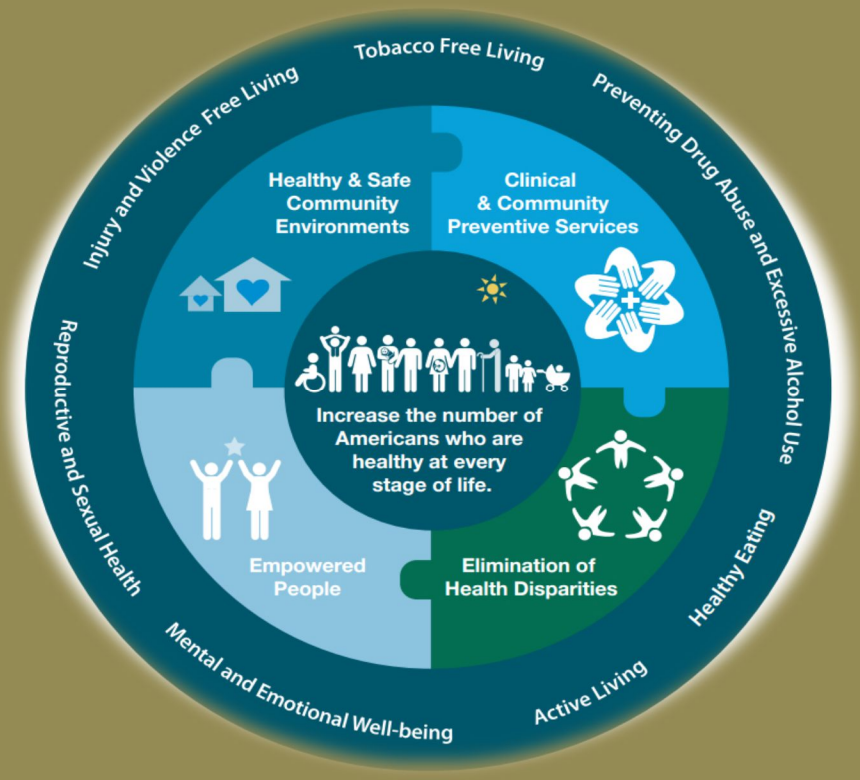
SUBSTANCE ABUSE PREVENTION - BEST PRACTICES

2017

PREVENTION NATIONAL STANDARDS

A GUIDE FOR:
PREVENTION FUNDERS
PROGRAM MANAGERS
TRIBAL COMMUNITIES
HEALTH AND WELLNESS
AND BEHAVIORAL HEALTH WORKERS



Author: Frank G. Magourilos, MPS, SCPS, ICPS
Prevention Works Consulting

preventionworks@msn.com

TABLE OF CONTENTS

FOREWORD

Prevention Works Consulting is committed to taking a leadership role in researching, developing, and utilizing the most up to date, evidence-based, widely accepted in the field, national standards in in the areas of substance abuse prevention, health and wellness.

To our knowledge, currently there is not a single all-encompassing comprehensive guide to evidence-based substance abuse prevention national standards. Although the information exists and is available, it is fragmented in many different documents, Websites, national organizations, and other entities. The need to have in one comprehensive guide all the nationally accepted, recognized, and researched standards for prevention is great.

Through this guide, program managers, prevention specialists, prevention funders, Tribal communities, Behavioral Health Councils, Planning Councils, and others in the behavioral health field will be able to make better decisions on funding, assessing needs, building capacity, planning, implementing, evaluating, sustaining, and culturally adapting to their local community needs prevention principles, programs, and policies.

The "Compiling Guide" Author is Frank G. Magourilos (preventionworks@msn.com); he is a Sr. Certified Prevention Specialist with a Master's Degree in Prevention Science from Oklahoma University and Bachelor's Degrees in Cognitive Behavioral Psychology and Intercultural Communication from the University of New Mexico. Mr. Magourilos is also a Professor at the University of New Mexico and a National Trainer for SAMHSA's Strategic Prevention Framework.

Chapter 1: SAMHSA's Substance Abuse Prevention Strategic Initiatives & Definitions

The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services (HHS), is charged with reducing the impact of substance abuse and mental illness on America's communities.

Prevention of Substance Abuse and Mental Illness— Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide.

SAMHSA's overarching goal is a high-quality, self-directed, satisfying life integrated in a community for all Americans. This life includes:

Health—Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;

Home—A stable and safe place to live that supports recovery;

Purpose—Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society; and

Community—Relationships and social networks that provide support, friendship, love, and hope.

The promotion of positive mental health and the prevention of substance abuse and mental illness have been key parts of SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities.

The evidence base in this area continues to grow and was recently summarized by the 2009 Institute of Medicine (IOM) report, Preventing Mental, Emotional, and Behavioral Disorders among Young People. The Affordable Care Act is also putting a heavy focus on prevention and promotion

activities at the community, State, Territorial, and Tribal levels. Unfortunately, much of the strong evidence in this area has not been moved into practice, and our Nation lacks a consistent infrastructure for the prevention of substance abuse and mental illness.

Through this Initiative, SAMHSA will work to take advantage of the opportunities presented by the Affordable Care Act and the growing evidence base behind prevention.

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.

Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.

Goal 1.4: Reduce prescription drug misuse and abuse.

Substance Abuse and Mental Health Services Administration, Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014 Executive Summary and Introduction. HHS Publication No. (SMA) 11-4629 Summary. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

http://store.samhsa.gov/shin/content//SMA11-4629/02-ExecutiveSummary.pdf

Chapter 2: NIDA's Guiding Principles

These prevention principles have emerged from research studies funded by the National Institute on Drug Abuse, NIDA on the origins of drug abuse behaviors and the common elements found in research on effective prevention programs. Parents, educators, and community leaders can use these principles to help guide their thinking, planning, selection, and delivery

of drug abuse prevention programs at the community level. The references following each principle are representative of current research.

Risk Factors and Protective Factors

PRINCIPLE 1

Prevention programs should enhance protective factors and reverse or reduce risk factors (Hawkins et al. 2002).

The risk of becoming a drug abuser involves the relationship among the number and type of risk factors (e.g., deviant attitudes and behaviors) and protective factors (e.g., parental support) (Wills and McNamara et al. 1996).

The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent (Gerstein and Green 1993; Kumpfer et al. 1998).

Early intervention with risk factors (e.g., aggressive behavior and poor self-control) often has a greater impact than later intervention by changing a child's life path (trajectory) away from problems and toward positive behaviors (Ialongo et al. 2001).

While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment (Beauvais et al. 1996; Moon et al. 1999).

PRINCIPLE 2

Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs (Johnston et al. 2002).

PRINCIPLE 3

Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors (Hawkins et al. 2002).

PRINCIPLE 4

Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness (Oetting et al. 1997).

Prevention Planning—Family Programs

PRINCIPLE 5

Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information (Ashery et al. 1998).

Family bonding is the bedrock of the relationship between parents and children. Bonding can be strengthened through skills training on parent supportiveness of children, parent-child communication, and parental involvement (Kosterman et al. 1997).

Parental monitoring and supervision are critical for drug abuse prevention. These skills can be enhanced with training on rule-setting; techniques for monitoring activities; praise for appropriate behavior; and moderate, consistent discipline that enforces defined family rules (Kosterman et al. 2001).

Drug education and information for parents or caregivers reinforces what children are learning about the harmful effects of drugs and opens opportunities for family discussions about the abuse of legal and illegal substances (Bauman et al. 2001).

Brief, family-focused interventions for the general population can positively change specific parenting behavior that can reduce later risks of drug abuse (Spoth et al. 2002b).

School Programs

PRINCIPLE 6

Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills, and academic difficulties (Webster-Stratton 1998; Webster-Stratton et al. 2001).

PRINCIPLE 7

Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Education should focus on the following skills (Ialongo et al. 2001; Conduct Problems Prevention Work Group 2002b):

- Self-control;
- Emotional awareness;
- Communication;
- Social problem-solving; and
- Academic support, especially in reading.

PRINCIPLE 8

Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills (Botvin et al.1995; Scheier et al. 1999):

- Study habits and academic support;
- Communication;
- Peer relationships;
- Self-efficacy and assertiveness;
- Drug resistance skills;

• Reinforcement of antidrug attitudes; and

• Strengthening of personal commitments against drug abuse.

Community Programs

PRINCIPLE 9

Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community (Botvin et al. 1995; Dishion et al. 2002).

PRINCIPLE 10

Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone (Battistich et al. 1997).

PRINCIPLE 11

Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting (Chou et al. 1998).

Prevention Program Delivery

PRINCIPLE 12

When communities adapt programs to match their needs, community norms, or differing cultural requirements, they should retain core elements of the original research-based intervention (Spoth et al. 2002b), which include:

• Structure (how the program is organized and constructed);

• Content (the information, skills, and strategies of the program); and

• Delivery (how the program is adapted, implemented, and evaluated).

PRINCIPLE 13

Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow up programs in high school (Scheier et al. 1999).

PRINCIPLE 14

Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster students' positive behavior, achievement, academic motivation, and school bonding (Ialongo et al. 2001).

PRINCIPLE 15

Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills (Botvin et al. 1995).

PRINCIPLE 16

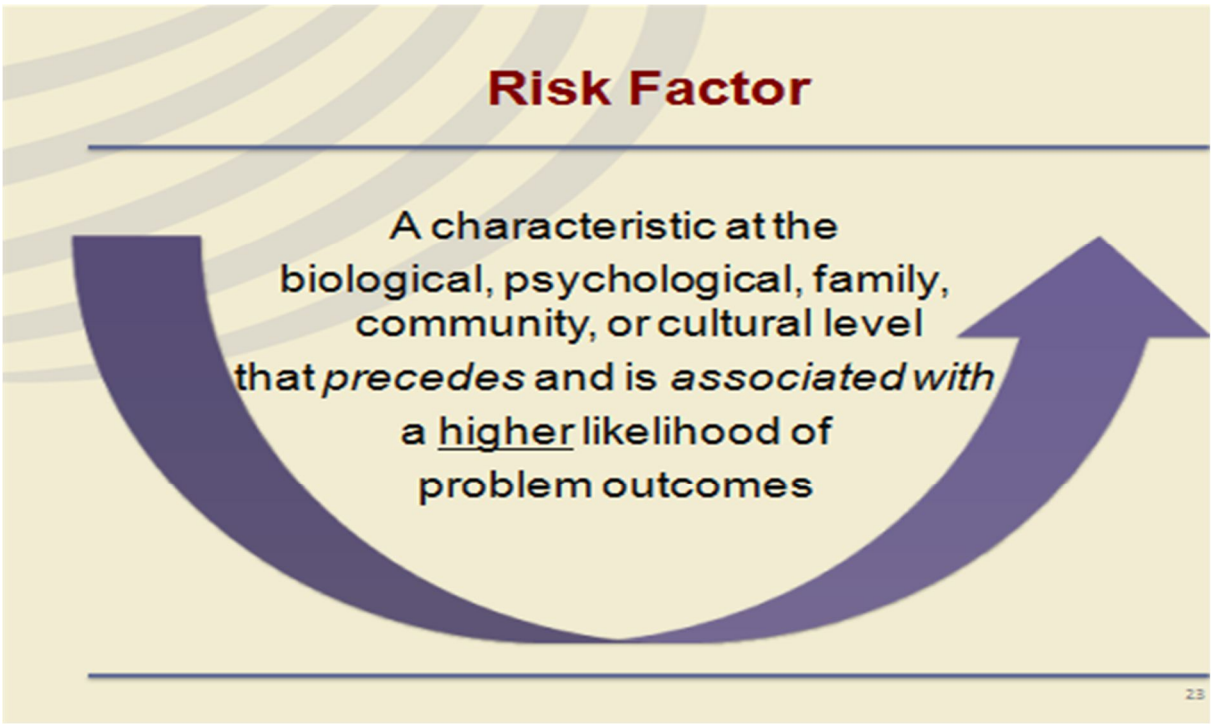
Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to $10 in treatment for alcohol or other substance abuse can be seen (Pentz 1998; Hawkins 1999; Aos et al. 2001; Spoth et al. 2002a).

NIH Publication No. 04-4212(A) Printed 1997Reprinted 1997, 1999, 2001Second Edition October 2003

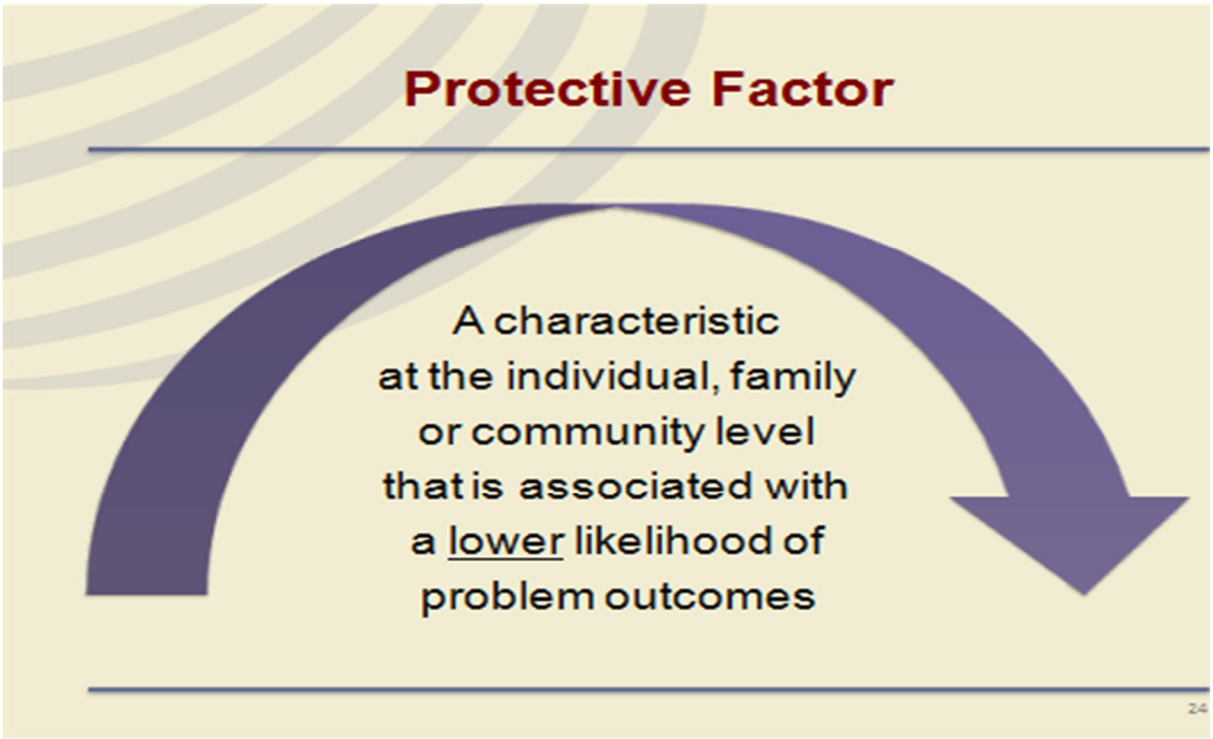
http://www.drugs.indiana.edu/publications/drugPPT/nida_redbook_inbrief.pdf

Chapter 3: Evidence-based Risk and Protective Factors

Key Features of Risk and Protective Factors



(Goal is to reduce risk factors)



(Goal is to increase protective factors)

Risk and Protective Factors Exist in Multiple Contexts

Individuals come to the table with biological and psychological characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health problems. Individual-level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors might include positive self-image, self-control, or social competence.

But individuals don't exist in isolation. They are part of families, part of communities, and part of society. A variety of risk and protective factors exist within each of these contexts. For example:

•In families, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision; a protective factor would be parental involvement

•In communities, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and after-school activities

•In society, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include policies limiting availability of substances or anti-hate laws defending marginalized populations, such as lesbian, gay, bisexual, or transgender youth

Practitioners must look across these contexts to address the constellation of factors that influence both individuals and populations: targeting just one context is unlikely to do the trick. For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults. A more effective—and comprehensive—approach might include school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training.

(Risk and protective factors in multiple domains)

Common Risk and Protective Factors for Alcohol and Drug Use

Decades of research have helped to identify several patterns of risk and protective factors contributing to alcohol and drug use in adolescence and in later life. The presence and impact of these factors and their interactions with one another can vary depending on the population for which prevention interventions are planned. Limiting risk factors while strengthening and increasing the availability of protective resources will help to reduce substance abuse and create healthier individuals and communities. Below are some of the most important risk and protective factors identified in the literature:

Age of onset

Alcohol and drug use tends to begin in mid-to-late adolescence, though it is greater among individuals who experience early puberty (O'Connell et al, 2009). The earlier the age at which someone starts drinking the greater the risk that s/he will develop alcohol-related problems later in life. A delay in drinking until 20- to 21-years-old reduces the risk of developing alcohol-related problems (Chou et al, 1992).

Youth perception that parents approve of their alcohol or drug use

One of the most consistent risk factors for adolescent drinking is perceived parental approval (Donovan, 2004). Reported maternal care perception has been shown to be significantly lower among alcohol and those who use multiple drugs (Gerra et al, 2004).

Peers engaging in problem behavior

Associating with drug- or alcohol-using peers, or being rejected by peers, can create problem behaviors and influence attitudes and norms related to substance use (O'Connell et al, 2009). Exposure to peer problem behavior is correlated with increased alcohol and other substance use in the same month (Dishion et al, 2000). Those who drink in a social setting, or who have peers who do so, are more likely to abuse alcohol later in life (Beck et al, 1996).

Early and persistent problem behaviors, risk-taking, and high sensation-seeking

Early aggressiveness or antisocial behavior persisting into early adolescence predicts later adolescent aggressiveness, drug abuse, and alcohol problems (Hawkins et al, 1995).

Parental monitoring (or perception of monitoring)

Adolescents who report low parental monitoring are significantly more likely to use a variety of substances (Shillington et al, 2005). Positive parental style and close monitoring by parents are proven protective factors for adolescent's use of alcohol and other drugs (Stewart, 2002).

Parent or older sibling drug use (or perception of use)

Familial alcohol-using behaviors are strong predictors of adolescent alcohol use (Birckmayer et al, 2004). In a 2003 study, alcohol initiation most often occurred during family gatherings. Moreover, a family history of alcoholism was a significant risk factor for the development of adolescent problem drinking (Warner et al, 2003).

Low perception of harm

Low perception of harm towards alcohol and drug use is a risk factor for use (Henry et al, 2005). Individuals with attitudes or values favorable to alcohol or drugs are more likely to initiate substance use (Hawkins et al, 1992).

Strong parent and adolescent relationship and family cohesion

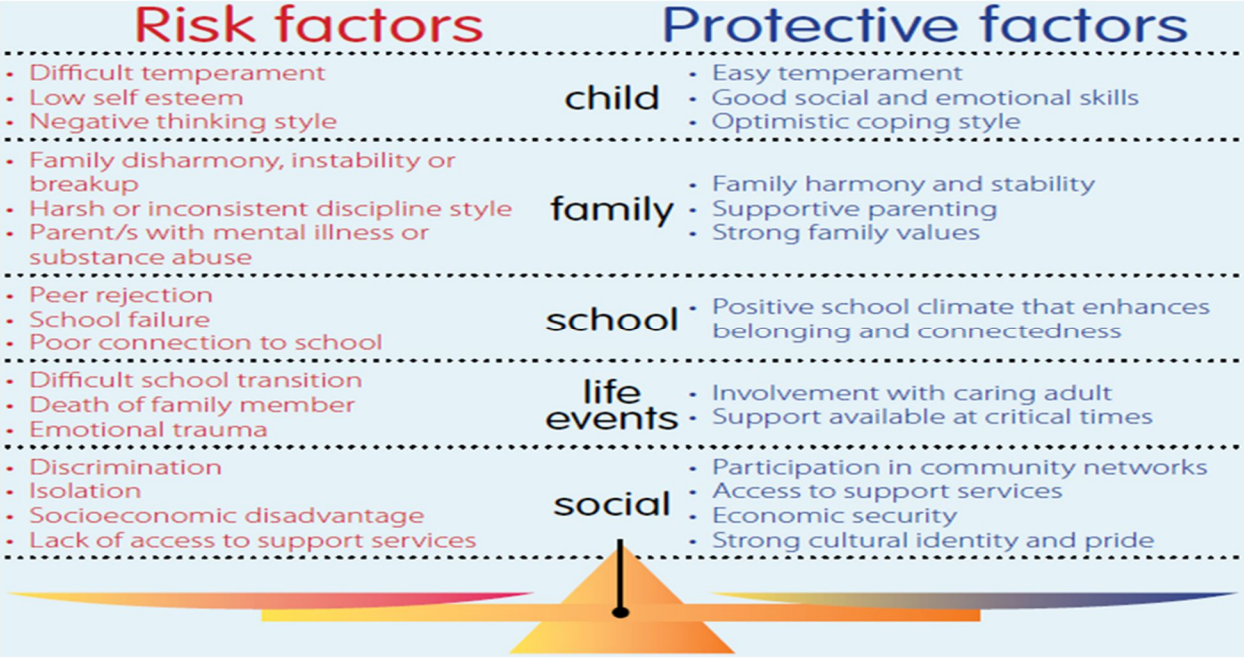
Adolescents who have a close relationship with their parents are less likely to become alcohol involved (Birckmayer et al, 2004).

Youth access and availability

The majority of alcohol consumed by youth is obtained through social sources, such as parents and friends, at underage parties and at home (Birckmayer et al, 2004). Availability of alcohol or illegal drugs leads to increased use (Hawkins et al, 1995).

Poor school achievement and low school bonding

Adolescents who have a low commitment to school or do poorly are more likely to become alcohol involved (Birckmayer et al, 2004).



(Researched-based Risk & Protective Factors in the 5 Life Domains)

Additional Risk and Protective factors information can be found in chapters 11 and 12.

References

Beck, K., Treiman, KA. (1996). The relationship of social context of drinking, perceived social norms, and parental influence to various drinking patterns of adolescents. Addictive Behaviors, 21(5), 633-44.

Birckmayer, JD, Holder, HD, Yacoubian, GS, & Friend, KB. (2004). A general causal model to guide alcohol, tobacco, and illicit drug prevention: Assessing the research evidence. Journal of Drug Education, 34(2), 121-153.

Chou, S. P. and R. P. Pickering. (1992). Early onset of drinking as a risk factor for lifetime alcohol-related problems. British Journal of Addiction, 87(8), 1199-1204.

Dishion, T. J. and N. M. Skaggs. (2000). An ecological analysis of monthly 'bursts' in early adolescent substance use. Applied Developmental Science, 4, 89-97.

Donovan, J.E. (2004). Adolescent alcohol initiation: A review of psychosocial risk factors. Journal of Adolescent Health, 35(6), 529.

Gerra, G., L. Angioni, et al. (2004). Substance use among high-school students: Relationships with temperament, personality traits, and parental care perception. Substance Use & Misuse, 39(2), 345-367.

Hawkins, J. D., M. W. Arthur, et al. (1995). Preventing substance abuse From Building a Safer Society: Strategic Approaches to Crime Prevention, Volume 19, P 343-427, 1995, Michael Tonry & David P Farrington, eds. United States.

Hawkins, D. J., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other substance problems in adolescence and early adulthood: Implications for substance abuse prevention. Psychological Bulletin, 112(1), 64–105.

Henry, K. L., M. D. Slater, et al. (2005). Alcohol use in early adolescence: The effect of changes in risk taking, perceived harm and friends' alcohol use. Journal of Studies on Alcohol, 66(2), 275-283.

O'Connell, M. E., Boat, T., & Warner, K. E., Eds. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults, Institute of Medicine. Washington, DC: National Academies Press.

Shillington, A. M., S. Lehman, et al. (2005). Parental monitoring: Can it continue to be protective among high-risk adolescents? Journal of Child & Adolescent Substance Abuse, 15(1), 1-15.

Stewart, C. (2002). Family factors of low-income African-American youth associated with substance use: An exploratory analysis. Journal of Ethnicity in Substance Abuse, 1(1), 97-111.

Warner, L. A. and H. R. White. (2003). Longitudinal effects of age at onset and first drinking situations on problem drinking. Substance Use & Misuse, 38(14), 1983-2016.

Chapter 4: CSAP Strategies

Because substance abuse is influenced by multiple risk factors in multiple domains, its prevention may be most effectively accomplished using multiple strategies across multiple domains.

The Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), has classified prevention strategies into six categories. The definition of each strategy is taken from the Federal Register, Volume 58, Number 60, March 31, 1993.

Community-based process: This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.

Environmental: This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

Information dissemination: This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. **[Note: Information dissemination alone has not been shown to be effective at preventing substance abuse.]**

Education: This strategy involves two-way communication arid is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Note: Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Alternatives: This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to—or otherwise meet the needs usually filled by—alcohol and drugs and would, therefore, minimize or obviate resort to the latter. **[Note: Alternative activities alone have not been shown to be effective at preventing substance abuse.]**

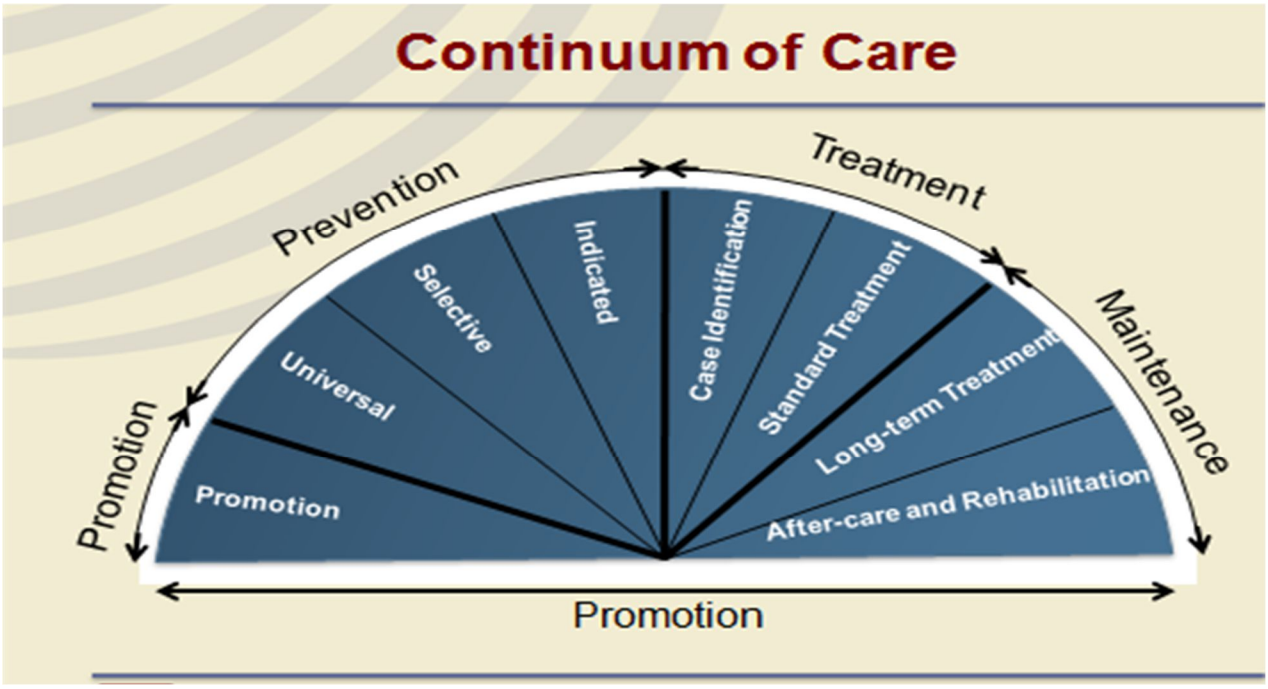
Problem identification and referral: This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Chapter 5: What is Behavioral Health?

Behavioral health refers to a state of emotional/mental being and/or choices and actions that affect health and wellness. Individuals engage in behavior and

make choices that affect their wellness, including whether or not to use alcohol, tobacco or other drugs. Communities can also impact choices and actions that affect wellness, such as assuring that all pregnant women have access to prenatal care or imposing and enforcing laws that restrict youth access to alcohol. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. The term behavioral health can also be used to describe the service systems surrounding the promotion of mental health, the prevention and treatment of mental and substance use disorders, and recovery support.

IOM Model



(IOM Continuum of Care Model including the recent addition of "Promotion")

In a 1994 report on prevention research, the Institute of Medicine (IOM 1994) proposed a new framework for classifying prevention based on Gordon's (1987) operational classification of disease prevention. The IOM model

divides the continuum of services into three parts: prevention, treatment, and maintenance. The prevention category is divided into three classifications--universal, selective and indicated prevention.

The prevention category is divided into three classifications--universal, selective and indicated prevention.

Universal

A Universal prevention strategy addresses the entire population (national, local community, school, and neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. For example, it would include the general population and subgroups such as pregnant women, children, adolescents, and the elderly. The mission of universal prevention is to prevent the problem. All members of the population share the same general risk for substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefiting from prevention programs.

Selective

Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment--for example, children of adult alcoholics, dropouts, or students who are failing academically. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994), and targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. One individual in the subgroup may not be at personal risk for substance abuse, while another person in the same subgroup may be abusing substances. The selective prevention program is presented to the entire

subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup.

Indicated

Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs. The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs. The individuals are exhibiting substance abuse-like behavior, but at a sub-clinical level (IOM 1994). Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors that increase their chances of developing a drug abuse problem. Indicated prevention programs address risk factors associated with the individual, such as conduct disorders, and alienation from parents, school, and positive peer groups. Less emphasis is placed on assessing or addressing environmental influences, such as community values. The aim of indicated prevention programs is not only the reduction in first-time substance abuse, but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to 'Indicated' prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends, or the courts. Young people may volunteer to participate in indicated prevention programs.

Promotion is the process of enabling people to increase control over, and to improve, their health. The focus is on well-being, rather than preventing a disease. Promotion of positive mental health can help reduce mental, emotional and behavioral disorders and related problems. According to the National Prevention Strategy, emotional well-being "allows people to realize their full potential, cope with the stresses of life, and make meaningful

contributions to their community. Early childhood experiences have lasting, measurable consequences later in life; therefore, fostering emotional well-being from the earliest stages of life helps build a foundation for overall health." The National Research Council and Institute of Medicine concur. The aim of promotion is to enhance people's ability to:

• Achieve developmentally appropriate tasks.

• Acquire a positive sense of self-esteem, mastery, well-being and social inclusion.

• Strengthen their ability to cope with adversity.

Promotion is intended for the general population or a defined, sometimes targeted, group.

Recommendations for promotion include:

• Promote positive early childhood development and violence-free homes.

• Facilitate social connectedness and community engagement across the lifespan.

• Provide individuals and families with support necessary to maintain positive well-being.

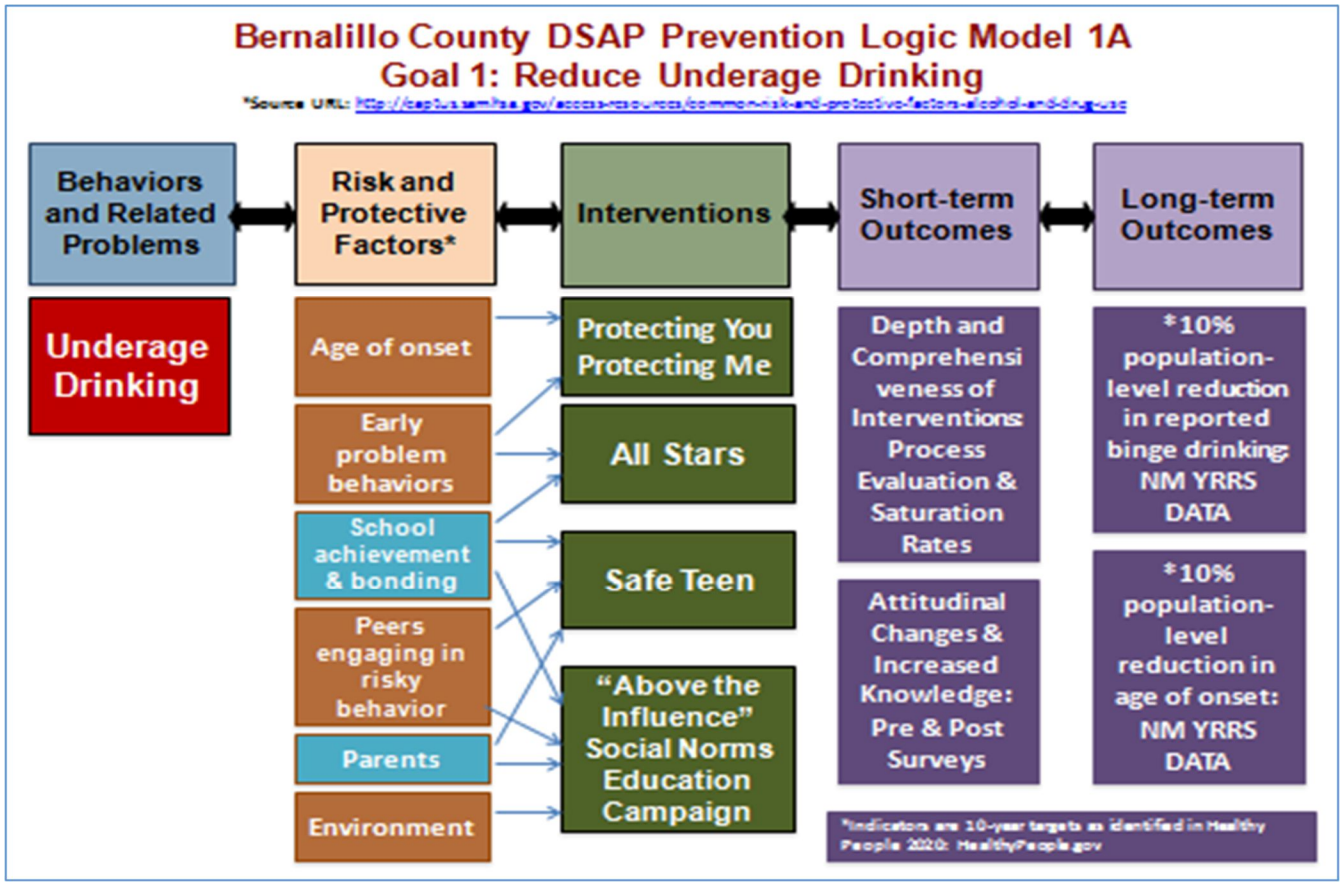
• Promote early identification of mental health needs and access to quality services.

"Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities" by Institute of Medicine and National Research Council is online at http://www.nap.edu/catalog.php?record_id=12480 . Purchase the book or download the free PDF.

Chapter 6: Logic Models

A logic model is defined as a picture of how your organization does its work – the theory and assumptions underlying the program. A logic model links

outcomes (both short- and long-term) with program activities/processes and the theoretical assumptions/principles of the program.



(Bernalillo County DSAP Prevention Logic Model)

In general, logic modeling can greatly enhance the participatory role and usefulness of evaluation as a management and learning tool. Developing and using logic models is an important step in building community capacity and strengthening community voice. The ability to identify outcomes and anticipate ways to measure them provides all program participants with a clear map of the road ahead. Map in hand, participants are more confident of their place in the scheme of things, and hence, more likely to actively engage and less likely to stray from the course – and when they do, to do so consciously and intentionally. Because it is particularly amenable to visual depictions, program logic modeling can be a strong tool in communicating with diverse audiences – those who have varying world views and different levels of experience with program development and evaluation.

Finally, the most basic logic model is a picture of how you believe your program will work. It uses words and/or pictures to describe the sequence of activities thought to bring about change and how these activities are linked to the results the program is expected to achieve.

Many evaluation experts agree that use of the logic model is an effective way to ensure program success. Using a logic model throughout your program helps organize and systematize program planning, management, and evaluation functions.

1. **In Program Design and Planning**, a logic model serves as a planning tool to develop program strategy and enhance your ability to clearly explain and illustrate program concepts and approach for key stakeholders, including funders. Logic models can help craft structure and organization for program design and build in self-evaluation based on shared understanding of what is to take place. During the planning phase, developing a logic model requires stakeholders to examine best practice research and practitioner experience in light of the strategies and activities selected to achieve results.

2. **In Program Implementation**, a logic model forms the core for a focused management plan that helps you identify and collect the data needed to monitor and improve programming. Using the logic model during program implementation and management requires you to focus energies on achieving and documenting results. Logic models help you to consider and prioritize the program aspects most critical for tracking and reporting and make adjustments as necessary.

3. **For Program Evaluation and Strategic Reporting**, a logic model presents program information and progress toward goals in ways that inform, advocate for a particular program approach, and teach program stakeholders.

Descriptions of Three Approaches to Logic Models:

Which Fits Your Program?

Theory Approach Models emphasize the theory of change that has influenced the design and plan for the program. These logic models provide

rich explanation of the reasons for beginning to explore an idea for a given program. Sometimes they have additional parts that specify the problem or issue addressed by the program, describe the reasons for selecting certain types of solution strategies, connect proven strategies to potential activities, and other assumptions the planners hold that influence effectiveness.

These models illustrate how and why you think your program will work. They are built from the "big picture" kinds of thoughts and ideas that went into conceptualizing your program. They are coming to be most often used to make the case in grant proposals. Models describing the beginnings of a program in detail are most useful during program planning and design.

Outcomes Approach Models focus on the early aspects of program planning and attempt to connect the resources and/or activities with the desired results in a workable program. These models often subdivide outcomes and impact over time to describe short-term (1 to 3 years), long-term (4 to 6 years), and impact (7 to 10 years) that may result from a given set of activities. Although these models are developed with a theory of change in mind, this aspect is not usually emphasized explicitly. Models that outline the approach and expectations behind a program's intended results are most useful in designing effective evaluation and reporting strategies.

Activities Approach Models pay the most attention to the specifics of the implementation process. A logic model of this type links the various planned activities together in a manner that maps the process of program implementation. These models describe what a program intends to do and as such are most useful for the purposes of program monitoring and management. This type provides the detailed steps you think you will need to follow to implement your program. It shows what you will actually do in your community if your proposal is funded. Models that emphasize a program's planned work are most often used to inform management planning activities.

Logic Models Outcomes and Impacts should be SMART:

• Specific; • Measurable; • Action-oriented; • Realistic; • Timed

http://www.ncleg.net/PED/Resources/documents/LogicModelGuide.pdf

Chapter 7: SAMHSA's Strategic Prevention Framework, SPF

SAMHSA's Strategic Prevention Framework (SPF) is a 5-step planning process to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The effectiveness of this process begins with a clear understanding of community needs and depends on the involvement of community members in all stages of the planning process.

The SPF includes these five steps:

- Step 1. Assess Needs
- Step 2. Build Capacity
- Step 3. Plan
- Step 4. Implement
- Step 5. Evaluation

These steps are guided by the principles of cultural competence and sustainability. The SPF is designed to help States, Jurisdictions, Tribes, and communities build the infrastructure necessary for effective and sustainable prevention. Each step contains key milestones and products that are essential to the validity of the process. Focused on systems development, the SPF reflects a public health, or community-based, approach to delivering effective prevention.

The SPF also utilizes the Public Health Approach to reach findings during the entire process. The focus of public health is on the safety and well-being of entire populations by preventing disease, rather than treating it. The Institute of Medicine defines public health as "what we, as a society, do collectively to assure the conditions for people to be healthy." Therefore, a public health approach to behavioral health involves working with allied health professionals, families, schools, social services, neighborhoods, and communities to create conditions that will foster well-being.

These important questions will be answered using the public health approach:

What? What substance abuse behaviors (or other behavioral problems such as mental health problems, suicide, and serious psychological distress) need to be addressed?

Who? Who will the interventions focus on—the entire population or a specific population group?

When? When in the lifespan—or at what specific developmental stage—is the population that the interventions will focus on? (e.g., adolescence, young adulthood)

Where? Where should the interventions take place? Prevention and promotion needs to take place in multiple contexts that influence health and where risk and protective factors can be found—in families, communities, and society.

Why? Why are these problems occurring? This refers to the risk and protective factors that influence the problems.

How? How do we do effective prevention? This refers to a planning process—the Strategic Prevention Framework—that will be used to determine what interventions will be most effective for a specific population group.

Key characteristics of a public health approach:

Promotion and Prevention

A public health approach promotes the conditions that foster health and well-being, and prevents the occurrence of disease.

Promotion seeks to optimize well-being by addressing the determinants of health—the biological, physical, geographical, social, and economic factors that impact health.

Prevention aims to reduce behavioral health problems by addressing the determinants of health.

Promoting well-being and preventing behavioral health problems require that interventions include every setting in which the population has meaningful interactions.

Distinctive Features of the SPF

Though the steps of the SPF should look familiar to most prevention practitioners, the framework has four distinctive features:

•**It is driven by the concept of outcome-based prevention**. Increasingly, funders require evidence that communities have defined and achieved their prevention outcomes. For example, many funders have threatened to discontinue drug-free zone programs at schools because there is no tangible proof that they work. The SPF drives people toward defining the specific results they expect to accomplish with their prevention plan. Outcomes-based prevention starts with looking at consequences of use, then identifying the patterns of consumption that produce these consequences.

•**It focuses on population-level change**. Earlier prevention models usually measured success by looking at individual program outcomes or changes among small groups. For example, a prevention program aimed at middle-school students might look for individual increases in resiliency or changes across one grade level. Under the SPF, a community might instead decide to implement a range of programs and practices which could collectively produce more broad-scale change--in this case, among all participating 7th and 8th graders, instead of just one grade level. Population-level change also forces practitioners to look at the constellation of factors, across related systems, which influence substance use.

•**It focuses on prevention across the lifespan**. Traditionally, prevention has focused on adolescent consumption patterns. The SPF challenges prevention practitioners to look at substance abuse among other populations which are often overlooked, such as 18 to 25-year-olds and adults over 65.

•**It emphasizes data-driven decision-making**. States, Jurisdictions, Tribes and communities are expected to collect data on consumption and consequence patterns. They are also expected to use data to describe their

community, as well as their community' capacity to address identified problems. Finally, communities are required to choose programs and practices whose effectiveness is supported by data.

Step 1. Assess Needs

Under the SPF, communities are expected to assess population needs, including levels of substance abuse and related problems; available resources to support prevention efforts, and community readiness to address identified prevention problems or needs. We explore each of these categories, below.

Collecting Consequence and Consumption Data

In the substance abuse prevention world, population-level needs assessment looks at the patterns and effects of substance abuse in particular populations, as well as related behavioral health problems. Assessment often begins at the State, Jurisdiction, or Tribe level, with a review of epidemiological data--when these data are available. In some cases, the State identifies one priority problem and expects all communities to address it through their local efforts. In other cases, communities may be asked to choose from among several priority problems.

In either case, communities need to collect additional data, either to better understand the problem identified by the State, or to help them decide which of several State-identified problems they should tackle. They also need to understand the nature, extent, and impact of identified problems at the local level, to uncover the factors that drive them, and to identify appropriate solutions.

Problems are typically thought of in terms of consequences and consumption patterns:

•**Consequences** describe what happens when people use substances. Any social, economic, or health problem can be defined as a substance-related consequence if the use of alcohol, tobacco, or illicit drugs increases the likelihood that the consequence will occur.

