Prevention and Reduction of Underage Drinking and Other Drug Use in Massachusetts

Guidance Document

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FOREWORD

The Massachusetts Technical Assistance Partnership for Prevention (MassTAPP) is funded by the Mass. 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 underage drinking and other drug use. MassTAPP 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, and Jack Vondras.

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:* MassTAPP 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, or visit MassTAPP.edc.org.

Prevention and Reduction of Underage Drinking and Other Drug Use in Massachusetts

INTRODUCTION

This guidance document is a resource for municipalities, individuals, organizations, community coalitions, and other groups who are implementing universal prevention efforts aimed at preventing and reducing underage drinking and other drug use in Massachusetts, including those whose efforts are funded by the Massachusetts Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS) and, more specifically, grantees of the Massachusetts Substance Abuse Prevention Collaborative (SAPC) grant program.

> Research has shown that **addressing the issue of underage drinking reduces the risk that youth will go on to use opioids and other substances** (see, for example, Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2012). As the SAPC initiative is primarily intended to prevent underage drinking, this guide focuses on strategies for preventing alcohol misuse and abuse.

The SAPC initiative is part of a comprehensive approach to substance misuse and abuse prevention in Massachusetts, which includes the Massachusetts Opioid Abuse Prevention Collaborative (MOAPC) grant program and SAMHSA's Partnerships for Success II (PFS II) and PFS 2015 grant programs. All initiatives implement evidence-based environmental strategies that can be sustained through local policy, practice, and systems changes to reduce substance misuse and abuse within Massachusetts communities and to increase both the number and the capacity of municipalities across the Commonwealth to address these issues.

> **BSAS-funded substance abuse prevention in Massachusetts**
>
> - *MOAPC:* $1.8M annually to 18 lead municipalities, currently covering more than 90 municipalities across the Commonwealth in targeted opioid misuse and overdose prevention efforts
> - *Partnerships for Success II and PFS 2015:* Funding to address prescription drug misuse and abuse among those ages 12–25 in high-need Massachusetts communities
> - *SAPC:* $2.9M annually to 26 lead municipalities in 127 communities to prevent substance abuse and underage drinking

In implementing the SAPC grant, funded municipalities ("lead municipalities") must work in partnership with neighboring municipalities, thereby forming a cluster. This cluster model is intended to increase the capacity of grantees to prevent and reduce underage drinking and other drug use among their combined populations.

Substance misuse is a complex problem that requires comprehensive, coordinated, evidence-based solutions. This guide is intended to help communities in Massachusetts develop and implement effective, data-driven, and culturally competent strategies that will have a measurable, sustained effect on preventing and reducing underage drinking and other drug use and their devastating consequences.

How to Use This Guide

- The first part of this guide presents national data on the issue of underage drinking, summarizes research demonstrating the relationship between underage drinking and subsequent substance misuse and abuse, and details the financial impact to the country.

- The second part of this guide presents Massachusetts state data on the issue of underage drinking.

- The sections that follow provide guidance on the use of the Strategic Prevention Framework, a model for implementing and evaluating evidence-based, culturally appropriate, sustainable substance misuse and abuse prevention strategies. Developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Strategic Prevention Framework is used by BSAS grantees and other communities nationwide to implement interventions addressing substance misuse and abuse.

- APPENDICES 1–4 contain milestones, deliverables, and timelines specific to SAPC grantees.

- APPENDICES 5–12 contain tools for communities to use throughout the strategic planning process.

- APPENDICES 13–15 summarize some of the research on underage drinking and the connection between alcohol and other illicit drug use.

- APPENDIX 16 spotlights a fairly comprehensive guidebook of evidence-based strategies to address underage drinking, including in college or university settings.

BSAS statement of grant intent
The SAPC initiative is intended to prevent underage drinking and other drug use across the Commonwealth. BSAS *strongly encourages* SAPC grant recipients to place the majority of their focus on the universal prevention of *underage drinking* through the implementation or amendment of local policies, practices, systems, and environmental change. By *addressing the issue of underage drinking, you will reduce the risk that youth will go on to use opioids and other substances*.
While this is not required, SAPC grantees may choose to use a subset of their resources on the universal prevention of other drug use, provided that they adequately address the issue of underage drinking with the majority of their SAPC funding and that there are substantial data to support other drug use beyond alcohol.

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:

- **Cluster model:** The objective of this model, in which groups of municipalities or public health districts enter into formal, long-term agreements to share resources and coordinate activities, is to increase both the number and the capacity of municipalities across the Commonwealth to implement substance misuse and abuse prevention strategies among their combined populations.

  Note: The cluster model will be discussed in more detail in the July 16 webinar for SAPC grantees.

- **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.

- **Consequences:** The social, economic, and health problems associated with substance misuse (e.g., increased mortality, morbidity, injury, school dropout, and crime).

▪ For detailed resources on addressing opioid misuse and overdose prevention, refer to MassTAPP's *Prevention and Reduction of Opioid Misuse in Massachusetts*
▪ For resources on addressing the misuse of prescription drugs, see MassTAPP's *PFSII Guidance Doc*
▪ Both documents are available at http://masstapp.edc.org

- **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, pregnant women).

- **Intervening variables:** 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, which include risk and protective factors, guide the selection of prevention strategies.

ALCOHOL MISUSE AND ABUSE NATIONWIDE

The Consequences and Costs of Underage Drinking

Underage drinking can have numerous consequences, including damage to the human brain, which continues to develop until around age 25 (OJJDP, 2012):

- The hippocampi (a part of the brain that handles memory and learning) of youth ages 14–21 who abuse alcohol has been found to be about 10% smaller than in those who did not drink—and such effects may be irreversible (American Medical Association, 2010).

> The adolescent brain may be particularly susceptible to long-term negative consequences from alcohol use.
> —*The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking* (2007, pp. v–vi)

- Alcohol can interfere with youth's ability to form new and lasting memories of facts and events, which has implications for their learning and academic performance (Hiller-Sturmhofel & Swartzwelder, n.d.).

- Youth with alcohol use disorders often perform worse on memory tests and have diminished ability to plan (National Research Council & Institute of Medicine [NRC & IOM], 2004).

- Alcohol use by youth is associated with abnormalities in the volume of the prefrontal cortex, which may lead to deficiencies in reasoning and to impulsive behavior (Medina et al., 2008).

Underage drinking is also *expensive*. The problems associated with underage drinking—including youth violence, property damage, high-risk sex, fetal alcohol syndrome, and alcohol dependence and treatment—all pose a cost to our society and to taxpayers. The Underage Drinking Enforcement Training Center at the Pacific Institute for Research and Evaluation, funded by the OJJDP, studies the consequences of underage drinking and reports on its associated costs every year (Taylor & Miller, 2015):

- In 2013, underage drinking cost the United States $56.9 billion, which includes medical care, work loss, treatment costs, and property crime.

- This breaks down to a cost of $1,903 per year for each youth in the United States, or $3.75 per drink consumed underage.

- Even if only tangible costs (i.e., medical care and work loss, rather than pain and suffering) are considered, the cost of underage drinking totals $20.01 billion each year, or $1.32 per drink.

The most costly problems related to underage drinking were youth violence and car crashes, as outlined in Figures 1 and 2, below.

Figure 1 : Costs of Underage Drinking by Problem, United States, 2013 $

Problem	Total Costs (in millions)
Youth violence	$32,637.40
Youth traffic crashes	$8,581.00
High-risk sex, ages 14–20	$3,836.30
Youth injury	$2,650.40
Youth alcohol treatment	$1,826.40
Fetal Alcohol Syndrome among mothers ages 15–20	$1,503.00
Poisonings and psychoses	$687.10
Property and public order crime	$230.20
Total	**$56,943.50 ($56.90 billion)**

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Figure 2: Costs of Underage Drinking United States, 2013 $

Total: $56.90 billion
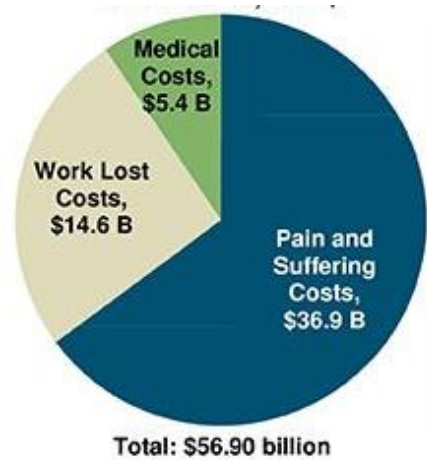
Source for Figures 1 and 2: Underage Drinking Enforcement Center (2015a).

See APPENDIX 13: EXCERPT FROM THE SURGEON GENERAL'S REPORT: *ADVERSE CONSEQUENCES OF UNDERAGE DRINKING* and APPENDIX 14: SELECTED RESEARCH ON UNDERAGE DRINKING for more on the costs and consequences of underage drinking.

Underage Drinking and Violence

Drinking is implicated in many deaths, injuries, and crimes (NRC & IOM, 2004):
* Homicide and suicide are the second- and third-leading cause of death for those ages 15–24 (Centers for Disease Control and Prevention [CDC], 2007). Research shows a causal link between alcohol and suicide, and alcohol is also linked to other mental health disorders, such as depression.

* Alcohol has been reported to be involved in 36% of homicides, 12% of male suicides, and 8% of female suicides involving people under 21.

* The Bureau of Justice Statistics (2008) found that close to one-third of violent crime is alcohol-related.

* Some researchers estimate that individuals under age 21 commit 45% of rapes, 44% of robberies, and 37% of other assaults (Levy, Miller, Spicer, & Cox, 2000).

Frequent heavy drinkers also carry a weapon and engage in fights more frequently than nondrinkers (NRC & IOM, 2004):
* Underage drinkers are more likely than their nondrinking peers to carry a weapon—44% of frequent heavy drinkers had carried a weapon, and 22% had carried a gun in the past 30 days, compared with 10% and 3%, respectively, of nondrinkers.

* Carrying a weapon increases the dangers associated with drinking; not surprisingly, injuries due to a physical fight were more common among frequent heavy drinkers (13%) than nondrinkers (about 2%).

Alcohol use is also heavily implicated in crimes reported on college campuses (NRC & IOM, 2004):

- Ninety-five percent of all violent crime on campus involves the use of alcohol by the assailant, the victim, or both (National Council on Alcoholism and Drug Dependence, n.d.).
- At least 50% of college student sexual assaults are associated with alcohol (Gray, 2012).
- Of the reported incidents of sexual victimization, 43% involve alcohol consumption by victims, and 69% involve alcohol consumption by the perpetrators (Gray, 2012).

> Given that many sexual assaults—especially acquaintance rape—are believed to be unreported, it is possible that alcohol figures into many more assaults than these studies indicate.
> —*Reducing Underage Drinking: A Collective Responsibility* (2004, p. 62)

In addition, the OJJDP (2012) reports that in 2001, 696,000 college students were hit or assaulted by another college student who had been drinking.

Underage Drinking and Driving

Research has found that the earlier age at drinking onset, the greater the likelihood of being in a drinking-involved motor-vehicle accident, and that those who drink at earlier ages are more likely to have alcohol-related driving offenses before age 21 (Hingson, Heeren, & Edwards, 2008).

The 2013 National Youth Risk Behavior Surveillance (YRBS) noted the following (Kann et al., 2014):
- 1 in 10 youth had driven a car or other vehicle one or more times when they had been drinking alcohol during the past 30 days
- The rates for male students were higher than for female students (12% and 7.8%, respectively)

> Alcohol-related crashes involving underage drinkers are more likely to result in death and serious injury than those involving other drivers.
> —*Reducing Underage Drinking: A Collective Responsibility* (2004, p. 60)

Grunbaum et al. (2002) break down these numbers by race and ethnicity: In 2000, 14.7% of white youth (ages 15–20), 13.1% of Latino youth, and 7.7% of African American youth drove a car after drinking alcohol.

Although alcohol-related youth motor vehicle fatalities have decreased substantially over the past decade or so, "youth are still overrepresented in alcohol-related fatal crashes compared with the older population" (NRC & IOM, p. 60). Underage drinking and driving is a serious issue with dire consequences:
- In 2000, 69% of alcohol-related traffic fatalities among youth involved underage drinking drivers.
- Almost 40% of youth traffic fatalities are alcohol-related (National Highway Traffic Safety Administration [NHTSA], 2002).
- In 2009, 19% of drivers ages 16–20 who were involved in fatal crashes had a blood alcohol concentration over the legal limit (OJJDP, 2012).

> While youth ages 15–20 comprise only 7% of licensed drivers, in 2000 they represented approximately 13% of the drivers involved in fatal crashes after drinking (NHTSA, 2002).

Underage drinkers make other poor driving decisions that affect their well-being (NRC & IOM, 2004):
- They are less likely to wear a seat belt. Alcohol-related traffic crashes are three times more likely to be fatal for youth who are not wearing a seat belt.

- They are more likely to allow an intoxicated driver to drive them: 38.3% of Latino youth (ages 15–20), 30.3% of white youth, and 27.6% of African American youth have ridden with a driver who had been drinking alcohol.

Use of Alcohol by Underage Youth

Lifetime and Current Use of Alcohol

The 2013 National YRBS found that underage drinking rates are decreasing (Kann et al., 2014):
- Lifetime use of alcohol by underage youth was 66.2%, which has fallen significantly over the past few decades (i.e., from 81.6% in 1991)

- *Current use* of alcohol among underage youth was 34.9%, which has also fallen since 1991 (50.8%)

> **Note:** A new report from SAMHSA (2015c) offers even more promising numbers: In 2013, current use of alcohol among those ages 12–20 was 22.7%, down from 28.8% in 2002.

- Rates of current alcohol use were higher among white (36.3%) and Hispanic (37.5%) students than black (29.6) students, higher among Hispanic female (39.7%) than black female (31.3%) students, and higher among white male (36.9%) and Hispanic male (35.2%) than black male (27.7%) students

- The percentage of youth using alcohol before age 13 (the *age of onset*) is now 18.6%, another significant decrease from 1991 (32.7%)

> - **Age of onset:** The age at which an individual first acquires or experiences the symptoms of a disease or disorder; for underage alcohol use, the average age of onset is 13
> - **Current use:** Having used alcohol within the past 30 days

Findings from the 2013 National Survey of Drug Use and Health (NSDUH) (SAMHSA, 2014):
- Current use rates for Asian youth ages 12–20 are 15.2%; for American Indians and Alaska Natives, 17.8%

- As expected, current use rates are higher for 10th- (30.9%), 11th- (39.2%), and 12th-graders (46.8%) than for 9th-graders (24.4%)

Alcohol and Other Illicit Drug Use

The 2013 National YRBS noted a relationship between alcohol and illicit drug use (Kann et al., 2014):
- Approximately one in five youth (19.9%) who currently use alcohol have also used illicit drugs within two hours of alcohol use

- The most commonly reported illicit drug used by underage drinkers in combination with alcohol was marijuana, which was used within two hours of alcohol use by 19.5% of current underage drinkers (1.6 million persons) on their last drinking occasion

Age of onset was found to be a strong predictor of use of other illicit drugs. The National Longitudinal Alcohol Epidemiologic Survey found that "approximately one-half of persons who began drinking at age 14 or younger had also used other drugs illicitly in their lifetime, compared to around one-tenth of those who began drinking at age 20 or

> Delaying the age of onset of first alcohol use as long as possible would ameliorate some of the negative consequences associated with underage alcohol consumption.
> —*The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking* (2007, p. 12)

older" (Center for Substance Abuse Research [CESAR], 2008, p. 1). The younger a person is when he or she begins using alcohol, the more likely he or she is to use other drugs and to do so at an earlier age (Hingson, Heeren, & Edwards, 2008), as illustrated in Figure 3.

