the only unique predictor of non-medical opiate prescription drug use was violent behavior. This relationship remained significant after accounting for licit (alcohol, tobacco) and illicit (marijuana, cocaine/crack, psychedelics, heroin) drug use (Catalano et al., 2011).

### Academic Functioning

Greater misuse of prescription drugs is associated with lower levels of educational attainment (Harrell & Broman, 2009). Adolescents reporting greater rates of NMUPD also demonstrate poorer academic performance (McCabe & Boyd, 2005; Schepis & Krishnan-Sarin, 2008) and a greater likelihood of school dropout (Havens et al., 2011; Wu, Pilowsky, & Patkar, 2008). Due to

the cross-sectional design of these research studies, it is not possible to rule out that poorer academic functioning occurs prior to the onset of NMUPD or that another factor is associated with both academic functioning and NMUPD.

## SELECTED INTERVENING VARIABLES<sup>2</sup>

*[Intervening variables are] factors that have been identified through research as being strongly related to and influencing the occurrence and magnitude of substance use and related risk behaviors and their subsequent consequences. These variables are the focus of prevention strategies, changes in which are then expected to affect consumption and consequences. (SAMHSA, 2009, p. 2)*

Intervening variables include, but are not limited to, risk and protective factors. *Risk factors* are characteristics of school, community, and family environments—as well as characteristics of youth and young adults and their peer groups—that are known to be related to an increased likelihood of drug use. *Protective factors* exert a positive influence or buffer against the negative influence of risks, and are related to reducing the likelihood that youth and young adults will engage in problem behaviors such as NMUPD.

Intervening variables fall into two categories: (1) those that cannot be modified and (2) those that can be modified. The former category is useful for identifying the *focus* of prevention interventions (i.e., individuals or groups that may be at disproportionate risk). The latter category is generally the focus of prevention interventions.

### Selected Immutable Factors

#### Gender

Evidence is mixed regarding gender differences and NMUPD. Some studies have found that adolescent females are more likely to report NMUPD (Ford, 2009; Sung et al., 2005; Wu, Ringwalt, Mannelli, & Patkar, 2008). In particular, females may be more likely to report non-medical use of opioids or sedatives/anxiolytics (McCabe, Boyd, & Young, 2007; McCabe, West, et al., 2007) and are more likely to report non-medical use for the purpose of “self-treating,” compared to males who tend to report more “sensation-seeking” reasons (e.g., to get high) (Boyd, Young, Grey & McCabe, 2009).

However, one study found that males reported more non-medical use of opioid analgesics than did females (McCabe & Boyd, 2005). Another study examining 2006 NSDUH data of all U.S. individuals age 12 or older found that males were more likely to report lifetime and past-year non-medical use of prescription opioids, but there were no gender differences for rates of abuse or dependence on prescription opioids. Additionally, males and females may gain access

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<sup>2</sup> For a more complete examination of the intervening variables related to NMUPD and its associated consequences, please see *Prescription Drug Misuse: Understanding Who Is at Increased Risk* (SAMHSA’s CAPT, 2016), *A Systematic Review of Risk and Protective Factors Associated with Nonmedical Use of Prescription Drugs Among Youth in the United States: A Social Ecological Perspective* (Nargiso, Ballard, & Skeer, 2015), and *Nonmedical Use of Prescription Medications Among Adolescents in the United States: A Systematic Review* (Young, Glover, & Havens, 2012).

to prescription drugs for non-medical purposes differently. Adolescent females are more likely to obtain opioid prescription drugs for free or to steal them from a friend or relative, while adolescent males are more likely to purchase opioid prescription drugs or to acquire them from a physician (Collins, Abadi, Johnson, Shamblen, & Thompson, 2011; Schepis & Krishnan-Sarin, 2009).

### Ethnicity/Race

Research has consistently found higher rates of NMUPD, including use of opioids, among individuals who identify as white (Benotsch, Koester, Luckman, Martin, & Cejka, 2011; Ford, 2009; McCabe & Boyd, 2005; McCabe, Boyd, et al., 2007; Wu, Ringwalt, et al., 2008) after accounting for other risk factors (e.g., availability, peer use). A larger percentage of white respondents reported sensation-seeking motives for NMUPD compared to non-white respondents (Boyd et al., 2009).

### **Selected Modifiable Factors**

SAMHSA's Center for the Application of Prevention Technologies (CAPT) has developed a decision support tool titled *Prescription Drug Misuse: Understanding Who Is at Increased Risk* (2016a). This document, provided as an appendix to the Guidance Document (see Appendix 2), presents findings from a scan of the literature that examined individual-, interpersonal/relationship-, community-, and society-level factors associated with NMUPD and its related consequences. It spans articles published between 2005 and 2015 and covers all age groups.

A review of the literature conducted by Nargiso, Ballard, and Skeer (2015) covered articles published between 2006 and 2014 and limited the age range of consideration to ages 14–24. In another literature review, Young, Glover, and Havens (2012) focused on ages 12–17 and covered the time period between 2000 and 2011.

### Access and Availability

Multiple studies have examined the relationship between access/availability and NMUPD (e.g., McCabe, Cranford, Boyd, & Teter, 2007). While causality has not been established, many studies *suggest* that increased availability is a contributing factor for NMUPD. Collins and colleagues (2011), for example, found that a perception that prescription drugs were readily available was associated with increased levels of prescription drug misuse among a sample of middle and high school students in Tennessee. According to pooled estimates from NSDUH in 2013 and 2014, the most common source of pain relievers among 12–25 year olds during their most recent use within the past year was from a friend or relative, which they received for free (43.1% for 12–17 year olds, 50% for 18–25 year olds). The second and third most common sources were from a single doctor (22.9% for 12–17 year olds, 16.8% for 18–25 year olds) and by buying it from a friend or relative (9.4% for 12–17 year olds, 13.6% for 18–25 year olds).

None of the other potential sources accounted for more than 8% for either age group (SAMHSA, 2015).

### Perception of Risk or Harm

Ford and Rigg (2015) found a protective effect of having greater perception of risk of substance abuse on prescription opioid misuse outcomes based on an analysis of NSDUH data. Arria and colleagues (2008) found a similar relationship among college students.

### Parents and Family

Collins and colleagues (2011) found that greater parental disapproval toward prescription drug misuse had a protective effect on prescription drug misuse outcomes. Similarly, Schroeder and Ford (2012) found that stronger bonds with parents was associated with lower levels of prescription drug misuse. Ford and Rigg (2015) found that favorable parental attitudes toward substance use were associated with higher levels of prescription opioid misuse.

### Peers

Greater misuse of prescription drugs by peers and peer attitudes favorable toward substance use have both been associated with prescription drug misuse (Collins et al., 2011; Ford & Rigg, 2015).

### Substance Use or Misuse

Current cigarette smoking, past-year alcohol misuse, past-30-day drunkenness, past-year marijuana misuse, past-year other illicit substance use, past-30-day other substance use, younger age of first prescription, and younger age of substance use initiation have each been associated with NMUPD (Arkes & Iguchi, 2008; Ford & Rigg, 2015; Mowbray & Quinn, 2015).

Individuals using this Guidance Document are strongly encouraged to refer to SAMHSA's CAPT Decision Support Tool (2016a), the review by Nargiso, Ballard, and Skeer (2015), and the review by Young, Glover, and Havens (2012) for a more comprehensive and detailed examination of intervening variables related to NMUPD.

**Note:** A draft version of the CAPT Decision Support Tool is available to PFS 2015 grantees. If you have not received a copy of this document, please contact your MasTAPP TA Provider. A link to the final document will be placed in Appendix 2, as soon as it is made available.

## SECTION 2: STRATEGIC PREVENTION FRAMEWORK

### OVERVIEW

The Strategic Prevention Framework (SPF), a model developed by SAMHSA, guides the selection, implementation, and evaluation of evidence-based, culturally appropriate, sustainable interventions addressing substance misuse and abuse (Figure 6). The SPF has five components:

**Figure 6. Components of the Strategic Prevention Framework**



- Step 1: Assessment
- Step 2: Capacity building
- Step 3: Strategic planning
- Step 4: Implementation
- Step 5: Evaluation

Although presented here as a list of sequential steps, the SPF model is a circular process with substantial overlap among the five components. For example, assessing and addressing capacity needs, listed as Steps 1 and 2, must take place throughout the SPF process. Similarly, plans for evaluation (Step 5) should begin immediately and continue after intervention activities end. Issues related to sustainability and cultural competence (in the center of the figure) must be addressed throughout each of the five steps as well.

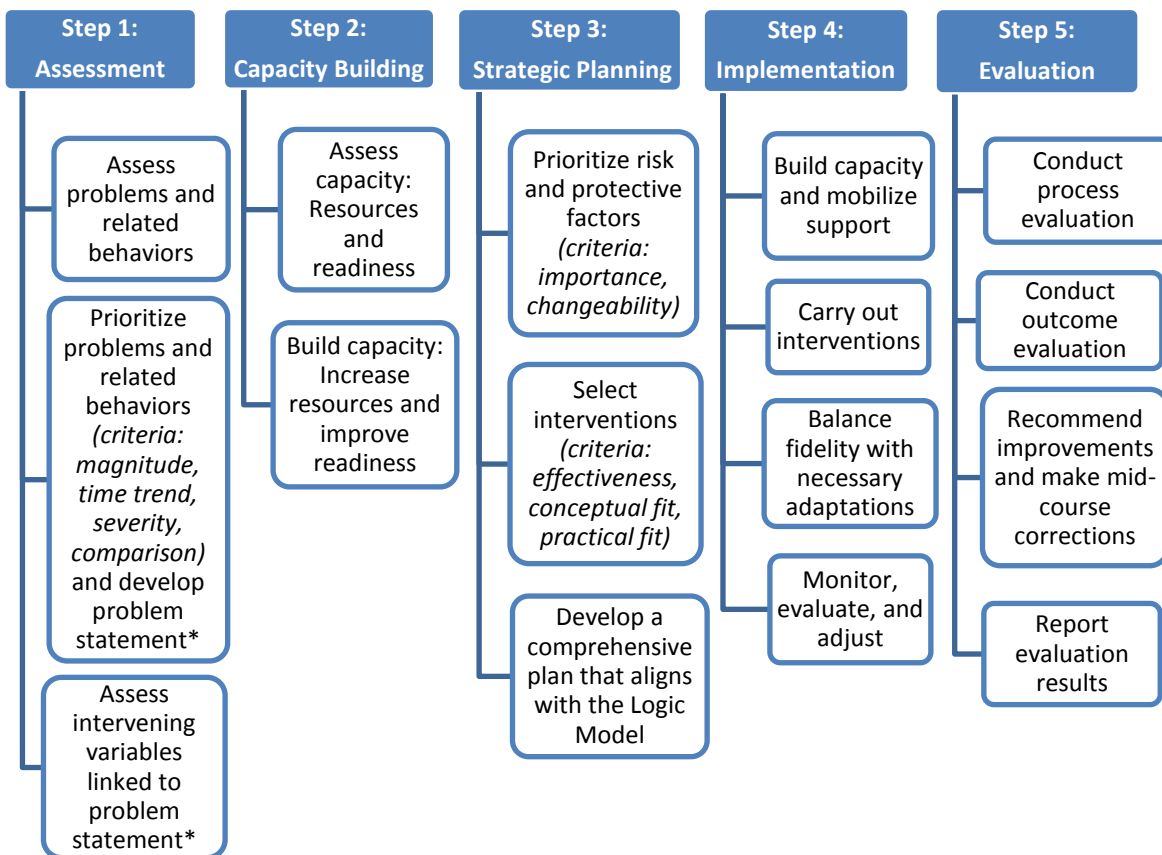
**Note:** Cultural competence, which is discussed in more detail later in this document, requires attention to both cultural and linguistic competence. The cultural competence component of the SPF model encompasses both concepts.

This section provides general guidance on how to use the SPF model to implement interventions that address substance misuse and abuse. Communities in Massachusetts conducting these efforts with substance misuse and abuse prevention grants from BSAS are required to incorporate the SPF model into their plans. Other organizations and groups may also find the SPF model useful in designing, implementing, and evaluating interventions

addressing substance misuse and abuse. To address the needs of both audiences, this document uses general terms (e.g., *your group, your target area*) rather than terms specific to a particular grant program (e.g., *cluster, coalition*).

The format of this section aligns with the five steps of the SPF, along with key tasks to complete during each step, as outlined in Figure 7.

**Figure 7. SAMHSA’s Strategic Prevention Framework at a Glance**



\* Adaptations made by MasTAPP.

Source: SAMHSA’s CAPT (2012).

More information and resources for using the SPF model are available from MasTAPP, which supports communities across the Commonwealth in addressing substance misuse and abuse prevention. MasTAPP (<http://masstapp.edc.org>) offers TA, capacity building, and resources to BSAS-funded grantees and other groups across the state.



## STEP 1: ASSESSMENT

The first step in the SPF model is to systematically gather and analyze local data related to the issue of substance misuse and abuse (i.e., NMUPD among high school-age youth). These data will help you better understand how substance misuse and abuse manifests within your community and, ultimately, identify appropriate strategies to address the issue. Assessment is a critical first step in prevention planning; without it, communities risk selecting strategies that do not address the true problem or its contributing factors.

### *Purpose of Assessment*

The data you collect as part of the assessment process will help you do the following:

- Identify the nature and extent of NMUPD problems and related behaviors among different groups, including those defined by age, gender, race/ethnicity, or other demographic characteristics (e.g., 6% of high school seniors in the community report having used prescription drugs that were not their own within their lifetime)
- Identify existing *health disparities* related to NMUPD (see sidebar)
- Determine whether your community or organization is ready to address the priority problem(s) and what additional resources may be needed
- Identify *intervening variables* (i.e., risk and protective factors linked to NMUPD within the community)

The data you gather in the assessment stage will also serve as a baseline for program monitoring and evaluation, as described in Steps 4 and 5 of the SPF.

#### **Health Disparities Statement**

Healthy People 2020 (HealthyPeople.gov, 2015) defines *health disparity* as “a health outcome [that] is seen in a greater or lesser extent between populations” (§ 1):

*Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (§ 5)*

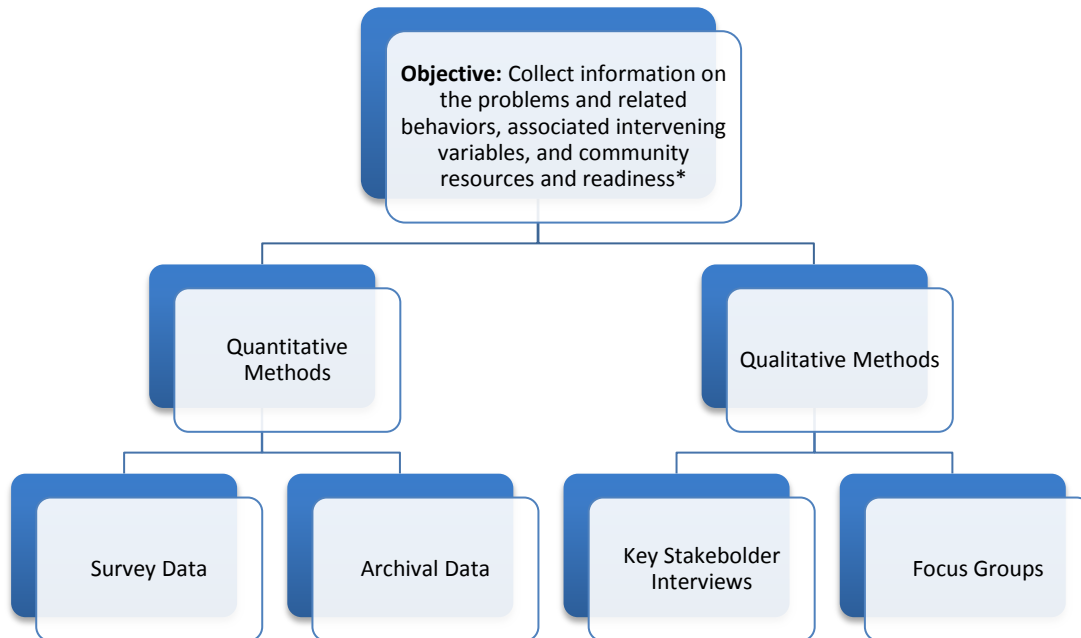
An examination of health disparities is a priority for the PFS 2015 initiative. Therefore, it will be important to consider differences in NMUPD consumption patterns and/or consequences among various sub-groups within your community.

A framework and tool for addressing health disparities during each step of the SPF process is provided in Appendix 3: Addressing Health Disparities in the SPF Process.

### **Types of Assessment Data**

Before conducting a local needs assessment, it is important to understand the types of data that are useful to the assessment process. Figure 8 lists the two main types of data—quantitative and qualitative—and common sources for obtaining each.

**Figure 8. Local Needs Assessment and Data Collection**



\* Adaptations made by MassTAPP.

Source: Rhode Island State Epidemiology and Outcomes Workgroup, Buka & Rosenthal (2015).

## Quantitative Data

Quantitative data show how often an event or behavior occurs or to what degree it exists (SAMHSA's CAPT, 2012). These data are usually reported numerically, often as counts or percentages. An example of this type of data is the percentage of high school students who reported NMUPD during the past 30 days. In addition to self-reported survey data, quantitative data can be mined from archival data sources, such as police reports, school incident and discipline reports, court records, hospital discharge data, and ED data. For a checklist of possible quantitative data sources, refer to APPENDIX 4: Archival and Survey Data Sources – A Community Data Checklist.

To define the needs of your community specific to substance misuse and abuse, problems and related behaviors are typically thought of in terms of *consumption* and *consequence* patterns. Both types of information may be collected from various quantitative data sources.

**Data on consumption.** Consumption (use) patterns describe NMUPD in terms of the frequency or amount used. For example:

- Percentage of high school students reporting current (past 30 days) non-medical use of prescription *opioids*

- Percentage of high school students reporting past-year non-medical use of prescription *stimulants*
- Percentage of high school students reporting non-medical use of prescription *sedatives* within their lifetime

These types of data may be collected by national or state surveys, such as the MYHS and the Massachusetts YRBS. However, local data specific to your community may not be as readily available. When collecting data from the community, it's ideal to use the same questions and wording as used in the national and state surveys, whenever possible. Many items in these instruments have been rigorously tested across multiple settings and may serve as good sources of comparative data in certain instances.

**Data on consequences.** NMUPD is associated with many social, economic, and health problems, including increased risk of overdose, injury, and death; delinquency and/or violent behavior; and poor academic performance.<sup>3</sup> Data related to consequences can help you better understand the substance misuse and abuse issue in your community.

Some examples of consequence-related data include:

- Number of prescription drug-related arrests
- School incident and discipline reports
- ED admittances and hospital discharge data.

This information may have to be compiled locally from different sources (e.g., schools, the police department, hospitals).

**Appendix 4: Archival and Survey Data Sources for NMUPD - A Community Data Checklist** includes numerous examples of quantitative consumption and consequence data relevant to prescription drug misuse and abuse among high school-age youth.

## Qualitative Data

Qualitative data may help you gain a deeper understanding of the substance misuse and abuse problem within your community by offering insight into the beliefs, attitudes, and values of various stakeholders, and may help explain why people behave or feel the way they do (SAMHSA's CAPT, 2012). Common methods for obtaining qualitative data include key stakeholder interviews and focus groups.

**Key stakeholder interviews.** Key stakeholders are those who are knowledgeable about substance misuse and abuse and/or who have an interest or stake in efforts to address the problem. Key stakeholders may include the following:

- People who are misusing and/or abusing substances
- Members of the recovery community
- Parents

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<sup>3</sup> This information is drawn from SAMHSA's Center for the Application of Prevention Technologies (CAPT) document on the terminology, patterns of use, and consequences of NMUPD. Available online at [http://masstapp.edc.org/sites/masstapp.edc.org/files/NMPUD\\_Lit%20Reviews%20andTerminology.pdf](http://masstapp.edc.org/sites/masstapp.edc.org/files/NMPUD_Lit%20Reviews%20andTerminology.pdf)

- School nurses, counselors, and administrators
- Social services agency personnel
- Substance abuse prevention and treatment providers
- Medical staff from local and regional hospitals, community health centers, health care systems, insurers, dental offices, and pharmacies
- Law enforcement and first responder personnel
- Municipal government officials (e.g., mayors, city council members, department heads)
- Local faith communities
- Youth
- Local businesses

The interviews use scripted, open-ended questions to obtain detailed responses about a specific topic. Information on how to conduct interviews with key stakeholders, including a sample interview guide, is provided in APPENDIX 5: Conducting Key Stakeholder Interviews.

**Note:** Engaging key stakeholders in all aspects of the assessment process promotes sustainability by securing their buy-in and laying the foundation for ongoing participation and support. It is likewise important to share the findings from the assessment process with key stakeholders and other community members. The better they understand the baseline issues, the more they will appreciate—and want to sustain—your substance misuse and abuse prevention efforts.