•**Consumption** describes the way people drink, smoke and use illicit drugs. Examples of consumption patterns include binge drinking among underage youth, women of child-bearing years who drink 5 or more drinks per day, and senior citizens who mix alcohol with their medications.

Who and where describe consumption patterns. The effects are the consequences.

Determining consumption patterns and consequences requires data. There are two basic kinds of data--quantitative and qualitative. Often, communities use a combination of qualitative and quantitative data to get a good handle on their local substance abuse problems.

•**Quantitative data** are usually reported numerically. An example of quantitative data is the percentage of car crashes caused by teens that have been drinking. Sources of quantitative data include counting, checklists, surveys, and analysis of statistics.

•**Qualitative data** are usually reported in words. Sources of qualitative data include stories, case studies, testimonials, and focus groups.

Before embarking on a major data collection undertaking at the community level, it is helpful to take stock of information that may already been collected. For example, States often collect community-specific data to inform the State epidemiological profile. Also, many communities routinely collect data on underage drinking through the Youth Risk Behavior Survey. Typically, however, communities need to supplement existing data by collecting additional information.

Setting Priorities

Once communities have completed data collection and review, they need to develop a process for setting prevention priorities. Criteria for analyzing and prioritizing assessment data include:

•**Magnitude**, which describes the number of people affected by a problem.

•**Changeability**, which describes how easily a problem can be changed.

•**Impact**, which describes the depth of a problem across a variety of dimensions, such as health, economic or criminal.

•**Concentration**, which describes how concentrated the problem is in a specific population.

•**Time lapse**, which describes the amount of time that elapses between consumption and consequence. This is important to consider if a community wants to show that it is having an impact within a set timeframe.

Each community will develop its own set of criteria for prioritizing needs--and for weighing these criteria again one another.

Risk and Protective Factors

Once communities have selected their prevention priorities, they also need to assess the factors driving the prioritized problem(s). Each substance abuse prevention problem has its own set of risk and protective factors. However, the factors driving a problem in one community may differ from the factors driving it in another community. One of the most important lessons learned from prevention research is that, in order to be effective, prevention strategies must address the underlying factors driving a problem. It doesn't matter how carefully a program or practice is implemented. If it's not a good match for the problem, it's not going to work.

Available Resources to Support Prevention Efforts

Communities take a big step toward effective prevention when they conduct a systematic resource assessment. Resource assessments help 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 sound organizational structure. But substance abuse prevention resources also include factors such as:

•Community efforts to address prevention issues

•Community awareness of those efforts

•Specialized knowledge of prevention research, theory and practice

•Practical experience working with particular populations

•Knowledge of the ways local politics and policies help or hinder prevention efforts.

It is important that communities focus their resources assessments on relevant resources (i.e., resources that are related to their priority problems). 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 well be found outside of the substance abuse prevention system, among the many organizations working to reduce the impact of behavioral health problems.

Community Readiness to Address Identified Prevention Problems or Needs

Data may reveal what problems to address--but is the community ready to commit resources to address these problems? Do they believe there is a problem? What are people's perceptions of it? How accurate are they? And how do key leaders perceive the problem? Assessing community readiness can help practitioners determine whether the time is right, the place is right, and whether there is a social momentum towards addressing the problem, or problems, they hope to tackle.

To be useful, readiness assessments should represent and reflect the readiness of all sectors of the community. To do this, communities must engage in a culturally competent assessment process. This means involving representatives from across sectors in assessment planning and data collection. It also means collecting information, across sectors, in ways that are appropriate and respectful. Finally, it means taking a close look at the people around the planning table and seeing if they reflect the diversity of the population, at large.

Ultimately, the assessment should include information about the cultural and ethnic make-up of the community, how substance abuse problems are perceived among different sectors, who has been engaged in prevention planning and implementation of prevention interventions, and what barriers to participation in prevention efforts exist.

Engaging key stakeholders in all aspects of the assessment process will contribute to the sustainability of the overall prevention initiative. It will help to ensure their buy-in and lay the foundation for ongoing participation and support. It is also vital to share assessment findings with key stakeholders and other community members. The better they understanding baseline issues, the more they'll appreciate--and want to sustain--all that the prevention efforts accomplish.

Step 2. Build Capacity

States and communities must have the capacity--that is, the resources and readiness--to support the prevention programs and practices they choose to address identified substance abuse problems. Why? Because programs and practices that are well-supported are more likely to succeed. Building capacity means taking a close look at the assessment data, finding the gaps that lie therein, and developing an action plan to address those gaps.

Keep in mind that resources and readiness often go hand-in-hand: building resource capacity also contributes to greater readiness. For example, when key stakeholders are engaged in solving problems, they often mobilize others to get involved. This leads to more people recognizing the value of prevention.

Key components of capacity building include:

•**Improving awareness** of substance abuse problems and readiness of stakeholders to address these problems. Stakeholders are often busy people, juggling multiple, competing priorities. To make your issue their priority, you will need to make a strong and compelling case for why they should devote their time, energy, and resources to the problems you have identified. It is especially important to educate other members of the behavioral health workforce, who may not recognize the role they can play in substance abuse

prevention, or understand how their health promotion efforts are related to the work you do. Increasing community awareness isn't about increasing the knowledge and awareness of every community member. But there are certain key stakeholders in every community who must be on board if your prevention initiative is going to succeed. To figure out who these players are, it is important to look critically at the readiness data collected in Step 1 and identify community members and groups who are not yet ready for prevention, but who must be brought around if your initiative is going to take off. Then develop and implement strategies for boosting their readiness levels.

•**Strengthening existing partnerships** and/or identifying new opportunities for collaboration. Engaging and involving a range of partners is an essential piece of prevention planning--to share resources and information, and to ensure that you're able to reach multiple populations with multiple strategies, in multiple settings. Building a team from the various groups that have expertise in or represent the target population will ensure better outcome and results. Involving different sectors of the community in early planning will also help to ensure that resources needed for sustainability will be available later on. When thinking about collaboration, consider both traditional and non-traditional partners. Important champions for prevention may be found in the local media, and in the legislature, faith, or business communities. It's important to foster relationships with stakeholders, individuals, or institutions that support your prevention efforts, as well as those who may stand in your way.

•**Improving organizational resources**. At the State level, this might involve strengthening data collection systems and infrastructure, re-allocating staff workloads to improve efficiency and effectiveness, or increasing coordination with other State systems that can support prevention efforts (e.g., public safety, juvenile justice). At the community level, this often means engaging or building planning groups, ensuring that planning groups reflect the ethnic make-up of the community, and /or enhancing how the group does its work (e.g., selects members, makes decisions).

•**Developing and preparing the prevention workforce**. The effectiveness of any prevention effort depends on the knowledge and sophistication of the people delivering the intervention. But workforce development means more than simply preparing individuals to complete specific tasks. It also means creating or enhancing systems to support development activities and making sure that practitioners can access the services provided.

When it comes to capacity building, cultural competence and sustainability are closely linked. Broad cultural representation is key to sustaining prevention efforts in the long-term: the wider your base of support, the greater the likelihood that the champions and resources needed for sustainability will be available later on. Consider developing a cultural outreach policy that will help you pay attention, in a systematic way, to the various neighborhoods and populations you serve. And make sure to include people from these neighborhoods and populations to help you develop this policy!

Together, these activities will not only improve the effectiveness of prevention activities in the short term, but also help to ensure the sustainability of these activities, over time.

Step 3. Plan

Planning is pivotal to prevention success. Planning will increase the effectiveness of prevention efforts--by focusing energy, ensuring that staff and other stakeholders are working toward the same goals, and providing the means for assessing and adjusting programmatic direction, as needed. If done carefully, planning will also make future evaluation tasks much easier.

Good planning is also key to sustainability. It ensures the involvement and commitment of community members who will continue program efforts and activities beyond the initial funding period. It establishes the organization structure necessary to maintain program activities, over time. And it greatly increases the likelihood that expected outcomes will be achieved, by ensuring that the activities selected are the right ones for the community.

Prevention practitioners at the State and Jurisdiction levels typically engage in these planning activities:

•Develop a State-level logic model that links the consequences, consumption patterns, and risk factors associated with the identified priority problem(s) with selected prevention approaches.

•Develop a comprehensive, logical, and data-driven plan that includes the State-level logic model, strategies for addressing resource and readiness gaps, and an evaluation plan.

•Establish a process and criteria for determining what is evidence-based and for reviewing selected strategies.

•Determine a mechanism for soliciting proposals (e.g., letter of intent, request for proposals), create the requisite documents, and create a systematic and culturally-competent review process.

Prevention practitioners at the community or tribe level typically engage in these planning activities:

•Prioritize the risk and protective factors associated with the problem(s) you plan to address. Establish criteria for doing so (e.g., changeability, importance). This will help you determine which factors are having the greatest impact in your community.

•Select prevention interventions that are evidence-based, most likely to influence the risk factors you have selected, and consistent with the beliefs and attitudes of your target audience. Before selecting a prevention intervention, map the cultural landscape of the community: create an inventory of commonly spoken languages, socio-economic issues, neighborhood alliances, and allegiances, and key leaders and their cultural connections. Then involve representatives from across the cultural landscape in the selection of your prevention approaches.

•Develop a community-level logic model that links local problems, related risk and protective factors, evidence-based strategies, and anticipated prevention

outcomes. In the context of the SPF, logic models display the relationship between:

•the consequences of substance abuse,

•the consumption patterns,

•the risk and protective factors affecting consumption,

•the approaches selected to change these factors, and

•expected outcomes (A logic model can be a useful tool for confirming that all working group members have a shared understanding of what they want to accomplish, and why. Logic models are also a useful way to explain your plans to others in the community.)

•Develop a comprehensive, logical, and data-driven plan that includes the community-level logic model, plans for addressing identified resource and readiness gaps, and how issues of cultural competence were addressed. Keep in mind that good planning requires a group process. Whether planning happens within a formal coalition, or among a more informal group of partners, it cannot represent the thoughts and ideas of just one person. Decisions must reflect the ideas and input of individuals from across community sectors.

Step 4. Implement

Implementation is where the rubber hits the road--where States, Tribes, Jurisdictions, and communities do what they've said they're going to do. Here are some important things to consider:

Fidelity and Adaptation

Fidelity refers to the degree to which a program is implemented as its original developer intended. Programs or practices that are implemented with complete fidelity are most likely to be effective. Yet practitioners often find the need to change the interventions they've selected. They may be working with a target population that is in some way different from the population that

was originally evaluated. Or they may need to change certain program elements due to budget, time, or staffing restraints.

In these cases, practitioners may adapt the program or practice to meet local circumstances. Balancing fidelity and adaptation can be tricky--because any time you change an intervention, you may be compromising outcomes. Even so, implementing a program that requires some adaptation may be more efficient, effective, and cost-effective than designing a program from scratch.

General guidelines for adapting an intervention include the following:

•Select programs with the best initial fit to local needs and conditions. This will reduce the likelihood that you will need to make adaptations later on.

•Select programs with the largest effect size. Effect size refers to the magnitude of the effects of an intervention. Policy change interventions generally have larger effect sizes than classroom-based interventions. The smaller an intervention's effect size, the more careful you want to be about changing anything--because you don't want to inadvertently compromise any good you're doing. In general, adaptations to programs with large effect sizes are less likely to affect relevant outcomes.

•Change capacity before program. It may be easier to change the program, but changing local capacity to deliver it as it was designed is a safer choice.

•Consult with the experts, including the program developer, an environmental strategies expert, or your evaluator. They may be able to tell you how the intervention has been adapted in the past and how well these adaptations have worked out.

•Retain core components. There is a greater likelihood of effectiveness when a program retains the core component of the original intervention. If you're not sure which elements are core, consult the program developer, an environmental strategies expert, or an evaluator.

•Adhere to evidence-based principles. Programs and practices that adhere to evidence-based principles are more likely to be effective, so it is important for adaptations to be consistent with the science.

•Add rather than subtract. Doing so will decrease the likelihood that you are eliminating a program element that is important.

•Effective cultural adaptation is especially important when it comes to implementation. Cultural adaptation refers to program modifications that are culturally sensitive and tailored to a particular group's traditional world views. 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. And it depends on strong linkages to cultural leaders and access to culturally competent staff.

Implementation Factors

Multiple factors influence implementation. These include:

•Staff or practitioner selection. Beyond academic qualifications or experience factors, certain practitioner characteristics are difficult to teach in training sessions, and so must be a part of your selection criteria.

•Pre- and in-service training. Trainings are efficient ways to communicate background information, theory, philosophy, and values; and to introduce the components and rationales for key practices. They also provide opportunities to practice new skills and receive feedback in a safe environment.

•Ongoing consultation or coaching. Implementation of evidence-based practices and programs requires behavior change at the practitioner, supervisor, and administrative support levels. Training and coaching are the principle ways in which behavior change is brought about.

•Staff and program evaluation. Assessments of practitioner performance and measures of fidelity can provide useful feedback to managers and implementers on the progress of implementation and the usefulness of training and coaching. Program evaluation can be used to ensure continued implementation of core intervention elements, over time.

•Facilitative administrative support provides leadership and makes use of a range of data inputs to inform decision-making and keep staff organized and focused on desired outcomes.

•History implementing prevention interventions in the past. What's your track record? Do you have past successes that you can point to proudly and build on? According to one school-based prevention coordinator, the most challenging part [of bringing in a new prevention program] is convincing veteran teachers that it is not just another program to place on the shelf.

•Key stakeholder support. For a program or practice to be effective, community members must be involved in its implementation. In the short term, these stakeholders will help to ensure that the prevention approach reflect the values and priorities of the target audience. In the long term, these individuals can become program champions, working to sustain program activities and prevention priorities.

Action Plan Development

An action plan is a written document that lays out exactly how you will implement the selected program or practice. It describes what you expect to accomplish, the specific steps you will take to get there, and who will be responsible for doing what. It also includes a timeline. Action plans help to ensure that everyone involved in the prevention effort is on the same page. If you are implementing more than one prevention strategy, it is helpful to develop a separate action plan for each.

Action plan development may fall to the person heading up your initiative. Or, it may be delegated to a group member who is good at sequencing events and realistic about timelines. The person assigned responsibility for developing the plan has a lot to do with the intervention, itself. For example, several people should optimally be involved in developing the action plan for a multi-site, multi-audience social marketing campaign, whereas one or two would be enough to develop a plan to implement a single, classroom-based intervention.

Step 5. Evaluation

Evaluation is the systematic collection and analysis of information about program activities, characteristics, and outcomes to reduce uncertainty, improve effectiveness, and make decisions. Evaluation isn't about acquiring

knowledge for the sake of knowledge. It's more practical. It's about utility. It helps States and communities become more skillful and exact in describing what they plan to do, monitor what they are doing, and improve. Evaluation results can and should be used to determine what efforts should be sustained and to assist in sustainability planning efforts. Ultimately, good evaluation will help improve not only our own programs but those implemented by others.

Evaluation in the Context of the SPF

Practitioners at the State, Jurisdiction, Tribe, and community levels engage in a variety of evaluation-related activities, including identifying evaluation expertise, designing evaluation plans, and collecting, analyzing, and reporting data. One unique aspect of SPF evaluation is that practitioners need to evaluate their entire, 5-step planning process. They will need to show how each step of the SPF connects to the steps around it. To do this, practitioners need to ask questions such as:

•How successful was the community in selecting and implementing appropriate strategies?

•Were these the right strategies, given the risk factors the community identified?

•Were representatives from across the community involved in program planning, selection, and implementation? In what ways were they involved?

•Was the planning group able to identify potential new partners with which to collaborate?

•What was the quality of the data used in decision making?

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 methods and instruments used, is consistent with the cultural norms of the people you serve. Stakeholders also can dictate how or even whether evaluation results get used.

Communicating Evaluation Results

The best way to ensure use is to communicate your findings in ways that meet the needs of your various stakeholders. Whether your results get used has a lot to do with the evaluation itself. This includes:

•How the findings are reported, including layout, readability, and user-friendliness.

•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 clearly influence whether the findings are taken seriously.

•Availability of support and technical assistance after findings are reported. Questions of interpretation will arise over time, and people will be more likely to use the results if those kinds of questions can get answered.

Evaluations are also always read within a particular political context or climate. Some evaluation results will get used because of political support, and others will get squashed because of political pressure. Other factors, like the size of the organization or the program, may matter. Sometimes larger programs get more press; sometimes targeted programs do. It is also important to consider competing information: Are there results from similar programs that confirm or deny your results? Are there other topics competing for attention?

Developing a Dissemination Plan

To facilitate communication, it is helpful to develop a plan for disseminating evaluation findings. An effective dissemination plan should include:

•A situation analysis that explains why you are creating the plan and what you hope to achieve.

•A description of the audiences you hope to reach. These might include current and potential funders, community administrators, board members, community groups, community organizations, national and State associations, the media, legislators, and/or the general public.

•Tailored messages that communicate key evaluation findings in language that is appropriate for the audience.

•Reporting methods--that is, how you will package your messages. Formats might include news articles, editorials, public service announcements, transportation ads, professional presentations, panels, or poster sessions.

•Channels for getting the word out--such as community newspapers, professional journals, association newsletters, conferences and workshops, or local radio or TV stations. Consider who you want to reach and how they get information.

•How you will evaluate your communication efforts.

In sharing results and lessons learned, make sure to tap into the diverse group of stakeholders who have been involved with you all along the way. They can be hugely helpful to you in spreading the word.

Cultural Competence

Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures. To produce positive change, prevention practitioners must understand the cultural context of their target community, and have the willingness and skills to work within this context. This means drawing on community-based values, traditions, and customs, and working with knowledgeable persons of and from the community to plan, implement, and evaluate prevention activities.

Why Cultural Competence?

Cultural competence helps to ensure that the needs of all community members are identified and addressed. Without input from every group

affected by a decision, there are bound to be things left out and mistakes made. Consider these examples:

•A community project wants to build an outside facility for children in an inner-city neighborhood. Project planners decide that tennis courts would be a nice addition to the neighborhood. After spending considerable money to build the courts, and much fanfare announcing their unveiling, community leaders find that the tennis courts remain largely unused. Why? Because few children in the neighborhood know how to play tennis, and funding for tennis lessons was not included in the project budget. Had planners involved community members in planning the project from the beginning, it might have seen a more successful outcome.

•The dean of admissions at a college is eager to increase the number of Native American students attending the school. He decides to raise funds to create a scholarship to send Native American students to the school for four years. He awards the first scholarship, but the family of the selected student turns him down. They explain that they have four daughters, and would prefer to send each daughter to the school for one year. They cannot send one daughter to school for four years and forget the other three. Equality is very important in the culture of the Native American. Had the dean taken the time to understand the Native American culture, he would have been able to craft a scholarship program that better reflected the needs of that culture.

CSAP Principles of Cultural Competence

SAMHSA's Center for Substance Abuse Prevention (CSAP) has identified these principles of cultural competence:

•Ensure community involvement in all areas.

•Use a population-based definition of community (that is, let the community define itself).

•Stress the importance of relevant, culturally-appropriate prevention approaches.

•Employ culturally-competent evaluators

•Promote cultural competence among program staff and hire staff that reflect the community they serve

•Include the target population in all aspects of prevention planning.

Sustainability

When thinking about sustainability, prevention practitioners typically think of sustaining prevention programs. But best practice challenges us to think about sustainability more contextually; to consider the multiple factors that contribute to program success--such as the existence of stable prevention infrastructure, available training systems, and community support--and work toward sustaining these contributors.

Best practice also encourages us to think critically about which activities we should, or should not, sustain. Our ultimate goal is to sustain prevention outcomes, not programs. Programs that produce positive outcomes should be continued. Programs that are ineffective should not be sustained.

In addition, the SPF emphasizes sustaining the prevention process, itself, recognizing that practitioners will return to each step of the process, again and again, as the problems communities face continue to evolve. Tips for increasing sustainability include the following:

•Think about sustainability from the beginning. Too often, practitioners wait until the 11th hour to begin thinking about sustainability. But building support, showing results, and ultimately, obtaining continued funding all takes time. So, it's critical to think about who needs to be at the table, from the beginning.

•Build ownership among stakeholders. The more invested 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 assessment activities are more likely to support prevention activities that stem from the assessment. They are also more likely to sustain these activities, over time.

•Track and tout outcomes. A well designed and executed evaluation helps you determine which activities to keep and which to get rid of. It can also help demonstrate effectiveness. Then share outcomes with community members so that they can become champions of your efforts.

•Identify program champions willing to speak about and promote prevention efforts.

•Invest in capacity--at both the individual and systems levels. Teach people how to assess needs, build resources, and effectively plan and implement prevention programs 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.

http://captus.samhsa.gov/access-resources/resource-types/ta-tools?tid=74&tid_1=All&term_node_tid_depth=All&term_node_tid_depth_1=All&title=

Chapter 8: Identifying and Selecting Evidence-Based Interventions for Substance Abuse Prevention

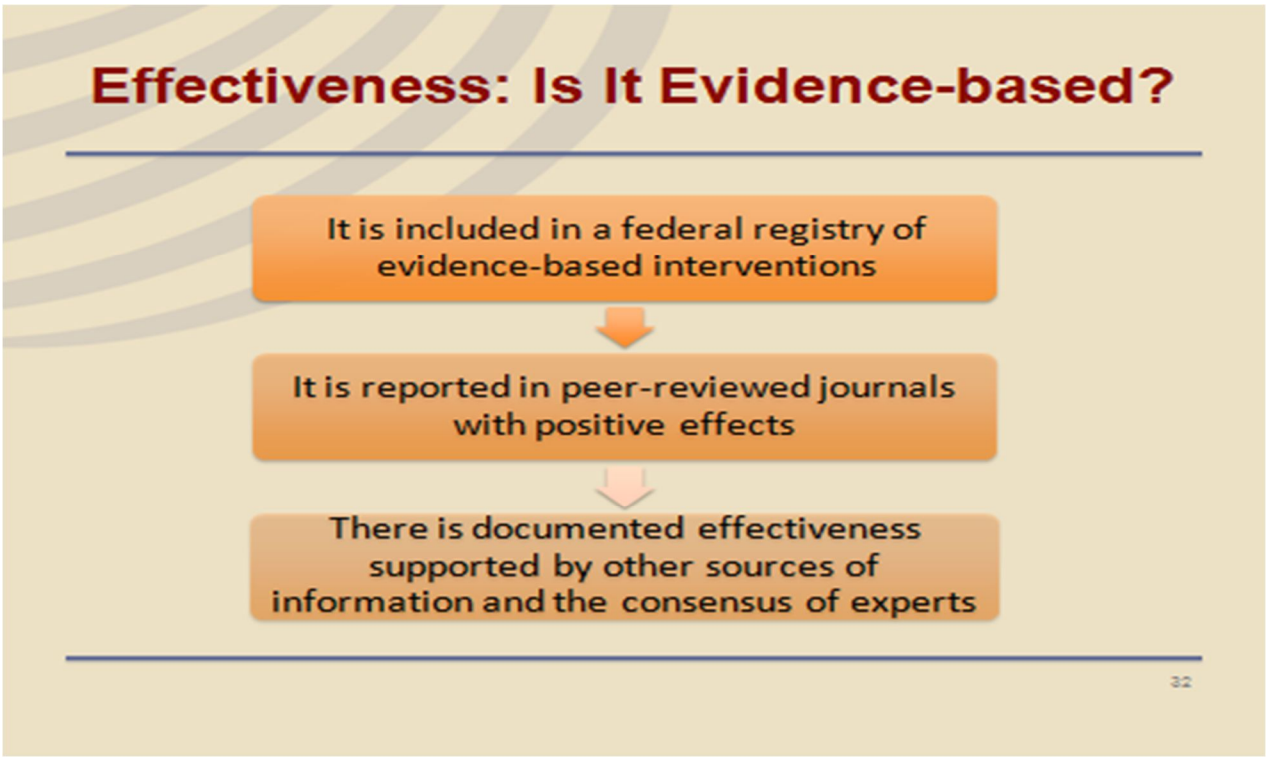
The purpose of this guidance is to assist State and community planners in applying the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Strategic Prevention Framework (SPF) to identify and select evidence-based interventions that address local needs and reduce substance abuse problems.

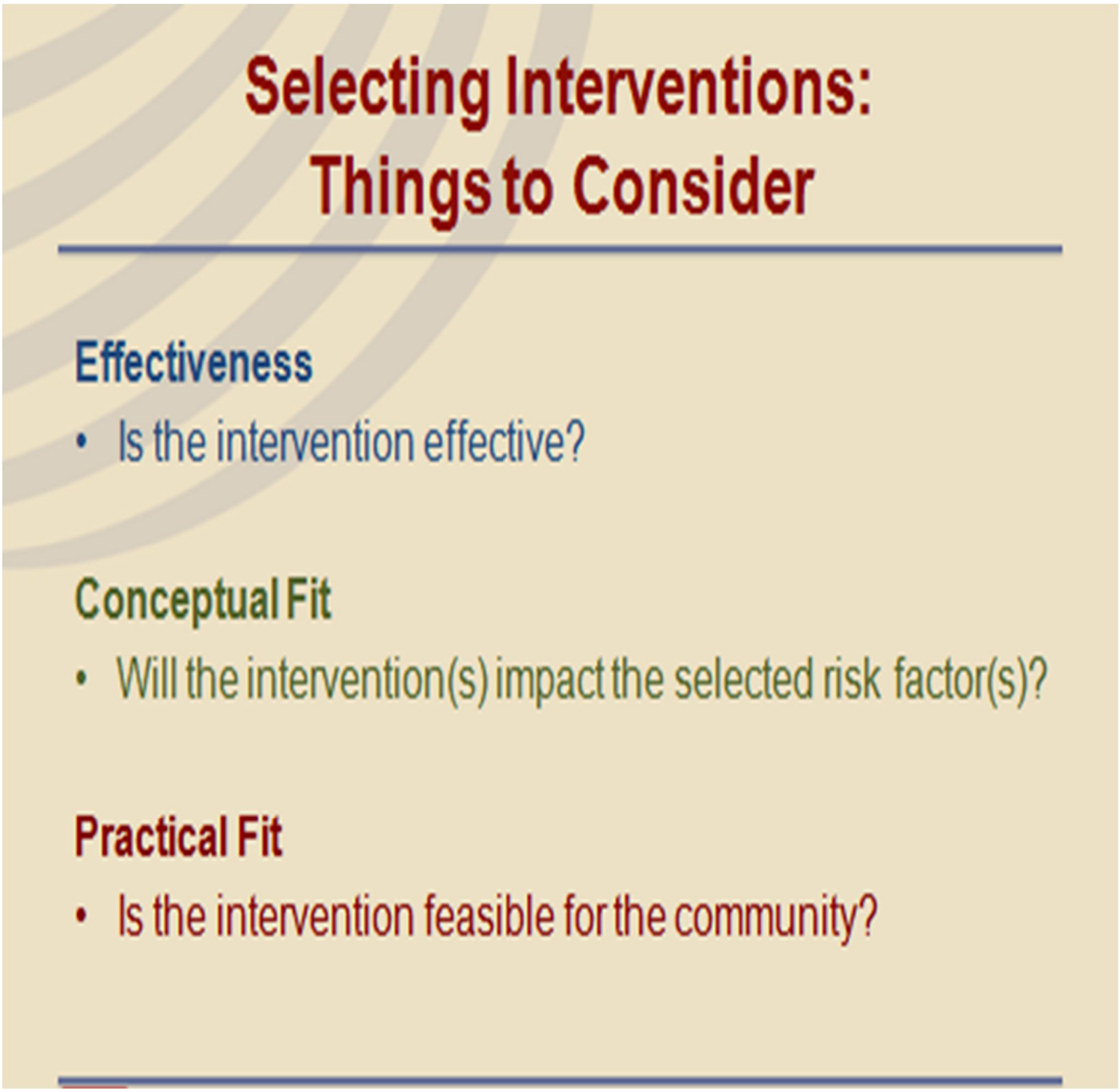
Prevention experts agree that substance abuse problems are usually best addressed locally—at the community level—because they are manifested locally. Yet some prevention approaches may be most effective when implemented on a larger scale, perhaps through a statewide change in laws (e.g., change in the alcohol index for driving under the influence). Experts also agree that substance abuse problems are among the most difficult social problems to prevent or reduce. Substance abuse problems require

comprehensive solutions—a variety of intervention approaches directed to multiple opportunities.

The challenge of selecting the optimal mix of strategies is complicated by the limited availability of public resources on evidence-based interventions. In practice, practitioners seeking to reduce substance abuse problems will need to put together their own mix of interventions. An optimal mix of interventions will fit the particular needs of the community–its population, cultural context, and unique local circumstances, including community readiness. Some interventions in the comprehensive plan may be deemed "evidence-based" through inclusion in Federal registries or reported findings in the peer-reviewed literature, while others may document effectiveness based on other sources of information and empirical data. An optimal mix of strategies will combine complementary and synergistic interventions.

Areas of consideration:





(What to consider when selecting interventions)

Conceptual fit refers to interventions that – Address the priority risk/protective factor and problem.

Produce positive outcomes with the substance abuse problem or risk/protective factors.

Target multiple contexts (i.e., individual, family school/community).

The following questions will help determine the practical fit of an intervention:

Is it feasible? – Does the community have the resources (human, organizational, etc.) needed for the intervention? (Refer to Step 2 covered in the previous day.)

Is there synergism? – Does the intervention add to or reinforce other prevention interventions?

Is the community ready? – Will stakeholders and the community support the intervention?

Is the intervention sustainable? – Will the intervention be able to be sustained over time?

And is the intervention culturally appropriate?

If the prevention program, practice, or strategy does not fit the community's capacity—their resources or readiness to act— then the community is unlikely to implement the intervention effectively.

In some cases, planners may not be able to find an intervention that meets their needs in the Federal registries or the peer-reviewed research literature. In these instances, other sources of information such as articles in non-peer-reviewed journals, book chapters, or unpublished program evaluation reports may be available. These sources may provide weaker support for effectiveness; thus, they should be reviewed as specified in the guidelines.

In general, we recommend using the following decision rules when considering these other sources of supporting information:

1. Out of two similar interventions that address the targeted needs equally well, choose the one for which there is stronger evidence of effectiveness, both in terms of the consistency and strength of effects on the desired outcomes and quality or rigor of the evaluation methodology utilized.

2. Reserve the option to select an intervention with little or weak evidence of effectiveness for circumstances in which there are no interventions with stronger evidence that appropriately address the needs identified for a particular population, culture, or local context.

Using Federal Registries

Federal registries are readily accessible and easy-to-use public resources for identifying interventions that reduce substance use risk factors and consequences or increase protective factors thought to be associated with reduced potential for substance abuse. Many registries use predetermined criteria and a formalized rating process to assess the effectiveness of interventions reviewed. Some registries apply quality scores to the intervention. These quality scores are indications of the strength of evidence according to the ratings applied.

Thus, inclusion of an intervention in a registry can be viewed as providing some evidence of effectiveness. However, the level of evidence required by registries varies considerably. When choosing among interventions that have been reviewed by registries, we generally recommend selecting the one with the highest average score, provided that it demonstrates positive effects on the outcomes targeted for the population identified. Ultimately, while selecting interventions from registries may seem easier in some respects, it still requires planners and practitioners to think critically and make reasoned judgments about intervention selection, taking into account the degree of congruence with the particular cultural context and local circumstances.

Federal registries include:

SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP)

http://www.nrepp.samhsa.gov

Provides descriptions of and rates evidence for various interventions related to substance use and abuse and mental health problems.

OJJDP Model Programs Guide

http://www.dsgonline.com/mpg2.5/mpg_index.htm

Provides descriptions of and rates evidence for youth-oriented interventions, many of which are relevant to the prevention of substance use and abuse.

Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs

Sponsored by the U.S. Department of Education

http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf

Provides descriptions of and rates evidence for educational programs related to substance use.

Guide to Clinical Preventive Services

Sponsored by the Agency for Healthcare Research and Quality [AHRQ]

http://www.ahrq.gov/clinic/cps3dix.htm

Provides recommendations regarding screening and counseling in clinical settings to prevent the use of tobacco, alcohol, and other substances.

Guide to Community Preventive Services

Sponsored by the Centers for Disease Control and Prevention [CDC]

http://www.thecommunityguide.org

Provides recommendations regarding generic programs and policies to prevent and reduce tobacco use and alcohol-impaired driving.

A list of other registries may be found at SAMHSA'S website:

http://www.samhsa.gov/ebpWebguide/appendixB.asp.

Using Other Sources for Documenting Effectiveness

When no existing evidence-based interventions are available in registries or the research literature to address the problem, then empirical support for other interventions may be found in unpublished reports (e.g., doctoral theses) or published, non-peer-reviewed sources (e.g., book chapters,

evaluation reports, and Federal reviews). We recommend caution when relying on these other sources of support because they usually have not been subjected to the methodological scrutiny provided by registries and peer-reviewed journals. Ultimately, the "burden of proof" for documented effectiveness lies with the program planners and practitioners making the selection decision. Under what conditions is it appropriate to select an intervention that is not included in an established Federal list of evidence-based programs or reported with positive effects in the peer-reviewed journal literature? When no appropriate interventions are available through these primary resources on evidence-based interventions, then prevention planners may need to rely on other, weaker sources of information to identify an intervention that is appropriate for the assessed community need, the population served, and the cultural and community context in which it will be implemented.

When selecting interventions based on other sources of supporting information, all four of the following guidelines should be met:

Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model;

Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; Identifying and Selecting Evidence-Based Interventions 19

Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.

Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures).

These guidelines are intended to assist prevention planners by expanding the array of interventions available to them. In a comprehensive prevention plan, these interventions should be considered supplements, not replacements, for traditional scientific standards used in Federal registry systems or peer-reviewed journals.

Summary Process Description: Selecting Best Fit

Prevention Interventions

The process described here is rooted in the work conducted by local communities during SPF steps 1 and 2. It begins with creating a community logic model to map the local substance abuse picture and draws from the findings of local needs and resource assessment. Prevention planners apply the logic model and assessment findings in a process of thinking critically and systematically about three considerations that determine best fit interventions to include in a comprehensive community prevention plan:

Conceptual fit with the community's logic model: Does the candidate intervention target the identified problem and the underlying factors that drive or contribute to changes in the problem or outcomes?

Practical fit with the community's needs, resources, and readiness to act: Is the candidate intervention appropriate for the particular population, cultural context, and set of local circumstances?

Evidence of effectiveness: Is there sufficient evidence or support for documented effectiveness to select the intervention and include it in the comprehensive community prevention plan?

Figure 4 depicts the process for thinking through these key considerations.

Identify types of programs, practices, and strategies that: target the identified problem, address the relevant underlying factors, target opportunities in multiple life domains.

Select specific programs, practices, and strategies that are: appropriate for the community's population, cultural context, and feasible, given local circumstances, including resources, organizational resources, and readiness to act, and that demonstrate sufficient evidence or support for documented effectiveness.

(Selecting prevention interventions)

Chapter 9: Developing a Comprehensive Prevention Plan:

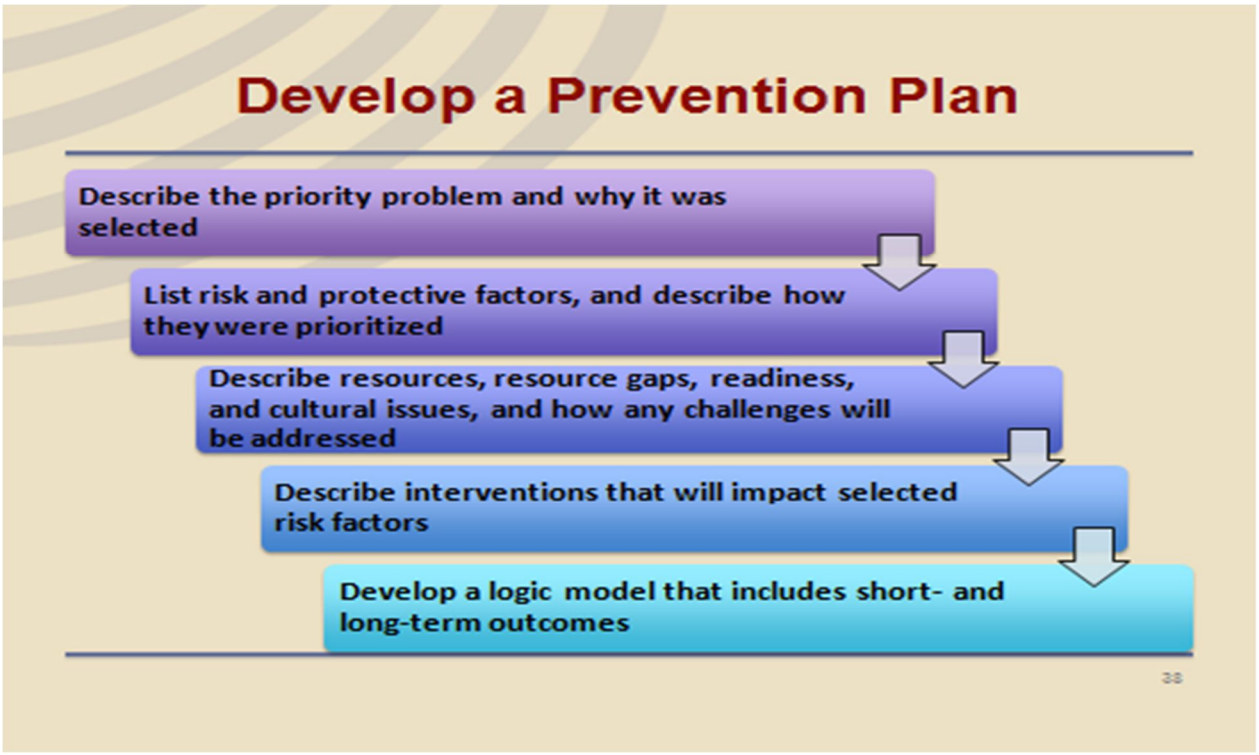
After determining which risk/protective factors to target, then develop a comprehensive, logical, and data-driven plan.

A comprehensive plan involves multiple interventions in multiple settings targeting the risk/protective factors identified. If a community is already doing things to address the problem, a comprehensive approach is achieved

by adding to what is going on already (For example: A community with the problem of underage drinking, and a risk factors of low perception of harm, is already addressing the problem with classroom-based education. So they may want to add other environmental strategies to reduce access to alcohol, which may be another risk factor in that community).

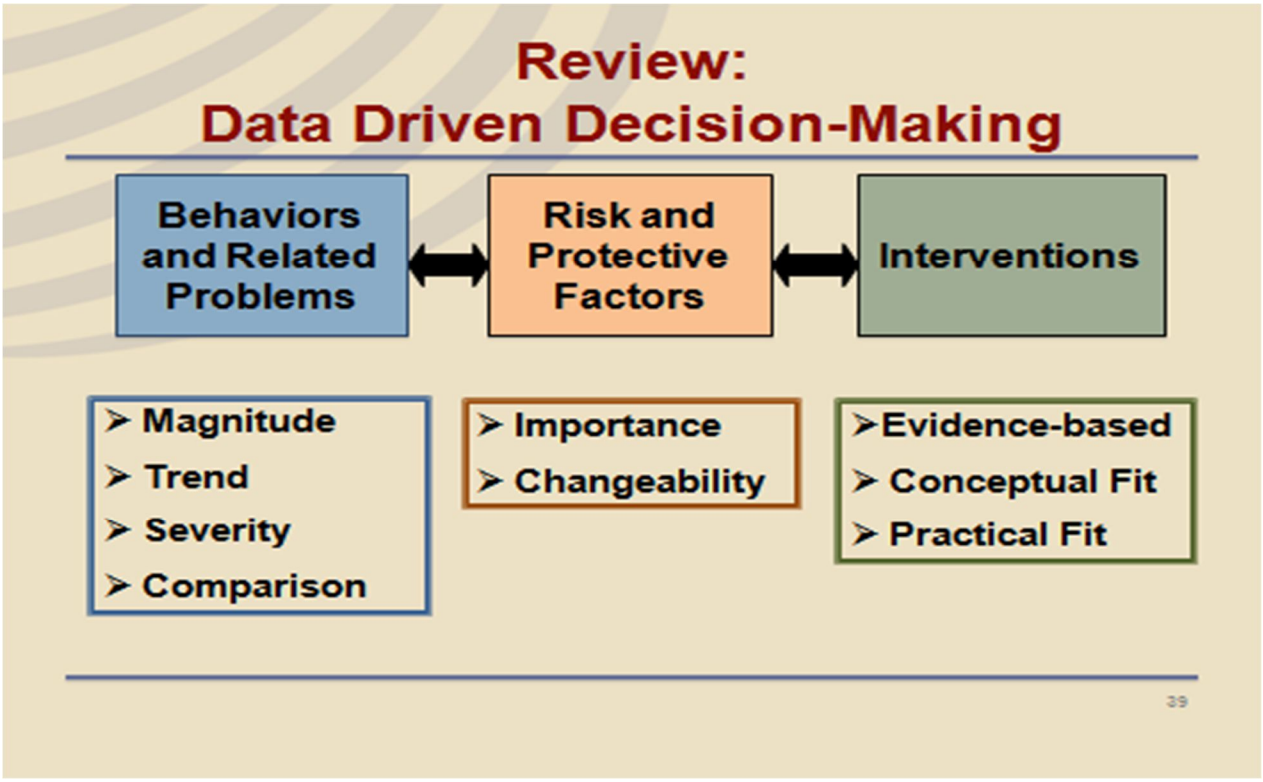
A comprehensive prevention plan includes –

- A description of the priority problem and why it was selected
- A list of the prioritized risk factors and a description of how they were prioritized
- Description of resources, resource gaps, readiness and cultural issues and how any challenges will be addressed
- Description of interventions that will impact the selected risk factors
- Developing a logic model with short and long term outcomes.
- An action plan with timetables, roles and responsibilities for implementing the intervention(s).



(Steps for developing a prevention plan)

Good planning requires a group process—whether planning happens within a formal task force, or among a more informal group of partners, it cannot represent the thoughts and ideas of just one person; decisions must reflect the ideas and input of individuals from across community sectors.



(Data Driven Prevention Decision Making Process)

1) Prioritizing behaviors and related problems:

Magnitude – What is the largest problem?

Trend – Is it getting worse over time?

Severity – How severe is it? What is the impact?

Comparison – How does the problem compare to surrounding communities or the state?

2) Prioritizing risk and protective factors:

Importance – How important is a particular risk or protective factor in reducing the problem in the community

Changeability – Does the community have the capacity—readiness and resources—to change a particular risk or protective factor? Is there a suitable evidence-based intervention that will address the risk or protective factor? Is it possible to change the risk or protective factor in a reasonable time frame?