Figure 3: Drinking and Other Illicit Drug Use, by Age at Drinking Onset

Percentage of Drinkers Who Have Used Other Illicit Drugs (N = 27,616)
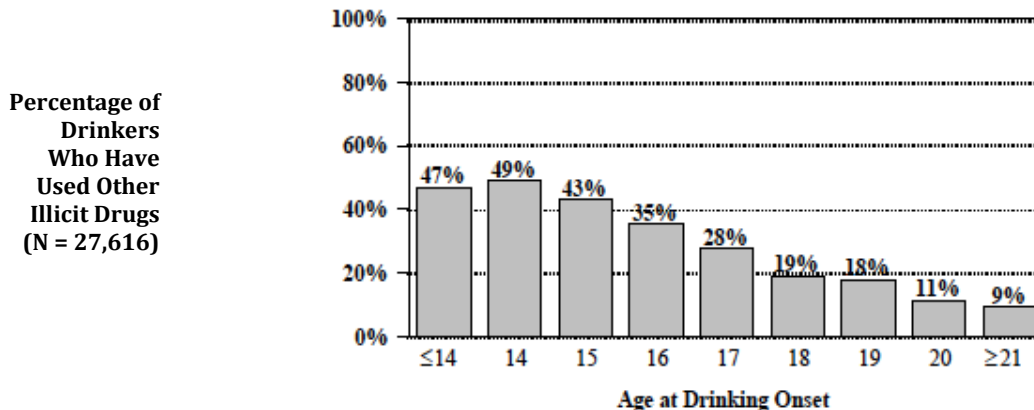
Source: Adapted by CESAR (2008) from Hingson, Heeren, and Edwards (2008).

The OJJDP (2012) reports that while "many factors can affect whether youth progress to the use of other drugs and which ones they choose to use, alcohol is frequently followed by tobacco, then marijuana, and then other illicit hard drugs" (p. 6; see also Degenhardt et al., 2009; Gfroerer, Wu, & Penne, 2002; and Welte & Barnes, 1995).

> See **APPENDIX 15: EARLY DRINKING INITIATION AND ILLICIT DRUG USE** for more on the relationship between alcohol and other illicit drug use.

Binge Drinking

SAMHSA defines *binge drinking* as having five or more alcoholic drinks within a couple of hours on at least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism is even more specific, defining it as a pattern of drinking that brings blood alcohol concentration levels to 0.08 g/dL, which typically occurs after four drinks for women and five drinks for men within two hours.

Findings from the 2013 National YRBS (Kann et al., 2014):

- More than one-fifth of youth (20.8%) were currently engaging in binge drinking, which is down by more than 10% since 1991 (31.3%)

- The prevalence of binge drinking was higher among white (23.2%) and Hispanic (22.6%) students than black (12.4%) students, higher among white female (21.1%) and Hispanic female (22.6%) students than black female (11.5%) students, and higher among white male (25.3%) and Hispanic male (22.7%) students than black male (13.1%) students

> Cause and effect is always hard to determine in these matters, but the many prevention measures adopted in recent years by governments, schools and other public service organizations seem to be having an impact.
> —*Washington Post* (2015, ¶ 1)

The 2013 NSDUH found that 7.6% of Asian youth and 13.9% of American Indian and Alaskan Native youth, ages 12–20, currently engage in binge drinking (SAMHSA, 2014).

Access to Alcohol by Underage Youth

Findings from the 2013 National YRBS (Kann et al., 2014):

- Among the youth who had a drink in the 30 days before the survey, 41.8% obtained the alcohol by having someone give it to them
- Female students were more likely than male students to have someone give alcohol to them (46.7% and 36.7%, respectively)

Underage youth obtain alcohol from a variety of sources, according to the 2013 NSDUH (SAMHSA, 2014):

- Among underage current drinkers who did not pay for the alcohol the last time they drank, the most common source (36.6%) was an unrelated person age 21 or older
- Parents, guardians, or other adult family members provided the last alcohol to 24.5% of nonpaying underage drinkers
- Other underage persons provided the alcohol on the last occasion for 16.4% of nonpaying underage drinkers
- The majority of underage current drinkers reported that their last use of alcohol in the past month occurred in a home setting, either in someone else's home (52.2%) or their own home (34.2%); the rate for drinking at home has increased from 2012 (31.4%)
- Underage females were more likely than males to have been in a restaurant, bar, or club on their last drinking occasion (8.8% and 4.5%, respectively)
- 28.7% of youth paid for the alcohol the last time they drank, including 7.8% who purchased the alcohol themselves and 20.5% who gave money to someone else to purchase it; these rates are similar to 2012 (28.2%, 7.6%, and 20.4%, respectively)

Perception of the Harm or Risk of Alcohol Use by Underage Youth

The NSDUH looked at data from 2002 to 2013 regarding perceptions of the risk of alcohol use among youth ages 12–17, as illustrated in Figure 4.

Figure 4: Perceived Risk of Substance Use Among Youth Ages 12–17: 2002–2013
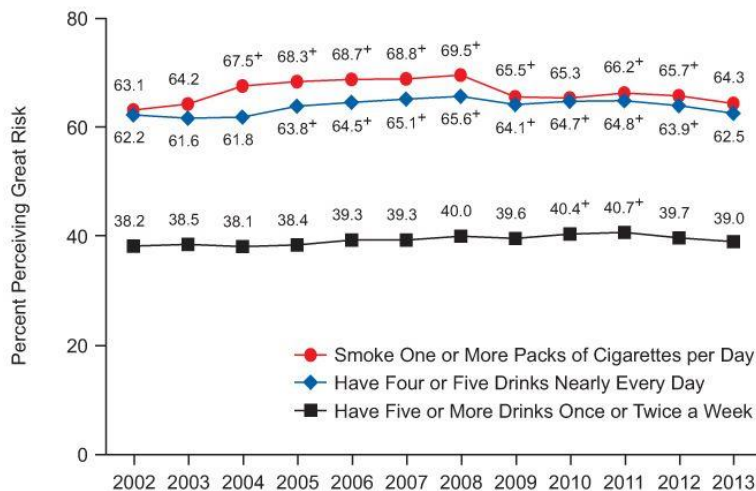
[+] The difference between this estimate and the 2013 estimate is statistically significant at the .05 level.
Source: SAMHSA (2014).

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- Youth who perceived great risk in having four or five drinks of an alcoholic beverage nearly every day increased from 62.2% in 2002 to 65.6% in 2008, but the rate then declined between 2009 (64.1%) and 2013 (62.5%), bringing the 2013 rate almost back to the 2002 rate.
- The percentage of youth who perceived great risk in having five or more drinks of an alcoholic beverage once or twice a week increased from 38.2% in 2002 to 40.7% in 2011; the rate then decreased 2% between 2011 and 2013 and went back down to 39%.
- The rate of binge alcohol use and heavy alcohol use also decreased, from 10.7% and 2.5% to 8.9% and 2%, respectively.
- Although perceived risk of alcohol use peaked in 2008 for each measure of perceived risk, the rate of adolescent alcohol use continued to decline between 2008 and 2013 for both binge alcohol use (6.2% in 2013) and heavy alcohol use (1.2% in 2013).

ALCOHOL MISUSE AND ABUSE IN MASSACHUSETTS

The Consequences and Costs of Underage Drinking

In addition to the harm that alcohol causes to young developing brains, in 2013, underage drinking cost the residents of Massachusetts $1.3 billion in medical costs, work loss, and costs associated with pain and suffering. Broken down, this represents a cost of $1,834 per youth each year, or $3.48 for every drink consumed by an underage youth. Even if we consider only tangible costs (property damage and criminal justice costs, as opposed to pain and suffering), the total still comes to $384.9 million each year, or $1.13 per drink, whereas a drink retails in Massachusetts for $1.01 (SAMHSA, 2014).

> **Who pays and who benefits?**
>
> The external costs of underage drinking in Massachusetts are chilling. Unfortunately, the alcohol industry has not had to share the burden of these costs. In 2013, *underage youth consumed 9.3% of all alcohol sold in Massachusetts*, resulting in profits to the alcohol industry of *$168 million* (SAMHSA, 2014).

The Underage Drinking Enforcement Training Center at the Pacific Institute for Research and Evaluation, funded by the OJJDP, looked at the various harms related to underage drinking in Massachusetts (Taylor & Miller, 2015):

- In 2012, an estimated 8 homicides, 12,700 nonfatal violent crimes (e.g., rape, robbery, assault), 13,100 property crimes (e.g., burglary, larceny, car theft), and 245,000 public order crimes (e.g., vandalism, disorderly conduct, loitering, curfew violations) were attributable to underage drinking.

- In 2011, an estimated four alcohol-involved fatal burns, drownings, and suicides were attributable to underage drinking.

- In 2013, an estimated 303 teen pregnancies and 16,378 occurrences of high-risk sex among teens were attributable to underage drinking.

The 2013 Massachusetts Youth Risk Behavior Survey (YRBS) (Massachusetts Department of Elementary and Secondary Education [DESE] & Massachusetts Department of Public Health [DPH], 2014) revealed the following:

- 7% of high school students have driven while under the influence of alcohol

- Males have done so at nearly double the rate of females (9.2% and 5.4%, respectively)

- Almost one in five high school youth (18.3%) have ridden with a driver who had been drinking alcohol

In addition, an estimated 18 traffic fatalities and 1,051 non-fatal traffic injuries in 2012 were attributable to driving after underage drinking (Taylor & Miller, 2015).

Youth violence and car crashes comprised the largest costs for the state in 2013, as illustrated in Figures 5 and 6:

Figure 5: Costs of Underage Drinking By Problem, Massachusetts, 2013 $

Problem	Total Costs (in millions)
Youth violence	$744.9
Youth traffic crashes	$159.1
High-risk sex, ages 14–20	$55.1
Youth alcohol treatment	$48.7
Youth injury	$41.8
Fetal Alcohol Syndrome among mothers ages 15–20	$19.8
Poisonings and psychoses	$18.6
Property and public order crime	$4.7
Total	**$1,179.7 ($1.2 billion)**

Figure 6: Costs of Underage Drinking Massachusetts, 2013 $

Total: $1.2 billion
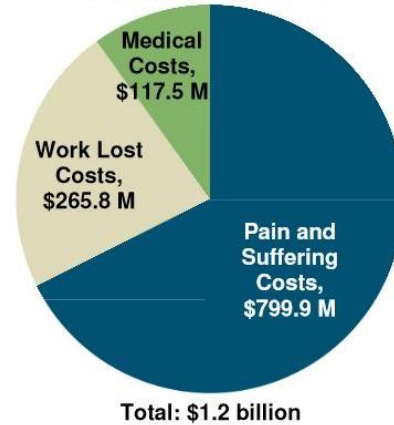
Source: Underage Drinking Enforcement Center (2015b).

Use of Alcohol by Underage Youth

High School

Underage drinking among high school youth in Massachusetts has declined significantly in the last decade. Findings from the 2013 Massachusetts YRBS (DESE & DPH, 2014):

- Lifetime use of alcohol by high school students has declined, from 76% in 2007 to 63% in 2013
- Current or past 30-day use rates have declined by more than 10%, from 48% in 2007 to 36% in 2013
- Eleven percent of high school students had their first drink before the age of 13 (average age of onset)
- Almost one-fifth of students (19%) reported binge drinking in the past 30 days; these numbers increased with grade level (9% for freshman vs. 29% for seniors)

Ninth-graders were significantly less likely to report lifetime and/or current alcohol use than students in all other grades:

Grade	Lifetime alcohol use	Current alcohol use
9	47%	22%
10	63%	33%
11	71%,	40%
12	74%	49%

Source: 2013 Massachusetts YRBS (DESE & DPH, 2014).

The rates for lifetime use, current use, and current binge drinking among Massachusetts high school students are illustrated in Figure 7:

Figure 7: Alcohol Use Among Massachusetts High School Students, 2005–2013
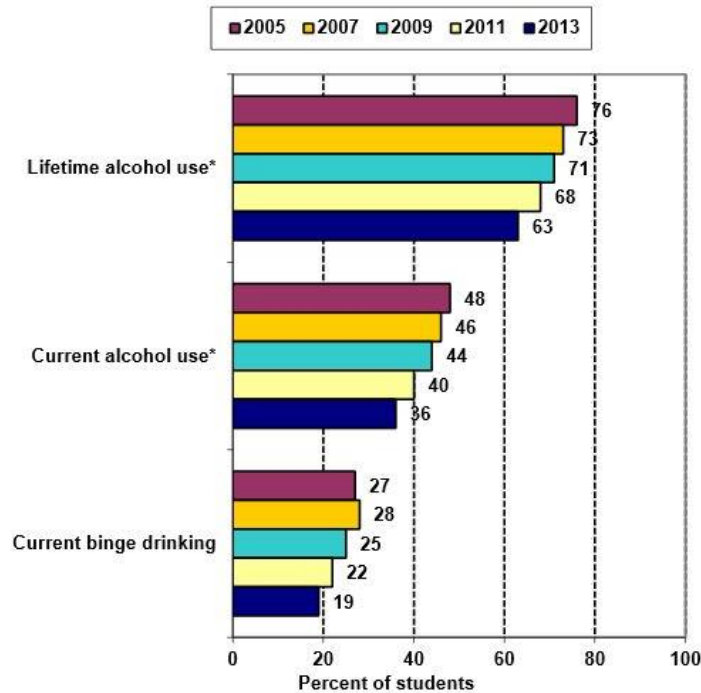
* Statistically significant difference comparing 2011 and 2013.
Source: 2013 Massachusetts YRBS (DESE & DPH, 2014).

Middle School

Findings from the 2013 Massachusetts YRBS (DESE & DPH, 2014):
- Lifetime use of alcohol has declined, from 24% in 2007 to 18% in 2013
- Current use rates declined by almost half, from 11% in 2007 to 6% in 2013
- Both lifetime use (10% for 6th-graders, 30% for 8th-graders) and current use (2% for 6th-graders, 10% for 8th-graders) increase with age
- Binge drinking in the past 30 days decreased by half, from 4% in 2007 to 2% in 2013

The rates of lifetime use, current use, and current binge drinking among Massachusetts middle school students are illustrated in Figure 8, below.

Figure 8: Alcohol Use Among Massachusetts Middle School Students, 2007–2013
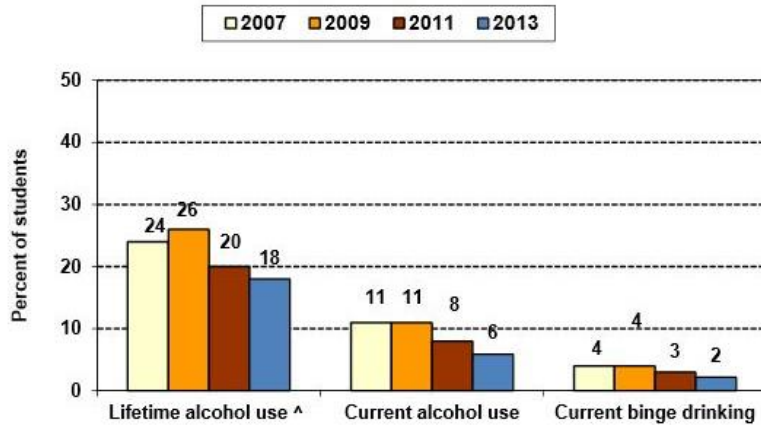
^ Percentages reflect a change in variable calculation.
Source: 2013 Massachusetts YRBS (DESE & DPH, 2014).

Perception of the Harm or Risk of Alcohol Use by Underage Youth

In 2012–2013, close to two in three (65.8%) of Massachusetts youth ages 12–17 perceived no great risk in drinking five or more alcoholic drinks once or twice a week (SAMHSA, 2015a). This is 5% higher than the national average, as shown in Figure 9.

Figure 9: Perception of Alcohol Risk Among Mass. and U.S. Youth, 2009–2013
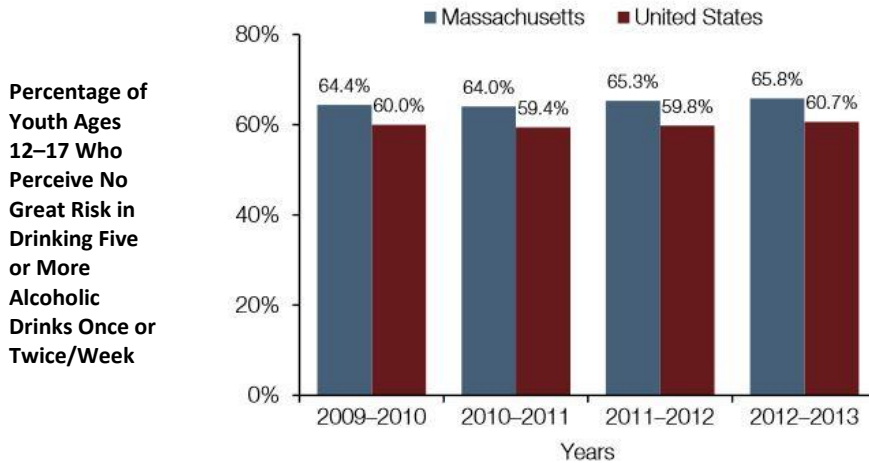
Source: SAMHSA (2015a).