**Focus groups.** *Focus groups* are a series of planned discussions that examine the perceptions of a particular group (e.g., high school-age youth, parents, law enforcement personnel). The format encourages group members to interact and to reflect on one another’s statements. A moderator leads the discussion, using a list of open-ended questions and probes. Each focus group typically includes 8–10 persons who are similar in regard to the issue of interest. Three to five focus groups are typically used per demographic (e.g., high school-age youth enrolled in an alternative high school). Transcripts are reviewed to identify recurring themes. For information on how to conduct focus groups, see APPENDIX 6: Conducting Focus Groups.

**Note:** When collecting qualitative data, it is important to use methods that are culturally competent and appropriate. For example, when

#### Assessing cultural competence

The assessment stage is a good time to find out how your group is currently functioning in regard to cultural competence. The following questions can help you assess your group’s strengths and weaknesses (Hernández, 2009):

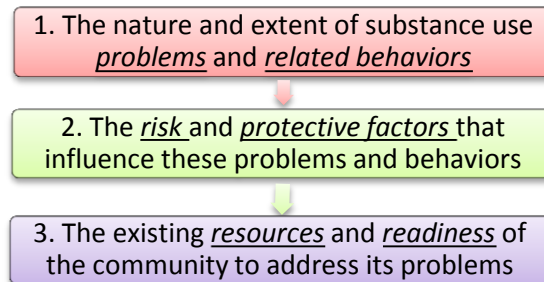
- *Does your assessment include information about the major cultural groups in your community?*
- *Do members of diverse groups assist in the analysis and interpretation of your data?*
- *Does your organization or coalition engage all sectors of the community in community-wide prevention efforts?*
- *Are all groups adequately represented or “at the table”?*
- *Do your organizational plans incorporate principles of cultural competence?*

developing your interview or focus group guide, carefully review all questions to make sure that they will not be perceived as too personal or inappropriate. Consider any translation needs, and make sure that the interviewers or group facilitators reflect the composition of the group being interviewed. Select an accessible meeting space, and consider providing childcare where appropriate.

## Conducting an Assessment

Conceptually, there are three main areas to examine during the assessment phase, as displayed in Figure 9.

**Figure 9. What to Assess**



Source: SAMHSA’s CAPT (2012).

During the assessment phase, it is recommended that you begin by assessing the nature and extent of NMUPD problems and related behaviors within your community (box 1). Doing so will give you a better understanding of what NMUPD looks like in your community and, more specifically, among the local high school-age youth. An important part of this process is to assess for the presence of differences among sub-groups defined by characteristics such as gender, grade, race, ethnicity, culture, sexual orientation, and other factors that may be differentially related to NMUPD consumption patterns. Furthermore, beginning your assessment with an examination of the nature and extent of NMUPD will help you to focus your assessment of intervening variables (box 2) and capacity (box 3) to those items that are most relevant to the local manifestation of NMUPD and, more importantly, the identified group(s) or sub-groups.

### Task 1: Assess Problems and Related Behaviors

Since *NMUPD among high school-age youth* has already been identified as the main issue to be addressed, the next step is to create a descriptive profile of the problems and related behaviors (i.e., consumption patterns and consequences), as they manifest within your community.

Data to collect may include the following:

- Percentage of high school students reporting current (past 30 day) NMUPD

<b>Key Assessment Tasks:</b>
Step 1 (Assessment) is comprised of the following tasks:
1.) Assess problems and related behaviors
2.) Prioritize problems and develop problem statement
3.) Assess intervening variables linked to problem statement.

- Percentage of high school-age youth of varying demographics (e.g., by age, gender, race/ethnicity, socio-economic status, educational attainment) reporting lifetime NMUPD
- Average age of first misuse or abuse of stimulants (or other category of prescription drug)
- Number of prescription drug-related emergency room visits among 14–18 year olds
- Number of prescription drug-related arrests involving 14–18 year olds
- Number of emergency medical services calls regarding prescription drug-related incidents involving 14–18 year olds
- Number of prescription drug-related school disciplinary incidents

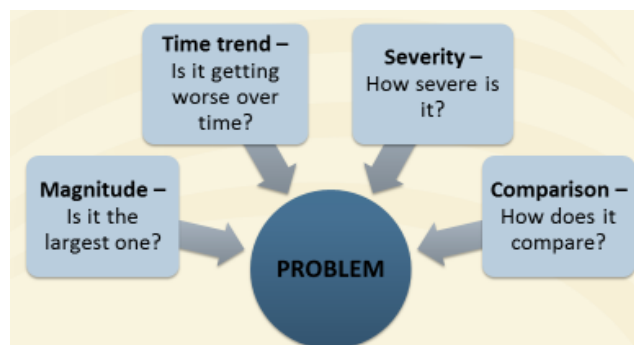
## Task 2: Prioritize Problems and Develop Problem Statement

Using the data collected in task 1, your next task is to decide which problem(s) is most important for your group to address.

**Prioritizing the problem.** The following criteria (outlined in Figure 10) can help a community prioritize the problem(s) it will address:

- **Magnitude:** Which problem seems to affect the largest number of people?
- **Time trend:** Is the problem getting worse or better over time? Is one problem getting worse more quickly than others?
- **Severity:** How severe is each problem? Is it resulting in mortality? Is one more costly than others?
- **Comparison:** How does the local rate of each problem compare to state or national rates?

**Figure 10. Problems, Problems, Problems: How to Choose What to Address**



Source: SAMHSA's CAPT (2012).

Once the data are analyzed, communities can determine which problem or problems are the most pronounced and need to be addressed. For more information and guidance on examining and prioritizing your data, refer to APPENDIX 7: TIPS FOR EXAMINING DATA.

If more than one problem related to NMUPD exists, the next step is to determine whether your group has the capacity to address only one problem or more than one. Since each problem will require multiple strategies, considering your community's available resources and readiness to address each problem is critical. Regardless of the number of problems identified, each one should then be formulated into its own problem statement.

**Note:** Remember that the PFS 2015 grant is a *primary prevention* program aimed at the prevention and reduction of NMUPD among high school-age youth. Therefore, addressing consumption patterns – *not* consequences – among this particular population is a priority. In other words, to affect the consequences that often result from NMUPD, the patterns of use *must* be addressed. However, grantees are encouraged to examine the consumption rates of different prescription drug categories (e.g., opioids, stimulants) among the target population, as well as group(s) or sub-group(s) disproportionately affected by the issue.

**Developing a problem statement.** Interventions without a clearly articulated problem statement may lose steam over time—and it's also difficult to know whether any progress has been made toward the identified issue.

As previously discussed, some communities find that they need to develop more than one problem statement. For example, you may need to develop one problem statement that addresses a problem related to consumption of prescription pain relievers and one that addresses a problem related to consumption of prescription stimulants.

A good problem statement will meet each of the following criteria:

- Identify one issue or problem at a time, driven by the collected data
- Identify why it is a problem or issue
- Identify a target population
- Identify the drug to be targeted
- Reflect community concerns as heard during the assessment process
- Avoid blame
- Avoid naming specific solutions or strategies

#### Example Problem Statements

Here are examples of good problem statements:

- Too many 10<sup>th</sup> graders in our community (10%) report having misused or abused prescription opioids in the past 30 days (current use), compared to the state rate (6%).
- Too many high school students (5%) in our community report misusing prescription stimulants before the age of 13.
- The rate of current misuse and abuse of prescription pain relievers among high school students (8%) in our community has increased by 10% over the past five years.

When you develop your problem statement(s), be sure to describe the consumption patterns that are problematic and not the intervening variables or lack of community resources needed to address the problem. For example, a problem statement that reads “The local school system lacks effective substance abuse prevention curricula” is more a statement of a resource deficiency than of the larger problem you are attempting to solve. It also assumes that addressing this lack of curricula alone will solve the problem. In reality, many factors may also contribute to the problem. The lack of curricula is not “the problem” and does not belong in a problem statement. A better statement might be, “20% of high school students report that they have ever used a prescription pain reliever not prescribed to them.” Defining a problem simply as a lack of something will narrow your planning focus and direct energy and resources to strategies that are not likely to be sufficient on their own, while missing other important factors.

Keeping the focus on the priority consumption patterns at this stage in the planning process will help you select accurate contributing risk and protective factors and, hence, a comprehensive array of strategies that are more likely to be effective in addressing the problems you have identified.

### Task 3: Assess Intervening Variables Linked to Problem Statement

*Intervening variables* are factors that have been identified through research as having an influence on substance misuse and abuse. They include *risk factors* that have been associated with substance misuse and abuse, and *protective factors* that exert a positive influence or buffer against the negative influence of risks. These risk and protective factors can be found at different levels, including individual, peer, family, and community.

Risk factors that have been specifically linked to NMUPD among 12–17 year olds include perceived acceptability and safety of prescription drug misuse, peer prescription drug misuse (Collins et al., 2011), experiencing multiple negative life events, and peer substance abuse or use (Schroeder & Ford, 2012). Protective factors include a high commitment to doing well in school, community norms against use (Collins et al., 2011), and a strong parental bond (Schroeder et al., 2012). For more information on these and other risk and protective factors identified through the research, see APPENDIX 2: CAPT Decision Support Tool - *Prescription Drug Misuse: Understanding who is at Increased Risk*. Individuals using this Guidance Document are also referred to the review conducted by Nargiso, Ballard, and Skeer (2015), and the review by Young, Glover, and Havens (2012).

**Note:** While there is some benefit to reviewing lists of risk and protective factors for NMUPD prior to conducting the assessment, it is advisable to resist the urge to make such lists the basis for the assessment for several reasons. First, the literature base on NMUPD is still relatively nascent. Many potential risk and protective factors for NUMPD have not yet been systematically examined across multiple studies or have not yet been



studied among different groups or sub-groups (including diverse age groups). There are still many holes in the literature and the number of studies on any given risk or protective factor is not necessarily representative of the magnitude or strength of association of that factor. Second, basing the assessment on lists of risk and protective factors can turn into a self-fulfilling prophecy. If you begin the assessment looking to find evidence of a risk factor such as poor parental monitoring, chances are that you will find it. This may, however, not be the factor that is actually contributing to the NMUPD consumption patterns in your local setting – or it may be a relatively weak factor in comparison to other local factors that may not have been considered. The best approach is to conduct the assessment and identify which themes and factors emerge organically. *Then* turn to the literature to examine the extent to which these factors have been linked to NMUPD elsewhere. You may find no support for these factors in the literature, you may find that they have not been studied among high school-age youth, or you may find that they have been studied with other substances or behavioral health issues but not with NMUPD. In these cases, you should consult with your MassTAPP TA provider to determine whether there is a strong basis for retaining them later on during the prioritization process in the strategic planning phase of the SPF or whether you should focus on more well-established factors.

Also, keep in mind that not all intervening variables are linked to all substance misuse and abuse problems or, more specifically, every type of substance. Ford (2008) found, for example, that adolescents 12-17 who associate with peers who use were more likely to have engaged in nonmedical prescription drug use in the past year. However, this relationship only held for misuse of pain relievers and tranquilizers – not for stimulants or sedatives. This same study found that having a parent with lenient attitudes about nonmedical use of prescription drugs was a risk factor for use of pain relievers, stimulants, and tranquilizers – but not sedatives.

Another thing to keep in mind is that studies may differ in the manner in which they define and measure NMUPD. Veliz and colleagues (2014) looked at prescription opioid use among male and female high school athletes. Specifically, they examined: (a) medical use – as prescribed, (b) medical misuse – taking too much of one’s own prescription or taking it to get high, and (c) non-medical use – using someone else’s prescription. They found that male athletes who participated in sports for multiple years were more likely than males who sporadically participated in sports and those who did not participate in sports to engage in medical misuse of their own opioid prescriptions. They were not, however, more likely than their peers to use someone else’s prescription. This relationship was not found among female athletes.

Both of these examples reinforce the need to: (1) have clear, strong problem statements for the specific drug identified and (2) familiarize yourself with the nuances in the literature regarding populations being studied and what exactly was measured.

Ultimately, when reviewing the literature, be sure to consider the specific circumstances (e.g., substance and population being studied) under which the research was conducted.

Risk and protective factors can be measured using both quantitative and qualitative data. There are many ways to organize and compare the data you gather in order to help you prioritize them; one example is shown in Table 5. A template is also available in APPENDIX 8: Risk and Protective Factor Data Organizer.

**Table 5. Risk and Protective Factor Data Organizer**

Risk or Protective Factor <sup>4</sup>	Mentioned During Key Stakeholder Surveys or Focus Groups			Supported by Quantitative Data?	
	<i>Frequently</i>	<i>Occasionally</i>	<i>Infrequently or Not at All</i>	<i>Yes</i>	<i>No or N/A</i>
Perceived acceptability and safety of NMUPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer prescription drug misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer substance misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community norms against use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong parental bond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Commitment to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other comments from qualitative data collection:					

Source: Adapted from Rhode Island State Epidemiology and Outcomes Workgroup, Buka, and Rosenthal (2015).

<sup>4</sup> These risk and protective factors are provided as examples, but please note that this is not an exhaustive list. Communities should fill in the table with the factors relevant to their local context.

## STEP 2: CAPACITY

*Capacity building* involves improving your group’s ability to address the substance misuse and abuse issue within your community. *Capacity* includes all the human, technical, organizational, and financial *resources* you will need, as well as your community’s *readiness* to address the priority problem(s). Capacity is an ongoing process; it takes place throughout all Steps of the SPF process and requires continuous attention in order to implement and evaluate your intervention in a culturally competent and sustainable way.

### Key Capacity Tasks:

Step 2 (Capacity) is comprised of the following tasks:

- 1.) Assess capacity: Resources and readiness
- 2.) Build capacity: Increase resources and improve readiness

Your capacity affects how (and how effectively) your group goes about every aspect of its work. Different elements of capacity become more important during different points in the SPF cycle. Your capacity needs may change as work progresses, goals are accomplished, and priorities shift or expand.

### Task 1: Assess Capacity—Resources and Readiness

Assessing your community’s readiness to address the substance misuse and abuse problem and the existing resources that may be dedicated to this purpose will help you identify the most appropriate and feasible prevention strategies to implement in your community.

**Assessing resources.** Identifying and assessing the resources that exist to address substance misuse and abuse in your community will help you identify potential resource gaps, build support for prevention activities, and ensure a realistic match between identified needs and available resources.

The word *resources* often connotes staff, financial support, and a sound organizational structure. However, prevention resources may also include the following:

- Existing community efforts to address the prevention and reduction of substance misuse and abuse
- Community awareness of those efforts
- Specialized knowledge of prevention research, theory, and practice
- Practical experience working with particular populations
- Knowledge of the ways that local politics and policies help or hinder prevention efforts

It is important to focus your assessment on relevant resources (i.e., those related to your priority problem). A well-planned and focused assessment will produce far more valuable information than one that casts too wide a net. At the same time, keep in mind that useful and accessible resources may also be found outside the substance abuse prevention system, including among the many organizations in your community that promote public health.

***Assessing community readiness.*** An assessment of community readiness will help you determine your community's level of awareness of, interest in, and ability and willingness to support substance misuse and abuse prevention initiatives. There are many resources available to measure community readiness, and most of them acknowledge that readiness occurs in stages. The Tri-Ethnic Center for Prevention Research at Colorado State University (2011), for example, has identified nine stages of community readiness:

- **Stage 1: Community tolerance / no knowledge.** Substance misuse and abuse is generally not recognized by the community or leaders as a problem. "It's just the way things are" is a common attitude. Community norms may encourage or tolerate the behavior in a social context. Substance misuse and abuse may be attributed to certain age, sex, racial, or class groups.
- **Stage 2: Denial.** There is some recognition by at least some members of the community that the behavior is a problem, but there is little or no recognition that it is a local problem. Attitudes may include "It's not *my* problem" and "We can't do anything about it."
- **Stage 3: Vague awareness.** There is a general feeling among some in the community that there is a local problem and that something ought to be done, but there is little motivation to do anything. Knowledge about the problem is limited. No identifiable leadership exists, and/or leadership is not encouraged.
- **Stage 4: Pre-planning.** Many folks clearly recognize that there is a local problem and that something needs to be done. There is general information about local problems and some discussion. There may be leaders and a committee to address the problem, but no real planning or clear idea of how to progress.
- **Stage 5: Preparation.** The community has begun planning and is focused on practical details. There is general information about local problems and about the pros and cons of prevention programs, but this information may not be based on formally collected data. Leadership is active and energetic. Decisions are being made, and resources (time, money, people, etc.) are being sought and allocated.
- **Stage 6: Initiation.** Data are collected that justify a prevention program; however, decisions may be based on stereotypes rather than data. Action has just begun. Staff are being trained. Leaders are enthusiastic, as few problems or limitations have occurred.
- **Stage 7: Institutionalization/stabilization.** Several planned efforts are underway and supported by community decision-makers. Programs and activities are seen as stable, and staff are trained and experienced. Few see the need for change or expansion. Evaluation may be limited, although some data are routinely gathered.
- **Stage 8: Confirmation/expansion.** Efforts and activities are in place, and community members are participating. Programs have been evaluated and modified. Leaders support expanding funding and program scope. Data are regularly collected and are used to drive planning.

- **Stage 9: Professionalization.** The community has detailed, sophisticated knowledge of the prevalence of the problem and related risk and protective factors. Universal, selective, and indicated efforts are in place for a variety of focus populations. Staff are well-trained and experienced. Effective evaluation is routine and used to modify activities. Community involvement is high.

To assess your community’s level of readiness, the *Community Readiness for Community Change: Tri-Ethnic Center Community Readiness Handbook* (Oetting et al., 2014) provides guidance for conducting both brief and in-depth readiness assessments, depending on your group’s preference.<sup>5</sup>

## Task 2: Build Capacity – Increase Resources and Improve Readiness

It is important to continually assess your capacity and make sure that you have the resources and readiness required to carry out each stage. For example, during Step 1 (Assessment), your group may need to assess its cultural competence and build its capacity to integrate or infuse cultural competence into the assessment process so that participants in planning meetings, focus groups, and other assessment activities experience a safe and supportive environment (see the sidebar on page 31). Additionally, your group may need to assess its readiness to successfully implement and sustain a particular strategy during the Planning phase (Step 3).

Key components of this task include the following (SAMHSA’s CAPT, n.d.):

- Increasing the availability of fiscal, human, organizational, and other resources
- Raising awareness of the substance misuse and abuse problem and the readiness of stakeholders to address this issue
  - Note:** One way to raise awareness is to conduct a media campaign. For tips for working with the media and crafting an effective message, see APPENDIX 9: Strategies for Working with the Media and Appendix 10: Effective Messaging for Substance Abuse Prevention.
- Developing or strengthening relationships with partners and/or identifying new opportunities for collaboration

### Capacity Building through Organizational Development

Part of capacity building is paying attention to the organizational infrastructure needed to plan, implement, evaluate, and sustain your intervention. Five factors are key to both organizational infrastructure development and sustainability (Johnson, Hays, Hayden, & Daley, 2004):

- Creating and strengthening administrative structures and formal linkages among all organizations and systems involved

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<sup>5</sup> The handbook may be downloaded from the Tri-Ethnic Center’s website ([http://triethniccenter.colostate.edu/docs/CR\\_Handbook\\_8-3-15.pdf](http://triethniccenter.colostate.edu/docs/CR_Handbook_8-3-15.pdf)).

- Encouraging *champion* (people who speak about and promote the strategies in the community) and leadership roles for multiple supporters across organizations and systems, and making sure that these roles are distributed across different ethnic, racial, socioeconomic, and other community subpopulations
- Making plans to ensure that adequate funding, staffing, TA, and materials will be in place as needed
- Developing administrative policies and procedures that support your prevention strategies and send a clear message about the desirability of and expectations for sustaining efforts
- Building and maintaining community and practitioner expertise in several areas, such as effective prevention, needs assessment, logic model construction, selection and implementation of evidence-based programs, fidelity and adaptation, evaluation, and cultural competence

### Capacity Building throughout the SPF

At each step of the SPF, it is important to document and track required assets and needs. This information will assist you in developing concrete plans for building your group's capacity and tracking the implementation of your plans. For example, after completing the assessment of needs, readiness, and resources in Step 1, your group might do the following:

- Review the quantitative and qualitative data collected regarding your community's capacity to prevent and reduce substance misuse and abuse
- Identify capacity needs
- If necessary, conduct additional assessments to further define your capacity needs

Next, your group should develop a capacity-building plan for addressing each identified need, building on the assets and resources you identified earlier in the process. See APPENDIX 11: Capacity Building Plan - Example and Template for further guidance.

### Capacity Building through Cultural Competence

Increasing the cultural competence of your organization or group involves looking at your current practices and considering whether your written guidelines or policies reflect a culturally competent perspective.

Answering the following questions can help you assess your group's strengths and weaknesses in this area (Community Anti-Drug Coalitions of America & National Coalition Institute [CADCA & NCI], 2010a):

- **Membership:** How well does your group reflect the communities you serve? To increase the breadth of your representation, should you add members? Should you forge partnerships with organizations that have stronger capacity for working with certain diverse groups?