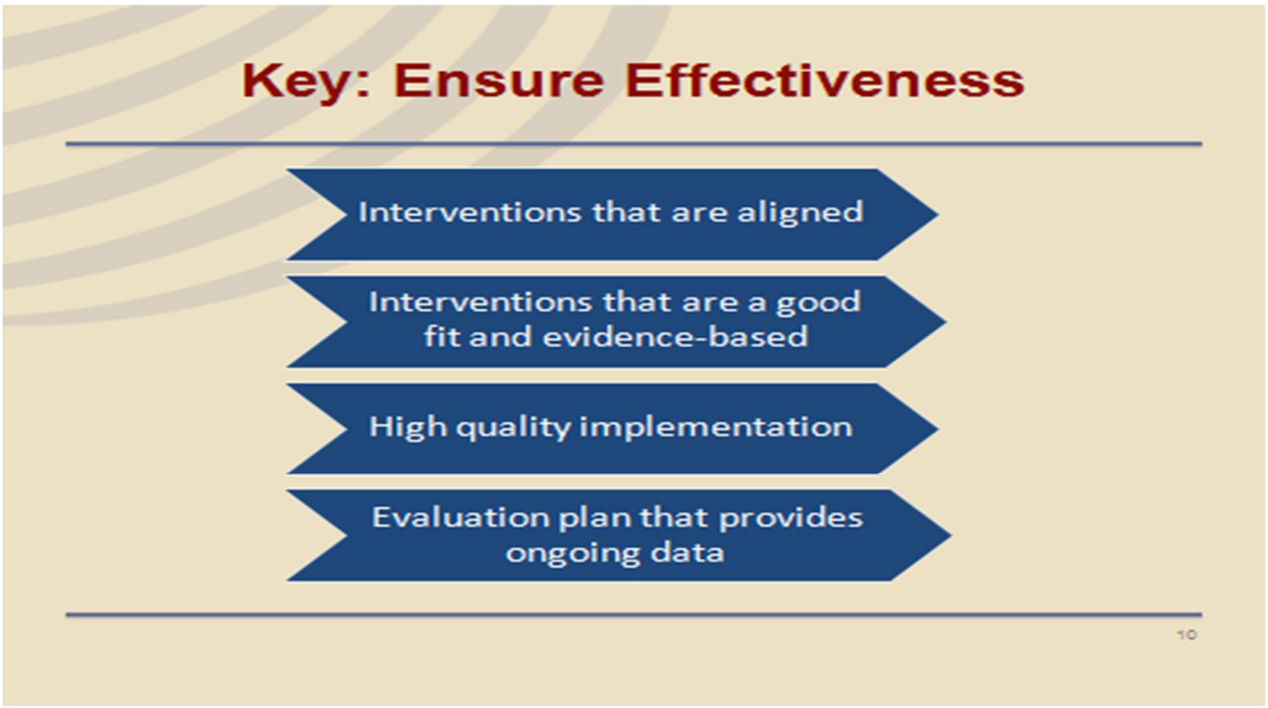
3) Selecting interventions:

Evidence-based – Is the intervention effective (based on research)?

Conceptual fit – Will the intervention impact the selected risk or protective factor?

Practical fit – Is the intervention feasible for the community?

Key to ensuring prevention programming effectiveness

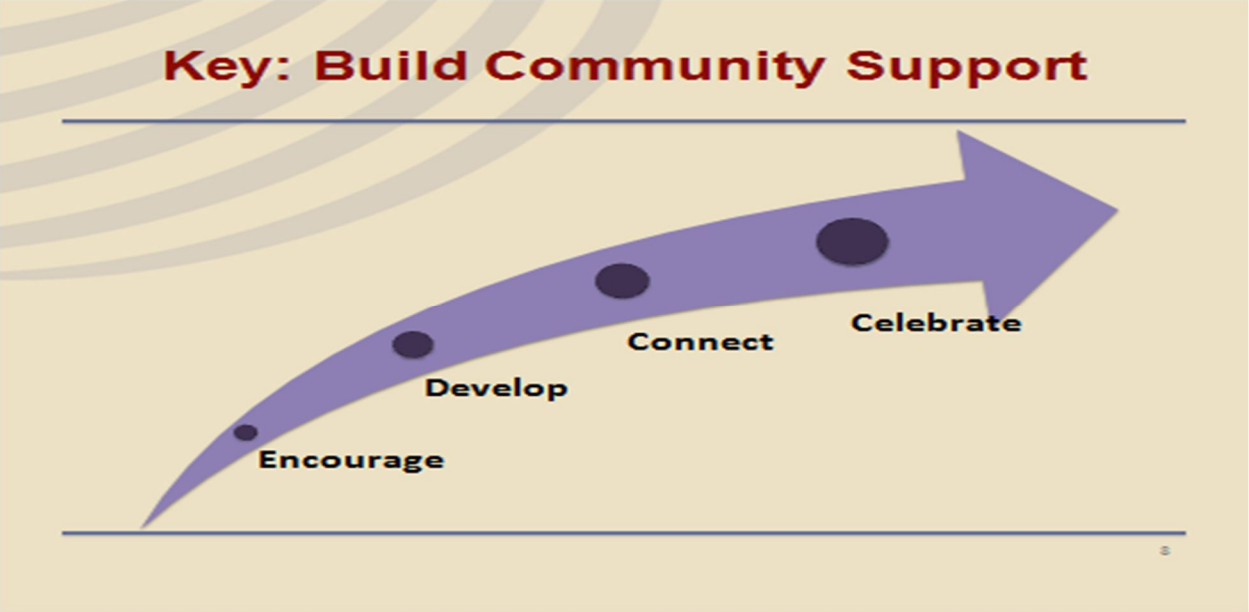


(Ensuring effectiveness)

Effectiveness is more than just using evidence-based interventions. Effectiveness depends on making sure the logic model lines up. Interventions are aligned with the problem and risk factors, and have sufficient reach.

Evidence-based interventions are selected that are a good fit conceptually and practically. Implementation is high quality, which involves buy-in from the community, administrative support, and adequate training for staff to do the intervention. There is a plan for evaluation that will provide ongoing data to make improvements as needed.

Key to building community support



(Steps needed to build community support)

Steps to building community support

Encourage community ownership (this relates to community readiness).

Develop community leaders and champions.

Connect to other prevention efforts locally, regionally, and statewide.

Celebrate your accomplishments publicly in media, local newsletters, and email blasts.

http://captus.samhsa.gov/access-resources/resource-types/ta-tools?tid=74&tid_1=All&term_node_tid_depth=All&term_node_tid_depth_1=All&title=

Chapter 10: Criteria for Analyzing Assessment Data

This document offers criteria prevention practitioners can use to analyze their assessment data including magnitude, impact, changeability, concentrated occurrence, and consumption/consequence.

When setting prevention priorities, communities often find it helpful to analyze their assessment data according to these five criteria:

Magnitude: This describes the numbers of people affected by the problem. Communities that use magnitude to prioritize problems seek to address problems that affect the greatest number of people. So, for example, in a community where more youth use alcohol than Oxycontin, community members are likely to direct their efforts at limiting alcohol use.

Impact: This describes the depth of a problem across dimensions, i.e. health, economic, criminal. So—comparing alcohol and Oxycontin use again—communities seeking to reduce impact might direct their efforts at reducing Oxycontin use, since Oxycontin use has more legal ramifications than alcohol use, because users are more likely to engage in illegal activity to obtain the drug.

Changeability: This describes the degree to which the indicator is amenable to change. In the above example, it may be easier to restrict access to Oxycontin than to alcohol, since Oxycontin is already illegal without a prescription, whereas alcohol is ubiquitous and more difficult to contain. Given this, community members may focus on reducing Oxycontin use because it will be easier to show change or results. Community members will also want to consider whether the problem has been successfully changed in the past or if there are any evidence-based interventions available to address the problem.

Concentrated occurrence in a specific sub-population: Directing prevention efforts at a specific sub-population can sometimes produce maximum effects. For example, targeting alcohol consumption among pregnant women is easier to tackle than targeting alcohol consumption in the general population.

Time lapse between consumption behavior and consequence: The amount of time between consumption of a substance and produced consequences can differ significantly by substance. For example, death from heroin overdose may be less frequent than tobacco-related deaths. However, the time lapse between consumption and the ultimate consequence is much shorter for heroin overdose than tobacco-related deaths. A short lapse between consumption and consequence can make it easier for communities to show relationships between prevention activities and outcomes.

Source URL: http://captus.samhsa.gov/access-resources/criteria-analyzing-assessment-data

Chapter 11: Developmental Perspective to Prevention

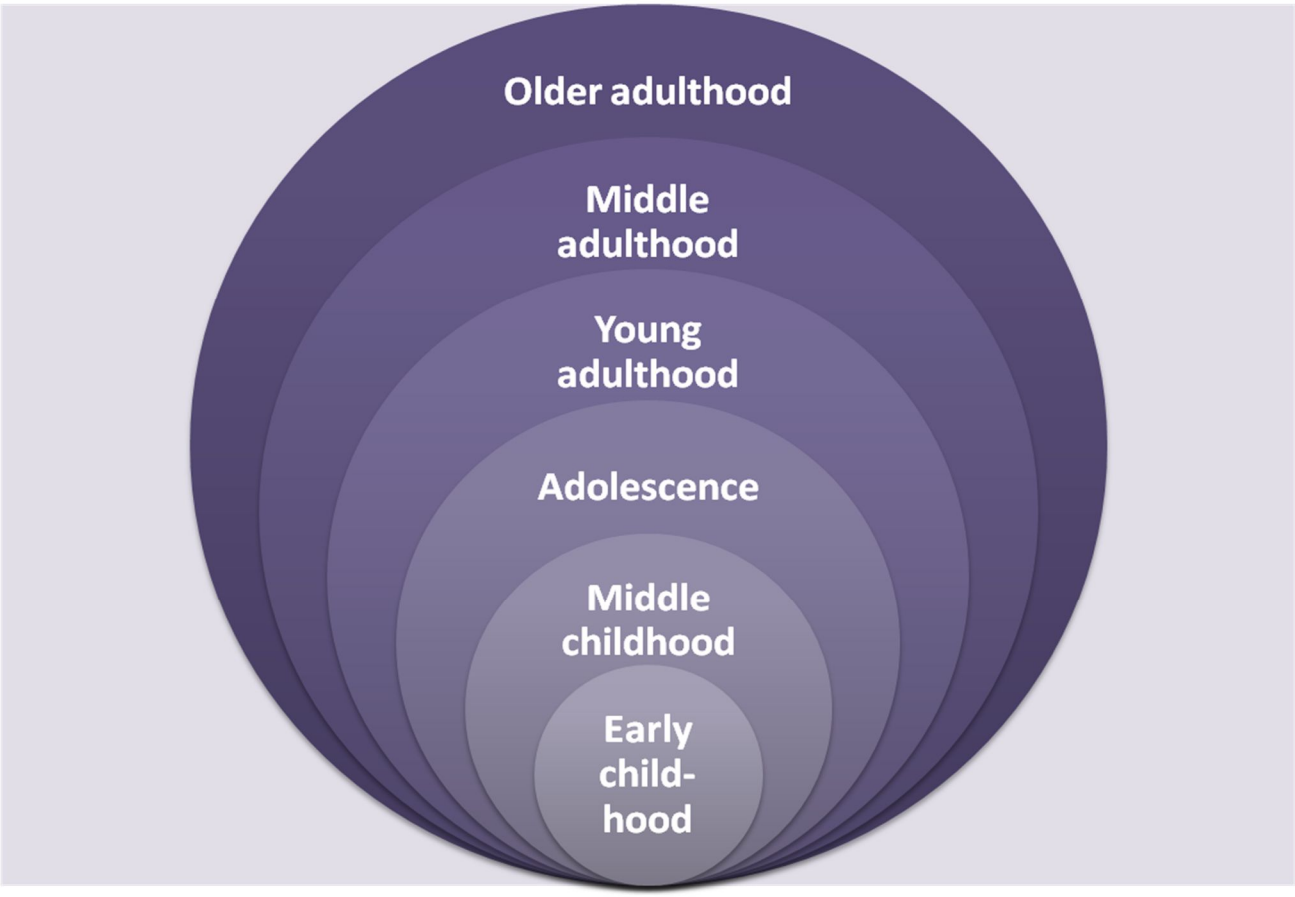
A developmental approach to prevention helps to ensure that interventions have the broadest and most significant impact. Risk and protective factors and their potential consequences and benefits are organized according to defined developmental periods. This enables practitioners to match their prevention and promotion efforts to the developmental needs and competencies of their audience. It also helps planners align prevention efforts with key periods in peoples' development, when they are most likely to produce the desired, long-term effects.

Windows of Opportunity

When addressing risk and protective factors, timing is critical. Half of all behavioral disorders appear during adolescence. The first symptoms of most behavioral health disorders typical occur two to four years before diagnosis. In the case of substance abuse disorders, for example, initial symptoms appear around age fourteen—about four years before these symptoms progress to the point of a diagnosable disorder.

If we can intervene during these windows of opportunity— during the period between the time when symptoms can be first detected and disorders can be diagnosed—we are more likely to prevent the onset of the disorder and produce lasting and long-term impacts. And if we can intervene even sooner,

to promote healthy lifestyles, our potential for reducing the toll of behavioral health problems on individuals, communities, and society is even greater.



(Goal is to match interventions to developmental windows of opportunity)
http://www.surgeongeneral.gov/library/calls/underagedrinking/calltoaction.pdf

Chapter 12: Characterizing Developmental Change:

There are several ways to characterize the changes that take place during the first three decades of life. All such descriptions are an attempt to capture the complex, dynamic processes of development from conception to maturity.

One traditional way to describe developmental change is to divide development into age-related segments and delineate normative behaviors and changes that usually occur in these segments of the life course. These

developmental categories often begin and end with significant transitions, such as birth or the transition into school. Common developmental categories include the following:

Prenatal: from conception to birth.

Early childhood: from birth to approximately age 5, encompassing infancy, the toddler years, and the preschool period.

Middle childhood: from entering school (around age 4 or 5) to the transition into adolescence, which is heralded by signs of puberty and changes in school or social contexts (around age 8 to 10).

Adolescence: encompasses the onset of puberty, secondary school transitions, and the second decade of life (from around age 8 to 10 to approximately age 18 to 20).

Transition-to-adulthood (sometimes called "emerging adulthood"): from approximately age 18 to 25.

A second way to describe developmental change is in terms of developmental tasks and accomplishments characteristically expected and achieved during a given time period. Some of these tasks are universal, whereas others are specific to a given culture, place, or time in history (for more information, see also the textboxes "Developmental Tasks and Transitions" and "Appropriate Drinking Behavior as a Developmental Task").

Examples of common developmental tasks in many contemporary societies include the following:

In early childhood:

- Forming attachment bonds with caregivers;
- Talking and learning the native language of the family; and
- Complying with and following simple adult commands.

In middle childhood:

- Adjusting to school;

- Learning to count, read, and do basic mathematics;
- Getting along with peers at school and making friends; and
- Engaging in rule-abiding behavior at home and school.

In adolescence:

- Achieving academic success in more advanced topics;
- Graduating from high school;
- Making and maintaining close friends; and
- Learning and following the rules and laws that govern conduct in society.

In early adulthood:

- Achieving higher education or vocational training;
- Gaining employment or other kinds of work;
- Forming a romantic or marital partnership;
- Engaging in responsible sexual behavior; and
- Parenting effectively when one becomes a parent.

Developmental changes can also be categorized in terms of changes in developmental processes at multiple levels of functioning, as reflected in changing adaptive capacities of the person. With this approach, developmental processes often are described in relation to changes in biological processes (e.g., brain development, puberty, growth), cognitive processes (e.g., perception, memory, executive functioning), and social–emotional processes (e.g., personality, motivation, relationships).

A fourth way to describe change focuses on the changing contexts in which an individual lives and interacts. Some changes are arranged by societal or community practices, such as school changes, whereas others result from life events, such as moving or disasters. Contextual changes bring new challenges and opportunities; alter the nature of parental, school, and other types of support; and increase life's complexity; the extent of adult monitoring changes with age, developmental progress, and contexts.

The primary contexts that shift are:

Physical contexts—for example, the places where children spend their time, such as at home, at school, on the playground, in extracurricular activities, in the mall, or in other gathering places;

Social contexts—for example, the network of people and social situations within which children interact on a routine basis, such as family, friends, classmates, sport teams, parties, etc.;

Societal and cultural contexts—for example, ethnic, community, civic, and religious activities, belief systems, expectations, and rituals; military service;

Media and virtual environments—for example, movies, television, the Internet, computer games, e-mail, instant messaging, and magazines, often resulting in exposure to adult content

Finally, it is possible to describe changes taking place in the interactions of individuals with other people and other contexts as all this change is occurring.

Collectively, these different ways to describe the nature of change in human development are attempts to simplify, yet capture, the highly complex processes of human maturation and the various influences involved. Although development is related to age, it is not the same thing as aging, which is one reason why it is difficult to "slice" development neatly by age. The timing of developmental changes varies, both within and across individuals. Some children begin the growth spurt of puberty earlier or later than others and grow more quickly or more slowly than others. Moreover, the growth spurt typically begins and peaks at younger ages for most girls compared with most boys. The result of this variable development can readily be observed in a group of young adolescents who are all the same age but clearly differing in pubertal development as well as height. Even within the same child, different aspects of development may have different timing. For example, a child may begin to walk earlier than most children but begin to talk later than most.

These multiple, simultaneously occurring developmental processes, combined with variations in timing and tempo, can result in interesting gaps between the maturity of development in one area of function compared with another. Just as a toddler may learn to walk before his or her judgment to stay out of the street is in place, a teenager may become motivated for adventure or romantic encounters before mature decision making and planning are fully developed. For example, within the developing brain, the regions governing some emotional and motivational systems mature early in adolescence (linked to the onset of puberty), whereas the systems responsible for considering future consequences as well as for cognitive and self-regulatory controls mature more gradually throughout adolescence and into early adulthood, creating a developmental dysynchrony that may help explain the increase in risk-taking behavior in adolescence (Dahl 2004; Romer and Walker 2007; Steinberg et al. 2006). Such gaps may be more pronounced in some individuals, depending on the patterning of their development in various areas of function.

Over the past 100 years, the age of onset of puberty and sexual maturation has decreased, most likely as a result of changes in diet and health. At the same time, young people in industrialized societies require more time than preceding generations to become established as adults in work and family life. This trend, which likely results at least in part from increased training and education requirements, has extended the time period of adolescence. In many modern societies, an extended transition period—recently described as "emerging adulthood" (Arnett 2000)—now exists between adolescence and full adult status that lacks the constraints imposed by the obligations of full adulthood.

The Interplay of Genes and Environment in Development

At one time, it was thought that genes and their function were static, were impervious to the effects of life experience, and could be described as a "blueprint" for building development. At that time, much discussion focused on "nature" (i.e., genes) versus "nurture" (i.e., environment) as explanatory causes of human behavior and outcomes. That notion now has been replaced

by the realization that genes and environment do not influence development independently but rather are inextricably bound through complex interactions involving bidirectional influences of genes and environments. The term “epigenesis” captures this idea of development unfolding from the interplay of genes and environment through many interactions over time. In its broadest sense, epigenesis refers to the dynamic, complex processes by which genes respond to each other and to environmental signals throughout a lifetime to produce an individual who is adaptive and functional (Gottesman and Hanson 2005). Interactions between genes, neurons, behavior, and contexts explain why the same genes can result in very different outcomes, depending on when and where specific genes are activated or repressed. For example, these complex interactions between genes and the environment explain why identical twins differentiate over the course of their development.

Although no definitive answers are as yet available, alcohol researchers are particularly interested in two areas of gene–environment interactions. The first area is the identification of specific genes that might interact with experience during the course of human development to increase or decrease the likelihood of alcohol use and AUDs. A second area of interest is the effect of ethanol exposure on gene expression in various tissues and organs, particularly the brain and liver, across human development.

Scaffolding for Positive Development

Across the millennia, parents have learned that certain developmental transitions can be hazardous, reflecting gaps in maturity between capacities and desires. Toddlers who have just learned to walk and adolescents who have just learned to drive share a common elevated risk for accidents related to a mismatch between their new capability and the judgment and experience required to handle it safely. In addition, there are periods of concentrated change in individuals and their contexts that create windows of both opportunity and vulnerability for the developing individual (Dahl 2004; Masten 2004, 2007b; Steinberg et al. 2006).

One of the most important roles adults and society have is to protect children and youth from harm, especially during periods of increased risk, by guiding, monitoring, disciplining, and supporting them in ways that are appropriate to their level of maturity, so that they can function beyond their independent capabilities or despite their vulnerabilities as they move toward adulthood (Masten 2004, 2007b). The broad term for this function in developmental science is scaffolding (Vygotsky 1978). A good example of a social scaffolding is a graduated driver's license, which attempts to reduce the risks to beginning adolescent drivers by setting limits on where, when, and with whom they can drive.

UNDERAGE ALCOHOL USE AS A DEVELOPMENTAL PHENOMENON

Each of the following observations supports the premise that underage alcohol use is a developmental phenomenon:

- Alcohol use, problems, abuse, and dependence have striking age-related patterns.
- The acute, intermediate, and longer-term effects of alcohol vary by age and development.
- Development itself may be altered by alcohol exposure.
- The likelihood of an adolescent eventually using alcohol or manifesting AUDs can be predicted from childhood factors.
- Risk and protective factors associated with higher or lower use/dependence have age-related patterns.

Alcohol Use, Problems, Abuse, and Dependence Have Striking Age-Related Patterns

Alcohol use, problems, abuse, and dependence are related to age in multiple ways. Although some children begin drinking in elementary school, alcohol use (defined as drinking a whole drink) typically begins in early adolescence, around ages 12–14 (Faden 2006). Between ages 12 and 21, rates of alcohol use and binge alcohol use increase sharply. For example, data from the 2005 National Survey on Drug Use and Health (NSDUH) indicate that the proportion

of youth who have ever drunk alcohol rises steeply during adolescence, leveling off around age 21. Data from the same study indicate that all levels of past-month alcohol usage increase steadily from ages 12 to 21, including any alcohol use (defined as drinking at least one whole drink in the past month), binge use (defined as drinking four or more drinks on one occasion), and heavy use (defined as drinking five or more drinks on five or more days within the past month).

Childhood Factors Predict Future Alcohol Use and Alcohol Use Disorders

Substantial research has implicated a set of risk factors that consistently precede and predict early alcohol use and/or dependence (National Research Council and Institute of Medicine 2004; Zucker 2006; Donovan 2004; NIAAA 2004–2005). These alcohol-specific risk factors include the following:

- Prenatal exposure to alcohol, including that which gives rise to FASD, including FAS;
- A family history of alcohol abuse, antisocial behavior (by either parent), and depression (in the mother);
- Poor parenting of the child (e.g., maltreatment, neglect, poor monitoring);
- Childhood antisocial behavior;
- Childhood smoking or other kinds of substance use;
- Early signs of cognitive and learning problems, including academic failures; and

Self-regulation problems that also predict antisocial and risk-taking behavior, such as attention problems, difficulty regulating emotion or behavior, poor impulse control, and effortful control problems.2 [2 Effortful control refers to the ability to make oneself perform tedious tasks, such as doing repetitive math homework.]

A majority of the risk factors for alcohol use and AUDs, however, are nonspecific to alcohol involvement—that is, they also predict many other kinds of problems, such as conduct and learning problems, risk-taking behaviors, dropping out of school, early sexual activity and pregnancy,

antisocial personality disorder, and mood disorder (Dodge and Pettit 2003; Evans et al. 2005; Kendler et al. 2003; NIAAA 2004–2005; Tsuang et al. 1998; Zucker 2006).

Many of these nonspecific risk factors already are evident in preschool age children, including the following:

- Temperament differences related to behavioral and emotional control;
- Problems with self-awareness and self-monitoring, attention, response inhibition, and effortful control; and
- A history of adversity in multiple forms, such as a family history of antisocial behavior, abuse and trauma, or other negative life experiences.

Risk and Protective Factors Associated With Higher or Lower Use/Dependence Have Age-Related Patterns

Of particular interest to parents and society are factors that either increase the risk of alcohol use/dependence or decrease that risk.

Research indicates that both risk and protective factors have age-related patterns. For example:

- The intent to use alcohol increases with age during elementary school (Donovan et al. 2004).
- Expectations about the effects of alcohol use shift from predominantly negative to positive during late middle childhood and early adolescence (Dunn and Goldman 1996, 1998). These changes may be linked to the transition from childhood to adolescence or from elementary school to secondary school. An analysis of the Pittsburgh Girls Study, for example, indicates that positive expectations about alcohol use rose and negative expectations fell between ages 8 and 10 (Hipwell et al. 2005). Dunn and Goldman (1996, 1998) also found that the shift in expectations occurs earlier than the transition from elementary school to middle school. (For more information on the role of middle childhood in the development of alcohol use behaviors, see the textbox “Middle Childhood.”)

- Access to alcohol tends to increase over the course of childhood and adolescence (Johnston et al. 2006).
- Popularity with peers generally is associated with lower risk for alcohol use in elementary school (Zucker 2006), but popular high school students may a have higher risk (Diego et al. 2003). Some of that heightened risk may result from the increased exposure to alcohol at parties that occurs with adolescence, because popular youth are more likely to be invited to parties.
- The timing of physical maturation has significant ramifications for social interactions and alcohol use. Early-maturing girls, for example, may date older boys who drink at parties and may find themselves unable to deal with resulting situations.
- Underage drinking is viewed as an adolescent rite of passage by many American parents and also by many adolescents (Jessor and Jessor 1977; Maddox and McCall 1964). Childhood drinking, on the other hand, generally is not culturally acceptable; therefore, a shift in adult expectations about adolescent alcohol use and at least tacit approval of drinking must also occur.
- The transition to college significantly increases the risk for binge drinking, particularly in the first few months of the freshman year (White et al. 2006). A subset of college binge drinkers already have been drinking at high levels in high school and continue this practice in college. Another group increases their alcohol consumption at the beginning of college but then reduces it. For still others, the risk of binge drinking declines (Schulenberg et al. 1996; also see the article by Brown and colleagues, pp. 41–52 in this issue).
- Smoking, which is a risk factor for alcohol use, typically begins in early adolescence (Klein 2006).
- Associating with deviant peers and delinquent behaviors among deviant peers both are key risk factors for alcohol use. They increase in early adolescence, especially among youth characterized by a cluster of risk factors for antisocial and risk-taking behavior (Dishion and Patterson 2006).

- A decline in parental and other adult monitoring, which can be protective, often occurs during adolescence, and unmonitored adolescent time increases, which can heighten risk.

REFERENCES

Arnett, J.J. Emerging adulthood: A theory of development from the late teens through the twenties. American Psychologist 55(5):469–480, 2000. PMID: 10842426

Barr, C.S.; Schwandt, M.L.; Newman, T.K.; and Higley, J.D. The use of adolescent nonhuman primates to model human alcohol intake: Neurobiological, genetic, and psychological variables. Annals of the New York Academy of Sciences 1021:221–233, 2004. PMID: 15251892

Bray, R.M.; Hourani, L.L.; Olmsted, K.L.R.; et al. Department of Defense Survey of Health Related Behaviors among Military Personnel. Research Triangle Park, NC: RTI International, 2006.

Brown, J.D., and Witherspoon, E.M. The mass media and American adolescents' health. Journal of Adolescent Health 31(Suppl. 6):153–170, 2002. PMID: 12470911

Brown, S.A., and Tapert, S.F. Adolescence and the trajectory of alcohol use: Basic to clinical studies. Annals of the New York Academy of Sciences 1021:234–244, 2004. PMID: 15251893

Cicchetti, D., and Cohen, D., Eds. Developmental Psychopathology, 2nd Ed. New York: Wiley, 2006.

Crews, F.T.; Braun, C.J.; Hoplight, B.; et al. Binge ethanol consumption causes differential brain damage in young adolescent rats compared with adult rats. Alcoholism: Clinical and Experimental Research 24:1712–1723, 2000. PMID: 11104119

Cummings, E.M.; Davies, P.T.; and Campbell, S.B. Developmental Psychopathology and Family Process. New York: Guilford, 2000.

Dahl, R.E. Adolescent brain development: a period of vulnerabilities and opportunities. Keynote address. Annals of the New York Academy of Sciences 1021:1–22, 2004. PMID: 15251869

DeBellis, M.D.; Clark, D.B.; Beers, S.R.; et al. Hippocampal volume in adolescent-onset alcohol use disorders. American Journal of Psychiatry 157:737–744, 2000. PMID: 10784466

Diego, M.A.; Field, T.M.; and Sanders, C.E. Academic performance, popularity, and depression predict adolescent substance use. Adolescence 38:35–42, 2003. PMID: 12803452

Dishion, T.J., and Patterson, G.R. The development and ecology of antisocial behavior in children and adolescents. In: Cicchetti, D., and Cohen, D.J., Eds. Developmental Psychopathology Vol. 3: Risk, Disorder, and Adaptation, 2nd Ed. New York: Wiley, 2006, pp. 503–541.

Dodge, K.A., and Pettit, G.S. A biopsychosocial model of the development of chronic conduct problems in adolescence. Developmental Psychology 39:349–371, 2003. PMID: 12661890

Donovan, J.E. Adolescent alcohol initiation: A review of psychosocial risk factors. Journal of Adolescent Health 35:529.e7–e18, 2004. PMID: 15581536

Donovan, J.E.; Leech, S.L.; Zucker, R.A.; and Loveland, C.J. Really underage drinkers: Alcohol use among elementary students. Alcoholism: Clinical and Experimental Research 28:341–349, 2004. PMID: 15112942

Dunn, M.E., and Goldman, M.S. Empirical modeling of an alcohol expectancy memory network in elementary school children as a function of grade. Experimental and Clinical Psychopharmacology 4:209–217, 1996.

Dunn, M.E., and Goldman, M.S. Age and drinking-related differences in the memory organization of alcohol expectancies in 3rd, 6th, 9th, and 12th grade children. Journal of Consulting and Clinical Psychology 66:579–585, 1998. PMID: 9642899

Evans, D.L.; Foa, E.B.; Gur, R.E.; et al., Eds. Treating and Preventing Adolescent Mental Health Disorders: What We Know and What We Don't Know: A Research Agenda for Improving the Mental Health of Our Youth. New York: Oxford University Press, 2005.

Faden, V.B. Trends in initiation of alcohol use in the United States 1975 to 2003. Alcoholism: Clinical and Experimental Research 30:1011–1022, 2006. PMID: 16737460

Foster, S.E.; Vaughan, R.D.; Foster, W.H.; and Califano, J.A. Jr. Estimate of the commercial value of underage drinking and adult abusive and dependent drinking to the alcohol industry. Archives of Pediatric and Adolescent Medicine 160:473–478, 2006. PMID: 16651488

Gottesman, I.I., and Hanson, D.R. Human development: Biological and genetic processes. Annual Review of Psychology 56:263–286, 2005. PMID: 15709936

Grant, B.F.; Dawson, D.A.; Stinson, F.S.; et al. The 12-month prevalence and trends in DSM–IV alcohol abuse and dependence: United States, 1991–1992 and 2001–2002. Drug and Alcohol Dependence 74:223–234, 2004. PMID: 15194200

Hipwell, A.E.; White, H.R.; Loeber, R.; et al. Young girls' expectancies about the effects of alcohol, future intentions and patterns of use. Journal of Studies on Alcohol 66:630–639, 2005. PMID 16331848

Jessor, R., and Jessor, S.L. Problem Behavior and Psychosocial Development: A Longitudinal Study of Youth. New York: Academic Press, 1977.

Johnston, L.D.; O'Malley, P.M.; Bachman, J.G.; et al. Monitoring the Future, National Survey Results on Drug Use, 1975–2005. Volume 1: Secondary School Students. NIH Pub. No. 06–5883. Bethesda, MD: National Institute on Drug Abuse, 2006.

Johnston, L.D.; O'Malley, P.M.; Bachman, J.G.; and Schulenberg, J.E. Monitoring the Future, National Survey Results on Drug Use, 1975-2006: Volume I, Secondary School Students. NIH Pub. No. 07–6205. Bethesda, MD: National Institute on Drug Abuse, 2007.

Jones, K.L., and Smith, D.W. Recognition of the fetal alcohol syndrome in early infancy. Lancet 302(7836):999–1001, 1973. PMID: 4127281

Kendler, K.S.; Prescott, C.A.; Myers, J.; and Neale, M.C. The structure of genetic and environmental risk factors for common psychiatric and substance use disorders in men and women. Archives of General Psychiatry 60:929–937, 2003. PMID: 12963675

Klein, J.D. Adolescents and smoking: The first puff may be the worst. Canadian Medical Association Journal 175:262, 2006. PMID: 16880446

Maddox, G.L., and McCall, B.C. Drinking Among Teenagers: A Sociological Interpretation of Alcohol Use by High-School Students. New Brunswick, NJ: Rutgers Center of Alcohol Studies, Publications Division, 1964.

Masten, A.S. Regulatory processes, risk and resilience in adolescent development. Annals of the New York Academy of Sciences 1021:310–319, 2004. PMID: 15251901

Masten, A.S. Developmental psychopathology: Pathways to the future. International Journal of Behavioral Development 31:47–54, 2006.

Masten, A.S, Ed. Multilevel Dynamics in Developmental Psychopathology: 34th Minnesota Symposium on Child Psychology. Mahwah, NJ: Erlbaum, 2007a.

Masten, A.S. Competence, resilience, and development in adolescence: Clues for prevention science. In: Romer, D., and Walker, E.F., Eds. Adolescent Psychopathology and the Developing Brain: Integrating Brain and Prevention Science. New York: Oxford University Press; 2007b, pp. 31–52.

Masten, A.S.; Burt, K.; and Coatsworth, J.D. Competence and psychopathology in development. In: Cicchetti, D., and Cohen, D., Eds. Developmental Psychopathology, Vol 3: Risk, Disorder and Psychopathology. 2nd ed. New York: Wiley, 2006, pp. 696–738.

Masten, A.S.; Faden, V.B.; Zucker, R.A.; and Spear, L.P. Underage drinking: A developmental framework. Pediatrics 121(Suppl. 4):S235–S251, 2008. PMID: 18381492

Masten, A.S.; Roisman, G.I.; Long, J.D.; et al. Developmental cascades: Linking academic achievement, externalizing and internalizing symptoms over 20 years. Developmental Psychology 41:733–746, 2005. PMID: 16173871

McBride, W.J.; Bell, R.L.; Rodd, Z.A.; et al. Adolescent alcohol drinking and its long-range consequences. Studies with animal models. Recent Developments in Alcoholism 17:123–142, 2005. PMID: 15789863

Nagel, B.J.; Schweinsburg, A.D.; Phan, V.; and Tapert, S.F. Reduced hippocampal volume among adolescents with alcohol use disorders without psychiatric comorbidity. Psychiatry Research: Neuroimaging 139(3):181–190, 2005. PMID: 16054344

National Institute on Alcohol Abuse and Alcoholism (NIAAA). A Call to Action: Changing the Culture of Drinking at U.S. Colleges. Bethesda, MD: NIAAA, 2002.

NIAAA. Alcohol and development in youth: A multidisciplinary overview. Alcohol Research & Health 28(3):105–176, 2004–2005.

National Research Council and Institute of Medicine. Reducing Underage Drinking: A Collective Responsibility. Bonnie, R.J., and O'Conell, M.E., Eds. Washington, DC: National Academies Press, 2004.

Romer, D., and Walker, E.F., Eds. Adolescent Psychopathology and the Developing Brain. New York: Oxford University Press, 2007.

Schneider, M.L.; Moore, C.F.; Barnhart, T.E.; et al. Moderate-level prenatal alcohol exposure alters striatal dopamine system function in rhesus monkeys. Alcoholism: Clinical and Experimental Research 29:1685–1697, 2005. PMID: 16205369

Schulenberg, J.; O'Malley, P.M.; Bachman, J.G.; et al. Getting drunk and growing up: Trajectories of frequent binge drinking during the transition to young adulthood. Journal of Studies on Alcohol 57:289–304, 1996. PMID 8709588

Spear, L.P., and Varlinskaya, E.I. Adolescence: Alcohol sensitivity, tolerance, and intake. Recent Developments in Alcoholism 17:143–159, 2005. PMID: 15789864

Steinberg, L.; Dahl, R.E.; Keating, D.; et al. Psychopathology in adolescence: Integrating affective neuroscience with the study of context. In: Cicchetti, D., Cohen, D., Eds. Developmental Psychopathology, 2nd ed. New York: Wiley, 2006, pp. 710–741.

Sulik, K.K.; Johnston, M.C.; and Webb, M.A. Fetal alcohol syndrome: Embryogenesis in a mouse model. Science 214(4523):936–938, 1981. PMID: 6795717

Tsuang, M.T.; Lyons, M.J.; Meyer, J.M.; et al. Co-occurrence of abuse of different drugs in men: The role of drug-specific and shared vulnerabilities. Archives of General Psychiatry 55:967–972, 1998. PMID: 9819064

Vygotsky, L.S. Mind in Society: The Development of Higher Psychological Processes. Cambridge, MA: Harvard University Press, 1978.

White, A.M., and Swartzwelder, H.S. Hippocampal function during adolescence: A unique target of ethanol effects. Annals of the New York Academy of Sciences 1021:206–220, 2004. PMID: 15251891

White, A.M.; Ghia, A.J.; Levin, E.D.; and Swartzwelder, H.S. Binge pattern ethanol exposure in adolescent and adult rats: Differential impact on subsequent responsiveness to ethanol. Alcoholism: Clinical and Experimental Research 24:1251–1256, 2000. PMID: 10968665

White, A.M.; Kraus, C.L.; and Swartzwelder, H.S. Many college freshman drink at levels far beyond the binge threshold. Alcoholism: Clinical and Experimental Research 30:1006–1010, 2006. PMID: 16737459

Zucker, R.A. Alcohol use and the alcohol use disorders: A developmental-biopsychosocial formulation covering the life course. In: Cicchetti, D., and Cohen, D.J., Eds. Developmental Psychopathology. Vol. 3: Risk, Disorder, and Adaptation. 2nd ed. New York: Wiley, 2006, pp. 620–656.

Zucker, R.A., and Wong, M.M. Prevention for children of alcoholics and other high risk groups. Recent Developments in Alcoholism 17:299–319, 2005. PMID: 15789872

Chapter 13: SAMHSA TRIBAL BEHAVIORAL HEALTH AGENDA

The concept for the National Tribal Behavioral Health Agenda (TBHA) was born from the voices of tribal leaders who spoke compellingly about the extent to which mental and substance use disorders are impacting tribal communities. Beyond the issues, they also spoke about the need for collaboration and working differently together in order to make a difference in the lives of American Indians and Alaska Natives. SAMHSA and IHS accepted the advice and worked with the National Indian Health Board to gather input on what would ultimately become the TBHA.

Through discussions, five elements which form the foundation for the TBHA were developed and affirmed by tribal leaders and tribal representatives. Through many more discussions, content of what would become the priorities and strategies for the TBHA emerged and were affirmed. Thus, the TBHA includes foundational elements, priorities, and strategies that chart a course for more meaningful collaborations and opportunities for strengthening policies, programs, and activities.

BACKGROUND

Native Americans are experiencing vast health inequities as evidenced by high rates of cancer, diabetes, trauma, mental and substance use disorders (including suicide), and unintentional injury. Present efforts to address the health status of American Indian and Alaska Native-people remain marginally effective in alleviating these health disparities.

To ensure the success of this declaration we recommend the following:

Respect our intent to keep sacred knowledge private and allow details of this cultural knowledge and wisdom to remain with the knowledge keepers (elders, traditional healers, storytellers, and American Indian and Alaska Native people).

Support our unique ideas and models of health and healing interventions that may not fit typical or standard western approaches.

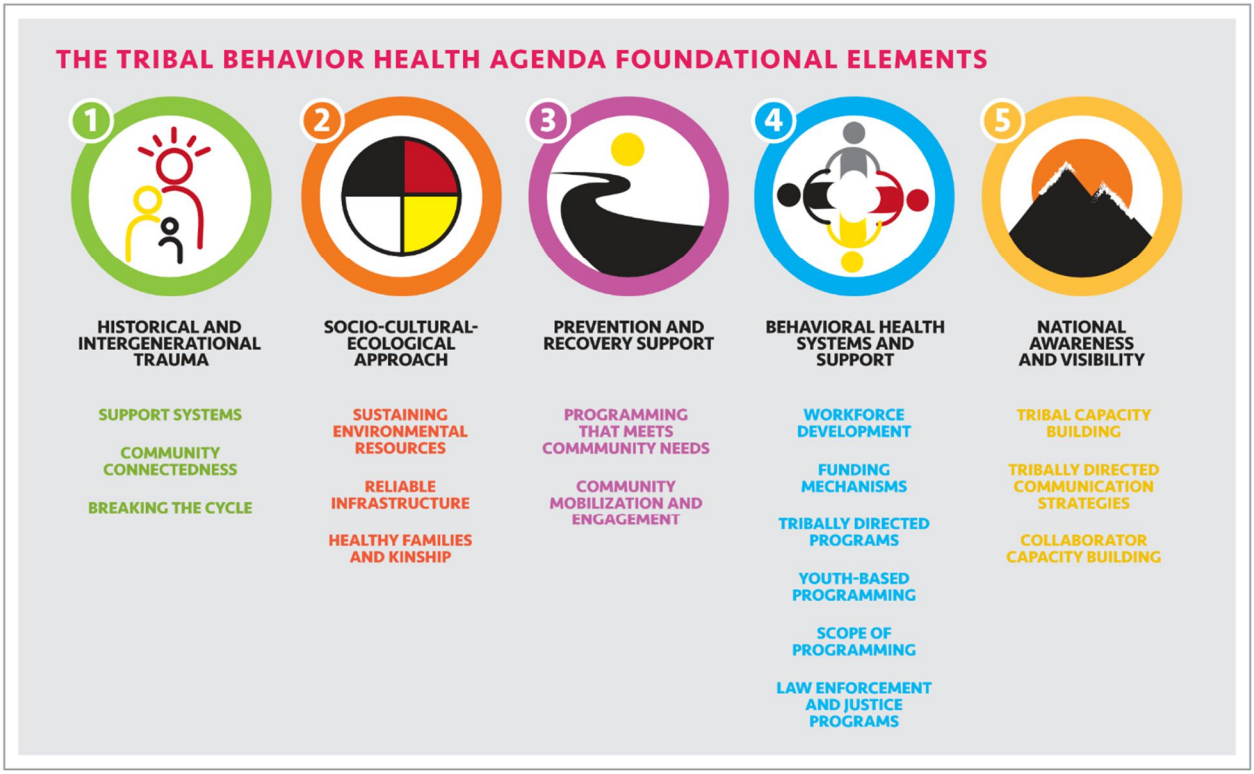
Modify your requirements to fit the relevant traditional tribal paradigm or allow room for flexibility when evaluating proposals submitted by American Indian and Alaska Native tribal nations.

Provide adequate time and financial resources required to work in rural and remote areas, with hard to reach populations and within the legal frameworks of sovereign nations. ɖ Trust the Nations to deliver their culturally derived interventions.

Accept our distinct American Indian and Alaska Native cultural ways of being, knowing and doing.

Support our authority to practice American Indian and Alaska Native culture as practiced for generations, without modification, without restriction.

Support the cost of structuring innovative and culturally tailored models of health promotion through advocating for additional funding in the form of budget increases.