THE STRATEGIC PREVENTION FRAMEWORK

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. The SPF has five components, as illustrated in Figure 10:

Figure 10: 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; there is 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.

> **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.

The sections that follow provide general guidance on how to use the SPF model to implement interventions addressing 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. These grantees include both groups of municipalities and those in partnership with experienced substance abuse prevention providers. Information specific to SAPC grantees is provided in APPENDICES 1–4.

Other organizations and groups may 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 specific grant program (e.g., *cluster*, *coalition*).

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

STEP 1: ASSESSMENT

The first step in the SPF model is to systematically gather and analyze local data related to the substance misuse and abuse problem. These data will help you better understand the issues related to substance misuse and abuse in your community and identify appropriate strategies for addressing these issues.

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 the substance misuse and abuse problem in different groups, including those defined by age, gender, race/ethnicity, or other demographic characteristics
- Identify the geographic areas where the problem is greatest
- Define one or more target populations (e.g., middle school youth, high school youth, young adults)
- Identify *intervening variables* (factors linked to substance misuse and abuse in your community)
- Determine your community's perception of the problem
- Determine whether your community or organization is ready to address the problem and what additional resources may be needed

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

The assessment process includes five tasks:
1. Collect data to assess needs
2. Identify intervening variables
3. Assess community readiness and resources
4. Analyze the assessment data
5. Develop your problem statement(s)

Each task is described in greater detail below.

> **Assessing cultural competence**
>
> The assessment stage may be 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 community assessment include information about the major cultural groups in your community?
> - Do members of diverse group(s) 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 cultural competence concepts?

Task 1: Collect Data to Assess Needs

Local data can help you better understand the problem of substance misuse and abuse in your community. Both quantitative (e.g., numbers, statistics) and qualitative (e.g., beliefs, attitudes, and values of stakeholders) data are useful to the assessment process.

Figure 11: Local Needs Assessment and Data Collection

Objective: Collect information on prevalence and risk and protective factors pertaining to underage substance misuse and abuse

- Quantitative Methods
  - Survey Data
  - Archival Data
- Qualitative Methods
  - Key Informant Interviews
  - Focus Groups
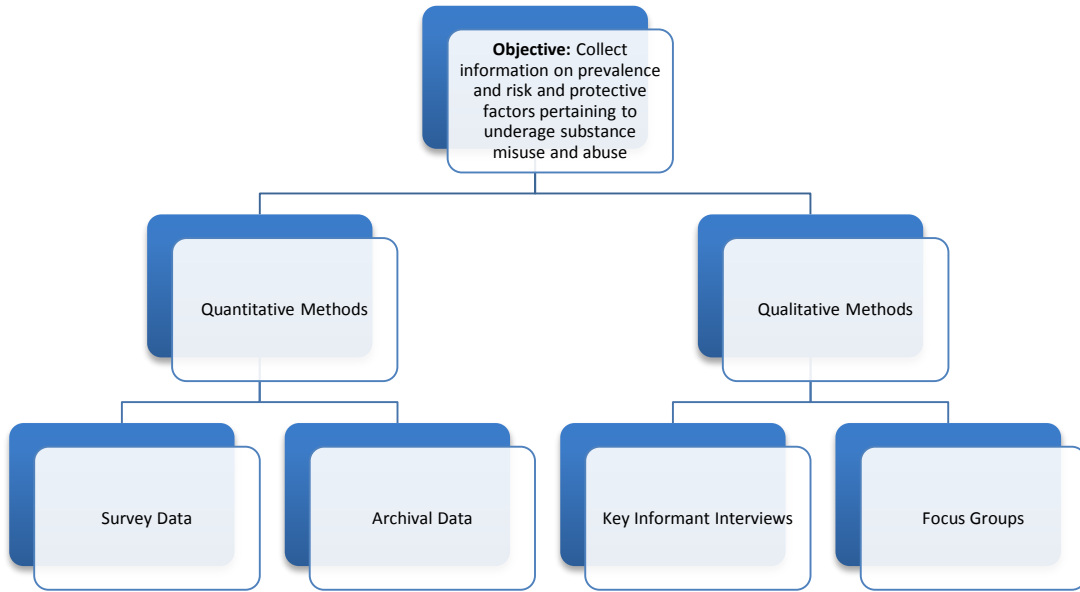
Source: Rhode Island State Epidemiology and Outcomes Workgroup, Buka, and Rosenthal (2015).

Quantitative Data

Several types of quantitative data may help you better understand the extent of substance misuse and abuse in your community and the related consequences. These data may also help you identify the areas and groups most affected by the problem.

Data on consumption. Consumption (use) patterns describe substance misuse and abuse in terms of the frequency or amount used. For example:

- Percentage of youth ages 12–17 reporting current (within the past 30 days) use of alcohol

- Percentage of young adults ages 18–21 reporting binge drinking in the past year

- Percentage of young adults ages 16–21 reporting drinking and driving in the past year

Consumption includes overall consumption, acute or heavy consumption, consumption in risky situations, and consumption by high-risk groups (e.g., youth, college students, pregnant women).

These types of data may be collected by national or state surveys, such as the Massachusetts Youth Health Survey (MYHS) and the Massachusetts YRBS. However, local data specific to your community may not be as readily available. When collecting data from your local target area, it's ideal

> **APPENDIX 5: ARCHIVAL AND SURVEY DATA SOURCES FOR UNDERAGE DRINKING: A COMMUNITY DATA CHECKLIST** includes numerous examples of quantitative consumption and consequence data relevant to underage drinking.

> **Quantitative and qualitative data**
>
> **Quantitative data** are usually reported numerically—often as counts or percentages. An example is the percentage of teens who report using alcohol during the last 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 emergency department data.
>
> **Qualitative data** are usually reported in words. Sources of qualitative data include key stakeholder interviews, focus groups, case studies, and observation.

to use the same questions and wording as used in the national and state surveys, whenever possible, in order to standardize data collection and allow for comparisons across different areas. As an example, questions and state-level data related to alcohol use, misuse, and abuse from the 2013 MYHS can be found here: http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/dmoa/health-survey/myhs/

Data on consequences. Alcohol misuse and abuse is associated with many social, economic, and health problems, including increased mortality (due to car crash deaths, cirrhosis of the liver, and homicide), morbidity (including fetal alcohol syndrome and alcohol addiction), injury, school dropout, and crime (New York State Office of Alcoholism and Substance Abuse Services, 2011). Data related to consequences can help you better understand the alcohol misuse and abuse issue in your community. Some examples of consequence data sources:

- Alcohol-related arrests (including juvenile arrests)

- School incident and discipline reports

- Emergency department admittances and hospital discharge data

You may have to compile this information locally from different sources (e.g., schools, the police department, hospitals).

Qualitative Data

These data may help you gain a deeper understanding of the substance misuse and abuse problem in your community by offering insight into the beliefs, attitudes, and values of various stakeholders. 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 have an interest or stake in efforts to address the problem. These individuals can help you better understand substance misuse and abuse and identify options for addressing the problem. Key stakeholders may include the following:

- People who are misusing and/or abusing substances

- Parents

- School nurses and school counselors

- 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 business owners (liquor retailers, bars, restaurants, etc.)

Sample data sources
The following data sources may help you assess your community's needs and resources: ▪ Public health statistics (e.g., local youth health survey data, parent surveys) ▪ Interviews and/or focus groups ▪ Public safety data (e.g., fire department data on emergency medical services for alcohol-related injury) ▪ Records from public meetings or forums ▪ Law enforcement data (e.g., alcohol-related arrests or DUIs) ▪ Department of Justice data (e.g., outcomes of criminal cases related to alcohol misuse) ▪ Hospital data (e.g., discharge codes for alcohol-related admittances)
See APPENDIX 5: ARCHIVAL AND SURVEY DATA SOURCES FOR UNDERAGE DRINKING: A COMMUNITY DATA CHECKLIST for more suggestions.

- Representatives from the faith community
- Youth

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 6.

> **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 and reduction efforts.

Focus groups. Focus groups are a series of planned discussions that examine the perceptions of a particular group (e.g., young adults currently misusing alcohol, 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 to 10 persons who are similar in regard to the issue of interest. Three to five focus groups are typically used per demographic (e.g., teens who drink alcohol regularly). Transcripts are reviewed to identify recurring themes. See APPENDIX 7 for information on how to conduct focus groups.

Cultural competence. In collecting qualitative data, it is important to use methods that are culturally competent and appropriate. For example, when 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.

Task 2: Identify Intervening Variables

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 shown by research to predict 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, such as individual, peer, family, and community. Risk factors for underage alcohol consumption include low perception of risk or harm, ineffective family management or parental monitoring, and youth social and commercial access. Protective factors include effective family management techniques and positive school climate.

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 1. (A template is available in APPENDIX 8.)

Table 1: Risk and Protective Factor Data Organizer[1]

Risk or Protective Factor[2]	Mentioned During Key Informant Surveys or Focus Groups			Supported by Quantitative Data?	
	Frequently	*Moderately*	*Infrequently or Not at All*	*Yes*	*No or N/A*
Low perception of risk or harm	☐	☐	☐	☐	☐
Ineffective family management or parental monitoring	☐	☐	☐	☐	☐
Perceived peer approval or actual peer use	☐	☐	☐	☐	☐
Community norms supporting use	☐	☐	☐	☐	☐
Youth access: Commercial	☐	☐	☐	☐	☐
Youth access: Social	☐	☐	☐	☐	☐
Other comments from qualitative data collection:					

After identifying and prioritizing the risk and protective factors in your community, you will select prevention strategies for addressing them, as described in Step 3 of the SPF.

Task 3: Assess Community Readiness and Resources

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

Assessing Community Readiness

An assessment 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.

> **Note:** Readiness assessments should reflect principles of cultural competence by involving representatives from across sectors in planning and data collection and by collecting information in ways that are appropriate and respectful.

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.

When people hear the word *resources*, they often think of staff, financial support, and a sound organizational structure. However, resources may also include the following:

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[1] Adapted from Rhode Island State Epidemiology and Outcomes Workgroup, Buka, and Rosenthal (2015).

[2] 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. A good resource is *Risk and Protective Factors Associated with Binge or Heavy Episodic Drinking Among Adolescents and Young Adults*, a literature review of risk and protective factors for binge drinking among adolescents and young adults conducted by SAMHSA's Center for the Application of Prevention Technologies (CAPT) in 2015. It can be found here: http://captus.samhsa.gov/sites/default/files/captresource/riskprotectivefactorsheavybingedrinking.rem.41215.pdf

- 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., resources 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.

Task 4: Analyze the Assessment Data

By identifying the types and the extent of substance misuse and abuse, and the populations and areas most affected, you can better understand the actual problem in your community.

Analyzing Quantitative Data

Examine the quantitative data you have collected to see if specific groups of people or other factors stand out. HealthyPeople 2020 (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.* (HealthyPeople 2020, 2015, ¶ 5)

Do any of your data suggest a particular impact on a group or subpopulation who may be vulnerable to health disparities? For example, is alcohol more accessible and available in a specific urban neighborhood vs. another? Are there gender differences in use patterns or with respect to risk and protective factors (Rhode Island Partnership for Success, 2014)?

If quantitative data are available for multiple years, then examining trend data may suggest factors that influence substance misuse and abuse and/or intervening variables. For example, if there was a sharp rise in binge drinking in the past year, what happened or what changed that may explain this? Did your community see an influx of an at-risk population? Was there a decrease in retail access initiatives?

Examine local data in relation to state data to determine if there may be something unique or unusual about the community associated with substance misuse or its intervening variables. Is there something different about the problem in your community? Does the difference point to an intervening variable that may be important, or perhaps to a strategy to consider later in the process?

Analyzing Qualitative Data

The first step when analyzing qualitative data is to read and reread the materials you have gathered (e.g., key stakeholder interviews, focus group notes, answers to open-ended survey questions) and identify the different themes that emerge for each question. To increase confidence in the process, it is best to have two or more people do this independently. The themes generated by each coder are then compared. If the themes identified by coders differ, the coders need to reconcile their views and reach consensus.

Record and report comments for each theme (verbatim responses or quotes may be preferred) and count the number of respondents who mentioned each theme. This is a good indicator of the importance of a particular theme to participants. In addition, be sure to note the passion and strength of respondents' comments, which is likewise important.

Comparing the Data

Compare quantitative data with qualitative data or vice versa to see if they reinforce one another or raise new questions. Do any of the qualitative data shed additional insight into why the problem exists or who experiences it?

Analyzing the data you collected during the assessment process will help you answer a key question: "Why are substance misuse and abuse happening *here*?" This may help you select strategies that get to the unique root causes of substance misuse and abuse in your community.

> **Sample problem statements**
>
> Here are two examples of good problem statements that identify one issue at a time:
> - Too many college freshmen in our community (22%) report binge drinking on a regular basis (weekly).
> - Too many eighth-graders (15%) in our town report trying alcohol for the first time.

Task 5: Develop Your Problem Statement(s)

Crafting a clear problem statement will help you focus on where to build capacity and how to measure outcomes and plan for sustainability. Interventions without a clearly articulated problem statement may lose steam over time; it's also difficult to know whether they have made a difference. Communities should use their data about consumption, consequences, readiness, and resources to frame their problem statement in specific terms.

Some communities find that they need to develop more than one problem statement. For example, you may need to develop a problem statement that addresses an issue related to consumption and one that addresses an issue related to consequences.

A good problem statement will meet each of the following criteria:
- Identify one issue or problem at a time
- Avoid blame (e.g., say, "Young people do not have enough positive activities" rather than, "The kids here have nothing to do and are troublemakers")
- Avoid naming specific solutions (e.g., say, "Young people in our neighborhood are getting into trouble during after-school hours" rather than "We don't have a youth center")
- Identify outcomes that are specific enough to be measurable
- Reflect community concerns as heard during the assessment process

When you develop your problem statement, be sure to describe what actually exists that is problematic, rather than what is lacking. For example, a problem statement that reads "Teachers lack training on how to address students drinking in school" assumes that addressing this lack by offering training alone will solve the problem. In reality, many factors may also contribute to the problem. A better statement might be, "The number of high school students who are misusing alcohol is higher than the national average." 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 other important factors are missed.

Keeping the focus on the priority behaviors, consequences, and/or underlying intervening variables at this stage in the planning process will help you select a comprehensive array of strategies that will be more effective in addressing the problems you have identified.

STEP 2: CAPACITY BUILDING

Capacity building involves improving your group's ability to prevent and/or reduce substance misuse and abuse in your community. *Capacity* includes all the human, technical, organizational, and financial resources you will need in order to implement and evaluate your intervention in a culturally competent and sustainable way.

Key components of capacity building 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. APPENDICES 11 and 12 offer tips for working with the media and crafting an effective message.

- Developing or strengthening relationships with partners and/or identifying new opportunities for collaboration

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.

It is important to continually examine your capacity and make sure that you have the resources required at each stage. For example, during Step 1 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 18). During Step 3, you may need to focus on learning how to implement an inclusive and collaborative strategic planning process.

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
- 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
- Identify assets and resources available for preventing and reducing substance misuse and abuse in your target area
- 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.

Increasing Capacity 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, or 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 capacity in order 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?

Measuring Community Readiness[3]

There are many resources available to measure community readiness, and most of them acknowledge that community 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.

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[3] This section was adapted from New York State Office of Alcoholism and Substance Abuse Services (2011).

- **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: Preplanning.** 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.

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.

Strategies for Increasing Community Readiness

The following strategies are recommended by the National Institute on Drug Abuse (1997):
- **Stage 1: Community tolerance / no knowledge**
  - Hold small-group and one-on-one discussions with community leaders to identify the perceived benefits of substance misuse and abuse 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

> **APPENDIX 12: EFFECTIVE MESSAGING FOR SUBSTANCE ABUSE PREVENTION** offers guidance on designing a consistent and effective message for your local media campaign.