- **Resources:** Do your members or partners need additional training or resources in order to serve all parts of your community equitably? For example, do you need to build your capacity to translate program materials into another language?
- **Barriers:** What is getting in your group’s way as you work to connect with and serve diverse communities? Without rehashing past mistakes, can you take a clear look at any problems that exist, and identify how your group might change its practices?
- **Leadership:** Has your group publicly endorsed cultural competence and inclusivity? Does it need more leadership in this area, perhaps from a partner with more expertise?

### Capacity Building through Improved Community Readiness

To improve community readiness, the National Institute on Drug Abuse (1997) recommends the following strategies, which coincide with the Tri-Ethnic Center’s (Colorado State University, 2011) nine stages of community readiness:

- **Stage 1: Community tolerance / no knowledge**
  - Hold small-group and one-on-one discussions with community leaders to identify the perceived benefits of substance use and how community norms reinforce use
  - Have small-group and one-on-one discussions with community leaders on the health, psychological, and social costs of substance misuse and abuse, in order to change perceptions among those most likely to be part of the group that initiates program development
- **Stage 2: Denial**
  - Offer educational outreach programs to community leaders and community groups interested in sponsoring local programs focusing on the health, psychological, and social costs of substance misuse and abuse
  - Use local incidents that illustrate the harmful consequences of substance misuse and abuse in your one-on-one discussions and educational outreach programs
- **Stage 3: Vague awareness**
  - Offer educational outreach programs on national and state prevalence rates of substance misuse and abuse and prevalence rates in communities with similar characteristics
  - Conduct local media campaigns that emphasize the consequences of substance misuse and abuse
  - Include local incidents that illustrate the harmful consequences of substance misuse and abuse in all outreach efforts
- **Stage 4: Pre-planning**
  - Offer educational outreach programs to community leaders and sponsorship groups that communicate the prevalence rates and correlates or causes of substance misuse and abuse

**APPENDIX 11: EFFECTIVE MESSAGING FOR SUBSTANCE ABUSE PREVENTION** offers guidance on designing a consistent and effective message for your local media campaign.

- Provide educational outreach programs that introduce the concept of prevention and illustrate specific prevention programs adopted by communities with similar profiles
- Conduct local media campaigns emphasizing the consequences of substance misuse and abuse and ways to reduce demand for illicit substances through prevention programming
- **Stage 5: Preparation**
  - Offer educational outreach programs to the general public on specific types of prevention programs, their goals, and how they can be implemented
  - Provide educational outreach programs for community leaders and local sponsorship groups on prevention programs, goals, staff requirements, and other startup aspects of programming
  - Conduct a local media campaign describing the benefits of prevention programs for reducing consequences of substance misuse and abuse
- **Stage 6: Initiation**
  - Offer in-service educational training for program staff (paid and volunteer) on the consequences, correlates, and causes of substance misuse and abuse and the nature of the problem in the local community
  - Conduct publicity efforts associated with the kickoff of the program
  - Hold a special meeting with community leaders and local sponsorship groups to provide an update and review of initial program activities
- **Stage 7: Institutionalization/stabilization**
  - Lead in-service educational programs on the evaluation process, new trends in substance misuse and abuse, and new initiatives in prevention programming, with trainers either brought in from the outside or with staff members sent to programs sponsored by professional societies
  - Conduct periodic review meetings and special recognition events for local supporters of the prevention program
  - Publicize local efforts associated with review meetings and recognition events
- **Stage 8: Confirmation/expansion**
  - Lead in-service educational programs on the evaluation process, new trends in substance misuse and abuse, and new initiatives in prevention programming, with trainers either brought in from the outside or with staff members sent to programs sponsored by professional societies
  - Conduct periodic review meetings and special recognition events for local supporters of the prevention program
  - Present results of research and evaluation activities of the prevention program to the public through local media and public meetings
- **Stage 9: Professionalization**
  - Provide continued in-service training of staff



- Continue to assess new drug-related problems and to reassess targeted groups within community
- Continue to evaluate program efforts
- Provide regular updates on program activities and results to community leaders and local sponsorship groups; share success stories with local media and at public meetings

Don't try to skip stages. For example, if you find that your community is in Stage 1, do not try to force it into Stage 5. Change must happen through preparation and process, not coercion.

## STEP 3: PLANNING

In this step, you will use the information you obtained during Steps 1 and 2 to develop a comprehensive plan and logic model for addressing substance misuse and abuse in your community. Guidelines for PFS 2015 grantees on developing a strategic plan and logic model are provided in APPENDIX 12: PFS 2015 Strategic Plan Development Guide and APPENDIX 13: PFS 2015 Logic Model Development Guide. While the guidelines are targeted to PFS 2015 grantees, the guidance in these resources will also be useful to other groups.

### Key Planning Tasks:

Step 3 (Planning) is comprised of the following key tasks:

- 1.) Prioritize intervening variables identified from Step 1
- 2.) Select interventions that address your specific intervening variables and show evidence of effectiveness for the populations you are trying to reach
- 3.) Develop a comprehensive plan that aligns with your logic model.

### Task 1: Prioritize Intervening Variables

As noted in Step 1 of the SPF, *intervening variables* are factors identified in the literature as being related to substance misuse and abuse, including risk and protective factors present in your community. Identifying these factors and prioritizing among them is a critical part of the SPF planning process. It is unlikely that you will have the resources and capacity to address them all simultaneously, which is the reason why prioritization and selection are important.

While different criteria can be used to prioritize these variables, communities often consider two in particular when making this decision:

- *Importance*: The extent to which various intervening variables have the potential to meaningfully impact the problem in question
- *Changeability*: How easy it would be to change the intervening variable given existing time, resources, and capacity

You may want to select intervening variables that are high in both.

Figure 11. Prioritization Matrix

		CHANGEABILITY	
		High	Low
IMPORTANCE	High		
	Low		

### Importance

When weighing the importance of intervening variables, consider the following:

- *How much does the intervening variable influence the problem?* For example, if you identified youth prescription opioid consumption as a problem, and the data showed that youth are more likely to obtain prescription opioids from peers (social access) than from pharmacies (via a personal script from a doctor), then social access would be considered high in importance, whereas retail access would be considered low.
- *Does the intervening variable impact other behavioral health issues or other identified problems?* For example, a younger age at first prescription is a risk factor for not only

initiation into opioid misuse, but also stimulant and tranquilizer misuse (Kecojevic et al., 2012). Therefore, focusing on this risk factor may impact more than one issue.

- *Do the intervening variables directly impact the specific developmental stage of those experiencing the problem?* For example, for the identified problem of NMUPD among high school-age youth, the risk factor of being a member of a social fraternity or sorority would be less important for high school-age youth than it would be for college-age populations.

## Changeability

When assessing the changeability of a factor, you may want to consider the following:

- Whether the community has the *capacity*—the readiness and resources—to change a particular intervening variable
- Whether a suitable evidence-based intervention exists that has been shown to impact the intervening variable
- Whether change can be brought about in a reasonable time frame (i.e., changing some intervening variables may take too long to be a practical solution)
- Whether the changes can be sustained over time

### **Other Considerations**

Additional questions you may want to consider when prioritizing intervening variables include:

- *Is the intervening variable identified independently by multiple sources?*
- *How reliable and valid are the data supporting it?*
- *How actionable is the variable?*
- *Are other efforts already in place to change the variable?*
- *Does addressing this intervening variable have the potential for unintended consequences?*
- *Are data systems in place to effectively evaluate changes in the variable?*

If the community has ample resources and sufficient readiness to address this intervening variable, a suitable evidence-based intervention exists, and sustainable change can occur within a reasonable time frame, then the factor would be considered high in changeability. If there are not adequate resources or if the community is not ready to address the intervening variable, the changeability of the factor may be low.

## **Task 2: Select Interventions**

When developing a plan to address substance misuse and abuse in your community, it is important to identify and select strategies that have been shown through research to be effective, are a good fit for your community, and are likely to promote sustained change. Although it is natural to want to jump directly to strategy selection, this step should only occur *after* your intervening variables have been identified. The intervening variables should drive strategy selection – not vice-versa.

## Evidence of Effectiveness

Literature reviews, published studies, unpublished evaluation findings, and other resources may help you identify strategies with the greatest potential to affect the intervening variables you identified as a priority. For the PFS 2015 initiative, BSAS recommends consulting the SAMHSA/CSAP publication titled, *Identifying and Selecting Evidence-Based Interventions for Substance Abuse Prevention* as the basis for determining the extent to which a strategy has suitable evidence of effectiveness.<sup>6</sup>

Despite the fact that there are few published studies yet demonstrating NMUPD prevention outcomes at the community level, there are several resources that can assist prevention practitioners in identifying evidence-based strategies in this area. The Center for the Application of Prevention Technologies (CAPT, 2016b) has developed an additional Decision Support Tool titled, *Prescription Drug Misuse: Prevention Programs and Strategies*. Other resources include an examination of state-level interventions on NMUPD that was prepared by Haegerich and colleagues (2014)<sup>7</sup>, the Office of National Drug Control Policy's Prescription Drug Abuse Action Plan<sup>8</sup>, Trust for American's Health Strategies to Stop the Epidemic<sup>9</sup>, and Johns Hopkins Bloomberg School of Public Health's The Prescription Opioid Epidemic: An Evidence Based Approach<sup>10</sup>. This is not intended to be an exhaustive list, but it does cover many of the strategies that constitute the current state of the science.

**Note:** A draft version of the CAPT Decision Support Tool is available to PFS 2015 grantees. If you have not received a copy of this document, please contact your MasTAPP TA Provider. A link to the final document will be placed in Appendix 14, as soon as it is made available.

For each strategy you consider:

- Review the research evidence that describes how the strategy is related to your selected intervening variable(s)
- Based on this evidence, present a rationale describing how the strategy addresses the intervening variable(s)

### **Possible strategies**

To prevent or reduce NMUPD, you might consider the following based on the extent to which they are appropriate for the intervening variables you have selected:

- *Mass Media/Social Marketing*
- *Targeted Social Norms*
- *Parent Education/Training*
- *Prescriber/Pharmacist Training*
- *Prescriber/Provider Policies and Protocols*
- *School Curriculum Infusion*
- *Safe Storage and Disposal*

<sup>6</sup> This document can be downloaded for free at: <http://store.samhsa.gov/product/Identifying-and-Selecting-Evidence-Based-Interventions-for-Substance-Abuse-Prevention/SMA09-4205>

<sup>7</sup> See <http://www.ncbi.nlm.nih.gov/pubmed/25454406>

<sup>8</sup> See [https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx\\_abuse\\_plan.pdf](https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf)

<sup>9</sup> See <http://healthyamericans.org/reports/drugabuse2013/>

<sup>10</sup> See <http://www.jhsph.edu/research/centers-and-institutes/center-for-drug-safety-and-effectiveness/opioid-epidemic-town-hall-2015/2015-prescription-opioid-epidemic-report.pdf>

**Note:** Be sure to discuss potential strategies with your TA provider.

As described later in this section, this process will help you develop a logic model that shows how your selected strategies will lead to improvements in outcomes related to substance misuse and abuse.

### Conceptual Fit

Think about how relevant the strategy is to your community and how it is logically connected to your intervening variable(s) and desired outcomes. To determine conceptual fit, consider the following questions:

- Has the strategy been tested with the identified target population? If so, how? If not, how can it be applied to the target population?
- How will implementing this strategy in your local community help you achieve your anticipated outcomes?

### Practical Fit

Given your community's readiness, population, and general local circumstances, how effectively could you implement this strategy? Consider the following:

- Resources (e.g., cost, staffing, access to target population)
- Organizational or coalition climate (e.g., how the strategy fits with existing prevention or reduction efforts, the organization's willingness to accept new programs, buy-in of key leaders)
- Community climate (e.g., the community's attitude toward the strategy, buy-in of key leaders)
- Sustainability (e.g., community ownership of the strategy, renewable financial support, community champions)

## **Task 3: Develop a Comprehensive Plan that Aligns with the Logic Model**

At this point in the SPF process, you have identified your community's priority problem(s), intervening variables, and resources and readiness. Additionally, you have identified appropriate strategies for addressing NMUPD among high school-age youth within your community. The next step is to bring all these elements together to create an overall vision of what your group is attempting to do and how it will evaluate the results of its efforts.

Developing a comprehensive plan requires you to do the following:

- Establish outcomes for each strategy
- Identify resources for implementation
- Develop a logic model (see APPENDIX 13: PFS 2015 Logic Model Development Guide)
- Develop an action plan (see APPENDIX 15: Action Plan - Example and Template)
- Develop an evaluation plan

## Establish Outcomes for Each Problem

For each selected problem, you will need to establish measurable outcomes. To do this, identify the intervening variable(s) being addressed, indicate the strategies, and list anticipated short-term, intermediate, and long-term outcomes (see sidebar).

For example:

### Three types of outcomes

- A **short-term outcome** is the change in the target group who received your strategy; often expressed as changes in knowledge, attitudes, and/or skills
- An **intermediate outcome** is the change in the intervening variable; often expressed as changes in behaviors, norms, and/or policies
- A **long-term outcome** is the ultimate impact of the strategy on the issue identified in your problem statement

**Problem Statement:** The rate of current misuse and abuse of prescription pain relievers among high school students (8%) in our community has increased by 10% over the past five years.

**Intervening variable:** Low levels of parental disapproval<sup>11</sup>

**Strategy:** Parent media campaign

#### **Outcomes:**

- *Short-term:* Increase in parents' awareness of NMUPD as an issue
- *Intermediate:* Increase in parents' level of disapproval of NMUPD
- *Long-term:* Decreased current (30-day) misuse and abuse of prescription pain relievers among high school students.

## Identify Resources for Implementation

Specify all resources needed to implement each selected strategy and to measure the related outcomes. Be sure to consider the following:

- Human resources (e.g., staffing, partnerships, volunteers, coalition membership)
- Skills (e.g., prevention and intervention knowledge and skills, data collection and analysis)
- Fiscal resources (e.g., monetary, in-kind)
- Material resources (e.g., space, equipment)
- Existing resource gaps that will limit your ability to effectively implement the selected strategy or strategies

## Develop a Logic Model

A *logic model* is a chart that describes how your effort or initiative is supposed to work and explains why your intervention is a good solution to the problem at hand. Effective logic models depict the activities that will bring about change and the results you expect to see in your

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<sup>11</sup> Ford, J. A., & Rigg, K. K. (2015). Racial/ethnic differences in factors that place adolescents at risk for prescription opioid misuse. *Prevention Science: The Official Journal of the Society for Prevention Research*, 16(5), 633–641.

community. A logic model keeps program planners moving in the same direction by providing a common language and point of reference.

Logic models may be used for various purposes (e.g., program planning, implementation, evaluation) and can feature different elements (e.g., inputs, activities, outputs, outcomes).

Use the information you gathered in Steps 1 and 2 of the SPF to develop a community-level logic model that links local problems, associated intervening variables, evidence-based strategies, and anticipated outcomes. Your logic model should include the following categories:

- *BSAS-Identified Problem*: State why BSAS has made the grant dollars available—for BSAS initiatives, this is taken from the RFR (Request for Response)
- *Local manifestation of the problem*: Describe the extent of the substance misuse and abuse problem within the local community – this is your problem statement from the Step 1
- *Intervening variable(s)*: List the risk and/or protective factors that research has shown to be associated with substance misuse and abuse and are present within your community.
- *Strategies*: List the programs, policies, and/or practices chosen to address the intervening variable(s); these should be evidence-based, with measurable outputs (e.g., number of advertisements placed, sessions conducted, persons trained)
- *Target group*: Describe the intended audience(s) or population(s) of interest – this can include both primary and secondary audiences or groups, if needed
- *Outputs*: List concrete measures of the extent to which the strategies are being implemented as planned, usually measured as “counts”.
- *Expected outcomes*: Include short-term, intermediate, and long-term outcomes

Further guidance on developing a logic model, including a template, is provided in APPENDIX 14: PFS 2015 Logic Model Development Guide. While the guidelines are targeted to PFS 2015 grantees, the guidance in this resource will also be useful to other groups.

Figure 12 shows a sample logic model using the example from the previous section. In this example, the problem identified by BSAS is NMUPD among high school-age youth. The local manifestation of the problem is a growing rate of prescription pain reliever misuse/abuse among the high school-aged population in the community. A key intervening variable that emerged from the assessment (*low levels of parental disapproval*<sup>12</sup>) has been identified. In order to address this intervening variable, the community has chosen to implement an

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<sup>12</sup> Collins, Abadi, Johnson, Shamblen, & Thompson. ( 2011). Non-medical use of prescription drugs among youth in an Appalachian population: Prevalence, predictors, and implications for prevention. *Journal of Drug Education*, 41(3), 309–326.

evidence-supported strategy (*media campaign*<sup>13</sup> geared towards parents). The community has identified several measures of implementation (outputs) and has specified its expected short-, intermediate-, and long-term outcomes.

**Figure 12. Sample Logic Model**

Problem identified by BSAS: NMUPD among high school-age youth						
Local manifestation of the problem: The rate of current misuse and abuse of prescription pain relievers among high school students (8%) in our community has increased by 10% over the past five years.						
Intervening Variable	Strategy	Target Group	Outputs	Outcomes		
				Short-Term	Intermediate	Long-Term
Low levels of parental disapproval	Parent media campaign  Parent workshop	All parents of 9 <sup>th</sup> -12 <sup>th</sup> graders in the community	Number of campaign ads placed/distributed throughout the community	Increase in parents' awareness of NMUPD as an issue	Increase in parents' level of disapproval of NMUPD  Increase in parents who report communicating their disapproval of NMUPD to their children.	Decreased current (30 day) misuse and abuse of prescription pain relievers among high school students
			Number of parents reached through media campaign	Increase in parents' knowledge of the addictiveness of prescription pain relievers		
			Number of parent workshops delivered			
			Number of parents who attended parent workshops			

Your logic model may target several intervening variables related to substance misuse and abuse. You will also likely choose multiple strategies to address each intervening variable. Complete a logic model for each problem identified (i.e., each problem statement) and include additional rows for each intervening variable you've targeted.

<sup>13</sup> Johnson, E. M., Porucznik, C. A., Anderson, J. W., & Rolfs, R. T. (2011). State-level strategies for reducing prescription drug overdose deaths: Utah's prescription safety program. *Pain Medicine*, 12(Suppl 2), S66–S72. doi: 10.1111/j.1526-4637.2011.01126.x



## Develop an Action Plan

An *action plan* is the detailed sequence of steps that must be taken for a strategy to succeed. It is one component of your larger strategic plan.

An action plan states:

- What needs to be accomplished
- Who is responsible
- The timeline for completion
- How you will measure success

Keep in mind that good planning requires a group process. Whether decisions are made within a formal coalition or among a more informal group of partners, these decisions cannot represent the thoughts and ideas of just one person; they must reflect the ideas and input of individuals from across community sectors. For a template and example of an action plan, see Appendix 15: Action Plan - Example and Template.

***Action plan and cultural competence.*** To increase your group's cultural competence, you'll need to be open to modifying your planning and thinking processes to reflect the preferences of the target population(s). For example, some American Indian and Alaska Native communities prefer planning processes that are circular, such as using a Mind Map to brainstorm rather than a linear list or table. Faith-based organizations may believe that action-oriented plans should be tempered by other forms of spiritual guidance about the best way to move forward. Listening to and incorporating different viewpoints will help you develop a plan that is culturally competent and shows respect for participants' values, and is therefore more likely to succeed (CADCA & NCI, 2010b).

As noted by CADCA, members of your municipality or coalition may come to the table with different levels of understanding regarding substance misuse and abuse and how to plan, implement, and evaluate interventions. Some may not be familiar with logic models or may not understand how a

### **Things to consider when developing an action plan:**

- Have a clear objective
- Start with what you will do *now*
- Clearly define the steps you will take
- Identify the end point for each step
- Arrange the steps in logical, chronological order, and include the date by which you will start each step
- Anticipate the types of problems you might encounter at each step, and brainstorm solutions.

### **Increasing cultural competence**

Cultural competence should be visibly interwoven throughout your intervention. A plan to increase your group's cultural competence should do the following:

- Include measurable goals and objectives with concrete timelines. For example, you might develop an outreach goal of contacting 30 different community organizations within six months, with the ultimate goal of recruiting 12 new partners.
- Ensure that you are involving representatives from all sectors of the community in your prevention efforts. For example, if the aim of your logic model is to prevent NMUPD among high school-age youth, outline the steps your group will take to include high school-age youth from diverse backgrounds as full participants in your efforts, rather than solely as the target of your activities.
- Indicate who is responsible for the proposed action steps, and outline some of the potential resources needed.

It's important to review your cultural competence plan on a regular basis.

formal logic model may differ from their usual approaches. Ideally, you will not start working on a logic model until all coalition members understand and are comfortable with the process. Several training sessions may be needed to get everyone to the same baseline of understanding, thereby promoting fruitful discourse and consensus building.

**Note:** The cultural competence planning process may identify several areas of discord among members of your organization or coalition. This is actually a good opportunity to address these differences early on, thereby preventing the issues from resurfacing later and derailing your work.