COMPONENTS OF INTEGRATED INTERVENTIONS

Interventions focused on individuals, families, and communities should occur early and be intergenerational. Content may include teachings on traditional narratives, beliefs, and practices: address historical events in culturally appropriate ways; and, relate them to current conditions and family dynamics. Activities should emphasize active skills-building; facilitate communication and interaction among elders, parents, and youth; and those at the community level should avoid addressing more than one issue at a time. Traditional knowledge and practices should be incorporated into care based on the preferences of the Tribe.

COMPONENTS OF INTEGRATED SYSTEMS

An integrated system links prevention and treatment systems and includes a flexible approach to provider-client and provider-patient relationships that allows for adaptive treatment approaches. Staff members should be educated and culturally competent, and the community should be involved in implementing structural changes to affect surrounding conditions.

HEALTH CARE AND SERVICE SYSTEMS

American Indians and Alaska Natives receive health care services through multiple sources, including the IHS, tribally operated facilities, urban Indian health care programs, the U.S. Veterans Administration (VA), private health care systems, and Federally Qualified Health Centers (FQHCs). The IHS is one of the primary Federal agencies responsible for fulfilling the Federal Government's health care obligation to American Indian and Alaska Native tribes. Through treaty agreements with Tribes, the Federal Government has committed to provide health care to American Indians and Alaska Natives, primarily in exchange for ceded land. To fulfill this component of the Federal Government's trust responsibility to tribes and Tribal members, a unique health care system has evolved that allows American Indians and Alaska Natives to receive physical and behavioral health services through a variety of mechanisms.

IHS, an HHS agency, is charged with providing primary care and behavioral health services to American Indians and Alaska Natives living on or near reservations. There are 12 regional service areas within the Indian Health Care System. The IHS and tribes provide primary medical care and community health services mainly in small, rural communities in more than 660 locations across 36 states, including 45 hospitals, 617 ambulatory facilities (343 health centers, 111 health stations, 163 Alaska Native village clinics,152 and 34 urban programs.

Tribes that receive health services from a facility operated directly by IHS are known as direct service tribes, and tribes that manage their own health systems are known as self-governance tribes.

WORKFORCE DEVELOPMENT

Lack of mental health services may in part be attributable to a shortage of behavioral health service providers. Barriers to recruitment include funding disparities across IHS regions, lack of opportunity to maintain skills, lack of opportunity for professional growth, lack of exposure to best practices and new developments, isolated work locations, highly stressful work environments, and a lack of support staff members. For example, across IHS there are 16 allocated psychiatric nursing positions located in Alaska and Navajo Areas.155 The vacancy rate for these positions averaged 38% over calendar year 2010, demonstrating the difficulty in filling these positions.

INDIAN HEALTH CARE SYSTEM FUNDING

The Indian Health Care System is supported through annual congressional appropriations. The fiscal year (FY) 2016 IHS funding was $6.2 billion and includes slight increases for mental health and alcohol treatment programs. Approximately 98% of the IHS budget for direct health services is focused primarily on serving American Indians and Alaska Natives who live on or near reservations. The IHS budget specifically focused on supporting urban Indian health clinics represents the remaining 2% of the budget for health services. Many programs are also dependent on grant funding, Tribal revenue, and collections from third-party payers (e.g., Medicaid) to remain financially

viable. IHS estimates it receives 22% of the funding needed for the Urban Indian Health Program.

OTHER IMPORTANT FEDERAL SOURCES OF FUNDING

Tribes that operate their own health systems also invest in their systems beyond funds received through 638 compacts, contracts, and reimbursements from Medicare, Medicaid, and private insurance. In addition, tribes are eligible for grants, contracts, and other support from Federal agencies across the Executive Branch.

Federal departments and agencies such as SAMHSA, ACF, ACL, HRSA, DOJ, and others support programs that address one or more of the following health, safety, and/ or wellness areas: suicide prevention; alcohol and other drug use prevention; services for 5ribal youth that promote prevention, treatment, and recovery from mental and substance use disorders; services for pregnant and postpartum women with substance use disorders; development of systems of mental health services for children with serious emotional disturbances; early childhood development; Native language preservation and maintenance; economic self-sufficiency; tribal healing to wellness courts that provide substance use treatment; domestic violence prevention; workforce training, development, and certification; and many other programs.

ATTITUDES TOWARD BEHAVIORAL HEALTH AND SERVICES

Individual, systemic, and cultural barriers influence decisions about accessing behavioral health services. Within many American Indian and Alaska Native communities, there is a wide range of cultural beliefs surrounding mental health. For some American Indian and Alaska Native tribes, speaking about negative things such as depression, suicide, and other mental disorders invites these things into their world, so such discussions are forbidden, avoided, or discouraged.

There are 12 Tribal Epidemiology Centers (TECs) that work to improve the health of American Indians and Alaska Natives by identifying and understanding health problems and disease risks, strengthening public health capacity, and developing solutions for disease prevention and control.188

These TECs have made progress in documenting the health problems facing American Indians and Alaska Natives and work regionally and nationally to design and evaluate culturally relevant health interventions.

TRIBAL, FEDERAL, AND STATE GOVERNMENT RELATIONSHIPS

Very few of the challenges cited in this document can be successfully addressed without collaborative efforts on the part of tribes and other stakeholders – most notably Federal and State governments. Tribes are sovereign entities with distinct governing structures and authorities. However, Federal and state governments bring a wealth of resources from which tribes can and do benefit. although there are actions that tribes undertake on their own, there are others where it is mutually described in the American Indian and Alaska Native Cultural Wisdom Declaration in this document. Finally, these opportunities allow for growth of thought that tribes not only use evidence-based practices along with traditional practices but also develop practices that have evidence and can inform the work of other communities. There are opportunities of mutual benefit, and those benefits are bidirectional.

ALIGNMENT OF LOCAL AND NATIONAL EFFORTS

Through a process of stakeholder engagement, the priority areas within the TBHA were created to reflect the current reality of behavioral health in Indian Country. Tribes and tribal organizations and Federal departments and agencies had opportunities to provide input. The priority areas were validated through extensive conversations and represent a unity of thought that supports the alignment of local and national efforts under common themes. Tribal, Federal, 4state, and local governments, as well as other stakeholders, can begin the process of examining their own efforts, identifying where those efforts connect and align to the priorities areas in the TBHA and determining how they might contribute to furthering them.

The process of alignment helps ensure that resources are allocated and spent most effectively, efforts target priority issues, communication is open, and collaboration is fruitful. These activities could lead to more informed

development of programs that more effectively allow tribes to respond in a manner that meets the unique needs of their communities. The activities also could lead to expansion of opportunities within existing programs that allow tribes to work in new areas, the inclusion of tribes or urban Indian health programs in funding streams that did not previously reach them, and flexibility to ensure that the programs allow for the incorporation of traditional ways as Indian health program, other governments, and other stakeholders design new program efforts or activities that carry out the recommendations through a new and innovative method. The priority areas can assist funders create or strengthen existing programs or initiatives, whereas tribes and urban Indian health programs can do the same at the local or area level. The priority areas and strategies lend themselves to incorporation into funding opportunity announcements, framing scopes of work, and/ or joint development of initiatives and programs.

YOUTH

American Indian and Alaska Native culture places importance on honoring youth and building strong foundations for future generations. Native youth hold an important role in the future of tribes; however, they are significantly and negatively affected by poverty, substance use disorder, depression, and suicide and are at high risk for other behavioral health challenges. Healthy youth lead to healthy adults and healthy communities. Across foundational elements, youth were identified as an important part of the solution for issues they face as well as those faced by their peers, families, and communities. Behavioral health planning should incorporate the voices of youth and engage them in developing and implementing activities.

IDENTITY

American Indians and Alaska Natives connect their political identity with varying aspects of cultural, geographic, tribal, familial, and social frameworks – creating a unique identity framework that is unique not only to American Indian and Alaska Native groups but also to American Indian and Alaska Native individuals. Understanding the sources of identity, honoring them, and embracing them can be a significant source of communal and individual

strength that can be harnessed to combat behavioral health challenges. Behavioral health professionals who are actively working with American Indians and Alaska Natives can incorporate identity exploration into their treatment plans; community action plans can celebrate communal identities; education can take place to ensure that external collaborators, entities, and funders understand the nature of American Indian and Alaska Native identity; and, traditional practitioners can work with clinicians on how best to honor the identities of the people they serve.

CULTURE

Culture is the root of American Indian and Alaska Native identities – culture incorporates aspects of living, interpersonal and communal relationships, communication, worldviews, traditional customs, and spirituality. The uniqueness of tribal cultures as well as their commonalities is a source of strength. Although each American Indian and Alaska Native tribe is unique, there are commonalities that tribes share, including valuing traditional practices, honoring elders, respecting nature, and emphasizing clan/community importance. American Indian and Alaska Native communities also have a Native language that serves to connect them to their culture and tribal identities as well as create a strong cultural bond with other Indigenous communities. These commonalities affect the manner in which tribes conduct themselves, including in health care delivery and behavioral health program design and implementation.

Revitalization of American Indian and Alaska Native languages is essential to continuing culture and strengthening self-determination. Research has shown that use of languages builds identity and assists communities in moving toward social cohesion and self-sufficiency. Language and culture foster higher educational outcomes by Native youth as a result of lower levels of depression, increased academic achievement, and strengthened problem-solving skills. Furthermore, American Indian and Alaska Native values and traditions are embedded in language, and there is growing evidence that language and culture act as protective factors against suicide and suicidal ideation, substance use disorders, and other risky behaviors. Languages are

among the most critical and meaningful culturally and linguistically based tools to not just survive, but to thrive.

In 2008, Canadian researchers could find only one article that examined the link between Indigenous language and health. The findings were significant: Bands with higher levels of language knowledge (as measured by a majority of its members having conversational-level abilities) had fewer suicides than those with lower levels. In fact, the rates of suicide in the bands with high language knowledge levels were "well below the provincial averages for both Aboriginal and non-Aboriginal youth." When the language knowledge factor was added to six other measures, "the presence of the language factor made a drastic difference in suicide rates." In all cases but one, the suicide rate dropped to zero when the language factor was added.

Tribal consultation and listening sessions held by HHS indicate that investments in Native language programs are critical to tribal communities. As educational institutions recognize that Native culture and language are inherent strengths, the self-worth and optimism of Native youth increase. It is by going back to traditional, ancestral, Indigenous ways of knowing based in culturally and linguistically specific values and norms that American Indian and Alaska Native communities will thrive on their own terms.

INDIVIDUAL SELF-SUFFICIENCY

Tribes and tribal members are autonomous – they have the capacity to act independently on their own behalf. While tribes know best what works and does not work for their communities, tribal members also have the ability to make individual decisions. At the individual level, self-sufficiency encompasses the full development of individuals – spiritually, mentally, physically, educationally, and economically among other ways – in a manner that contributes to their success in life. The intent is for one to have the capacity and initiative to take care of self and ultimately contribute to the well-being of their families and communities. The value is in being able to take care of self in order to effectively contribute to the lives of others. Individual self-sufficiency contributes to tribal self-sufficiency and the responsibilities of sovereign nations to their people. Tribal representatives who contributed to

building the TBHA believe that opportunities should exist across foundational elements that contribute to the ability of tribal members and tribes to be self-sufficient. This could include availability, accessibility, and/or oversight of education and training opportunities; access to Native foods; access to prevention and treatment resources to address unique behavioral health challenges that exist in communities; referral networks across systems that support well-being; and law enforcement agreements, among others.

DATA

The problems of accuracy and access to viable data have long impacted American Indian and Alaska Native communities. Small sample sizes make it difficult to capture accurate data, and the same small sample sizes make sharing data even more tenuous for fear of violating confidentiality. Frequently data available to tribes is significantly outdated, requiring them to use data sets that may not reflect the reality within their community. And, all too often, American Indians and Alaska Natives are not a distinct group captured within larger data sets. Without access to timely and accurate data, communities are unable to capture their true needs, thereby inhibiting effective community-based planning and improvement of outcomes.

As a cross-cutting consideration, improving data accuracy, availability, and access offers real opportunities to improve definitions for data collection; strengthen tribal data collection systems; provide capacity building for tribes and partners on how to collect and manage data that is tribally owned; interpret and use data to improve systems and programs; and create systems that allow partners to benefit from available data. Methodologies used in national and other non-tribal data collection systems should be assessed in order to more accurately include American Indian and Alaska Native populations in urban areas, counties, and states. These opportunities should be leveraged within strategies that support foundational elements and their accompanying priority areas and strategies.

TRIBAL LEADERSHIP

Tribal leaders care deeply for their communities and hold significant responsibility for the welfare of their people. Their leadership is critical in helping empower communities and support readiness to change. They also have the authority and communal support to take action and can serve as drivers of meaningful community change. To be most effective on behavioral health matters, tribal leaders must be informed about problems in their communities; lead community-based dialogs to hear from their people about behavioral health and factors that influence wellness; work with their tribal councils and with a range of Federal departments and agencies to address prevention as well as systems, facilities, and service needs; and seek, identify, and/or champion funding and programs that most effectively support behavioral health needs.

Priority Areas and Strategies

Priority areas emerged from tribal input that focus on creating viable and appropriate support mechanisms, promoting community connectedness, and breaking the cycle of trauma.

HIT1.1: Actively inform communities about the forms of trauma and their manifestations as a means for enhancing the potential for family engagement in services.

HIT1.2: Incorporate into Federal, Tribal, and other programs opportunities for engaging family members who live with trauma as part of funded activities to ensure that they have access to support mechanisms.

HIT1.3: Allow tribes, within existing programs and new funding streams, the flexibility to develop, tailor, and/ or implement support mechanisms that best address their local and specific manifestations of trauma.

HIT1.4: Incorporate opportunities to address unresolved grief as a root cause of behavioral health challenges and a core component in positive healing within programs that focus on tribal communities.

HIT1.5: Strengthen support systems across health, behavioral health, education, child welfare, and justice services programming to ensure

continuity and availability of support for family members who connect through different systems.

HIT2.1: Expand opportunities for tribes to incorporate Native language learning and development as a means for strengthening pride, self-esteem, identity, and other contributions to community connectedness.

HIT2.2: Provide support for creating new or maximizing existing healthy social structures and social supports through schools and other local settings that permit community members to engage and be validated as valuable members of the community.

HIT2.3: Support Gathering of Native Americans (GONA) events to support community healing from historical trauma and enhance local prevention capacity through meaningful activities that incorporate healthy traditions; focus on a holistic approach to wellness; empower community members; and provide a safe place to share, heal, and plan for action.

HIT3.1: Align Tribal, Federal, and other programs that support actions to address trauma and prevent re-traumatization as a means for supporting trauma-informed services that are continuous across systems.

HIT3.2: Integrate authentic cultural interventions and

culturally tailored evidence-based practices into existing tribal programs as a means for reestablishing tribal spiritual conditions of physical, mental, and spiritual health.

HIT3.3: Review and modify Tribal, Federal, state, and other programs to recognize and address the impacts of adverse childhood experiences among American Indian and Alaska Native populations.

HIT3.4: Widely diffuse strategies, in concert with established support mechanisms, across tribal communities to encourage families to talk in safe ways about their own identities and experiences with trauma to begin the process of healing.

HIT3.5: Develop a research agenda on current, historical and intergenerational trauma to aid building knowledge in areas that require further investigation.

HIT3.6: Use existing workforce development/learning centers to intensify education for health, behavioral health, and other professionals about historical and intergenerational trauma and support efforts to more effectively address trauma in clinical and professional settings.

Priority Areas and Strategies

Priorities areas emerged from tribal input that focus on sustaining environmental resources, ensuring reliable infrastructure, and supporting healthy families and kinship.

SCE1.1: Proactively advance collaborations among Tribal, Federal, and State programs to protect environmental resources as a vital part of the spiritual connection and traditional lifestyle.

SCE1.2: Incorporate actions across Tribal, Federal, and State programs that improve access to safe and healthy traditional foods.

SCE2.1: Strengthen educational capacity of schools and access to education resources.

SCE2.2: Collaborate with 'FEFSBM and 4UBUF agencies on creative opportunities for addressing the determinants of health, including opportunities to increase housing stock, facilitate transportation needs, and improve job readiness.

SCE2.3: Improve collaboration during the planning of new tribal housing to ensure water and waste infrastructure needs are considered.

SCE2.4: Strengthen tribal capacity to effectively manage water programs.

SCE3.1: Support broader efforts to strengthen families as integral prevention and invention mechanisms and develop family-driven strategies for reinforcement.

SCE3.2: Collaborate across local, Tribal, State, Federal, and private and non-profit organizations to leverage opportunities to create safe and nurturing environments for youth.

SCE3.3: Expand collaboration across education, health, and human service systems that engage, support, and protect elders.

Lessons learned from a decade of SAMHSA-funded American Indian and Alaska Native suicide prevention efforts include:

Suicide prevention efforts must be organized in a comprehensive way to be successful and must include all youth-serving organizations and institutions. Buy-in by the community and tribal leadership is essential and can be facilitated by a tribal resolution. Building organizational infrastructure from the beginning is important.

Tribes need access to their own data to be able to plan meaningful and effective suicide prevention activities. Understanding that historical trauma affects resistance to evaluation is vital since, historically, evaluation meant that something would be taken away from a community or used without community consent. Data and evaluation should be used by the community for the community.

Tribes should have protocols in place to guide how to respond to at-risk youth encountering any part of Tribal youth-serving systems.

Youth with suicidal ideation or who have made a suicide attempt must receive active outreach in the community. Discharge from a hospital inpatient unit or emergency department cannot be considered sufficient to eliminate suicide risk; rather, connection with the youth needs to be maintained for a minimum of 90 days during this high-risk period.

Trained community workers can play a vital role in suicide prevention efforts.

Suicide clusters can have a profound, tragic, and potentially multigenerational impact on tribal communities. Sharing learning and experiences in responding to a suicide cluster is of great significance in helping us learn how to prevent clusters from starting and how to interrupt them once they have begun.

Health and mental health programs serving tribes would benefit from utilization of a systematic suicide prevention effort such as that encapsulated in the Zero Suicide prevention model.

Coordinated crisis response and crisis intervention systems are critical.

There is a need for increased family participation in suicide prevention work. Much of the federally supported work has focused on the community and youth, but there is a need to work more intensively on family involvement.

Priority Areas and Strategies

Priority areas that emerged from tribal input focus on restructuring programming to meet community needs and advance community mobilization and engagement. Following each priority area below are recommended strategies for addressing them.

PR1.1: Create and support culturally and spiritually based programming and healing that aligns with the diversity and needs of the local Uribal population and engages communities in the development of diversion and reentry programs.

PR1.2: Support and coordinate reentry programming across service sectors and programming for incarcerated persons and their families, especially their children.

PR1.3: Prioritize and collaborate on behavioral health-related prevention efforts as a primary strategy across education, health, behavioral health, child welfare, law enforcement, and other systems.

PR1.4: Treat mental and substance use disorders as chronic conditions that require support and services across the spectrum – from prevention for individuals at all levels of risk through recovery.

PR1.5: Advocate for and support comprehensive suicide prevention efforts that incorporate protocols for at-risk youth and adults, required infrastructure for supporting suicide prevention, active community outreach following discharge from the hospital or the emergency department, trained

community workers, and coordinated crisis response and intervention systems.

PR1.6: Support, establish, or improve data collection systems to support the collection of information on suicide prevention activities that is managed locally or in collaboration with a Tribal Epidemiology Center.

PR1.7: Support suicide prevention efforts that include youth, families, and communities.

PR1.8: Build and sustain supportive environments in schools.

PR1.9: Support and promote Tribal Healing to Wellness Courts,

Veterans Courts (or the VA Diversion Courts Peer-to-Peer Support Program), and other courts that support recovery.

PR2.1: Formulate and implement long-term, communitywide engagement and mobilization strategies that emphasize community ownership of their issues and solutions.

PR2.2: Support and train community

members to serve as peer counselors.

PR2.3: Actively address and support the behavioral health related programming needs of urban- and reservation-based American Indian and Alaska Native populations.

NA1.1: Support and engage in capacity-building efforts to raise the collective capacity of tribes to speak about the effectiveness of culture in prevention and care and their own best practices.

NA1.2: Support and raise the capacity of tribes to discuss the impact of historical and intergenerational trauma within their own communities and with external partners, if they choose.

NA1.3: Actively educate tribal communities about behavioral health in an effort to normalize topics of behavioral and emotional health.

NA1.4: Support and raise the capacity of tribes to create and implement media and public relations plans.

NA2.1: Establish a national behavioral health communications campaign, in collaboration with tribes, to educate individuals about behavioral health issues affecting tribal communities. The campaign would focus on specific mental and substance use disorders and/or co-occurring disorders that could be shared through multiple platforms and also tailored by tribes for local use. Broad national dissemination would ensure that urban Indian populations receive similar messages and support.

NA2.2: Develop messages for American Indians and Alaska Natives that contain positive, Native-focused, media images and incorporate the voices of survivors and tribal strengths to discuss issues and lived experiences.

NA2.3: Package existing communications messages developed by Federal agencies and ensure that multiple entities leverage the messages to improve diffusion to communities requiring support and stakeholders who can assist.

NA2.4: Create web-based tools and resources that tribal leaders and officials can utilize to craft media communication and public relations strategies, especially during times of crisis or increased need.

REFERENCES

1. Substance Abuse and Mental Health Services Administration (2016). Health Care and Health Systems Integration: Overview. Retrieved from http://www.samhsa.gov/ health-care-health-systems-integration.

2. National Conference of State Legislatures. (2015). Federal and state recognized tribes. Washington, DC. Retrieved from http://www. ncsl.org/research/state-tribal-institute/list-offederal-and-state-recognized-tribes.aspx.

3. Centers for Disease Control and Prevention (CDC). (2008, August 29). Alcohol-attributable deaths and years of potential life lost among American Indians and Alaska Natives – United States, 2001-2005. MMWR. Morbidity and

Mortality Weekely Reports. Retrieved from https://www.cds.gov/mmwr/preview/ mmwrhtml/mm5734a3.htm.

4. Borowsky, I.W., Resnick, M.D., Ireland, M., & Blum, R.W. (1999). Suicide attempts among American Indian and Alaska Native youth: Risk and protective factors. Archives of Pediatric Adolescent Medicine 153, 573-580.

5. Clark, D.B., Lesnick, L., & Hegedus, A.M. (1997). Traumas and other adverse life events in adolescents with alcohol abuse and dependency. Journal of the American Academy of Child and Adolescent Psychiatry 36(12), 1744-1751.

6. Bohn, D.K. (2003). Lifetime physical and sexual abuse, substance abuse, depression, and suicide attempts among Native American women. Issues in Mental Health Nursing 24(3) (333-352).

7. Lormand, D.K., Markham C.M., Peskin,

M.F., Byrd, T., Addy, R.C., Baumler, E.R., Tortolero, S.R. (2013). Dating violence among urban, minority, middle school youth and associated sexual risk behaviors and substance use. Journal of School Health 83(6), 415-421.

8. Roberts, T.A., Klein, J.D., & Fisher, S. (2003). Longitudinal effect of intimate partner abuse on high-risk behavior among adolescents. Archives of Pediatrics and Adolescent Medicine 157, 875-881.

9. Silverman, J.G., Raj, A., Mucci, L.A., & Hathaway, J.E. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. Journal of the American Medical Association 286(5), 572-579

10. Friedman, M.J., Ashcraft, M.L., Beals, J.A., Keane, T.M., Manson, S.M., & Marsella, A.J. (1997). Maatsunaga Vietnam Veterans Project (Volumes 1 and 2): National Center for Posttraumatic Stress Disorder and National Center for American Indian and Alaska Native Mental Health Research.

Chapter 14: Workforce Development; Prevention Certification Standards

Worldwide, substance abuse is gaining attention for the damage it does to families and communities, and the need for trained, ethical addiction and prevention professionals is growing rapidly.

Furthermore, recent political developments in the U.S. also mean that it is a critical time for the field. Both the Affordable Health Care for America Act of 2010 and President Obama's National Drug Control Strategy have the potential to transform how the profession is practiced in North America.

Setting global standards and recognized by SAMHSA is the International Certification and Reciprocity Consortium, IC&RC. Incorporated in 1981, IC&RC represents 76 Member Boards, including 24 countries, 47 U.S. states and territories, five Native American territories, and all branches of the U.S. Armed Forces.

In 2011, the number of professionals who hold IC&RC credentials crossed the 45,000 mark. Up to half of all substance abuse professionals in the U.S. hold IC&RC certificates, including Certified Prevention Specialist.

Current IC&RC Prevention Standards:

The new 150 multiple choice examination will include the following six domains:

1. Planning and Evaluation

2. Prevention Education and Service Delivery

3. Communication

4. Community Organization

5. Public Policy and Environmental Change

6. Professional Growth and Responsibility

IC&RC Prevention Specialist Content Outline

Updated April 2013

Domain 1: Planning and Evaluation

Weight on Exam: 30%

Associated Tasks:

• Determine the level of community readiness for change.

• Identify appropriate methods to gather relevant data for prevention planning.

• Identify existing resources available to address the community needs.

• Identify gaps in resources based on the assessment of community conditions.

• Identify the target audience.

• Identify factors that place persons in the target audience at greater risk for the identified problem.

• Identify factors that provide protection or resilience for the target audience.

• Determine priorities based on comprehensive community assessment.

• Develop a prevention plan based on research and theory that addresses community needs and desired outcomes.

• Select prevention strategies, programs, and best practices to meet the identified needs of the community.

• Implement a strategic planning process that results in the development and implementation of a quality strategic plan.

• Identify appropriate prevention program evaluation strategies.

• Administer surveys/pre/posttests at work plan activities.

• Conduct evaluation activities to document program fidelity.

• Collect evaluation documentation for process and outcome measures.

• Evaluate activities and identify opportunities to improve outcomes.

• Utilize evaluation to enhance sustainability of prevention activities.

• Provide applicable workgroups with prevention information and other support to meet prevention outcomes.

• Incorporate cultural responsiveness into all planning and evaluation activities.

• Prepare and maintain reports, records, and documents pertaining to funding sources.

Domain 2: Prevention Education and Service Delivery

Weight on Exam: 15%

Associated Tasks:

• Coordinate prevention activities.

• Implement prevention education and skill development activities appropriate for the target audience.

• Provide prevention education and skill development programs that contain accurate, relevant, and timely content.

• Maintain program fidelity when implementing evidence-based practices.

• Serve as a resource to community members and organizations regarding prevention strategies and best practices.

Domain 3: Communication

Weight on Exam: 13%

Associated Tasks:

• Promote programs, services, activities, and maintain good public relations.

• Participate in public awareness campaigns and projects relating to health promotion across the continuum of care.

• Identify marketing techniques for prevention programs.

• Apply principles of effective listening.

• Apply principles of public speaking.

• Employ effective facilitation skills.

• Communicate effectively with various audiences.

• Demonstrate interpersonal communication competency.

Domain 4: Community Organization

Weight on Exam: 15%

Associated Tasks:

• Identify the community demographics and norms.

• Identify a diverse group of stakeholders to include in prevention programming activities.

• Build community ownership of prevention programs by collaborating with stakeholders when planning, implementing, and evaluating prevention activities.

• Offer guidance to stakeholders and community members in mobilizing for community change.

• Participate in creating and sustaining community-based coalitions.

• Develop or assist in developing content and materials for meetings and other related activities.

• Develop strategic alliances with other service providers within the community.

• Develop collaborative agreements with other service providers within the community.

• Participate in behavioral health planning and activities.

Domain 5: Public Policy and Environmental Change

Weight on Exam: 12%

Associated Tasks:

• Provide resources, trainings, and consultations that promote environmental change.

• Participate in enforcement initiatives to affect environmental change.

• Participate in public policy development to affect environmental change.

• Use media strategies to support policy change efforts in the community.

• Collaborate with various community groups to develop and strengthen effective policy.

• Advocate bringing about policy and/or environmental change.

Domain 6: Professional Growth and Responsibility

Weight on Exam: 15%

Associated Tasks:

• Demonstrate knowledge of current prevention theory and practice.

• Adhere to all legal, professional, and ethical principles.

• Demonstrate cultural responsiveness as a prevention professional.

• Demonstrate self-care consistent with prevention messages.

• Recognize importance of participation in professional associations locally, statewide, and nationally.

• Demonstrate responsible and ethical use of public and private funds.

• Advocate for health promotion across the life span.

• Advocate for healthy and safe communities.

• Demonstrate knowledge of current issues of addiction.

• Demonstrate knowledge of current issues of mental, emotional, and behavioral health.

IC&RC Prevention Specialist Reference List

Revised May 2013

1. Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., et al. (2010). Alcohol: No Ordinary Commodity. Research and Public Policy (2nd ed.). Oxford: Oxford University Press.

2. Benard, B. (2004). Resiliency: What We Have Learned (1st ed.). San Francisco: WestED.

3. Community Anti-Drug Coalitions of America, National Community Anti-Drug Coalition Institute. (2010). Assessment Primer: Analyzing the Community, Identifying Problems and Setting Goals. Retrieved from http://www.cadca.org/resources/detail/assessment-primer.

4. Community Anti-Drug Coalitions of America, National Community Anti-Drug Coalition Institute. (2010). Evaluation Primer: Setting the Context for a Drug-Free Communities Coalition Evaluation. Retrieved from http://www.cadca.org/resources/detail/evaluation-primer.

5. Community Anti-Drug Coalitions of America, National Community Anti-Drug Coalition Institute. (2010). Research Support for Comprehensive Community Interventions to Reduce Youth Alcohol, Tobacco and Drug Use and Abuse. Retrieved from http://www.cadca.org/resources/detail/research-support-comprehensive-community-interventions.

6. Compton, M. (2010). Clinical Manual of Prevention in Mental Health. Washington, DC: American Psychiatric Publishing, Inc.

7. Corey, G., Corey, M. S., & Callanan, P. (2011). Issues and Ethics in the Helping Professions (8th ed.). Belmont: Brooks/Cole.

8. National Institute of Drug Abuse. (2008). Drugs, Brains, and Behavior-The Science of Addiction. Retrieved from http://www.drugabuse.gov/publications/science-addiction.

9. National Research Council and Institute of Medicine. (2009). Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington, DC: The National Academies Press. Retrieved from http://books.nap.edu/openbook.php?record_id=12480.

10. Substance Abuse and Mental Health Services Administration. (2005). Focus on Prevention. Retrieved from http://store.samhsa.gov/product/Focus-on-Prevention/SMA10-4120.

11. White, W. L., & Popovits, R. M. (2001). Critical Incidents: Ethical Issues in the Prevention and Treatment of Addiction (2nd ed.). Bloomington: Lighthouse Institute.

IC&RC

298 S. Progress Ave

Harrisburg, PA 17109

www.internationalcredentialing.org

+1(717)-540-4457

New Mexico IC&RC Representative Board

The New Mexico Credentialing Board For Behavioral Health Professionals, NMCBBHP, is the Board representing Prevention Certification. In addition to the above exam requirements the IC&RC/NMCBBHP also has the following requirements for Prevention Certification:

Certified Prevention Specialist Requirements

Standards for the Certified Prevention Specialist (PS) reciprocal credential are listed below.

Experience

2000 hours of Alcohol, Tobacco and Other Drug (ATOD) prevention work experience.

Education

100 hours of prevention specific education. Fifty hours of this education must be ATOD specific.

Six hours must be specific to prevention ethics. These hours must have been completed within five years prior to application submission.

Supervision

120 hours specific to the domains (see above) with a minimum of ten hours in each domain.

Examination

Applicants must pass the IC&RC International Written Prevention Specialist Examination.

Code of Ethics

Applicants must sign a prevention specific code of ethics statement & statement of understanding.

Recertification

40 hours of continuing education earned every two years, 6 of those hours must be in Prevention Ethics and Responsibility.

NMCBBHP Inc.

PO Box 66405

Albuquerque, NM 87193

Email us - info@nmcbbhp.org

http://nmcbbhp.org/Home_Page.html

Chapter 15: Definitions—Substance Abuse Prevention Terminology

SOURCE: SAMHSA--

ABC Model - Antecedents (an event or occurrence) lead to Behavior, which then leads to Consequences. This standard behavior change model focuses on the individual level (Individual behavior theory).

Absenteeism - Time taken off from work. May be classified separately as employee sick leave, personal days, mental health days, jury duty, vacation, holidays, family illness or bereavement, Family and Medical Leave Act, workers compensation program days, short-term disability, or long-term disability. Substance abuse program theory should be used to determine which of these types of absenteeism are appropriate for analysis of the impact of a substance abuse prevention or early intervention program. Absenteeism does not include telecommuting and working off-site.

Abstinence - Abstinence means total avoidance or non-use of substances such as alcohol, tobacco, and illicit drugs. All should abstain from tobacco and illicit drugs. Abstinence from alcohol is the behavioral goal for youths under age 21, for pregnant and nursing women, for those taking certain kinds of medications, and for persons who have a history of alcohol or drug-use problems.

Abuse - Occurs when alcohol or drug use adversely affects the health of the user or when the use of a substance imposes social and personal costs.

Access to Services - The extent to which services are available for individuals who need care. Ease of access depends on several factors, including availability and location of appropriate care and services, transportation, hours of operation, and cultural factors, including languages and cultural appropriateness. For many populations access also includes insurance coverage.

Access to Substances - The extent to which illicit and licit substances are available in the home, community, or schools.

Accessing Services and Funding - Assisting States and communities in increasing or improving their prevention and treatment service capacity by developing resources to support those services. Examples include developing and maintaining a resource listing of Federal, State, and local funding programs; accessing and coordinating Federal, State, and local grants; and developing program budgets.

Accident - Unintended negative occurrences, both preventable and not. Most people understand that accidents are usually unavoidable. This term is misleading for most prevention materials because virtually all alcohol-related vehicle crashes are preventable.

Accountability - Systematic inclusion of critical elements of program planning, implementation, and evaluation in order to achieve results.

Acronyms - Many agencies and organizations are involved in substance abuse prevention, either as their primary focus or as an important part of their total program. Also, there are many "terms of art" associated with substance abuse prevention (e.g., COSAPs or children of substance abusing parents). These agencies and terms are often reduced to their

acronyms, which can be confusing to persons new to the field. Click here to see a list of acronyms and what they stand for that will help you make sense of the "alphabet soup."

Action Plan - Translates the conceptual map represented by a logic model into an operation application, detailing the key tasks that must be completed, including the measurement of outcomes. The Achieving Outcomes Guide's action plan details (a) how resources are used to get the planned work done; (b) whether or not the work was completed as planned; and (c) the result of the work (e.g., outreach brought in 40 participants) or the outcome at the completion of a component (e.g., 75 percent of the participants who completed at least 20 hours express significantly more negative feelings about recreational substance abuse than they expressed at baseline) (*Achieving Outcomes*, 12/01).

Activities - What a program does with its resources to produce outcomes.

Activity Code - A unique identifier used as a means of linking each session of a recurring program.

Activity Code Description - A means of describing or logging in the activity code used for a recurring prevention service.

Acute Care - Medical treatment rendered to individuals whose illnesses or health problems are life-threatening or debilitating, requiring immediate response, and are short-term or episodic in nature. Acute care facilities are those hospitals that predominantly serve persons requiring these kinds of services.

Adaptation - Modification made to a chosen intervention (e.g., qualitative and/or quantitative changes to components); changes in audience, setting, and/or intensity of program delivery. Research indicates that adaptations are more effective when (a) underlying program theory is understood; (b) core program components have been identified; and (c) both the community and needs of a population of interest have been carefully defined. Research also indicates that success improves when adaptations are handled as additions to, rather than deletions of, program components (*Achieving Outcomes*, 12/01).

Addiction - A compulsive physiological craving for a habit-forming substance. Addiction is a chronic and progressive disease usually characterized by physiological symptoms upon withdrawal. The term "dependence" is often used synonymously to avoid the pejorative connotations of addiction.

Adjusted Community Rating (ACR) - A community rating impacted by group-specific demographics and the group's prior experience. Also known as *prospective rating.*

Administrative Services Only Organization (ASO) - A healthcare organization that provides administrative support services only for a self-funded plan or startup Managed Care Organization (MCO).

Adolescents - An upcoming surge in the youth population is evident: experts predict that the 12-20 year old group will increase by 21 percent during the next 15 years. This translates into an additional 6.75 million youth needing age-appropriate and culturally appropriate substance abuse prevention services. Adolescence has traditionally been the

time during which substance-use problems emerge because of the increased vulnerability of the individual during this period. Adolescent substance abuse is associated with many other social problems, among them violence, HIV incidence, academic failure, and unemployment. Although CSAP and other agencies develop prevention programs for persons of all ages, adolescents have been and continue to be a special focus. See NCADI's publications about teens.

Adults and their Roles in Prevention - Youth exposed to caring adults who offer positive, appropriate, and supportive supervision and guidance are less likely to develop substance abuse and other problems than youth whose adult contact is less frequent or largely negative. Adults can serve as advocates for youth, can provide opportunities (e.g., employment) for youths, and can engage in one-on-one personal relationships with youths as mentors, teachers, coaches, and in many other roles. See CSAP's publication, *Adult Involvement in Improving the Lives of Youth*.

Adverse Selection - A tendency for utilization of health services in a population group to be higher than average. From an insurance perspective, adverse selection occurs when persons with poorer-than-average life expectancy or health status apply for, or continue, insurance coverage to a greater extent than do persons with average or better health expectations.

African Americans - Use of alcohol and other drugs is low among urban African Americans under age 16 who stay in school. Although the onset of use for these youths is delayed for a longer period of time than for their white, Hispanic/Latino, and American Indian peers, young African Americans are at risk for developing heavy patterns of use because of negative environmental factors including daily exposure to use by friends and family and the lure of the surrounding drug trade and drug culture. Many environmental prevention approaches have been tried with success in African American communities, notably protests against billboard advertising of tobacco and alcohol. Other successful strategies include mentoring young African Americans, improving parenting skills and reducing teen pregnancies, encouraging African American churches to become involved, communicating to young African Americans their rich cultural heritage, persuading TV programmers to be more sensitive in their portrayals of African Americans, using African American radio shows to convey anti-drug messages, and making information available in places where youths congregate such as movie theatres, recreation centers, and corner grocery stores.

For more information, see NCADI's publications related to substance abuse prevention among African Americans.

Age of Onset - In substance abuse prevention, the age of first use (*Achieving Outcomes*, 12/01).

Agent - In the Public Health Model, the agent is the catalyst, substance, or organism causing the health problem. In the case of chicken pox, a virus is the agent. In the case of substance abuse, the agents are the sources, supplies (drugs), and availability.

AIDS (Acquired Immune Deficiency Syndrome) - See "HIV/AIDS Prevention."

Alcohol and Drug Abuse Agency (State) - The State agency designated as the Single State Authority for the management of Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, including the 20 percent required minimum set-aside for primary prevention.

Alcohol and Drug Abuse Prevention Provider - An entity (agency or organization) whose principal objective is the prevention of substance use or abuse, or a program whose activities are related to education of and/or early intervention with populations at risk for substance abuse or dependency. A private provider is a for-profit or not-for-profit entity (agency or organization) that does not receive any SAPT Block Grant, State, or other public funds to provide services intended to prevent substance use or abuse. A public provider is a for-profit or not-for-profit entity (agency or organization) that receives SAPT Block Grant, State, or other public funds to provide services intended to prevent substance use or abuse.

Alcohol, Tobacco, and Other Drug-Free Social/Recreational Events - Social and recreational activities for youth and adults that specifically exclude the use of alcohol, tobacco, and other drugs. Examples are Project Graduation and similar events; after-prom parties; alcohol, tobacco, and other drug-free school events; alcohol, tobacco, and other drug-free community events; and smoke-free gatherings and events.

Alternatives Approach - One of the strategies mandated by the SAPT Block Grant regulations, the alternatives approach is based on the observation that providing opportunities for recognition and drug-free leisure activities is an effective means of halting or reducing substance abuse. Alternative programs include a wide range of activities that appeal to children and youth: athletics, art, music, movies, and community service projects. Youths who live in high-risk communities need safe alternative environments such as Boys or Girls Clubs and opportunities to develop relationships with non-substance-using peers. (See the NCAP monograph *Alternative Activities and Alternatives Programs in Youth Oriented Prevention*.)

Ambulatory Care - All types of health services provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services that do not require an overnight stay.

American Indians/Native Alaskans - Overall rates of alcohol and other drug use are high among American Indians and Native Alaskans, but prevalence varies tremendously from tribe to tribe and by age and sex within tribes. Members of this group die more frequently than other ethnic/racial groups from suicide, homicide, and unintentional injuries related to alcohol, and from cirrhosis of the liver. American Indians/Native Alaskans have had their traditional way of life disrupted, and the subsequent feelings of powerlessness and hopelessness may be related to the high incidence of substance abuse problems. To help prevent substance abuse problems, this ethnic group can draw upon traditional sources of strength including the family, the tribe, and the land itself. Use of culturally appropriate strategies is important for the success of prevention programs. See Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *Prevalence of Substance Use Among Racial and Ethnic Subgroups in the United States, 1991-1993.* Also, see NCADI's Publications for American Indians/Alaska Natives.

Anecdotal Evidence - Information derived from a subjective report, observation, or example that may or may not be reliable but cannot be considered scientifically valid or representative of a larger group or of conditions in another location (*Achieving Outcomes*, 12/01).

Antisocial (and Other Problem Behaviors) - Acting disruptive or disrespectful of others. Such actions can be classified as behavior-related problems (e.g., poor conduct and

impulsiveness), behavior-related disorders (e.g., attention deficit-hyperactivity disorder), or both.

Approach - A set of prevention strategies that typify a program and can be employed in an intervention setting without adopting the program in total.

Archival Data - Relative to the collection of data for needs assessment purposes, information that is collected and stored on a periodic basis. For example, most public agencies collect data that can be used directly or indirectly for an overall picture of substance use or abuse within the geographic area served by that agency (e.g., emergency room statistics, school surveys on substance abuse trends, crime reports). Once collected, the data can be cross-referenced in various combinations to identify individuals, groups, and geographic areas that are most appropriate for prevention or reduction purposes (*Achieving Outcomes*, 12/01).

Arrestee Drug Abuse Monitoring (ADAM) Program - a program of the National Institute of Justice, formerly known as the Drug Use Forecasting System, which tracks trends in the prevalence and types of drug use among booked arrestees in urban areas. The data play an important role in assembling the national picture of drug abuse in the arrestee population and have been a central component in studying the links between drug use and crime. ADAM is the only national drug data program that utilizes drug testing. The data provided by the ADAM program allow policymakers and analysts to view trends as they develop, potentially permitting earlier intervention against problems. The ADAM program currently operates in 35 sites. In addition, the NIJ/ADAM staff provide technical assistance to domestic and international affiliated sites, including Albany, New York, Australia, Chile, England, Netherlands, and South Africa. (See the ADAM Home Page for more information.)