- **Stage 4: Preplanning**
  - Offer educational outreach programs to community leaders and sponsorship groups that communicate the prevalence rates and correlates or causes of substance misuse and abuse
  - 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

- o Conduct periodic review meetings and special recognition events for local supporters of the prevention program
- o Publicize local efforts associated with review meetings and recognition events
- **Stage 8: Confirmation/expansion**
  - o 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
  - o Conduct periodic review meetings and special recognition events for local supporters of the prevention program
  - o Present results of research and evaluation activities of the prevention program to the public through local media and public meetings
- **Stage 9: Professionalization**
  - o Provide continued in-service training of staff
  - o Continue to assess new drug-related problems and to reassess targeted groups within community
  - o Continue to evaluate program efforts
  - o 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

Completing the Capacity-Building Worksheet

The Capacity-Building Worksheet (see APPENDIX 9 for the template) is a tool that can help you identify the issue or area of needed growth, how this capacity need will be addressed, the person(s) responsible, the timeline for addressing this need, and the measure of success. You may want to fill out a similar worksheet for each capacity need you identify as you carry out each step in the SPF model. Remember to also keep in mind needs related to cultural and linguistic competence and sustainability.

The following is an example of a completed worksheet addressing a capacity need related to Step 1 of the SPF.

SPF Step 1: Assessment	Issue/Area of Growth	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.
	How the Capacity Need Will Be Addressed	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.
	Person(s) Responsible	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.
	Timeline	Jane will contact Betty by July 9 and schedule the meeting for the week of July 14.
	Measure of Success	Betty or another representative from Prevention Inc. becomes an active participant in our needs assessment process.

STEP 3: STRATEGIC PLANNING

In this step, you will use the information you obtained via your needs assessment to develop a strategic plan for addressing substance misuse and abuse in your community. Guidelines for developing a strategic plan are provided in APPENDIX 2.

In this stage, you will do the following:
- Identify the intervening variables most relevant to and present within your community
- Select strategies that address your specific problem statement and show evidence of effectiveness for the populations you are trying to reach
- Define your desired outcomes
- Identify the resources needed for implementation
- Create a logic model that spells out the connections between the identified problem(s), intervening variables, strategies, and desired outcomes (a Logic Model Template is provided in APPENDIX 3)
- Create an action plan that outlines how you will implement your chosen strategies (an Action Plan Template and Example is provided in APPENDIX 10)

Each step in this process is described in more detail below.

Prioritizing 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 in your community. Identifying these factors and prioritizing among them is a critical part of the SPF planning process.

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 impact the problem in question, and *changeability*, how easy it may be to change the intervening variable. You may want to select intervening variables that are high in both.

When prioritizing intervening variables, it is also important to look at substance misuse and abuse in a comprehensive way and to consider the potential consequences of addressing one risk or protective factor vs. another. For example, restricting or reducing access to certain substances may cause an increase in consumption of others. For each intervening variable you consider, think about the potential for unintended consequences and ways to anticipate and address these issues.

> **Examples of intervening variables**
>
> The following are examples of factors that could help to explain a substance misuse problem in a community:
> - Adolescents have easy access to alcohol in their parents' homes
> - Adolescents do not perceive the use of alcohol as potentially harmful
> - Adults in the community host house parties in which alcohol is provided to all attendees regardless of age
> - Local businesses inconsistently implement responsible alcoholic beverage service strategies (e.g., always asking for identification and refusing to sell in absence of proper ID)
> - A college campus in your community has high levels of social availability of alcohol
>
> Questions to consider:
> - What factors help explain substance misuse and its consequences in *your* community?
> - Which are most important (i.e., have the greatest impact)?
> - Which are you most likely to be able to change?

When examining the data you have collected, ask yourself how important a particular factor is in addressing substance misuse and abuse in your community. For example, if you identified youth alcohol consumption as a problem, and the data show that youth are more likely to obtain alcohol from peers via their parents (social access) than from stores (via fake IDs or targeting stores that are known not to ask for ID), then social access would be considered high in importance, whereas retail access would be considered low.

When weighing the importance of intervening variables, consider the following:
- Does the intervening variable impact other behavioral health issues? For example, poor parental monitoring may be a risk factor for not only alcohol misuse and abuse but also such risky behaviors as early sexual activity and prescription drug misuse and abuse. 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, if the identified problem is binge drinking among 18–25 year olds, the risk factor of parental monitoring would be less important than it would be among 12–17 year olds.

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
- 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

If the community has ample resources and sufficient readiness to address this intervening variable, if a suitable evidence-based intervention exists, and if 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.

Another factor you may want to consider is *time lapse*, or the amount of time between substance misuse and abuse and its consequences. A short time lapse may make it easier for you to show a relationship between your activities and improved outcomes.

Selecting Evidence-Based 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.

Evidence of Effectiveness

There is a great body of research demonstrating the effectiveness of various strategies to reduce underage alcohol consumption and its consequences. Literature reviews, published studies, unpublished

evaluation findings, and other resources may help you identify the strategies with the greatest potential to affect the intervening variables you identified as a priority.

> **Note:** The *Catalog of Environmental Prevention Strategies*, created by the Wyoming Survey & Analysis Center at the University of Wyoming, is an excellent starting point; it covers the most strategies and reviews the most research (including assessments of the strength and effectiveness of the evidence) of any resource we've found, and it includes strategies appropriate for higher education settings. However, it's important to note that this resource represents neither an exhaustive nor a mandated list of strategies. More information on this resource can be found in APPENDIX 16.

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)

> **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.

Possible strategies
To prevent or reduce underage alcohol misuse and its consequences, you might consider the following:
▪ Alternative events for youth
▪ Teen party ordinances
▪ Responsible beverage service training
▪ Compliance checks of alcohol retailers
▪ Social marketing
▪ Social norms campaigns
▪ Social host liability policy enforcement

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)

When selecting strategies, it is important to consider their comprehensiveness and potential for long-term impact. While strategies that are more narrow in focus (e.g., educating parents or teachers) may be simpler to implement, approaches aimed at changing policies, systems, and environments (e.g., development and implementation of social host liability laws) may be more likely to promote sustained improvement in outcomes.

Establishing Outcomes for Each Strategy

For each selected strategy, you will need to establish measurable outcomes. Identify the intervening variable(s) being addressed, indicate the strategy, and list anticipated short-term, intermediate, and long-term outcomes. For example:

- **Intervening variables:** Poor parental monitoring and supervision of children, lack of clear parental disapproval of substance misuse and abuse

- **Strategy:** Communication campaign aimed at reaching 90% of parents of eighth grade students with information on the importance of communicating the harms of alcohol use to their children

- **Outcomes:**

  o *Short-term:* Parents of eighth grade students believe that alcohol use is harmful for youth

  o *Intermediate:* Parents of eighth-graders clearly communicate disapproval of alcohol use to their children

  o *Long-term:* Decreased rates of alcohol use among eighth grade youth

> **Three types of outcomes**
>
> - A **short-term outcome** is the change in the target group who received your strategy
> - An **intermediate outcome** is the change in the intervening variable
> - A **long-term outcome** is the ultimate impact of the strategy on the issue identified in your problem statement

Identifying Resources for Implementation

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

- Human resources (e.g., staffing, partnerships, volunteers, coalition membership)

- Skills (e.g., data collection and analysis, prevention and intervention knowledge and skills)

- 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

Developing 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 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, related intervening variables, evidence-based strategies, and anticipated outcomes. Your logic model should include the following categories:

- Problem statement (for BSAS initiatives, this is taken from the RFR [Request for Response])

- Brief description of the local manifestation of the problem (can be quantitative, qualitative, or both)

> Further guidance on developing a logic model, including a template, is provided in APPENDIX 3.

- Intervening variable(s) (the biological, social, environmental, and economic factors that research has shown to be related to substance use and consequences of use, including risk and protective factors)

- Strategies (programs, policies, and/or practices to address the problem, and specifically the intervening variable; these should be evidenced-based, with measurable outputs—e.g., number of advertisements placed, sessions conducted, persons trained)

- Target group

- Outputs (the extent to which the strategies are being implemented as planned)

- Expected outcomes (short-term, intermediate, and long-term)

Below is an example of a logic model to address a specific problem: the high rate of alcohol use among local high school students. A key intervening variable (*High perceived ease of access to alcohol from commercial sources among 9th–12th-graders in the cluster*) is identified, which then drives the selection of the strategy: *Offer responsible beverage service training to all alcohol retail establishments in the cluster*.

Problem identified by BSAS: Underage drinking						
Local manifestation of the problem: In 2014, past-30-day use of alcohol among high school students in the cluster was higher than the state average of 36% (Smithtown: 42%; Jackson: 38%; Redmond: 39%) **Note:** A *cluster*—which is the organizing structure for SAPC grantees—is a group of towns or municipalities that are banding together to implement a program or grant.						
Intervening Variable	**Strategy**	**Target Group**	**Outputs**	**Outcomes**		
				Short-Term	**Intermediate**	**Long-Term**
High perceived ease of access to alcohol from commercial sources among 9th–12th-graders in the cluster	Responsible beverage service training	All alcohol retail establishments in the cluster (both on- and off-premise)	Number of establishments targeted Number of establishments trained Number of individuals trained	Increase in awareness, knowledge, attitudes, and responsible serving/selling practices among those trained	Decrease in perceived ease of access to alcohol from commercial sources among 9th–12th-graders in the cluster	Decrease in the % of 9th–12th grade students in the cluster who report past-30-day use of alcohol

Prevention and Reduction of Underage Drinking and Other Drug Use in Massachusetts

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

Developing 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 you are trying to accomplish
- Who is responsible
- The timeline for completion
- How you will measure success

Your action plan should be comprehensive, logical, and data-driven; it should include your community-level logic model, plans for addressing identified resource and readiness gaps, and how you have and will address issues of cultural competence and sustainability. (See APPENDIX 10: ACTION PLAN TEMPLATE AND EXAMPLE.)

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.

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 municipal grouping 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 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

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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
- Review your progress

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 reduce the consumption of alcohol among 10th-graders, outline the steps your group will take to include young adults 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.

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.

Developing 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.

> Note: Evaluation is discussed in greater detail in Step 5 of the SPF.

You will need to make plans to collect baseline information before implementing your intervention and 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. Your evaluation plan will also monitor how well your group is functioning and identify areas for improvement.

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

SAMPLE EVALUATION PLAN			
Short-Term Outcomes			
Outcomes	Indicator	Data Source	Collection Frequency
Intermediate Outcomes			
Outcomes	Indicator	Data Source	Collection Frequency
Long-Term Outcomes			
Outcomes	Indicator	Data Source	Collection Frequency

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 will shift 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.

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 agree with the goals and strategies and understand how the activities to be implemented will lead to the desired outcomes.

Capacity Building for the Implementation Phase

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, cluster) have that capacity?
- If not, how will you improve your capacity?

These types of questions should be addressed in your strategic plan.

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).

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.

Addressing Fidelity and Adaptation

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.

> **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.

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 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.
- 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.

Monitoring the Implementation Plan

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 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 use 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.

Sustainability Planning

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 various funders, which promotes the sustainability of both your group and its strategies.

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

> **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—both in terms of 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?

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.

You may want to continue working with the same stakeholders who served as your key informants (etc.), or you might want to reach out to new stakeholders. The Strategic Action Plan for the West Virginia Bureau for Behavioral Health and Health Facilities includes a number of specific action steps for engaging new stakeholders in evaluation (West Virginia Department of Health and Human Resources, 2014, p. 19):

Objective 3.3: Incorporate stakeholders into the planning, implementation, and evaluation of services	
Action Steps	**Success Measure**
Facilitate a series of stakeholder focus group sessions that include youth, leaders of youth, law enforcement, and prevention and health care providers	Four stakeholder group sessions completed
Develop an underage drinking plan that incorporates national collaborative initiatives with key stakeholders	Plan completed and disseminated
Promote youth voice in all aspects of prevention services	• Increase in number of youth participating in community coalitions • Increase in number of statewide youth initiatives

Host town hall/public meetings to gather information on and create awareness of substance abuse in West Virginia	• A minimum of four public meetings hosted by Bureau staff • A minimum of 40 town hall meetings hosted by prevention grantees in West Virginia communities
Use Web-based mechanisms to solicit input on ongoing basis from system stakeholders about substance abuse prevention capacity and models	• Completion of two surveys yearly • Website, with community blog, completed
Include prevention at all communication and advisory-level meetings	Cross-planning Council meetings conducted four times yearly

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).

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 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?

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.

An outcome evaluation can be done in various ways:
- The "gold standard" involves two groups that are similar at baseline. One group is assigned to receive the intervention and the other group serves as the control group. After the intervention, the outcomes among the intervention group are compared with the outcomes among the control group. Ideally, data should continue to be collected after the intervention ends in order to estimate effects over time.

- If it is not possible to include a control group (e.g., due to financial constraints), you can evaluate just the intervention group, collecting data at several points before, during, and after the intervention (e.g., at 3-, 6-, and/or 12-month intervals). This design allows the evaluator to analyze any trends before the intervention and to project what would have happened without the intervention, so that the projection may be compared to the actual trend after the intervention. This type of impact evaluation is less conclusive than one using a control group comparison because it does not allow you to rule out other possible explanations for any changes you may find. However, having *some* supporting evidence is better than not having any.

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?

- 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.

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 also can 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.

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 TA.** 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.

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 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*

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 underage alcohol consumption. 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.

- To reduce alcohol misuse, a community group hires professional outreach workers to deliver messages to friends, family members, and individuals who are misusing alcohol. 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.

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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 2 highlights some of the main differences between the 2000 and 2013 National CLAS Standards (Office of Minority Health, 2013a).

Table 2. 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 *health* was implicit	Explicit definition of *health* 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 3). Resources for implementing the National CLAS Standards are available from the Office of Minority Health's Think Cultural Health website (www.ThinkCulturalHealth.hhs.gov).

Table 3. 2013 National CLAS Standards

Principal Standard	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
Governance, Leadership, and the Workforce	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
Communication and Language Assistance	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
Engagement, Continual Improvement, and Accountability	9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations 10. Conduct ongoing assessments of the organization's CLAS-related activities, and integrate CLAS-related measures into measurement and continual quality improvement activities

	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
	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
	13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness
	14. Create culturally and linguistically appropriate conflict and grievance resolution processes to identify, prevent, and resolve conflicts or complaints
	15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public

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.

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.

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

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SAPC GRANT MILESTONES, TIMELINE, AND DELIVERABLES

| July 1, 2015 | April 29, 2016 | June 30, 2016 |
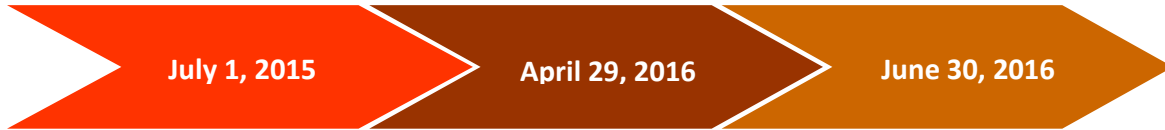
This document reflects the desire of the Massachusetts Department of Public Health's Bureau of Substance Abuse Services (BSAS) to do two things:

1. Provide SAPC grantees with **10 months to create a strategic plan** that will guide their work in subsequent years
2. Provide SAPC grantees with an opportunity to begin to pilot a prevention strategy or discrete intervention within the first six months of funding, even though this pilot may not be continued into subsequent years based on the results of the strategic planning process

- Overview
- Pilot Project Requirements: November 2, 2015–June 30, 2016
- Deadlines: July 1, 2015–June 30, 2016

Overview

- **Assessment:** The lead municipality/agency and partner municipalities (where applicable) begin work on assessing needs and resources across all municipalities within their cluster or catchment area.
- **Capacity building:** The lead municipality/agency and partner municipalities (where applicable) begin work on coalition building and developing the decision making structure that will support successful implementation of the grant.
- **Planning:** The lead municipality/agency begins to develop the strategic plan, which should be a synthesis of information from all communities within the municipal cluster region. It should identify site-by-site variation in needs, readiness, and capacity *and* draw overall conclusions about how to allocate and distribute financial and programmatic resources in a way that will best serve the entire service area.
- **Implementation (Pilot):** A *partner* municipality is required to pilot *one* universal prevention strategy while the strategic plan is being developed. In the case of a Large Individual Municipality or Public Health District, the lead municipality/agency will be responsible for implementing the pilot strategy. Implementation of the pilot strategy *must* be approved by BSAS and should begin no later than *Monday, November 2, 2015*.