### Develop an Evaluation Plan

It is a common misperception that evaluation starts only at the end of a project. Though evaluation is the focus of the last step of the SPF, it should be considered during each preceding step. Ongoing monitoring and evaluation are essential to determine whether your desired outcomes are achieved and to assess the effectiveness and impact of your intervention and the quality of service delivery. Data collection for evaluation purposes should be built into the project design and should be part of your strategic plan. Your evaluation will ultimately affect the sustainability of your intervention.

You will need to make sure that all relevant baseline information is collected before implementing your intervention, and make plans to track outcomes over time by collecting quantitative and qualitative data. In addition, you should have a plan for securing and maintaining the commitment of community members, agencies, and other strategic partners who will be involved in the evaluation. By fostering relationships among all the partners involved, it is more likely that they will be inclined to provide political support, cooperation, volunteers, and other resources on a long-term, ongoing basis. Refer to your Capacity-Building Worksheet from Step 2 to monitor how well your group is functioning and to identify areas for improvement.

A number of good models for evaluation plans are available online. Here is a very basic example:

SAMPLE EVALUATION PLAN			
<i>Short-Term Outcomes</i>			
Outcomes	Indicator	Data Source	Collection Frequency
<i>Intermediate Outcomes</i>			
Outcomes	Indicator	Data Source	Collection Frequency

<i>Long-Term Outcomes</i>			
<b>Outcomes</b>	<b>Indicator</b>	<b>Data Source</b>	<b>Collection Frequency</b>

See step 5 of the SPF process for further guidance on developing evaluation plans.

## STEP 4: IMPLEMENTATION

In the implementation phase, you will focus on carrying out the various components of your action plan and identifying and overcoming any potential barriers. You will assess your capacity to carry out the implementation plan, determine what training or other assistance is needed, and decide how to engage additional community partners who have the necessary expertise.

In this phase, the role of your group shifts from planning to oversight, mutual accountability, and monitoring of the implementation process. You must make sure that the plan is implemented with fidelity, allowing for adaptations only when necessary. It is especially important to integrate the principles of cultural competence into the implementation phase, so that the intervention is accessible to and effective with the identified target population.

### Key Implementation Tasks:

Step 4 (Implementation) is comprised of the following tasks:

- 1.) Build capacity and mobilize support
- 2.) Carry out interventions
- 3.) Balance fidelity with necessary adaptations
- 4.) Monitor, evaluate, and adjust

At this point, it is important to make sure that all partners understand the identified goals and selected strategies, as well as their own specific contributions. All members should support the goals and strategies and understand how the activities to be implemented will lead to the desired outcomes.

### Task 1: Build Capacity and Mobilize Support

Assess your group's capacity to implement the selected strategies by answering three questions:

- *What capacity is required to implement these strategies?*
- *Does your group (e.g., organization, coalition) have that capacity?*
- *If not, how will you improve your capacity?*

These types of questions should also be addressed in your strategic plan. Be sure to review the Capacity Building Plan you completed in Step 2, and make any necessary edits.

Partners who are involved in the assessment and planning processes may find that they lack the skills needed to carry out one or more of the selected strategies. A plan to improve capacity may include involving additional community partners who already have appropriately trained staff, hiring staff with the necessary expertise, or providing training opportunities for staff and members who will be involved in implementing the intervention. When seeking community partners, keep in mind the principles of cultural competence; ensuring diversity among your partners and developing links with community institutions are good strategies for supporting cultural competence (CADCA & NCI, 2010b).

## Task 2: Carry Out Interventions

Everyone involved in the effort should understand his or her role in implementing the identified strategies. All too often, the tasks of implementation are handed over to a few staff members, while others sit back and expect to hear about how the work is going, without being directly involved. Staff may be able to fill a number of important roles, including preparing meeting minutes, compiling reports, coordinating meetings, facilitating communication with partners, maintaining accurate records for funding and reporting requirements, and assisting with planning, problem solving, and information management. However, with all these roles to fill, staff cannot also be expected to implement the selected strategies by themselves.

You may consider forming small committees that will each focus on a specific strategy. In doing so, remember to support cultural competence by ensuring diversity in your leadership. Providing additional leadership opportunities can also be an integral way to promote sustainability. The more invested your partners become, the more likely they will be to support your group's activities in the long term.

Some members may be willing to become program *champions*—those who speak about and promote the strategies in the community. In addition, members can leverage resources for change in the community through their professional and personal spheres of influence. For example, a member might serve as a liaison to help implement an inter-organizational prevention effort, bringing together organizations to which he or she has connections.

## Task 3: Balance Fidelity with Necessary Adaptations

*Fidelity* is the degree to which an intervention is implemented as its original developer intended. Interventions that are implemented with fidelity are more likely to replicate the results from the original implementation of the intervention than are those that make substantial adaptations. Training on how to implement the intervention, especially if it's available from the program developer, will increase your ability to implement with fidelity.

Although ensuring fidelity is an important concern, at times it may be necessary to adapt the intervention to better fit your local circumstances. You may find, for example, that you are working with a target population that is in some way different from the population that was originally evaluated, or that some intervention elements must be adjusted due to budget, time, or staffing restraints. In these cases, it may be necessary to adapt the intervention to meet your needs. Balancing fidelity and adaptation can

### Cultural adaptation

*Cultural adaptation* refers to program changes that are culturally sensitive and tailored to a particular group's traditional worldviews. Effective cultural adaptation is especially important when it comes to implementation.

Too often, people equate cultural adaptation with translation, but it is much more than that. Effective cultural adaptation considers the values, attitudes, beliefs, and experiences of the target audience. It depends on strong linkages to cultural leaders and access to culturally competent staff.

be tricky—any time you change a strategy or intervention, you may compromise the outcomes. Even so, implementing an intervention that requires some adaptation may be more efficient, effective, and cost-effective than designing a new intervention.

Here are some general guidelines for adapting an intervention:

- Select strategies with the best initial fit to your local needs and conditions. This will reduce the likelihood that you will need to make adaptations later.
- Select strategies with the largest possible *effect size*—the magnitude of a strategy’s impact. For example, policy change generally has a larger effect size than classroom-based programs.

**Note:** The smaller a strategy’s effect size, the more careful you need to be about changing anything. You don’t want to inadvertently compromise any good that you are doing. In general, adaptations to strategies with large effect sizes are less likely to affect relevant outcomes.

- Implement the strategy as written, if possible, before making adaptations, since you may find that it works well without having to make changes.
- When implementing evidence-based interventions, consult with the intervention developer, when possible, before making adaptations. The developer may be able to tell you how the program has been adapted in the past and how well these adaptations have worked. If the developer is not available, work with an implementation science expert or your evaluator.
- Retain the core components, since interventions that include these components have a greater likelihood of effectiveness. If you aren’t sure which elements are core, refer to the intervention’s logic model, if it is available, or consult the program developer or your evaluator for assistance.
- Stick to evidence-based principles. Strategies that adhere to these principles are more likely to be effective, so it is important that adaptations are consistent with the science<sup>14</sup>.
- Change your coalition’s capacity before you adapt an intervention. While it may seem easier to change the intervention, changing local capacity to deliver it as it was designed is a safer choice.

#### Task 4: Monitor, Evaluate, and Adjust

In addition to carrying out the activities in your implementation plan, your group will need to document the process and describe any changes you make to your original plan along the way. A complete description of how your intervention was implemented helps provide information on fidelity of the implementation; this is part of the process evaluation described in Step 5 of the SPF. Information to document may include participant demographics, recruitment

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<sup>14</sup> See: <https://drive.google.com/file/d/0B1hSjxdXe2YOZ1ViVIUc21zUHM/view>

methods, actual attendance, planned and implemented adaptations, cultural issues and how they were addressed, indications of unmet needs, and any other issues that arise (e.g., lack of organizational capacity, community resistance).

Generally, within three to six months of beginning a new strategy or activity, your staff or an appropriate committee should develop a systematic way to review your logic model and strategic plan. The goals of this review are as follows:

- Document intervention components that work well
- Identify where improvements need to be made
- Provide feedback so that strategies may be implemented more effectively
- Make timely adjustments in activities and strategies to better address identified problems
- Assess whether enough resources have been leveraged and where you might find more
- Engage key stakeholders (e.g., community members, providers, staff) so they feel a sense of responsibility and pride in helping to ensure that your group's goals and objectives are met and that the substance misuse problem in the community is reduced

One way to do this review is to create a fidelity checklist, if one is not already available from the intervention developers. List all the activities in your action plan and put a checkbox next to each activity. Check off each activity as you complete it and document the following:

- Activities that were not implemented in the order suggested by developers
- Activities you tried that did not work
- New activities you created to take the place of ones that did not work

At the end of this process, you will have a good record of what you did and did not implement, the challenges you faced, and how you overcame each challenge.

### *Planning for Sustainability*

The implementation of strategies to bring about significant community change rarely takes place in a short time frame. As you build capacity to bring about change, you should be aware of the need to generate resources to sustain your strategies, beyond the expense of carrying out an intervention.

Sustaining your work includes both institutionalizing strategies and finding additional financial support for them—both of which should be planned for by the time you begin to implement activities. It is important to form a working group of staff and coalition partners to focus on sustainability planning, since getting key stakeholders involved from the beginning can inspire them to become advocates for your work and champions for sustaining your activities.

Planning for financial stability involves figuring out strategies and action steps to obtain and grow the diverse resources—human, financial, material, and technological—needed to sustain your efforts over time. Additional resources may include finding in-kind support, recruiting and sustaining a volunteer staff, obtaining commitments for shared resources from other organizations, or persuading another organization to take on a project begun by your group.

Institutionalizing your work is a long-term process that requires finding ways to make the policies, practices, and procedures you have established become successfully rooted in the community. This includes existing systems and frameworks relevant to your work, which can be stepping stones to eventual policy changes. This can also help extend the length of time you have to work on the issues, since it may take years to build a comprehensive solution. Partnerships are key in finding ways to integrate your work into existing departments within a municipality or into other organizations. To do this, it is important to invest in capacity, teach people how to assess needs, build resources, and effectively plan and implement prevention interventions to create the systems necessary to support these activities going forward.



## STEP 5: EVALUATION

*Evaluation* is the systematic collection and analysis of information about intervention activities, characteristics, and outcomes. Evaluation activities help groups describe what they plan to do, monitor what they are doing, and identify needed improvements. The results of an evaluation can be used to assist in sustainability planning, including determining what efforts are going well and should be sustained, and showing sponsors that resources are being used wisely.

### Purpose of Evaluation

Information gathered through an evaluation has five functions (CADCA & NCI, 2009):

- **Improvement.** This is the most important function of an evaluation—improving the efficiency and effectiveness of your chosen strategies and how they are implemented.
- **Coordination.** The evaluation process assesses the functioning of your group, allowing partners to know what the others are doing, how this work fits with their own actions and goals, and what opportunities exist for working together in the future.
- **Accountability.** Are the identified outcomes being reached? A good evaluation allows your group to describe its contribution to important population-level change.
- **Celebration.** This function is all too often ignored. The path to reducing drug use at the community level is not easy, so a stated aim of any evaluation process should be to collect information that allows your group to celebrate its accomplishments.
- **Sustainability.** A thorough evaluation can help you provide important information to the community and to various funders, which promotes the sustainability of both your group and its strategies.

Program evaluations are often conducted in response to a grant or other funding requirement. As a result,

#### Key Evaluation Tasks:

Step 5 (Evaluation) is comprised of the following tasks:

- 1.) Conduct process evaluation
- 2.) Conduct outcome evaluation
- 3.) Recommend improvements and make mid-course corrections
- 4.) Report evaluation results

#### Cultural Competence in Evaluation

Culture can influence many elements of the evaluation process, including data collection, implementation of the evaluation plan, and interpretation of results. Tools used to collect data (e.g., surveys, interviews) need to be sensitive to differences in culture—in terms of both the language used and the concepts being measured.

When selecting evaluation methods and designing evaluation instruments, you should consider the cultural contexts of the communities in which the intervention will be conducted. Here are some guiding questions to consider:

- *Are data collection methods relevant and culturally sensitive to the population being evaluated?*
- *Have you considered how different methods may or may not work in various cultures?*
- *Have you explored how different groups prefer to share information (e.g., orally, in writing, one on one, in groups, through the arts)?*
- *Do the instruments consider potential language barriers that may inhibit some people from understanding the evaluation questions?*
- *Do the instruments consider the cultural context of the respondents?*

reporting may be structured only to address the requirement rather than to provide a functional flow of information among partners and supporters. To accomplish the five functions of evaluation, you need a more comprehensive and well-rounded evaluation process in which you provide the needed information to the appropriate stakeholders so that they make better choices (improvement), work more closely with your partners (coordination), demonstrate that commitments have been met (accountability), honor your team's work (celebration), and show community leaders why they should remain invested in the coalition process (sustainability).

## Engaging Stakeholders

Evaluation cannot be done in isolation. Almost everything done in community health and development work involves partnerships—alliances among different organizations, board members, those affected by the problem, and others who each bring unique perspectives. When stakeholders are not appropriately involved, evaluation findings are likely to be ignored, criticized, or resisted. People who are included in the process are more likely to feel a good deal of ownership for the evaluation plan and results. They will probably want to develop it, defend it, and make sure that the evaluation really works. Therefore, any serious effort to evaluate a program must consider the viewpoints of the partners who will be involved in planning and delivering activities, your target audience(s), and the primary users of the evaluation data.

Engaging stakeholders who represent and reflect the populations you hope to reach greatly increases the chance that evaluation efforts will be successful. Stakeholder involvement helps to ensure that the evaluation design, including the methods and instruments used, is consistent with the cultural norms of the people you serve. Stakeholders can also influence how or even whether evaluation results are used.

All partners in your substance misuse and abuse prevention or reduction efforts should be involved in developing and implementing your evaluation plan. To facilitate this process, you may consider forming a committee focused on evaluation. The committee would work in collaboration with an evaluator to collect the data, analyze results, and share findings with partners, the community, the media, and others. Having more people trained in data collection and analysis and able to spread the word about the group's successes contributes to sustainability.

A strong evaluation system can provide monthly data about activities and accomplishments that can be used for planning and better coordination among partners. In addition, sharing evaluation data can give the group a needed boost during the long process of facilitating changes in community programs, policies, or practices.

## Implementing the Evaluation Plan

Your evaluation plan should address questions related to both *process* (i.e., program operations, implementation, and service delivery) and *outcomes* (the ultimate impact of your intervention).

### Task 1: Conduct Process Evaluation

A *process evaluation* monitors and measures your activities and operations. It addresses such issues as consistency between your activities and goals, whether activities reached the appropriate target audience(s), the effectiveness of your management, use of program resources, and how your group functioned.

Process evaluation questions may include the following:

- *Were you able to involve the members and sectors of the community that you intended to involve at each step of the way? In what ways were they involved?*
- *Did you conduct an assessment of the situation in the way you planned? Did it give you the information you needed?*
- *How successful was your group in selecting and implementing appropriate strategies? Were these the “right” strategies, given the intervening variables you identified?*
- *Were staff and/or volunteers the right people for the jobs, and were they oriented and trained before they started?*
- *Was your outreach successful in engaging those from the groups you intended to engage? Were you able to recruit the number and type of participants needed?*
- *Did you structure the program as planned? Did you use the methods you intended? Did you arrange the amount and intensity of services, other activities, or conditions as intended?*
- *Did you conduct the evaluation as planned?*
- *Did you complete or start each element in the time you planned for it? Did you complete key milestones or accomplishments as planned?*

### Task 2: Conduct Outcome Evaluation

An *outcome evaluation* looks at the intervention’s effect on the environmental conditions, events, or behaviors it aimed to change (whether to increase, decrease, or sustain). Usually, an intervention seeks to influence one or more particular behaviors or conditions (e.g., risk or protective factors), assuming that this will then lead to a longer-term change, such as a decrease in the use of a particular drug among youth. You may have followed your plan completely and still had no impact on the conditions you were targeting, or you may have ended up making multiple changes and still reached your desired outcomes. The process evaluation will tell how closely your plan was followed, and the outcome evaluation will show whether your strategy made the changes or results you had intended.

At a minimum, your community should strive to put measures in place that allow you to track the problem of interest over time. For example, comparing the percentage of high school students in the community who report past 30-day misuse of pain relievers prior to the implementation of any strategies (baseline) and again at the end of the project – i.e., your long-term outcomes (preferably at multiple points in time if you are engaged in a long-term, multi-year project). This will help you identify whether the issue is getting better, getting worse, or remaining the same over time. There are several additional steps that you should try to build in to enhance the quality of your evaluation. These include things such as:

- 1) Measuring changes in your intervening variables over time – this will help demonstrate if any changes in your long-term outcomes are related to the intervening variables that you are targeting with your strategies (i.e., your theory of change).
- 2) Measuring changes in your short-term outcomes that are the expected antecedents of changes in your intervening variables (e.g., changes in knowledge as a result of the intervention). This will help you determine whether your strategies are having their desired effect.
- 3) Examining whether there is a dose-response relationship between your short-, intermediate-, and long-term measures and variations in the amount (dose) or prevention services received by different individuals.
- 4) Comparing differences in your short-, intermediate-, and long-term measures between individuals that were exposed to the intervention(s) versus those that were not exposed to the intervention(s)

A more in-depth exploration of the concepts related to process and outcome evaluation can be accessed through SAMHSA's Center for the Application of Prevention Technologies<sup>15</sup>. Sites that are interested in more elaborate or sophisticated evaluation designs should consult with a professional evaluator.

### Task 3: Recommend Improvements and Make Mid-Course Corrections

If the intervention produced the outcomes you intended, then it achieved its goals. However, it is still important to consider how you could make the intervention even better and more effective. For instance:

- *Can you expand or strengthen parts of the intervention that worked particularly well?*
- *Are there evidence-based methods or best practices out there that could make your work even more effective?*
- *Would targeting more or different behaviors or intervening variables lead to greater success?*

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<sup>15</sup> <http://www.samhsa.gov/capt/applying-strategic-prevention-framework/step5-evaluation/process-outcomes-evaluation>

- *How can you reach people who dropped out early or who didn't really benefit from your work?*
- *How can you improve your outreach? Are there marginalized or other groups you are not reaching?*
- *Can you add services—either directly aimed at intervention outcomes, or related services such as transportation—that would improve results for participants?*
- *Can you improve the efficiency of your process, saving time and/or money without compromising your effectiveness or sacrificing important elements of your intervention?*

Good interventions are dynamic; they keep changing and experimenting, always reaching for something better.

#### Task 4: Report Evaluation Results

Sharing your evaluation results can stimulate support from funders, community leaders, and others in the community. The best way to ensure the use of your data is to communicate your findings in ways that meet the needs of your various stakeholders. Consider the following:

- **Presentation.** Think about how your findings are reported, including layout, readability, and user-friendliness, and who will present the information.
- **Timing.** If a report is needed for the legislative session but is not ready in time, the chances of the data being used drop dramatically.
- **Relevance.** If the evaluation design is logically linked to the purpose and outcomes of the project, the findings are far more likely to be put to use.
- **Quality.** This will influence whether your findings are taken seriously.
- **Post-evaluation Technical Assistance.** Questions of interpretation will arise over time, and people will be more likely to use the results if they can get their questions answered after the findings have been reported.

#### **Evaluation and Sustainability**

Evaluation plays a central role in sustaining your group's work. Evaluation enables you to take key pieces of data and analyze and organize them so that you have accurate, usable information. This process facilitates the development of the best plan possible for the community and allows your group to accurately share its story and results with key stakeholders. It can also help you track and understand community trends that may have an impact on your group's ability to sustain its work.

A good evaluation monitors progress and provides regular feedback so that your strategic plan can be adjusted and improved. Your group may implement a variety of activities aimed at changing community systems and environments. By tracking information related to these activities and their effectiveness, as well as stakeholder feedback, community changes, and substance misuse and abuse outcomes, you can build a regular feedback loop for monitoring your progress and results. With this information, you can quickly see which strategies and activities have a greater impact than others, determine areas of overlap, and find ways to improve your group's functioning. Using information from the evaluation, your group can adjust its strategic plan and continually improve its ability not only to sustain its work, but also to achieve community-wide reductions in substance misuse and abuse and its consequences.

Evaluations are always read within a particular political context or climate. Some evaluation results will get used because of political support, while others may not be widely promoted due to political pressure. Other factors, such as the size of your organization or program, may matter as well. Sometimes larger programs get more press; sometimes targeted programs do.

It is also important to consider competing information: Do results from similar programs confirm or conflict with your results? What other topics may be competing for attention? It is helpful to develop a plan for disseminating your evaluation findings, taking these types of questions into consideration.

## CULTURAL COMPETENCE

Cultural competence, which also includes linguistic competence, must be considered at each step of the SPF model. Your group should incorporate cultural and linguistic competence into every step of the SPF, as discussed throughout this document.

### What Is Cultural Competence?

*Cultural competence* is the ability of an individual or organization to interact effectively with people from different cultures (SAMHSA’s CAPT, n.d.). Developing cultural competence is an evolving, dynamic process that takes time and occurs along a continuum (SAMHSA’s CAPT, n.d.). For your efforts to prevent or reduce substance misuse and abuse to be effective, you must understand the cultural context of your target community and have the required skills and resources for working within this context.