Asian/Pacific Islanders (A/PIs) - This minority category includes more than 60 separate ethnic/racial groups and subgroups who are very diverse in terms of their histories and experiences in the U.S., languages and dialects, religions, cultures, and places of birth. They are likewise very different in the degree to which they are assimilated into the mainstream culture. Although substance abuse may not be as extensive in this group as it is in other population groups, there are significant differences in use among the different ethnic/racial groups and subgroups. Numerous prevention programs for Asians/Pacific Islanders have been developed during the past few years, reflecting the values and norms of that group and how substances are viewed and used within that culture. The National Asian Pacific American Families Against Substance Abuse (NAPAFASA) is an umbrella organization that has implemented several CSAP prevention efforts. For more information, see NCADI's publications related to Asian/Pacific Islanders and substance abuse prevention. Also see the CSAP Technical Assistance Bulletin, *Communicating Appropriately with Asian and Pacific Islander Audiences*.

Assessing Community Needs - Implementing prevention-focused tasks to determine the need for prevention services, identify at-risk and high-risk populations, or determine priority prevention populations for service delivery. Examples are conducting/participating in statewide prevention needs assessments, community prevention needs assessments, or neighborhood needs assessments.

Assessment Package - An ordered set of evaluation instruments and measures that are applied to assess the evaluation target at specific occasions.

Assets - In social development theory, the individual skills and strengths that can protect against substance abuse. In the Achieving Outcomes Guide, the term is also used to describe social, fiscal, recreational, and other community support and resources that can be marshaled in the interest of prevention. See also "Protective Factors" (*Achieving Outcomes*, 12/01).

Assets Assessment - As described in "Prevention Works! A Guide to Achieving Outcomes", the process of identifying personal and community resources that build resistance to substance abuse (*Achieving Outcomes*, 12/01).

Assignment - The process by which researchers place study subjects in an intervention, control, or comparison group. Experimental design studies randomly assign study subjects to both intervention and control conditions. In quasi-experimental studies, study subjects are nonrandomly assigned to intervention and comparison conditions. Random assignment increases the likelihood that the intervention and control groups are equal or comparable and have similar characteristics.

At Risk - For persons, the condition of being more likely than average to develop an illness or condition, e.g., substance abuse, because of some predisposing factor such as family history or poor environment. For organizations, a situation in which a healthcare organization is vulnerable to providing or paying for the delivery of more services than are received through premiums or per capita payments.

ATOD - Alcohol, tobacco, and other drugs

Attendee - An individual receiving a single prevention service. Demographic data (age, race/ethnicity and gender) are collected for attendees.

Attribution - The ability to link a particular effect with a specific cause.

Attrition - An unplanned reduction in size of a study sample due to participants' dropping out of the evaluation (e.g., they moved away from the study location).

Attrition Bias - Differences between comparison groups due to attrition (drop out) of participants from a study or intervention. For example, participants may drop out of an intervention study for a number of reasons. This attrition of participants may affect the results in determining the effectiveness of the intervention.

Audiences - Social marketing has shown that prevention messages are most effective when they are tailored to particular audiences. Accordingly, audiences have been identified because they include people at risk of drug abuse or they represent people who interact regularly with persons at risk and influence their actions. Specific prevention messages and interventions have been developed for youth, pregnant and post- partum women, members of minority groups (African American, Native American, Asian American and Pacific Islander, and Hispanic/Latino), rural residents, persons with HIV/AIDS, persons involved with the criminal justice system, and many other groups. CSAP also targets categories of people who exert influence on groups at risk: parents, school and community leaders, peers, employers, various kinds of health providers, religious leaders, and the media.

Average Payment Rate - The money that the Centers for Medicare & Medicaid Services (CMS) can pay an HMO.

Baseline - Observations or data about the target area and target population prior to treatment or intervention, which can be used as a basis for comparison once a program has been implemented.

Baseline Data - The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention (*Achieving Outcomes*, 12/01).

Behavioral Health - A managed care term that applies to the assessment and treatment of problems related to mental health and substance abuse. Substance abuse includes abuse of alcohol and other drugs.

Behavioral Healthcare - A continuum of services to individuals at risk of or suffering from mental, addictive, or other behavioral disorders.

Benchmark - For a particular indicator or performance goal, the industry (healthcare or non-healthcare) measure of best performance. The benchmarking process identifies the best performance in the industry for a particular process or outcome, determines how that performance is achieved, and applies the lessons learned to improve performance elsewhere.

Benefit Package - The types of healthcare and other services to be provided by an employer to employees. The employer as primary payor can contract for the healthcare portion of the services. The contractor arranges for delivery of healthcare services that can include substance abuse prevention and early intervention programs.

Benefit-cost Ratio (also known as Return on Investment Ratio) - For workplace prevention programs, the inflation-adjusted, discounted benefits of a program or intervention divided by the inflation-adjusted discounted costs of providing and consuming the program. Values above 1.0 generally denote economically attractive programs that provide more than one dollar in benefits for each dollar spent on the program.

Best Practices - See "Prevention Best Practices."

Bias - Bias is the extent to which a measurement, sampling, or analytic method systematically underestimates or overestimates the true value of something. Bias in questionnaire data can stem from a variety of other factors, including choice of words, sentence structure, and the sequence of questions. Bias is also created when a significant number of respondents do not answer a question. If those responding and those not responding have different characteristics, the responding cases may not be representative of the entire group.

Bicultural Stress - The difficulty or strain associated with living in a culture that is different from one's own (*Achieving Outcomes*, 12/01).

Blackouts - Memory impairment that occurs when a person is conscious but cannot remember the blackout period. In general, blackouts consist of periods of amnesia or memory loss, typically caused by chronic, high-dose alcohol or drug use. Blackouts are most often caused by sedative-hypnotics, such as alcohol and benzodiazepines.

Blind Sample - In drug testing, a sample either negative or spiked with a drug, submitted as a donor specimen in order to perform a "blind" quality control check on processes and procedures.

Bootstrapping - A process of repeated subsampling, with replacement, from a larger sample, followed by analysis of each repeated subsample. Analyses with the subsample are used to estimate variances or standard errors of variables of interest (Vogt, 1993).

Break-Even Analysis - An analysis designed to determine the dollar cost or the value of benefits that would have to be assigned to make two alternative programs equally attractive (Warner and Luce, 1982).

Buffer - In the Achieving Outcomes Guide, a descriptive term to describe an asset, protective factor, condition, behavior, or attitude that serves as a shield or insulator against a harmful condition (*Achieving Outcomes*, 12/01).

Business and Industry - Examples are small businesses, companies, corporations, industrial plants, and unions. Business and industry can be valuable partners in supporting and providing resources for prevention in a community.

CAGE Questionnaire - A brief alcoholism screening tool asking subjects about attempts to CUT down on drinking, ANNOYANCE over others' criticism of the subject's drinking, GUILT related to drinking, and use of an alcoholic drink as an EYE opener.

Capacity - In the Achieving Outcomes Guide, the various types and levels of resources that an organization or collaborative has at its disposal to meet the implementation demands of specific interventions (*Achieving Outcomes*, 12/01).

Capitation - A method for payment to healthcare providers that is common or targeted in most managed care arenas. Unlike the older fee-for-service arrangement, in which the provider is paid per procedure, capitation involves a prepaid amount per month to the provider per covered member, usually expressed as a PMPM (per member per month) fee. The provider is then responsible for providing all contracted services required by members of that group during that month for the fixed fee, regardless of the actual charges incurred. In such an arrangement, the provider is now *at risk*, picking up risk that the payor or employer used to have exclusively in fee-for-service or indemnity arrangements.

Carve-Out - A strategy for the employer in contracting or providing managed care services in which a portion of the benefit (such as a behavioral health benefit) is separated (carved-out) from the overall medical benefit. A second organization is contracted under a separate agreement to provide these benefits. The term "carve-out" usually refers to a managed behavioral healthcare organization; many HMOs and insurance companies adopt this strategy because they do not have in-house expertise related to behavioral health. Carve-out vendors may be specialized units within larger managed care organizations or they may be independent companies.

Case Management - The monitoring and coordination of treatment rendered to covered persons with a specific diagnosis or requiring high-cost or extensive services. The goal is to achieve optimum patient outcome in the most cost-effective manner.

Case Mix - The overall clinical diagnostic profile of a defined population, which influences intensity, cost, and scope of healthcare services typically provided.

Case Rate - A flat fee paid for a patient's treatment based on the diagnosis and/or presenting problem. For this fee the provider covers all of the services the patient requires for a specific period of time. Also referred to as "bundled rate" or "flat fee-per-case." Very often used as an intervening step prior to capitation. Diagnostic Related Groups (DRGs) are an example of a case rate.

Case Study - Descriptive account of behavior, past history, and so forth, of a certain individual.

Cause - A cause is something that brings about an effect or a result. Establishing causal relationships is difficult in the social sciences because many variables affect human behavior. For example, young people whose parents are critical or abusive are at higher risk for using drugs. However, it would be difficult to prove that parental criticism and abuse actually caused a teenager to abuse drugs.

Censored Data - Data about an event or phenomenon of interest that are unavailable for periods of time or to groups of people. For example, medical expenditures may be unavailable for persons who switch health plans, or for time periods before or after employment, or some other event of interest, such as the employer changing the healthcare provider.

Center for Mental Health Services (CMHS) - An agency of the Substance Abuse and Mental Health Services Administration (SAMHSA). CMHS' constituencies often overlap with those of its sister agencies, CSAP and CSAT, because a number of mentally ill people also suffer from the disorders of alcoholism and/or drug abuse; i.e., they have dual diagnoses or co-occurring disorders. (See the CMHS site.)

Center for Substance Abuse Prevention (CSAP) - Under the umbrella of SAMHSA, CSAP is the lead Federal agency for substance abuse prevention, and the Federal sponsor of this Decision Support System. CSAP makes grants to State and local governments and private organizations to engage in a wide variety of prevention activities. The mission of CSAP is to decrease substance use and abuse and related problems among the American public by bridging the gap between research and practice. CSAP fosters the development of comprehensive, culturally appropriate prevention policies and systems that are based on scientifically defensible principles and target both individuals and the environments in which they live. (See CSAP's website.) See also "ABOUT CSAP" on our home page.

Center for Substance Abuse Treatment (CSAT) - One of three SAMHSA centers, CSAT has programs designed to improve treatment services and make them more available to those in need. CSAT makes grants to States and local treatment centers to run substance abuse treatment programs and funds special treatment programs for incarcerated persons, pregnant and postpartum women, and other targeted groups. (See CSAT's Web site.)

Centers for Disease Control and Prevention (CDC) - A major operating division of the Department of Health and Human Services, located in Atlanta, GA. CDC sponsors programs in school health, health education, and HIV/AIDS prevention. All these activities give CDC a role in substance abuse prevention, as well. (See the CDC's site.)

Centers for Medicare & Medicaid Services (CMS) - Formerly known as the Health Care Financing Administration (HCFA), CMS is the Federal agency responsible for administering the Medicare, Medicaid, SCHIP (State Children's Health Insurance Program), HIPAA (Health Insurance Portability and Accountability Act), CLIA (Clinical Laboratory Improvement Amendments), and several other health-related programs. CMS provides health insurance for more than 74 million Americans through Medicare, Medicaid, and Child Health. CMS is working to maintain and measure quality of care in managed care through HEDIS (see below) measures, increase emphasis on responsiveness to beneficiaries and providers, and improve quality. Visit CMS' Web site for more information.

Centers for the Application of Prevention Technology (CAPTs) - These are grantees of CSAP that serve 5 regions in the U.S. (Northeast, Southeast, Central, Southwest, and Western) and provide information, training, and technical assistance on the latest prevention technologies and how they can be adapted to local circumstances. The mission of the CAPT program is to promote the adoption of best practices in meeting the expanded and targeted capacity needs within States. The process of transferring proven research to daily application involves packaging knowledge into practical, user-friendly formats that are culturally appropriate, and then facilitating their adoption in the field. Each CAPT grantee has a history of work in the prevention field and expertise in skills development and training, publishing, conferencing, personalized technical assistance to Single State Agencies and other entities, electronic media, community coalition building, social marketing, evaluation, and grassroots mobilization. (See the National Centers for the Application of Prevention Technologies, and from there to each separate CAPT.)

Certificate of Need - A certificate of approval issued by a governmental agency to an organization that proposes to construct or modify a healthcare facility, incur a major capital expenditure, or offer a new or different health service.

Certification of Authority - The State-issued operating license for an HMO.

Chain-of-Custody Form - In drug testing, the process used to track the handling and storage of a urine specimen for a drug test from time of collection to time of disposal.

Change Score - A measure of difference (often from one time to another).

Changing Environmental Codes, Ordinances, Regulations and Legislation - Efforts intended to change environmental codes, ordinances, regulations or other laws to reduce the availability of, access to, or incidence or prevalence of abuse of ATOD. Examples are zoning ordinances to prohibit new alcohol outlets, zoning ordinances to reduce the number of existing outlets, State Alcoholic Beverage Control (ABC) regulations (passed or improved), other local control powers (passed or improved), prevention efforts aimed at State legislatures, and prevention efforts aimed at city or county officials.

Charges - The prices of healthcare services or other goods and services imposed by suppliers of those services. Charges typically exceed the costs of producing those services and sometimes reflect additional monies needed to recoup bad debt, offset losses or lower payments from some customers.

Child Abuse and Neglect - A contributing factor or risk factor for substance abuse. High rates of substance abuse are found among parents who engage in child abuse and neglect and among children and youth who are or have been victims of child abuse and neglect. Some studies have indicated that the majority of parents who abuse or neglect their

children are substance abusers. See the National Clearinghouse on Child Abuse and Neglect Information, sponsored by the HHS Administration on Children and Families. The Clearinghouse is a national resource for professionals seeking information on prevention, identification, and treatment of child abuse and neglect and related child welfare issues.

Children of Substance Abusing Parents (COSAP) Groups - Substance abuse prevention educational services targeted to youth and adults who are children of substance abusers. Examples include Children of Substance Abusers (COSA) 12-step programs, short-term educational groups, risk and protective factor programs, and Adult Children of Alcoholics (ACOA) meetings. Some children are at increased risk for substance use because of their parents' substance abuse. A program of CSAP focuses on three age groups of COSAPs (6-8, 9-11, and 12-14) and their siblings whose parents are currently in or have been in treatment. The programs are intended to determine the best prevention models and services for enhancing protective factors and minimizing risk factors.

Also, see the *CSAP Resource Guide: Children of Alcoholics*.

Civic Groups/Coalitions - Members of civic organizations, nonprofit organizations, and community coalitions. Examples are men's and women's State or local civic groups, nonprofit agency boards of directors or staff, community or statewide coalition members, community partnership groups and community task forces, and alliances and similar community organizations. Such groups are often very active in local substance abuse prevention efforts.

Claims Review - The method by which an enrollee's healthcare service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

Classroom Educational Services - Prevention lessons, seminars, or workshops that are recurring and are presented primarily in a school or college classroom. Examples are delivery of recognized prevention curricula (e.g., "Babes," "Talking with Your Kids About Alcohol," etc.), and regular and recurring health education presentations to students. (See also "school-based prevention.")

Clearinghouse/Information Resource Center - A central repository of or a dissemination point for current, factual, and culturally relevant written and audiovisual information and materials concerning substance use and abuse. Examples are information resource centers, resource libraries, electronic bulletin boards, Internet sites, prevention resource centers, and regional alcohol and drug awareness resource (RADAR) network centers.

Closed Panel - Preferred Provider Organization in which enrollees can use only a specified group of providers in order to receive benefits.

Coalition - A union of people and organizations working for a common cause.

Cocaine - A powerfully addictive and potentially lethal drug that can be snorted, smoked, or injected. Cocaine is a strong stimulant to the central nervous system; it produces an accelerated heart rate and constricts blood vessels, causing rises in temperature and blood pressure that can be accompanied by seizures, cardiac or respiratory arrest, or stroke. CSAP and other agencies have sponsored prevention programs specifically focused on cocaine. (See NCADI's list of publications about cocaine.)

Coinsurance - The portion of the covered healthcare cost for which the person insured has the responsibility to pay, usually based on a fixed percentage; a percentage of cost to be paid by the insured, having already paid the maximum deductible for the year. (Source: Rognehaugh R., *The Managed Care Dictionary*.)

Collaboration - The process by which people/organizations work together to accomplish a common mission (*Achieving Outcomes*, 12/01).

Collection Site - In drug testing, a place where a donor provides a urine specimen; includes the work area for the collector and the rest room, toilet stall, or partitioned area used to give the donor privacy while providing a specimen.

College and University Students - Youth and adults enrolled in public or private institutions of higher education, including enrollees in universities, colleges, community colleges, technical colleges, and other institutions for advanced education. Alcohol is the drug of choice among U.S. college students, who drink at higher rates than persons of the same age not attending college. College students have particularly high rates of heavy drinking compared to the general population; in fact, student drinking is the top health problem on college and university campuses throughout the U.S. and exposes students to a host of related problems including academic failure, trauma, date rape, vehicle crashes, and vandalism. In response to these problems, experts have tried numerous prevention approaches, such as enforcing existing drinking laws, reducing availability of alcohol on campuses, and halting "bargain pricing" of alcoholic beverages at establishments near college campuses. Other strategies include server intervention, peer counseling, banning of alcohol advertising in student newspapers, and sponsorship of student events by alcoholic beverage companies, and alcohol-free residence halls. CSAP is collaborating with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the Department of Education in a 5-year research grant program, "Prevention of Alcohol-Related Problems Among College Students."

Communication Channels - In social marketing terminology, a communications channel is a "Place" (one of the "4 Ps") through which promotional messages are disseminated to the target audience. Channels include the mass media, as well as physical places such as schools, churches, or workplaces. In Diffusion of Innovations theory, the communication channels are seen as accommodating a complex flow of information. Information is communicated in various ways and in multiple settings, with the repetition and reinforcement of information viewed as increasing chances that people will decide to make changes.

Community - A group of individuals who share cultural and social experiences within a common geographic or political jurisdiction.

Community Awareness - In this publication, a perception or recognition on the part of the community that there is a substance abuse problem. The level of this awareness can change over time.

Community Drop-In Centers - Centers that provide community facilities and structured prevention services and that do not permit alcohol, tobacco, or other drug use on their premises. Activities held in these centers include recreation, activities for teens, senior citizens, and children.

Community Epidemiology Work Group (CEWG) - A network composed of researchers who provide ongoing community-level surveillance of drug abuse through analysis of quantitative and qualitative research data. Through this program the CEWG provides current descriptive and analytical information regarding the nature and patterns of drug abuse, emerging trends, characteristics of vulnerable populations, and social and health consequences.

Community Indicators - A defined, measurable variable used to monitor the quality of a community.

Community Mobilization - One of the six prevention strategies mandated by the SAPT Block Grant. This strategy tries to enhance the ability of the community to provide prevention services, and includes such activities as organizing, planning, inter-agency collaboration, coalition building, and networking. The strategy also includes community and volunteer training, systematic planning, multi-agency coordination and collaboration, funding procurement, and community team building. (See also "Community Partnerships and Coalitions," below.)

Community Organization (Theory) - The process by which community groups are helped in order to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching goals they have set. Empowerment, the central concept in community organization, is an enabling process through which individuals or communities take control over their lives and their environment. Community organization is composed of several alternative change models including locality development, social planning, and social action.

Minkler, M. (1990). Improving health through community organization. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (pp. 257-287). San Francisco, CA: Jossey-Bass.

Community Partnerships and Coalitions - From 1990 to 1995, through its Community Partnership grant program, CSAP supported morte than 250 projects nationwide, using a "systems approach" to prevention that views the community and the environment as interconnected parts needing to work together. Cooperation and support through this systems approach help communities to create environments for youths that consistently discourage involvement with alcohol, tobacco, and other drugs. The 5-year demonstration grant supported the development of long-term primary intervention efforts in communities of varying sizes. CSAP also provided numerous training opportunities for communities. (See PrevLine's curricula library.) This program was succeeded in 1996 by the CSAP Community Coalitions program. Coalitions had to consist of two or more partnerships (each partnership being a multi-organizational entity to begin with). This program, now nearly complete, sought to create public/private linkages in communities.

Community Readiness - The community's awareness of, interest in, and ability and willingness to support substance abuse prevention initiatives (*Achieving Outcomes,* 12/01).

More broadly, connotes readiness for changes in community knowledge, attitudes, motives, policies, and actions.

Community Services - Functions intended to prevent substance abuse by involving youth and adults in providing a variety of community services. Examples are community clean-up

activities; events to repair or rebuild neighborhoods; fundraising for charitable causes; and support to the elderly, handicapped, or ill.

Community Survey Data - Includes the results from community-administered surveys.

Community Team Activities - Activities or services conducted with or sponsored by formalized community teams for the purpose of fostering, supporting, or enhancing community prevention services. Examples include multi-agency coordination and collaboration, community mobilization events, development or implementation of action plans, civic advocacy, joint planning or programming between two or more agencies or organizations, and development of inter-agency or multi-agency cooperative agreements to provide prevention services.

Community Tolerance - Community norms that view problematic behavior such as use/abuse of alcohol, tobacco, and drugs as socially acceptable or actively encourage it.

Community/Volunteer Services - Structured prevention activities intended to impart information and teach organizational development skills to individuals or community groups. Examples are community volunteer services, action planning for community decisionmakers, multicultural leadership mobilization activities, or neighborhood action services.

Community-Oriented Primary Care - An approach to primary care that uses epidemiologic and clinical skills in a complementary fashion to tailor programs to meet the particular health needs of a defined population.

Comparison group - A group of individuals whose characteristics are similar to those of the program participants but who do not receive the program services, products, or activities being evaluated.

Component Logic Model - Shows how the activities that make up a component of a prevention program link together to achieve immediate and intermediate outcomes (program objectives). See also "Logic Model" (*Achieving Outcomes*, 12/01).

Conceptual Soundness - In the Achieving Outcomes Guide, refers to the linkage of underlying factors and theory to interventions and outcomes in a logical way. The extent of conceptual soundness is based on existing theory or research underlying the model of change that supports the intervention (*Achieving Outcomes*, 12/01).

Conduct Disorder - A behavior-related disorder that has a repetitive and persistent pattern of violating the basic rights of others or major age-appropriate societal norms or rules. The disorder can include aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules.

Construct - An attribute, usually unobservable (such as educational attainment or socioeconomic status) that is represented by an observable measure.

Consumer - An individual who receives care, who purchases care directly, or who selects among health plans purchased on his or her behalf by an employer or another entity.

Continuous Quality Improvement (CQI) - The systematic assessment, feedback, and use of information relevent to planning, implementation, and outcomes (*Achieving Outcomes*, 12/01).

Continuum of Service - Prevention is part of an interrelated continuum of service that also includes intervention and treatment, which are often called secondary and tertiary prevention. Primary prevention is differentiated from intervention and treatment in that it is aimed at general population groups who as yet have no substance abuse problems but who may have different levels of risk for substance abuse. Secondary prevention (intervention) is concerned with those (usually youths) who have only recently begun to experiment with substances. Tertiary prevention, or treatment, is concerned with those who have actually developed a dependence on substances, and tries to arrest their dependency to prevent it from worsening, and for individuals who have completed treatment and are drug-free to prevent relapse from occurring.

Control Group - In experimental evaluation design, a group of participants that is essentially similar to the intervention (i.e., experimental) group but is not exposed to the intervention. Participants are designated to be part of either a control or an intervention group through random assignment.

Coordinated Care Networks - Term used by the Federal Government to describe managed care.

Coordination of Benefits (COB) - Provisions and procedures used by third-party payers to determine the amount payable to each payer when a claimant is covered under two or more group plans.

Copayment - The portion of the covered healthcare cost that the person insured has the responsibility to pay, usually as a fixed fee for a specific service type (e.g., $10 per doctor visit).

Core Components - Program elements that are demonstrably essential to achieving positive outcomes (*Achieving Outcomes*, 12/01).

Core Measures - As used in SAMHSA terminology, a compendium of data collection instruments that measure underlying conditions-risks, resources, attitudes, and behaviors of different populations-related to the prevention and/or reduction of substance abuse.

Core Measures Initiative - A CSAP initiative to identify soundly established measurements and factors proven to be successful with prevention. This initiative will help programs to measure outcomes, even if they don't have the resources to conduct their own research. CSAP has consulted with experts in substance abuse who identify, review, and recommend appropriate outcome measures. This consultation will result in an inventory of the best prevention instruments. Eventually adaptations of these instruments for special populations will be available.

Corporate Health Management Programs - Health promotion and disease prevention/wellness programs that use health education techniques to promote employee health. These programs usually include components such as exercise regimens, health-risk appraisals, weight control, nutrition information, stress management, disease screening, and smoking cessation.

COSAs/Children of Substance Abusers - Youth and adults who are children of substance abusers. Examples are adult children of alcoholics, children whose parents abuse alcohol or other drugs, and children raised in or chronically exposed to situations involving substance abuse.

Cost Effectiveness of Prevention - Data on cost effectiveness are particularly useful in persuading funding agencies to award money for prevention programs. CSAP and other agencies have sponsored research and designed methods of calculating the cost-effectiveness of prevention programs. For examples of these, see the NIDA Monograph 176: *Cost Benefit/Cost-Effectiveness Research of Drug Abuse Prevention; Implications for Programming and Policy*.

Cost-based Reimbursement - Method of reimbursement in which third parties pay providers for services provided based upon the documented costs of providing that service.

Cost-Benefit - Type of economic analysis of medical interventions in which the cost of treatment is compared with the cost of the outcome (benefit). In this analysis, results are valued monetarily.

Cost-benefit Analysis (CBA) - A systematic method for valuing over time the monetary costs and consequences of producing and consuming substance abuse program services. Results from a CBA are often provided in terms of a net present value figure, which shows the difference in inflation-adjusted, discounted costs and benefits of the program in today's dollars or in the dollars of a base year of interest. Results may also be shown in terms of an internal rate of return or a benefit-cost ratio. The data is used in determining the content of a benefit package.

Cost-Effectiveness - Inherent measure of a therapy's worth in relation to its cost. In mathematical terms, Cost-Effectiveness=Worth/Cost. There are several ways to define and measure both worth and cost. (For example, if a cancer patient has his or her tumor size reduced, yet can't walk or eat without assistance, what is the worth of the therapy? How can it be quantified?) For cost-effectiveness comparisons among therapeutic regimens to be useful, cost and worth must be measured the same way for each course of therapy. As health care dollars become more scarce, payors are increasingly reliant on cost-effectiveness data for making coverage decisions. In the absence of these data, they often make decisions based on cost alone. It is crucial, therefore, that health care manufacturers measure, understand, and promote the cost-effectiveness of their products.

Cost-Effectiveness Analysis (CEA) - A systematic method for valuing over time the monetary costs and non-monetary consequences of producing and consuming substance abuse program services. Results from a CEA are often shown in terms of total costs and total levels of effectiveness (e.g., total quality adjusted life-years saved or total numbers of substance abuse cases avoided), or in terms of cost per unit of effectiveness. These data are used by employers to determine contents of a benefits package.

Cost-Sharing - Health insurance practice that requires the insured person to pay some portion of covered expenses (e.g., deductibles, coinsurance, and copayments) in an attempt to control utilization.

Cost-Shifting - Charging one group of patients more in order to make up for underpayment by others. Most commonly, charging some privately insured patients more in order to make up for underpayment by Medicaid or Medicare.

Covered Days - Maximum number of days for which an insurer will reimburse for services rendered. Days may be limited per episode of illness, per year, per lifetime, or per length of policy.

Covered Lives - Individuals having health insurance coverage under a particular contract, payer, or provider group. In the private sector, this refers to employees and family members.

Crack - Cocaine (cocaine hydrochloride) that has been chemically modified so that it will become a gas vapor when heated at relatively low temperatures; also called "rock" cocaine.

Credentialing - The process of reviewing a practitioner's credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining whether criteria for clinical privileges are met.

Credibility of Findings - Represents a continuum that is at its highest when the quality of implementation and evaluation are both high (*Achieving Outcomes*, 12/01).

Crime - A contributing factor or risk factor for substance abuse. Higher rates of substance abuse are found among both victims and perpetrators of crimes. Use of some substances by some people is defined as a crime in most jurisdictions (e.g., use of illegal drugs by anyone; use of alcohol and tobacco by underage persons). Certain national data systems regularly collect data on the association between crime and substance use/abuse. (See NIJ's Arrestee Drug Abuse Monitoring (ADAM) Program.)

Cultural Competence - The capacity of individuals to incorporate ethnic/cultural considerations into all aspects of their work relative to substance abuse prevention and reduction. Cultural competence is maximized with implementer/client involvement in all phases of the implementation process, as well as in the interpretation of outcomes (*Achieving Outcomes*, 12/01).

Cultural Competence Promotion - Educative interventions to develop capacity for culturally competent knowledge, attitudes, and behaviors. Typically they involve instruction on how to avoid use of stereotypes and biases, identify positive characteristics of a particular group, increase readiness to take into account cultural differences, and use language and terminology that will best convey culturally sensitive prevention messages to a particular group. CSAP has sponsored the development of prevention training for various ethnic minority groups.

Cultural Diversity - Differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation.

Cultural Sensitivity - The ability to recognize and demonstrate an understanding of cultural differences (*Achieving Outcomes*, 12/01).

Culture - The values, traditions, norms, customs, arts, history, folklore, and institutions shared by a group of people who are unified by race, ethnicity, language, nationality, or religion.

Data - Information collected according to a methodology using specific research methods and instruments.

Data Analysis - The use of statistical and/or classification procedures that provide at least a preliminary understanding of the phenomena in question. In general terms, the assessment, interpretation, and/or appraisal of systematically collected information. (*Achieving Outcomes*, 12/01).

Data Driven - A process whereby decisions are informed by and tested against systematically gathered and analyzed information (*Achieving Outcomes*, 12/01).

Data Source - The entity (person or device) providing responses to measurement devices (see Respondent).

Data Targets - The Who or What that is being evaluated (see Evaluation Targets).

Data Warehouse - A component of a computer-based patient record that accepts, files, and stores clinical data over time from a variety of intervention systems for the purposes of developing population-based practice guidelines, outcomes management, and research.

Database Builder - The portable component of the Evaluation Tool. It has the resources to sustain the evaluation databases you develop on this site. It allows you to finalize data sources and data targets, select and/or build measures and assessment instruments, enter and manage prevention service/project participant data, export the data, and prepare descriptive reports.

Deductible - The minimum threshold payment that must be made by a health plan enrollee each year before the plan begins to make payments on a shared or total basis. (Source: Rognehaugh R., *The Managed Care Dictionary*.)

Defined Population - In the Achieving Outcomes Guide, the people whose attitudes, knowledge, skills, risks/assets, and behaviors are to be strengthened or changed. Also known in the field as the target group, the population of interest, or the target population/group (*Achieving Outcomes*, 12/01).

Delinquent/Violent Youth - Youth who display risk factors for delinquency or violence or who have been determined to be delinquent or violent. Examples are youth declared delinquent by a State child welfare system; youth who have been arrested for juvenile delinquent behavior; youth who are chronically truant; and youth who display chronic or periodic violent behavior, including youth who display antisocial behavior (e.g., chronic fighting, hitting, using weapons).

Demand-Side Management - Use of employer-provided health education, wellness, and client empowerment programs to assist members to make cost-effective healthcare decisions, thereby decreasing unnecessary utilization and costs. These programs may be part of a carve-out service. Also, the process of responding to service utilization at higher-than-projected levels. Demand-side management controls demand for expensive services through health promotion, wellness, and other prevention strategies.

Demographic Estimate Indicator - Identifies whether demographic data are estimated for single services. Actual members should be used whenever possible.

Demographics - The characteristics of a human population, including sex, age, socioeconomic status (SES), and so forth.

Department of Defense (DoD) - Sponsors prevention programs for members of the uniformed services. Also maintains statistics on alcohol and other substance abuse problems among the military.

Department of Education, Safe and Drug-Free Schools - The Safe and Drug-Free Schools Program is the Federal Government's primary vehicle for reducing drug, alcohol, and tobacco use, and violence, through education and prevention activities in our Nation's schools, so as to ensure a disciplined environment conducive to learning. These initiatives are designed to prevent violence in and around schools; to strengthen programs that prevent the illegal use of alcohol, tobacco, and drugs; involve parents; and coordinate with related Federal, State and community efforts and resources. The Safe and Drug-Free Schools Program consists of two major programs: State Grants for Drug and Violence Prevention Programs, and National Programs. State Grants is a formula grant program that provides funds to State and local education agencies, as well as governors, for a wide range of school- and community-based education and prevention activities. National Programs carries out a variety of discretionary initiatives that respond to emerging needs. Among these are direct grants to school districts and communities with severe drug and violence problems, program evaluation, and information development and dissemination.

The Safe and Drug-Free Schools Program (SDFS) of the U.S. Department of Education is also launching an expert panel process to identify, validate, and recommend to the Secretary of Education those programs that should be promoted nationally as promising and exemplary. This Expert Panel oversees a valid and reliable process for identifying exemplary school-based programs that promote safe, disciplined and drug-free schools. Once programs are designated as exemplary or promising, the Department will disseminate information about the programs and will encourage their use in new sites. The Expert Panel initiative is a way of enhancing prevention programming by making schools aware of alternative programs that have proven their effectiveness when judged against rigorous criteria. (See a list of grants and programs under SFDS.)

Department of Justice, Office of Juvenile Justice & Delinquency Prevention - The Federal agency that administers the Drug-Free Communities Program, a program that supports community efforts to strengthen collaboration among communities, enhance intergovernmental cooperation, increase citizen participation, and disseminate state-of-the-art information about proven, effective prevention initiatives and strategies. CSAP provides technical assistance to DOJ/OJJDP in this endeavor. (See information about Drug-Free Communities Support Program Awards and information about OJJDP.)

Dependence - A mental and sometimes physical state resulting from taking a drug, characterized by a compulsion to take a drug on a continual or periodic basis. Tolerance may or may not be present, and a person may be dependent on more than one drug. This provides financial incentive for the provider to contain costs and also results in lower costs for the payor.

Descriptors - A word or phrase used to identify an item in an information retrieval system.

Design - An outline or plan of the procedures to be followed in scientific experimentation and research studies in order to reach valid conclusions.

Developmental Assets - The developmental assets framework espoused by the Search Institute specifies critical factors in young people's growth and development. The internal

and external assets offer a set of benchmarks for positive child and adolescent development.

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) - This manual published by the American Psychiatric Association provides diagnostic criteria and descriptions to help classify and diagnose mental disorders. The TR version (Text Revision) was published in 2000 to update the fourth edition of the DSM. Most changes in this edition are in Associated Conditions and Disorders, Specific Culture, Age, and Gender Features; Prevalence; Course; and Familial Patterns sections of the text.

Diagnostic-Related Groups (DRGs) - A payment system that reimburses healthcare providers a fixed amount for all care in connection with a standard diagnostic category. The DRG system was instituted by Medicare and is now used by many insurance companies. It is a form of case rate payment system.

Diffusion - Diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system. It is a special type of communication, in that the messages are concerned with new ideas.

Diffusion of Innovations - A theoretical framework that seeks to explain the means by which new ideas and practices are communicated and accepted among members of a social system. The diffusion of innovations approach has been applied in many countries to evaluate the impact of new programs in areas such as public health, family planning, and nutrition.

Discount Rate - The rate at which future dollars or future units of effectiveness are devalued, relative to current dollars or units of effectiveness.

Discounting - The process of devaluing future dollars or units of effectiveness to reflect preferences for dollars or goods or services now, versus in the future.

Disease Management Programs - Comprehensive, integrated programs for managing patients' disease conditions. These programs usually target specific disease conditions for which there are effective, evidence-based practice guidelines, and are designed for diseases such as depression, diabetes, arthritis, hypertension, and heart disease.

Documentation - Entails keeping records, collecting data, and making observations in order to obtain specific kinds of information, such as the rates of alcohol-related problems, consumption, and sales.

Domain - Sphere of activity or affiliation within which people live, work, and socialize (e.g., self, peer, school, workplace, community, society) (*Achieving Outcomes*, 12/01). See also "Prevention Domains."

Domestic Violence - Domestic violence is violence occurring in the home and inflicted by one spouse on another, by a parent upon a child or children, or vice versa, or by one sibling on another. Domestic violence is a contributing factor or risk factor for substance abuse. Higher rates of substance abuse are found among both victims and perpetrators of domestic violence.

Drug Abuse Warning Network (DAWN) - A national probability survey of hospital emergency departments (EDs) conducted annually by SAMHSA. It captures data on ED episodes that are induced by or related to use of an illegal drug or the nonmedical use of a legal drug. DAWN data thus do not measure prevalence of drug use in the population, but focus on comparisons of estimates from the first half of current year with that of previous year as well as long-term trends in drug use. (See the current DAWN data set.)

Drug Free Communities Act (DFCA) - This Act serves as a catalyst for increased citizen participation in our efforts to reduce substance abuse among our youth and provide community anti-drug coalitions with much needed funds to carry out their important missions. The Act provides for grants to coalitions of representatives of youth, parents, businesses, the media, schools, and other organizations. The Office of National Drug Control Policy in carrying out the Program will provide technical assistance, training, data collection, and dissemination of information on state-of-the-art practices that have been shown to be effective in reducing substance abuse. For more information about DFCA, visit the Drug-Free Communities Support Program website.

Drug Free Workplace Act - The 1988 Federal act that laid the groundwork for subsequent regulation of workplace drug testing.

Drug Testing in the Workplace - Because an estimated 70 percent of illicit drug users are employed, the workplace is an important environment for preventive efforts. One method is to conduct drug testing in the workplace, a controversial practice, but one that sends a strong message that the company supports non-use and encourages users to stop. Workplace drug testing is used for many reasons: pre-employment applicant testing, post-accident testing, scheduled testing (e.g., during routine physicals), random testing (used for jobs involving public safety/security), treatment followup, oversight of the maintenance of a drug-free state. For employers considering drug testing, legal counsel is advisable, because lawsuits have been filed against employers for invasion of privacy, wrongful discharge, defamation, and discrimination. However, statistics show that comprehensive workplace prevention programs, including drug testing, do reduce drug use problems and improve health, safety, and productivity. CSAP has a drug-free workplace program with a drug-testing component. (See CSAP's Workplace Resource Center.)

Drug Utilization Review - A review to establish the medical appropriateness of medications given by providers to patients for particular medical conditions; performed by peers, with feedback and education given to the providers, as appropriate.

Dual Diagnosis - Identification of dual diseases, disorders, or injuries, commonly used to describe individuals diagnosed with both mental disorders and addictive diseases.

DUI/DWI/MIP Programs - In states that count Driving Under the Influence (DUI), Driving While Intoxicated (DWI), and Minor in Possession (MIP) programs as a prevention service, structured prevention education programs intended to change the behavior of youth and adults who have been involved in the use of alcohol and/or other drugs while operating a motor vehicle. Examples are alcohol-related highway traffic safety classes, alcohol and other drug awareness seminars, court-mandated alcohol, and other drug awareness and education programs (includes MIP).

Early Indicators - Subtle symptoms or other outwards signs that someone may have a substance abuse problem. Examples: frequent absences from work, sudden poor job performance, mood swings, difficulty eating or sleeping.

Early Intervention - Refers to identifying persons at high risk prior to their having a serious consequence, or persons at high risk who have had limited serious consequences related to substance use on the job; or having a significant personal, economic, legal, or health/mental health consequence, and providing these persons at high risk with appropriate counseling, treatment, education, or other intervention.

Ecological Model (Theory) - Views behavior as being affected by and affecting multiple levels of influence. Five levels of influence that have been identified for health-related behaviors and conditions are 1) intrapersonal or individual factors; 2) interpersonal factors; 3) institutional or organizational factors; 4) community factors; and 5) public policy factors. This model can be used to understand and develop interventions for changing behavior.

McLeroy, K.R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*. Vol. 15, pp. 351-377.

Economically Disadvantaged Youth/Adults - Youth and adults considered to be underprivileged in material goods due to poor economic conditions. Examples are youth and adults living in poor housing conditions or who are enrolled in State or Federal public assistance programs.

Ecstasy - Slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family. MDMA increases metabolism, produces euphoria and alertness, and gives the user a sense of increased energy. Higher doses or chronic use increases nervousness, irritability, and paranoia. (See NCADI's list of publications about ecstasy.)

Education - One of the six prevention strategies mandated by the SAPT Block Grant. This strategy involves two-way communication between an educator or facilitator and participants. The strategy focuses on improving critical life and social skills such as decision making, refusal, critical analysis of media messages, and improved judgement. Examples include classroom sessions for all ages, parenting and family management classes, and peer leader programs.

Educational Services for Youth Groups - Structured substance abuse prevention lessons, seminars, or workshops directed to a variety of youth groups (children, teens, young adults) and youth organizations. Examples are substance abuse education for youth groups such as Boys & Girls Clubs and Scouts, general substance abuse prevention education for other groups, or organizations serving youth.

Effect - A result, impact, or outcome (*Achieving Outcomes*, 12/01).

In evaluation research, attributing an effect to a prevention program or intervention requires establishing, through careful evaluation, logical cause and effect relationships among factors internal and external to the program or intervention.

Effect Size - The magnitude of a relationship between the dependent and independent variables in the population, or the degree of departure from the null hypothesis. Typical measures of effect size include d, eta, and r.

Effective Prevention Programs - Effective Prevention Programs (as defined by CSAP's National Registry of Effective Prevention Programs [NREPP]) are science-based programs that produce a consistent, positive pattern of results.

Effective Program - In CSAP's terminology, an intervention that builds upon established theory, comprises elements and activities grounded in that theory, demonstrates practical utility for the prevention field, has been well implemented and well evaluated, and has produced a consistent pattern of positive outcomes (*Achieving Outcomes*, 12/01).

Effectiveness - The ability to achieve stated goals or objectives, judged in terms of outcomes and impact.

Elementary School Students - Youth enrolled in public or private elementary schools in kindergarten through grade 5.

Eligible Employee - An employee who qualifies to receive health benefits through his/her employer.

Employee Assistance Programs (EAPs) - Programs to assist employees, their family members, and employers in finding solutions for workplace and personal problems. The EAP may be provided directly by the employer or be part of the healthcare contract with a managed care organization or managed behavioral healthcare organization. These programs are intended to help employees overcome problems that interfere with their work, including substance abuse and other health issues, and a variety of personal, marital, legal, and financial problems. EAPs emphasize constructive rather than punitive treatment of employees and operate on the assumption that the program will reduce turnover and restore the employee to effective work performance. An EAP program may include some or all of the following components: employee education, supervisor training, drug testing, needs assessments, wellness programs, support for parents, health fairs, peer-to-peer counseling, interactive Web sites, health risk appraisals, newsletters, and employee seminars and information campaigns. (Visit CSAP's Workplace Resource Center for more information about preventing substance abuse in the workplace.)

Employee Retirement Income Security Act of 1974 (ERISA) - Also called the Pension Reform Act, this act regulates the majority of private pension and welfare group benefit plans in the United States. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct.

Enrollment - The total number of covered persons (employees and their dependents) enrolled in a health plan. Also refers to the process by which a health plan signs up groups and individuals for membership, or to the number of enrollees who sign up in any one group.

Entity - An agency or organization that provides substance abuse prevention services as prescribed by the State in which it is located.