  > **Note:** Details on this aspect of the project appear below under "Pilot Project Requirements."

- **Evaluation:** Programs are required to begin to track MIS service data on SAPC activities *immediately* upon award. Templates for doing so will be provided by your BSAS Contract Manager. The MIS due dates for state fiscal year 2016 are October 30, 2015; January 30, 2016; April 30, 2016; and July 30, 2016. Narrative progress reports will also be due on the same dates and follow the same timeline as the MIS reports. A link to the online narrative quarterly report

due by October 30, 2015, will be provided to you by your BSAS Contract Manager in early October. **Note: this requirement was updated in an email from Scott Formica on 12/17/2015. Programs will submit the combined MIS/narrative report throughout the first year of the grant.

No later than **Friday, April 29, 2016**, all *municipal clusters* will submit their strategic plans. The plan will cover, in detail, all five steps of the SPF, along with a list of the strategies the program plans to implement in Year 2 and a detailed implementation plan.

Pilot Project Requirements: November 2, 2015–June 30, 2016

A *partner* municipality is required to pilot *one* universal prevention strategy while the strategic plan is being developed. In the case of a Large Individual Municipality or Public Health District, the lead municipality/agency will be responsible for implementing the pilot strategy. It is our preference that this pilot be implemented by a partner municipality so that the lead municipality/agency may devote its time and resources to the Assessment, Capacity Building, and Strategic Planning phases of this project, which are vital for the creation of a comprehensive and well-developed strategic plan.

In addition, it is crucial for the lead municipality/agency to develop an effective decision-making structure to coordinate efforts across the municipal cluster or catchment area during this time period. Programs may request that the pilot strategy be implemented by the lead municipality/agency and/or more than one partner municipality within their cluster or catchment area, provided the program can demonstrate that it has the capacity to implement the pilot strategy without significantly impacting its ability to carry out the aforementioned activities. This request may be included in the **October 19th** memo (described below) and *must* be approved by BSAS.

The pilot strategy *does not* need to be chosen based on a complete SPF process—selection should be guided by capacity, feasibility, fit, and the wisdom of practice, as follows:

- REQUIRED: No later than **Monday, October 19, 2015**, the Lead Municipality must identify one cluster community that will implement one pilot strategy. This must be submitted via email to **both** your BSAS Contract Manager and your MassTAPP TA representative. Please ensure this email includes the following:

    1. Identify **one Cluster Community** implementing a Pilot Strategy.

    2. Identify **one Pilot Strategy** being implemented.

- Questions and/or requests regarding implementing more than one strategy, implementing a strategy in more than one community, continuing a previous prevention strategy (for previous UAD program grantees) or any other matters should be directed to your BSAS Contract Manager and the BSAS Assistant Director of Prevention, Fernando Perfas: fernando.perfas@state.ma.us. *Please also be sure to copy your MassTAPP TA provider on this request*.

- Acceptable strategies are activities that would serve to increase awareness, support, and/or capacity of the community to engage in activities aimed at preventing and reducing underage drinking and other drug use such as (1) sticker shock campaigns, (2) town hall meetings, or (3) alcohol alternative events (e.g., community-sponsored alcohol free events for youth, parents, and/or community members such as "early release" days, post-sporting event pep rallies, etc.). Please contact your BSAS Contract Manager for additional information or clarification around these strategies.

- The pilot strategy is intended to be an opportunity for the cluster to enhance its capacity around collaboration, coordination, and implementation. Depending on the activity, it may also benefit the Assessment portion of your strategic plan by engaging new partners/stakeholders with access to relevant data and/or providing an opportunity to collect new data to support the planning process.

- The pilot strategy does not need to be chosen based on a complete SPF process—selection should be guided by capacity, feasibility, fit, and the wisdom of practice.

- This strategy may or may not be continued into subsequent years based on the final strategic plan.

- **Important Note:** Programs _may not_ invest time or resources to labor or resource intensive strategies during this pilot period (e.g., media campaigns, social marketing/social norms campaigns, or trainings).

The determination of which partner municipality (or lead municipality/agency, if applicable) within each cluster or catchment area will implement the pilot strategy should be determined collaboratively by the members of the cluster. Priority should be given to communities that demonstrate a need for the strategy and the capacity and the readiness to implement the strategy, and that represent an appropriate fit.

Deadlines: July 1, 2015–June 30, 2016

1. **July 1, 2015**

   - SAPC grant begins.
   - The lead municipality/agency begins work on assessment and capacity-building activities.

2. **Thursday, July 16, 2015, 1 pm**

   - Mandatory 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 lead municipality
     - If applicable, a representative from the non-municipal organization named in the grant award

   Topics to be covered include an overview of the grant and statewide objectives and a detailed discussion of the municipal cluster model.

3. **Wednesday, September 30, 2015, 12 pm**
   - Mandatory webinar for new grantees in which the following individuals are required to participate:
     - Project coordinator (if this individual has been hired) or other appropriate lead municipality representative
     - Topics to be covered include an overview of the contract reporting deliverables including MIS and Narrative reports.

4. No later than **Friday, October 2, 2015**
   - Programs must schedule a meeting with their MassTAPP TA provider to discuss:

- - Status of the development of a decision-making structure for coordinating efforts across the municipal cluster region
  - 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

5. No later than **October 19, 2015**
   - Lead municipality/agency must submit a memo to BSAS that includes the following:
     - An outline of the pilot strategy that will be implemented while the strategic plan is being developed
     - The partner municipality/agency being designated to implement the pilot strategy
     - A one-page description of the designated partner's capacity and readiness to implement the strategy, as well as the need for and the appropriateness of the strategy in that community

6. **October 13-16, 2015**
   - Mandatory Substance Abuse Prevention Skills Training for SAPC Coordinators in Waltham. Contact your contract manager with questions about this training.

7. **October 30, 2015**
   - First MIS/Narrative reporting deadline.

8. No later than **Monday, November 2, 2015**
   - Programs begin pilot strategy after receiving approval from BSAS.

9. **December 14, 2015, 10:30-12**
   - Mandatory webinar *Selecting and Prioritizing Intervening Variables for your SAPC Grant*

10. No later than **Friday, December 18, 2015**
    - Programs must schedule a meeting with their MassTAPP TA provider to discuss the following:
      - Completion of the Assessment phase and beginning of analysis of data collected
      - Identification and prioritization of Intervening Variables and Strategies based on the data collected during the Assessment phase

11. No later than **Friday, January 29, 2016**
    - Programs must submit a draft of Sections 1 and 2 of their Strategic Plan to their BSAS Contract Manager and their MassTAPP TA provider for review.

12. **January 30, 2016**
    - Second MIS/Narrative reporting deadline.

13. **February 24, 2016, 10am-12pm**
    - Mandatory webinar: *Strategic Planning 201: Re-visiting IV Prioritization, Selecting Strategies, and Developing your Logic Model.* This is a required webinar for all program coordinators.

14. No later than **Friday, April 8, 2016**
    - Programs must submit a draft of their completed **strategic plan, including logic model,** to their MassTAPP TA provider for review.

15. No later than **Friday, April 29, 2016**

    - Programs must submit their completed **strategic plan** to BSAS.

16. **April 30, 2016**
    - Third MIS/Narrative reporting deadline.

17. **June 30, 2016:**
    - End of the first year of the SAPC grant.

18. **July 1, 2016**
    - Beginning of the second year of the SAPC grant.
    - Upon BSAS approval of the **strategic plan** all programs begin **full implementation** of the strategies identified in their strategic plan, which may or may not include their pilot strategy, based on the results of their needs assessment.

19. **July 30, 2016**
    - Fourth MIS/Narrative reporting deadline.

20. **July 2016, date TBD**
    - Mandatory webinar for grantees in which the following individuals are required to participate:
        o Project coordinator or other appropriate lead municipality representative
    - Topics to be covered include an overview of the contract reporting systems including instructions on how to complete MIS and Narrative reports.

APPENDIX 2: SAPC STRATEGIC PLAN DEVELOPMENT GUIDE

This template outlines the sections and content of the regional strategic plan that must be submitted to BSAS no later than **April 29, 2016**. Please note that this plan covers the time period beginning July 1, 2016, when you move to full implementation—it does not cover what you may have done during the pilot period.

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 MassTAPP TA provider for review no later than **April 8, 2016**, prior to the final submission to BSAS on **April 29, 2016**.

Statement of Grant Intent

The SAPC initiative is intended to prevent underage drinking and other drug use across the Commonwealth. BSAS *strongly encourages* SAPC grant recipients to place the majority of their focus on the universal prevention of underage drinking through the implementation or amendment of local policies, practices, systems, and environmental change. Research shows that by addressing the issue of underage drinking, you will reduce the risk that youth will go on to use opioids and other substances.

While this is not required, SAPC grantees may choose to use a subset of their resources on the universal prevention of other drug, provided that they adequately address the issue of underage drinking with the majority of their SAPC funding and that there are substantial data to support other drug use beyond alcohol.

> **Note:** If you do not intend to focus any of your SAPC resources on other drug use, just respond in relation to underage drinking when you see the term "underage drinking and other drug use" below.

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 cluster (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 underage drinking and other drug use in the cluster

- The strategies you will implement related to the universal prevention of underage drinking and other drug use (including the area[s] of your cluster in which they will be implemented)

Step 1: Assessment

1.1. Assessment Data on Underage Drinking and Other Drug Use

Briefly describe the process you used to collect data on underage drinking and other drug use across your cluster:
- What data sources and techniques for data collection did you use (e.g., focus groups, surveys, key informant interviews)?

Include numbers/rates/percentages demonstrating your best source(s) of evidence related to what underage drinking and other drug use looks like in your cluster.

- Identify the source(s) of information for any quantitative (numerical) and qualitative (narrative) data.

- Are any subpopulations of youth disproportionately affected by underage drinking and other drug use in your cluster? If so, please list these populations and refer to the data/evidence that were used to determine this.

- Note any gaps in the available data on underage drinking and other drug use 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 underage drinking and other drug use data was conducted.

- 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)?

1.2. Assessing Intervening Variables on Underage Drinking and Other Drug Use

Briefly describe the process you used to collect data on intervening variables as they relate to underage drinking and other drug use across your cluster:

- What data sources and techniques for data collection did you use (e.g., focus groups, surveys, key informant interviews)?

- List all intervening variables related to underage drinking and other drug use that you investigated, including data (qualitative and/or qualitative) on each variable and the source(s) of evidence.

- Note any gaps in the available data on intervening variables related to underage drinking and other drug use 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 underage drinking and other drug use was conducted.

1.3. 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 starting on July 1, 2016?

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) currently collaborating with you on SAPC.

- Describe how, if at all, you intend to collaborate with local colleges and/or universities located within your cluster.

- Please explain how members of the general community will be engaged in SAPC.

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

2.2. Structure and Functioning of the Cluster

- Please provide an organizational chart of the governing structure of the SAPC project within your cluster, including any subgroups.
- How are the representatives of each community within the cluster functioning as a team?
- What is the decision-making process in your cluster?
- 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 for the Cluster

- Please list the membership of the core planning committee responsible for guiding the SAPC 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 Underage Drinking and Other Drug Use

- Describe the strengths within your cluster to address underage drinking and other drug use.
- Describe areas of growth in your cluster that will need to be addressed in order for you to more effectively address the issue of underage drinking and other drug use.
- 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 MassTAPP, BSAS, or others in the area of capacity building once your strategic plan has been approved and you move into the implementation phase starting on July 1, 2016?

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 Underage Drinking and Other Drug Use

Please describe the following related to your plan for underage drinking and other drug use:

- The final set of intervening variable(s) from section 1.2 *that you selected*, including how this list was selected (prioritized) from among the larger list of variables considered
- The specific target population(s) for underage drinking and other drug use
- The list of strategies you propose to implement to address underage drinking and other drug use, and the area(s) in your cluster in which they will be implemented
- The rationale for each selected strategy (conceptual fit, practical fit, link to research)
- The cultural competence of the selected strategy or strategies
- The sustainability of the selected strategy or strategies
- How risk and protective factors were considered in the planning and identification of strategies

3.3. Problem Statement Related to Underage Drinking and Other Drug Use

- Based on your analysis and understanding of the issue, please provide a two- to four-sentence problem statement that describes *why* underage drinking is an issue in your cluster and the *basis* for making this claim.
- If you are also focusing on other drug use, please provide a concise problem statement about other drug use in your cluster.

3.4 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 3: SAPC LOGIC MODEL DEVELOPMENT GUIDE for additional guidance.

3.5. 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 ongoing strategic planning or logic models once your strategic plan has been approved and you move into the implementation phase starting on July 1, 2016?

Step 4: Implementation

4.1. Implementation of Underage Drinking and Other Drug Use Strategies

In this section, describe your underage drinking and other drug use 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; the scope of implementation [multiple cities w/in the cluster, across the cluster, etc.]).

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 MassTAPP, BSAS, or others in the area of implementation once your strategic plan has been approved and you move into the implementation phase starting on July 1, 2016?

Step 5: Evaluation

5.1. Existing and Planned Youth Surveys

For the community in which the **lead municipality/agency** is located, please answer the following:
- Has the community administered a student health survey within the past three years among public school students in grades 6–12 that includes questions about underage alcohol and other drug use? If so, when was the survey implemented, how often, and at which grade levels?

- Does the community plan to administer a student health survey within the next two years among public school students in grades 6–12 that includes questions about underage alcohol and other drug use? If so, please identify the grade levels and anticipated timing of the survey(s).

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 starting on July 1, 2016?

APPENDIX 3: SAPC LOGIC MODEL DEVELOPMENT GUIDE

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.

Logic Model Template

Problem identified by BSAS:

Local manifestation of the problem:

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

Logic Model Example

Problem identified by BSAS: Underage drinking						
Local manifestation of the problem: In 2014, past-30-day use of alcohol among high school students in the cluster was higher than the state average of 36% (Smithtown: 42%; Jackson: 38%; Redmond: 39%) **Note:** A *cluster*—which is the organizing structure for SAPC grantees—is a group of towns or municipalities that are banding together to implement a program or grant.						
Intervening Variable	**Strategy**	**Target Group**	**Outputs**	**Outcomes**		
				Short-Term	**Intermediate**	**Long-Term**
High perceived ease of access to alcohol from commercial sources among 9th–12th-graders in the cluster	Responsible beverage service training	All alcohol retail establishments in the cluster (both on- and off-premise)	Number of establishments targeted Number of establishments trained Number of individuals trained	Increase in awareness, knowledge, attitudes, and responsible serving/selling practices among those trained	Decrease in perceived ease of access to alcohol from commercial sources among 9th–12th-graders in the cluster	Decrease in the % of 9th–12th grade students in the cluster who report past-30-day use of alcohol

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 is taken from the RFR (Request for Response) for each BSAS initiative. It describes why BSAS has made these grant dollars available.

Example:

Problem identified by BSAS: Underage drinking

Part 2: Local Manifestation of the Problem

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

Example:

Local manifestation of the problem: In 2014, past-30-day use of alcohol among high school students in the cluster was higher than the state average of 36% (Smithtown: 42%; Jackson: 38%; Redmond: 39%)

Note: A *cluster*—the organizing structure for SAPC grantees—is a group of towns or municipalities that are banding together to implement a program or grant.

Part 3: Intervening Variable

These are the biological, social, environmental, and economic factors that research has shown to be related to substance use and consequences of use. This category includes but is not limited to risk and protective factors.

Example:

Intervening Variable
High perceived ease of access to alcohol from commercial sources among 9th–12th-graders in the cluster

Part 4: Strategy (or Intervention)

These are the programs, policies, and/or practices to reduce use and/or consequences of use. They are expected to 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:

Strategy
Responsible beverage service training

Part 5: Target Group

This refers to the immediate audience for each strategy. Please also specify whether this group is specific to the entire area/cluster or to specific communities.