Although some people may think of culture solely in terms of race or ethnicity, there are many other elements to consider, such as age, educational level, socioeconomic status, gender identity, language(s), and cognitive and physical abilities and limitations (Office of Minority Health, 2013b). You must be respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of the diverse population groups in your target community. This means learning more about the community; drawing on community-based values, traditions, and customs; and working with persons from the community to plan, implement, and evaluate your strategies.

### What Is Linguistic Competence?

*Linguistic competence* involves more than having bilingual staff; it refers to the ability to communicate with a variety of different cultural groups, including people with low literacy, non-English speakers, and those with disabilities. The National Center for Cultural Competence defines linguistic competence as follows:

*The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse*

#### Cultural and linguistic competence matter

Cultural and linguistic competence help to ensure that the needs of all community members are identified and addressed, thereby contributing to the effectiveness of your strategies. Consider the following examples:

- A community group wants to educate parents of high school students on the risks of NMUPD. As Spanish is the primary language of many parents, the group asks a teacher to translate the take-home flyer. However, the teacher’s translation does not use vocabulary and idioms that match the parents’ ethnicity, so families don’t read it or don’t understand it, and some are even offended by it.

The flyer is then revised based on input from a small group of parents. It is now much more clear and useful to the school’s Spanish-speaking families.

- A community group hires professional outreach workers to provide support services to family members of people who are abusing opioids. However, the professionals don’t connect well with the people they are trying to educate. The group then recruits members of the community who are in recovery, and trains them to deliver outreach education. This strategy has *much* greater success.

*audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. (Goode & Jones, 2009, p. 1)*

You might consider some or all of the following approaches:

- Hiring bilingual/bicultural or multilingual/multicultural staff
- Providing foreign language interpretation services
- Printing materials in easy-to-read, low-literacy, picture, and symbol formats
- Offering sign language interpretation services
- Using TTY and other assistive technology devices
- Offering materials in alternative formats (e.g., audiotape, Braille, enlarged print)
- Adapting how you share information with individuals who experience cognitive disabilities
- Translating legally binding documents (e.g., consent forms, confidentiality and patient rights statements), signage, health education materials, and public awareness materials and campaigns
- Using media targeted to particular ethnic groups and in languages other than English (e.g., television, radio, Internet, newspapers, periodicals)

**Guiding values and principles for language access**

The National Center for Cultural Competence (n.d.) identifies the following guiding values and principles for language access:

- Services and supports are delivered in the preferred language and/or mode of delivery of the population served
- Written materials are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the populations served
- Interpretation and translation services comply with all relevant federal, state, and local mandates governing language access
- Consumers are engaged in evaluation of language access and other communication services to ensure quality and satisfaction

**National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)**

The National CLAS Standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services (Office of Minority Health, 2013b). Originally developed by the HHS Office of Minority Health in 2000, the standards were updated in 2013 after a public comment period, a systematic literature review, and input from a National Project Advisory Committee.



The standards have been updated and expanded to address the importance of cultural and linguistic competence at every point of contact throughout the health care and health services continuum. Table 6 highlights some of the main differences between the 2000 and 2013 National CLAS Standards (Office of Minority Health, 2013a).

**Table 6. Differences Between 2000 and 2013 National CLAS Standards**

Expanded Standards	2000 National CLAS Standards	2013 National CLAS Standards
Culture	Defined in terms of racial, ethnic, and linguistic groups	Defined in terms of racial, ethnic, and linguistic groups, as well as geographical, religious, and spiritual, biological, and sociological characteristics
Audience	Health care organizations	Health and health care organizations
Health	Definition of <i>health</i> was implicit	Explicit definition of <i>health</i> includes physical, mental, social, and spiritual well-being
Recipients	Patients and consumers	Individual and groups

The 15 standards are organized into one Principal Standard and three themes (see Table 7). Resources for implementing the National CLAS Standards are available from the Office of Minority Health’s Think Cultural Health website ([www.ThinkCulturalHealth.hhs.gov](http://www.ThinkCulturalHealth.hhs.gov)).

**Table 7. 2013 National CLAS Standards**

<b>Principal Standard</b>	1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
<b>Governance, Leadership, and the Workforce</b>	2. Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practices, and allocated resources 3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area 4. Educate and train governance, leadership, and the workforce in culturally and linguistically appropriate policies and practices on an ongoing basis
<b>Communication and Language Assistance</b>	5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services 6. Inform all individuals of the availability of language assistance services, clearly and in their preferred language, both verbally and in writing 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided 8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

<p><b>Engagement, Continual Improvement, and Accountability</b></p>	<ol style="list-style-type: none"> <li>9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations</li> <li>10. Conduct ongoing assessments of the organization’s CLAS-related activities, and integrate CLAS-related measures into measurement and continual quality improvement activities</li> <li>11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery</li> <li>12. Conduct regular assessments of community health assets and needs, and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area</li> <li>13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness</li> <li>14. Create culturally and linguistically appropriate conflict and grievance resolution processes to identify, prevent, and resolve conflicts or complaints</li> <li>15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public</li> </ol>
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## SUSTAINABILITY

Sustainability is often thought of as the ability to find another source of funding after an initial grant ends. But sustainability is not only about sustaining funds; it also means sustaining the gains you have made in addressing a health problem—in this case, preventing or reducing substance misuse and abuse. It means constantly building on your efforts by retaining and improving strategies that are shown to be effective in achieving your identified outcomes, and discontinuing or modifying those that do not seem to be working as well.

Sustainability does not mean that an intervention must continue as originally designed or must be implemented by the same people as before. Rather, you should use the findings from your evaluation to make continual, ongoing improvements. As you learn more about what works and does not work in your community, you may find it useful to bring in new partners and implement new strategies.

More information and resources on sustainability, as well as on all other components of the SPF model, is available from MassTAPP (<http://masstapp.edc.org>).

Planning for sustainability requires that you consider the many factors that will ensure the success of your efforts over time. For example, forming a stable prevention infrastructure, ensuring the availability of training systems, and developing a strong base of community support.

Here are some tips for increasing sustainability (SAMHSA’s CAPT, n.d.):

- **Think about sustainability from the beginning.** Building support, showing results, and obtaining continued funding all take time. It is critical to think about who needs to be at the table from the beginning.
- **Build ownership among stakeholders.** The more invested that stakeholders become, the more likely they will be to support prevention activities for the long term. Involve them early on and find meaningful ways to keep them involved. Stakeholders who are involved in the assessment process are more likely to support the strategies used to address the identified problems and support this work over time.
- **Track and share outcomes.** A well-designed and well-executed evaluation will help you improve your efforts and show evidence of the effectiveness of your strategies. Share your outcomes with community members so that they can become champions of your efforts.
- **Identify program champions** who are willing to speak about and promote your prevention efforts.
- **Invest in capacity**, at both the individual and the systems levels. Teach people how to assess needs, build resources, effectively plan and implement effective strategies, and create the systems necessary to support these activities over time.
- **Identify diverse resources**, including human, financial, material, and technological. Be sure to identify and tap as many of these as possible.

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## **SECTION 3: APPENDICES**

**Appendix 1:** PFS 2015 Grant Milestones, Timeline, and Deliverables

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**Appendix 15:** Action Plan - Example and Template

## APPENDIX 1: PFS 2015 GRANT MILESTONES, TIMELINE, AND DELIVERABLES



**Deadlines: January 29, 2016 – October 31, 2016**

### 1. By Friday, January 29, 2016

- Programs must submit the following information to Fernando Perfas at [Fernando.perfas@state.ma.us](mailto:Fernando.perfas@state.ma.us):
  - a) **A letter of agreement** to provide bi-annual high school survey data using an existing instrument in the community  
OR  
**A letter from the Superintendent of School, his/her designee, or the Principal in the high school(s)** that are likely to be targeted by this initiative indicating that you are not currently able to meet the data requirement for the duration of the grant, but that the designated school spokesperson will work with the state and UMASS to fulfill the data requirement.
  - b) **A Memorandum Of Understanding (MOU)** from *each* of the following list of local partners:
    - Schools
    - Law Enforcement/Fire/First Responders
    - Health Care Providers
    - Local Prevention Coalitions/Groups

### 2. Monday, February 1, 2016

- PFS 2015 grant begins.
- Begin work on Assessment and Capacity-Building sections.

### 3. Wednesday, February 17, 2016 (Time: 11:00am-12:30pm)

- Mandatory introductory webinar for new grantees, in which the following individuals are *required* to participate:
  - Project Coordinator (if this individual has been hired)
  - A representative from the municipality and/or a representative from the non-municipal organization named in the grant award (if applicable)

### 4. By Friday, March 4, 2016

- Programs must submit a staffing plan that describes project staff, education, qualifications, responsibilities and percentage of time devoted to the project (with résumés attached) to Andrew Robinson at [Andrew.robinson@state.ma.us](mailto:Andrew.robinson@state.ma.us)

**5. March 8-11, 2016**

- Mandatory Substance Abuse Prevention Skills Training for PFS 2015 Coordinators. Contact your contract manager with questions about this training.

**6. No later than Friday, April 1, 2016**

- Programs must schedule a meeting with their MasTAPP TA provider to discuss:
  - Status of the development of a decision-making process for coordinating efforts across the community
  - Status of Assessment efforts and whether any data gaps remain
  - Status of Capacity-Building efforts and any challenges being faced in this area
  - Remaining steps toward completing the Assessment and Capacity-Building stages

**7. No later than Friday, April 22, 2016**

- Programs must submit a draft of Sections 1 and 2 of their Strategic Plan to their BSAS Contract Manager and their MasTAPP TA provider for review.

**8. Wednesday, June 1, 2016 (Time: TBD)**

- Mandatory webinar for grantees, in which the following individual should participate:
  - Project Coordinator and/or other appropriate community grantee representative

**9. No later than Friday, June 17, 2016**

- Programs must submit a draft of their completed **strategic plan, including logic model**, to their MasTAPP TA provider for review.

**10. Thursday, June 30, 2016**

- End of the first year of PFS 2015 grant.

**11. No later than Friday, July 1, 2016**

- Beginning of the second year of the PFS 2015 grant
- Programs must submit their **completed Strategic Plan** to BSAS.

**12. Monday, August 1, 2016**

- Upon BSAS approval of the **strategic plan**, all programs **begin full implementation** of the strategies identified in their strategic plan, based on the results of their needs assessment.

### **13. Monday, October 31, 2016**

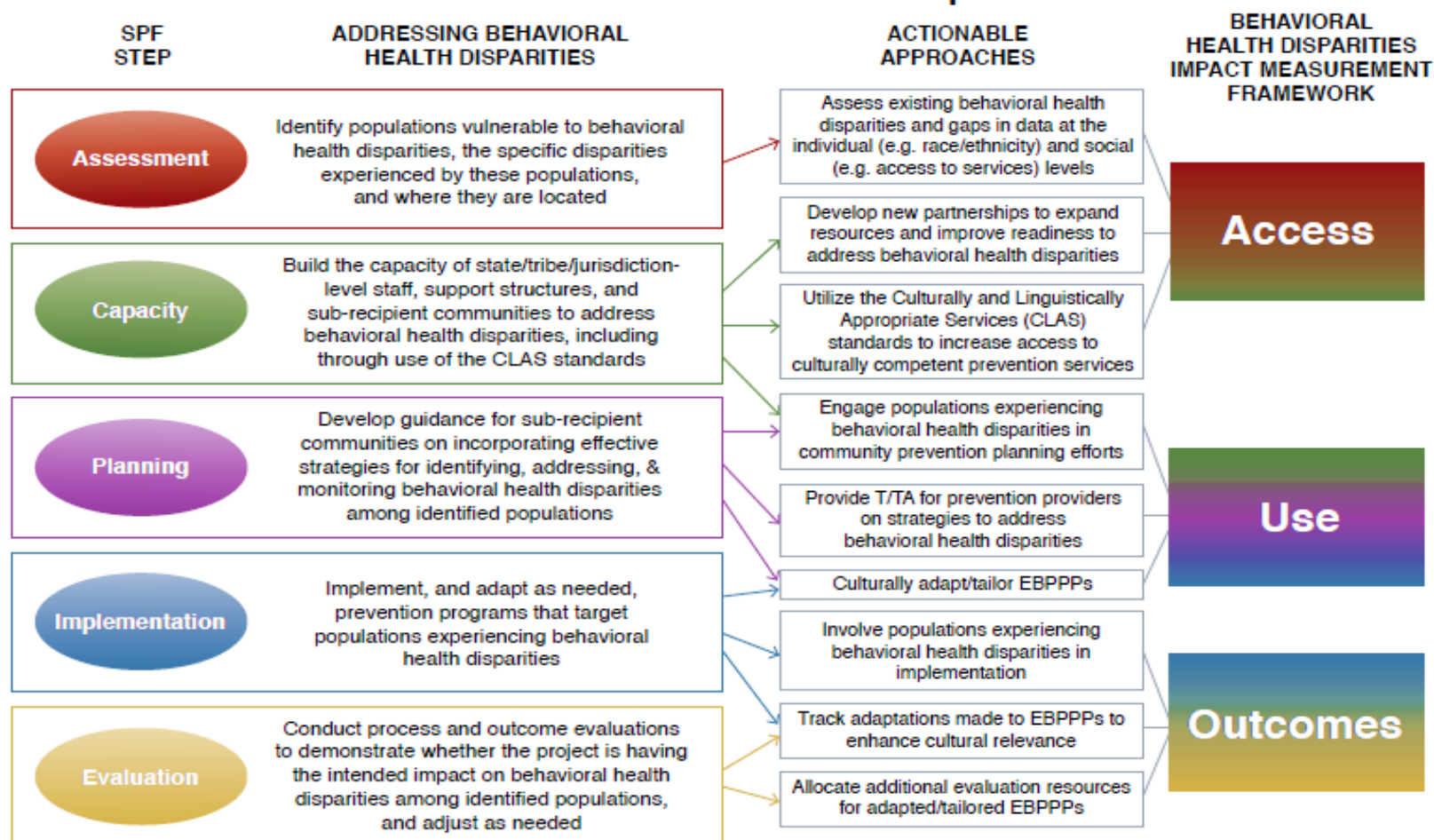
- Initial CLI-R data submission deadline. (For strategies implemented April 1, 2016 – September 30, 2016)
- CLI-R data reporting will take place every six months after initial submission
- A shorter, yet to be determined DPH-BSAS narrative report will also be required at minimum twice a year opposite the CLI-R reporting.

**APPENDIX 2: CAPT DECISION SUPPORT TOOL - *PRESCRIPTION DRUG MISUSE: UNDERSTANDING WHO IS AT INCREASED RISK***

(Link to document will be inserted, once final version is available.)

### APPENDIX 3: ADDRESSING HEALTH DISPARITIES IN THE SPF PROCESS

## Applying the Strategic Prevention Framework and HHS Disparity Impact Measurement Framework to Address Behavioral Health Disparities



*This document was developed under the Substance Abuse and Mental Health Services Administration's Center for the Application of Prevention Technologies task order. Reference #HHSS283201200024/HHSS28342002T.*



## Health Disparities Impact Statement

Coalition/Group Name: \_\_\_\_\_

**Assessment:** Assess existing behavioral health disparities and gaps in data at the individual (e.g., race/ethnicity) and social (e.g., access to services) levels.

Our coalition/group will:

**Capacity:** Develop new partnerships to expand resources and improve readiness to address behavioral health disparities.

Utilize the Culturally and Linguistically Appropriate Services (CLAS, see pages 66-68) standards to increase access to culturally competent prevention services.

Our coalition/group will:

**Strategic Planning:** Engage populations experiencing behavioral health disparities in community prevention planning efforts.

Provide training/technical assistance for coalition/group members on strategies to address behavioral health disparities.

Our coalition/group will:

**Implementation:** Culturally adapt/tailor evidence-based environmental strategies.

Involve populations experiencing behavioral health disparities in implementation.

Our coalition/group will:

**Evaluation:** Track adaptations made to evidence-based environmental strategies to enhance cultural relevance.

Allocate additional evaluation resources for adapted/tailored evidence-based environmental strategies.

Our coalition/group will:

New York Office of Alcoholism and Substance Abuse Services. September 2015.

*Prevention and Reduction of Non-Medical Use of Prescription Drugs Among High School-Age Youth in Massachusetts*

## APPENDIX 4: ARCHIVAL AND SURVEY DATA SOURCES FOR NMUPD – A COMMUNITY DATA CHECKLIST

Possible data sources related to NMUPD are listed below. The more information you can gather, the more comprehensive your needs assessment will be. However, if the data are unavailable or difficult to obtain, indicate that fact and move on to other questions or sources.

This checklist is not intended to be comprehensive or all-inclusive. It is a suggested plan of action, not a requirement. The data you gather should be based on your own priorities and customized to your local situation.

Distribute this checklist to members of your group and/or key members of the community, and request their assistance. Incorporate the data you collect into your strategic plan.

**Note:** The primary population of interest for the PFS 2015 initiative is **high school-age youth**. It may behoove communities to collect or retrieve ancillary data on younger age groups (e.g., middle school students) and organizations and systems that interact with these youth (e.g., parents, pediatric prescribers), but the investigation of data sources should be conducted with **high school-age youth** in mind and should strive to highlight data points relevant to this population.

### A. Demographics

1. *Population*  
Total by city/town
2. *Gender breakdown (by %)*  
Females  
Males
3. *Age breakdown (by %)*  
Children ages 0–11  
Youth ages 12–17  
Young adults ages 18–20  
Young adults ages 21–25  
Adults age 26 or older
4. *Race breakdown (by %)*  
American Indian or Alaska Native  
Black or African American  
White  
Asian  
Native Hawaiian or Other Pacific Islander

Multiracial

5. *Ethnic breakdown (by %)*  
Hispanic, Latino/Latina, or of Spanish origin  
Other relevant cultural groups (e.g., Cape Verdean)
6. *Primary language at home (by %)*  
English  
Spanish  
Other language
7. *Sexual identity and/or sexual orientation (by %)*  
Transgender  
Cisgender  
Heterosexual  
Gay or lesbian  
Bisexual  
Unsure/questioning
8. *Students with disabilities (by %)*
9. *Economically disadvantaged / high needs*
10. *Other demographic factors that may be related to NMUPD*

*Potential sources:* U.S. Census Bureau, [State & County QuickFacts](#) (select a “fact” [topic], then a state, county, city, or town for demographic data on that topic); [Massachusetts Student Information Management System](#); local school administrative data

## **B. Highway Safety Data—Past Year<sup>16</sup>**

Number of prescription drug-related traffic crashes

% of total traffic crashes

Number of prescription drug-related traffic injuries

% of total traffic injuries

*Potential sources:* Police department, [Fatality Analysis Reporting System](#), Massachusetts Department of Transportation

## **C. Access and Disposal—Past Year**

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<sup>16</sup> If trend data are available, it might also be helpful to know if the numbers are going up or down.

Number of prescribers in the community  
Number of pediatric prescribers in the community  
Number of dental prescribers in the community  
Number and percent of prescribers registered in the state Prescription Monitoring Program  
Number of pharmacies in the community  
Number and location of prescription drug disposal kiosks  
Number of prescription drug take-back events/days  
Statistics on drug return/take-back efforts (e.g., weight, volume, type)  
Total schedule II opioid prescriptions  
Total number of schedule II opioid solid dosage units  
Number and percent of individuals with schedule II opioid prescriptions  
Number and rate of individuals with activity of concern

*Potential sources:* Police department, [Mass. Drug Control Program](#), [Mass. Prescription Monitoring Program](#)

#### **D. School Data—Past Year**

*Middle school (grades – ):*

Number of prescription drug-related suspensions, expulsions, and other events

*High school (grades – ):*

Number of prescription drug-related suspensions, expulsions, and other events

*Potential sources:* Superintendent of schools, police department

#### **E. Other Criminal Justice Data—Past Year**

Number of prescription drug-related arrests (i.e., crimes in which prescription drugs are involved, such as forged or altered prescriptions, doctor shopping, health care fraud, and theft, sale, or possession of prescription drugs)

% of total arrests

*Potential sources:* Police department

#### **F. Injuries and Deaths Involving Prescription Drugs (except those involving motor vehicles)—Past Year**

Number of prescription drug-related emergency room admissions/EMS data

Number of fatal and non-fatal opioid overdoses

Number of naloxone administrations

Number of overdose calls to EMS

*Potential sources:* Local hospital emergency rooms, local fire department, EMS, police data, death certificate data from town clerk

### **G. Treatment—Past Year**

Number of admissions to BSAS treatment facilities

Number of beds for youth and young adults

Number of beds filled by youth and young adults

Number of prescription drug-related admissions

Number of youth on waiting list for admission or other indication of need

*Potential sources:* Local hospitals, local treatment centers; [MassCHIP](#)

### **H. Prevention Initiatives**

Number of substance abuse education and prevention programs for parents

Number of substance-free programs and activities for youth

Number of local substance abuse prevention organizations

Number of youth-led substance abuse prevention organizations

*Potential sources:* School health and wellness coordinators, state and community substance abuse prevention agencies

### **I. NMUPD Consumption, Attitudes, and Perceptions**

*Middle school (grades – ):*

Number and % of students who report NMUPD—lifetime, past year, and/or past 30 days (local)

Number and % of students who report NMUPD—lifetime, past year, and/or past 30 days (state)

Number and % of students who report parental disapproval of NMUPD (local)

Number and % of students who report parental disapproval of NMUPD (state)

Number and % of students who report peer disapproval of NMUPD (local)

Number and % of students who report peer disapproval of NMUPD (state)

Number and % of students who report moderate/great risk of NMUPD (local)

Number and % of students who report moderate/great risk of NMUPD (state)

Number and % of students who report talking to their parents about NMUPD (local)

Number and % of students who report talking to their parents about NMUPD (state)

*High school (grades – ):*

Number and % of students who report NMUPD—lifetime, past year, and/or past 30 days (local)

Number and % of students who report NMUPD—lifetime, past year, and/or past 30 days (state)

Number and % of students who report parental disapproval of NMUPD (local)

Number and % of students who report parental disapproval of NMUPD (state)

Number and % of students who report peer disapproval of NMUPD (local)

Number and % of students who report peer disapproval of NMUPD (state)

Number and % of students who report moderate/great risk of NMUPD (local)

Number and % of students who report moderate/great risk of NMUPD (state)

Number and % of students who report talking to their parents about NMUPD (local)

Number and % of students who report talking to their parents about NMUPD (state)

*Potential sources:* Youth risk behavior and use surveys, state and community substance abuse prevention agencies

## J. Parental Monitoring and Involvement—Past Year

*Middle school (grades – ):*

Number of students who report that parents care about their grades (local)

Number of students who report that parents care about their grades (state)

Number of students who report that parents ask about what they are studying (local)

Number of students who report that parents ask about what they are studying (state)

Number of parents who report that they talk with their child about school (local)

Number of parents who report that they talk with their child about school (state)

*High school (grades – ):*

Number of students who report that parents care about their grades (local)

Number of students who report that parents care about their grades (state)

Number of students who report that parents ask about what they are studying (local)

Number of students who report that parents ask about what they are studying (state)

Number of parents who report that they talk with their child about school (local)

Number of parents who report that they talk with their child about school (state)

*Potential sources:* Youth risk behavior surveys, parent surveys

**Note:** These data may be readily available in some states. For example, Rhode Island's [InfoWorks!](#), the state's education data reporting system, has gathered and posted student data since 2008.

## K. School Climate and Norms

*Middle school (grades – ):*

Number of teachers who teach life and social skills

Number of teachers who report use of guidance counselor as a resource for students

Number of teachers who work with counseling and/or health staff to help students obtain health and social services

*High school (grades – ):*

Number of teachers who teach life and social skills

Number of teachers who report use of guidance counselor as a resource for students

Number of teachers who work with counseling and/or health staff to help students obtain health and social services

*Potential sources:* Teacher surveys, school health and wellness coordinators, school guidance department.

## APPENDIX 5: CONDUCTING KEY STAKEHOLDER INTERVIEWS

This appendix provides information on how to conduct stakeholder interviews. A sample interview guide and summary sheet are also included. Note that the sample questions are generic in nature and should be adapted to the specific problem being targeted if a problem has been pre-defined (e.g., underage drinking, nonmedical use of prescription drugs).

### Pre-Interview Planning Process

Key stakeholder interviews involve identifying different members of your community who are especially knowledgeable about a topic (whom we call *key stakeholders*) and asking them questions about their experiences working or living within a community. It is typical to do 8–10 interviews and to seek out people with more than average knowledge to interview. These interviews are usually conducted face to face using either an outside interviewer specifically hired to conduct the interviews, or a member (or members) of your organization. Group members with the needed skill set can be recruited to conduct the interviews (and can train other members, which will help sustain this skill among your group). The length of these interviews can vary and will depend on the number of questions you decide to ask.

There are several factors to consider when deciding who will conduct the interviews, for example:

- **Time:** Interviews will need to be scheduled, conducted, written up, and analyzed. Preparation and follow-up activities can easily take up to twice the time of the interview itself.
- **Skills:** The interviewer must possess specific skills, such as the capacity to listen well, the ability to write and take accurate notes, a good memory, comfort with meeting new people, attention to detail, and strong communication skills.
- **Consistency:** It is best to have one or two people conduct interviews so that knowledge and experience about how best to frame questions is built up. Also, a limited number of interviewers greatly facilitates identification of themes, since only one or two people have heard all the information.
- **Cultural competency:** Interviewers should be individuals whom key stakeholders can relate to. This could mean the interviewer shares attributes with the stakeholder (e.g., race/ethnicity, gender, age) or that the interviewer is particularly familiar with the culture of the stakeholder.

The pre-interview planning process comprises three steps:

1. **Send a letter of introduction.** Once you have identified the key stakeholders in your community, send an official letter of introduction. The letter should include information about your coalition, provide background information on the substance misuse and abuse prevention initiative, briefly describe the needs and assets assessment that is being conducted, describe how key stakeholders were identified, briefly highlight what



sort of information you will request during the interview and how the information will be used, and inform them that they will be contacted by phone in the near future to set up the interview.

2. **Call to set up the interview.** After a reasonable amount of time has passed, call each key stakeholder to set up the interview. Introduce yourself and briefly review the information in your letter of introduction. Make an appointment to interview the stakeholder at a time and place that is convenient for him or her.
3. **Send the questions ahead of time.** Once the interview has been scheduled, send each key stakeholder a copy of the questions you plan to ask. This allows respondents adequate time to prepare their thoughts and to identify any relevant materials ahead of time.

## Conducting the Interview

**Begin by introducing your project and purpose.** Remind the respondent about your purpose and the ultimate use of the information. Explain who will have access to your interview notes and whether the respondents will be identified in any reports or public discussions of your investigation.

**Don't let the interview go much over an hour.** The people you choose as key stakeholders are likely to be busy, and the quality of the conversation can deteriorate if they feel rushed. Many of your respondents may be people whom you will want to collaborate with in the future, so do not antagonize them by letting the interview go on too long.

**Don't move to a new topic prematurely.** Do not leave important issues hanging—you might run out of time before you can return to them. Also, you will get more useful information by discussing one subject at a time.

**Don't get stuck on a question.** Sometimes you just won't get the information you want from a particular respondent. Know when to move on so you don't frustrate yourself or antagonize your respondent by trying to elicit information that he or she does not have, cannot articulate, or isn't willing to share.

**Use two interviewers.** While not always feasible, it can be useful to have two people at the interview—one to conduct the interview and one to take detailed notes. Primary interviewers will still need to take their own notes to help with summarizing the information at the end of the interview, but knowing that their partner is taking more detailed notes allows them to pay more attention to the interview process itself.

**Use active listening techniques.** Pay close attention to what the key stakeholder is telling you. Follow up on anything that is unclear or that you don't understand.

**Take notes.** As described above, whether a single interviewer or a team of two conducts the interviews, it is essential to take detailed notes. Do not rely on your memory of the conversation after the fact.

**Record the interview.** If possible, do this in addition to taking formal notes. Recording allows you the opportunity to go back and clarify any points of confusion from your notes. If you choose to record the interviews, you need to obtain permission from the key stakeholder at the beginning of the interview. It is also traditional when taping an interview to inform respondents that they have the option of going “off the record” at any time they wish—at which point the recorder should be turned off.

**End the interview by summarizing the key points.** Summarizing what was said is a good way to end the interview. This step is important because it gives you an opportunity to put what the stakeholder said into your own words. This also allows the stakeholder to correct any mistakes or to emphasize key points that you may have overlooked.

## Post-Interview

**Review your notes immediately after the interview.** This is the best time to clarify your notes and to add any additional information that was not possible to note during the interview, including information about the tenor of the interview, such as the degree to which the respondent was cooperative, how strongly he or she felt about issues discussed, and whether and why the interview may have been cut short. It’s also the best time to create a formal summary of the discussion based on your notes. As discussed above, analysis of the qualitative interview data should involve at least one other person who will rely on your notes.

**Follow up with a thank you.** Send a thank-you call or letter after each interview. This provides an additional opportunity to thank key stakeholders for their time and participation, and allows you a chance to follow up on any themes or pieces of information that were missed during the interview, or items that you found to be confusing when preparing your summary.

## Key Stakeholder Interviewer Guide

This guide is intended for the individual(s) conducting the key stakeholder interview and should not be distributed to the key stakeholders.

- Instructions to interviewers appear in brackets.
- All questions and probes should be answered (even if only by a “don’t know”). It is not necessary to continue with a probe if the respondent has already provided a response in his or her answer to the general question or to another probe.

- When selecting interview questions, keep in mind that open-ended questions are likely to elicit more thought and explanation, and therefore richer data, than closed-ended (“yes or no”) questions.
- Ask the questions/probes in the order shown.
- You may add questions, but do so only after Part VI. Be sure to ask the final question (“Do you have any other comments or observations you would like to make?”) before concluding the interview.
- Begin with introductions as needed.
- Explain that you will take notes and audio-record the interview. Discuss the respondent’s option of “going off the record.”
- Ask, “Do you have any questions about how the interview is going to work?” Answer all questions the respondent may have before proceeding to the questions below.

### Part I: Assessment of the Issue

**Question:** How would you describe the substance misuse and abuse situation in the community?

**Probes:** What is the severity of the issue? How has the issue changed over time? Which groups are most affected? [Get specific information about age, gender, and race] What are the consequences? When do the use and consequences occur (i.e., during what specific days of the week or times)? Where do the use and consequences occur? What are the factors that drive the problem?

**Note:** One thing you’ll want to determine from your interviews is whether specific groups of people or other factors stand out. Is there a particular impact on a group or subpopulation who may be vulnerable to health disparities (see sidebar)?

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

—Healthy People 2020, 2015 (¶ 5)

### Part II: Steps to Address the Issue

**Questions:** What has your organization done, if anything, to address substance misuse and abuse in the community? What do you think should be done to address substance misuse and abuse in the community?

**Probes:** How well have these efforts worked? Did you work with any other agencies or organizations in the community on this? [If so] Which organization(s), and how and how well did you work together?

### Part III: Readiness to Address the Issue

**Question:** What is your assessment of the level of readiness within your agency or organization to address substance misuse and abuse in the community?

**Probes:** What is the level of interest in the issue? What is the level of willingness to address the issue? What factors would facilitate this work (e.g., what resources are available)? What factors might undermine or complicate this work?

**Question:** What is your assessment of the level of readiness in the community at large to address substance misuse and abuse?

**Probes:** Who are the leaders or champions of this issue? What is the level of interest in the issue? What is the level of willingness to address the issue? What factors would facilitate this work (e.g., what resources are available)? What factors might undermine or complicate this work?

**Question:** What impact, if any, has the misuse and abuse of substances in the community had on the functioning of your agency or organization?

**Probes:** How much of a burden has this placed on your agency or organization? How has it made your job harder? [Note that this information may be useful in recruiting the respondent's support for your initiative]

#### **Part IV: Data on the Issue**

**Question:** What data are collected by your agency or organization, if any, that might help inform our assessment of substance misuse and abuse in the community or related factors?

**Probes:** How are the data collected? How often are the data collected? How recent are the data? Where are the current data gaps? Are there any problems with the data? How would we go about getting permission to access the data?

#### **Part V: Resources to Address the Issue**

**Questions:** What role, if any, would your agency or organization be willing to play in our efforts to reduce substance misuse and abuse in the community? What other individuals do you think we should talk to in order to obtain more information about substance misuse and abuse in the community?

**Probe:** Are there any other individuals in your agency or organization whom we should talk to?

## Key Stakeholder Interview Summary Form

Use this form to record information related to setting up an interview and to provide a summary of the information you gathered. If you contact someone and he or she does not want to participate, record that information at the top of the form.

Key Stakeholder Contact Information: \_\_\_\_\_

Name: \_\_\_\_\_

Organization and Address: \_\_\_\_\_

Phone, Fax, and E-mail: \_\_\_\_\_

Date Contacted: \_\_\_\_\_

Response? Yes / No

Interview Date(s), Time(s), and Location(s): \_\_\_\_\_

Interviewer: \_\_\_\_\_

Additionally, make note of the following:

- Why you conducted this research:

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- The general focus of your questions:

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**Note:** Please attach the actual questions you used.

- The themes that emerged:

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- Your conclusions—the big take-away messages:

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## APPENDIX 6: CONDUCTING FOCUS GROUPS

*Focus groups* are small, structured group discussions during which 8–10 respondents reply to open-ended questions in their own words. Focus group subjects (or participants) are chosen to represent the larger group of people about whom you want information—your target audience. Discussion typically focuses on one or two specific topics. Ideally, the moderator/facilitator will be someone with experience in facilitating focus groups.

### Developing Questions—Focus Group Protocol

**Develop a protocol.** A focus group needs a plan. Give some thought to what you want to learn from the group and the questions that will best elicit this information. Develop a written protocol that includes primary questions, potential follow-up questions (or probes), the order in which these questions should be asked, and introductory and closing statements.

**Rely on a small number of core questions.** Your protocol should include between 10 and 12 questions. When developing a protocol, imagine that each participant will respond to every question. Focus groups should not last more than 90 minutes.

**Use broad, open-ended questions.** Don't ask questions that call for a "yes" or "no" response, as they tend to end discussion and make it harder to learn why people believe what they do.

**Ask participants to speak from their own experience.** In general, it is more useful to have participants speak from their own experience than to ask them what other people do or think or to predict what they might do or think in the future.

**Start easy.** Start with a question that everyone should be able to answer and that doesn't require much disclosure. This will help get everyone talking and provide you with an indication of people's styles so you can better manage the group.

**End by asking if participants have anything to add to the discussion.** This may result in some incredibly useful information that you did not anticipate.

### Group Characteristics and Composition

**Focus groups are typically composed of 8–10 participants.** If the group gets much smaller, it can be difficult to sustain a lively and interesting discussion. If it gets much larger, people have less opportunity to participate, which often leads to disruptive side conversations among small clusters of two or three participants.

**The environment should be conducive to open discussion.** It is the job of the facilitator to create an environment that nurtures differences in points of view, protects participants, and does not pressure participants to reach consensus or vote on issues discussed.

**Typical focus group discussions last 60–90 minutes.** In addition, you should allocate another 30 minutes: 15 minutes at the beginning to check people in, orient them to the group, have them introduce themselves, and lay out the ground rules for the discussion, and 15 minutes at the end to debrief the discussion and allow participants to ask any questions they might have about the study and or how the information will be used.

**Participants should share characteristics that relate to the topic being investigated.** For example, you may convene a group of parents of middle school students, parents of high school students, teachers, 8th grade girls, 10th grade boys, or members of specific cultures that are highly prevalent in your community. You should not recruit participants who know little or nothing about the issues being discussed.

**Participants should be similar to one another (though not in their opinions about the topics being investigated).** The rule for selecting focus group participants is commonality, not diversity. You don't want to combine dissimilar people in focus groups—for example, don't put together people with high levels of education and people with low levels of education. People are more likely to reveal their opinions and beliefs and to talk about sensitive issues when they are with people they perceive to be like themselves, rather than those whom they perceive to be more knowledgeable than they are, wealthier than they are, or more influential than they are.

**Participants should be selected so that they are likely to represent the views and opinions of a defined population.** For example, focus group members might be chosen to represent all police officers or all school nurses in a community.

**Participants should be unfamiliar with one another.** This helps to ensure the validity of the data by encouraging participants to state their real opinions and views. When participants know one another, they (1) are often less likely to reveal highly personal or sensitive information, (2) are more likely to express views that conform to those of others in the group (especially others whom they perceive as having some power or influence outside the group), and (3) may respond to questions based on their past experiences with one another, which can confound the data.

## Locating and Recruiting Participants

**When recruiting participants, try to define the group as precisely as possible.** It usually makes sense to consider gender, age, occupation, geographic location, ethnicity, and language. Think about what you want, then think about how you might identify potential members who match

your needs, and then think about whether they are so diverse that you need to eliminate some or put some in a separate group.

**Try different strategies to find participants.** One way to reach potential focus group participants is to go where they are. For example, to recruit law enforcement officers, you might work with their unions. You might also put announcements in local newspapers and on public access cable stations or post notices in public places such as libraries, supermarkets, or public health clinics. Once you find potential participants, simple screening questions can help you decide whom to include.

**Convince people to participate.** Make an upbeat pitch. People may be more likely to participate if they believe that the project will benefit their community. Remind them that participating in the group gives them a chance to offer their opinions and experience to the project.

Also, make it easy. Schedule groups at a convenient time (one that will not interfere with, for example, the participants' jobs) and in a convenient place (one that is easy to reach by public transportation and has adequate parking). Consider offering food or childcare if that is feasible within your budget.

Here are some other things you might mention:

- The name of the agency or organization sponsoring the research or conducting the focus group
- The reason the focus group is being conducted
- How participants were selected
- What they will do in the group (for example, "If you agree to participate in the group, you will be asked to take part in a one-hour discussion about misuse and abuse of alcohol among youth. The discussion will include 8–10 other community members and 2 discussion leaders")
- Who is eligible to participate in the group
- How their confidentiality will be protected and how they will be expected to respect the confidentiality of the other participants
- When and where the focus group will take place, and how much time it will take
- (Optional) That a reminder letter will be sent to participants
- Your name and telephone number so they can call you if they have additional questions or discover they are unable to attend the group

**Do your best to ensure that participants attend.** Send a follow-up letter to each participant, and telephone them the day before the meeting. Recruit more subjects than you need (e.g.,



recruit 12 people with the hope that 10 show up). Sometimes offering a monetary incentive, such as a \$25 gift card per participant, is effective.

## Setting and Other Conditions

**Provide refreshments.** When possible, it is a good idea to serve light refreshments. Sometimes participants are served a meal and given a chance to socialize under the supervision of the group leaders before the focus group. The theory is that this increases their willingness to converse once the group convenes. If you do this, make sure that participants don't discuss the topic before the focus group officially begins—this pre-discussion tends to solidify their positions and to make the group discussion something of an anticlimax.

**Use a comfortable and private meeting space.** Don't hold focus groups in high-traffic areas. The surroundings should be comfortable and private so participants feel free to speak openly. For example, use a private conference room.

## Typical Opening Procedures

**Keep an attendance list, and collect demographic information if needed.** Keep a checklist of those expected to attend the group. If age, gender, or other demographic attributes are important for correlation with focus group findings, collect this information from participants. Design a short half-page form that requires no more than two or three minutes to complete, and administer it before the focus group begins. Questions to consider include age, gender, occupation, grade in school, school attended, and town of residence.

**Determine how to deal with late arrivals.** Generally it's best to dismiss people who arrive late because it is difficult to integrate them successfully into a group discussion that has already started.

**Obtain informed consent, if needed.** Generally, informed consent is not necessary, provided that the group comprises adults, the topic is not sensitive, and the questions do not focus on members' illegal or potentially embarrassing behavior. With minors, informed consent from a parent or guardian is always needed.

**Distribute name tags/cards (with first names only).** Another option is to have participants fill out their own name cards/tags (again, with their first name only).

## Conducting the Focus Group

**Use two facilitators—a primary and a secondary leader.** There is a lot to manage in a focus group, and while it is possible to have just one leader, two are better. One person (who is experienced with group process) should be primarily responsible for putting questions to the group and managing the group process. The second leader can assist in the discussion but

should mostly be responsible for taking detailed notes. Both leaders should take notes, but the assistant will have more time to keep careful notes. He or she should also be responsible for managing latecomers, housekeeping issues, etc.

**Read the opening remarks statement.** Begin the group by reading the opening remarks to all group members and having group members introduce themselves to one another. Consider articulating ground rules to the group, for example:

- We want you to do the talking.
- We would like everyone to participate. I may call on you if I have not heard from you in a while.
- There are no right or wrong answers. Every person's experiences and opinions are important. Speak up whether you agree or disagree. We want to hear a wide range of opinions.
- What is said in this room stays here. We want folks to feel comfortable sharing when sensitive issues come up.
- We will record the group because we want to capture everything you have to say, but we won't identify anyone by name in our report. You will remain anonymous.

**Follow your focus group protocol.** Ask the questions in the order specified in your protocol. Not following your plan can get confusing, both to you and to the participants.

**Invite and promote participation by all members.** At times it is necessary to ask participants who have not spoken to contribute. Use prompts, such as, "John, we haven't heard your opinions about this issue yet. What do you think?" But don't put people on the spot if they simply don't have anything to say.

**Wait for responses.** Give people time to think. Don't bias their answers by suggesting possible responses.

**Clarify responses using neutral probes.** For example: Can you explain further? Can you give us an example of what you mean? Is there anything you would like to add? Can you say more about that? I'm not sure I understand, can you help me out?

**Elicit and protect minority opinion.** Focus groups should help you understand the perspectives and experiences present in your target population, not just the perspectives and beliefs of the majority of that population.

**Do not state or show your opinion.** Avoid body language that reflects how you feel—especially nodding or shaking your head. Avoid approving or disapproving comments after people speak, such as saying "Good" or "Correct" or "Really?"

**Maintain order.** It is the leader’s job to cope with our “favorite” group members—the expert, the endless rambler, the shy participant, and the dominant talker. It is better to intervene with them a bit early than to let things go.

## Note Taking

**Consider using a “Focus Group Notes” form to assist you in taking notes.** Here are some other tips:

- Indicate individual responses or different points of view held by several members by beginning notes for each on a new line.
- Try to identify speakers so you can keep track of individual themes.
- Try to record the number of people holding various views.
- Try to record important comments verbatim.
- Review and summarize your notes immediately after the group ends.

**Consider recording the group.** If the adults present consent to recording, it may facilitate easier note taking. Please note that use of a tape recorder with youth may not be permitted. In any case, it is good to also take notes by hand in case there is a malfunction with recording technology.

## Debriefing

**Record your observations of the group process.** The two leaders should meet immediately after the group ends to share and record their views about the group. Consider the following issues:

- Were there any major departures from the protocol?
- Were there any unusual events? If so, how were they handled?
- Was there sufficient time to complete the protocol comfortably? If not, why not? What issues were cut short?
- Was the group fairly unified in its views, or was there diversity of opinion? If there was diversity, did it seem associated with particular types of participants, such as males vs. females?
- Were there any major disagreements in the group? If so, what were they?
- What was the group process like—were people bored, restless, excited, angry, silent, confused?
- What, if anything, should be changed for the next group?

## Focus Group Analysis and Reporting<sup>17</sup>

**Transcribe the recording.** After each focus group, transcribe the tape and insert notes as needed. Clean up transcripts by stripping off nonessential words. Assign each participant comment a separate line on the page. Label each line with a participant ID number (e.g., 1, 2, 3 . . .).

**Compile your results.** Use different-colored highlighters (ideally, five or six different colors) to identify recurrent themes, which will make compilation and analysis easier. Create a database in Excel, or use a table format (if no one is proficient in Excel). Here are some guidelines:

- Use a separate spreadsheet or table for each focus group
- Within each spreadsheet, use one sheet per question
- Make three columns and label them Coding, Participant ID, and Responses
- Fill in Participant ID and Responses for each question (coding will be done in analysis)

**Analyze your results.** Once all the comments have been entered, look for common categories or themes across responses for each question. One thing you'll want to determine is whether specific groups of people or other factors stand out. Is there a particular impact on a group or subpopulation who may be vulnerable to health disparities (see sidebar)?

### Health disparities

Healthy People 2020 (HealthyPeople.gov, 2015) defines a *health disparity* as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion” (¶ 5).

It is ideal to have several people participate in this process. Once consensus has been achieved regarding the best categories for organizing the data, assign a number or letter to each category. (See the example in the table below.) Repeat this process for each question in each focus group.

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<sup>17</sup> This section was adapted from Rhode Island State Epidemiology and Outcomes Workgroup, Buka, and Rosenthal (2015).

### Sample Analysis Table

Focus Group 1: Youth		
Question 3: What are the main reasons, do you think, that kids drink alcohol?		
Category Code*	Participant ID	Responses
B	4	"Some kids are just bored"
A	3	"Usually they are just trying to be cool"
C	1	"They might feel sad or depressed"
A	4	"Everyone does it"
B	2	"It's fun"
C	6	"They want to escape their problems"
A	5	"They want to fit in"
D	4	"Their parents are okay with it"
B	2	"It feels good"

\* A – Peer influence, B – Enhancement, C – Coping, D – Parental influence

**Note:** The “sort” function in Excel can be used to group entries by category. If some entries seem inconsistent for their category, consider re-categorizing them or adding another category. It may also become apparent that one or more categories can be collapsed.

**Synthesize your results.** Identify category heading titles. Write a short paragraph summarizing findings for each category, possibly noting similarities and differences across groups. Add powerful quotes to each section.

## APPENDIX 7: TIPS FOR EXAMINING DATA



Substance Abuse Prevention Skills Training (SAPST)  
SESSION 2

### INFORMATION SHEET 2.6

## Tips for Examining Data

### Comparisons

Comparing your data to other existing data provides a context for understanding your assessment results. For example, survey data from a high school may seem, at a glance, to reveal high smoking rates among 9th graders. However, a comparison of these data to statewide data might actually show that your school's smoking rates are much lower than the statewide average.

When examining data, it's useful to make comparisons in some of the following ways:

- Between the community now and sometime in the past
- Between the community and the state (or similar communities)
- Among different population groups in the community, including different age groups and genders

For example, you can look at data from an indicator such as 30-day alcohol use and draw comparisons in different ways. For instance, you can compare it to the past and discover that your community has a lower or higher rate than it did previously. Or when comparing it to the state, you might discover that your community has a lower or higher rate than your state. When you compare population groups, you may notice whether there is a higher rate among males than females, or a lower rate among 14-year-olds than among 17-year-olds.

When looking at data and making comparisons, be careful using small numbers to calculate rates—they may cause rates to appear exaggerated.

**Rates** – In epidemiology, rates are a measure of the frequency with which a health event occurs in a specific population over a period of time. Rates are used to standardize data in order to be able to compare it across different population sizes.

For example, a town with a population of 30,000 has 500 arrests in a given year for driving under the influence (DUIs). Divide 500 by 30,000 to get a rate of .017 arrests per person per year. To make the rate easier to understand, multiply by 1,000—now you can say that the rate of DUIs for the town is 17 per 1,000 people per year.

The following calculation provides a rate per 1,000 people per time period:

$$\text{Rate} = \frac{\text{Number of cases}}{\text{Population over time period}} \times 1,000$$

Source: SAMHSA'S CAPT (2012).



For national data sources or larger population sizes, the rate is often calculated with 10,000 or 100,000 population size. You can multiply by whatever size makes sense for your community.

**Small numbers** – When rates or percentages are calculated using small numbers, they may appear more exaggerated. For example, a 100% increase in motor vehicle accidents from 2003 to 2006 in Smithtown would sound like a lot of accidents. However, what if there had been one motor vehicle accident in 2003 and two in 2006? Although, still a 100% increase, the severity is greatly diminished.

Small numbers can sometimes be misleading, as this example illustrates, when they are used to calculate percentages. A small number as a percentage may lead us to believe that there has been a significant increase, but when we look at the actual numbers we see that the increase is very small.

Low, or even very low, percentages of some behaviors may be significant, however, and should not be dismissed as unimportant, especially if the behavior has severe consequences.

### Things to Remember

- **Examine different kinds of data** – Substance use and other behavioral health problems are complex, so understanding them requires looking at different kinds of data, both quantitative and qualitative, to get an accurate and complete picture of the problems.
- **Look for relationships and patterns** – Numbers alone have no meaning, so look for patterns over time, as well as relationships between data.
- **Notice any data gaps** – After determining what data exists, you may discover “gaps” in the data or that you need additional data to answer certain assessment questions.
- **Be aware that not all data are equal** – Some data are more valid and available than others. You may need to use qualitative data to fill in some of your data gaps. Keep in mind that these data are less objective.

**Comparison** is one of the criteria to consider when determining which problem(s) to address. Other criteria can include:

**Magnitude** – Which problem seems to be the largest? (Be careful of small numbers.)

**Time trend** – Is the problem getting worse over time or is it getting better over time?

**Severity** – What is the severity of the problem? Is it resulting in mortality? Is it more costly?

***Make sure you collect data on these criteria.***

## APPENDIX 8: RISK AND PROTECTIVE FACTOR DATA ORGANIZER

This tool allows you to organize and compare the data you gather, which can then help you prioritize them. Fill in the table with the risk or protective factors that are relevant in your community. (An example of a completed table appears on page 34.)<sup>18</sup>

Risk or Protective Factor	Mentioned During Key Stakeholder Surveys or Focus Groups			Supported by Quantitative Data?	
	<i>Frequently</i>	<i>Occasionally</i>	<i>Infrequently or Not at All</i>	<i>Yes</i>	<i>No or N/A</i>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other comments from qualitative data collection:					

### Notes:

- A response of **Frequently** means that the risk or protective factor was mentioned by half or more of the participants; **Occasionally** means fewer than half but more than one-quarter; **Infrequently or Not at All** means fewer than one-quarter or no mention at all.
- A response of **Yes** to “Supported by Quantitative Data” means that data related to the risk or protective factor are being experienced or are strongly influencing conditions in the community. **No or N/A** means that either data were unavailable, or there is no clear indication that the risk or protective factor is a strong influencer of conditions in the community, or that the analysis is not applicable to your community.

<sup>18</sup> Adapted from Rhode Island State Epidemiology and Outcomes Workgroup, Buka, and Rosenthal (2015).



## APPENDIX 9: STRATEGIES FOR WORKING WITH THE MEDIA

### Tip Sheet: Strategies for Working with the Media

In 2013, an estimated 17.3 million people reported being dependent on or abusing alcohol,<sup>i</sup> and approximately 7 million said they had been dependent on or abused illicit drugs<sup>ii</sup> within the previous year. Interest in how we prevent substance misuse, addiction, and overdoses is growing, with media outlets paying attention, and devoting more column inches and airtime to discussing these topics.

For their part in the substance abuse prevention effort, the media wants to understand why these issues are occurring in their communities, and they want to offer readers, listeners, and viewers solutions for resolving these growing problems. To obtain the information they need—on emerging trends, troubling consequences, and/or current prevention efforts—media representatives frequently turn to recognized prevention leaders and practitioners.

As a prevention provider, understanding how to handle the media effectively is essential. Media outlets can be important partners in your prevention efforts, so you will want to nurture these relationships at every opportunity. Good media engagement helps to ensure that prevention efforts are represented accurately and communicated broadly. Poor engagement can lead to confusion and misinformation, and potentially a lack of faith in the prevention process.

This tip sheet offers key steps to consider before the media calls, when they call, and during the interview.

#### Before the Media Calls<sup>iii</sup>

- ✓ **Identify your spokesperson.** Know the person in your organization—usually a leader or expert in a specific area—who will be the person to answer the media’s questions in person, by phone, by email, or even on camera. Then make sure that everyone knows who this person is.
- ✓ **Be prepared.** Preparation is important for managing media questions. Well before the media calls, determine the five easiest, harder, and toughest questions you are likely to be asked, then determine in advance how you would answer them, and practice delivering your answers.

#### Easy, Harder, and Tough Question

- **Easy:** What kind of prevention services do you provide the community?
- **Harder:** What more could parents be doing to prevent their children from abusing substances?
- **Tough:** Why are more people using—and dying from—opioids?

Developed under the Substance Abuse and Mental Health Services Administration’s Center for the Application of Prevention Technologies task order. Reference #HHSS2832012000241/HHSS28342002T. For training use only.

- ✓ **Build relationships with the media now.** Get to know the media outlets and reporters in your community who cover stories related to health and substance use issues. Introduce your organization as a story resource *before* a problem occurs and reporters want answers *now*. Develop and submit letters to the editor and op-eds as a way to position your organization as an expert in those areas; this will help you proactively gain media exposure for your prevention work.
- ✓ **Develop a media policy.** Create a play-by-play guidebook for how your organization will respond to and manage media requests—and let people know it exists! As part of your media policy, indicate which staff member should receive and assess media inquiries (i.e., your spokesperson). Also specify the types of questions and/or interview situations in which your organization might refuse to engage with media (e.g., film crews recording client activities that could compromise client confidentiality; not interviewing youth or young adults). Having a clear and transparent policy in place will help staff know how to respond, and let the media know what to expect. If your prevention agency has a fiscal agent, or is part of a larger organization, make sure that your own policies are consistent with those of the parent organization.

### When the Media Calls<sup>iv</sup>

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- ✓ **Research the media outlet and reporter before granting an interview.** When your organization receives a media inquiry, try to learn as much about the media outlet and the reporter’s background, interest, and story angle before connecting the media with your spokesperson for an interview. Here are some questions to consider:
  - What prompted the media to call your organization?
  - What is the media interested in knowing?
  - What specific subject areas will the interview cover?
  - Is the media willing to share the interview questions in advance?
  - With whom do the media want to speak? Leadership? Other stakeholders?
  - Where will the story appear?
  - When will the story run or be posted?
  - When is the reporter’s story deadline?
  - How will the interview be conducted—by phone, email, or in person?
  - Will the interview be recorded?
  - How long will the interview last?



Developed under the Substance Abuse and Mental Health Services Administration’s Center for the Application of Prevention Technologies task order. Reference #HHSS283201200024/HHSS28342002T. For training use only. <sup>2</sup>

- ✓ **Assess the media inquiry.** While it's important to be responsive when the media calls, it's also important to take a moment when you receive the inquiry to assess what you know about the request and determine how best to respond. Doing so will allow you to respond in a thoughtful way and help you avoid falling back on "no comment."
- ✓ **Prepare your spokesperson.** Before your spokesperson sits down with a reporter, share with him or her everything you know about the media outlet, the media request, key talking points, and potential questions and answers. Depending on the type of interview, this prep session can take anywhere from 10 minutes to an hour.

### During the Media Interview<sup>v</sup>

- ✓ **Stay on message.** Regardless of what the reporter asks or how forceful he or she may be, control the interview by reiterating your key messages. Use transitions such as "The real issue is," "And just as important is," or "Let me explain" to bring you back to your talking points.
- ✓ **Reference the best resources for the story.** Your organization may be the best source for the story—or it may not. If your organization does not know an answer to a question, or is not the best resource, let the reporter know. Correct any misinformation quickly during or immediately after the interview.
- ✓ **Recommend additional interview subjects.** They may be able to provide additional context or a different perspective on the story. But before handing over their contact information, make sure to get their permission to do so, and share any information you've collected on the outlet, reporter, and request. This will help to ensure that your expert is both willing and prepared for the interview.
- ✓ **Frame your responses as "sound bites."** Anything you say or write could show up in an article, so keep your responses in "sound bite" format: be brief, clear, and only respond to what is asked. Sound bites are a product that originated with TV and radio news media, where the

#### Interview Transition Ideas

Transitions are easy-to-use phrases to bring you back to your talking points:

- The real issue is ...
- And just as important is ...
- Let me explain ...
- And equally important ...
- It's important to tell your viewers (readers, listeners) ...
- You know, I think it's equally important to know ...
- I'm also frequently asked ...
- Let me add ...
- Another question I'm asked is ...
- We might be overlooking ...
- A common concern is ...
- You can go a step further ...
- For instance ...
- I'm proud to be able to tell you ...
- For example ...
- Let me give you the facts ...
- You should also know that ...

Developed under the Substance Abuse and Mental Health Services Administration's Center for the Application of Prevention Technologies task order. Reference #HHSS2832012000241/HHSS28342002T. For training use only. <sup>3</sup>

day's news had to be compressed into short segments that were strung together to provide a brief overview of the day's events. Today, sound bites are expected everywhere, from articles to tweets, and the spokesperson who can convey a message in a lively sentence or two is more likely to be quoted than someone who rambles. Here are some tips for providing sound bites:

- *Avoid exaggerations.* Give specific examples of success stories or relevant case studies.
- *Use analogies.* The more relatable the better, especially on such complex issues as substance abuse prevention.
- *Use absolutes when you are sure of them.* Reporters and editors love “the best,” “the first,” “the only,” and “the greatest,” but only if you can back up the claim with facts.
- *Where appropriate, use proportions or approximations (e.g., about one-quarter, nearly a thousand).* If a reporter needs the exact number, he or she will ask. Be familiar with—and mention—your data sources, too.
- *Quote your opposition, especially if they agree with you.* Your supporters will always be on your side. If your enemy agrees with you, you’ve got a story.
- *Include a second-person perspective.* Let the reader or viewer know what will happen to her or him. Explain how the prevention issue or message touches the reader or viewer personally.<sup>vi</sup>

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<sup>i</sup> SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013.

<sup>ii</sup> Ibid.

<sup>iii</sup> Excerpted from a spokesperson training developed by Vanguard Communications, 2015.

<sup>iv</sup> Ibid.

<sup>v</sup> Ibid.

<sup>vi</sup> Excerpted from a persuasive storytelling training developed by Vanguard Communications, 2013.



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For training use only.

## APPENDIX 10: EFFECTIVE MESSAGING FOR SUBSTANCE ABUSE PREVENTION

### SAMHSA's Center for the Application of Prevention Technologies The Do's and Don'ts of Effective Messaging for Substance Abuse Prevention

This tip sheet provides general guidance on the design and delivery of consistent and effective messaging for substance abuse prevention. Please note that all public health messages should be tailored and tested with intended audiences prior to distribution and promotion.

#### The Do's

- ✓ Do frame the conversation as a health issue. Talking about substance use as a health issue puts it in a context that our society has learned to view positively and openly. Just like annual check-ups and cancer screenings, substance abuse prevention should become part of an individual's list of overall health concerns and health-promoting activities.<sup>1</sup>
- ✓ Do use realistic, real-life examples. Rather than emphasizing what COULD happen to a person who misuses or abuses substances, provide examples and stories from individuals who HAVE abused substances, resulting in life-altering effects.<sup>11</sup>
- ✓ Do help individuals identify potential consequences. Though the consequences of substance use are well-known, it can be difficult for an individual to relate to broad, general concepts. It is more effective to talk about how substance abuse might specifically affect an individual's personal, daily life.<sup>11</sup>
- ✓ Do engage peers as messengers. Individuals—both young and adult—respond best to individuals with whom they can relate. First-person accounts or stories of use and abuse by peers can often engage individuals who may be resistant to more general prevention messages.<sup>16,17</sup>
- ✓ Do de-glamorize substance use. Drug use is often seen as a recreation of the young and beautiful—particularly the celebrity set. For youth, in particular, messaging should emphasize the outward effects of drug use, including damage to teeth, breath, and skin.<sup>14</sup>

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- ✓ **Do emphasize safe use and disposal of prescription medication.** Those who misuse and become addicted to opioids often obtain them from family, friends, employers, and other sources where prescription medication was left unsecured.<sup>vii</sup>

## The Don'ts

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- ✓ **Don't lecture, guilt, or shame.** Particularly in youth culture, using substances is often viewed as part of becoming an independent adult. Framing substance use avoidance simply as an unbreakable rule can cause individuals to seek it as a form of rebellion.<sup>viii</sup>
- ✓ **Don't encourage sensation-seeking.** Recounting days of college experimentation without explaining the negative consequences can encourage youth to conclude that using drugs is survivable and a normal part of growing up.<sup>ix</sup>
- ✓ **Don't use scare tactics.** Scare tactics challenge some to prove that their authority figures are wrong. Individuals who believe a presentation is exaggerated or untrue may ignore the meaning of the message.<sup>ii</sup>
- ✓ **Don't illustrate or dramatize drug use.** Such depictions may encourage and/or inadvertently teach people ways to prepare, obtain, or ingest illegal substances.<sup>x</sup>

## Messages from Drug Prevention Campaigns and Champions

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“Drug addiction is treatable. Like diabetes, asthma, and heart disease, drug addiction is a chronic disease that can be managed successfully. Relapse is not a sign of treatment failure, but rather an indication that treatment should be reinstated or adjusted to help addicted individuals fully recover.”

—*National Institute on Drug Abuse*

“Two-thirds of teens who report abuse of prescription medicine are getting them from family, friends, and acquaintances. Make sure the teens in your life don't have access to your medicine. Find out how to monitor, secure, and properly dispose of unused and expired prescription and over-the-counter cough medicine in your home.”

—*Kentucky Office of Drug Control Policy*



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“Talk to your kids. Talking about the dangers of substance use and showing disapproval of such behavior are key factors in preventing drug and alcohol use. Talk in your home, during meals, in the car, at the game. Always keep the lines of communication open.”

—*New York State Office of Alcoholism and Substance Abuse Services*

“In Ohio, since 2007, there have been more deaths from drug overdose than from motor vehicle traffic crashes.”

—*Prescription for Prevention, Ohio*

“Record and understand prescription information, and rely on the experts, pharmacists, and doctors, for help. Safely acquire medication, whether buying your prescription at the neighborhood pharmacy or an online pharmacy. Appropriately use and administer medications. Find a secure storage spot, and dispose of unneeded medications. Educate family and friends on abuse and misuse dangers.”

—*National Association of Boards of Pharmacy*

“You might hear teens (and even some parents) say that alcohol and marijuana aren’t ‘that bad’ or ‘OK in moderation.’ However, substances like alcohol and marijuana are especially dangerous for teen brains, which are still growing and developing until about age 25.”

—*Reality Check, Cambridge Prevention Coalition*

“Inhalants are gases and vapors from products used in homes, offices, and schools that are inhaled. Because they get into your lungs and blood so quickly and because they are toxic and pollutants, they can damage all parts of your body. When people use inhalants like drugs, they are really poisoning themselves.”

—*Massachusetts Department of Public Health, Bureau of Substance Abuse Services*

“Always remember these skills to give you the strength to confidently choose not to use drugs or alcohol: THINK through every situation and then make the best possible decision. CLARIFY the decision to be made or the problem to be solved. CONSIDER the alternatives and the likely outcome of your selection. CHOOSE the best alternative and take action. ANTICIPATE how you will react to risky situations. STAY AWAY from situations that you know may be risky. WALK AWAY from risky or dangerous situations. Remember, you are in control of your future.”