Environment - In the Public Health Model, the environment is the context in which the host and the agent exist. The environment creates conditions that increase or decrease the chance that the host will become susceptible and the agent more effective. In the case of substance abuse, the environment is a societal climate that encourages, supports, reinforces, or sustains problematic use of drugs.

Environmental Analysis - An assessment of the formal and informal policies and the social, physical, or cultural conditions affecting an individual or a community (*Achieving Outcomes*, 12/01).

Environmental Approaches - One of the six strategies mandated by the SAPT Block Grant regulations. This strategy establishes or changes community standards, codes, and attitudes and thus influences incidence and prevalence of substance abuse. Approaches can center on legal and regulatory issues or can relate to service and action-oriented initiatives. Examples include TA to communities to maximize enforcement of laws governing availability and distribution of legal drugs, product pricing strategies, and modification of practices of advertising alcohol and tobacco. (See the announcement for the Prevention Enhancement Protocols System (PEPS), *Preventing Problems Related to Alcohol Availability: Environmental Approaches*.)

Environmental Consultation to Communities - Consultation or guidance intended to maximize the development and/or enforcement of substance abuse norms and standards. Examples are TA to Initiatives to Mobilize People for the Control of Tobacco Use (IMPACT), TA to the American Stop Smoking Intervention Study (ASSIST), TA to communities in monitoring enforcement of laws relative to the sale of alcohol to tobacco to minors, and TA to develop drug-free workplaces, TA in developing drug-free school zones.

Environmental Factors - Those factors that are external or perceived to be external to an individual but that may nonetheless affect his or her behavior. At a narrow level these factors relate to an individual's family setting and relationships. At the broader level, these refer to social norms and expectations as well as policies and their implementation.

Epidemiology - The study of the determinants and distribution of disease with respect to person, place, or time. It is the basic science of developing and applying disease prevention and control.

Establishing ATOD-Free Policies - Activities intended to establish places of education and workplaces free of ATOD products and use. These activities track efforts to establish or enhance school and workplace policies regarding ATOD use. Examples are establishment of drug-free zones, establishment of drug-free workplaces, school use policies and procedures (passed or improved), business/workplace use policies and procedures (passed or improved), and tobacco use policy (passed or improved).

Ethnicity - Belonging to a common group-often linked by race, nationality, and language--that shares a cultural heritage and/or origin.

Evaluation - Evaluation helps prevention practitioners discover the strengths and weaknesses of their activities so they can do better over time. Time spent on evaluations is well spent because it allows groups to use money and other resources more efficiently in the future. Also, evaluation does not have to be expensive or complicated to be useful. Some evaluations can be done at little or no cost, and some can be completed by persons who are not professional evaluators. Local colleges and universities can be sources of professional evaluation support by persons working on degrees in sociology, educational psychology, social work, biostatistics, public health, and other areas.

Evaluation Component - In this site's Evaluation module, an evaluation component is a logical part or thematic set of the Evaluation Performance Unit's structure or activities that

can be evaluated together. For example, a community project may have a school component and a media component in its evaluation plan.

Evaluation Goal - Statement of the ultimate outcome of an evaluation.

Evaluation Instruments - Specially designed data collection tools (e.g., questionnaires, survey instruments, structured observation guides) to obtain measurably reliable responses from individuals or groups pertaining to their attitudes, abilities, beliefs, or behaviors (*Achieving Outcomes*, 12/01).

Evaluation Objectives - Statements of shorter-term, measurable outcomes of an evaluation.

Evaluation Plan - The systematic blueprint detailing all the evaluation aspects of the project including the database structures to manage the project data.

Evaluation Plan Hierarchy - In this site's Evaluation module, the ordering of relationships among the parts of the evaluation plan (i.e., Performance Units contain Evaluation Components that contain Evaluation Tasks that contain Assessment Packages).

Evaluation Questions - Questions designed to guide an evaluation. Also, the questions that the evaluator wants the data to answer. These questions may require process, outcome, or other types of data.

Evaluation System - This site offers an integrated Web-enabled evaluation system to help evaluators (1) build evaluation capacity for one project or a service system; (2) set performance indicators to goals and objectives; (3) design process and outcome evaluations; (4) select measures from the Measures and Instrument Repository; (5) customize assessment instruments; (6) create portable Web-enabled databases and enter/edit data; (7) specify evaluation components (i.e., the evaluation design/type and questions); (8) define Assessment Packages (measure selection, assessment instrument construction, observation occasions, and database layouts); (9) export the databases to non-Federal Government "Client Data Servers"; and (10) generate descriptive reports and export data for analyses.

Evaluation Targets - The Who or What that is being evaluated (see Data Targets).

Evidence-based Program - A program that is theory-driven, has activities/interventions related to the theory of change underlying the program model, has been well implemented, and has produced empirically verifiable outcomes, which are assumed to be positive.

Evolving Program - A program that is theory driven, has activities related to its underlying theory of change, and has an ongoing evaluation mechanism. While there may be anecdotal or even documented evidence of outcomes, the program has not been subject to a rigorous evaluation that includes at least one methodologically sound and reasonably well-implemented effectiveness trial.

Exclusive Provider Organization - A plan in which the patient must remain in the network to receive benefits (out-of-network costs are paid by the patient); a plan regulated under a State insurance statute that provides coverage only for contracted providers and does not extend to non-preferred-provider services.

Experimental Design - A research design involving random selection of study subjects, random assignment of them to control or intervention groups, and measurements of both groups. Measurements are sometimes conducted before, and always after the intervention. The results obtained from such studies typically yield the most definitive and defensible evidence of an intervention's effectiveness.

Extant - Currently existing. Extant data are often data that are routinely collected either as part of program operations or through an ongoing related research efforts (for example, tracking alcohol-related traffic accidents and deaths).

Faith Community - A community that includes religious groups or churches.

Family - Parents (or persons serving as parents) and children who are related either through biology or through assignment of guardianship, whether formally (by law) or informally, who are actively involved together in family life and who share a social network, material and emotional resources, and sources of support.

Family Strengthening Programs - Family dysfunction, like crime and domestic violence, is an important risk factor for substance abuse. Accordingly, the Office of Juvenile Justice and Delinquency Prevention sponsors various grant programs that attempt to strengthen families and promote effective parenting practices. They also sponsor a project to analyze the literature on such programs and identify model programs. (Visit OJJDP's Stengthening American Families Web site for information about effective family programs for preventing delinquency.)

Also, CSAP has its own Parenting and Family Strengthening Intervention Program in which 95 community agencies received funding and are being supported to use one of the 28 best parenting and family programs identified by a panel of experts. A recent meta-analysis commissioned by CSAP found that family strengthening programs were nine times more powerful in reducing the risks for drug abuse than the most powerful school-based programs. See *Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches*, which is available in three versions. The Reference Guide is a comprehensive text intended for national, State, and local organizations and researchers. The Practitioner's Guide is a shorter version, designed for practitioners and program planners. The Family and Community Guide is an informational brochure for concerned citizens. These publications may be ordered from NCADI, 1-800-729-6686.

See also Etz, K.E., E.B. Robertson, and R.S. Ashery, 1999, *Drug Abuse Prevention Through Family-Based Interventions: Future Research,* (NIDA Research Monograph 177).

Family Therapy - A prevention approach that provides professionally led counseling services to a family for the purpose of decreasing maladaptive family functioning and negative behaviors, and increasing skills for healthy family interaction.

Federal Agencies - A number of Federal agencies sponsor drug abuse prevention and treatment programs. These include various agencies of the Departments of Defense, Education, Health and Human Services, Housing and Urban Development, Justice, Labor, State, Transportation, and Veterans Affairs. Overseeing and coordinating these efforts is the Office of National Drug Control Policy (ONDCP), which is part of the Executive Office of the President. All these agencies are listed separately in this glossary, and links are provided to more information about them.

Fidelity - Agreement (concordance) of a replicated program model or strategy with the specification of the original.

On a continuum of high to low, where high represents the closest adherence to the developer's design, the degree of fit between the developer-defined components of a substance abuse prevention intervention and its actual implementation in a given organizational or community setting. In operational terms, the rigor with which an intervention adheres to the developer's model (*Achieving Outcomes*, 12/01).

Fidelity/Adaptation Balance - A dynamic process that addresses both the need for fidelity to the original program model and the demonstrable need for local adaptation (*Achieving Outcomes*, 12/01).

Final Outcomes - Outcomes inferred from the change as measured between the baseline descriptions of the substance abuse problem (for the people, places, or policies that are the focus of the intervention) and the results, using the same measures, at the completion of the intervention (*Achieving Outcomes*, 12/01).

Focus Group - A representative group of people questioned together about their opinions, usually in a controlled setting. Focus groups are widely used as a method of gathering qualitative data. When created and implemented skillfully, they can bring an evaluator or evaluation team "inside" the issue of interest (*Achieving Outcomes,* 12/01).

Formal Community Teams - Formalized community organizations concerned with fostering common interests and advocacy for prevention services. Examples are regular and ongoing participation in interagency councils or multiagency task forces, alliances, coalitions and groupings of citizens (including youth) that promote healthy communities, families, schools and activities.

Foundations - Private foundations, both regional and national, are an important source of funding for substance abuse prevention programs. For information about grants from foundations in the area of substance abuse prevention, see ONDCP's funding resources.

Framework - A general structure supporting the development of theory.

Full-Service Employee Assistance Program (EAP) - A comprehensive EAP with a human resource management consultation orientation; typically well-funded and well-staffed; most are offered internally. (See also Employee Assistance Program, above.)

Gatekeeper Model - A situation in which a primary care provider, the "gatekeeper," serves as the consumer's contact for healthcare and referrals. Also called *closed access* or *closed panel*.

Gay, Lesbian, and Bisexual Persons - Research shows that this group is at increased risk for substance abuse problems, yet many existing prevention programs do not meet their needs. For information about effective prevention and treatment programs targeting gays, lesbians, and bisexuals, see *Celebrating the Pride and Diversity Among and Within the Lesbian, Gay, Bisexual, and Transgender Populations*, *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*, and the *CSAP Substance Abuse Resource Guide: Lesbian, Gay, Bisexual, and Transgender Populations*.

Gays/Lesbians - Individuals who identify themselves as emotionally and sexually attracted to others of the same gender.

General Population - Youth and adult citizens of a State rather than a specific group within the general population.

Generalizabilty - The extent to which the positive or negative findings produced by specific interventions under specified conditions can be expected to produce the same findings in future efforts in different settings with different populations (*Achieving Outcomes*, 12/01).

Geographic Information System (GIS) - A Geographic Information System (GIS) is software that can graphically present any type of data that is associated with a geographic reference. It can help you map substance abuse risks and prevention priority locations. A demographic data example could be average family income levels (with levels indicated by different colors) displayed on geographic area maps such as census tracts, counties, or States. See the Geographic Information System Tool, located in the Assessment module.

Goal - The clearly stated, specific, measurable outcome(s) or change(s) that can be reasonably expected at the conclusion of a methodically selected intervention (*Achieving Outcomes*, 12/01).

Government Performance and Results Act of 1993 (GPRA) - The purposes of this Act are to improve the confidence of the American people in the capability of the Federal Government by systematically holding Federal agencies accountable for achieving program results; to initiate reform with a series of pilot projects in setting program goals, measuring program performance against those goals, and reporting pubicly on their progress; to improve Federal program effectiveness and public accountability by promoting a new focus on results, service quality, and customer satisfaction; to help Federal managers improve service delivery by requiring that they plan for meeting program objectives, and by providing them with information about program results and service quality; to improve congressional decisionmaking by providing more objective information on achieving statutory objectives and on the relative effectiveness and efficiency of Federal programs and spending; and to improve internal management of the Federal Government. Agencies must set specific GPRA goals each year and report on progress in attaining them.

Government/Elected Officials - Individuals holding government positions, including those who have been elected to public office. Examples are government workers, mayors, city administrators, city or county commissioners, supervisors, freeholders, or other elected officials, State legislators and staff, and members of the U.S. Congress and their legislative staff.

Grant Funding Announcement/Application (GFA) - Federal agencies periodically describe the types of programs and projects for which they intend to award grants, and publish these announcements in the *Federal Register* and other publications. See the Office of Justice Program's Resource Guide for a current list of GFAs in substance abuse prevention. For a list of public- and private-sector drug control grants, refer to ONDCP's funding resource page.

Group Description and Sampling Information - A brief description of the population being studied or surveyed. This description would usually include population size and demographic and socioeconomic characteristics. Information on sampling methods would

include percentage of the population studied or surveyed, variables considered, and steps taken to assure that any sample less than 100% is representative.

Group Model HMO - A healthcare model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for the care of their patients.

Group Name - The name of the group from which you are collecting data.

Hallucinogens - Substances that distort the perception of objective reality. The most well-known hallucinogens include phencyclidine (PCP, or angel dust); lysergic acid diethylamide (LSD, or acid); mescaline; peyote; and psilocybin, or "magic" mushrooms. Reactions to hallucinogens include increased heart rate and blood pressure, sleeplessness and tremors, lack of coordination, incoherent speech, decreased awareness of touch and pain, convulsions, coma, heart and lung failure, a sense of distance and estrangement, depression, anxiety, paranoia, violent behavior, confusion, suspicion, loss of control, flashbacks, behavior similar to schizophrenic psychosis, and catatonic syndrome.

Health Belief Model (Theory) - Addresses a person's perception of the threat of a health problem and the appraisal of a recommended behavior for preventing or managing the problem. The model can be used to understand why people do or do not adhere to preventive health care recommendations and services. The main concepts include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy.

Rosenstock, I.M. (1990). The health belief model: Explaining health behavior through expectancies. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (pp. 39-62). San Francisco, CA: Jossey-Bass.

Health Education - Health education in schools can include an alcohol, tobacco, and drug educational program that teaches students about the dangers and risks associated with their use, fostering a more accurate perception of norms than they may receive from the media or peers.

Health Fair - Generally, a school or community-focused gathering, such as a carnival or bazaar, traditionally held for barter or sale of goods, often for charity. These events offer an opportunity to disseminate materials and information on substance abuse prevention and health-related issues. Examples are school health promotion gatherings, health screening programs in shopping malls, church fairs, or carnivals.

Health Insurance - Protection that provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, regular medical expense insurance, and accidental death and dismemberment insurance.

Health Insurance Organization (HIO) - HIOs act as fiscal intermediaries between State Medicaid agencies and healthcare providers. They receive a per capita payment from a Medicaid agency to finance the care of Medicaid enrollees. As with HMOs, they assume the risk of a loss if the payment is inadequate to cover a beneficiary's healthcare expenses. Unlike HMOs, however, HIOs typically do not deliver care. Since 1985, Congress has subjected HIOs engaged in full-risk contracting to the same regulatory standards as HMOs.

HIOs that do not offer a comprehensive set of services, however, face fewer regulatory requirements. States contracting with HIOs for a less-than-comprehensive set of services must only address such issues as the term of the capitation arrangement, renegotiation, and distribution of shared savings.

Health Maintenance Organization (HMO) - An organized system of healthcare that provides a comprehensive range of healthcare services to a voluntarily enrolled population in a geographic area on a primarily prepaid and fixed periodic basis. An HMO contracts with healthcare providers, e.g., physicians, hospitals, and other health professionals. Plan members are required to use participating providers for all health services. Model types include staff, group practice, network, and IPA.

Under the Federal HMO Act, an entity must have three characteristics in order to call itself an HMO:
1. An organized system for providing healthcare services
2. An agreed-upon set of basic supplemental health and treatment services
3. A voluntarily enrolled group of people.

Health Plan Employer Data and Information Set (HEDIS) - A set of performance measures designed to standardize the way health plans report data to payers. HEDIS currently measures five major areas of health plan performance: (1) quality, (2) access and patient satisfaction, (3) membership utilization, (4) finance, and (5) descriptive information on health plan management. HEDIS guidelines are published by HCFA, which oversees federally funded healthcare.

Health Policy Changes - Health policy interventions can be used to affect the social, economic, and regulatory environments as they affect substance abuse. These policies attempt to change the environment in such a way that substances become less available and/or more expensive. Such interventions include formal changes in laws, as well as changes in institutions (e.g., schools, law enforcement agencies, retail establishments, or families). Policy interventions also change norms, values, and expectations so that they are less supportive of substance use behaviors that result in health and social problems.

Health Professionals - Individuals employed by or volunteering for health care services. Examples are physicians, nurses, medical social workers, medical support personnel, medical technicians, and public health personnel.

Health Promotion - A wide array of services and methods for dissemination of information intended to educate individuals, schools, families, and communities about specific substance abuse and health-related risks, risk-reduction activities, and other activities to promote positive and healthy lifestyles. Examples are dissemination of materials at health education programs, health screening services, and the airing of substance abuse prevention video tapes at fairs and similar events.

Health Promotion Program - In the worksite, a program designed to improve employee health and productivity and to save the company money.

Health System Descriptors - Key words that describe health systems such as hospitals and patient care.

Healthcare Delivery Systems - Healthcare delivery systems refer to how health services are delivered to patients.

Healthy People 2010 - Healthy People 2010 is the prevention framework for the Nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. This framework was established with a great deal of input from public and private organizations, and will be carefully monitored throughout the present decade. A number of prevention goals have been established with respect to substance abuse. (See the Healthy People 2010 Web site for more information.)

Heavy Drinker - Someone who reports having five or more drinks on five or more occasions in the past 30 days. A form of alcohol abuse.

Heroin - Heroin is an illegal opiate drug. It is highly addictive as users find that they have a need for persistent, repeated use of the drug (known as craving) and that their attempts to stop using the drug lead to significant and painful physical withdrawal symptoms. Use of heroin causes physical and psychological problems such as shallow breathing, nausea, panic, insomnia, and a need for increasingly higher doses of the drug to get the same effect. Heroin is so addictive because it activates many regions of the brain, particularly the regions that are responsible for producing both the pleasurable sensation of "reward" and physical dependence. Together, these actions account for the user's loss of control and the drug's habit-forming action. Heroin is a drug that is primarily taken by injection (a shot) with a needle in the vein. This form of use is called intravenous injection or IV injection, and can have grave consequences. Uncertain dosage levels (due to differences in purity), the use of unsterile equipment, the sharing of needles with infected persons, the contamination of heroin with cutting agents, or the use of heroin in combination with such other drugs as alcohol or cocaine can cause serious health problems such as serum hepatitis, HIV/AIDS, skin abscesses, inflammation of the veins, and cardiac disease (subacute bacterial endocarditis). Of great importance, however, is that the user never knows whether the next dose will be unusually potent, leading to overdose, coma, and possible death. (See Prevline's heroin-related publications.)

HHS Certified Laboratory - The term used to describe a laboratory that is certified by the Department of Health and Human Services and that participates in the National Laboratory Certification Program.

High Risk Youth (HRY) Grant Program - The initial HRY program, started in 1987, was CSAP's first knowledge development program undertaken to prevent substance abuse and associated problems among high risk youth. Many grants tested the most effective models of prevention with ethnic youth, and recently the program strove to increase the number of adults helping to educate youth about the dangers of drug use. A current project, Project Youth Connect, is demonstrating mentoring and advocacy models for youth ages 9-15 and their families. The project builds on knowledge gained from previous programs that school bonding and academic performance, as well as life management skills and family bonding, are important to prevent or reduce substance abuse.

Compiling and disseminating the results of HRY program evaluations are viewed as important steps for CSAP, both to promote the effectiveness of substance abuse prevention programming and to disseminate the models and intervention strategies that proved most successful. Data collected by CSAP adds to the growing professional literature, offering a rich body of research on risk factors for substance use and abuse among children, youth, and young adults.

Recently, results from the HRY cross-site study revealed new findings about factors either placing youth at risk or protecting them. HRY grants have also been used to help analyze why youths use tobacco, alcohol, and drugs.

Current emphases of the HRY program include focus on an even higher risk group of youth (children of substance abusers, siblings of youth in the juvenile justice system, female school drop outs, and homeless youth). (For more information, visit the National Cross-Site Evaluation of High-Risk Youth Programs.)

High School Students - Youth enrolled in public or private high schools (generally grades 10 through 12) and home-study youth in these grades.

High-Risk Youth (HRY) Databank - The HRY Databank is an evaluation-oriented information system with a comprehensive, unifying framework. It has four information components: (1) descriptive information (e.g., location, number, and types of sites, settings, and population demographics); (2) compilations of specific interventions (prevention strategies); (3) formal characterization of the evaluation methods used; and (4) objective ratings of both strength (direction and magnitude) and credibility of findings. To date, seven programs have been identified as effective/model programs and have agreed to be part of this dissemination effort. They successfully underwent the HRY screening process, which involves gaining expert consensus on the quality of program implementation, evaluation methodology, and effectiveness. Although the seven programs differed in terms of participants' age groups, economic and ethnic backgrounds, and community settings, they all focused on building caring and supportive relationships. They are: Across Ages, SMART Leaders, Child Development Project, Dare To Be You, Creating Lasting Connections, FAN Club, and Residential Student Assistance Program. (For more information, see the National Cross-Site Evaluation of High-Risk Youth Programs.)

Hispanic/Latino - Once thought of as a hard-to-reach population, Hispanic/Latinos are now recognized as highly accessible and the fastest-growing segment of the population. Those developing prevention initiatives should recognize that this group has many subgroups such as Mexican Americans, Puerto Ricans, Central Americans, South Americans, and Cubans, and includes a large proportion of young people. Moreover, Hispanics/Latinos place high importance on the family, although they may also experience conflict between generations related to differences in acculturation. Hispanic/Latino youth are at higher risk for teen pregnancy and juvenile incarceration than youth in the general population. Hispanic/Latino children are exposed at an early age to substance use. Prevention practitioners must appreciate the diversity of subgroups in a geographic area, the evolving values and norms concerning substance use, shifts in family structure and religious affiliation, and changes in attitude toward substance use. (See also *A Hispanic/Latino Family Approach to Substance Abuse Prevention*, Jose Szapocznik (Ed.), CSAP Cultural Competence Series 2, 1994; and CSAP's *Substance Abuse Resource Guide: Hispanic/Latino Americans*.

HIV/AIDS Prevention - The link between the human immunodeficiency virus (HIV), which causes AIDS, and intravenous drug use is well known. Also, there is a link between non-injectable substances, such as alcohol and crack, and unsafe sexual activity that can result in the spread of HIV. Prevention workers are challenged to develop programs to reach those at risk for contracting HIV through the deadly combination of drug use and unsafe sex, namely teenagers, young adults, and homosexuals. Outreach efforts to identify injected drug users and encourage them to enter treatment is an important part of AIDS prevention, as is the more controversial strategy of supplying injected drug users with clean needles.

A particular focus of CSAP is the Substance Abuse Prevention and HIV/AIDS Prevention Initiative for Youth and Women of Color, which builds capacity in communities with the highest incidence rates. This initiative provides funds to community-based organizations, Historical Black Colleges and Universities, Hispanic Colleges and Universities, faith communities, and other entities. The initiative seeks to strengthen the integration of substance abuse and HIV prevention services at the local level, and provide integrated services to African American youth and women of color.

For more information, see NCADI's resources for HIV/AIDS prevention.

Homeless/Runaway Youth - Youth and adults who do not have a stable residence or who have fled their primary residence. Examples are street youth and adults, youth and adults in homeless shelters, and youth in unsupervised living situations.

Horizontal Integration - Merging of two or more firms at the same level of production in some formal, legal relationship. In hospital networks, this integration may refer to the grouping of several hospitals, the grouping of outpatient clinics within the hospital, or a geographic network of various healthcare services. Integrated systems seek to integrate vertically with some organizations and horizontally with others.

Host - In the Public Health Model, the host is the individual affected by the health problem. In the case of substance abuse, the host is the potential or active user of drugs.

Human Capacity/Resources - The collective knowledge, attitudes, motivation, and skills of the program implementers and other stakeholders (*Achieving Outcomes*, 12/01).

Hypothesis - A statement regarding the relationship between two variables. In evaluation research, this typically involves a prediction that the program or treatment will cause a specified outcome. Hypotheses are confirmed or denied based on empirical analysis.

ICD-10-CM - A standardized system of codes describing diagnoses developed and maintained by the World Health Organization. The full name is *International Classification of Diseases, 10th Revision.*

Ice - Slang term for smokable methamphetamine. Methamphetamine can be prepared so that it will produce a gas vapor when heated at relatively low temperatures. When smoked, ice produces an extremely potent and long-lasting euphoria and an extended period of high energy and possible agitation, followed by an extended period of deep depression.

Illegal Drugs - Refers to drug use. For example, an underage person who buys or possesses alcohol, a licit drug, is doing so illegally. But, it is illegal for anyone to buy or have marijuana, an illicit drug.

Illicit - Refers to drugs themselves. All illegal drugs are illicit, but alcohol and tobacco may be either licit or illicit, depending on whether they are used legally or illegally.

Immediate Outcome - The initial change in a sequence of changes expected to occur as a result of implementation of a science-based program (*Achieving Outcomes*, 12/01).

Impact - The long-term effect and/or influence of the intervention on the conditions described in baseline data. *(Achieving Outcomes, Dec. 2001)*

Impact Evaluation - A type of outcome evaluation that focuses on the broad, long-term impacts or results of program activities (e.g., an impact evaluation could show that a decrease in a community's crime rate is the direct result of a program designed to provide community policing).

Impaired Driving - Impaired driving is the joint occurrence of (1) driving a vehicle and (2) having a BAC of 0.1 (0.08 in some States) or greater or being under the influence of some other psychoactive substance. Driving while impaired by alcohol or other substances is a major problem among American youth and older drivers. Tools for fighting the problem include preventing under-age purchases of alcohol, zero tolerance policies, and graduated licensing. See *Impaired Driving Among Youth: Trends and Tools for Prevention* (1999, CSAP, 34 pp. MS665).

Implementation Assessment - In general, this term is used as a synonym for process evaluation. Process evaluation focuses on how a program was implemented and operates.

Implementation Plan - As used in the Prevention Works! Achieving Outcomes Guide, a planning tool for the program manager. Developing such a plan enables the program manager to gain control by identifying the functional and specialized requirements of the carefully chosen intervention; to pull together the team that must work together to produce a whole -- without gaps, friction, or unnecessary duplication of effort; and to identify performance expectations for each of the program components. The plan need not be more detailed than that required by the program manager to establish initial direction and clarity of vision for the implementation group *(Achieving Outcomes*, Dec. 2001).

Imputation - The process of replacing missing data. May be done logically (based on other existing data) or with statistical techniques based on variables that are correlated with the variable and the missing data.

Incidence - A measure of the number of people (often in a defined population) who have initiated a behavior--in this case drug, alcohol, or tobacco use--during a specific period of time. The measure's special value is that it identifies new users to be compared to the number of new users historically, over comparable periods of time (*Achieving Outcomes*, 12/01).

In epidemiology, incidence generally refers to **new cases** observed during 1 year's time.

Incremental Net Benefit Value - The difference in the inflation-adjusted, discounted average benefits and costs of two alternative programs.

Incremental Cost-Effectiveness Ratio - The difference in the inflation-adjusted, discounted average costs of two programs, divided by the difference in discounted average levels of effectiveness of the two programs.

Indicated Preventive Interventions - Strategies designed for persons who are identified as having minimal but detectable signs or symptoms or precursors of some illness or condition, but whose condition is below the threshold of a formal diagnosis of the condition.

Indicator - A variable that relates directly to some part of a program goal or objective. Positive change on an indicator is presumed to indicate progress in accomplishing the larger program objective. For example, a program may aim to reduce drinking among teens. An

indicator of progress could be a reduction in the number of drunk driving arrests or the number of teens found to be drinking underage in clubs. It can also be a substitute measure for a concept that is not directly observable or measurable (e.g., prejudice, substance abuse). For example, an indicator of "substance abuse" could be "rate of emergency room admissions for drug overdose." Because of the imperfect fit between indicators and concepts, it is better to rely on several indicators rather than just one when measuring this type of concept (*Achieving Outcomes*, 12/01).

Individual Practice Association (IPA) Model HMO - A healthcare model that contracts with an entity, which in turn contracts with physicians, to provide healthcare services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.

Individual-Centered Approach - A prevention approach that focuses on the problems and needs of the individual.

Information Dissemination - One of the six prevention strategies mandated by the SAPT Block Grant. This strategy focuses on building awareness and knowledge of the nature and extent of substance use, abuse and addiction, and their effects on individuals, families, and communities, as well as dissemination of information about prevention programs and resources. The strategy is characterized by one-way communication from source to audience, with limited contact between the two. Examples include clearinghouses, resource directories, media campaigns, speaking engagements, and health fairs.

Innovate - To develop a new program or environmental intervention according to a systematic approach that includes needs and resources assessment, capacity review and development, rigorous implementation, and thorough evaluation involving control groups.

Innovation - An innovation is an idea, practice, or object that is perceived as new by an individual or group.

Institute of Medicine - As part of the National Academy of Sciences, the mission of the Institute of Medicine (IOM) is to advance and disseminate scientific knowledge to improve human health. The IOM is a private, non-governmental organization and does not receive direct Federal funding. The Institute provides objective, timely, authoritative information and advice concerning health and science policy to government, the corporate sector, the professions, and the public. The IOM process establishes it as an independent body, with most reports authored by unpaid volunteer experts. Each report must go through a rigorous and formal peer review process. Findings and recommendations must be evidence-based whenever possible and otherwise noted as expert opinions. IOM has published a number of landmark studies of prevention, including *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* , edited by Patricia J. Mrazek and Robert J. Haggerty, Committee on Prevention of Mental Disorders. In this publication, IOM came up with a new classification of prevention programs as universal, selected, and indicated. (See also "prevention types.")

Instrument - An ordered set of measures or a device researchers use to collect data in organized fashion, such as a standardized survey or interview protocol.

Intangible Costs - Costs that cannot be measured in monetary terms, such as changes in quality of life.

Integrated Health Plan - A single entity serving as an integrated delivery network that is fully responsible for obtaining and managing payer contracts, assuming healthcare risk, collecting revenue, and controlling assets by lease or ownership.

Integrated Service Delivery and System - A generic term referring to a joint effort of physician/hospital integration for a variety of purposes. It also refers to a system of providers and diverse organizations working collaboratively to coordinate a full range of care and services within a community.

Integration - A concept describing how previously separate organizations, functions, and/or caregivers are blending their services and operations to function more efficiently and effectively in offering a seamless system of care within which consumers can easily move.

Integrity - The level of credibility of study findings based on peer consensus ratings of quality of implementation and of evaluation methods.

Intent-to-Treat Design - An evaluation design in which analyses are conducted upon the basis of a treatment or comparison group assigned or chosen at baseline, regardless of how long observations remained in that group.

Intermediate Outcomes - In a sequence of changes expected to occur in a science-based program, the changes that are measured at program completion. Depending on the theory of change guiding the intervention, an intermediate outcome in one intervention may be an immediate or final outcome in another. See also "Outcomes" (*Achieving Outcomes*, Dec. 2001).

Internal Rate of Return - The discount rate associated with a net present value figure of $0. Programs with higher internal rates of return are more economically attractive.

Internal Validity - Refers to the ability to make statements about causal relationships between variables. Internal validity threats may diminish the truthfulness of those statements.

International Classification of Diseases, Ninth Revision (ICD-9) - The ICD-9 system is a classification system that groups related disease entities and procedures for the reporting of statistical information. Responsibility for maintenance of the classification system is shared between the National Center for Health Statistics (NCHS), which handles diagnosis classification, and the Health Care Financing Administration (HCFA), which handles procedure classification.

Intervention - An activity or set of activities to which a group is exposed in order to change the group's behavior. In substance abuse prevention, interventions are used to prevent or lower the rate of substance abuse or substance abuse-related problems.

Item - A question or query accompanied by a response measurement system.

Key Informant Interview - Interview with a member of, or someone who is knowledgeable about, the social phenomena you wish to study.

Knowledge Development and Application Programs - A comprehensive portfolio of CSAP programs intended to develop and facilitate use of knowledge generated from

prevention theory, methods development, controlled trials, and other avenues of inquiry. These programs help to bridge the gap between research and practice. Programs include the Developmental Predictor Variables Study; Starting Early/Starting Smart; Children of Substance Abusing Parents; Parenting Adolescents and Welfare Reform; Aging, Mental Health, and Substance Abuse in Primary Care; Workplace and Managed Care; Community-Initiated Prevention Interventions; Alcohol and Youth Studies; Strengthening Families; and Women and Violence. (For more information, see the SAMHSA/CSAP Budget Justification for the current fiscal year.

Law Enforcement/Military - Individuals employed in law enforcement agencies or in one of the U.S. Armed Services. Examples are police, sheriffs, State law enforcement personnel and members of the National Guard, Army, Navy, Marines, Air Force, and Coast Guard.

Lead Agency - The organization responsible for fiscal management and performance accountability (*Achieving Outcomes*, Dec. 2001).

Legal Problems - Result of alcohol and other drug problems. Alcohol and other drug abusers are at a higher risk for engaging in illegal activity. These behaviors may result in arrest and other problems with the criminal justice system. Examples of legal problems include driving while intoxicated, writing bad checks to obtain money for drugs, failing to pay bills and credit card debts, and being arrested for drug-related violence.

Licit Drugs - Drugs that are legal to use, such as medicines and alcohol and tobacco. Note that it is possible to misuse a licit drug, as occurs with some prescription drugs and when tobacco and alcohol are used by underage persons.

Locality Development (Theory) - A component of community organization that is also known as community development. This community change model involves a selection of people from the community to help identify and solve local problems. Some of the areas that are examined include consensus development, capacity building, and task orientation.

Rothman, J., and Tropman, J.E. (1987). Models of community organization and macro practice: Their mixing and phasing. In F.M. Cox, J.L. Ehrlich, J. Rothman, and J.E. Tropman (Eds.), *Strategies of Community Organization,* (4th ed.). Itasca, IL: Peacock.

Logic Model - A graphic depiction of the components of a theory, program, initiative, or activity that shows the program's components and plausible linkages between the program components. See also "Program Logic Model" and "Component Logic Model" for two types of logic models used by the Prevention Works! Achieving Outcomes Guide (*Achieving Outcomes*, Dec. 2001).

Long-Term Disability Expenditures - Includes salary continuation payments for those covered by insured, self-administered, or trust plans (Source: U.S. Chamber of Commerce definition, 1995).

Long-term Outcomes - Over time, the change(s) that result from the program or intervention.

Mainstream - A term that is often used to describe the "general market," which generally refers to a broad population that is primarily white and middle class.

Managed Behavioral Health Care - Any of a variety of strategies to control behavioral health (i.e., mental health and substance abuse) costs while ensuring quality care and appropriate utilization. Cost-containment and quality assurance methods include the formation of preferred provider networks, gatekeeping (or precertification), case management, relapse prevention, retrospective review, claims payment, and others. In many employer-negotiated health plans, behavioral healthcare is separated from care available in the rest of the health plan for the separate management of costs and quality of care.

Managed Behavioral Health Care Organizations (MBHO) - An organized system of behavioral healthcare delivery, usually to a defined population or members of HMOs, PPOs, and other managed care structures; also known as a behavioral health carve-out.

Managed Care - For Workplace Managed Care definitional purposes, managed care includes the following four characteristics: (1) a network of healthcare providers operating within some degree of management control; (2) assumption of financial risk by the provider network or health benefit intermediary; (3) management of service utilization through guidelines, protocols, and case management techniques; and (4) provision of preventive care.

Managed Care and Prevention - Prevention and managed care organizations agree that substance abuse is a devastating problem that adversely impacts our children, family members, communities, and our country. We can collaborate within this mutual agreement. The field of prevention has come of age and is ready to move into new alliances and collaborations that will reinforce the importance and credibility of the profession. Prevention professionals should understand that their skills and leadership are essential to complete the evolutionary cycle from managing health care costs to managing the health of our citizens. (For more information, see SAMHSA's Managed Care Initiative site.)

Managed Care Organization (MCO) - A generic term applied to a managed care plan; may be in the form of an HMO, PHO, PPO, EPO, or other structure.

Managed Healthcare Plan - A healthcare plan that integrates financing and management with the delivery of healthcare services to an enrolled population; employs or contracts with an organized provider network that delivers services and which (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; and uses an information system capable of monitoring and evaluating patterns of covered persons' use of healthcare services and the cost of those services.

Management Services Organization (MSO) - An organization that provides practice management, administration, and support services to individual physicians or group practices. MSOs are typically owned by hospital(s) or investors.

Mandatory Guidelines - In drug testing, the term used to refer to the Mandatory Guidelines for Federal Workplace Drug Testing Programs initially published in the *Federal Register* on April 11, 1988, and revised on June 9, 1994, to establish the scientific and technical guidelines for Federal drug testing programs.

Marijuana - Most commonly used illicit drug, especially among youth. Nearly one quarter of 8th graders and about half of all high school seniors have tried marijuana. Youthful attitudes toward and behavior concerning marijuana are important predictors of drug abuse trends for the Nation. Marijuana is a harmful drug, with more serious consequences now that the

potency of available marijuana has increased enormously during the past decade. These consequences include chronic lung disease, impairment of memory, distortion of perception, hampering of judgement, and diminishing of motor skills. Long- and short-term development of children and adolescents may be affected by marijuana use. Observers of marijuana users have noted mood changes, apathy, loss of ambition, diminished ability to carry out plans, difficulty in concentrating, and decline in school or work performance. Driving under the influence of marijuana is dangerous. (For more information, see NCADI's marijuana-related publications.)

Materials Development - The creation of original documents and other educational pieces for use in information dissemination activities related to substance abuse and its effects on individuals, schools, families, and communities. Services under this category include audiovisual materials, printed materials, curricula, newsletters, public service announcements, and resource directories as follows: (1) Audiovisual material (prevention material involving both hearing and sight such as videotapes and films); (2) printed material (written materials designed to inform individuals, schools, families, and communities about the effects of substance abuse and available prevention approaches and services) i.e., brochures, flyers, factsheets, posters, pamphlets, prevention plans; (3) curriculum (a course of study in prevention); (4) newsletter (a report giving prevention news or information of interest to a particular group); (5) public service announcement (PSA) (a media message or campaign, usually less than five minutes long and provided through public airways at no charge, designed to inform and educate audiences concerning substance abuse and its effects on individuals, schools, families and communities. Examples are television PSA's, radio PSA's and no-charge newspaper advertisements and announcements; (5) resource directory (a list of substance abuse and related programs and services in a particular community, county or State. Examples include State services resource directory, community services resource directory, certification directory, and training course directory.

Materials Dissemination - Distribution of written and audiovisual prevention information. Examples are providing handouts for a speaking engagement or providing materials for health fairs. Products included in the category are defined under Materials Development. Services under this category are audiovisual material, printed material, curriculum, newsletter, public service announcement, and resource directory.

Maternal and Child Health Programs (MCHP) - A State service organization to assist children under 21 years of age who have conditions leading to health problems.

MDMA - Short for methylenedioxymethamphetamine, MDMA is an amphetamine derivative long known to be neurotoxic in animals. In recent years use of the drug has been on the rise, in part because of the popularity of large, organized, all-night social gatherings known as "raves." Many young adults who use the drug take doses similar to those that cause brain damage in animals. MDMA use has been reported most frequently among young adults and adolescents at clubs, raves, and rock concerts in Atlanta, Miami, St. Louis, Seattle, and areas of Texas. In 1996, NIDA and the University of Michigan Institute for Social Research began collecting data on MDMA use among 8th, 10th, and 12th graders. Rates of use remained relatively stable from 1996 to 1997. In 1997, 6.9 percent of 8th graders had used MDMA at least once in their lives. (For more information, see the NIDA Research Report Series, *Methamphetamine Abuse and Addiction*.)

MDS3 - A portable component of this site's Evaluation module that States use to quantify delivery of prevention services as part of their State Block Grant reporting. MDS3 quantifies

and reports the numbers of participants in different types of preventive interventions and supporting activities.

Measure - An assessment item or ordered set of items (see Outcome Measure and Process Measure). Measures are the tools used to obtain the information or evidence needed to answer a research question. They are similar to indicators, but more concrete and specific. Often an indicator will have multiple measures. Indicators are statements about what will be measured; measures answer the question exactly how will it be measured.

Measure and Instrument Repository - The Evaluation module's storehouse of measures and instruments. It contains SAMHSA's National Outcome Measures for substance abuse prevention, substance abuse treatment, and mental health treatment.

Media - Although they have often exacerbated substance abuse problems in the past, the media can just as easily function as an important part of the prevention effort. Media campaigns are a powerful and effective way of getting out prevention messages to general and specific audiences, and are even more effective when followed up by hands-on local programs that keep providing messages and other prevention services. Some ongoing media programs in prevention include the ONDCP National Youth Anti-Drug Media Campaign, the CSAP-sponsored "Parents. The Anti-Drug" Campaign, and the Your Time-Their Future Campaign.

Media Advocacy (Theory) - This theoretical and innovative approach aggressively promotes health awareness and policy changes with the aid of mass media. This approach increases public concern, improves response to public health issues, and is often used in community models.

Glanz, K. & Rimer, B.K., (Eds.). (1997) *Theory at a Glance: A Guide for Health Promotion Practice.* National Institutes of Health, National Cancer Institute (NIH Publication No. 97-3896).

Media Campaigns - Structured activities that use print and broadcast media to deliver prevention information or health promotion messages relative to substance abuse. In contrast with PSAs, campaign messages are usually more than five minutes long. Examples include media promotion of Red Ribbon, Project Graduation, or other similar events; printing of ads with "no-use" messages; distribution of signs to stores and businesses; distribution of bumper stickers, posters, etc.; use of national substance abuse prevention media materials tagged to a state or community (e.g., Partnership for a Drug-Free America); and prevention ads and messages in newspapers.

Mediating - A term that describes a third variable's relationship to a dependent and an independent variable, in which the third variable represents the generative mechanism through which the independent variable is able to influence the dependent variable of interest. A variable functions as a mediator when it meets the following criteria: (1) variations in the levels of the independent variable significantly account for variations in the presumed mediator; (2) variations in the mediator significantly account for variations in the dependent variable; and (3) a previously significant relationship between the independent and the dependent variable is lost or greatly attenuated when the variance accounted for by the independent/mediator relationship is removed.

Medical Necessity - The evaluation of healthcare services to determine if they are medically appropriate and necessary to meet basic health needs, consistent with the

diagnosis or condition and rendered in a cost-effective manner, and consistent with national medical practice guidelines regarding type, frequency, and duration of treatment.

Medical Review Officer - In drug testing, a licensed medical doctor specially trained in substance abuse who is responsible for receiving, interpreting, and evaluating drug test results.

Member Assistance Program - A human risk management program that focuses on lowering behavioral and healthcare costs by proactively reducing demand for treatment. Also known as "demand reduction" or "demand management program."

Memorandum for Record (MFR) - In drug testing, a statement prepared by an individual that provides or corrects information on any documents associated with a drug test.

Mentoring - A mentoring program exposes youth to positive adult role models and encourages high academic and professional standards. Activities may include tutoring, recreational activities, attending sporting or cultural events, and performing community service.

Methodology - A procedure for collecting and analyzing data.