Example:

Target Group
All alcohol retail establishments in the cluster (both on- and off-premise)

Part 6: Outputs

This measures 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:

Outputs
• Number of establishments targeted • Number of establishments trained • Number of individuals trained

Part 7: Short-Term Outcomes

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

Example:

Short-Term Outcomes
Increase in awareness, knowledge, attitudes, and responsible serving/selling practices among those trained

Part 8: Intermediate Outcomes

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

Example:

Intermediate Outcomes
Decrease in perceived ease of access to alcohol from commercial sources among 9th–12th-graders in the cluster

Part 9: Long-Term Outcomes

These are the ultimate goals of the program, which often take time to achieve.

Example:

Long-Term Outcomes
Decrease in the % of 9th–12th grade students in the cluster who report past-30-day use of alcohol

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 SAPC grant following the strategic planning year).
- You are *required* to update your logic model *annually*.

Appendix 4: MIS Guidance Document for Calculating the Number and Demographics of People Served

Note: SAPC grantees will use an online system to do their reporting. The form will be available in July 2015 and will be explained in the webinar for grantees on July 16. An example of the old Excel spreadsheet, which the new system is based on, is currently available online if you'd like an idea of what to expect.

What Is This Document?

This guidance document explains how to use the accompanying spreadsheet that MassTAPP has developed with BSAS. The spreadsheet will help you report your data as accurately as possible and in a manner consistent with all other funded communities. It is designed to calculate all the totals you will need to report to BSAS using the numbers you populate the spreadsheet with, according to the instructions below. The spreadsheet can also help you answer other questions, for example:

- Which strategies reach which age groups?

- Which strategies require me to estimate demographic information?

- For which strategies can I analyze the demographic groups reached?

- How do my coalition's strategies compare to one another, in terms of ages reached, numbers reached, and overall reach?

As BSAS grantees, you are required to report on how many people in your community you reach and how you reach them. As part of this requirement, you must submit an Excel spreadsheet to BSAS that includes counts of the numbers of people reached each month and their demographic information, accompanied by a narrative report. Your MassTAPP TA provider is available to assist you with this process.

The Big Picture of MIS Reporting

The Prevention Management Information System (MIS) data collection instrument has been designed for the purpose of capturing the information that BSAS needs to complete the yearly federal Uniform Block Grant Application to SAMHSA. The Substance Abuse Prevention Treatment Block Grant supports the staff and the operation of the prevention programs.

The aggregated statistical data from states can be used by SAMHSA to (1) demonstrate to Congress the array of substance abuse prevention strategies being implemented, (2) give them an understanding of who benefits from these strategies, and (3) provide them with a better understanding of future needs. Data from your reports may also be used by BSAS to get the big picture of how prevention work is impacting communities across the state.

Completing the Spreadsheet

Demographics

Whenever possible, demographic information should be collected through self-reports (ask people how they identify in terms of gender, race, ethnicity, language group, and age). If that's not possible, try to access information about the demographics of the people you reached through other means, such as

school records or program files where participants have reported their own ethnicity, race, and language. In these cases, you'll have to write an explanation about how you gathered the information.

It is important that you collect this information from a reliable source, such as school demographic data, and that you do not try to guess. If demographic information isn't available, report the demographics as "unknown."

Strategies and Activities

Your first step in using the new spreadsheet should be to enter the names of the strategies that are part of your logic model and action plan under the "Strategies/Activities" tab.

Calculating the "New" and "Total" Number of Participants

Each person should be counted as "new" only once each fiscal year (the state fiscal year goes from July 1 to June 30). For example, if you hold a monthly community meeting starting in July, you would only count the individuals as "new" in the month of July, and you would not include them in your "new" count again even if they attend your meeting each month. Demographics are only entered for new participants in order to avoid double-counting. You should keep track of the total number of people served by activity each month, but these totals will not be used by the spreadsheet to create the totals you submit in your quarterly summaries, since they will likely include multiple counts of the same people.

Definitions of Prevention Strategies

Information Dissemination

These strategies provide awareness and knowledge of the nature and extent of substance abuse and addiction and its effects on individuals, families, and communities. Information dissemination is characterized by one-way communication from the source to the audience. Types of services conducted and methods used for implementing this strategy include clearinghouse/information resource centers, resource directories, media campaigns (including positive social norms marketing campaigns), brochures, radio and TV public service announcements, speaking engagements, health fairs, and other types of health promotion (e.g., conferences, meetings, seminars).

Community-Based Process

These strategies aim to enhance the ability of the community to more effectively provide substance abuse prevention and treatment. This includes organizing, planning, and enhancing the efficiency and effectiveness of, for example, community and volunteer training (e.g., neighborhood action training, training of key people in the system, training of staff and officials), systematic planning, multi-agency coordination and collaboration, community team-building, and accessing services and funding.

Education

Substance abuse prevention education involves two-way communication and interaction between the educator/facilitator and the participants. Types of services conducted and methods used include groups for children of substance abusers, classroom educational services, educational services for youth groups, parenting or family management services, peer leader/helper programs, and small-group sessions.

Environmental

This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs by the general population. Types of services include compliance checks in liquor outlets or establishments; promoting the establishment or review of alcohol, tobacco, and drug use policies in schools; guidance and TA on monitoring the availability and distribution of alcohol, tobacco, and other drugs; modifying alcohol and tobacco advertising practices; and product pricing strategies.

> **Note:** Social marketing and positive social norms marketing campaigns are not examples of environmental strategies, according to the Center for Substance Abuse Prevention. These fall under "information dissemination."

Problem Identification and Referral

These strategies aim to classify those who have indulged in illegal or age-inappropriate use of tobacco or alcohol and those who have indulged in the first use of illicit drugs, and to assess whether their behavior can be reversed through education. Types of services include employee assistance programs, student assistance programs, and DUI, DWI, and MIP (Minor In Possession of Alcohol) programs.

Alternatives

These strategies provide for the participation of target populations in activities that exclude substance abuse, for example, drug-free dances and parties, youth-adult leadership activities, community service activities, community drop-in centers, Outward Bound, and recreation activities.

APPENDIX 5: ARCHIVAL AND SURVEY DATA SOURCES FOR UNDERAGE DRINKING: A COMMUNITY DATA CHECKLIST

Possible data sources related to underage drinking 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.

> **Note:** 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.

A. Demographics
1. *Population*
   Total population of city / town (circle one)

   Note: If these (or any other) data are unavailable, note "n/a."

2. *Race breakdown (by %)*
   White
   African American
   Asian
   Native American
   Other (please indicate)

3. *Ethnic breakdown (by %)*
   Hispanic/Latino
   Other relevant cultural groups (e.g., Cape Verdean)
   Other (please indicate)

4. *Under 21 youth*
   Number of youth ages 0–14
       % of the total population
   Number of youth ages 15–20
       % of the total population

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)

B. Highway Safety Data—Past Year[4]
   Number of underage DWI/DUI arrests
       % of total DWI/DUI arrests
   Number of underage DWI/DUI convictions
       % of total DWI/DUI convictions

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[4] If trend data are available, it might also be helpful to know if the numbers are going up or down.

Potential sources: Police department, local or municipal court

Number of students saying that they rode in a car or other vehicle driven by someone who had been drinking alcohol one or more times

Number of students saying that they drove a car or other vehicle when they had been drinking alcohol in the past 30 days

Potential source: Youth risk behavior survey

C. Alcohol Sales and Liquor Law Violations—Past Year

Number of retail outlets in the community that sell alcohol (i.e., retail liquor establishments, restaurants, bars, and any other licensed alcohol venue)

Number of retail outlets that have been cited for selling alcohol to a minor

Number of license suspensions for sales to minors

Number of license revocations for sales to minors

Number of citations for underage possession of alcohol or use of a fake ID

Number of citations for underage consumption of alcohol

Number of citations for adult purchase of alcohol for and/or provision of alcohol to a minor

Potential sources: Police department, town/city clerk, local liquor licensing board, state Alcoholic Beverages Control Commission, local alcohol purchase survey

D. School Data—Past Year

Middle school (grades –):

Number of alcohol-related suspensions, expulsions, and other events

Number of alcohol-related incidents of vandalism and campus disruptions

High school (grades –):

Number of alcohol-related suspensions, expulsions, and other events

Number of alcohol-related incidents of vandalism and campus disruptions

Potential sources: Superintendent of schools, police department

E. Other Criminal Justice Data—Past Year

Number of parties to which police were called because of underage drinking

Number of cases of vandalism, property damage, rape, robbery, assault, murder, etc. that also involved underage alcohol use

Potential sources: Local or municipal court, juvenile justice services, police department, local hospitals

F. Injuries and Deaths Involving Alcohol (except those involving motor vehicles)—Past Year

Number of underage youth alcohol-related emergency room admissions/EMS data

Potential sources: Local hospital emergency rooms, local fire department

G. Alcohol Treatment—Past Year

Number of beds for underage youth

Number of beds filled by underage youth

Number of alcohol-related admissions
Number <<of underage youth>>on waiting list for admission or other indication of need

Potential sources: Local hospitals, local alcohol treatment centers

H. Prevention Initiatives
Number of alcohol education and prevention programs for parents
Number of alcohol-free programs and activities for youth
Number of local substance abuse prevention organizations
Number of youth substance abuse prevention organizations (SADD, etc.)

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

I. Youth Risk Behaviors and Attitudes
Youth risk behavior survey is administered
    (If yes) Results of this survey are available
Survey on youth behaviors and attitudes regarding alcohol use is administered
    (If yes) Results of this survey are available

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

J. Alcohol Use
Middle school (grades   –   ):
    Number of students who report skipping class due to being drunk or high in the past year (local)
    Number of students who report skipping class due to being drunk or high in the past year (statewide)
    Number of students who report past-30-day alcohol use (local)
    Number of students who report past-30-day alcohol use (statewide)
    Number of students who report being under the influence of alcohol at school in the past year (local)
    Number of students who report being under the influence of alcohol at school in the past year (statewide)
    Number of students who had more than five drinks in a row in the past year (local)
    Number of students who had more than five drinks in a row in the past year (statewide)
High school (grades   –   ):
    Number of students who report skipping class due to being drunk or high in the past year (local)
    Number of students who report skipping class due to being drunk or high in the past year (statewide)
    Number of students who report past-30-day alcohol use (local)
    Number of students who report past-30-day alcohol use (statewide)
    Number of students who report being under the influence of alcohol at school in the past year (local)
    Number of students who report being under the influence of alcohol at school in the past year (statewide)
    Number of students who had more than five drinks in a row in the past year (local)
    Number of students who had more than five drinks in a row in the past year (statewide)

College:
   Number of students who report skipping class due to being drunk or high in the past year (local)
   Number of students who report skipping class due to being drunk or high in the past year (statewide)
   Number of students who report past-30-day alcohol use (local)
   Number of students who report past-30-day alcohol use (statewide)
   Number of students who report being under the influence of alcohol at school in the past year (local)
   Number of students who report being under the influence of alcohol at school in the past year (statewide)
   Number of students who had more than five drinks in a row in the past year (local)
   Number of students who had more than five drinks in a row in the past year (statewide)

Potential sources: Youth risk behavior and use surveys, state and community substance abuse prevention agencies, campus health and wellness center

K. 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 (statewide)
   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 (statewide)
   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 (statewide)
   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 (statewide)
   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 (statewide)
   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 (statewide)

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 these data for the academic year 2013–2014.

L. 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 6: KEY STAKEHOLDER/INFORMANT INTERVIEWS

This appendix provides information on how to conduct stakeholder interviews. An interview guide and summary sheet are also included.

Pre-Interview Planning Process

Key informant interviews involve identifying different members of your community who are especially knowledgeable about a topic (whom we call *key informants*) and asking them questions about their experiences working or living within a community. It is typical to do 8–10 key informant interviews and to seek out people with more than average knowledge to interview. These interviews are usually conducted face to face with your informants, 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 key informant 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 informants can relate to. This could mean the interviewer shares attributes with the key informant (e.g., race/ethnicity, gender, age) or that the interviewer is particularly familiar with the culture of the key informant.

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? Who is misusing alcohol? [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.
> —*HealthyPeople 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?

Part VI: Questions for Specific Groups of Interviewees[5]

Questions for Medical Providers and Youth-Serving Groups

- Do you think that underage drinking is a serious problem in this community?
  Probe: [If yes] Why? [If no] Why not?

- Do you know youth in this community under the age of 21 who use alcohol?

- Are there certain subpopulations of kids under 21 who are more likely to drink alcohol in this community?

- Do you know of parents or adults in this community who permit youth under the age of 21 to consume alcohol in their homes?

- Where do you think minors under age 21 in this community obtain alcohol?

- Under what circumstances is it acceptable for an adult to provide alcohol to minors under age 21?

- What forms of media or advertising do you think influence alcohol use among minors under age 21 in this community?

- If you were aware of a minor under the age of 21 who was consuming alcohol, what would you do?

- What resources are available in this community to address alcohol use among minors under age 21?

Questions for Law Enforcement

- Do you think that underage drinking is a serious problem in this community?
  Probe: [If yes] Why? [If no] Why not?

- What specific measures are being taken in this community to enforce laws against underage drinking?

- What specific measures are being taken in this community to enforce laws regarding sales of alcohol to minors? to enforce laws regarding adults supplying alcohol to minors? to conduct party patrols?
  Probe: Do you know of any other measures?

- How effective do you think those measures are at enforcing laws against underage drinking? What would help make them more effective?

- Are there certain subpopulations of kids who are more likely to drink alcohol in this community?

- Do you think the legal consequences for underage drinking offenses are sufficient?
  Probe: [If yes] Why? [If no] Why not?

- Do you think judges and the juvenile justice system are doing a good job with respect to underage drinking violations?
  Probe: [If yes] Why? [If no] Why not?

- Based on your view of this community, how acceptable is it for minors to drink alcohol?

- Where do you think people under the age of 21 in this community get alcohol (e.g., home, liquor store, grocery store, convenience store, bar/restaurant, friends)?

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[5] The questions in Part VI were adapted from Rhode Island State Epidemiology and Outcomes Workgroup, Buka, and Rosenthal (2015).

- Where do you think people under the age of 21 in this community drink alcohol?

Questions for School-Based Personnel/Educators

- Do you think that underage drinking is a serious problem in this community?
  Probe: [If yes] Why? [If no] Why not?
- Do you know youth in this community under the age of 21 who use alcohol?
- Do you know of parents or adults in this community who permit youth under the age of 21 to consume alcohol in their homes?
- Are there certain subpopulations of kids who are more likely to drink alcohol in this community?
- Does your school have an alcohol policy? If yes, is it enforced?
- Is alcohol education part of the school's curriculum? If yes, is it effective?
- Does your school sponsor extracurricular activities to prevent underage drinking?
- Do you think parents understand the seriousness of the underage drinking problem?
  Probe: [If yes] Why? [If no] Why not?
- What role do you think that teachers and counselors can play in reducing underage drinking?
- What is the most effective way to keep underage youth from drinking alcohol?
- Does your school have a mechanism in place for identifying and assisting students who may have an alcohol problem?

Questions for Community Leaders and Public and Elected Officials

- Do you think that underage drinking is a serious problem in this community?
  Probe: [If yes] Why? [If no] Why not?
- Do you know youth in this community under the age of 21 who use alcohol?
- Where do you think people under the age of 21 in this community get alcohol (e.g., home, liquor store, grocery store, convenience store, bar/restaurant, friends)?
- Do you think that there are sufficient laws to reduce underage drinking?
  Probe: [If yes] What are the most effective laws? [If no] What additional laws need to be passed to reduce underage drinking?
- Do you think the public is aware of current underage drinking laws and regulations?
- How would you improve underage drinking legislation in this state?
- What is the role of public and elected officials in reducing underage drinking?
- How would you improve local laws, policies, or procedures related to underage drinking?

Questions for Health and Prevention/Treatment Specialists

- Do you think that underage drinking is a serious problem in this community?
  Probe: [If yes] Why? [If no] Why not?
- Do you know youth in this community under the age of 21 who use alcohol?
- Do you know of parents or adults in this community who permit youth under the age of 21 to consume alcohol in their homes?
- Where do you think people under the age of 21 in this community get alcohol (e.g., home, liquor store, grocery store, convenience store, bar/restaurant, friends)?

- What are the barriers, if any, to reducing underage drinking in this community?
- Are there certain subpopulations of kids who are more likely to drink alcohol in this community?
- What is the role of health professionals, prevention specialists, and treatment personnel in reducing underage drinking in this community?
- Do you think the general public understands the underage drinking problem in this community?
- What can be done to solve the problem of underage drinking in this community?

Questions for Business Leaders

- Do you think that underage drinking is a serious problem in this community?
  Probe: [If yes] Why? [If no] Why not?
- Where do you think people under the age of 21 in this community get alcohol (e.g., home, liquor store, grocery store, convenience store, bar/restaurant, friends)?
- Do you think that there are sufficient laws to reduce underage drinking?
  Probe: [If yes] What are the most effective laws? [If no] What additional laws need to be passed to reduce underage drinking?
- Do you think local businesses are aware of current underage drinking laws and regulations?
  Probe: [If yes] Why? [If no] Why not?
- What is the role of local business officials in reducing underage drinking?
- How would you improve local laws, policies, or procedures related to underage drinking?

Questions for Faith Leaders

- Do you think that underage drinking is a serious problem in this community?
  Probe: [If yes] Why? [If no] Why not?
- Do you know youth in this community under the age of 21 who use alcohol?
- Do you know of parents or adults in this community who permit youth under the age of 21 to consume alcohol in their homes?
- What are the main reasons, do you think, that kids in this community drink alcohol?
- What role can the church play in reducing underage drinking?
- Do you think parents understand the seriousness of the underage drinking problem?
  Probe: [If yes] Why? [If no] Why not?
- What is the most effective way to keep underage youth from drinking alcohol?
- What resources are available in your community to address alcohol use among minors under age 21?

Part VII: Additional Comments, Observations, or Questions

- **Question:** Do you have any other comments or observations you would like to make?
- **Probe:** Do you have any questions about this project?

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: _____

  _____

  _____

  _____

- The general focus of your questions (note: please attach the actual questions you used): _____

  _____

  _____

  _____

- The themes that emerged: _____

  _____

  _____

  _____

- Your conclusions—the big take-away messages: _____

  _____

  _____

  _____

APPENDIX 7: 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

Note: Sample questions for focus groups of youth and focus groups of parents are included on pages 91 and 92.

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 they 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 were 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[6]

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)?

> Healthy People 2020 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."
> —*Developing Healthy People 2020* (2008), p. 28

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.

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"

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[6] This section was adapted from Rhode Island State Epidemiology and Outcomes Workgroup, Buka, and Rosenthal (2015).

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.

SAMPLE QUESTIONS FOR YOUTH FOCUS GROUPS ON ALCOHOL[7]

Social norms:
- Is underage drinking a serious problem in (name of the community)?
  Probe: [If yes] Why? [If no] Why not?
- Do all youth engage in underage drinking, or is it just a few?
  Probe: What percentage of students at your school do you think drink alcohol?
- How old are most kids when they started drinking alcohol?
- In your opinion, how often do kids drink alcohol?
- In your opinion, what are the main reasons that kids drink alcohol?
- Are there certain subpopulations of kids who are more likely to drink alcohol in this community?

Perceptions of harm:
- What are the potential consequences of underage drinking?
- Do you think underage drinking is harmful?
  Probe: [If yes] How or why? [If no] Why not?
- What do you think should happen to a kid who is caught drinking alcohol?

Drinking and driving:[8]
- Do you know kids who've ridden in a car or other vehicle driven by someone who had been drinking alcohol?
- Do you someone who's driven a car or other vehicle when he or she had been drinking alcohol?
- Do you know someone who was killed or injured in a drunk driving crash?
- Do you know someone who has been arrested for drunk or impaired driving?
- What do you think should be the penalty for underage drinking and driving?

Parental monitoring:
- How do parents in this community feel about their kids drinking alcohol?
- If kids in your community drink alcohol, how likely are other people to find out?
  Probe: Parents? Family members? Police? Teachers?

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[7] The questions in this section were adapted from Rhode Island State Epidemiology and Outcomes Workgroup, Buka, & Rosenthal (2015).

[8] Some questions in this section were adapted from the Wyoming Department of Health (2007).

- Do you know of parents or adults who permit youth under the age of 21 to consume alcohol in their homes?

Access and availability:
- How do most kids get alcohol?
- How easy would it be for people your age to get alcohol from those sources?
- Where do kids go when they want to drink alcohol?

Outreach/programs:
- Does your school have an alcohol policy?
- Does your school offer any education about alcohol?
- What programs or services are available in your community to help students avoid drinking alcohol?
- Are you aware of local resources that can help students with alcohol-related problems?
- How effective do you think our community is at enforcing laws against underage drinking?
- In your opinion, would any of the following solutions be effective at stopping underage drinking in your community: tagging beer kegs with the ID of the purchaser, offering an 800 number for citizens to report stores that sell to minors, providing server/seller training programs for places that sell alcohol, conducting a public awareness campaign?
- What other ideas or strategies could [name of your group] try to keep students from drinking alcohol?

Sample Questions for Parent Focus Groups on Alcohol

Social norms:
- Is underage drinking a serious problem in (name of the community)?
  Probe: [If yes] Why? [If no] Why not?
- Do all youth engage in underage drinking, or is it just a few?
  Probe: What percentage of students at your child's school do you think drink alcohol?
- Do you know any youth under the age of 21 who use alcohol?
- How old are most kids when they started drinking alcohol?
- In your opinion, how often do kids drink alcohol?
- In your opinion, what are the main reasons that kids drink alcohol?
- Are there certain subpopulations of kids who are more likely to drink alcohol in this community?

Perceptions of harm:
- What are the potential consequences of underage drinking?
- Do you think underage drinking is harmful? If so, how or why?
- What do you think should happen to a kid who is caught drinking alcohol?

Parental monitoring:
- Do parents in your community talk to children about alcohol?

- How do parents feel about their kids drinking alcohol?

- Under what circumstances is it acceptable for an adult to provide alcohol to minors under age 21—holidays, special occasions, at meals, never, other?
  Probe: If you picked "other," please specify.

- If kids in your community drink alcohol, how likely are other people to find out?
  Probe: Parents? Family members? Police? Teachers?

- Do you know of parents or adults who permit youth under 21 to consume alcohol in their homes?

Access and availability:
- How do most kids in your community get alcohol?

- How easy is it for kids to get alcohol from those sources?

- Where do kids go when they want to drink alcohol?

Outreach/programs:
- Are you aware of local resources that can help students with alcohol-related problems?

- What's happening in the community to educate parents about underage drinking?

- How effective do you think our community is at enforcing laws against underage drinking?

- What ideas or strategies could [name of your group] try in order to keep students from drinking alcohol?

APPENDIX 8: RISK AND PROTECTIVE FACTOR DATA ORGANIZER

This tool allows you to organize and compare the data you gather in order to 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 22.)[9]

Risk or Protective Factor[10]	Mentioned During Key Informant Surveys or Focus Groups			Supported by Quantitative Data?	
	Frequently	*Moderately*	*Infrequently or Not at All*	*Yes*	*No or N/A*
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
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; **Moderately** 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.

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[9] Adapted from Rhode Island State Epidemiology and Outcomes Workgroup, Buka, and Rosenthal (2015).

[10] A good resource is *Risk and Protective Factors Associated with Binge or Heavy Episodic Drinking Among Adolescents and Young Adults*, a literature review of risk and protective factors for binge drinking among adolescents and young adults conducted by SAMHSA's Center for the Application of Prevention Technologies (CAPT) in 2015. It can be found here: http://captus.samhsa.gov/sites/default/files/captresource/riskprotectivefactorsheavybingedrinking.rem.41215.pdf

Appendix 9: Capacity-Building Worksheet

Instructions: Fill out this worksheet for each identified area of needed growth.

Issue / Area of Growth:

How the Capacity Need Will Be Addressed:

Person(s) Responsible:

Timeline:

Measure of Success:

APPENDIX 10: ACTION PLAN TEMPLATE AND EXAMPLE

Template

Strategy 1:

Action Steps	Person Responsible	Timeline	Measure(s) of Success

Example

Strategy 1: Responsible beverage service training

Action Steps	Person Responsible	Timeline	Measure(s) of Success
• Identify current server trainings (if any)—who does them, who pays for them, how frequently do they happen, how effective are they?	• Cathy Smith	• October	• Trainings identified
• If trainings are needed, compile list of local licensed establishments (a comprehensive list is sometimes available for purchase through your state Alcoholic Beverages Control Commission; otherwise, active licenses are on file with local licensing boards)	• John West	• November	• List created or obtained
• Identify appropriate trainer(s) (continued on next page)	• TBD	• November	• Trainer(s) identified

Strategy 1: Responsible beverage service training (continued)

Action Steps	Person Responsible	Timeline	Measure(s) of Success
• Schedule, publicize, and host/facilitate trainings	• TBD	• January	• Servers trained; public informed of training; servers apply knowledge from training; decrease in retail access by teens; decrease in perception of retail access

APPENDIX 11: STRATEGIES FOR WORKING WITH THE MEDIA

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Tip Sheet: Strategies for Working with the Media

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In 2013, an estimated 17.3 million people reported being dependent on or abusing alcohol,[i] and approximately 7 million said they had been dependent on or abused illicit drugs[ii] 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[iii]

✓ **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?

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✓ **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[iv]

✓ **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:
   o What prompted the media to call your organization?
   o What is the media interested in knowing?
   o What specific subject areas will the interview cover?
   o Is the media willing to share the interview questions in advance?
   o With whom do the media want to speak? Leadership? Other stakeholders?
   o Where will the story appear?
   o When will the story run or be posted?
   o When is the reporter's story deadline?
   o How will the interview be conducted—by phone, email, or in person?
   o Will the interview be recorded?
   o How long will the interview last?

✓ **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[v]

✓ **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

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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 …

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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.[vi]

[i] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013.
[ii] Ibid.
[iii] Excerpted from a spokesperson training developed by Vanguard Communications, 2015.
[iv] Ibid.
[v] Ibid.
[vi] Excerpted from a persuasive storytelling training developed by Vanguard Communications, 2013.

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Appendix 12: 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, however, 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.[i]

- ✓ **Do describe addiction as an illness.** Just like any other illness—such as cancer—individuals can be predisposed to addiction, meaning that for some people, trying a drug just once could lead to a pattern of addictive use.[i]

- ✓ **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.[ii]

- ✓ **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.[iii]

- ✓ **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, abuse, and/or recovery by peers can often engage individuals who may be resistant to more general prevention messages.[iv,v]

- ✓ **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.[vi]

✓ **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.[vii]

The Don'ts

✓ **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.[viii]

✓ **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.[ix]

✓ **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.[ii]

✓ **Don't illustrate or dramatize drug use.** Such depictions may encourage and/or inadvertently teach people ways to prepare, obtain, or ingest illegal substances.[x]

Messages from Drug Prevention Campaigns and Champions

"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

"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

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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

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

[ii]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.

[iii]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.

[iv]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.

[v]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.

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

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

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

[ix] 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.

[x] 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.

APPENDIX 13: EXCERPT FROM THE SURGEON GENERAL'S REPORT: *ADVERSE CONSEQUENCES OF UNDERAGE DRINKING*[11]

The short- and long-term consequences that arise from underage alcohol consumption are astonishing in their range and magnitude, affecting adolescents, the people around them, and society as a whole. Adolescence is a time of life characterized by robust physical health and low incidence of disease, yet overall morbidity and mortality rates increase 200 percent between middle childhood and late adolescence/early adulthood. This dramatic rise is attributable in large part to the increase in risk-taking, sensation-seeking, and erratic behavior that follows the onset of puberty and which contributes to violence, unintentional injuries, risky sexual behavior, homicide, and suicide (Dahl 2004). Alcohol frequently plays a role in these adverse outcomes and the human tragedies they produce. Among the most prominent adverse consequences of underage alcohol use are those listed below. Underage drinking:

- Is a leading contributor to death from injuries, which are the main cause of death for people under age 21. Annually, about 5,000 people under age 21 die from alcohol-related injuries involving underage drinking. About 1,900 (38 percent) of the 5,000 deaths involve motor vehicle crashes, about 1,600 (32 percent) result from homicides, and about 300 (6 percent) result from suicides (Centers for Disease Control and Prevention [CDC] 2004; Hingson and Kenkel 2004; Levy et al. 1999; National Highway Traffic Safety Administration [NHTSA] 2003; Smith et al. 1999).

- Plays a significant role in risky sexual behavior, including unwanted, unintended, and unprotected sexual activity, and sex with multiple partners. Such behavior increases the risk for unplanned pregnancy and for contracting sexually transmitted diseases (STDs), including infection with HIV, the virus that causes AIDS (Cooper and Orcutt 1997; Cooper et al. 1994).

- Increases the risk of physical and sexual assault (Hingson et al. 2005).

- Is associated with academic failure (Grunbaum et al. 2004).

- Is associated with illicit drug use (Grunbaum et al. 2004).

- Is associated with tobacco use (Shiffman and Balabanis 1995).

- Can cause a range of physical consequences, from hangovers to death from alcohol poisoning.

- Can cause alterations in the structure and function of the developing brain, which continues to mature into the mid to late twenties, and may have consequences reaching far beyond adolescence (Brown et al. 2000; Crews et al. 2000; De Bellis et al. 2000; Swartzwelder et al. 1995a, 1995b; Tapert and Brown 1999; White and Swartzwelder 2005).

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[11] From *The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking*, U.S. Department of Health and Human Services (2007), pp. 10–14.

- Creates secondhand effects that can put others at risk. Loud and unruly behavior, property destruction, unintentional injuries, violence, and even death because of underage alcohol use afflict innocent parties. For example, about 45 percent of people who die in crashes involving a drinking driver under the age of 21 are people other than the driver (U.S. Department of Transportation Fatality Analysis Reporting System 2004). Such secondhand effects often strike at random, making underage alcohol use truly everybody's problem.

- In conjunction with pregnancy, may result in fetal alcohol spectrum disorders, including fetal alcohol syndrome, which remains a leading cause of mental retardation (Jones and Smith 1973).

Further, underage drinking is a risk factor for heavy drinking later in life (Hawkins et al. 1997; Schulenberg et al. 1996a), and continued heavy use of alcohol leads to increased risk across the lifespan for acute consequences and for medical problems such as cancers of the oral cavity, larynx, pharynx, and esophagus; liver cirrhosis; pancreatitis; and hemorrhagic stroke (reviewed in Alcohol Research & Health 2001).

Early Onset of Drinking Can Be a Marker for Future Problems, Including Alcohol Dependence and Other Substance Abuse

Approximately 40 percent of individuals who report drinking before age 15 also describe their behavior and drinking at some point in their lives in ways consistent with a diagnosis for alcohol dependence. This is four times as many as among those who do not drink before age 21 (Grant and Dawson 1997).

Besides experiencing a higher incidence of dependence later in life, youth who report drinking before the age of 15 are more likely than those who begin drinking later in life to have other substance abuse problems during adolescence (Hawkins et al. 1997; Robins and Przybeck 1985; Schulenberg et al. 1996a); to engage in risky sexual behavior (Grunbaum et al. 2004); and to be involved in car crashes, unintentional injuries, and physical fights after drinking both during adolescence and in adulthood. This is true for individuals from families both with and without a family history of alcohol dependence (Hingson et al. 2000, 2001, 2002). Delaying the age of onset of first alcohol use as long as possible would ameliorate some of the negative consequences associated with underage alcohol consumption.

The Negative Consequences of Alcohol Use on College Campuses Are Widespread

Alcohol consumption by underage college students is commonplace, although it varies from campus to campus and from person to person. Indeed, many college students, as well as some parents and administrators, accept alcohol use as a normal part of student life. Studies consistently indicate that about 80 percent of college students drink alcohol, about 40 percent engage in binge drinking,[12] and

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[12] In college studies, *binge drinking* is usually defined as "five or more drinks in a row for men and four or more drinks in a row for women" (National Institute on Alcohol Abuse and Alcoholism [NIAAA] National Advisory Council). The definition was refined by the NIAAA National Advisory Council in 2004 as follows: "A 'binge' is a pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 gram percent or above. For the typical adult, this pattern

about 20 percent engage in frequent episodic heavy consumption, which is bingeing three or more times over the past 2 weeks (National Institute on Alcohol Abuse and Alcoholism [NIAAA] 2002). The negative consequences of alcohol use on college campuses are particularly serious and pervasive. For example:

- An estimated 1,700 college students between the ages of 18 and 24 die each year from alcohol-related unintentional injuries, including motor vehicle crashes (Hingson et al. 2005).

- Approximately 600,000 students are unintentionally injured while under the influence of alcohol (Hingson et al. 2005).

- Approximately 700,000 students are assaulted by other students who have been drinking (Hingson et al. 2005).

- About 100,000 students are victims of alcohol-related sexual assault or date rape (Hingson et al. 2005).

Underage Military Personnel Engage in Alcohol Use That Results in Negative Consequences

According to the most recent (2005) Department of Defense Survey of Health-Related Behaviors Among Military Personnel, 62.3 percent of underage military members drink at least once a year, with 21.3 percent reporting heavy alcohol use.[13] Problems among underage military drinkers include: serious consequences (15.8 percent); alcohol-related productivity loss (19.5 percent); and as indicated by AUDIT scores,[14] hazardous drinking (25.7 percent), harmful drinking (4.6 percent), or possible dependence (5.5 percent) (Bray et al. 2006).

Children of Alcoholics Are Especially Vulnerable to Alcohol Use Disorders

Children of alcoholics (COAs) are between 4 and 10 times more likely to become alcoholics than children from families with no alcoholic adults (Russell 1990) and therefore require special consideration when addressing underage drinking. COAs are at elevated risk for earlier onset of drinking (Donovan 2004) and earlier progression into drinking problems (Grant and Dawson 1998). Some of the elevated risk is attributable to the socialization effects of living in an alcoholic household, some to genetically transmitted differences in response to alcohol that make drinking more pleasurable and/or less aversive, and some to elevated transmission of risky temperamental

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corresponds to consuming 5 or more drinks (male), or 4 or more drinks (female), in about 2 hours." It is a criminal offense in every State for an adult to drive a motor vehicle with a blood alcohol level of 0.08 gram percent or above.

[13] *Heavy alcohol use* in this survey refers to drinking five or more drinks per typical drinking occasion at least once a week.

[14] The Alcohol Use Disorders Identification Test (AUDIT), which was developed by the World Health Organization, consists of 10 questions scored 0 to 4 that are summed to yield a total score ranging from 0 to 40. It is used to screen for excessive drinking and alcohol-related problems. Scores between 8 and 15 are indicative of hazardous drinking, scores between 16 and 19 suggest harmful drinking, and scores of 20 or above warrant further diagnostic evaluation for possible alcohol dependence.

and behavioral traits that lead COAs, more than other youth, into increased contact with earlier-drinking and heavier-drinking peers.

APPENDIX 14: SELECTED RESEARCH ON UNDERAGE DRINKING

Note: There is a vast body of research on the consequences of underage drinking and its connection to other substance use. This is a small sample of resources that we have found particularly helpful.

Ten-Year Prospective Study of Public Health Problems Associated With Early Drinking[15]

- Authors: Phyllis L. Ellickson, PhD, Joan S. Tucker, PhD, and David J. Klein, MS
- Published in: *Pediatrics*, Volume 111, Number 5, May 1, 2003, pp. 949–955

The objective of this study was to compare early nondrinkers, experimenters, and drinkers on the prevalence of problem behaviors at three different ages. Respondents were originally recruited from 30 California and Oregon schools in grade 7 (1985, *N* = 6,338) and assessed again in grade 12 (1990, *N* = 4,265) and at age 23 (1995, *N* = 3,369).

> This study is available at http://pediatrics.aappublications.org/content/111/5/949.short.

The researchers found that early drinkers and experimenters were more likely than nondrinkers to report academic problems, substance use, and delinquent behavior in both middle and high school. By young adulthood, early alcohol use was associated with employment problems, other substance use, and criminal and violent behavior. The researchers concluded that early drinkers do not necessarily mature out of a problematic lifestyle as young adults. Interventions for these high-risk youth should start early and address their other public health problems, particularly their tendency to smoke and use other illicit drugs.

Early Drinking Onset and Its Association with Alcohol Use and Problem Behavior in Late Adolescence[16]

- Authors: Enid Gruber, Ph.D., Ralph J. DiClemente, Ph.D., Martin M. Anderson, M.D., and Mark Lodico, Ph.D.
- Published in *Preventive Medicine*, Volume 25, Issue 3, May 1996, pp. 293–300

The objective of this study was to examine the relationship between age of drinking onset and patterns of use, the use of other substances, and the prevalence of other alcohol-related problems in a population of Midwestern high school seniors. Respondents comprised 2,650 male and female seniors, representing a 10% random sample of all white seniors in the 1989 Minnesota Student Survey.

> This study is available at http://www.sciencedirect.com/science/article/pii/S0091743596900596

The researchers found indications that early onset of alcohol use (by age 12) is associated with subsequent misuse of alcohol and related problem behaviors in later adolescence, including alcohol-related violence, injuries, drinking and driving, and absenteeism from school or work, as well as

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[15] This text is slightly adapted from the article abstract on the *Pediatrics* journal website, copyright © 2013 American Academy of Pediatrics.

[16] This text is slightly adapted from the article abstract on the ScienceDirect website, copyright © 2015 Elsevier B.V.

increased risks for using other drugs. They concluded that ages 10–12 are a particularly vulnerable period for the development of early alcohol dependence and misuse. Delaying alcohol use onset to age 13 may significantly reduce the risk of severe alcohol misuse in later adolescence.

Strategies to Prevent Underage Drinking[17]

- Authors: Kelli A. Komro, M.P.H., Ph.D., and Traci L. Toomey, M.P.H., Ph.D.

The authors note that alcohol use by underage drinkers is a persistent public health problem in the United States and that alcohol is the most commonly used drug among adolescents. Accordingly, numerous approaches to prevent underage drinking have been developed and studied:

- School-based approaches, involving curricula targeted at preventing alcohol, tobacco, or marijuana use

- Extracurricular approaches, offering activities outside of school in the form of social or life skills training or alternative activities

> This article is available from the National Institute on Alcohol Abuse and Alcoholism website, http://pubs.niaaa.nih.gov/publications/arh26-1/5-14.htm

- Family approaches, striving to involve the adolescents' families in the prevention programs

- Policy approaches, for example, increasing the minimum legal drinking age, reducing the commercial and social access of adolescents to alcohol, and reducing the economic availability of alcohol

- Community-based approaches, involving the entire community

The authors explore each approach in detail and offer a number of examples of programs employing these strategies. They conclude that any program by itself is unlikely to create sustained reductions in underage drinking. School-based programs may need to be combined with extracurricular, family, and policy strategies that help change the overall social and cultural environment in which young people live in order to create sustained decreases in consumption and alcohol-related problems among youth. As researchers, clinicians, and policymakers learn more about each strategy, this knowledge must be synthesized to develop multicomponent projects consisting of high-quality and complementary components that together create interventions strong enough to overcome the drinking culture found throughout U.S. communities.

Reducing Underage Drinking: A Collective Responsibility[18]

- Authors: National Research Council and Institute of Medicine. Committee on Developing a Strategy to Reduce and Prevent Underage Drinking, Richard J. Bonnie and Mary Ellen O'Connell (Editors). Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education.

- Published by the National Academies Press, Washington, D.C. (2004)

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[17] This text is slightly adapted from the article's introductory text and Conclusion on the National Institute on Alcohol Abuse and Alcoholism website.

[18] This text is slightly adapted from the Description on the National Academies Press website, copyright © 2015 National Academy of Sciences.

Given its association with traffic fatalities, violence, unsafe sex, suicide, educational failure, and other problem behaviors that diminish the prospects of future success, underage alcohol use is extremely dangerous. The earlier teens start drinking, the greater the danger.

A PDF of this book may be downloaded at http://www.nap.edu/catalog/10729/reducing-underage-drinking-a-collective-responsibility

Why is this dangerous behavior so pervasive? What can be done to prevent it? What will work, and who is responsible for making sure that it happens? *Reducing Underage Drinking* explores the ways in which different individuals and groups contribute to the problem and how they can be enlisted to prevent it, and proposes a new way to combat underage alcohol use.

APPENDIX 15: EARLY DRINKING INITIATION AND ILLICIT DRUG USE

Early Drinking Initiation Related to Ever Using Illicit Drugs

The earlier a person begins drinking alcohol, the more likely they are to have ever used other drugs illicitly, according to an analysis of data from the National Longitudinal Alcohol Epidemiologic Survey (NLAES). Approximately one-half of persons who began drinking at age 14 or younger had also used other drugs illicitly in their lifetime, compared to around one-tenth of those who began drinking at age 20 or older. Even after controlling for relevant sociodemographic and substance use factors[*], starting alcohol use at a younger age was the strongest independent predictor of ever using drugs illicitly. A similar relationship was found between age at first alcohol use and ever being drug dependent—persons who began drinking before age 14 were nearly three times more likely to have ever been drug dependent that those who began drinking after age 20 (data not shown). According to the authors, these findings "point to a need to further explore why people who start drinking at early ages . . . are more likely to use drugs and develop drug dependence" (p. 200).

Percentage of U.S. Adult Drinkers Who Ever Used Other Drugs Illicitly, by Age at Drinking Onset
(N=27,616)
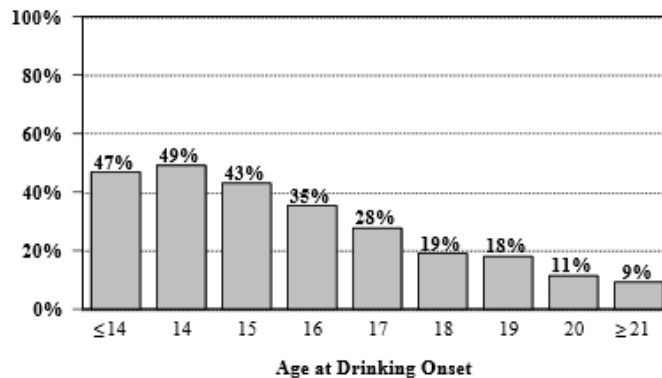
*Factors controlled for were age, gender, race/ethnicity, education, marital status, cigarette use history, childhood depression, family history of alcoholism, and personal history of alcohol dependence.

NOTE: Among those who ever drank alcohol, 22% ever used illicit drugs. Of those, 39% began to drink at least 1 year before they started using drugs, 29% began both during the same year, and 32%% started drug use at least a year before they began drinking.

SOURCE: Adapted by CESAR from Hingson, R.W., Heeren, T., and Edwards, E.M. "Age at Drinking Onset, Alcohol Dependence, and Their Relation to Drug Use and Dependence, Driving Under the Influence of Drugs, and Motor-Vehicle Crash Involvement Because of Drugs," *Journal of Studies on Alcohol and Drugs* 69(2):192-201, 2008.

APPENDIX 16: EVIDENCE-BASED STRATEGIES TO REDUCE UNDERAGE ALCOHOL CONSUMPTION

Notes:

- Many good and fairly comprehensive lists of evidence-based strategies to address underage drinking are available online.

- The resource featured here—*Catalog of Environmental Prevention Strategies*, created by the Wyoming Survey & Analysis Center at the University of Wyoming—is an excellent starting point; it covers the most strategies and reviews the most research of any resource we've found, and it includes strategies appropriate for higher education settings. However, it represents neither an exhaustive nor a mandated list of strategies.

- Communities should be sure to discuss potential strategies with their TA providers.

- For your reference, we have included the table of contents (which lists the strategies reviewed in this guide) and the guidance pages on how to use the catalogue. The full text of the document can be found here: http://www.wishschools.org/resources/ Catalog%20of%20Environmental%20Prevention%20Strategies_Final4%20Wyoming.pdf
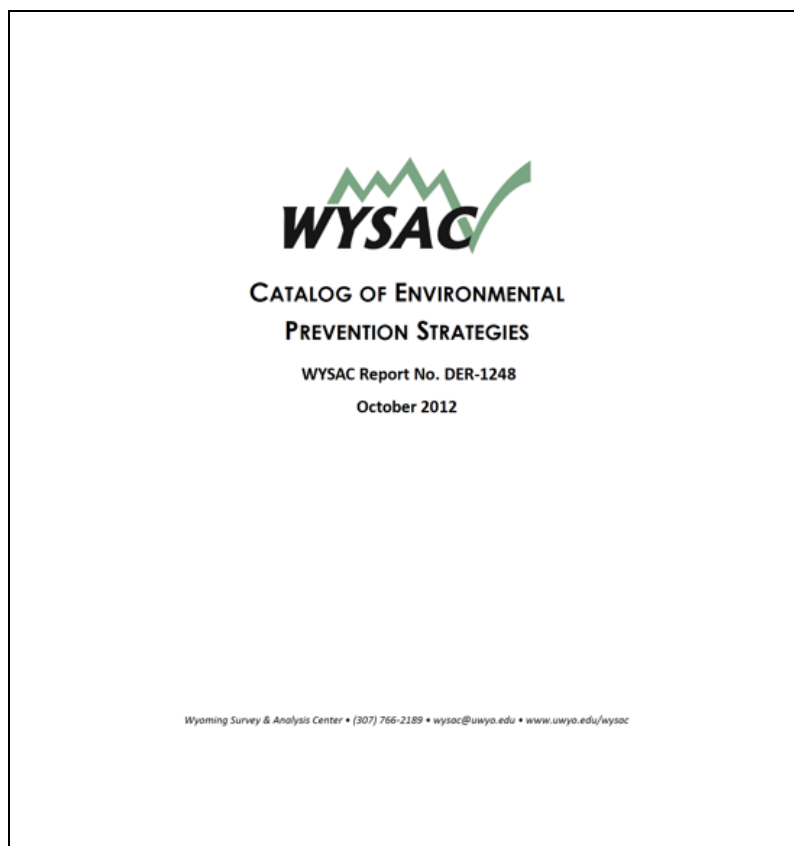
From *Catalog of Environmental Prevention Strategies* by H. Costello, N. M. Nelson, K. Henry, and K. S. Freedman (2012). WYSAC Report DER-1248. Laramie, WY: Wyoming Survey & Analysis Center, University of Wyoming.

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HOW TO USE THIS DOCUMENT

This catalog has been created for use by the Wyoming Community Prevention Professional Team to assist Community Prevention Professionals in selecting environmental prevention strategies targeting alcohol, tobacco, and other drugs that can be implemented at the community-level. Each included strategy entry include a strategy name, description of the strategy, discussion of effectiveness, and an easy-to-read composite indicator specifying the level of effectiveness and strength of the evidence based on the available literature. Each entry also indicates the target substance(s) for each strategy, whether the strategy is used in Wyoming, a list of other names or examples of the strategy, and a table that denotes the causal domain and/or CDC tobacco goal pertaining to each strategy. The following graphic provides a breakdown and description of a typical catalog entry.

Strategy name
The name of the strategy appears across the top banner of each catalog entry

Description of strategy
This provides a general description of the strategy

Discussion of effectiveness
This provides a description of the evidence for each strategy, including a brief discussion of the evidence of effectiveness as it relates to each identified substance

General information
This provides basic information about each strategy, including the target substance, whether the strategy is used in Wyoming, and other names or examples of the strategy

Composite indicator
The composite indicator is an easy-to-read symbol illustrating the level of effectiveness and strength of the evidence for each strategy

Indicator key
The indicator key provides a guide for how to read the composite indicator symbol

Causal domain & tobacco goal table key
This table indicates the causal domain and, where applicable, the corresponding CDC tobacco goal for each strategy

How to Use This Document

The back page of each catalog entry lists references for the evidence base and suggestions for further reading to help Community Prevention Professionals learn more about specific strategies when making a decision about which strategies to implement in their communities.

To increase the utility of the environmental strategies catalog, it includes indexes for the strategies organized by causal domain, CDC tobacco goal, substance, and indicator (pg. 12-32). Appendix A includes a list of other names and examples of policies or programs known to be used in Wyoming that pertain to included strategies, and Appendix B provides contact information for all Community Prevention Professionals across the state.

Finally, this catalog presents information current at the time of publication, but research on prevention continues to be published. Similarly, prevention strategies employed in Wyoming change and evolve. WYSAC researchers hope to update the catalog as new research on environmental prevention strategies for alcohol, tobacco, and other drug use becomes available, and to reflect changes in prevention work conducted in our state.