—*OxyContin: The Facts, Massachusetts Department of Public Health, Bureau of Substance Abuse Services*



Developed under the Substance Abuse and Mental Health Services Administration’s Center for the Application of Prevention Technologies task order. Reference #HHSS283201200024I/HHSS28342002T.

For examples of prevention campaigns and messages developed by states, jurisdictions, and national organizations, see the CAPT resource [Statewide Prescription Drug Misuse and Abuse Prevention and Education Campaigns: Selected Examples](#)

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<sup>i</sup>Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science*, 278(5335): 45-47.

<sup>ii</sup>Fishbein, M., Hall-Jamieson, K., Zimmer, E., von Haeften, I., & Nabi, R. (2002). Avoiding the boomerang: Testing the relative effectiveness of antidrug public service announcements before a national campaign. *American Journal of Public Health*, 92(2), 238–245.

<sup>iii</sup>Katz, E. C., Fromme, K., & D’Amico, E. J. (2000). Effects of outcome expectancies and personality on young adults’ illicit drug use, heavy drinking, and risk sexual behavior. *Cognitive Therapy and Research*, 24(1), 1–22.

<sup>iv</sup>Valente, T. W., Ritt-Olson, A., Stacy, A., Unger, J. B., Okamoto, J., & Sussman, S. (2007). Peer acceleration: Effects of a social network tailored substance abuse prevention program among high-risk adolescents. *Addiction*, 102(11), 1804–1815.

<sup>v</sup>Miller-Day, M., & Hecht, M. L. (2013). Narrative means to preventative ends: A narrative engagement framework for designing prevention interventions. *Health Communication*, 28(7), 657–670.

<sup>vi</sup>Coyne, S. M., Callister, M., & Phillips, J. C. (2011). Getting boozy in books: Substance use in adolescent literature. *Health Communication*, 26(6), 512–515.

<sup>vii</sup>National Association of Boards of Pharmacy. (2015). Abuse and Misuse Dangers. Retrieved from [AwareRx.org](http://www.awarerx.org/get-informed/abuse-misuse-dangers). <http://www.awarerx.org/get-informed/abuse-misuse-dangers>.

<sup>viii</sup>Cho, H., & Franklin, J. B. (2008). Effects of gain versus loss frame antidrug ads on adolescents. *Journal of Health Communication*, 58(3), 428–446.

<sup>ix</sup>Greene, K., Krcmar, M., Walters, L. H., Rubin, D. L., & Hale, J. L. (2000). Targeting adolescent risk-taking behaviors: The contribution of egocentrism and sensation-seeking. *Journal of Adolescence*, 23(4), 439–461.

<sup>x</sup>Weinstein, A., Lingford-Hughes, A., Martinez-Raga, J., & Marshall, J. (1998). What makes alcohol-dependent individuals early in abstinence crave for alcohol: Exposure to the drink, images of drinking, or remembrance of drinks past? *Alcoholism: Clinical and Experimental Research*, 22(6), 1376–1381.



Developed under the Substance Abuse and Mental Health Services Administration’s Center for the Application of Prevention Technologies task order. Reference #HHSS283201200024/HHSS28342002T.



## APPENDIX 11: CAPACITY BUILDING PLAN - EXAMPLE AND TEMPLATE

### Example

Area of Growth/ Capacity Need	How It Will Be Addressed	Who Is Responsible	Timeline	Measure of Success
<ul style="list-style-type: none"> <li>We need to have a representative from Prevention Inc. participate in the needs assessment process, since that group works with one of the populations at risk for substance misuse and abuse in our community and could give us important input.</li> </ul>	<ul style="list-style-type: none"> <li>We will meet with Betty Leader, the director of Prevention Inc., to discuss the project and identify ways that Prevention Inc. might participate. Betty Leader and/or other staff will also be invited to future project meetings.</li> </ul>	<ul style="list-style-type: none"> <li>Jane Smith will contact Betty to set up a meeting. Other members who will attend include J. Jones and A. Black from our group, both of whom already work with Jane on other projects. A TA provider from MassTAPP will also attend.</li> </ul>	<ul style="list-style-type: none"> <li>Jane will contact Betty by July 9 and schedule the meeting for the week of July 14</li> </ul>	<ul style="list-style-type: none"> <li>Betty or another representative from Prevention Inc. becomes an active participant in our needs assessment process.</li> </ul>

## Template

Area of Growth/ Capacity Need	How It Will Be Addressed	Who Is Responsible	Timeline	Measure of Success

## **APPENDIX 12: PFS 2015 STRATEGIC PLAN DEVELOPMENT GUIDE**

This template outlines the sections and content of the strategic plan that must be submitted to BSAS no later than **July 1, 2016**. Please note that this plan covers state fiscal year 2017 (July 1, 2016 – June 30, 2017) when you move to full implementation upon approval of the plan by BSAS.

The strategic plan **must not exceed 45 pages**, including the information and tables outlined in this document. However, this total does not include any supporting materials or appendices that you choose to submit.

A draft of this plan must be submitted to your MasTAPP TA provider for review no later than **June 17, 2016**, prior to the final submission to BSAS on **July 1, 2016**.

### **Statement of Grant Intent**

The PFS 2015 initiative is intended to prevent nonmedical use of prescription drugs (NMUPD) among high school-age youth across the Commonwealth. PFS 2015 grant recipients are required to place the majority of their focus on the prevention/reduction of NMUPD among high school-age youth through the implementation or amendment of local policies, practices, systems, and environmental change. The *primary* target population is high school-age youth – which can be reached both in and/or outside of the school setting. *Secondary* target populations (e.g., parents, prescribers, etc.) can be served provided that the effects of any services delivered to these groups are likely to have an impact on past 30-day use of prescription drugs among high school-aged youth in the community. This is not strictly an opioid grant. It can be any type of prescription drug (pain relievers, stimulants, tranquilizers, sedatives). A sub-set of programming can target misuse of over-the-counter medication if this emerges as a local issue and is related (based on the data) to prescription drug misuse/abuse rates.

### **Overview/Abstract**

**Note:** The overview/abstract may not exceed one page.

Please provide a one-page summary of your plan that includes the following:

A brief description of your community (including any demographic information, or other information related to cultural or environmental factors, that is relevant to the issue)

The intervening variable(s) you are targeting related to NMUPD among high school-age youth

The strategies you will implement related to the prevention/reduction of NMUPD among high school-age youth

## Step 1: Assessment

### 1.1. Assessment Data on NMUPD among High School-age Youth

Briefly describe the process you used to collect data on the nature and extent of NMUPD among high school-age youth within your community:

What data sources and techniques for data collection did you use (e.g., school discipline reports, surveys, focus groups, key stakeholder interviews)?

Include numbers/rates/percentages demonstrating your best source(s) of evidence related to what NMUPD among high school-age youth looks like in your community.

**Health Disparities Statement.** Are any subpopulations of youth disproportionately affected by NMUPD in your community? If so, please list these populations and refer to the data/evidence that were used to determine this. **Note:** An examination of health disparities is a priority for the PFS 2015 initiative. Reviewers will be looking for evidence that the assessment considered differences in consumption patterns or consequences among sub-groups<sup>19</sup>.

Note any gaps in the available data on NMUPD among high school-age youth that may limit your understanding of the issue, and how you plan to address these gaps moving forward.

How are you integrating cultural competence and sustainability into this step of the SPF process (e.g., how will data collection be sustained, how often do you plan to re-assess, what is in place to guarantee ongoing access to data, what are the established baselines that all future data will be measured against)?

Add any additional information that you think would help the reader understand how the assessment of NMUPD among high school-age youth data was conducted.

### 1.2. Problem Statement Related to NMUPD

Based on your understanding of NMUPD consumption patterns among high school-age youth in your community, please list the problem statement(s) that your group *selected* to address within your strategic plan. If you considered multiple problems, please identify how you selected (prioritized) among the larger list of problem statements.

### 1.3. Assessing Intervening Variables linked to NMUPD Among High School-age Youth

Briefly describe the process you used to collect data on intervening variables as they relate to NMUPD among high school-age youth:

What data sources and techniques for data collection did you use (e.g., school discipline reports, surveys, focus groups, key stakeholder interviews)?

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<sup>19</sup> Healthy People 2020 defines health disparity as a *particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.*

List all intervening variables related to NMUPD that you investigated, including data (qualitative and/or quantitative) on each variable and the source(s) of evidence.

Note any gaps in the available data on intervening variables related to NMUPD among high school-age youth that may limit your understanding of the issue, and how you plan to address these gaps moving forward.

Add any additional information that you think would help the reader understand how the assessment of the data on intervening variables related to NMUPD among high school-age youth was conducted.

#### ***1.4. Technical Assistance Needs Related to Assessment***

What assistance, if any, do you anticipate needing from MassTAPP, BSAS, or others in the area of assessment once your strategic plan has been approved and you move into the implementation phase?

### **Step 2: Capacity Building**

#### ***2.1. Community and Key Stakeholder Involvement***

Please list the key sectors (e.g., municipal government, education, prevention, treatment, health care, law enforcement, social service) that are actively engaged with you on PFS 2015.

Describe how, if at all, you intend to collaborate with local schools located in your community.

Please explain how members of the general community will be engaged in PFS 2015.

Please describe how you will engage key stakeholders and other individuals from sectors not yet represented.

#### ***2.2. Structure and Functioning***

Please provide an organizational chart of the governing structure of the PFS 2015 project within your community, including any subgroups.

How are the representatives of each key sector functioning as a team?

What is the decision-making process in your group?

What challenges have you encountered so far related to the functioning of your team, and what are you doing to overcome these challenges?

#### ***2.3. Core Planning Committee***

Please list the membership of the core planning committee responsible for guiding the PFS 2015 strategic planning process.

What challenges have you encountered so far related to the functioning of your core planning committee, and what are you doing to overcome these challenges?

#### ***2.4. Capacity-Building Needs Related to NMUPD Among High School-age Youth***

Describe the existing strengths within your community to address NMUPD among high school-age youth.

Describe areas of growth that will need to be addressed in order for you to more effectively address the issue of NMUPD among high school-age youth.

Include a capacity-building action plan to address your identified areas of growth/capacity need that includes the following information:

Area of Growth/ Capacity Need	How It Will Be Addressed	Who Is Responsible	Timeline	Measure of Success

How are you integrating cultural competence and sustainability into this step of the SPF process?

### 2.5. Technical Assistance Needs Related to Capacity

What assistance, if any, do you anticipate needing from MasTAPP, BSAS, or others in the area of capacity building once your strategic plan has been approved and you move into the implementation phase?

## Step 3: Strategic Planning

### 3.1. Planning Process

Briefly describe the process that was followed to develop this plan, including who was involved.

### 3.2. Planning to Address NMUPD Among High School-age Youth

Please describe the following related to your plan for addressing NMUPD among high school-age youth:

The final set of intervening variable(s) from section 1.3 *that you selected*, including how this list was selected (prioritized) from among the larger list of variables considered

The specific target population(s) for NMUPD among high school-age youth (e.g., specific grade levels, sub-groups, parents, prescribers, etc.)

The list of strategies you propose to implement to address NMUPD among high school-age youth

The rationale for each selected strategy (conceptual fit, practical fit, link to research, how intervening variables were considered in the planning and identification of strategies)

The cultural competence of the selected strategy or strategies

The sustainability of the selected strategy or strategies

### 3.3. Logic Model

Attach your logic model, covering the period from **July 1, 2016**, to **June 30, 2017**. You are **required** to update your logic model **annually**.

Please refer to APPENDIX 13: PFS 2015 LOGIC MODEL DEVELOPMENT GUIDE for additional guidance.

### 3.4. Technical Assistance Needs Related to Strategic Planning and Logic Models

What assistance, if any, do you anticipate needing from MasTAPP, BSAS, or others in the area of ongoing strategic planning or logic models once your strategic plan has been approved and you move into the implementation phase?

## Step 4: Implementation

### 4.1. Implementation of NMUPD among High School-age Youth

In this section, describe your NMUPD strategy implementation plans in depth, using the format below. Be specific (e.g., how many training sessions will be offered, for how many participants, and how long each session will last; when the intervention will begin and end).

Strategy 1:

Action Steps	Who Is Responsible	Timeline	Measure of Success

Strategy 2:

Action Steps	Who Is Responsible	Timeline	Measure of Success

### 4.2. Technical Assistance Needs Related to Implementation

What assistance, if any, do you anticipate needing from MasTAPP, BSAS, or others in the area of implementation once your strategic plan has been approved and you move into the implementation phase?

## Step 5: Evaluation

SAMHSA/CSAP has mandated that all Partnerships for Success 2015 sub-recipient communities collect bi-annual high school student survey data on: (1) past 30-day use of prescription drugs and alcohol; and (2) perception of parental disapproval of use; perception of peer disapproval of use; and/or perceived risk/harm of use of prescription drugs and alcohol. The Massachusetts PFS 2015 grant is not addressing underage drinking prevention, but other states are, henceforth it is a requirement that each funded state collect data on both issues. The survey must occur for the first time either in Federal Fiscal Year 2016 (10/1/15 – 9/30/16) or Federal Fiscal Year 2017 (10/1/16 – 9/30/17). If the site does not have an existing high school survey in place or is unable to add these items to an existing survey, the state will collect these data using a brief

community instrument that will be administered with a small sample of high school students in your community via our partners at the University of Massachusetts Survey Research Center. We will work with each site on a case-by-case basis immediately following the start of the grant to determine how to best meet this federal requirement of funding.

The PFS 2015 initiative does not provide additional support for program evaluation, but some sites have decided to contract for local evaluation support on their own. In addition, the Massachusetts Technical Assistance Partnership for Prevention (MassTAPP) TA center is available to assist program staff to build internal capacity for basic local evaluation.

#### ***5.1a. Evaluation of Strategies***

If you are conducting local evaluation, please describe what information you will collect and which outcomes you will track when evaluating your NMUPD prevention strategies.

#### ***5.2. Affirmation***

Please affirm that you will participate in the Massachusetts State Cross-Site Evaluation and the Center for Substance Abuse Prevention National Cross-Site Evaluation.

#### ***5.2. Technical Assistance Needs Related to Strategic Planning and Logic Models***

What assistance, if any, do you anticipate needing from MassTAPP, BSAS, or others in the area of evaluation once your strategic plan has been approved and you move into the implementation phase?



## APPENDIX 13: PFS 2015 LOGIC MODEL DEVELOPMENT GUIDE

### Example

Problem identified by BSAS: NMUPD among high school-age youth						
Local manifestation of the problem: The rate of current misuse and abuse of prescription pain relievers among high school students (8%) in our community has increased by 10% over the past five years.						
Intervening Variable	Strategy	Target Group	Outputs	Outcomes		
				Short-Term	Intermediate	Long-Term
Low levels of parental disapproval	Parent media campaign  Parent workshop	All parents of 9 <sup>th</sup> -12 <sup>th</sup> graders in the community	Number of campaign ads placed/distributed throughout community	Increase in parents awareness of NMUPD as an issue	Increase in parents' level of disapproval of NMUPD	Decreased current (30-day) misuse and abuse of prescription pain relievers among high school students
			Number of parents reached through media campaign	Increase in parents' knowledge of the addictiveness of prescription pain relievers	Increase in parents who report communicating their disapproval of NMUPD to their children	
			Number of parent workshops delivered			
			Number of parents who attended parent workshops			

### Developing Your Logic Model

- Complete a logic model sheet for each problem identified.
- Include additional rows for each intervening variable being targeted.

#### Part 1: Problem Identified by BSAS

This language comes from the RFR (Request for Response) for each BSAS initiative, stating why BSAS has made these grant dollars available.

Example:

**Problem identified by BSAS:** NMUPD among high school-age youth

#### Part 2: Local Manifestation of the Problem/Problem Statement

In this section, define the extent of the problem in your community (your description can be quantitative or qualitative).

Example:

<b>Local manifestation of the problem/problem statement:</b> The rate of current misuse and abuse of prescription pain relievers among high school students (8%) in our community has increased by 10% over the past five years.
--

### Part 3: Intervening Variable

List the biological, social, environmental, and economic factors that research has shown to be related to substance use and the consequences of use, including (but not limited to) risk and protective factors.

Example:

<b>Intervening Variable</b>
Low levels of parental disapproval

### Part 4: Strategy (or Intervention)

List the programs, policies, and/or practices your group has chosen to reduce use—the strategies that you expect will affect the intervening variable(s), which will then affect outcomes. It is likely that you will use multiple strategies to address each intervening variable.

Example:

<b>Strategy</b>
Parent media campaign

### Part 5: Target Group

Name the immediate audience for each strategy, and specify whether this group is specific to the entire community or to a specific subgroup.

Example:

<b>Target Group</b>
All parents of 9 <sup>th</sup> -12 <sup>th</sup> graders in the community

### Part 6: Outputs

State how you will measure the extent to which your chosen strategies are being implemented as planned (e.g., head counts of individuals participating in a program, estimated views of a prevention billboard).

Example:

<b>Outputs</b>
----------------

Number of campaign ads placed/distributed throughout community. Number of parents reached through media campaign.
--

**Part 7: Short-Term Outcomes**

List the anticipated immediate effects of a program. These often focus on the knowledge, attitudes, and skills gained by a target audience.

Example:

<b>Short-Term Outcomes</b>
Increase in parents' awareness of NMUPD as an issue.

**Part 8: Intermediate Outcomes**

List the anticipated changes in behaviors, norms, and/or policies. These are often expressed as changes in the intervening variable.

Example:

<b>Intermediate Outcomes</b>
Increase in parents' level of disapproval of NMUPD

**Part 9: Long-Term Outcomes**

List the ultimate goals of the program, which often take time to achieve. These are often directly related to the selected problem statement(s).

Example:

<b>Long-Term Outcomes</b>
Decreased current misuse and abuse of prescription pain relievers among high school students

**Additional Notes**

- Your logic model should cover the period from **July 1, 2016**, to **June 30, 2017** (the first full year of *strategy implementation* of the PFS 2015 grant following the strategic planning year and approval of the strategic plan by BSAS).
- You are *required* to update your logic model *annually*.

By providing a common language and a point of reference regarding what your group hopes to accomplish, logic models create a solid foundation for evaluating your program's success.

## Template

**Problem identified by BSAS:** NMUPD among high school-age youth

**Local manifestation of the problem/problem statement:**

				Outcomes		
Intervening Variable(s)	Strategy	Target Group	Outputs	Short-Term	Intermediate	Long-Term

**APPENDIX 14: CAPT DECISION SUPPORT TOOL - *PRESCRIPTION DRUG MISUSE: PREVENTION PROGRAMS AND STRATEGIES***

(Link to document will be inserted, once final version is available.)

## APPENDIX 15: ACTION PLAN - EXAMPLE AND TEMPLATE

### Example

#### Strategy 1: Parent Media Campaign

Action Steps	Person Responsible	Timeline	Measure(s) of Success
<ul style="list-style-type: none"> <li>Appoint a “Parent Media Campaign” subcommittee</li> </ul>	<ul style="list-style-type: none"> <li>Judy Smith</li> </ul>	<ul style="list-style-type: none"> <li>June</li> </ul>	<ul style="list-style-type: none"> <li>Subcommittee formed and actively meeting</li> </ul>
<ul style="list-style-type: none"> <li>Hire a consultant who specializes in health promotion messaging</li> </ul>	<ul style="list-style-type: none"> <li>Subcommittee</li> </ul>	<ul style="list-style-type: none"> <li>July</li> </ul>	<ul style="list-style-type: none"> <li>Consultant hired</li> </ul>
<ul style="list-style-type: none"> <li>Develop media campaign goals, message(s), and timeline</li> </ul>	<ul style="list-style-type: none"> <li>Subcommittee</li> </ul>	<ul style="list-style-type: none"> <li>July</li> </ul>	<ul style="list-style-type: none"> <li>Development and presentation of parent media campaign work plan to coalition</li> </ul>
<ul style="list-style-type: none"> <li>Identify appropriate media outlet(s)</li> </ul>	<ul style="list-style-type: none"> <li>Bill Murray</li> </ul>	<ul style="list-style-type: none"> <li>August</li> </ul>	<ul style="list-style-type: none"> <li>Media outlets chosen and confirmed</li> </ul>
<ul style="list-style-type: none"> <li>Pilot test campaign with parents</li> </ul>	<ul style="list-style-type: none"> <li>Subcommittee</li> </ul>	<ul style="list-style-type: none"> <li>August</li> </ul>	<ul style="list-style-type: none"> <li>Feedback obtained from pilot are incorporated into final campaign</li> </ul>

**\*Note:** This example is included as an example only and does not represent a complete action plan.

## Template

Strategy: \_\_\_\_\_

Action Steps	Person Responsible	Timeline	Measure(s) of Success

Strategy: \_\_\_\_\_

Action Steps	Person Responsible	Timeline	Measure(s) of Success