Middle/Junior High School Students - Youth enrolled in public or private middle schools or junior high schools including grades 6 through 8, 6 through 9, or 7 through 9, sixth grade and seventh grade centers, and home study youth in comparable grades.

Minimum Data Set - Terms used to describe an agreed upon collection of measures to be collected as the core of a cross-site or multi-State evaluation plan (see MDS3).

Misuse - Occurs when people of legal age use legal substances in a harmful way.

Mobilization - As used in the Achieving Outcomes Guide, the process of bringing together and putting into action volunteers, community stakeholders, staff, and/or other resources in support of one or more prevention initiatives (*Achieving Outcomes*, 12/01).

Model Program - In CSAP's terminology, model programs have all of the positive characteristics of effective programs with the added benefit that program developers have agreed to participate in CSAP-sponsored training, technical assistance, and dissemination efforts (*Achieving Outcomes*, 12/01).

Moderating - A term that describes a third variable's relationship to a dependent and an independent variable, in which the third variable partitions the independent variable into subgroups that establish its domains of maximal effectiveness in regard to the dependent variable. The moderator may be qualitative or quantitative, and it affects the direction and/or strength of the relation between the independent and the dependent variable. Within an ANOVA framework, the moderator effect can be represented as an interaction between an independent variable and a factor that specifies particular conditions for its effect.

Monitoring the Future (MTF) - Monitoring the Future is a national survey of American secondary school students conducted annually in the spring of the year by University of Michigan scientists and sponsored by the National Institute on Drug Abuse. A nationally representative sample of students in the 8th, 10th, and 12th grades is studied. In 1999,

more than 45,000 students in 433 schools across the Nation participated. The 1999 survey marked the third year in a row that overall drug use among teenagers has declined or stayed level in all categories: lifetime, past year, and past month use. Slight increases were reported in use of MDMA (ecstasy) among 10th and 12th graders, decreases in use of crack cocaine among 8th and 10th graders, and increase in use of steroids among 8th and 10th graders.

Morbidity - Any subjective or objective departure from a state of physiological or psychological well-being. (Sickness, illness, and morbid condition are synonyms in this sense.) Also, an actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

Mortality - An actuarial determination of the death rate at each age as determined from prior experience.

Multicomponent Program - A prevention program that simultaneously uses multiple interventions that target one or more substance abuse problems. Programs that involve coordinated multiple interventions are likely to be more effective in achieving the desired goals than single-component programs and programs that involve multiple but uncoordinated interventions.

Multicultural - Intended for or about two or more distinctive cultures.

Name of Group - The descriptive name of the group of individuals who received the prevention service.

National Association of State Alcohol and Drug Abuse Directors (NASADAD) - NASADAD is a national advocacy organization made up of directors of single State agencies for alcohol and drug abuse prevention and treatment.

National Center for the Advancement of Prevention II (NCAP II) - A contract that enables CSAP to develop, synthesize, update, adapt and disseminate state-of-the-art prevention knowledge about what works in prevention, for whom, and under what conditions. NCAP II synthesizes scientific and practice-based prevention knowledge and creates useful activities and products to support decisionmaking by Federal, State, and community substance abuse policymakers, planners, and practitioners. It makes available knowledge-based tools, principles, and models useful for developing prevention plans, making resource allocation decisions, implementing programs, and satisfying demands for public accountability for cost-effective prevention efforts.

National Clearinghouse for Alcohol and Drug Information (NCADI) - The hub of the Federal effort to collect and communicate information about effective prevention and treatment policies, programs, and strategies, and a link to scientific research on substance abuse. NCADI uses multilevel approaches to reach audiences across the U.S., and for more than 10 years has served as a point of entry for comprehensive information services. NCADI now operates 24 hours a day, 7 days a week, in response to interest generated by the ONDCP National Youth Anti-Drug Media Campaign, as well as other CSAP and HHS public education campaigns.

National Committee for Quality Assurance (NCQA) - A national organization founded in 1979 and composed of 14 directors representing consumers, purchasers, and providers of

managed healthcare. It accredits quality assurance programs in prepaid managed healthcare organizations, and develops and coordinates programs for assessing the quality of care and service in the managed care industry.

National Congress for Substance Abuse Prevention - The National Substance Abuse Prevention Congress was the culmination of a series of nine regional meetings during which the prevention field came together to shape the evolving framework of the National Prevention System (NPS) and articulate recommendations to strengthen this partnership. The overarching goal of the National Prevention Congress was to develop a comprehensive, strategic plan designed to articulate a unified national vision of substance abuse prevention and organize NPS priorities.

National Criminal Justice Reference Service (NCJRS) - The National Criminal Justice Reference Service (NCJRS) is one of the world's most extensive sources of information on criminal and juvenile justice, providing services to an international community of policymakers and professionals. NCJRS is a collection of clearinghouses supporting all bureaus of the U.S. Department of Justice, Office of Justice Programs (OJP): the National Institute of Justice (NIJ), the Office of Juvenile Justice and Delinquency Prevention (OJJDP), the Bureau of Justice Statistics (BJS), the Bureau of Justice Assistance (BJA), the Office for Victims of Crime(OVC), and the OJP Program Offices. It also supports the Office of National Drug Control Policy (ONDCP), and has an extensive collection of materials on drugs and crime.

National Drug Control Strategy - (See also "ONDCP," below.) See the 2002 National Drug Control Strategy annual report from ONDCP.

National Household Survey on Drug Abuse (NHSDA) - See **National Survey on Drug Use and Health**.

National Institute of Mental Health (NIMH) - The mission of the National Institute of Mental Health (NIMH) is to diminish the burden of mental illness through research. This public health mandate demands that the institute harness powerful scientific tools to achieve better understanding, treatment and eventually, prevention of mental illness. Through research in basic neuroscience, and behavioral science, and genetics the institute aims to gain an understanding of the fundamental mechanisms underlying thought, emotion, and behavior.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) - NIAAA supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems. NIAAA also provides leadership in the national effort to reduce the severe and often fatal consequences of these problems by: (1) conducting and supporting research directed at determining the causes of alcoholism; (2) discovering how alcohol damages the organs of the body; (3) developing prevention and treatment strategies for application in the Nation's health care system; (4) supporting and conducting research across a wide range of scientific areas including genetics, neuroscience, medical consequences, medication development, prevention, and treatment through the award of grants and within the NIAAA's intramural research program; (5) conducting policy studies that have broad implications for alcohol problem prevention, treatment and rehabilitation activities; (6) conducting epidemiological studies such as national and community surveys to assess risks for and magnitude of alcohol-related problems among various population groups; (7) collaborating with other research institutes and Federal programs relevant to alcohol abuse and alcoholism; (8) providing coordination for Federal

alcohol abuse and alcoholism research activities; (9) maintaining continuing relationships with institutions and professional associations; international, national, state and local officials; and voluntary agencies and organizations engaged in alcohol-related work; and (10) disseminating research findings to health care providers, researchers, policymakers, and the public. NIAAA is one of 18 institutes that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the Federal Government. NIH is a component of the Public Health Service within the Department of Health and Human Services.

National Institute on Drug Abuse (NIDA) - Recent scientific advances have revolutionized our understanding of drug abuse and addiction. The majority of these advances, which have dramatic implications for how to best prevent and treat addiction, have been supported by the National Institute on Drug Abuse (NIDA). NIDA supports more than 85 percent of the world's research on the health aspects of drug abuse and addiction. NIDA-supported science addresses the most fundamental and essential questions about drug abuse, ranging from the molecule to managed care, and from DNA to community outreach research. NIDA is not only seizing upon unprecedented opportunities and technologies to further understand how drugs of abuse affect the brain and behavior, but also is working to ensure the rapid and effective transfer of scientific data to policymakers, drug abuse practitioners, other health care practitioners, and the general public. The scientific knowledge that is generated through NIDA research is a critical element to improving the overall health of the Nation. The Institute's goal is to ensure that science, not ideology or anecdote, forms the foundation for all of our Nation's drug abuse reduction efforts.

National Institutes of Health (NIH) - The National Institutes of Health is an operating division of the Department of Health and Human Services and the umbrella organization for research institutes including NIAAA, NIDA, and NIMH.

National Prevention Network (NPN) - The National Prevention Network (NPN), an organization of State alcohol and other drug abuse prevention representatives and an affiliate of NASADAD, provides a national advocacy and communication system for prevention. State prevention representatives work with their respective State Agency Directors to ensure the provision of high quality and effective alcohol, tobacco, and other drug abuse prevention services in each State. The NPN, in collaboration with the NASADAD Prevention Committee and staff, implements its mission at the national level. NPN's mission is to support and enhance national, State, and local alcohol, tobacco, and other drug abuse prevention efforts that will reduce the incidence and prevalence of such abuse. The NPN believes that prevention is a complex process that requires more than a single strategy or approach. Many factors contribute to alcohol and other drug problems, and prevention is based on the understanding that these factors vary among individuals, geographic regions, age groups, racial/ethnic groups, and gender groups. Effective prevention is a systemic responsibility involving local, State, and national agencies, organizations, and groups, and to the prevention field in general.

National Prevention System (NPS) - The National Prevention System is made up of many public and private organizations with interests, responsibilities, mandates, and activities to reduce substance abuse in America. Local community coalitions, civic groups, youth-serving organizations, employers, and parent groups who engage in substance abuse prevention efforts at the grass roots level constitute the bulk of the system. These local entities are joined by Federal, State, and local governments, businesses, national organizations and advocacy groups. Prevention researchers and providers are also

represented. They include those who are (1) specialists in substance abuse prevention; and (2) practitioners from health and social service organizations who may influence substance abuse behavior or its precursors among their clientele.

National Registry of Effective Programs (NREP) - An effort under development to collect and transfer information on effective substance abuse prevention and treatment as well as mental health methods and models derived from SAMHSA's knowledge development programs. Experts will rate nominated programs on the following criteria: theoretical soundness; fidelity of implementation; quality of the process evaluation; quality of the sampling design and implementation; evidence of sample quality based on information about attrition; operational relevance and psychometric quality of measures used in the evaluation and the quality of supporting evidence; quality and method of data collection; appropriateness and technical adequacy of data analysis; degree to which the evaluation design and implementation addresses and eliminates plausible alternative hypotheses concerning program effects; the overall level of confidence that the reviewer can place in project findings based on research design and implementation; the overall usefulness of project findings for informing prevention theory and practice; the number of replications of the model or cultural, gender, age, or local adaptations of model with similar positive results; and the dissemination of program materials. To search for a program or register your program with NREP, visit CSAP's Prevention Registry.

National Survey - Most often, a data collection effort conducted among a specially selected sample of people, who are, at the least, statistically representative of a larger population or group. National surveys are generally free from regional biases because they cover every region of the country and are typically sponsored by a Federal agency interested in determining national trends on a selected issue (*Achieving Outcomes*, Dec. 2001).

National Survey on Drug Use and Health - This annual survey, formerly known as the National Household Survey on Drug Abuse (NHSDA), is conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey has been the primary source of estimates of the prevalence and incidence of illicit drug, alcohol, and tobacco use in the population since 1971. The survey is based on a nationally representative sample of the civilian, noninstitutionalized population of the United States age 12 years and older. Beginning with the 1999 survey, the sample was expanded from 18,000 to 70,000 respondents. The survey now includes 25,000 youth ages 12-17, and improves the precision of estimates for this age group. The sample size makes it possible to estimate substance use and attitudes among respondents over the age of 55 and for minority groups. (For a full report on the most recent survey, see SAMHSA's National Survey on Drug Use and Health)

NCAPtion Training Guide - These training guides provide scientific and prevention-based knowledge and create useful activities to support decisionmaking by substance abuse prevention practitioners.

Needs Assessment - Needs assessment activities include surveys of various targeted populations and communities, assessment of prevention resources within the State, studies of current outcome indicators, geographic and demographic analyses of social marketing data, and household and school surveys. CSAP has supported 27 States in various needs assessment activities and methodologies for the past 4 years, helping them to target their prevention programming dollars by providing sound data on specific populations and localities, and identifying the distribution of particular risk factors. For more information, see the CSAP State Needs Assessment Profiles (SNAP) database.

The DIADS Assessment is a school-based needs assessment survey developed by the Center for Adolescent Studies, Indiana University.

Net Present Value - The inflation-adjusted, discounted benefits of a program or intervention, minus the inflation-adjusted, discounted costs of producing and consuming it, expressed in today's dollars or the dollars of a base year of interest.

Network Model HMO - An HMO type in which the HMO contracts with more than one physician group, and may contract with single-specialty and multispecialty groups. The physician works out of his/her own office. The physician may be paid by either discounted fee-for-service or capitation, but does not necessarily provide care exclusively for HMO members.

Nodding Out - Slang term for the early stages of depressant-induced sleep. Opioids and sedative-hypnotics induce depression of the central nervous system, causing mental and behavioral activity to become sluggish. As the nervous system becomes profoundly depressed, symptoms may range from sleepiness to coma and death. Typically, "nodding out" refers to fading in and out of a sleepy state.

Non-experimental or Pre-experimental evaluation design - This design is characterized by measurements of the intervention group (sometimes randomly selected), but these groups are not randomly assigned to the intervention condition, and there is no comparison group.

Nonquantifiable - Costs, such as social costs, that cannot be measured. Sometimes ad hoc methods are used to put estimates on nonquantifiable costs, rather than leave them out of the evaluation altogether.

Norms - A behavior or belief that is considered typical of a community.

Not Applicable - Used for prevention services not directed at a service population (e.g., clearinghouse, community drop-in centers, community teams).

Number Completed - For recurring prevention services, the number of participants who met the criteria for program completion.

Number of Units - The number of prevention items counted, disseminated, or developed (e.g., number of brochures). It is not the number of participants, attendees, unit costs, or units of time such as hours.

Objective - Specific results or effects of a program's activities that must be achieved in pursuing the program's ultimate goals [for example, a treatment program may expect to change participants' attitudes (objective) in order to ultimately reduce recidivism (goal). As used in the Achieving Outcomes Guide, measurable statements of the expected changes in risks, assets, or other underlying conditions as expressed in the program's guiding theory of change (*Achieving Outcomes*, Dec. 2001).

Objectivity - As used in the Achieving Outcomes Guide, refers to the expectation that data collection, analysis, and interpretation will adhere to standards of research that protect outcomes or results from the influence of personal preferences or loyalties (*Achieving Outcomes*, 12/01).

Observation - A measurement/assessment occasion.

Observer - In drug testing, the individual who watches the donor urinate into a collection container or specimen bottle when a direct-observed collection is required.

Office of National Drug Control Policy (ONDCP) - The Office of National Drug Control Policy (ONDCP) is part of the Executive Office of the President, which oversees the total Federal drug control budget and sets the National Drug Control Strategy.

Older adults - Adults considered to be older (in general, persons more than 65 years of age). Examples are older persons who are living independently, or residing in a nursing home or an assisted living facility. Although substance use generally declines with age, problems among older adults (age 60 and older) are still a source of concern, and with the growth of the older population the problem will become larger. Late-onset alcohol problems have been increasingly observed, and some people increase their consumption in response to age-related stresses such as loss of employment, bereavement, and declining health. Changing metabolism can make older adults more susceptible to effects of alcohol, as can interactions with the prescription drugs they may be taking. For more information, see NCADI's online catalogue for publications related to older adults and substance abuse.

Opiates - A type of depressant drug that diminishes pain and central nervous system activity. Prescription opiates include morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called "smack," "horse," and "boy."

Opportunity Cost - The value of resources used to produce or consume goods or services in their next best alternative use.

Organizational Development (Theory) - The application of behavioral sciences to improve organizational effectiveness. Interventions are directed at organizational processes and structures and at worker behaviors. Applications of this theory target human relationships and quality of work for problem diagnosis, action planning, interventions, and evaluation.

Goodman, R.M., Steckler, A., Kegler, M.C. (1997). Mobilizing organizations for health enhancement: Theories of organizational change. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (pp. 287-312). San Francisco, CA: Jossey-Bass.

Organized Delivery Systems - Proposed networks of providers and payors that would provide care and compete with other systems for enrollees in their region. Systems could include any providers and/or sites that offer a full range of preventive and treatment services.

Other - Individuals or organizations who do not fit any of the above definitions or who represent a special population on which a particular State wishes to capture prevention services data.

Outcome Evaluation - The systematic assessment of the results or effectiveness of a program or activity (see Performance Measures). It is a type of evaluation used to identify the results of a program's effort. It seeks to answer the question, "What difference did the

program make?" It yields evidence about the effects of a program after a specified period of operation.

Outcome Measures - Assessments that gauge the effect or results of services provided to a defined population. Outcomes measures include the consumers' perception of restoration of function, quality of life, and functional status; as well as objective measures of mortality, morbidity, and health status.

Outcomes - The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be immediate, intermediate, final, and longer term outcomes. For example, changes in attitudes and values may be the final outcome of an informational intervention. However, changes in attitudes and values may be the immediate outcome of a parenting program that builds on those changes to bring about changes in communication patterns and other skills (intermediate outcomes). Changes in communication patterns would, in turn, strengthen middle school children's resistance to negative peer pressure (intermediate outcome), resulting in a delay in the onset of substance use (final outcome) (*Achieving Outcomes*, 12/01).

Outlier Data - Extremely high or low values of a variable of interest.

P Value - The probability of error associated with a statistical test.

Parent and Family Skills Training - Intervention programs considered parent and family skills training seek to reduce risk factors for substance abuse by strengthening family life. Depending on the type of program, parents and/or children receive training in skills to improve the structure, functioning, and interaction of the family. Parents receive specific instruction on addressing the problem behaviors of their children. These interventions may take place with individual families or groups of families in a clinic or classroom.

Parenting Programs - Research confirms the importance of parents in influencing their children's behavior with regard to substance use. Parental attitudes and practices related to alcohol are the strongest social influence on children's use or nonuse. The interaction between parent and child is a key factor in predicting adolescent use of alcohol, tobacco, and other drugs. However, parents need help in their role. Widespread availability of alcohol, tobacco, and other drugs to children and youth is a relatively new phenomenon. In recent years, CSAP and other agencies have sponsored a number of programs to assist parents. For more information, see CSAP's Parenting IS Prevention initiative, *Parenting Skills: 21 Tips & Ideas to Help You Make a Difference*, and NCADI's online catalog for publications for parents and caregivers.

Parenting/Family Management Services - Structured classes and programs intended to assist parents and families in addressing substance abuse risk factors, implementing protective factors, and learning about the effects of substance abuse on individuals and families. Topics typically include parenting skills, family communications, decisionmaking skills, conflict resolution, family substance abuse risk factors, family protective factors, and related topics. Examples are parent effectiveness training, parenting and family management classes, prevention programs targeting the family, and programs designed to strengthen families.

Parents/Families - Parents and families, including biological parents, adoptive parents, foster parents, grandparents, aunts and uncles, or other relatives in charge of or concerned with the care and raising of youth, nuclear families, and mixed families.

Participant - An individual formally enrolled or registered in a recurring prevention service. Demographic data (age, race/ethnicity, and gender) are collected for participants.

Pathway to Change - A set of related assumptions (also called hypotheses) about how and why desired change is most likely to occur as a result of a program. Typically, the pathway (theory) of change is based on past research or existing theories of human behavior and development. Alternatively, a theory of change can be described as a pathway to change that systematically links actions to expectations or intended results.

Payor - The party, including employers, government agencies, and insurance companies, that purchases the health services provided to consumers.

Peer Leader/Helper Programs - Structured, recurring prevention services that utilize peers (people of the same rank, ability or standing) to provide guidance, support, and other risk reduction activities for youth or adults. Examples are peer resistance development, peer/cross-age tutoring programs, student nonusing groups (e.g., Just Say No clubs), teen leadership institutes, and peer support activities (e.g., clubs, church groups).

People Using Substances - Youth and adults who may have used or experimented with alcohol, tobacco, or other drugs. Examples are youth or adults charged with driving under the influence (DUI), driving while intoxicated (DWI) or being a minor in possession (MIP); social or casual users of illicit substances; and youth and adults who smoke tobacco or consume alcoholic beverages but who are not yet in need of treatment services.

People with Disabilities - Youth and adults who have disabilities. Examples are individuals who are physically handicapped, hearing impaired, speech impaired, or visually impaired.

People with Mental Health Problems - Youth and adults with mental health problems. Examples are persons with major mental illnesses such as schizophrenia, manic depression; and depression, severely emotionally disturbed youth; and persons with dual diagnoses, i.e., mental illness and co-occuring substance abuse.

Performance Goals - The desired level of achievement of standards of care or service. These may be expressed as desired minimum performance levels (thresholds), industry best performance (benchmarks), or the permitted variance from the standard. Performance goals usually are not static but change as performance improves and/or the standard of care is refined.

Performance Measure(s) - Methods or instruments to estimate or monitor the extent to which the actions of a healthcare practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.

Performance Unit - In the Evaluation module, the performance unit is the largest unit in the evaluation plan hierarchy. Examples include (1) "Regional Centers" in a State service system; (2) "Separate project grants" in a multiproject collaboration, and (3) the "School sites" in a community project.

Physically/Emotionally Abused People - Youth and adults who have experienced physical or emotional abuse. Examples are victims of physical abuse, sexual abuse, incest, emotional abuse, and domestic abuse.

Physician-Hospital Community Organization - Similar to a physician-hospital organization, with the addition of community governance representation.

Physician-Hospital Organization (PHO) - An IPA (individual practice association) associated with and often initiated by a hospital that provides management services; features a contracting mechanism for obtaining "covered lives," generally with 50:50 physician/hospital control and hospital financing.

PMPM - Stands for "per member per month," a fixed rate paid per enrolled member under a managed care contract for the provision of healthcare. This is the form that a capitated payment usually takes.

Point-of -Service (POS) - A type of healthcare benefit plan in which the insured person can choose to use a nonparticipating provider at a reduced coverage level and with more out-of-pocket cost. Such POS plans combine HMO-like systems with indemnity systems. Often known as open-ended HMOs or PPOs, these plans permit the insured to choose providers outside the plan, yet are designed to encourage the use of network providers. One of the most popular plans with consumers and employers, POS services represent the area of greatest HMO growth.

Policy - A legal document issued by an insurance company to a policyholder, which outlines the conditions and terms of insurance. Also referred to as the "policy contract" or the "contract."

Posttest - The test administered at the end of the data gathering sequence of an evaluation (usually after the program or activity being evaluated has been completed).

Power - In statistics, the probability of rejecting the null hypothesis. In a statistical comparison of two groups, the power of a statistical test is the probability of correctly identifying a difference between the groups, given that the difference does, in fact, exist. Power = 1-ß, where ß is type II error.

Practical Significance - Meaningful and relevant information or results that have utility for the field. Some results may have statistical significance but little utility (e.g., statistically, left-handed people use more drugs than right-handed people). Evaluators often struggle with how to present findings and/or outcomes so they are relevant, meaningful, and useful to the practitioner and decisionmakers (*Achieving Outcomes*, 12/01).

A finding of sufficient magnitude that is more than just interesting as it could lead to an important decision or action.

Practice Guidelines - Systematically developed statements on healthcare practices that assist healthcare providers and consumers in making decisions about appropriate healthcare for specific situations or conditions. Managed care organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care.

PRECEDE-PROCEED (Theory) - A program planning model that seeks to empower individuals with understanding, motivation, and skills, and encourages active engagement in the community to improve their quality of life. This model is based on the assumption and well-documented research showing that behavior change is more lasting when people have actively participated in decisions about it. The PRECEDE-PROCEED model has nine phases, the first five of which are diagnoses and the remaining four of which are implementation and evaluation. The diagnoses (social, epidemiological, behavioral and environmental, educational and organizational, and administrative and policy) involve researching target communities and the change-initiating organization to identify causes and factors contributing to problems or needs, and determining how to address them. The result of the diagnoses is a plan with specific objectives and strategies.

Green L.W., & Kreuter, M.W. (1991). *Health Promotion Planning: An Educational and Environmental Approach,* (2nd ed.). Mountain View, CA: Mayfield.

Precipitating Factors - Conditions or events that prompt or facilitate another condition or event (*Achieving Outcomes*, Dec. 2001).

Predictive - One variable is considered to be predictive of another if there is a systematic relationship between the two. However, the fact that there is a relationship does not mean that one thing causes the other. For example, low school achievement is often associated with drug abuse in the teen years, but low school achievement does not cause drug abuse. Young people who perform poorly in school are at high risk, but there are many other risk factors, none of which predict with complete accuracy who will become involved with drugs.

Predictor Variables Program - The purpose of this program was to discover the most effective prevention programs for different age groups of youth in urban or rural settings; thus grants were awarded to a matrix of urban and rural programs across four developmental periods. The program focused on four variables: social competence, self-regulation and control, school bonding and cognitive development, and parental involvement. CSAP sponsored an investigation of which interventions in these areas at which developmental stages work effectively to redirect negative behaviors predictive of substance abuse. The aim of the study is to promote emotional well-being in children at risk and to enhance their social and emotional development.

Preferred Provider Organization (PPO) - A network discount, fee-for-service provider arrangement with incentives to stay inside the network; allows healthcare services outside of the PPO network at an increased copayment and/or deductible; has structured quality and utilization management.

Pregnant and Postpartum Women - A key audience for substance abuse treatment and prevention programs, because of the danger posed to the unborn or newborn child whose mother abuses alcohol and/or other drugs. For more information, see NCADI's online catalog - women for resources related to women's health and substance abuse.

Pregnant Females/Women of Childbearing Age - Women who are of the physiological age to bear children and for whom the intent of prevention services is to ensure healthy newborns.

Preschool Students - Youth enrolled in, or of an age to be enrolled in, public or private preschool programs. Examples are youth enrolled in preschool programs, child day care, and Head Start programs and other children aged 4 or younger.

Pretest - The collection of measurements before an intervention to assess its effects.

Prevalence - The number of instances of a given disease or other condition in a given population at a designated time. If the period is not mentioned, the concept usually refers to the situation at a specified point in time, that is, point prevalence.

The numbers of people using or abusing substances during a specific period (*Achieving Outcomes*, 12/01).

In general epidemiological terms, the number of new plus old cases existing at or during a specified time.

Preventing Underage Alcoholic Beverage Sales - Activities intended to prevent the sale of alcoholic beverages to minors. They are also intended to track activities such as placing signs (e.g.,about drinking and pregnancy) in bars, restaurants, and other establishments, and track efforts to educate vendors and law enforcement personnel about these issues. Examples are social host training and management programs, commercial host training and management programs, holiday campaigns and special events, server education programs, signage activities, law enforcement education, vendor carding and working with alcohol beverage vendors (e.g., bars, restaurants) to reduce the sale and consumption of alcoholic beverages by minors.

Preventing Underage Sale of Tobacco and Tobacco Products - Synar Amendment - Activities intended to prevent the sale of tobacco and tobacco products to minors. They are also intended to track activities that meet the block grant requirements under the Synar amendment. Examples are conducting compliance activities, and offering vendor education and law enforcement education.

Prevention - A proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. The goal of substance abuse prevention is the fostering of a climate in which (a) alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal; (b) prescription and over-the-counter drugs are used only for the purposes for which they were intended; (c)other abusable substances, e.g., aerosols, are used only for their intended purposes; and (d) illegal drugs and tobacco are not used at all.

Prevention Assessment and Referral Services - Refers to those activities intended to provide a risk screening, assessment, and referral to prevention service populations for placement in prevention or other appropriate services.

Prevention Best Practices or Model Programs - Many agencies that sponsor prevention programs are attempting to identify the best of these programs (sometimes called model programs) so that they can be replicated in other sites. CSAP has a Model Programs initiative to nominate programs.

Prevention Continuum - See "Continuum of Services," above.

Prevention Domain - Prevention domains are spheres of influence in which prevention activities are conducted. Domains are usually considered to include individuals (self and peers), school, workplace, family, community, and society.

Prevention Enhancement Protocol System (PEPS) - The Prevention Enhancement Protocol System (PEPS) is a pioneering effort to develop program and intervention guidelines for the field. Following established rules of evidence for assessing practice and research findings and combining this evidence into prevention approaches, the PEPS initiative has published guidelines on preventing tobacco use among youth, and on family-centered approaches to prevention. Guidelines in development include environmental approaches to retail alcohol availability, mass media and prevention, and school-based approaches to prevention. (See the PEPS Series titled *Reducing Tobacco Use Among Youth: Community-Based Approaches (A Practitioner's Guide)*, and *Preventing Problems Related to Alcohol Availability: Environmental Approaches*.)

Prevention Research - The U.S. Public Health Service definition defines prevention research as research designed to show results directly applicable to interventions to prevent occurrences of disease or disability.

Prevention Service - An effort intended to prevent substance use or abuse that can be conducted as a single or a recurring service.

Prevention Strategies - The SAPT Block Grant regulations require that each State receiving a block grant adopt a comprehensive prevention program that includes a broad array of prevention strategies for individuals not identified to be in treatment. These strategies (defined separately in this glossary) include information dissemination, education, alternatives, problem identification and referral, community-based process, and environmental approaches.

Prevention Types (Selected, Indicated, Universal) - Universal prevention measures are desirable for everyone in the eligible population, both general and specific groups. Often such measures can be applied without professional advice or assistance. The benefits outweigh the risks and costs for everyone. Examples of universal prevention include use of seatbelts, a good diet, avoidance of smoking, and immunization. Selected prevention is desirable only when the individual is a member of a subgroup whose risk of becoming ill is above average. Subgroups can be based on age, gender, occupation, or family history. An example of selective prevention would be immunization against yellow fever for some travellers; another is breast cancer examinations at young ages for those with a family history of breast cancer. Indicated prevention is for persons who have a risk factor, condition, or abnormality that places them at high risk for future development of the disease. Examples are various screening programs for particular diseases, e.g., HIV testing and needle exchange programs for injected drug users. (See P.J. Mrazek and R.J. Haggerty (Eds.), *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*, pg. 20, 1994.)

Prevention/Treatment Professionals - Individuals employed as substance abuse prevention or treatment professionals. Examples are counselors, therapists, prevention professionals, preventionists, clinicians, prevention or treatment supervisors, and agency directors.

Preventive Care - Comprehensive healthcare emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including risk assessment appraisals, routine physical examinations, immunizations, and well-baby care.

Preventive Intervention - An intervention that is designed for the prevention of a disease or risk behavior.

PREVline - PREVline is CSAP's electronic communication system on the Internet, which disseminates knowledge at the local level by offering "one-stop shopping" for alcohol and drug information, program funding information, and survey data to the American public and the international prevention community.

Primary Care - Basic or general healthcare, traditionally provided by family practice, pediatrics, and internal medicine.

Primary Care Case Management (PCCM) - Case management that requires a gatekeeper to coordinate and manage primary care services, referrals, pre-admission certification, and other medical or rehabilitative services. The primary advantage of PCCM for Medicaid eligibles is increased access to PCP while reducing use of hospital outpatient departments and emergency rooms. (There is encouragement within Medicare Choices to provide PCP coordination for patients being treated by a wide variety of specialists but who no longer have a PCP for oversight.)

Primary Care Provider (PCP) - A term used to denote the health care provider who typically delivers health care services to the patient, such as a family practitioner, general internist, pediatrician, and sometimes an ob/gyn. Generally, under managed care, a PCP supervises, coordinates, and provides initial ambulatory medical care, acting as a "gatekeeper" for the initiation of all referrals for non-urgent specialty care.

Primary Enforcement - A stipulation of a safety belt use law that allows law enforcement officials to stop a driver solely on the basis of a safety belt violation.

Primary Partner - The main person, group, or organization that you will be working with.

Primary Prevention - Prevention activities designed to prevent substance abuse before any signs of a problem appear. Also, strategies designed to decrease the number of new cases of a disorder or illness.

Principles of Effectiveness (U.S. Department of Education) - According to the Department of Education, to ensure that recipients of Title IV funds use those funds in ways that preserve State and local flexibility and are most likely to reduce drug use and violence among youth, a recipient shall (1) base its programs on a thorough assessment of objective data about the drug and violence problems in the schools and communities served; (2) with the assistance of a local or regional advisory council where required by the SDFSCA, establish a set of measurable goals and objectives and design its programs to meet those goals and objectives; (3) design and implement its programs for youth based on research or evaluation that provides evidence that the programs used prevent or reduce drug use, violence, or disruptive behavior among youth; and (4) evaluate its programs periodically to assess its progress toward achieving its goals and objectives; use its evaluation results to refine, improve, and strengthen its program; and to refine its goals and objectives as appropriate. For more information, visit *The Challenge: Safe & Drug-Free Schools Newsletter* online.

Problem Identification and Referral - Another prevention strategy mandated by the SAPT Block Grant regulations. It aims to identify those who indulged in illegal or age-inappropriate use of tobacco or alcohol, and identify first use of illicit drugs in order to reverse their behavior in the early stages. Examples of activities include employee and student assistance programs and driving under the influence/driving while intoxicated programs.

Process Evaluation - Process evaluation focuses on how a program was implemented and operates. It identifies the procedures undertaken and the decisions made in developing the program. It describes how the program operates, the services it delivers, and the functions it carries out. It addresses whether the program was implemented and is providing services as intended. However, by additionally documenting the program's development and operation, it allows an assessment of the reasons for successful or unsuccessful performance, and provides information for potential replication.

Process Measures - Measures of participation, "dosage," staffing, and other factors related to implementation. Process measures are *not* outcomes, because they describe events that are inputs to the delivery of an intervention (*Achieving Outcomes*, 12/01).

Productivity - Defined generally by economists as the amount of output of a good or service produced per unit of input needed to produce it. May be measured more easily in manufacturing processes in terms of goods or units produced per staff member or machine. More difficult to measure for services, because the boundaries that define services may be less well understood or the quality of services produced may be more difficult to measure.

Productivity Correlates - Factors related to productivity, such as various forms of absenteeism, restricted activity days, employee morale, production delays, job tenure, etc.

Productivity Loss - Reductions in productivity resulting from illness, such as higher absenteeism or lower output on the job. This loss of production is included in the costs of illness. In principle, loss of productivity should cover consequences outside the market economy, such as reductions in human carework and housework by the sick person.

Program - A structured intervention, including environmental initiatives, that is designed to change social, physical, fiscal, or policy conditions within a definable geographic area or for a defined population (*Achieving Outcomes*, 12/01).

Program Advocate - A person or group that is a supporter of the program.

Program Logic Model - Shows how all components of the program link together and lead to the achievement of program goals/outcomes. See also "Logic Model" (*Achieving Outcomes*, 12/01).

Promising Program - In CSAP's terminology, the first of three categories of science-based programs on a continuum that concludes with model programs. Promising programs are those that have been reasonably well evaluated, but the positive findings are not yet consistent enough, or the evaluation not yet rigorous enough, for the program to qualify as an effective program. CSAP's hope is that promising programs, through additional refinement and evaluation, will evolve into effective and model programs (*Achieving Outcomes*, 12/01).

Propensity Score - In the context of performing adjustments for selection bias, the propensity score is the predicted probability that each client participates in a substance abuse program.

Protective Factors - Conditions that build resilience to substance abuse and can serve to buffer the negative effects of risks. Also referred to as assets (*Achieving Outcomes*, 12/01).

Provider (Participating Provider) - Individuals and/or organizations that directly deliver prevention, treatment, and maintenance services to consumers within the defined plan. Depending upon the arrangement, usually involves contracts.

Provider ID - The identification number or code of a specific prevention agency or organization.

Providers Service Organization/Provider-Sponsored Network (PSN) - A formal affiliation of healthcare providers organized and operated to provide a full range of healthcare services; a term used in draft language of the 1996 budget discussions of House and Senate proposals that would allow Medicare to contract directly with PSNs on a full-risk capitated basis in a way that would "cut some HMOs out of the middle" depending on the ultimate language. The degree to which PSNs must be subject to licensing, financing, and insurance considerations, as regulated by State insurance commissioners. These regulations will determine the number of providers to qualify as PSNs, as compared to the more rigid HMO standards under which provider networks must currently qualify.

Proxy Measures - Data that can be used as an indicator, an indirect measure of of substance use or abuse. In general, multiple indirect measures (proxies) are more reliable than a single proxy. An individual can also serve as a proxy. For example, a parent can serve as a proxy for his or her child; a community stakeholder can serve as the spokesperson/proxy for a group unwilling to talk with an interviewer (*Achieving Outcomes*, 12/01).

Public Health Model of Prevention - This model can be illustrated by a triangle, with the three angles representing the agent, the host, and the environment. (The agent is the substance, the host is the individual using the substance, and the environment is the social and physical context of use.) A public health model, using the science of epidemiology, stresses that problems arise through the relationships and interactions among host, agent, and environment. Primary prevention is the focus of CSAP. Prevention programs in the past, including substance abuse prevention, often neglected to deal with the environment, and focused exclusively on inoculating the host through educational efforts, expecting that information on the dangers of drugs would be sufficient to deter use. However, a public health approach requires not only an understanding of how host, agent, and environment interact, but also must include a plan of action for influencing all three.

Public Housing - Public housing projects are environments in which drug trafficking and drug abuse flourish. CSAP and the Department of Housing and Urban Development (HUD) have collaborated on a number of prevention programs for residents of public housing, especially for youth. One such program is Drug Elimination Grants.

CSAP also has a prevention training course titled *Prevention in Housing Communities*.

Public Policy Efforts - Activities intended to reflect efforts to change public policy about ATOD. Examples are managing advertising campaigns, public policy campaigns to change product pricing, and public policy campaigns to change the location of alcohol and tobacco products to reduce accessibility to minors; conducting public policy campaigns (e.g., warning campaigns, health and safety campaigns); and developing uniform law enforcement policies within a jurisdiction or a series of surrounding jurisdictions to provide a community standard in the management of underage drinking and smoking and related behaviors.

Qualitative - A term used to refer to information that is difficult to measure, count, or express in numerical terms (for example, how safe a resident feels in his or her neighborhood). In evaluation, qualitative data provide contextual information that describes participants and interventions. These data are often presented as text. A strength of qualitative data is their ability to illuminate findings derived from quantitative methods.

Qualitative Data - Qualitative data is information that is difficult to measure, count, or express in numerical terms (for example, the nature of relationships among various groups in a community). These types of data are used in research involving detailed, verbal descriptions of characteristics, cases, and settings. Qualitative research typically uses observation, interviewing, and document review to collect data. A qualitative analysis might lead to the conclusion that relationships between parents and teens are strained, that parents are often working two jobs to make ends meet, and that there are not enough positive recreational opportunities for youth. In evaluation studies, this is the contextual information that usually describes participants and interventions. These data are often presented as text. The strength of qualitative data is their ability to illuminate evaluation findings derived from quantitative methods.

Quality Assurance (QA) - A formal set of measures, requirements, and tasks to monitor the level of care being provided. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing effectiveness and may measure care against preestablished standards.

Quality of Care - The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality-Adjusted Life-Year (QALY) - Measurement unit to define health outcomes that result from medical or surgical care, expressed in terms of the number of years of life in a less-desirable health condition as compared to years of full health. If the quality of life for a bedridden patient is 50 percent with a life expectancy of 10 years, the measurement would be 5 quality-adjusted life-years. As the U.S. system of medicine becomes more focused on how to allocate limited healthcare resources, more attention will be given to this and other measures of intervention benefits.

Quantitative - A term used to refer to information that can be expressed in numerical terms, counted, or compared on a scale (for example, the number of alcohol-related traffic accidents per month). In evaluation, quantitative data are used to measure changes in targeted outcomes (for example, substance use) and intervening variables (for example, attitudes toward substance use). The strength of quantitative data is their use in testing hypotheses and determining the strength and direction of effects.

Quantitative Data - Quantitative data is information that can be expressed in numerical terms, counted, or compared on a scale (for example, the number of 911 calls received in a month). Quantitative data might lead to the conclusion that there has been an increased number of arrests for selling drugs, that the quantity involved in sales is larger than in previous years, and that the sellers are younger. In evaluation studies, quantitative data includes measures that capture changes in targeted outcomes (e.g., substance use) and intervening variables (e.g., attitudes toward substance use). The strength of quantitative data is their use in testing hypotheses and determining the strength and direction of effects.

Quasi-experimental evaluation design - This design uses subjects found in pre-existing, non-equivalent intervention and comparison groups (sometimes randomly selected but not randomly assigned).

Race - A socially defined population based on visible, genetically transmitted physical characteristics.

Random Assignment - The process through which members of a pool of eligible study participants are assigned to either an intervention group or a control group on a random basis such as through the use of a table of random numbers.

Randomization Test - A process of repeated testing used to eliminate P-values for statistical tests with small samples.

Recurring Prevention Service - A prevention service provided to a fixed group of people at risk for substance use or abuse, who are enrolled for a fixed period of time in a planned sequence of activities. The activities, through the practice or application of recognized prevention strategies, are intended to inform, educate, develop skills, alter risk behaviors, deliver services, and/or provide referrals to other services (e.g., a parent education group where the same group meets once a week for 6 weeks).

Recurring Service Session Number - An incremental number denoting the session number of a recurring prevention service (01 for the first session, 02 for the second session). For single prevention services, the number in this field will always be 00 (zeroes).

Reference Group - The group that is the focus of a needs assessment. Members of the reference group are similar in some important way. For example, they may all live in the same community, attend the same school, or be members of the same organization.

Reinforcement (Theory) - Responses to a person's behavior that increase or decrease the chances of recurrence. This is a component of the social learning/social cognitive theories and behavior change models.

Baronowski, T., Perry, C.L., Parcel, G.S. (1997). How individuals, environments, and health behavior interact: Social cognitive theory. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (pp. 161-164). San Francisco, CA: Jossey-Bass.

Relative Risk - The chances of contracting a disease from a particular cause (e.g., smoking) relative to the chances of contracting a disease in general. For example, if the relative risk of lung cancer from smoking is 6.1 for men smoking less than a pack a day, it means men smoking less than a pack a day are 6.1 times more likely to contract lung cancer than men who do not smoke.

Reliability - The consistency of a measurement, measurement instrument, form, or observation over time. The consistency of results (similar results over time) with similar populations, or under similar conditions, confirms the reliability of a measure (*Achieving Outcomes*, 12/01).

Religious Groups - Individuals involved with or employed in religious denominations or organized religious groups such as churches, synagogues, temples, or mosques. Examples

are members, deacons, elders, clergy, religious associations, ministerial associations, ecumenical councils or organizations, lay leaders, and religious education staff.

Report Card on Healthcare - An emerging tool that can be used by policymakers and healthcare purchasers such as employers, government bodies, employer coalitions, and consumers to compare and understand the actual performance of health plans. The tool provides health plan performance data in major areas of accountability, such as healthcare quality and utilization, consumer satisfaction, administrative efficiencies and financial stability, and cost control.

Representative Sample - A segment of a larger body or population that mirrors the characteristics of the larger body or population.

Resilience - Refers to the ability of an individual to cope with or overcome the negative effects of risk factors or to "bounce back" from a problem (*Achieving Outcomes*, 12/01). This capability develops and changes over time, is enhanced by protective factors, and contributes to the maintenance or enhancement of health.

Resistance Skills Training - Resistance skills training programs are designed to increase the ability of youth to withstand the pressure of temptation to use alcohol, tobacco, or drugs.

Resources - Social, fiscal, recreational, and other community support that presently target substance abuse prevention and/or reduction.

Respondent - An individual from whom data are collected via questionnaire, interview, or other means. Respondents may be members of the target population, but they also include others from whom information is gathered. For prevention programs, respondents often include program staff, social service providers, educators, parents, and others.

Risk Analysis - The process of evaluating expected healthcare costs for a prospective group and determining what product, benefit level, and price to offer in order to best meet the needs of the group and the carrier.

Risk Factor - Conditions for a group, individual, or defined geographic area that increase the likelihood of a substance use/abuse problem occurring (*Achieving Outcomes*, 12/01).

Risk Sharing - The distribution of financial risk among parties furnishing a service. For example, if a hospital and a group of physicians from a corporation provide healthcare at a fixed price, a risk-sharing arrangement would entail both the hospital and the physician group being held liable if expenses exceed revenues.

Sample Size - Reflects the number of subjects from a population in your study. Determining the sample size involves using certain techniques and procedures in selecting elements of a population for study.

Sampling, Matched - Pairing (or blocking) of two units because they are similar, followed by the random assignment of one unit to one intervention and the other to another intervention.

SAPT Block Grant - See Substance Abuse Prevention and Treatment Block Grant, below.

School Dropouts - Youth under the age of 18 who have not graduated from school or earned a general educational development certificate, and/or who are not enrolled in a public or private learning institution.

School Survey - A process, most often using a specially designed instrument, to collect information relevant to school administration, student attitudes and behavior, and/or student performance (*Achieving Outcomes*, 12/01).

School System Descriptors - Key words that describe school systems such as classes, schedules, and student demographics.

School-Based Prevention - Schools have been a traditional venue for prevention programs, and the Department of Education has an entire program to ensure that schools include substance abuse prevention. School-based prevention has several advantages: it can be sustained over a long period of time (theoretically throughout most of a child's developmental stages); it is given to a more or less "captive audience;" and it has a certain amount of stability in that a known group (e.g., all 7th graders) attends each session. Meta-evaluations of school-based programs have been done to determine which kinds of programs are most effective. (See William J. Bukoski (Ed.), 1997, *Meta-Analysis of Drug Abuse Prevention Programs*, NIDA Research Monograph 170, Bethesda, MD: National Institutes of Health, for a list of references.) Moreover, the Department of Education is sponsoring an expert panel to identify promising school-based education programs (see Prevention Best Practices, above.) (For more information, visit the U.S. Department of Education's Safe and Drug-Free Schools program.)

Science-Based Prevention - "Science-based" refers to a process in which experts use commonly agreed-upon criteria for rating research interventions and come to a consensus that evaluation research findings are credible and can be substantiated. From this process, a set of effective principles, strategies, and model programs can be derived to guide prevention efforts. This process is sometimes referred to as research- or evidence-based. Experts analyze programs for credibility, utility, and generalizability. Credibility refers to the level of certainty concerning the cause-and-effect relationship of programs to outcomes. Utility refers to the extent to which the findings can be used to improve programming, explain program effects, or guide future studies. Generalizability refers to the extent to which findings from one site can be applied to other settings and populations. (For more information, see Central CAPT's Science-Based Prevention page.)

Lists of science-based programs appear in CSAP and other Internet sites, notably in the Centers for the Application of Prevention Technologies.

Science-Based Program - In CSAP's terminology, a program that is theory-driven, has activities related to theory, and has been reasonably well implemented and well evaluated (*Achieving Outcomes*, 12/01).

Screening - A clinical screening is a preliminary gathering and sorting of information used to determine whether an individual has a problem with AOD abuse, and if so, whether a detailed clinical assessment is appropriate.

Secondary Enforcement - A stipulation of a safety belt use law that allows law enforcement officials to address a safety belt use violation only after a driver has been stopped for some other purpose.

Secondary Prevention - Prevention activities designed to intervene when risk factors or early indicators of substance abuse, such as marital strife or poor school performance, are present. Also, prevention strategies designed to lower the rate of established cases of a disorder or illness in the population (prevalence).

Selection Bias - A bias in the estimate of a program effect that arises from the inability to separate the impact of the program on an outcome of interest from the impact of other factors that are correlated with program participation and outcome measures. Such bias often occurs in nonrandomized or poorly randomized settings, resulting in treatment and comparison groups that differ on measurable and unmeasurable factors. For example, self-referral to (or self-selection into) a substance abuse program may result in substantial differences between substance abusers who participate in the program and those who do not. These differences, along with participation status, may influence observed outcomes.

Selective Preventive Interventions - Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Self-Efficacy (Theory) - Confidence in one's ability to do a particular behavior. This factor is a component of the social learning/social cognitive theory.

Bandura, A. (1986). *Social Foundations of Thought and Action.* Englewood Cliffs, N.J.: Prentice-Hall.

Glanz, K. & Rimer, B.K. (Eds.), (1997). *Theory at a Glance: A Guide for Health Promotion Practice.* National Institutes of Health, National Cancer Institute (NIH Publication No. 97-3896).

Sensitivity - In the context of the accuracy of diagnosis coding, sensitivity refers to the ability to identify persons with a particular disorder using claims data or survey data among persons who really have that disorder.

Sensitivity Analysis - A process of repeating the CBA or CEA several times, each time varying one or more assumptions necessary to carry out the analysis, to see how robust the results are to these changing assumptions.

Service Day/Month/Year - The day, month, or year in which the prevention service was delivered.

Service Population (SP) Code - The code used to designate the group or category of people who directly received the prevention service (includes CSAP high-risk populations).

Service Type (ST) Code - The code used to designate the prevention strategy and the type of service and/or method used to implement the strategy.

Service Utilization - A description, usually statistical, of the level, frequency, and necessity of services actually used by consumers. Generally aggregated into population measures, rather than individual consumer measures.

Short-Term Disability Expenditures - Includes company payments for sickness and accident benefits beyond any sick leave or other days not included in the short-term

disability program. For example, many companies do not pay for the first five consecutive absence days under a short-term disability program.

Single Prevention Service - A one-time activity that, through the practice or application of recognized prevention strategies, is intended to inform or educate general and specific populations about substance use or abuse (e.g., a one-time student assembly).

Single State Agency (for substance abuse treatment and prevention) - Each State has a designated agency for substance abuse treatment and prevention that is the recipient of Federal block grant (see SAPT block grant, above) funds. These agencies may be free-standing entities or bureaus of the State's department of health and human services. They may also be part of the office of the governor. For information about State agencies, see the Web site of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), which gives links to the various single State agencies. (Link to http://www.nasadad.org/Features/visit1.htm.)

Single/Recurring Service Code - The code used to designate a prevention service as single (S) or recurring (R).

Skills Building - Skills building programs in schools are designed to increase life skills, including social and academic abilities. Curriculum topics may include such areas as stress management, self-esteem, problem solving, social networks, and peer resistance.

Small Group Sessions - Provision of educational services to youth or adults in groups of not more than 16 members. Examples are substance abuse education groups, short-term education groups, youth education groups, parent education groups, business education groups, and church education groups.

Social Action (Theory) - Aims to increase the problem-solving ability of the community and achieve concrete changes that make amends in social injustices that are identified by a disadvantaged group. This is one component of community organization.

Rothman, J., and Tropman, J.E. (1987). Models of community organization and macro practice: Their mixing and phasing. In F.M. Cox, J.L. Ehrlich, J. Rothman, and J.E. Tropman (Eds.), *Strategies of Community Organization,* (4th ed.). Itasca, IL: Peacock.

Social Bonding - A promising concept for prevention efforts, social bonding is a protective factor for youth. Studies show that young people who establish a bond with societal norms and standards are less likely to develop substance abuse problems. Elements of social bonding include attachment to parents, commitment to school and education, involvement in church activities, and belief in the norms and values of society. Conversely, characteristics of youths who have not bonded to society include alienation from societal values, rebelliousness, tolerance of deviance, and resistance to authority. Youth who are bonded have a stake in their society and good reasons not to abuse substances.

Social Development Model - A model that seeks to explain behaviors-which are themselves risk factors for substance abuse-by specifying the socialization process (the interaction of developmental mechanisms carried out through relationships with family, school, and peers) that predicts such behavior.

Social Health Maintenance Organization - Federally funded Medicare demonstration project for the elderly; provides comprehensive health and long-term care benefits to Medicare beneficiaries. Unlike other Medicare-enrolling HMOs, care in a social HMO is reimbursed at 100 percent.

Social Indicator - A measure of a social issue that has been tracked over time (e.g., family and community income, educational attainment, health status, community recreation facilities, per pupil expenditures, etc.). Social indicators are often used to document levels of community and group risk, and to serve as proxies for the existence of social problems, such as substance use/abuse (*Achieving Outcomes*, 12/01).

Social Learning / Social Cognitive Theory - Suggests that people learn not only through their own experiences, but also through the environment, by observing others, or being influenced by peer norms. Some of the main concepts include reciprocal determinism, observational learning, self-efficacy, reinforcement, and behavior capability. This interpersonal-level theory pays close attention to the relations between persons and how this may affect their behavior.

Bandura, A. (1986). *Social foundations of thought and action.* Englewood Cliffs, NJ: Prentice-Hall.

Glanz, K. and B.K. Rimer (Eds.). (1997) *Theory at a Glance: A Guide for Health Promotion Practice.* National Institutes of Health, National Cancer Institute (NIH Publication No. 97-3896).

Social Marketing - Using commercial marketing techniques to develop, implement, and evaluate programs designed to influence the behavior of a target audience. Social marketing integrates health communication theory into research and practice. The six-stage process includes planning, channel selection, materials development, implementation, effectiveness evaluation, and revision. Social marketing often relies on the use of mass media and involves identifying the needs of a specific group, supplying information so people can make informed decisions, offering services that meet needs, and assessing how well the needs were met. CSAP and other agencies involved in substance abuse prevention use a variety of social marketing programs to get their message across. (For example, see ONDCP's National Youth Anti-Drug Media Campaign).

Lefebvre, R.C. & Rochlin L. (1997). Social marketing. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (pp. 384-402). San Francisco, CA: Jossey-Bass

Social Networks (Theory) - Set of relationships among individuals within a person's web of social ties. The structure of social networks can be described in terms of interpersonal and interrelational characteristics within the network of people and their interactions. Social networks are characterized by size and density; frequency of interaction and reciprocity; affective support, instrumental support, and social outreach.

Israel, B.A. and Schurman, S.J. (1990). Social support, control, and the stress process. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (pp. 187-215). San Francisco, CA: Jossey-Bass.

Social Planning (Theory) - This community change model is another component of the community organization model. Social planning creates specific task goals and objectives

developed by community members with expert assistance in order to engage in problem solving within the community.

Rothman, J., & Tropman, J.E. (1987). Models of community organization and macro practice: Their mixing and phasing. In F.M. Cox, J.L. Ehrlich, J. Rothman, & J.E. Tropman (Eds.), *Strategies of Community Organization,* (4th ed.). Itasca, IL: Peacock.

Social Support (Theory) - The functional content of relationships that can be categorized along four types of supportive behaviors: emotional support, instrumental support, informational support, and appraisal support. *Emotional* support is empathy, love, trust, and caring expressed to the person in need. *Instrumental* support is tangible aid and services that assist a person in need. *Informational* support is advice, suggestions, and information that can be used to address problems. *Appraisal* support is information that can be used for self-evaluation, such as feedback, affirmation, and social comparison.

Israel, B.A. and Schurman, S.J. (1990). Social support, control, and the stress process. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (pp. 187-215). San Francisco, CA: Jossey-Bass.

Sociodemographic Factors - Social trends, influences, or population characteristics that affect risks, attitudes, or behaviors related to substance abuse. Such factors can have an indirect but powerful influence.

Speaking Engagements - A wide range of prevention activities intended to impart information about substance abuse issues to general and/or targeted audiences. Examples are speeches, talks, news conferences, briefings, one-time classroom presentations, one-time assembly presentations, hearings and volunteer bureaus.

Specificity - In the context of the accuracy of diagnosis coding, specificity refers to the ability to identify those who do not have a disorder of interest using claims data or survey data among those who really do not have that disorder.

Specimen - In drug testing, urine that has been provided by a donor for a drug test. The entire sample is contained in a single specimen bottle.

Split Specimen - In drug testing, a single specimen that is split into two separate specimen bottles. Split specimens are never collected from two different voids by the donor.

Staff ID - The identification of the staff person who provided the prevention service.

Staff Model HMO - A healthcare model that employs physicians to provide healthcare to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.

Stages of Change (Theory) - Conceives behavioral change as a process, rather than as an event, and states that an individual's readiness or motivation to change progresses through a series of stages. Five stages identified by this model are precontemplation, contemplation, decision/determination, action, and maintenance. This model is not linear in that people may enter and exit a stage at any point in time and may move back and forth between stages *(Theory at a Glance)*.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist,* Vol. 47, pp. 1102-1114.

Stakeholders - All members of the community who have a vested interest (a stake) in the activities or outcomes of a substance abuse intervention (*Achieving Outcomes*, 12/01).

In general, groups or persons with a vested interest in something tangible or intangible.

Standardized Instruments - An assessment, inventory, questionnaire, or interview that has been tested with a large number of individuals and is designed to be administered to program participants in a consistent manner. Results of tests with program participants can be compared to reported results of the tests used with other groups.

State Code - The standard two-letter state abbreviation.

State Incentive Grants (SIGs) - CSAP has awarded 21 of these grants, also called Targeted Prevention Capacity grants. Governors of States awarded these grants have formed prevention councils and statewide advisory committees to advise them on how to allocate prevention dollars. The first five States to be awarded a SIG have already awarded numerous subrecipient community-based prevention grants, and have begun to leverage funds for additional community-based prevention efforts. As a result of the SIG program's emphasis on collaboration, States are beginning to regard substance abuse prevention from a broader, systems standpoint. By consensus, SIG States have developed a comprehensive evaluation framework, identified common measures, and selected standardized instruments to be used across sites.

State Survey Data - Includes the results from statewide administered surveys.

Statistical Power - The ability to accurately detect differences between groups or relationships between variables.

Statistical Significance - The strength of a particular relationship between variables. A relationship is said to be statistically significant when it occurs so frequently in the data that the relationship's existence is probably not attributable to chance.

Statistical Testing - A type of statistical procedure that is applied to data to determine whether the results are statistically significant (that is, the outcome is not likely to have resulted by chance alone.)

Strategic Planning - A disciplined and focused effort to produce decisions and activities to guide the successful implementation of an intervention (*Achieving Outcomes*, 12/01).

Stratification Variables - These variables represent different subsegments of a pool of individuals being studied. Stratification variables include age, gender, socioeconomic status, and location.

Student Assistance Programs - Structured prevention programs intended to provide substance abuse information for students whose substance abuse may be interfering with their school performance. Examples are early identification of student problems, referral to designated helpers, follow-up services, in-school services (e.g., support groups), screening for referral, referral to outside agencies, and school policy development.

Subjectivity - Said to exist when the phenomena of interest is described, discussed, or interpreted in personal terms, related to one's attitudes, beliefs, or opinions (*Achieving Outcomes*, 12/01).

Substance Abuse - Abuse of or dependency on alcohol, tobacco and other drugs. There are many definitions. The DSM-IV definition is-
The maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period:

- recurrent substance use resulting in a failure to fulfill major role obligations
- recurrent substance use in situations in which it is physically hazardous
- recurrent substance-related legal problems
- continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.

Substance Abuse and Mental Health Data Archive (SAMHDA) - The Substance Abuse and Mental Health Data Archive (SAMHDA) is an initiative of the Office of Applied Studies at the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services. The goal of the archive is to provide ready access to substance abuse and mental health research data, and to promote the sharing of these data among researchers, academicians, policymakers, service providers, and others. This sharing of data will serve to increase the use of the data in understanding and assessing substance abuse and mental health problems and the impact of related treatment systems. The data archive also is intended to expand the variety of media on which data are available and ensure that data are in a user-friendly format. Current SAMHDA holdings include Monitoring the Future, DAWN, and the National Household Survey on Drug Abuse.

Substance Abuse and Mental Health Services Administration (SAMHSA) - SAMHSA is an operating division within the Department of Health and Human Services, and the umbrella agency housing the Centers for Mental Health Services (CMHS), Substance Abuse Prevention (CSAP), and Substance Abuse Treatment (CSAT).

Substance Abuse Prevention and Early Intervention Programs (components of) - There are six key components: (1) Written company/managed care policy that includes prevention and early intervention; (2) Substance abuse education for covered lives; (3) A clearly identified locus (e.g., managed care corporation, personnel, human resources, EAP, etc.) for prevention and early intervention activities; (4) Program with all covered lives having access to prevention/early intervention programs and activities; (5) Capacity for prevention and early intervention; and (6) Trained medical/behavioral interventionists for prevention and early intervention.

Substance Abuse Prevention and Treatment (SAPT) Block Grant - This is Section 501 of the Public Health Services Act, which is now expired. Funding continues each year under a continuing resolution. The SAPT Block Grant is the primary funding vehicle for substance abuse prevention; 20 percent of all funds allocated to states must be spent on substance abuse primary prevention services as outlined in Block Grant legislation (Federal Register, 58:60, March 31, 1993, 17062 ff., 45 CFR Part 96).

Substate Entity Code - The code used to designate the geographic region, county, or district within the state where the prevention service was provided.

Suppressor or Masking Variable - A variable that may have a low correlation with a dependent variable, but which, when entered in a multiple regression analysis, leads to improvement in the predictive power of another predictor in the equation. The inclusion of the variable is thought to control for irrelevant variance, that is, variance that it shares with the predictors but which may not be shared with the dependent variable.

Survey Data - Information collected from specially designed instruments that provide data about the feelings, attitudes, and/or behaviors of individuals (*Achieving Outcomes*, 12/01).

Sustainability - The likelihood of a program to continue over a period of time, especially after grant monies disappear (*Achieving Outcomes*, 12/01).

Synar Amendment - The SAMHSA regulation implementing the Synar Amendment requires the State to have in effect a law prohibiting any manufacturer, retailer, or distributor of tobacco products from selling or distributing such products to any individual under the age of 18; enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18; conduct annual random, unannounced inspections in such a way as to provide a valid sample of outlets accessible to youth; and develop a strategy and timeframe for achieving an inspection failure rate of less than 20 percent of outlets accessible to youth. CSAP has a program to assist States in complying with the Synar Amendment. (For more information, see *Implementing the Synar Regulation: Issues and Strategies for Reducing Sales of Tobacco to Minors*.

Systematic Planning - Structured services that help States and communities identify prevention needs; assess existing prevention services; and set priorities and allocate prevention resources systematically, based on objective needs assessments. The specific plan is the product to be counted. Examples are agency/provider strategic plan, community team/organization plan, block grant plan, and state prevention plan.

Systems Development Theory - A theory that seeks to explain how entire systems (such as society) experience generations of change.

Tamper-evident Label/Seal - In drug testing, the label that is used to seal a urine specimen bottle. In addition to sealing the specimen bottle, it also provides an appropriate specimen number and space for the donor to initial and date the label.

Tangible Costs - Costs that can be easily measured in monetary terms.

Target Population - The group of persons (usually those at high risk) whom program interventions are designed to reach.

Targeted Capacity Expansion (TCE) Program - This program helps States and communities address gaps in availability and improve the quality of prevention services. The TCE programs are a major means of promoting science-based best practices in prevention. TCE is composed of three major efforts: (1) State Incentive Grants, (2) Centers for the Application of Prevention Technologies, and (3) HIV/AIDS Prevention, all of which are separately described in this glossary.

Targeted Message - A message that someone designs to appeal to a specific group or subset of the general market. Target audiences may be based on race, ethnicity, age,

gender, income level, occupation, health, behavior, or a combination of these or other factors.

Teachers/Administrators/Counselors - Individuals employed in the education field. Examples are teachers, coaches, deans, principals, faculty and counselors, and school administrators.

Technical Assistance (TA) - Services provided by professional prevention staff intended to provide technical guidance to prevention programs, community organizations, and individuals to conduct, strengthen, or enhance activities that will promote prevention. Services recorded under this service type code should be viable technical assistance that will lead to a final product. Examples are addressing cultural competence, developing an action plan/capacity building, ensuring quality assurance and improvement, conducting evaluations, adding programs and services, developing funding and resources, and providing professional expertise and organizational development.

Technical Capacity - Specialized skills or specific expertise required for program implementation and sustainability (*Achieving Outcomes*, 12/01).

Telephone Information Services - Telephone services intended to provide information about substance abuse prevention and treatment issues and services. These services do not include telephone calls that are a normal part of day-to-day business. Examples include toll-free telephone number services, information and referral lines, hotlines, and crisis lines.

Tertiary Prevention - Intervention, also known as treatment, that seeks to address symptoms of substance abuse and prevent further problems. Also, strategies designed to decrease the amount of disability associated with an existing disorder or illness.

Testing Bias - Testing bias is introduced to participants as a result of their participating in repeated administrations of a data collection instrument. The experience of participating in the first test may affect their subsequent reactions to the program or to retesting (for example, responding to a similar questionnaire).

Theory of Change - As used in the Achieving Outcomes Guide, a set of assumptions (also called hypotheses) about how and why desired change is most likely to occur as a result of a program. Typically, the theory of change is based on past research or existing theories of human behavior and development (*Achieving Outcomes*, 12/01).

Theory of Reasoned Action/Theory of Planned Behavior - Posits that behavioral intention is the immediate determinant of behavior and that all other factors that influence behavior are mediated through intention. The strength of the behavioral intention is based on a person's attitude toward doing a behavior and the influence of the social environment or subjective norms on the behavior. An extension of the Theory of Reasoned Action, the Theory of Planned Behavior, adds a third construct concerned with perceived control over performance of the behavior. This extension is based on the idea that performance of the behavior is determined jointly by motivation (intention) and ability (behavioral control).

Montano, D.E., Kasprzyk, D. and Taplin, S.H. (1997). The theory of reasoned action and the theory of planned behavior. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (pp. 39-62). San Francisco, CA: Jossey-Bass.

Third-Party Administrator (TPA) - Usually an out-of-house professional firm providing healthcare administrative services, such as paying claims, collecting premiums, and carrying out other administrative support services, for employee benefit plans. (Synonyms: administrative agent, carrier, insurer, underwriter).

Total Present - For recurring prevention services, the number of participants, including new participants, who were present on the service day.

Training Services - Delivering structured substance abuse prevention training events intended to develop proficiency in prevention program design, development, and delivery skills. General public education or serving as a guest speaker at a training delivery is not included in this set of services and should be counted under Speaking Engagements under the Information Dissemination strategy. Examples of training services include developing prevention training curricula, conducting prevention training programs, training of trainers, and other formal skill-building activities.

Treatment - Screening for already existing disorders and appropriate standard care, including efforts to avoid relapse.

Triangulated - Triangulation is the process of combining methods to study the same aspect of a program. Comparing three or more types of independent points of view on data sources (for example, interviews, observations, and program documentation) helps to ensure that the information used to assess the program is accurate.

Turnover Rate - Includes all permanent separations, whether voluntary or involuntary. Monthly turnover rates are calculated by employers and collected as part of the Bureau of National Affairs (BNA) Quarterly Employment Survey. BNA then calculates the monthly median rates and the average of monthly median rates for the year. Monthly rates are calculated as (number of separations during month / average number of employees on payroll during the month). (Source: BNA definition, 1995). SAMHSA grantees may wish to calculate separate turnover rates for voluntary and involuntary separations if their programs are more likely to affect one type of turnover than another.

Type I Error - The error committed when a true null hypothesis is rejected.

Type II Error - The error committed when a false null hypothesis is accepted.

Unavoidable Costs - Costs that result from actions taken in the past, despite any new treatment or policy. If everyone stopped smoking, there would still be morbidity and mortality effects from the physiological damage of past smoking. The continuing costs of these would be unavoidable.

Underlying Factors - Behaviors, attitudes, conditions, or events that cause, influence, or predispose an individual to resist or become involved in problem behavior, in this case, substance abuse. See also "Risk and Protective Factors" (*Achieving Outcomes*, 12/01).

Unit of Analysis - Level at which data will be analyzed (e.g., individual, group) or other higher collective level (e.g., classroom, school, school district).

Universal Prevention - Prevention designed for everyone in the eligible population, both the general public and all members of specific eligible groups. Also, activities targeted to the

general public or a whole population group that has not been identified on the basis of individual risk.

Uppers- - Slang term used to describe drugs that have a stimulating effect on the central nervous system. Examples include cocaine, caffeine, and amphetamines.

User ID - The identification of a person who utilizes a computer.

Utilization Management (UM) - The process of evaluating the necessity, appropriateness, and efficiency of healthcare service. A review coordinator or medical director gathers information about the proposed hospitalization, service, or procedure from the patient and/or providers, then determines whether it meets established guidelines and criteria. These guidelines may be written or may be automated protocols approved by the organization. A provider or integrated delivery network that proves it is skilled in UM may negotiate more advantageous pricing if UM is normally performed by the HMO, but efficient UM could be more effectively passed downward at a savings to the HMO.

Utilization Review (UR) - The evaluation of the medical necessity and the efficiency of healthcare services, either prospectively, concurrently, or retrospectively; contrasted with utilization management in that UR is more limited to the physician's diagnosis, treatment, and billing amount. In contrast, UM addresses the wider program requirements.

Validity - The extent to which a measure of a particular construct/concept actually measures what it purports to measure. For example, is "years of schooling" a valid measure of education? (*Achieving Outcomes*, 12/01).

Validity, Threats to - Plausible alternative explanations for measured program effects (e.g., history, maturation, selection, attrition, measurement).

Variable - A factor or characteristic of an intervention, participant, or context that may influence or be related to the possibility of achieving intermediate or long-term outcomes.

Variables, Mediating - Measured constructs that fall between the interventions and outcomes in the causal sequence.

Variables, Predictive - One variable is considered to be predictive of another if there is a systematic relationship between the two. However, the fact that there is a relationship does not mean that one thing causes the other. For example, low school achievement is often associated with drug abuse in the teen years, but low school achievement does not cause drug abuse. Young people who perform poorly in school are at high risk, but there are many other risk factors, none of which predict with complete accuracy who will become involved with drugs.

Vertical Integration - An organization of production whereby one business entity controls or owns all stages of the production and distribution of goods or services. In healthcare, vertical integration can take many forms, but generally implies that physicians, hospitals, and health plans have combined their organizations or processes in some manner to increase efficiencies, increase competitive strength, or to improve quality of care. Integrated delivery systems or healthcare networks are generally vertically integrated.

Violence - An act carried out with the intention or perceived intention of causing physical pain or injury to another person.

Vision - A statement that captures as concisely as possible, what a group is striving to do. This statement should be realistic and credible, well-articulated and easily understood, appropriate, ambitious, and responsive to change.

Vulnerable Populations - Refers to children, elderly persons, and persons with disabilities.

Wellness Program - Programs, typically oriented toward healthy lifestyle and preventive care, that may decrease healthcare utilization and costs. From an employer perspective the emphasis is on keeping employees healthy.

Workers Compensation Payments - Includes actual disbursements for injuries and illnesses covered under Workers Compensation program rules.

Workplace Injuries and Illnesses - Nonfatal occupational illnesses or injuries that involve one or more of the following: loss of consciousness, restriction of work or motion, lost work time, transfer to another job, or medical treatment (other than first aid).

Workplace Managed Care (WMC) - In WMC, workplaces integrate their substance-abuse prevention and early-intervention programs, strategies, and activities for employees and their families (covered lives). Integrated activities frequently include internal and external workplace and workplace-related components: employee assistance programs (EAPs), human resources, security, management, and managed care organizations and providers (primary and behavioral health care). Services may be received in various locations and through face-to-face encounters (e.g., at the workplace, physician's office, health fairs) or multimedia (e.g., video, telephone, Internet, publications). It is the strategy of integrating these elements and agents that constitutes the WMC approach to providing substance abuse prevention and early intervention to employees and their families. (See CSAP's Workplace Managed Care initiative for more information.)

Workplace Prevention - Preliminary information indicates substantial gains resulting from prevention efforts in the workplace. For example, in an insurance-related industry, addition of substance abuse prevention materials to health promotion in the workplace improved attitudes and behavior related to substance use. Also, workers who participated in SA interventions were more likely to access healthcare for SA problems. Employee injury rates can be reduced when substance abuse prevention initiatives are introduced. For more information, see NCADI's publications about workplace prevention issues.

Wraparound Services - Services that address consumers' total healthcare needs in order to achieve health or wellness. These services "wrap around" core clinical interventions, usually medical. Typical examples include such services as financial support, transportation, housing, job training, specialized treatment, or educational support.

Youth/Adult Leadership Functions - Services through which youth/adult role models work with youth to help prevent substance abuse. Examples are tutoring programs, coaching activities, adult mentoring programs, adult-led youth groups and youth/peer mentoring programs.

Youth/Minors - Children under age 18 who are not otherwise counted under one of the school grade categories. Examples are youth in recreation programs (camps, summer programs), youth in employment programs and youth in clubs or recreation centers.

SAMHSA-NREPP GLOSSARY

Adaptation--A modest to significant modification of an intervention to meet the needs of different people, situations, or settings.

Adverse effect--Any harmful or unwanted change in a study group resulting from the use of an intervention.

Attrition--The loss of study participants during the course of the study due to voluntary dropout or other reasons. Higher rates of attrition can potentially threaten the validity of studies. Attrition is one of the six NREPP criteria used to rate Quality of Research.

Baseline--The initial time point in a study just before the intervention or treatment begins. The information gathered at baseline is used to measure change in targeted outcomes over the course of the study.

Co-occurring disorders In the context of NREPP, substance abuse and mental disorders that often occur in the same individual at the same time (e.g., alcohol dependence and depression); also known as comorbid disorders.

Comparative effectiveness research--The Federal Coordinating Council on Comparative Effectiveness Research defines comparative effectiveness research, in part, as the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies (e.g., medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, and delivery system strategies) to prevent, diagnose, treat, and monitor health conditions in "real world" settings.

Comparison group--A group of individuals that serves as the basis for comparison when assessing the effects of an intervention on a treatment group. A comparison group typically receives some treatment other than they would normally receive and is therefore distinguished from a control group, which often receives no treatment or "usual" treatment. To make the comparison valid, the composition and characteristics of the comparison group should resemble that of the treatment group as closely as possible. Some studies use a control group in addition to a comparison group.

Confounding variables--In an experiment, any characteristic that differs between the experimental group and the comparison group and is not the independent variable under study. These characteristics or variables "confound" the ability to explain the experimental results because they provide an alternative explanation for any observed differences in outcome. In assessing a classroom curriculum, for example, a confounding variable would exist if some students were taught by a highly experienced instructor while other students were taught by a less experienced instructor. The difference in the instructors' experience level makes it harder to determine if the differences in student outcomes (e.g., grades) were caused by the effects of the curriculum or by the variation in instructors. The likelihood that confounding variables might have affected the outcomes of a study is one of the six NREPP criteria used to rate Quality of Research.

Control group-- A group of individuals that serves as the basis of comparison when assessing the effects of an intervention on a treatment group. Depending upon the study design, a control group may receive no treatment, a "usual" or "standard" treatment, or a placebo. The composition and characteristics of the control group should resemble that of the treatment group as closely as possible to make the comparison valid.

Core components--The most essential and indispensable components of an intervention (core intervention components) or the most essential and indispensable components of an implementation program (core implementation components).

Cultural appropriateness-- In the context of public health, sensitivity to the differences among ethnic, racial, and/or linguistic groups and awareness of how people's cultural background, beliefs, traditions, socioeconomic status, history, and other factors affect their needs and how they respond to services. Generally used to describe interventions or practices.

Cultural competence-- In the context of public health, the knowledge and sensitivity necessary to tailor interventions and services to reflect the norms and culture of the target population and avoid styles of behavior and communication that are inappropriate, marginalizing, or offensive to that population. Generally used to describe people or institutions. Because of the changing nature of people and cultures, cultural competence is seen as a continual and evolving process of adaptation and refinement.

Dissemination--The targeted distribution of program information and materials to a specific audience. The intent is to spread knowledge about the program and encourage its use.

DSM (Diagnostic and Statistical Manual of Mental Disorders)--The Diagnostic and Statistical Manual of Mental Disorders, or DSM, is the standard reference handbook used by mental health professionals in the United States to classify mental disorders. There have been five revisions of the DSM since it was first published by the American Psychiatric Association in 1952. The most recent version is the DSM-IV or Fourth Edition, published in 1994; a text revision (DSM-IV-TR) was published in 2000. Earlier editions that may be referenced in NREPP include the DSM-III (1980) and DSM-III-R (1987).

Effective Program-- A few Effective Programs were re-reviewed for NREPP using updated criteria in 2006-2007 and can now be found by searching for the program on the Find an Intervention page.

Evidence-based Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation. "Evidence-based" stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

Experimental--A study design in which (1) the intervention is compared with one or more control or comparison conditions, (2) subjects are randomly assigned to study conditions, and (3) data are collected at both pretest and posttest or at posttest only. The experimental study design is considered the most rigorous of the three types of designs (experimental, quasi-experimental, and pre-experimental).

Externalizing behaviors Social behaviors and other external cues that reflect an individual's internal emotional or psychological conflicts. Examples include spontaneous

weeping, "acting out," and uncharacteristic aggression. Reduction of externalizing behaviors is a frequently used measure of the success of treatment or intervention for mental or emotional disorders.

Fidelity--Fidelity of implementation occurs when implementers of a research-based program or intervention (e.g., teachers, clinicians, counselors) closely follow or adhere to the protocols and techniques that are defined as part of the intervention. For example, for a school-based prevention curriculum, fidelity could involve using the program for the proper grade levels and age groups, following the developer's recommendations for the number of sessions per week, sequencing multiple program components correctly, and conducting assessments and evaluations using the recommended or provided tools.

Generalizability--The extent to which a study's results can be expected to occur with other people, settings, or conditions beyond those represented in the study. Threats to generalizability include lack of randomization, effects of testing, multiple-treatment interference, selection-treatment interference, effects of experimental arrangements, experimenter effects, and specificity of variables.

Implementation--The use of a prevention or treatment intervention in a specific community-based or clinical practice setting with a particular target audience.

Implementation team--A core set of individuals charged with providing guidance through full implementation of the intervention. This team helps ensure engagement of the stakeholders, increases readiness for implementation, ensures fidelity to the intervention, monitors outcomes, and addresses barriers to implementation.

Indicated--One of the three categories (Universal, Selective, Indicated) developed by the Institute of Medicine to classify preventive interventions. Indicated prevention strategies focus on preventing the onset or development of problems in individuals who may be showing early signs but are not yet meeting diagnostic levels of a particular disorder.

Internal validity--The degree to which the intervention or experimental manipulation was the cause of any observed differences or changes in behavior.

Internalizing behaviors-- Behaviors that reflect an individual's transfer of external social or situational stresses to emotional, psychological, or physical symptoms. One well-known internalizing behavior is a child's development of stomach cramps when the parents argue; another is insomnia during a high-stress situation at work. Reduction of internalizing behaviors is a frequently used measure of the success of treatment or intervention for mental or emotional disorders.

Intervention--A strategy or approach intended to prevent an undesirable outcome (preventive intervention), promote a desirable outcome (promotion intervention) or alter the course of an existing condition (treatment intervention).

Legacy Programs-- The label used by SAMHSA for all former Effective and Promising Programs, which were reviewed between 1997 and 2004 as part of the Center for Substance Abuse Prevention's Model Programs Initiative. Summaries for these Legacy Programs are listed in the Legacy Programs section of the NREPP Web site.

Logic model--A tool that allows key stakeholders to develop a strategic plan to address an identified community problem.

Mental health promotion-- Attempts to (a) encourage and increase protective factors and healthy behaviors that can help prevent the onset of a diagnosable mental disorder and (b) reduce risk factors that can lead to the development of a mental disorder.

Mental health treatment --Assistance to individuals for existing mental health conditions or disorders.

Meta-analysis--A statistical procedure for combining the results of two or more studies on the same topic.

Missing data-- Data or information that researchers intended to collect during a study that was not actually collected or was collected incompletely. Missing data may occur, for example, when survey respondents do not answer all questions in a survey, or when the researchers "throw out" or exclude survey questions because the responses do not meet validation checks. Missing data can threaten the validity and reliability of a study if steps are not taken to compensate for or "impute" (replace with calculated data) the missing information. Missing data are one of the six NREPP criteria used to rate Quality of Research.

Model Program-- Most of the Model Programs were re-reviewed for NREPP using updated criteria in 2006-2007 and can now be found by searching for the program on the Find an Intervention page.

Outcome--A change in behavior, physiology, attitudes, or knowledge that can be quantified using standardized scales or assessment tools. In the context of NREPP, outcomes refer to measurable changes in the health of an individual or group of people that are attributable to the intervention.

Outcome evaluation--An evaluation to determine.the extent to which an intervention affects its participants and the surrounding environments. Several important design issues must be considered, including how to best determine the results and how to best contrast what happens as a result of the intervention with what happens without the program.

Pre-experimental--A study design in which (1) there are no control or comparison conditions and (2) data are collected at pretest or posttest only; includes simple observational or case studies. The pre-experimental study design provides the most limited scientific rigor of the three types of designs (experimental, quasi-experimental, and pre-experimental).

Process evaluation--An evaluation to determine whether an intervention has been implemented as intended.

Program drift--A threat to fidelity due to compromises made during implementation.

Program fit--The degree to which a program matches a community's needs, resources, and implementation capacity.

Promising Program-- A few Promising Programs were re-reviewed for NREPP using updated criteria in 2006-2007 and can now be found by searching for the program on the Find an Intervention page.

Psychometrics--The construction of instruments and procedures for measurement.

Quality assurance-- Activities and processes used to check fidelity and the quality of implementation.

Quality of Research-- One of the two main categories of NREPP ratings. Quality of Research (QOR) is how NREPP quantifies the strength of evidence supporting the results or outcomes of the intervention. Each outcome is rated separately. This is because interventions may target multiple outcomes, and the evidence supporting the different outcomes may vary. These QOR ratings are followed by brief "Strengths and Weaknesses" statements where reviewers comment on the studies and materials they reviewed and explain what factors may have contributed to high or low ratings. For more information on the scientific reviewers who rate QOR and how ratings are derived, see the NREPP page on Review Process Quality of Research.

Quasi-experimental--A study design in which (1) the intervention is compared with one or more control or comparison conditions, (2) subjects are not randomly assigned to study conditions, and (3) data are collected at pretest and posttest or at posttest only; includes time series studies, which have three pretest and three posttest data collection points. The quasi-experimental study design provides strong but more limited scientific rigor relative to an experimental design.

Ratings--NREPP provides two types of ratings for each intervention reviewed: Quality of Research and Readiness for Dissemination. Each intervention has multiple Quality of Research ratings (one per outcome) and one overall Readiness for Dissemination rating. QOR and RFD ratings are followed by brief "Strengths and Weaknesses" statements where reviewers comment on the studies and materials they reviewed and explain what factors may have contributed to high or low ratings.

Readiness for Dissemination-- One of the two main categories of NREPP ratings. Readiness for Dissemination (RFD) is how NREPP quantifies and describes the quality and availability of an intervention's training and implementation materials. More generally, it describes how easily the intervention can be implemented with fidelity in a real-world application using the materials and services that are currently available to the public. For more information on the reviewers who rate RFD and how ratings are derived, see the NREPP page on Review Process Readiness for Dissemination.

Reliability of measure--The degree of variation attributable to inconsistencies and errors involved in measures or measurements. Key types include test-retest, interrater, and interitem. Reliability of measures is one of the six NREPP criteria used to rate Quality of Research.

Replication--The original investigator(s) or an independent party has used the same protocol with an identical or similar target population, and/or has used a slightly modified protocol with a slightly different population, where results are consistent with positive findings from the original evaluation.

Selective--One of the three categories (Universal, Selective, Indicated) developed by the Institute of Medicine to classify preventive interventions. Selective prevention strategies focus on specific groups viewed as being at higher risk for mental health disorders or substance abuse because of highly correlated factors (e.g., children of parents with substance abuse problems).

Substance abuse prevention --Attempts to stop substance abuse before it starts, either by increasing protective factors or by minimizing risk factors.

Substance abuse treatment-- Assistance to individuals for existing substance abuse disorders.

Sustainability--The long-term survival and continued effectiveness of an intervention.

Symptomatalogy--The combined symptoms or signs of a disorder or disease.

Systematic review--A literature review that attempts to collect, summarize, and present results of individual studies, and then synthesizes findings on a specific topic.

Universal--One of the three categories (Universal, Selective, Indicated) developed by the Institute of Medicine to classify preventive interventions. Universal prevention strategies address the entire population (national, local community, school, neighborhood), with messages and programs to prevent or delay the use/abuse of alcohol, tobacco, and other drugs.

Validity of measure--The degree to which a measure accurately captures the meaning of a concept or construct. Key types include pragmatic/predictive, face, concurrent/criterion, and construct. Validity of measures is one of the six NREPP criteria used to rate Quality of Research.

http://www.nrepp.samhsa.gov/AboutGlossary.aspx

Chapter 16: Links to Additional Resources

1. http://pubs.niaaa.nih.gov/publications/arh283/121-124.htm
2. http://pubs.niaaa.nih.gov/publications/AA67/AA67.htm
3. https://www.stopalcoholabuse.gov/prevention.aspx
4. http://www.surgeongeneral.gov/library/calls/underagedrinking/calltoaction.pdf
5. http://pediatrics.aappublications.org/content/121/Supplement_4/S235.full
6. http://oas.samhsa.gov/2k9/159/ParentInvolvement.htm
7. http://www.oas.samhsa.gov/2k8/underageGetAlc/underageGetAlc.htm
8. http://www.oas.samhsa.gov/2k8/location/underage.htm
9. http://oas.samhsa.gov/2k9/108/FatherAlcUse.htm

10. http://www.thecommunityguide.org/alcohol/index.html
11. http://www.niaaa.nih.gov/YouthGuide
12. http://pubs.niaaa.nih.gov/publications/PSA/underagepg2.htm
13. http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/connectedness.pdf
14. http://alcoholpolicy.niaaa.nih.gov/
15. http://captus.samhsa.gov/access-resources/common-risk-and-protective-factors-alcohol-and-drug-use
16. http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx
17. http://aspe.hhs.gov/hsp/PositiveYouthDev99/index.htm#toc
18. http://pubs.niaaa.nih.gov/publications/arh321/3-15.htm
19. http://store.samhsa.gov/shin/content//SMA09-4205/SMA09-4205.pdf
20. http://www.samhsa.gov/underagedrinking/
21. http://www.cadca.org/
22. http://www.whitehouse.gov/ondcp
23. https://www.stopalcoholabuse.gov/
24. http://captus.samhsa.gov/access-resources/national-sources-existing-data
25. http://captus.samhsa.gov/access-resources/online-tools-support-substance-abuse-prevention-efforts
26. http://www.promoteacceptance.samhsa.gov/10by10/default.aspx
27. http://www.ihs.gov/behavioral/index.cfm
28. http://honoringnativelife.org/?page_id=7311
29. http://healthypeople.gov/2020/
30. http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf