

Needs Assessment Guidebook

Ohio's Strategic Prevention Framework – State Incentive Grant (SPF SIG)

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INTRODUCTION

The needs assessment process involves conducting an analysis of the problem in your community. This includes:

- Gathering data on the nature and scope of the problem
- Examining existing resources and assets
- Analyzing the information to clarify needs and opportunities

Through this process, your local planning team should come to a shared understanding of the nature, extent, and underlying causes of alcohol- and/or other drug-related problems in the community. Your Prevention Data Committee should take the lead on conducting the needs assessment and set data collection procedures in place that will be sustained beyond the SPF SIG grant. There are multiple information sources to consult, including previous needs assessments, surveys, key informant interviews, focus groups, field observations, arrest and incident data, and other community data.

In any needs assessment, it is important to keep the project's goals at the forefront.

Ohio's SPF SIG Goals

1. Decrease the number of 18-25 year olds engaged in high risk use of alcohol.
2. Decrease the number of 18-25 year olds engaged in the use of illicit drugs.
3. Decrease the number of 18-25 year olds misusing prescription medication.

Measurement of Ohio's SPF SIG Goals

To meet requirements set forth by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (SAMHSA – CSAP), each SPF SIG sub-recipient community must measure progress toward Ohio's SPF SIG Goals using at least one of the National Outcome Measures (NOMs). Appendix A provides clarification on survey items that are considered NOMs. The NOMs that Ohio has specifically chosen to measure progress are:

1. 30-day substance use
2. Age of first use
3. Perception of disapproval/attitude
4. Perceived risk/harm of use

Sub-population C: _____

BEGINNING THE LOCAL LEVEL NEEDS ASSESSMENT PROCESS

The purpose of this needs assessment process is not to reinvent the wheel; it is designed to help you:

- collect and organize the data and information you already have
- identify gaps in the available data and information
- create tools and procedures that help fill the gaps
- assemble a data profile related to 18-25 year old substance use/abuse in your community that will help drive your SPF SIG process

Therefore, to begin the needs assessment process at the local level, first brainstorm all of the needs assessments that have been done in your community in the past five years. You will need to gather copies of the results of these needs assessments and use them to complete the following form for each needs assessment. *Please feel free to photocopy if your community has completed more than one needs assessment.*

Name of Needs Assessment: _____

Year Conducted: _____

Sponsoring Agency/Agencies: _____

Findings Relevant to 18-25 Year Old Substance Use/Abuse: For this section, you will be creating a bullet-point list. Please keep these clear and concise! *Do not write more than two sentences for each bullet point.* If there is no information related to 18-25 year old substance use/abuse, state that in your first bullet point and move on to the next section. (Feel free to add more bullet points if you need to.)

- _____

- _____

- _____

- _____

- _____

Findings Relevant to Community Readiness to Address 18-25 Year Old Substance Use/Abuse: For this section, you will be creating a bullet-point list. Please keep these clear and concise! *Do not write more than two-sentences for each bullet point.* If there is no information related to community readiness to address 18-25 year old substance use/abuse, state that in your first bullet point and move on to the next needs assessment.

- _____

- _____

- _____

- _____

- _____

SETTING THE STAGE TO EXPAND LOCAL NEEDS ASSESSMENT EFFORTS

The purpose of the SPF SIG needs assessment process is to *compile* and *organize* previous needs assessment work done in your community. It will also help your group expand on these initial efforts to fill in any gaps that may exist that will help you answer these questions:

- **Community readiness** – Why do you need to do a community readiness assessment? The answer is simple: if your community is not ready or receptive to prevention messages, then the effort you make will not be as successful. A community readiness survey can assist you in deciding what strategy is best for your community.
- **When** are the consumption issues occurring? (Is there a seasonal pattern? Is it year-round? Is it linked to special events?)
- What is your community's current **capacity** for impacting change (related to your chosen issue)?
- What is your community's **cultural competency** related to your chosen issue?
- **Intervening Variables - the Why?** Of course, this is the big question – the one that will help guide your strategic planning process. The “why” is also known as the intervening variables that contribute to an issue. Having as much information as possible about the intervening variables will help inform your choice of intervention(s).

The sections of the guidebook that follow will provide you with resources to help your community organize and utilize the data and information you have into a format that will help build your SPF SIG Logic Model and drive your SPF SIG Strategic Planning Process.

COMMUNITY READINESS ASSESSMENT

Many SPF SIG communities began their Needs Assessment process with a Community Readiness Assessment. Although there are several instruments available to measure community readiness, they all share common stages. Below are the stages of community readiness identified through the scoring process of many community readiness assessments:

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

When your Community Readiness Assessment is finished, please complete the Community Readiness Worksheet.

Community Readiness Worksheet

1. Which community readiness assessment tool did your community use?

- MIPH Community Readiness Survey
- Tri-Ethnic Center for Prevention Research's Community Readiness Model
- Community Partner Institute's Community Prevention Readiness Index
- Goodman and Wandersman's Community Key Leader Survey
- CSAP's Prevention Platform
- Other [Please describe *in detail*. Please cite the sources for your community readiness assessment items.]

2. When did your community readiness assessment take place (Month/Year)?

_____ to _____

3. After reviewing your community readiness assessment and discussing it among your SPF SIG coalition, what stage of community readiness best describes your community with respect to your priority substance?

- | | |
|--|--|
| <input type="radio"/> Community Tolerance/No Knowledge | <input type="radio"/> Initiation |
| <input type="radio"/> Denial | <input type="radio"/> Institutionalization/Stabilization |
| <input type="radio"/> Vague Awareness | <input type="radio"/> Confirmation/Expansion |
| <input type="radio"/> Preplanning | <input type="radio"/> Professionalization |
| <input type="radio"/> Preparation | |

4. How did you communicate the findings of your Community Readiness Assessment back to your community? What was the response?

5. How will the data and information from your community readiness assessment drive your SPF SIG process? That is, how will you use the data from your community readiness assessment in your strategic planning process?

6. What strategies will you employ in your strategic planning process to increase readiness in your community? It is important to keep in mind that it is not suggested that communities should try to skip stages. For example, if you find your community is in stage 1, do not try to force it into stage 5. Change must happen through preparation and process, not coercion.

7. How will you evaluate these strategies? That is, how will you know that your strategies are, in fact, increasing readiness in your community?

USING THE SOCIAL-ECOLOGICAL MODEL TO ORGANIZE NEEDS ASSESSMENT DATA AND INFORMATION

One of the most important tasks in the needs assessment process is to identify the intervening variables associated with your target priority. To help your local planning team determine the intervening variables, we are using the **Social-Ecological Model**¹ (SEM) to frame the needs assessment. The SEM is a multi-level model that encompasses individual, interpersonal, community, organization/institution, and policy factors that influence health behavior. The SEM is widely used by the Centers for Disease Control and Prevention to guide prevention activities in many health areas (i.e., violence prevention,² cancer prevention,³ etc.). You can also find this model in the CADCA document titled *Research Support For Comprehensive Community Interventions to Reduce Youth Alcohol, Tobacco and Drug Use and Abuse* (Appendix B). The figure that follows presents an overview of the Social-Ecological Model. You may notice that the labeling to this figure presented here is slightly different than the model presented on page 4 of the CADCA document. Please be assured that all of the elements of the model remain intact; we are presenting the model in a way that we hope will be more accessible to coalition members who may not have advanced-level training in public health.

¹ McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15, 351-377.

² <http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html>

³ <http://www.cdc.gov/cancer/crccp/sem.htm>

SOCIAL-ECOLOGICAL MODEL



POLICY

The fifth and outermost band of the Social-Ecological Model circle surrounds the community band and represents substance abuse prevention activities at the policy level. These activities are intended to facilitate individual behavior change through regulation, communication, and support by promoting, developing, and implementing local, state, and federal policies and guidelines. Policy-level institutions and representatives such as federal government agencies, tribal governments, national advocacy groups, and local, state, and national legislators represent potential sources for regulation, communication, and support.

COMMUNITY

The fourth band of the SEM circle surrounds the organizational band and represents substance abuse prevention activities implemented at the community level. These activities are intended to facilitate individual behavior change through communication and support by leveraging resources and participation of community-level institutions such as substance abuse coalitions, health departments, media, and community advocacy groups, which represent potential sources of community communication and support.

ORGANIZATIONAL

The third band of the SEM circle surrounds the interpersonal band and represents substance abuse prevention activities implemented at the organization level. These activities are intended to facilitate individual behavior change through communication and support aimed at influencing organizational systems and policies. Health care systems, employers or worksites, health care plans, local health departments, health clinics, and professional organizations represent potential sources of organizational messages and support.

INTERPERSONAL

The second band of the Social-Ecological Model circle surrounds the individual band and represents substance prevention activities implemented at the interpersonal level. This part of the needs assessment is intended to facilitate individual behavior change through interpersonal communication and support aimed at affecting social and cultural norms and overcoming individual-level barriers. Friends, family, health care providers, community health workers, and prevention providers represent potential sources of interpersonal messages and support.

INDIVIDUAL

The center of the SEM circle represents the individual who is ultimately affected by substance abuse and prevention activities. This is the core of any prevention program since it is the area of critical concern for public health and social welfare. Individuals who abuse AOD are in need of help to reduce and quit using. From the service perspective, once individuals are introduced to messages and activities concerning the need to prevent, reduce and stop consuming harmful substances in their bodies, it is their behavior change that will determine whether or not the messages and activities are effective.

INDIVIDUAL LEVEL

For the SPF SIG needs assessment, all sub-recipient communities must perform a scan for data which will provide information pertaining to the selected outcomes for Ohio:

1. 30-day substance use
2. Age of first use
3. Perception of disapproval/attitude
4. Perceived risk/harm of use

In addition, SAMHSA-CSAP requires that you track (once pre-implementation and once post-implementation) at least one of Ohio’s outcome measures for *each priority substance in your community*. Therefore, if you have more than one priority (e.g., alcohol use and prescription drug use), you must track at least one of these outcomes for alcohol use and at least one of these outcomes for prescription drug use.

SAMHSA-CSAP *also* requires that at least one of your outcome measures is a National Outcome Measures (NOM) – *if there is one that matches your priority substance*. Please see Appendix C for the list of SAMHSA-CSAP approved NOMs. You will notice that there is not a NOM specifically for prescription drug abuse and for any specific illicit drug other than marijuana. **Please work with your OSET evaluator for assistance in determining an appropriate indicator if there is not one on the approved list that meets your needs.**

Please complete the following “data profiles” that are applicable to your community’s priority substance. The profiles ask for detailed information regarding any data that are available in your community related to your selected priority. If you do not have data at this time, please indicate as such. *If you have more than one measure for a particular concept (e.g., disapproval of substance use), please feel free to make photocopies of the workbook page and complete a “data profile” for that particular item.*

We realize the information needed on each indicator is quite lengthy. **The information we are asking you to complete is required by SAMHSA-CSAP.** Please see Appendix D for an overview of the Community Outcome Measures process.

30 DAY USE INDICATORS

30 Day Use – Alcohol

Complete only if your SPF SIG project is focusing on alcohol consumption.

Are these data available for your *target population*? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage? Response 0-30).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University's main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University's main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey. _____

Number of Respondents:

How many persons actually participated in the survey? _____

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., % of individuals who report having used alcohol in the past 30 days).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting having used alcohol in the past 30 days); it may be a mean (e.g., number of days used alcohol in the past 30).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

30 Day Use – Marijuana or Hashish

Complete only if your SPF SIG project is focusing on marijuana or hashish.

Are these data available for your *target population*? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., During the past 30 days, on how many days did you use marijuana or hashish? Response 0-30).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University's main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University's main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey. _____

Number of Respondents:

How many persons actually participated in the survey? _____

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., % of individuals who report having used marijuana or hashish in the past 30 days).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting having used marijuana or hashish in the past 30 days); it may be a mean (e.g., number of days used marijuana or hashish in the past 30).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

30 Day Use – Any Other Illegal Drugs

Complete only if your SPF SIG project is focusing on any other illegal drugs.

Are these data available for your *target population*? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., During the past 30 days, on how many days did you use other illegal drugs? Response 0-30).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University’s main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University’s main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey. _____

Number of Respondents:

How many persons actually participated in the survey? _____

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., % of individuals who report having used any other illegal drugs in the past 30).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting having used any other illegal drugs in the past 30 days); it may be a mean (e.g., number of days used any other illegal drugs in the past 30 days).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

30 Day Use – Misuse/Abuse of Prescription Drugs

Complete only if your SPF SIG project is focusing on misuse/abuse of prescription drugs.

Are these data available for your *target population*? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., During the past 30 days, on how many days did you use a prescription drug that was not prescribed for you? Response 0-30).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University's main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University's main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey. _____

Number of Respondents:

How many persons actually participated in the survey? _____

Reported Outcome:

Note: This is how the outcome is reported in the results(e.g., % of individuals who report having used a prescription drug that was not prescribed for self in the past 30).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting having used a prescription drug that was not prescribed for them in the past 30 days); it may be a mean (e.g., number of days used use a prescription drug that was not prescribed for self in the past 30 days).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

AGE OF FIRST USE

Age of First Use – Alcohol

Complete only if your SPF SIG project is focusing on alcohol consumption.

Are these data available for your *target population*? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., Think about the **first time** you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you had only a sip or two from a drink. Response 0-100).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University's main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University's main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey. _____

Number of Respondents:

How many persons actually participated in the survey? _____

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., mean age of first use of alcohol).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting first use of alcohol between the ages of 18-25); it may be a mean (e.g., mean age of first use of alcohol).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

Age of First Use – Marijuana or Hashish

Complete only if your SPF SIG project is focusing on marijuana or hashish.

Are these data available for your target population? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How old were you the **first time** you used marijuana or hashish? Response 0-100).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University’s main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University’s main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population

E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., mean age of first use of marijuana or hashish).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting first use of marijuana or hashish between the ages of 18-25); it may be a mean (e.g., mean age of first use of marijuana or hashish).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

Age of First Use – Any Other Illegal Drugs

Complete only if your SPF SIG project is focusing on any other illegal drugs.

Are these data available for your *target population*? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument(e.g., How old were you the **first time** you used any other illegal drug? Response 0-100).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University’s main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University’s main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population

E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., mean age of first use of any other illegal drugs).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting first use of any other illegal drugs between the ages of 18-25); it may be a mean (e.g., mean age of first use of any other illegal drugs).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

Age of First Use – Misuse/Abuse of Prescription Drugs

Complete only if your SPF SIG project is focusing on misuse/abuse of prescription drugs.

Are these data available for your *target population*? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How old were you the **first time** you used a prescription drug that was not prescribed for you? Response 0-100).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University’s main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University’s main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., mean age of first use of a prescription drug that was not prescribed for self).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting first use of a prescription drug that was not prescribed for self between ages 18-24); it may be a mean (e.g., mean age of first use of a prescription drug that was not prescribed for self).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

DISAPPROVAL OF SUBSTANCE USE

Disapproval of Substance Use – Alcohol

Complete only if your SPF SIG project is focusing on alcohol consumption.

Are these data available for your *target population*? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?

Responses: 1. Neither approve nor disapprove, 2. Somewhat disapprove, 3. Strongly disapprove).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University's main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University's main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., percent somewhat or strongly disapproving).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percent somewhat or strongly disapproving); it may be a mean (e.g., mean approval rating).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

Disapproval of Substance Use – Marijuana or Hashish

Complete only if your SPF SIG project is focusing on marijuana or hashish.

Are these data available for your *target population*? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How do you feel about someone your age using marijuana or hashish once a month or more? Responses: 1. Neither approve nor disapprove, 2. Somewhat disapprove, 3. Strongly Disapprove).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University's main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University's main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Disapproval of Substance Use – Any Other Illegal Drugs

Complete only if your SPF SIG project is focusing on misuse/abuse on any other illegal drugs.

Are these data available for your target population? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How do you feel about someone your age using any other illegal drug once a month or more? Responses: 1. Neither approve nor disapprove, 2. Somewhat disapprove, 3. Strongly disapprove

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University’s main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University’s main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., percent somewhat or strongly disapproving).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage somewhat or strongly disapproving); it may be a mean (e.g., mean approval rating).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

Disapproval of Substance Use – Misuse/Abuse of Prescription Drugs

Complete only if your SPF SIG project is focusing on misuse/abuse of prescription drugs.

Are these data available for your target population? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How do you feel about someone your age using prescription drugs that are not prescribed for him/her once a month or more? Responses: 1. Neither approve nor disapprove, 2. Somewhat disapprove, 3. Strongly disapprove).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University's main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University's main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., percent somewhat or strongly disapproving).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage somewhat or strongly disapproving); it may be a mean (e.g., mean approval rating).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

PERCEIVED RISK/HARM OF USE

Perceived Risk/Harm of Use – Alcohol

Complete only if your SPF SIG project is focusing on alcohol consumption.

Are these data available for your target population? YES NO
If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How much do people risk harming themselves physically and in other ways when they have **five or more drinks of an alcoholic beverage once or twice a week?** Responses: 1. No risk, 2. Slight risk, 3. Moderate risk, 4. Great risk).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University's main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University's main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., percent reporting moderate or great risk).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percent reporting moderate or great risk); it may be a mean (e.g., mean risk rating).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

Perceived Risk/Harm of Use – Marijuana or Hashish

Complete only if your SPF SIG project is focusing on alcohol consumption.

Are these data available for your target population? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How much do people risk harming themselves physically and in other ways when they smoke **marijuana once or twice a week**? Responses: 1. No risk, 2. Slight risk, 3. Moderate risk, 4. Great risk).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University’s main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University’s main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population

E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., percent reporting moderate or great risk).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the target population. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting moderate or great risk); it may be a mean (e.g., mean risk rating).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

Perceived Risk/Harm of Use – Any Other Illegal Drugs

Complete only if your SPF SIG project is focusing on any other illegal drugs.

Are these data available for your target population? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How much do people risk harming themselves physically and in other ways when they use any other illegal drug **once or twice a week**? Responses: 1. No risk, 2. Slight risk, 3. Moderate risk, 4. Great risk).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University's main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University's main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population
- E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., percentage reporting moderate or great risk).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting moderate or great risk); it may be a mean (e.g., mean risk rating).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

Perceived Risk/Harm of Use – Misuse/Abuse of Prescription Drugs

Complete only if your SPF SIG project is focusing on misuse/abuse prescription drugs.

Are these data available for your target population? YES NO

If yes:

Data Source: _____

Year(s): _____

Measure:

Note: This is the actual question on the survey instrument (e.g., How much do people risk harming themselves physically and in other ways when they use any prescription drugs that are not prescribed for them? Responses: 1. No risk, 2. Slight risk, 3. Moderate risk, 4. Great risk).

Population Information:

From what population was the survey sample drawn? Please provide a brief description of population represented by this measure (e.g., Undergraduate students attending Ohio University’s main campus).

Population Size:

Approximately how many persons were part of the survey population? Provide the size of the population represented by data (e.g., There are 17,212 students attending Ohio University’s main campus; therefore, the size = 17,212.)

Sampling Strategy:

What sampling strategy was used for this survey? Please select the best response.

- A. Full census of the specified population
- B. Randomly selected sample of the specified population
- C. Convenience sample of the specified population
- D. Targeted or purposive sample of the specified population

E. Other: _____

Sample Size:

How many persons were drawn as part of the survey sample? This pertains to the number of persons who were recruited for participation in the survey.

Number of Respondents:

How many persons actually participated in the survey?

Reported Outcome:

Note: This is how the outcome is reported in the results (e.g., percent reporting moderate or great risk).

Calculated Value/Value Type:

Enter the value (the numeric results, the actual statistics) of this measure for the *target population*. For example, this may be the prevalence rate expressed as a percentage (e.g., percentage reporting moderate or great risk); it may be a mean (e.g., mean risk rating).

_____ Percentage _____ Mean _____ Rate

NOMs Item

Indicate whether the survey item qualifies as a NOMs item. Note: In order for the item to be considered a NOMs item, the item wording must match the approved NOMs item *exactly*. Please refer to the NOMs Definitions document (Appendix C) for clarification.

Does this measure qualify as a NOMs item? YES NO

INDIVIDUAL LEVEL: DATA AVAILABILITY SUMMARY

Now that you have done a scan of the availability of individual data related to Ohio's outcome measures, here is where you will summarize your process.

For which National Outcome Measures (NOMs) do you have data for your *target population*? Please circle all that apply.

1. 30-day substance use (also an Ohio outcomes measure)
2. Age of first use (also an Ohio outcomes measure)
3. Perception of disapproval/attitude (also an Ohio outcomes measure)
4. Perceived risk/harm of use (also an Ohio outcomes measure)
5. We currently do not have any NOMs-related data for our target population.
6. There is not a NOM that is relevant to our priority substance.

If you currently do not have at least one National Outcome Measure (NOM) for your *target population*, when do you plan on collecting your data? Please circle one response.

1. We will collect NOMs data as part of the needs assessment process
2. We will collect baseline NOMs data prior to implementation (i.e., data collection will be specified as part of the strategic plan and will occur prior to implementation)

If you are planning on creating a survey instrument to capture individual-level data from your target population, please know that your OSET evaluator is here to assist you with that process. We can provide consultation on survey development and deployment.

INDIVIDUAL LEVEL: BRINGING IT ALL TOGETHER

If you have gathered data regarding individual consumption patterns within your *target population*, please complete this section. If you do not have data available at this time, please enter “N/A” and continue to the next section.

Based on the **consumption data** (30-day use and age of first use) you analyzed, what are your community’s major concerns surrounding the problem of [enter your priority substance(s) here] consumption? Justify your decision with the data.

Based on the **perceptions of disapproval data** (attitudes) you analyzed, what are your community’s major concerns regarding the attitudes surrounding [enter your priority substance(s) here] consumption? Justify your decision with the data.

Based on the **perceived risk/harm data** you analyzed, what are your community’s major concerns surrounding the perceived risk/harm of consuming [enter your priority substance(s) here]? Justify your decision with the data.

INTERPERSONAL LEVEL

This part of the needs assessment is intended to explore the social and cultural norms surrounding substance use in your community.

Social norms refer to the acceptability or unacceptability of certain behaviors in a community, and it is the one causal factor that most often overlaps with other factors. In this section you will mostly gather data around community events. However, be aware that issues like social availability and law enforcement also reflect community norms.

The following table provides examples of possible contributing factors to social norms.

Please review these factors and comment on how your group sees the contributing factors presenting themselves related to your priority substance in your community. You will also need to identify the type of data/evidence you have to support your examples. If you do not have data, but really feel the factor is at work in your community, please enter “anecdotal evidence.”

Please note that you may enter “N/A” if you do not believe a particular contributing factor is at work in your community. You may also enter other contributing factors that are not listed.

You may continue this table with as many rows as you need.

If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Contributing Factors	Examples of Contributing Factors Presenting in Our Community	What type of data/evidence do we have to support these examples? Please choose from: Anecdotal Evidence, Survey Data, Focus Group Data, Town Hall Meeting Information, etc.
Acceptance		
“Rite of Passage”		
Multigenerational Use		
Public Substance Use		
18-25 Year Old Perceptions		
Culturally Acceptable		
Available in Homes		

Interpersonal Level: Data Availability Summary

Now that you have done a scan of the availability of interpersonal data related to social norms, here is where you will summarize your process. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

What contributing factors do you feel your community has good data and/or evidence to justify that they are impacting [insert priority substance here] use in your community?

What contributing factors do you feel your community needs to collect more data and/or evidence to justify that they are impacting [insert priority substance here] use in your community?

How do you plan on collecting that data and/or evidence?

INTERPERSONAL LEVEL: BRINGING IT ALL TOGETHER

After you have gathered all of the data and/or information you need regarding social norms, please complete this section. If you do not have data available at this time, please wait until you have collected the data. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Based on the data you gathered on social norms, what are the concerns around social norms that might contribute to [insert priority substance here] in your community? Justify your decision.

Please indicate up to three factors (based on your data) relating to social norms that contribute most to [insert priority substance here] in your community.

1. _____
2. _____
3. _____

Next, please complete the following worksheet for each selected contributing factor. *Please photocopy the worksheet as needed.*

Intervening Variable: Social Norms

Priority Substance:

Contributing Factor # _____ :

Whom does this affect/occur with?

Who allows this?

When does this occur?

Where does this occur?

How does this occur?

Under what conditions is this allowed to happen?

COMMUNITY LEVEL

For the needs assessment, *all sub-recipients* must perform a scan of their community. The community scan will consist of exploring the following data elements:

- Retail Availability
- Social Availability
- Pricing
- Promotion

1. Retail Availability (Priority Substances: Alcohol and Prescription Drugs)

Retail availability refers to how available alcohol and/or prescription drugs are in your community and how easy they are to obtain.

The following table provides examples of possible contributing factors to retail availability. Please review these factors and comment on how your group sees the contributing factors presenting themselves related to alcohol and/or prescription drugs in your community. You will also need to identify the type of data/evidence you have to support your examples. If you do not have data, but really feel the factor is at work in your community, please enter “anecdotal evidence.”

Please note that you may enter “N/A” if you do not believe a particular contributing factor is at work in your community or pertains to your priority substance. You may also enter other contributing factors that are not listed. *You may continue this table with as many rows as you need.*

If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Contributing Factors	Examples of Contributing Factors Presenting in Our Community	What type of data/evidence do we have to support these examples? Please choose from: Anecdotal Evidence, Survey Data, Focus Group Data, Town Hall Meeting Information, etc.
ID Issues: Use of fake IDs, Failure of Retailers to Properly Check IDs		
Density: High-density package sales locations; high-density open-container sales locations		
Product Characteristics: Forty-ounce containers; keg registration tags are easy to remove; lack of lock caps on hard liquor bottles		
Employees: Clerks have underage friends and sell to them		
Product Placement: Ease of shoplifting; alcohol placement in store; segregated sales, etc.		
Potential sources for prescription drugs: pain clinics, urgent care centers, trauma centers, etc.		
Prescription drug retailers: 24-hour pharmacies		

Retail Availability (Alcohol and/or Prescription Drugs): Data Availability Summary

Now that you have done a scan of the availability of community data related to retail availability, here is where you will summarize your process. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

What contributing factors do you feel your community has good data and/or evidence to justify that they are impacting [insert priority substance here] use in your community?

What contributing factors do you feel your community needs to collect more data and/or evidence to justify that they are impacting [insert priority substance here] use in your community?

How do you plan on collecting that data and/or evidence?

**RETAIL AVAILABILITY (ALCOHOL AND/OR PRESCRIPTION DRUGS):
BRINGING IT ALL TOGETHER**

After you have gathered all of the data and/or information you need regarding retail availability, please complete this section. If you do not have data available at this time, please wait until you have collected the data. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Based on the data you gathered on retail availability, what are the concerns around retail availability that might contribute to [insert priority substance here] in your community? Justify your decision.

Please indicate up to three factors (based on your data) relating to retail availability that contribute most to [insert priority substance here] in your community.

1. _____
2. _____
3. _____

Next, please complete the following worksheet for each selected contributing factor. *Please photocopy the worksheet as needed.*

Intervening Variable: Retail Availability

Priority Substance:

Contributing Factor # _____ : _____

Whom does this affect/occur with?

Who allows this?

When does this occur?

Where does this occur?

How does this occur?

Under what conditions is this allowed to happen?

2. Social Availability (Alcohol, Prescription Drugs, Other Drugs)

Social availability includes the obtaining of alcohol, prescription drugs, and/or other drugs from friends, associates, and family members, but it also refers to the availability of alcohol, prescription drugs, and other drugs at gatherings such as parties and other social events where the substance is provided as part of the event.

The following table provides examples of possible contributing factors to social availability. Please review these factors and comment on how your group sees the contributing factors presenting themselves related to alcohol, other drugs, and/or prescription drugs in your community. You will also need to identify the type of data/evidence you have to support your examples. If you do not have data, but really feel the factor is at work in your community, please enter “anecdotal evidence.”

Please note that you may enter “N/A” if you do not believe a particular contributing factor is at work in your community or pertains to your priority substance. You may also enter other contributing factors that are not listed. *You may continue this table with as many rows as you need.*

If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Contributing Factors	Examples of Contributing Factors Presenting in Our Community	What type of data/evidence do we have to support these examples? Please choose from: Anecdotal Evidence, Survey Data, Focus Group Data, Town Hall Meeting Information, etc.
18-25 year olds getting the [insert priority substance here] from...		
18-25 year olds attending gatherings with large amounts of [insert priority substance here]...		

Social Availability (Alcohol, Prescription Drugs, and/or Other Drugs): Data Availability Summary

Now that you have done a scan of the availability of community data related to social availability, here is where you will summarize your process. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

What contributing factors do you feel your community has good data and/or evidence to justify that they are impacting [insert priority substance here] use in your community?

What contributing factors do you feel your community needs to collect more data and/or evidence to justify that they are impacting [insert priority substance here] use in your community?

How do you plan on collecting that data and/or evidence?

SOCIAL AVAILABILITY (ALCOHOL, PRESCRIPTION DRUGS, AND/OR OTHER DRUGS): BRINGING IT ALL TOGETHER

After you have gathered all of the data and/or information you need regarding social availability, please complete this section. If you do not have data available at this time, please wait until you have collected the data. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Based on the data you gathered on social availability, what are the concerns around social availability that might contribute to [insert priority substance here] in your community? Justify your decision.

Please indicate up to three factors (based on your data) relating to social availability that contribute most to [insert priority substance here] in your community.

1. _____
2. _____
3. _____

Next, please complete the following worksheet for each selected contributing factor. *Please photocopy the worksheet as needed.*

Intervening Variable: Social Availability

Priority Substance:

Contributing Factor # _____ : _____

Whom does this affect/occur with?

Who allows this?

When does this occur?

Where does this occur?

How does this occur?

Under what conditions is this allowed to happen?

3. Promotion (Alcohol, Prescription Drugs)

Promotion refers to attempts by retailers and industry to increase demand through the marketing of their products. Once again, this will require some original data collection to acquire a sense of the depth of marketing surrounding alcohol and prescription drugs in your community.

The following table provides examples of possible contributing factors to promotion. Please review these factors and comment on how your group sees the contributing factors presenting themselves related to alcohol and/or prescription drugs in your community. You will also need to identify the type of data/evidence you have to support your examples. If you do not have data, but really feel the factor is at work in your community, please enter “anecdotal evidence.”

Please note that you may enter “N/A” if you do not believe a particular contributing factor is at work in your community or pertains to your priority substance. You may also enter other contributing factors that are not listed. *You may continue this table with as many rows as you need.*

If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Contributing Factors	Examples of Contributing Factors Presenting in Our Community	What type of data/evidence do we have to support these examples? Please choose from: Anecdotal Evidence, Survey Data, Focus Group Data, Town Hall Meeting Information, etc.
<p>Local Promotion: Stores have excessive numbers of alcohol ads; large number of alcohol ads on college campuses; drinking is often promoted at community festivals and other activities; placement of cold beer near entrance to convenience store; advertising and promotional practices encourage excessive alcohol consumption; inadequate media attention to promotional practices</p>		
<p>National Promotion: Pro-alcohol messages from alcohol industry; large number of pro-alcohol messages; alcohol ads promote use as sexy and fun-filled; movies are “alcohol-centric” and promote binge drinking; national campaigns target minority young adults; Social media creates expectations for young adults around drinking behavior</p>		

Promotion (Alcohol and/or Prescription Drugs): Data Availability Summary

Now that you have done a scan of the availability of community data related to promotion, here is where you will summarize your process. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

What contributing factors do you feel your community has good data and/or evidence to justify that they are impacting [insert priority substance here] use in your community?

What contributing factors do you feel your community needs to collect more data and/or evidence to justify that they are impacting [insert priority substance here] use in your community?

How do you plan on collecting that data and/or evidence?

**PROMOTION (ALCOHOL AND/OR PRESCRIPTION DRUGS):
BRINGING IT ALL TOGETHER**

After you have gathered all of the data and/or information you need regarding promotion, please complete this section. If you do not have data available at this time, please wait until you have collected the data. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Based on the data you gathered on promotion, what are the concerns around promotion that might contribute to [insert priority substance here] in your community? Justify your decision.

Please indicate up to three factors (based on your data) relating to promotion that contribute most to [insert priority substance here] in your community.

1. _____
2. _____
3. _____

Next, please complete the following worksheet for each selected contributing factor. *Please photocopy the worksheet as needed.*

Intervening Variable: Promotion

Priority Substance:

Contributing Factor # _____ : _____

Whom does this affect/occur with?

Who allows this?

When does this occur?

Where does this occur?

How does this occur?

Under what conditions is this allowed to happen?

4. Pricing (Alcohol)

Pricing refers to the cost of alcohol and the extent to which changes (i.e., discounting or price increases) affect consumption.

The following table provides examples of possible contributing factors to pricing. Please review these factors and comment how your group sees the contributing factors presenting themselves related to alcohol in your community. You will also need to identify the type of data/evidence you have to support your examples. If you do not have data, but really feel the factor is at work in your community, please enter “anecdotal evidence.”

Please note that you may enter “N/A” if you do not believe a particular contributing factor is at work in your community or pertains to your priority substance. You may also enter other contributing factors that are not listed. *You may continue this table with as many rows as you need.*

Contributing Factors	Examples of Contributing Factors Presenting in Our Community	What type of data/evidence do we have to support these examples? Please choose from: Anecdotal Evidence, Survey Data, Focus Group Data, Town Hall Meeting Information, etc.
Drink Pricing: Bars near campuses compete for student purchasers with drink specials; pricing specials that target young adults (e.g., 50-cent drafts); happy hours; density of bars creates competition and can lead to low pricing		
Container Pricing: Discount pricing is available in quantity alcohol purchases from warehouse retailers; convenience stores price beer cheaply to attract customers; holiday discounts on alcohol; density of alcohol retailers creates competition and can lead to low pricing		

Pricing (Alcohol): Data Availability Summary

Now that you have done a scan of the availability of community data related to pricing, here is where you will summarize your process.

What contributing factors do you feel your community has good data and/or evidence to justify that they are impacting alcohol use in your community?

What contributing factors do you feel your community needs to collect more data and/or evidence to justify that they are impacting alcohol use in your community?

How do you plan on collecting that data and/or evidence?

PRICING (ALCOHOL): BRINGING IT ALL TOGETHER

After you have gathered all of the data and/or information you need regarding pricing, please complete this section. If you do not have data available at this time, please wait until you have collected the data.

Based on the data you gathered on pricing, what are the concerns around pricing that might contribute to alcohol use in your community? Justify your decision.

Please indicate up to three factors (based on your data) relating to pricing that contribute most to alcohol use in your community.

1. _____
2. _____
3. _____

Next, please complete the following worksheet for each selected contributing factor. *Please photocopy the worksheet as needed.*

Intervening Variable: Pricing

Priority Substance:

Contributing Factor # _____ :

Whom does this affect/occur with?

Who allows this?

When does this occur?

Where does this occur?

How does this occur?

Under what conditions is this allowed to happen?

ORGANIZATIONAL LEVEL

Substance abuse prevention activities implemented at the organization level are intended to facilitate individual behavior change through communication and support aimed at influencing organizational systems and policies. Health care systems, employers or worksites, health care plans, local health departments, health clinics, and professional organizations represent potential sources of organizational messages and support.

For the SPF SIG needs assessment, *all sub-recipients* must perform a scan of their community at the organizational level. This portion of the needs assessment will arm you with the knowledge of what is already being done in your community to impact your specific priority issue. This is especially helpful when you begin the process of selecting a strategy. You do not want to duplicate services; you want to fill the gaps. After completing this assessment, you may know where you can build capacity in your community.

Please photocopy and complete the following Organizational-Level Assessment Tool for *each* prevention program, policy, and/or practice that targets *your priority issue*.

Organizational-Level Assessment Tool

Agency Name: _____

Contact Person: _____

Address: _____

Phone: _____

Email: _____

1. Is this resource a program, policy or practice? (Select One)

Program Policy Practice Other [Please explain:]

2. What is the name of the program, policy, and/or practice and brief description?

3. What is the target population of the program, policy, and/or practice?

4. What are the causal factor(s) targeted by the program, policy, and/or practice? (Select All)

Social Availability Retail Availability Promotion Criminal Justice/Enforcement

Community Norms Individual Factors Provider Lack of Knowledge

Other [Please explain:]

5. What are the risk and/or protective factors targeted by the program, policy, and/or practice? Please list out each risk and/or protective factor within the appropriate domain.

Family _____

Community _____

School _____

Individual/Peer

6. What agency or group delivers the program, policy, and/or practice?

7. Approximately how many people (those targeted for change) will the program, policy, and/or practice reach during the current calendar year?

8. What is the duration of the program, policy, and/or practice?

9. How often is the program, policy, and/or practice offered to the target population?

10. What prevention strategy does the program, policy, and/or practice use? (Select All)

- Education
- Environmental strategies
- Alternative activities
- Community-based process
- Problem Identification and referral
- Information dissemination
- Other [Please explain:]

11. What type of implementation data is collected? (Select All)

- Attendance
- Satisfaction
- Other [Please explain:]

12. Is the program, policy, and/or practice evidence based? YES NO

If yes, which agency(s) list contains the program, policy, and/or practice? NIDA CDC
 CSAP DOE Drug Strategies OJJDP None of the above

13. Has the implementing agency (as listed in Question 6) evaluated the outcomes of the program, policy, and/or practice? NO YES If yes, please explain.

14. What geographical area is served?

15. Is this strategy culturally appropriate? NO YES If yes, please explain how:

ORGANIZATIONAL LEVEL: BRINGING IT ALL TOGETHER

After you have completed the Organizational-Level Assessment Tool for *each* prevention program, policy, and/or practice that targets your priority issue, please complete this section. If you do not have data available at this time, please wait until you have collected the data. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Capacities:

1. What organizations are currently implementing prevention strategies for your priority substance?

2. What opportunities are there for your SPFSIG coalition to work with those organizations?

3. What types of prevention strategies are currently being implemented for your priority substance in your community?

4. What opportunities are there for your SPF SIG coalition to capitalize on current prevention programming to help support or buttress your SPF SIG efforts?

Gaps

1. What gaps in prevention programming currently exist for your priority substance?

2. How can your SPF SIG coalition fill those gaps as you move forward?

POLICY LEVEL

For the needs assessment, *all sub-recipients* must do a policy scan. The policy scan will consist of exploring the following data elements:

1. State-Level Policy Scan

OSET will provide an Excel spreadsheet *for state-level* alcohol, other drug, and prescription drug policies on the OSET Website.

2. Local-Level Policy Scan

Local policies or ordinances are a very important part of your community needs assessment.

All sub-recipient communities must conduct a local-level policy scan for the needs assessment.

3. Institution of Higher Education (IHE) Policy Scan

If you are focusing on a population that is enrolled in an institution of higher education (IHE), you must conduct a policy scan related to substance use/abuse for the university or college.

4. Enforcement of Policy

As part of your policy scan, all sub-recipients must assess the level of enforcement of policy. Please collaborate with law enforcement and your institution of higher education to determine the number of infractions (i.e., infractions, arrests, etc.) reported on each policy for 2007, 2008, and 2009.

You must complete the following table for each priority substance. Please photocopy the table as necessary.

Table of Policy Level Influences

Priority Substance: _____

Level: State-, Local-, or IHE- level	Policy	Number of Infractions (Arrests, etc.) 2007	Number of Infractions (Arrests, etc.) 2008	Number of Infractions (Arrests, etc.) 2009

POLICY LEVEL: BRINGING IT ALL TOGETHER

After you have gathered all of the data and/or information you need regarding policy issues, please complete this section. If you do not have data available at this time, please wait until you have collected the data. If you have more than one priority substance, please photocopy this worksheet and complete one for each substance.

Based on the data you gathered on policy issues, what are the concerns around policy issues that might contribute to [insert priority substance here] in your community? Justify your decision.

Please indicate up to three factors (based on your data) relating to policy issues that contribute most to [insert priority substance here] in your community.

1. _____
2. _____
3. _____

Next, please complete the following worksheet for each selected contributing factor. *Please photocopy the worksheet as needed.*

Intervening Variable: Policy Issues

Priority Substance:

Contributing Factor # _____ : _____

Whom does this affect/occur with?

Who allows this?

When does this occur?

Where does this occur?

How does this occur?

Under what conditions is this allowed to happen?

CULTURAL COMPETENCE

CADCA's Cultural Competence Primer (Appendix E) outlines key guiding principles of cultural competence that your local planning team should consider in the needs assessment process:

1. *Culture: first, last and always.* Culture has an impact on how a person thinks, believes and acts. Acknowledge culture as a predominant and effective force in shaping behaviors, values and institutions.
2. *One goal—many roads.* Each group has something to share. Acknowledge that several paths can lead to the same goal.
3. *Diversity within diversity.* Recognize the internal diversity and complexity of cultural groups. Remember that one individual cannot speak for all.
4. *People are unique.* Acknowledge people's group and personal identities and treat people as individuals.
5. *Viewpoint shift.* The dominant culture serves the community with varying degrees of success. Acknowledge that what works well for the dominant group may not serve members of other cultural groups. Try viewing issues from alternative viewpoints.

MILLENNIALS (GENERATION NEXT)

Ohio's SPF SIG process is focused on 18-25 year olds. Individuals in this population are often referred to as *Millennials or Generation Next* (<http://pewresearch.org/millennials/>). The Millennial population has a definite culture and, therefore, requires culturally competent strategies.

In the needs assessment process, *all sub-recipients* must respond to the following questions. To answer the questions, you may need to review the results from previous community needs assessments, hold focus groups with prevention providers, hold focus groups with 18-25 year olds, send a short survey out to community organizations, etc.

1. Prevention Programming:

- a. What prevention programs are offered to Millennials and who is offering them? (If there are none, state that.)

b. What programs are offered that are not specifically targeting Millennials, but could potentially be reaching them or modified to reach them? Who is offering them? (If there are none, state that.)

c. What is your source(s) of information for this section related to prevention programming? (i.e., survey of community organizations, focus group of prevention providers, etc.)

2. Expertise:

a. Who in the community has expertise working with Millennials? (Name, Agency/Organization, Contact Information)

b. How can their expertise be tapped into for the SPF SIG process?

c. What is your source(s) of information for this section related to expertise? (i.e., survey of community organizations, focus group of prevention providers, etc.)

3. Gaps:

a. What are the perceived gaps in prevention programming for Millennials?

b. How have you identified these gaps (you must substantiate your claim(s) with evidence – i.e., focus groups with prevention professionals, focus groups with 18-25 year olds, survey of community agencies, etc.)?

c. How can you close those gaps?

SUB-TARGET POPULATION(S)

As an Ohio SPF SIG sub-recipient, you are *required* to identify an under-represented sub-target population not typically served within your identified target group. The sub-target population you have identified will have a definite culture and, therefore, requires culturally competent strategies.

In the needs assessment process, *all sub-recipients* must respond to the following questions for *each* sub-target population that you have identified. *Please photocopy these pages as necessary.*

Brief Description of Sub-Target Population: _____

1. Prevention Programming:

- a. What prevention programs are offered to [sub-target population] and who is offering them? (If there are none, state that.)

b. What programs are offered that are not specifically targeting [sub-target population], but could potentially be reaching them *or* modified to reach them? Who is offering them? (If there are none, state that.)

c. What is your source(s) of information for this section related to prevention programming? (i.e., survey of community organizations, focus group of prevention providers, etc.)

2. Expertise:

a. Who in the community has expertise working with [sub-target population]? (Name, Agency/Organization, Contact Information)

b. How can their expertise be tapped into for the SPF SIG process?

c. What is your source(s) of information for this section related to expertise? (i.e., survey of community organizations, focus group of prevention providers, etc.)

3. Gaps:

a. What are the perceived gaps in prevention programming for [sub-target population]?

b. How have you identified these gaps (you must substantiate your claim(s) with evidence – i.e., focus groups with prevention professionals, focus groups, survey of community agencies, etc.)?

c. How can you close those gaps?

GENERATION RX

Some sub-recipients have identified prescription drug misuse/abuse as a priority. The term “Generation Rx” (<http://www.pharmacy.ohio-state.edu/outreach/generation-rx/index.cfm>) has been used to describe all of us in American society, because we use medications at unprecedented rates at every age, we expect “quick fixes” to our health problems, prescription drugs are marketed directly to us (note: the U.S. and New Zealand are the only developed countries that allow this), and the use of pharmaceuticals has become normalized within our day-to-day lives. Prescription drugs have impacted our culture. Therefore, prevention activity surrounding prescription drug misuse/abuse requires culturally competent strategies.

In the needs assessment process, *sub-recipients who have identified prescription drug misuse/abuse as a priority* must respond to the following questions:

1. Prevention Programming:

- a. What prevention programs are offered to Generation Rx and who is offering them?
(If there are none, state that.)

b. What programs are offered that are not specifically targeting Generation Rx, but could potentially be reaching them or modified to reach them? Who is offering them? (If there are none, state that.)

c. What is your source(s) of information for this section related to prevention programming? (i.e., survey of community organizations, focus group of prevention providers, etc.)

2. Expertise:

a. Who in the community has expertise working with Generation Rx? (Name, Agency/Organization, Contact Information)

b. How can their expertise be tapped into for the SPF SIG process?

c. What is your source(s) of information for this section related to expertise? (i.e., survey of community organizations, focus group of prevention providers, etc.)

3. Gaps:

a. What are the perceived gaps in prevention programming for Generation Rx?

b. How have you identified these gaps (you must substantiate your claim(s) with evidence – i.e., focus groups with prevention professionals, focus groups, survey of community agencies, etc.)?

c. How can you close those gaps?

APPENDIX A: NATIONAL OUTCOME MEASURES (NOMS)



**Center for Substance Abuse Prevention (CSAP)
Data Coordination and Consolidation Center (DCCC)**

**Overview of the National Outcome Measures
For the CSAP Substance Abuse Prevention and Treatment Block Grant and
Discretionary Grants**

As of August 11, 2006



Overview of National Outcome Measures For the Substance Abuse Prevention and Treatment Block Grant

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), has identified specific outcome measures that will be required of block grant recipients with full implementation by the end of Federal fiscal year 2007. These National Outcome Measures (NOMs) include the following domains:

- Abstinence From Alcohol and Other Drugs
- Employment/Education
- Crime and Criminal Justice
- Access/Service Capacity
- Retention
- Social Support/Social Connectedness
- Cost-Effectiveness
- Use of Evidence-Based Practices

These NOMs relate to youth ages 12 to 17 and to adults ages 18 and older. CSAP intends to implement the following approach.

Required NOMs Data

CSAP requires States to report annually and electronically on five specific NOMs measures for 2 domains for youth and adults:

1. Number of persons served by age
2. Number of persons served by gender
3. Number of persons served by race
4. Number of persons served by ethnicity
5. Total number of evidence-based programs and strategies

Note: Archival and State estimates for the National Survey on Drug Use and Health (NSDUH) will be prepopulated by CSAP DCCC through the CSAP Services Accountability and Monitoring System (CSAMS).

· The word “States” refers to the United States including the District of Columbia and tribal entities.

Overview of National Outcome Measures for Discretionary Grantees

SAMHSA's CSAP has identified specific outcome measures that will be required of discretionary grant recipients with full implementation by the end of Federal fiscal year 2007. These National Outcome Measures (NOMs) include the following domains: Abstinence from Alcohol and Other Drugs, Employment/Education, Crime and Criminal Justice, Access/Service Capacity, Retention, Social Support/Social Connectedness, Cost-Effectiveness, and Use of Evidence-Based Practices. These NOMs relate to youth ages 12 to 17 and to adults ages 18 and older.

Prevention NOMs

- **Abstinence from Drug Use/Alcohol Abuse**
 - 30-day Substance Use (nonuse/reduction in use)
 - Age of First Substance Use
 - Perception of Disapproval/Attitude
 - Perceived Risk/Harm of Use

- **Increased/Retained Employment or Return to/Stay in School**
 - Perception of Workplace Policy
 - Substance Abuse-Related Suspensions and Expulsions
 - School Attendance and Enrollment

- **Decreased Criminal Justice Involvement**
 - Alcohol-Related Car Crashes and Injuries
 - Alcohol and Drug-Related Crime

- **Increased Access to Services (Service Capacity)**
 - Number of Persons Served by Age, Gender, Race, and Ethnicity

- **Increased Retention in Service Programs – Substance Abuse**
 - Total Number of Evidence-Based Programs and Strategies Employed
 - Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

- **Increased Social Support/Social Connectedness**
 - Family Communication Around Drug Use

- **Cost-Effectiveness of Services (Average Cost)**
 - Services Provided Within Cost Bands (Universal, Selective, and Indicated)

- **Use of Evidence-Based Practices**
 - Total Number of Evidence-Based Programs and Strategies Employed

CSAP Programs - NOMs Reporting Roadmap

Strategic Prevention Framework – State Incentive Grant (Current Grantees)

STATE Level (generated annually by DCCC). DCCC will prepopulate State-level NOMs data, and States are responsible for reporting the aggregate elements that are not available through CSAMS. The elements are as follows:

- Total Number of Participants Served
 - Number of Males
 - Number of Females
 - Number by Race and Ethnicity
 - Number by Age Category
- Number of Evidence-Based Practices, Strategies, and Policies Implemented
- Cost Band Information (from annual reports) for Universal, Selective, and Indicated Interventions

COMMUNITY Level (entered annually by States for their communities, however defined). States that have a survey in the defined community can use that survey as a proxy as long as it maps to the NOMs domains and constructs.

If States have neither a survey that measures that community nor a proxy for the NOMs, they can use some of the community funding to support a random sample of the collection of this information using the NOMs Community Tool, available from CSAP through CSAMS. States only have to report these data:

- Aggregate reporting of NOMs or
- NOMs proxy by the community/State through CSAMS
- Cost Band Information (from annual reports) for Universal, Selective, and Indicated Interventions

PROGRAM Level. Data are NOT required.

Strategic Prevention Framework – State Incentive Grant (New Grantees To Be Funded September 2006)

STATE Level (generated annually by DCCC). DCCC will prepopulate State-level NOMs data, and States are responsible for reporting the aggregate elements that are not available through CSAMS. These elements are the following:

- Total Number of Participants Served
 - Number of Males
 - Number of Female
 - Number by Race and Ethnicity
 - Number by Age Category
- Number of Evidence-Based Practices, Strategies, and Policies Implemented
- Cost Band Information (from annual reports) for Universal, Selective, and Indicated Interventions

Note: Some of this information is contained in the cross-site evaluation interviews.

COMMUNITY Level (entered annually by States for their communities, however defined). States that have a survey in the defined community can use that survey as a proxy as long as it maps to the NOMs domains and constructs.

If the States have neither a survey that measures that community nor a proxy for the NOMs, the State can use some of the community funding to support a random sample of the collection of this information using the NOMs Community Tool, available from CSAP through CSAMS. States only have to report these data in the aggregate:

- Aggregate reporting of NOMs or
- NOMs proxy by the community/State through CSAMS
- Cost Band Information (from annual reports) for Universal, Selective, and Indicated Interventions

PROGRAM Level (entered quarterly for any pre-, post-, or followup data collection points by program entity). For direct service activities, the following data are required:

- Reporting in the aggregate of NOMs (for NOMs tool question items) or
- NOMs proxy through CSAMS
- Cost Band Information (from annual reports) for Universal, Selective, and Indicated Interventions



HIV, Methamphetamine, or Other Focused Direct Service Program (Grantees Funded From September 2005 and Future)

PROGRAM Level (entered quarterly for any pre-, post-, or followup data collection points by program entity). The following data are required:

- Incorporation of the NOMs tool question items and other program-focused question items for each individual participant (“individual, raw data entry function” through CSAMS)
- Cost Band Information (from annual reports) for Universal, Selective and Indicated Interventions

APPENDIX B: RESEARCH SUPPORT FOR COMPREHENSIVE COMMUNITY INTERVENTIONS TO REDUCE YOUTH ALCOHOL, TOBACCO AND DRUG USE AND ABUSE RESEARCH SUPPORT FOR COMPREHENSIVE COMMUNITY INTERVENTIONS TO REDUCE YOUTH ALCOHOL, TOBACCO AND DRUG USE AND ABUSE

Research Support For Comprehensive Community Interventions to Reduce Youth Alcohol, Tobacco and Drug Use and Abuse

EXECUTIVE SUMMARY

The substance abuse prevention field is at a crossroads. In this time of healthcare reform, the opportunity exists to combat substance abuse and related harms with concerted, community-based and comprehensive efforts to change norms, behaviors, systems and contexts that contribute to substance abuse problems in our communities. The purpose of this paper is to discuss how a truly comprehensive response to substance use and abuse in our country can be implemented. Specifically, this response includes BOTH environmental/policy efforts and individually-focused prevention efforts in order to reduce substance abuse population-wide. Furthermore, it is critical to recognize the invaluable role local, community-based coalitions play in implementing a comprehensive array of evidence-based strategies to reduce underage drinking, tobacco use and illicit drug use. Coalitions have had great success at choosing and implementing the right combination of strategies to address local conditions contributing to substance use and abuse in their communities. Continued efforts are needed to support the role coalitions play in creating safe, healthy and drug-free communities.

This paper was developed to be responsive to the coalition field. It provides evidence to support their use of environmental strategies to address substance abuse in their communities. Environmental strategies are used to change the context (environment) in which substance use and abuse occur. Environmental strategies incorporate efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies (Babor, 2003). This paper was written to help coalitions understand how environmental strategies are critical elements of a comprehensive plan to reduce substance use and abuse. As such, the paper provides an overview of the research on the effectiveness of a variety of environmentally focused-strategies to reduce underage drinking, tobacco use and drug use. These strategies are especially effective at reducing access and availability of substances for youth and young adults and mitigate the damage caused to the community. Environmental strategies also are critically important to support individually and family-focused interventions. It is up to the coalition to pick the right combination of individual, family and community-level interventions to reduce substance abuse in their community.

Substance abuse is a problem facing each community in America. The pervasiveness of substance abuse is apparent in how it cuts across racial, socio-economic, geographic and generational lines (Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2008). Results from the 2009 Monitoring the Future study, an annual survey on the incidence and prevalence of youth substance use rates funded by the National Institute on Drug Abuse (NIDA), indicate that past declines in substance abuse rates are leveling off and researchers are concerned that softening attitudes among youth on the perceived risk and disap-

proval of marijuana and inhalant use may predict future increases in usage rates (Johnston, O'Malley, Bachman, & Schulenberg, 2009). With 37 percent of 12th graders reporting they have used an illicit drug in past year, 15 percent of 8th graders reporting drinking alcohol in the last month, and 27 percent of 10th graders reporting using marijuana in the last year, the potential costs of substance abuse are enormous, especially if efforts are not put into prevention and treatment.

A complex social problem like substance abuse has multiple causes and when framed using a social-ecological model, we are able to better see the multi-

layered context that affects substance use and abuse in our society. The ecological levels of analysis promoted by Bronfenbrenner (1979) show that individuals are nested within broader contexts that play a critical role in their health and well-being. Given the ecological nature of substance use/abuse in this country, it is important to intervene at all levels, using interventions that improve not only individuals, peers and families but also interventions that improve organizations/services within the community, improve our neighborhoods and cities, and impact change on the broader societal level in order to comprehensively address substance abuse at the population-level.

Coalitions engage in multi-strategy, comprehensive action to work at all levels of the ecological model and facilitate linkages between levels. The real work of an effective coalition is its efforts to change community norms, attitudes, behaviors, systems and environments. "As the field of prevention has matured, it has been recognized that any single strategy is unlikely to succeed and a reinforcing set of strategies has the greatest potential to reduce use" (Johnson et al., 2007, p. 229). As such, coalitions need to engage in strategies to improve conditions in individuals, families, organizations, systems and communities and take action using a wide array of interventions at their disposal, including advocacy efforts and implementation of evidence-based interventions to reduce substance use/abuse at the population-level (Fawcett, Francisco & Schultz, 2004). Research indicates that coalitions are very capable at implementing this comprehensive response. They have been successful at selecting and implementing evidence-based prevention programs targeting youth, peers and families (e.g., individual and microsystems levels) (Hawkins et al., 2009) and implementing strategies to improve conditions in organizations, systems and communities (Hingson, Zakocs, Winter, Rosenbloom & DeJong, 2005; Snell-Johns et al., 2003).

Environmental strategies, as part of a comprehensive prevention effort, are strongly supported by prevention researchers and practitioners as well as government and nongovernmental agencies and organizations working to prevent substance abuse (U.S. Department of Justice, 2006; Centers for Disease Control, 1999; U.S. Department of Health and Human Services, 1994; Imm, Wandersman, Rosenbloom, Guckenburg & Leis, 2007).

The Institute of Medicine's (IOM) 2009 report on Preventing Mental, Emotional and Behavioral Disorders Among Youth People also reinforces the need to reduce access and availability of alcohol and drugs by changing norms and policies (National Research Council and Institute of Medicine, 2009).

A general causal model to guide population-level alcohol, tobacco and illicit drug prevention has been proposed (Birckmayer, Holder, Yacoubian & Friend, 2004). The researchers suggest that alcohol, tobacco and illicit drugs are essentially retail products and as such, economic theories of supply and demand come into play. Most of prevention has focused on reducing demand for these substances (e.g., individual-level prevention programs). However, a comprehensive model for ATOD prevention also requires addressing supply factors, such as availability and promotion (marketing of substances). Norms also play a critical role in this model, affecting availability, promotion and demand factors. In addition, enforcement of laws and policies to reduce ATOD use/abuse is critical.

A variety of environmental strategies have been shown to be effective at reducing youth drinking, tobacco use and illicit drug use, including increasing price of alcohol, enforcing underage drinking laws, limiting availability of alcohol and tobacco, establishing smoke-free indoor air laws, controlling the sale of meth precursor chemicals, reducing drug dealing in private rental places and Crime Prevention Through Environmental Design.

In summary, there is strong scientific evidence to support the effectiveness of environmental strategies as well as evidence that coalitions can be successful at implementing the full array of prevention programs and environmental/policy strategies to address local substance abuse problems. As indicated by the socio-ecological model, effective interventions to address behavior such as substance use and abuse require a comprehensive approach, seeking change at multiple levels (Bronfenbrenner, 1979; Sorensen, Emmons, Hunt & Johnston, 1998). Such an approach addresses the problem using both individually-focused and environmentally-focused interventions as part of a strategic plan to achieve population-level reductions in alcohol, tobacco and illicit drug use.

INTRODUCTION

Substance abuse is a problem facing each community in America. The pervasiveness of substance abuse is apparent in how it cuts across racial, socio-economic, geographic and generational lines (Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2008). Results from the 2009 Monitoring the Future study, an annual survey on the incidence and prevalence of youth substance use rates funded by the National Institute on Drug Abuse (NIDA), indicate that past declines in substance abuse rates are leveling off and researchers are concerned that softening attitudes among youth on the perceived risk and disapproval of marijuana and inhalant use may predict future increases in usage rates (Johnston, O'Malley, Bachman, & Schulenberg, 2009). With 37 percent of 12th graders reporting they have used an illicit drug in past year, 15 percent of 8th graders reporting drinking alcohol in the last month, and 27 percent of 10th graders reporting using marijuana in the last year, the potential costs of substance abuse are enormous, especially if efforts are not put into prevention and treatment.

These costs go beyond the individual and their family, also affecting society. The public health burden of these risk behaviors is tremendous. 79,000 alcohol-attributable deaths occur each year with 2.3 million Years of Potential Life Lost (YPPL) per year (Brewer & Sparks, 2010). According to the National Highway Traffic Safety Administration (2008), while the proportion of alcohol-related traffic fatalities attributable to alcohol has been in decline in the last 20 years, as of 2005 they were still as high as 33 percent. Additionally, the cost of substance abuse to society is staggering with estimates ranging from \$468 billion (NCASA, 2009) to \$638 billion (Miller & Hendrie, 2009). The economic costs of alcohol and drug abuse include prevention and treatment costs as well as costs accrued in the justice and social welfare systems (Harwood, Fountain & Livermore, 1999).

Given the large scale social and financial impact of substance abuse, efforts must be made to decrease substance use/abuse in our society, with a particular emphasis on prevention. Drug addiction is a developmental disorder that begins in adolescence, sometimes as early as childhood, for which effective prevention is critical. According to studies by the NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the younger a person first uses drugs or alcohol, the greater the likelihood that they will become dependent and/or addicted to drugs and alcohol as an adult. Youth who first smoke marijuana under the age of 14 are more than five times as likely to abuse drugs in adulthood (Department of Health and Human Services, 2003). Forty-five percent of youth who began drinking before age 15 were classified as dependent later in life, whereas among youth who began drinking between age 17 and 21, 24.5 percent were classified as dependent, and of youth who began drinking at age 21 or 22, 10 percent were classified as dependent (Grant & Dawson, 1997). It is therefore critical to focus intently on preventing substance use and abuse.

A focus on prevention also can yield major economic dividends. The savings per dollar spent on substance abuse prevention can be substantial and range from \$2.00 to \$20.00 (Swisher, Scherer & Yin, 2004). Miller and Hendrie (2009) indicate that some prevention efforts result in cost-benefit ratios of more than 30:1. Investing in prevention yields savings and reduces economic and healthcare burdens (National Institute on Drug Abuse, 2007).

Complex community health problems, like substance use and abuse (defined as underage drinking, tobacco, illegal drugs and/or the misuse/abuse of over-the-counter and prescription medications and products), require comprehensive, collaborative solutions to achieve benefit for the entire community or targeted population. This broad degree of change, called popu-

lation-level change, is the ultimate goal of coalitions (Roussos & Fawcett, 2000). Substance abuse prevention coalitions have developed based on a core belief that a collaborative, community-based solution is required to change conditions in the community environment, system and structures that contribute to substance abuse problems (Saxe, et al., 1997). Coalitions are “a group of individuals representing diverse organizations, factions or constituencies who agree to work together to achieve a common goal” (Feighery & Rogers, 1989, p.1). Since no two communities are alike, the premise of coalitions for substance

abuse prevention is that local, coordinated efforts best address the unique needs of the community. Substance abuse coalitions comprise multiple groups of stakeholders, often a mix of citizens, including youth and parents, service agencies, prevention and treatment providers, public health, law enforcement, schools and community organizations, representatives from the faith community, businesses and volunteer groups. By encouraging collaboration among stakeholders, coalitions take a comprehensive approach to addressing substance abuse in their communities.

ADDRESSING SUBSTANCE ABUSE USING A SOCIAL-ECOLOGICAL MODEL

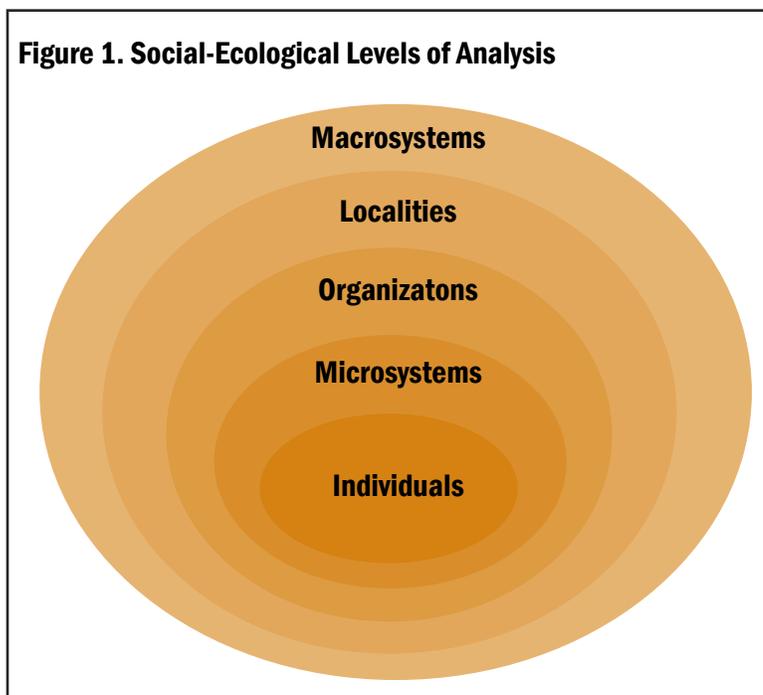
A complex social problem like substance abuse has multiple causes and when framed using a social-ecological model it is easier to see the multi-layered context that affects substance use and abuse in our society. The ecological levels of analysis promoted by Bronfenbrenner (1979) show that individuals are nested within broader contexts that play a critical role in their health and well-being. This same model can be used to better understand communities and community issues (Dalton, Elias & Wandersman, 2007). (See Figure 1 at right.)

The web of connections that surround individuals necessitates interventions at multiple levels:

- **Individuals**—The individual is located at the inner-most level. Many of our interventions are designed to impact the individual directly, such as developing academic and social skills of children, promoting social-emotional competence and building drug refusal skills in youth.
- **Microsystems**—The next level represents the environments in which in-

dividuals interact directly with other people, such as families, friends, classrooms and work groups. These microsystems can provide resources and support to the individual but can also cause harm and stress. Interventions targeting the microsystem include those designed to support positive peer groups, improve parenting skills, and provide strong adult role models.

Figure 1. Social-Ecological Levels of Analysis



- **Organizations**—Organizations are the formal entities surrounding individuals and microsystems. These include schools, human service agencies, health care settings, workplaces, religious groups and neighborhood organizations. Examples of interventions at this level are those focusing on school climate, access to SBIRT (Screening, Brief Intervention and Referral to Treatment) and workplace initiatives.
- **Localities**—This level represents geographic areas, such as towns, cities and neighborhoods. Organizations, microsystems and individuals are housed within localities. Neighborhood conditions are linked to health, academic achievement, behavior problems and well-being (Shinn & Toohey, 2003). Interventions at this level affect policies and practices that govern localities and influence broader community health, such as strategies to reduce underage access to alcohol, improving community lighting, park clean-ups, community development efforts and enforcement of anti-drug laws.
- **Macrosystems**—This is the outer-most level in the ecological model. Societies, cultures, politics and economic and social forces reside at this level. For example, the negative impact of macrosystem-level factors on substance use include legalization of medical marijuana and alcohol and tobacco marketing. On a positive side, the class action lawsuits against big tobacco have provided substantial tobacco settlement funds to states and communities to prevent tobacco use and promote cessation of smoking, and the Drug Free Communities Support Program has infused \$794.8 million into communities across the country. These are important social forces that have supported substance abuse prevention in this country.

Given the ecological nature of substance use/abuse in this country, it is important to intervene at all these levels and change laws, norms and policies to reduce substance abuse and its

impact on our society. However, many of the science-based interventions, such as Life Skills and Strengthening Families, have focused primarily on the individual and micro-system levels. While worthwhile and necessary, these proximally focused interventions target only the levels closest to the individual. In contrast, interventions at more distal levels (i.e., those less immediate to the individual) can have more widespread impacts. It is important to intervene at all levels, using interventions that improve not only individuals, peers and families but also organizations/services within the community, improve our neighborhoods and cities, and impact change on the broader societal level to comprehensively address substance abuse at the population-level.

Environmental strategies used in substance use/abuse prevention are levers to shift political, social and economic conditions that contribute to substance use and abuse. These are community-level interventions seeking to achieve population-level benefits for the entire community. They are used to change levers at the more distal levels of the ecological model. For example, reducing alcohol outlet density and conducting compliance checks with alcohol retailers are environmental strategies used to reduce retail availability of alcohol to underage individuals. These interventions change retail business practice (organizations), change community norms that support underage drinking (locality) and on a large-scale create an infrastructure of communities that support the health and safety of their youth (macrosystem). A focus on organizations, localities and macrosystems is needed to have broad impact on substance use/abuse and to achieve population-level reductions in substance abuse and related-problems. Interventions at these outer three levels are of critical importance to the substance abuse field in achieving population-level reductions in use and abuse.

Coalitions Work at All Levels of the Social-Ecological Model

Coalitions by design engage in multi-strategy, comprehensive action to work at all levels of the ecological model and facilitate linkages between levels. The convergence of community stakeholders involved with a coalition is not an end in and of itself. The real work of an effective coalition is its efforts to change community norms, attitudes, behaviors, systems and environments. “As the field of prevention has matured, it has been recognized that any single strategy is unlikely to succeed and a reinforcing set of strategies has the greatest potential to reduce use” (Johnson et al., 2007, p. 229). A single intervention is unlikely to achieve the high level of community transformation needed to improve health and well-being (Merzel & D’Affitti, 2003). Instead, ecological theory proposes that substance use and abuse is influenced at multiple levels and as such interventions must be broad-based, comprehensive and seek change at multiple levels (Bronfenbrenner, 1979; Sorensen, Emmons, Hunt & Johnston, 1998).

Research indicates that coalitions are very capable of selecting and implementing evidence-based prevention programs targeting youth, peers and families (e.g., individual and microsystems levels) (Hawkins et al., 2009) and implementing strategies to improve conditions in organizations, systems and communities (Hingson, Zakocs, Winter, Rosenbloom & De-Jong, 2005; Snell-Johns et al., 2003). Coalitions need to engage in strategies to improve conditions in individuals, families, organizations, systems and communities and take action using a wide array of interventions at their disposal, including advocacy efforts and implementation of evidence-based interventions to reduce substance use/abuse at the population-level (Fawcett, Francisco & Schultz, 2004).

Researchers have put effort into categorizing the interventions implemented by coalitions to bring about changes in substance abuse and

other health outcomes (Florin et al., 1993; Paine-Andrews et al., 2002; Roussos & Fawcett, 2000). Interventions targeting substance abuse prevention can be categorized by scale and impact. Activities focused more on individuals seek change on a smaller scale in terms of the number of individuals that might be reached via the intervention (i.e., inner levels of ecological model) while those activities focused more at the community and systems-level seek broader change for more individuals (i.e., outer levels of ecological model). Coalition intervention efforts can be categorized into the following areas, ranging from more individually-focused activities to those that are considered to be “environmental strategies” in the substance abuse prevention world (Paine-Andrews et al., 2002):

- **Providing information**—Educational presentations, workshops or seminars, and data or media presentations (e.g., public service announcements, brochures, billboard campaigns, community meetings, town halls, forums, Web-based communication).
- **Enhancing skills**—Workshops, seminars or activities designed to increase the skills of community members, such as youth, parents and citizens (e.g., training, parenting classes, evidence-based prevention programs for youth).
- **Providing support**—Creating opportunities that reduce risk or enhance protection (e.g., providing alternative activities, mentoring, support groups, youth clubs, parenting groups, Alcoholics or Narcotics Anonymous).
- **Enhancing access/reduce barriers**—Improving community and service delivery processes to increase the ease, ability and opportunity for community members to access and use the services (e.g., access to treatment, childcare, transportation, housing, education, special needs, cultural and language sensitivity).

- **Changing consequences**—Using incentives and disincentives to alter consequences of a specific behavior (e.g., increasing public recognition for deserved behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges).
- **Changing the physical design of the environment**—Altering the physical structure of the community so individuals are less likely to engage in substance use (e.g., creating parks, improving landscapes, limiting alcohol advertising signage, improving lighting, decreasing outlet density).
- **Modifying/changing policies**—Working to create formal changes in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., public policy actions, systems change within government, communities and organizations).

These interventions support the social-ecological model in that they can be used to influence all levels of the analysis, with the last four intervention strategies considered “environmental” in nature. Coalitions apply all seven behavior change strategies to address local conditions—factors unique to each community that contribute to substance abuse locally (i.e., availability of marijuana via individuals that purchase from medical marijuana dispensaries). To select the correct combination of strategies under each category, coalitions must invest time and resources to identify these local conditions. Through a community needs assessment, coalitions need to understand not just the substances causing problems within the community, but also the root causes and local conditions that illuminate why and how substance abuse manifests itself within the community. This process then leads to actionable data on which coalitions can take action to select the specific combination of seven behavior change strategies that will target each specific local condition. This results in a truly comprehensive and effective response to substance

abuse prevention that engages all levels of the ecological model.

Coalitions Success at Taking Evidence-Based Programs to Scale

One role coalitions have successfully carried out is in selecting and implementing evidence-based prevention programs for their local community. For example, the PROSPER model (Promoting School-community-university Partnerships to Enhance Resilience) has three components comprised of community teams, university Extension offices and researchers. The PROSPER community teams have been very successful at implementing family-focused and school-based substance abuse prevention programs, such as Life Skills, Project ALERT, Strengthening Families and All Stars (Spoth, Guyll, Lillehoj, Redmond & Greenberg, 2007).

State governments also have supported coalitions in their use of evidence-based prevention programs. One example is the Kentucky State Incentive Grant (SIG) (Collins, Johnson & Becker, 2007). Nineteen coalitions were studied in the Kentucky SIG project, called the Kentucky Incentives for Prevention Project (KIP). Each coalition implemented one to four of the following universal evidence-based programs: Project ALERT, Life Skills Training, SMART Moves, Preparing for the Drug-Free Years and Project Northland. The study examined if coalitions that implement evidence-based programs reduce substance abuse among adolescents. The researchers compared 8th and 10th graders in KIP schools (communities implementing KIP) to 8th and 10th graders in non-KIP schools. These schools were matched based on school size and percentage of students living in urban areas. Student survey data were analyzed at two time points, 1999 and 2002 in KIP schools and 2000 and 2002 in non-KIP schools. While 8th graders in KIP schools did not experience decreases in substance use, the picture is different when looking at 10th graders. Tenth graders did experience slightly lower use of cigarettes (37.4% to 29.7%), alcohol (40.2% to

35.6%) and binge drinking (28.9% to 26.6%). 10th graders in non-KIP schools also experienced decreases in cigarette and alcohol use but these decreases were smaller than KIP-schools. Additionally, non-KIP 10th graders experienced an increase in binge drinking.

The Communities That Care (CTC) model is another example of a coalition building approach focused on helping communities learn substance abuse prevention principles and strategies. The CTC model trains communities to bring key leaders together, build their understanding of prevention science and the risk and protective factors associated with youth problems, implement a survey to assess each community for its specific risk and protective factor profile, and design a plan targeted at implementing evidence-based programs to address the community's identified risk factors. CTC is a popular coalition building model used in this country and has undergone multiple cross-site evaluations of the effectiveness of the model (Feinberg, Greenberg, Osgood, Anderson & Babinski, 2002; Quinby, Hanson, Brooke-Weiss, Arthur, Hawkins, & Fagan, 2008)

The Community Youth Development (CYD) study empirically examined the effectiveness of CTC communities. The CYD study was conducted in eight states with 24 matched pairs of communities, and intervention sites demonstrated reductions between 6th and 8th grades in the prevalence of alcohol, tobacco and marijuana use. The matched comparison sites did not experience these same declines (Hawkins et al., 2009). These studies indicate that with support from researchers and technical assistance providers, communities can successfully implement evidence-based programs targeting the individual, school and family environments, resulting in changes in risk and protective factors and community-level reductions in substance abuse rates (Feinberg et al., 2009; Spoth & Greenberg, 2005).

Coalitions Success at Implementing Environmental Strategies

Coalitions have often been the entities established to bring stakeholders together to engage in environmental and policy strategies. For example, The Fighting Back Program was a Robert Wood Johnson Foundation initiative that funded 12 communities to develop coalitions to combat substance abuse and related problems. A case study of the policy efforts of the Fighting Back Coalition in South Carolina illustrates various roles that a coalition can play toward facilitating community efforts aimed at environmental and policy change to prevent and decrease substance use (Snell-Johns et al., 2003). The coalition actively engaged in generating ideas, strategies and language for specific environmental changes at various levels, such as no-ATOD use policies at county recreational facilities and a multi-strategy early intervention program for the local university. The coalition also became the facilitator of important policy efforts by being responsive to community members' requests. For example, when parents of a young teenager lost their child in an alcohol-related boating accident, they went to the coalition for help. The coalition was able to facilitate a community process to enact a "Safe in the Lake Campaign," resulting in boating under the influence legislation. Because the coalition was considered to be a neutral, community-led organization, it had the trust and buy-in of the community to bring about significant environment and policy level change efforts.

A follow-up study of the entire Fighting Back Program looked more carefully at a subset of the original Fighting Back communities—those that devoted a significant portion of their time and effort to limiting access to alcohol and expanding treatment services (Hingson et al., 2005). The researchers found that these coalitions were successful at implementing a variety of environmental and systems-change focused interventions, including limiting alcohol availability; engaging in sting operations; conducting

responsible beverage training; enacting ordinances to prohibit public consumption or beverage sales; closing problem liquor stores/blocking new stores/monitoring problematic outlets; persuading liquor stores to sign voluntary responsible sales agreements; limiting marketing/advertising; increasing publicly funded treatment; establishing referral and/or awareness campaigns about treatment services; creating or expanding treatment/aftercare programs; initiating hospital ED screens/referrals; establishing drug courts and opening new treatment/aftercare facilities. Five of 12 sites initiated eight or more concentrated activities in these areas.

This focus on environmental strategies by coalitions (i.e., targeting outer levels of the ecological model) is also associated with population-level reductions in substance abuse and related problems. The five Fighting Back sites that initiated eight or more of the concentrated activities limiting access to alcohol and expanding treatment services subsequently achieved a significant 22 percent decrease in alcohol-related crashes (at 0.01 percent or higher blood alcohol concentration or BAC) relative to fatal crashes not involving alcohol during the 10 years of the FB program compared to 10 years prior to the program (Hingson et al., 2005).

Other outcomes associated with coalitions and the community-mobilization efforts in which they engaged include:

- **Communities Mobilizing for Change on Alcohol (CMCA)**—CMCA is a community-organizing program designed to reduce 13 - 20 year old youth's access to alcohol by changing community policies and practices. Community strategy teams employ a range of social-organizing techniques to eliminate illegal alcohol sales to minors, obstruct the provision of alcohol to youth, and ultimately reduce alcohol use by teens. Community members are involved in seeking and achieving changes in local public policies and practices of community institutions that
- can affect youths' access to alcohol. Outcomes include: decreased youth access to alcohol in bars/restaurants; self-reported decreases in youth's attempts to buy alcohol and provision of alcohol to underage teens, decreased number of drinks consumed the last time they drank and number of times in the last month that they drank; and decreased driving under the influence (DUI) arrests (Wagenaar et al., 1999).
- **Community Trials Intervention to Reduce High-Risk Drinking**—This multi-component, community-based coalition initiative was created to alter the alcohol use patterns and reduce alcohol-related accidents among people of all ages. Its environmental interventions help communities to: 1) use zoning and municipal regulations to restrict alcohol access through alcohol outlet density control; 2) enhance responsible beverage service by training, testing, and assisting beverage servers/retailers to develop policies and procedures that reduce intoxication and driving after drinking; 3) increase law enforcement and sobriety checkpoints to raise actual and perceived risk of arrest for driving after drinking; and 4) reduce youth access to alcohol by training retailers to avoid selling to minors and those who provide alcohol to minors (Holder et al., 2000). Outcomes include: reductions in 1) drinking quantities; 2) driving when having had too much to drink; 3) driving over the legal limit; and 4) monthly rates of alcohol related traffic crashes and injuries. The Sacramento Neighborhood Prevention Program (SNAPP) was a follow-up to the Community Trials Intervention. This initiative also had positive outcomes in reducing underage drinking and related harms (Treno, Gruenewald, Lee, & Remer, 2007).
- **Tobacco Policy Options for Prevention (TPOP)**—TPOP is designed to reduce youth cigarette smoking by restricting youth access to tobacco products. The success of this community-based intervention relies

heavily on the mobilization efforts of local coalitions to advocate for, and successfully change local policies and practices that affect youth access to tobacco. TPOP requires four phases to complete the intervention: 1) information gathering and team recruitment, 2) community awareness building and ordinance development, 3) preparation for city council, and 4) ordinance establishment and enforcement. Outcomes include: an increase in retailers asking for identification to purchase tobacco products, decreased perceived availability from retail sources, and a lower prevalence of daily smoking among youth (self-reported youth surveys) when compared to control communities (Forster, Murray, Wolfson, Blaine, Wagenaar & Hennrikus, 1998).

- **Border Binge-Drinking Reduction Program—** This program used an innovative process to change the social and community norms associated with underage and binge drinking that has proven effective at reducing alcohol-related trauma caused by young American's binge drinking across the U.S.-Mexican border. A Binational Policy Council was formed which recommended policy changes on both sides of the border and provided spokespersons for media advocacy and community organizing. This effort to curb irresponsible drinking practices used several environmental and communitywide strategies: 1) surveys of youths returning from a night of drinking with blood alcohol concentration (BAC) breath tests; 2) strong media advocacy using survey data to heighten awareness, mobilize the community to action, and reframe the issue from an accepted norm to a health and safety issue for the community; 3) increased enforcement of existing laws and policies, such as ID checks at border crossings and in bars in Tijuana, Mexico; and 4) implemented policies and practices that impact the environment

where cross-border drinking occurs. Outcomes measured during the 2-year intervention (1997-99) include: 1) decreased numbers of Americans arrested in Tijuana, Mexico, for alcohol-related violations; 2) 20 percent decrease in the number of Tijuana bars with a majority of American patrons; 3) 45 percent reduction in the number of night-time alcohol-related crashes involving 16- to 20-year-old drivers; 4) 29 percent decrease in number of youth crossing into Tijuana to drink; and 5) 40 percent decrease in the number of youth returning from Tijuana with high BACs (Voas, Tippetts, Johnson, Lange, & Baker, 2002).

- **Challenging College Alcohol Abuse (CCAA)—** CCAA is a social norms and environmental management program to reduce high-risk drinking and related negative consequences among 18-24 year old college students. CCAA uses a campus-based media campaign (using articles, press releases in the school newspaper and campus displays) and other strategies to address misperceptions about alcohol and make the campus environment less conducive to drinking. CCAA funds and promotes non-alcohol social events that compete with traditional drinking occasions and encourages increased restrictions and monitoring of on- and off-campus alcohol use by faculty, staff, parents and the local community. Outcomes include a decrease in binge and frequent drinking among freshmen, improved alcohol-related knowledge, attitudes, and perceptions; and decreases in negative consequences of alcohol and drug use (getting into a fight, argument or trouble with campus police/authorities, memory loss, being taken advantage of sexually, doing poorly on test/project, and missing class) (Glider, Midyett, Mills-Novoa, Johannessen, & Collins, 2001).

OVERVIEW OF ENVIRONMENTAL STRATEGIES TO ADDRESS SUBSTANCE ABUSE

This section discusses the role environmental strategies play to decrease substance use/abuse and associated harms. A great deal of research has been conducted examining the effectiveness of a variety of school and family-focused evidence-based programs targeting the inner circles of the ecological model (i.e., Life Skills, Strengthening Families, All Stars, etc.). These individual-level approaches are more commonly found on lists of effective programs, such as SAMHSA's National Registry of Effective Programs and Practices (NREPP) and the National Institute on Drug Abuse's (NIDA) Preventing Drug Use Among Children and Adolescents (2003), than their environmental-level counterparts. They have met the scientific rigor of improving substance abuse and other health and well-being outcomes for the individuals that participate in the program (Institute of Medicine, 2009). Less well advertised are environmental strategies. It is important to note that many environmental strategies have also been well tested and passed rigorous standards to be considered effective.

The Centers for Disease Control and Prevention publishes Community Guides—documents that describe the effectiveness of a variety of environmental/policy interventions to improve the public health, including strategies/interventions focused on reducing and preventing alcohol and tobacco use and abuse (<http://www.thecommunityguide.org/index.html>). The CDC's Community Guides are developed using an independent, rigorous and systematic scientific review process of the research literature and provide clear evidence of the effectiveness of a variety of strategies to reduce substance abuse at the population-level via the use of environmental/policy-level strategies. Environmental strategies do work and complement individual-level strategies in the following ways: emphasis on changing community systems instead of individual-level actions; use of marketing and media to impact community leaders and organizations

instead of changing individual-level behaviors; valuing the community as a resource to support systems change instead of as groups of individuals to receive and disseminate information; and focus on decreasing supply and/or associated risk instead of the decreasing demand for drugs (Gruenewald et al., 2003 as cited in Johnson et al., 2007).

Environmental strategies, as part of a comprehensive prevention effort, are strongly supported by prevention researchers and practitioners, and government and nongovernmental agencies and organizations working to prevent substance abuse (U.S. Department of Justice, 2006; Centers for Disease Control and Prevention, 1999; U.S. Department of Health and Human Services, 1994; Imm, Wandersman, Rosenbloom, Guckenbug & Leis, 2007). The Institute of Medicine's (IOM) 2004 report on Reducing Underage Drinking: A Collective Responsibility cites the importance of environmental strategies to reduce access of alcohol by minors, including compliance checks and sobriety check points (National Research Council and Institute of Medicine, 2004). In addition, another more recent IOM report on Preventing Mental, Emotional and Behavioral Disorders Among Youth People also reinforces the need to reduce access and availability of alcohol and drugs by changing norms and policies (National Research Council and Institute of Medicine, 2009). The Surgeon General's Call to Action To Prevent and Reduce Underage Drinking (2007) also recommends efforts to increase the consequences of underage drinking, including enforcing underage drinking laws and holding adults responsible for underage drinking parties.

Additionally, environmental strategies, commonly referred to as community-level interventions, are increasingly emphasized over individual-level interventions; especially when limited resources are available for prevention activities. This is because by changing systems

and policy and increasing enforcement efforts, environmental strategies can produce rapid results in behavior changes at the population level with little to no associated monetary costs (Pacific Institute for Research and Evaluation, 1999; The Marin Institute, 2005).

Much of the evidence in support of environmental strategies to address substance abuse comes from the alcohol and tobacco prevention literature and relates to limiting access and availability to substances. However, just as the alcohol prevention field applied lessons learned from the tobacco prevention field, some of the lessons learned in both fields are being applied to the prevention of other substances of abuse. For example, as a strategy to reduce methamphetamine production and associated problems, many states have restricted access to medications containing pseudoephedrine by placing them behind the counter and requiring buyer identification.

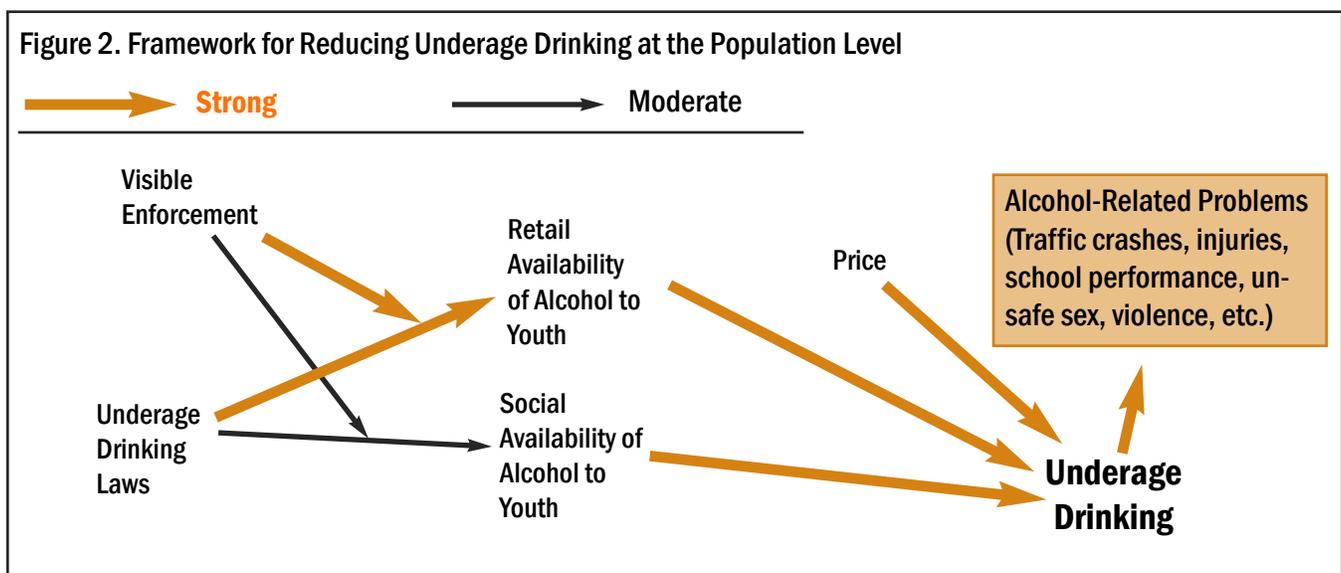
While researchers are currently exploring the efficacy of a variety of environmental strategies to reduce illicit drug use, a general causal model to guide population-level alcohol, tobacco and illicit drug prevention has been proposed (Birckmayer, Holder, Yacoubian & Friend, 2004). The researchers suggest that alcohol, tobacco and illicit drugs are essentially retail products and as such, economic theories of

supply and demand come into play. Most of prevention has focused on reducing demand for these substances (e.g., individual-level prevention programs). However, a comprehensive model for ATOD prevention also requires addressing supply factors, such as availability and promotion (marketing of substances). Norms also play a critical role in this model, affecting availability, promotion and demand factors. In addition, enforcement of laws and policies to reduce ATOD use/abuse is critical. This model can be used to identify a variety of strategies that may have population-level prevention effects for illicit drugs.

Community-Level Strategies for Prevent and Control Underage Drinking

A Framework to Understand the Evidence to Prevent Underage Drinking

Recently, researchers from the Pacific Institute for Research and Evaluation (PIRE) conducted a comprehensive review of the existing literature related to underage drinking prevention. They synthesized the findings into a graphic picture, or framework, that depicts how different environmental variables are associated with the level of underage drinking in a community and subsequent alcohol-related problems (Birckmayer, Boothroyd, Fisher, Grube & Holder,



2007). The first of its kind, and informed entirely by empirical evidence, this framework depicts the direction and strength of the relationships between and among a variety of variables (e.g., price, drinking context, retail availability of alcohol to youth) as they relate to underage drinking and alcohol-related problems. More importantly in terms of community prevention planning, this framework indicates the most effective points of intervention for communities to implement evidence-based environmental strategies to produce lasting, population-level effects. (See Figure 2 on page 12.)

Factors Strongly Associated with the Level of Underage Drinking in a Community

The following outlines the current state of the literature on the factors related to underage drinking and what research says about the environmental interventions associated with them.

Price of Alcohol

The most extensive research evidence to date is the effect of price on the level of alcohol consumption. Studies within and outside of the United States consistently confirm that even small increases in the price of alcohol result in decreases in alcohol consumption and related problems among youth and adults (Chaloupka, 2004; Cook & Moore, 2002). A recent review of the literature confirms this inverse relationship (Wagenaar, Salois & Komro, 2009). Interestingly, it appears that increases in the price of alcohol may have stronger effects on the drinking behaviors of youth when compared to adults (Chaloupka & Warner, 2001). In addition:

- Price consistently affects the drinking behaviors of all types of drinkers from light to heavy. While the effects of price on drinking may vary depending on other variables (individual, societal, commu-

nity, etc.), the overall finding across studies is that there is an inverse relationship. As the price goes up, the consumption of any type of beverage goes down (Wagenaar, Salois & Komro, 1999).

- Increasing the price of alcohol reduces incidents of drinking and driving (Chaloupka et al., 1993; Kenkel, 1993; Chaloupka & Laixuthai, 1997).
- Price increases appear to have a greater effect on reducing alcohol related problems such as youth traffic fatalities in communities with weak alcohol regulations (Ponicki, Gruenewald & LaScala, 2007).

Price Interventions with Strong Evidence of Population-Level Prevention Effects

Increasing Alcohol Taxes

There is substantial evidence in support of increases in alcohol taxes to reduce heavy alcohol consumption and related problems. In 1988, Coate and Grossman estimated that if the United States increased the price of alcohol by restoring the federal excise taxes to the rate of current inflation, fewer young people would report frequent beer drinking (32 percent fewer) and fairly frequent beer drinking (24 percent fewer). Tax increases also appear to reduce instances of traffic crash fatalities (Ruhm, 1996).

Promising Price Interventions

Restricting Happy Hours

Alcohol price discounts and promotions greatly affect the price of alcohol. Happy hours are associated with an increase alcohol consumption in both casual and heavy adult drinkers (Babor, Mendelson, Greenberg & Kuehnle, 1978) as well as in youth aged 14-17 years-old (Van Hoof, Van Noordenburg & DeJong, 2008). While more research is needed on this intervention, it appears to be promising as part of a comprehensive plan.

Underage Drinking Laws (MLDA-21)

There is a large body of evidence demonstrating that the minimum legal drinking age of 21 is an effective policy in reducing heavy drinking and associated harms among young people (Wechsler & Nelson, 2010). The policy is easily studied given that throughout history, the laws have not always remained constant. It is clear, however that in cases where states lower the minimum legal drinking age, alcohol consumption increases along with alcohol-involved traffic deaths; particularly among youth aged 18-20 years old (Wagenaar & Toomey, 2002; Dang, 2008; Douglass, 1980). Of course, the minimum legal drinking age law of 21 does not stand on its own. It is supported by a variety of state laws and alcohol control policies that tend to vary in terms of how well they are enforced. Without consistent enforcement of the laws, youth will have access to alcohol. Recent research continues to confirm the association between comprehensive alcohol policies and reductions in youth alcohol use (Paschall, Grube & Kypri, 2009).

Underage Drinking Law Interventions with Strong Evidence of Population-Level Prevention Effects

Limiting Retail Availability of Alcohol

Depending on their geographic location, is estimated that between 30 and 90 percent of on-premise (e.g. bars, restaurants) and off-premise (e.g., liquor stores, gas stations, grocery stores) alcohol outlets sell to minors (Wagenaar & Wolfson, 1995). Research has identified numerous effective strategies to address the retail access of alcohol to young people. The following describes these strategies and some of the supporting research:

- **Regulating Alcohol Outlet Density**—Alcohol outlet density is defined as the number of licensed establishments per capita in any defined community. Alcohol outlet density directly affects the availability of alcohol. By reducing or limiting the num-

ber of licensed alcohol retailers, alcohol consumption and related problems will decrease (Gruenewald, Johnson & Treno, 2002). Numerous studies have found a relationship between alcohol outlet density and the consumption of alcohol as well as related problems:

- Young people who live within walking distance of alcohol establishments report more binge drinking and driving after drinking. Higher outlet densities are associated with greater instances of these behaviors among young people (Dang Truong & Sturm, 2009; Chen, Grube & Gruenewald, 2010).
- Communities with high alcohol outlet densities experience more problems with drinking and driving and riding in a car with a person under the influence of alcohol among 16 to 20 year-olds (Treno, Grube & Martin, 2003).
- Students at college campuses with high alcohol outlet density in the surrounding area are more likely to report heavy and frequent drinking and experience other drinking-related problems among their students (Weitzman, Folkman, Folkman & Wechsler, 2003; Kypri, Bell, Hay & Baxter, 2008).
- As alcohol outlet density increases, young people report easier access to alcohol from an individual over 21 and by purchasing it themselves without identification (Todd, Grube & Gruenewald, 2005).
- **Restricting Hours and Days of Alcohol Sales**—Studies find that states and communities that limit the hours and days of alcohol sales have fewer drinking and drinking-related problems. The effectiveness of this strategy is easily studied when hours and days of alcohol sales are modified from being more restrictive to more liberal. Few studies found specific effects on youth drinking, but the effects

seen in the general population are significant enough to assume that limiting hours and days of alcohol sales also affect young people. The following summarize key findings supporting this strategy:

- A temporary weekend ban of alcohol sales in Mexico drastically reduced cross-border binge drinking among American youth as measured by Breath Alcohol Content (BAC) (Kelley-Baker, Johnson, Voas & Lange, 2000).
- Increasing the number of days that licensed retailers can sell alcohol is associated with an increase in the consumption of beer and spirits (Stehr, 2007).
- Limiting hours and days of sale can reduce alcohol related traffic

- RBS training is most effective when follow-up sessions are offered over a period of time. This is particularly important for younger merchants whose positive behavior effects as a result of the training may diminish over time (Buka & Birdthistle, 1999).
- When combined with additional strategies such as compliance checks, policy development and media advocacy, RBS is most likely to be successful (Grube, 1997; Saltz & Stanghetta, 1997).
- Research associates the implementation of RBS programs with a reduction in sales of alcohol to minors, violence in areas surrounding alcohol establishments, traffic crashes and sales to intoxicated individuals (Wallin, Norstrom & Andreasson, 2003; Holder & Wagenaar, 1994).

Promising Underage Drinking Law Interventions

Responsible Beverage Service Training

Enforcing the minimum legal drinking age laws and preventing sales of alcohol to youth requires multiple interventions as part of a comprehensive effort (Imm, Chinman, Wandersman, Rosenbloom, Guckenburg & Leis, 2007). One key component involves educating the individuals that sell or serve alcohol about the laws and the consequences of selling to underage youth. The program teaches servers skills such as how to check identification and recognize false ID's, the importance of offering food and alcohol-free beverages and how to determine when an individual has had too much to drink (Birckmayer et al., 2007). Responsible Beverage Service (RBS) is a program that targets all merchants that sell alcohol including servers at bars and restaurants where drinking occurs on-site, sellers in retail establishments where individuals purchase alcohol and consume it at another location as well as managers and owners. Responsible Beverage Service training is considered a promising strategy with the following research support:

Retail Monopolies on Alcohol Sales

When states restrict private licensing of alcohol sales, it not only reduces the number of establishments that sell alcohol, but may also make it easier to enforce laws against selling to minors (Her, Giesbrecht, Room & Rehm, 1999). States that allow private sales of alcohol and therefore price competition, experience more alcohol consumption among youth and more fatal traffic deaths involving alcohol-impaired drivers than states that control alcohol sales and price through a state retail monopoly (Miller, Snowden, Birckmayer & Hendrie, 2006).

Limiting Social Availability of Alcohol

Research finds that the most common source of alcohol for underage youth comes from social sources such as an adult friend or family member over the age of 21 (Wagenaar, Toomey, Murray, Short, Wolfson & Jones-Webb, 1996). In another study, 87 percent of underage youth reported obtaining alcohol through social sources such as a friend or family mem-

ber while only 23 percent reported the ability to purchase alcohol in retail commercial settings (Paschall, Grube, Black & Ringwalt, 2007). While social availability is a large source of alcohol for young people, research knows less about how to intervene in this area. The following strategies are promising approaches:

Promising Social Availability Interventions

Keg Registration

One way to potentially control underage access to alcohol outside of licensed alcohol establishments is to monitor the sales of beer kegs which are often purchased for private parties (Imm et al., 2007). Keg registration laws allow retailers to keep track of when a keg was purchased and who purchased it. This allows law enforcement to determine, when necessary, the individual responsible for providing alcohol to minors. Research is not yet clear as to how keg registration laws might impact youth drinking rates, but there appears to be an association with reduced rates of traffic fatalities among the general population (Cohen, Mason & Scribner, 2001).

Social Host Laws

In another effort to deter individuals from providing alcohol to minors, social host laws place liability on adults in situations where an intoxicated person is killed, injured or causes harm or death to another individual (Imm et al., 2007). Advocating for social host liability laws is increasingly popular among communities in an effort to decrease social access to alcohol. However, more research is needed to better understand the effectiveness of this strategy; in particular how it affects youth alcohol consumption. Currently, research has linked social host liability laws with the following:

- Individuals residing in states with social host liability laws engage in heavy drinking and drinking and driving less fre-

quently than those residing in states without the laws (Stout, Sloan, Liang & Davies, 2000).

- Social host liability laws are associated with a reduction in alcohol-related traffic fatalities (Whetten-Goldstein, 2000).

Other recommended interventions include: (1) Curfews for youth, (2) Restricting access to alcohol at social events, (3) Party patrols and (4) Restrictions on drinking locations and possession of alcohol (Birckmayer et al., 2007; Imm et al., 2007). Currently, little is known about how these interventions affect alcohol consumption among young people. However, these interventions may prove effective in combination with a comprehensive plan that includes evidence-based environmental interventions.

Visible Enforcement

Visible enforcement is a necessary component of any comprehensive prevention plan and is important in generating deterrence around youth drinking, as well as the sales and provision of alcohol to young people (Birckmayer et al., 2007). In fact, research finds that when adolescents perceive high rates of alcohol policy enforcement and compliance in their community they are less likely to use commercial sources to obtain alcohol, drink at school, drink and drive and drink heavily in any circumstances (Dent, Grube & Biglan, 2005). Enforcement of the minor in possession laws also is associated with less binge and overall drinking (Dent, Grube & Biglan, 2005). In addition, a recent study found that young people's perceptions of the level of police enforcement of the underage drinking laws positively related to their perceptions of community disapproval of youth alcohol use (Lipperman-Kreda, Grube & Paschall, 2010). While visible enforcement is important, studies find that it is often low and tends to vary significantly across states (Wagenaar & Wolfson, 1995). Given this, it is important for communities to consider implementing

strategies to increase the visibility of enforcement. The following describes the research behind compliance checks, one evidence-based enforcement intervention:

Compliance Checks

Compliance checks are used to determine whether or not licensed alcohol establishments sell to underage youth. Law enforcement obtains parental consent of youth who are then trained in the procedures of a compliance check. If asked for identification, underage youth present their own identification and do not lie about their age. The goal is to reduce the likelihood that retailers will sell alcohol to an underage person. Often, compliance checks are implemented in combination with media recognition for retailers that refuse sales to individuals under the age of 21. They demonstrate to the community that selling alcohol to underage persons is unacceptable.

Compliance checks have been instrumental in lowering rates of sales to underage youth as well as their smoking rates (Biglan et al., 2000). In fact, research finds that when compliance rates increase, young people report less use of commercial sources for alcohol (Paschall, Grube, Black, Flewelling, Ringwalt & Biglan, 2007). Increasingly, compliance checks are being used to reduce youth retail access to alcohol and have been demonstrated effective in a variety of studies.

- Implementation of compliance checks reduced the number of licensed retailers selling alcohol to individuals under age 21 by more than 20 percent (Stroh, 1998).
- In combination with other interventions, compliance check programs reduced reported alcohol consumption among youth (Grube 1997, Grube 1998).
- Compliance checks are more likely to reduce illegal alcohol sales when they are

conducted on a regular basis, as they appear to have a decaying effect over time (Wagenaar, Toomey & Erickson, 2005a; Wagenaar, Toomey & Erickson, 2005b)

Community-Level Strategies for Tobacco Prevention and Control

Research shows that most smokers begin smoking before the age of 21 (Gilpin, Lee, Evans & Pierce, 1994). Given this, preventing the early onset of tobacco use is critical in reducing the many negative health consequences associated with both early and prolonged use. In 1994, the Surgeon General responded to this problem by publishing a report called “Preventing Tobacco Use Among Young People” (U.S. Department of Health and Human Services, 1994). The report highlights the importance of implementing comprehensive, communitywide efforts to prevent and reduce tobacco use among young people. Specific strategies such as increasing tobacco taxes, enforcing existing tobacco control policies, implementing mass media campaigns, developing tobacco-free school policies, establishing education and prevention programs in schools, and restricting tobacco advertising and promotions are mentioned as components of a comprehensive approach.

In 1999, the CDC published a manual to support states in planning comprehensive tobacco control programs to reduce disease, disability, and death associated with tobacco use. To achieve these goals, the CDC also emphasized the importance of preventing the initiation of tobacco use as well as promoting cessation, decreasing exposure to second hand smoke, and eliminating disparities in tobacco use effects among different populations. To achieve these aims, the CDC emphasizes the need for the federal government, states, and local communities to work in partnership and at multiple levels to successfully address tobacco prevention (CDC, 1999). Key strategies include those focused on

the individual-level as well as the community-level, or environmental strategies.

Environmental strategies important for tobacco control and prevention include the adoption and enforcement of public and private tobacco control policies. It should be noted that rigorous enforcement is important in the success of any policy. In fact, research shows that the strict enforcement of youth access laws can effectively reduce youth access to cigarettes (Feighery, Altman & Shaffer, 1991; Jason, Yi, Anes & Birkhead, 1991; Jason, Billows, Schnopp-Wyatt & King, 1996). The following briefly describes a few of the key strategies currently being implemented in states and local communities (often led by community coalitions and other community mobilization efforts) across the country and some of the associated research:

Increasing Tobacco Excise Taxes

Tobacco excise taxes are determined by the state and therefore vary across the country. Research shows that young people are highly sensitive to an increase in cigarette prices when compared to adults. As prices increase, young people are less likely to report smoking (Ross & Chaloupka, 2004; Lewit, Coate & Grossman, 1981).

Restricting Youth Access to Tobacco

Research provides little information about how to reduce tobacco access through social sources. Similar to alcohol, while young people do report obtaining tobacco by purchasing it themselves, the majority of early experimenters, advanced experimenters and established youth smokers obtain cigarettes from others who either purchase it for them or who give them away. Some youth also report taking cigarettes without permission (Emery, Gilpin, White & Pierce, 1999). While more research is needed in the area of social sources for tobacco, research is growing in the area of retail access and there is significant evidence that strategies to reduce retail access of tobacco products can reduce youth smoking

rates. The following highlights some of these strategies that can be implemented at the state and community levels:

- **Compliance Checks**

Unannounced compliance checks in which minors attempt to purchase tobacco products can aid in the enforcement of tobacco control laws. Research finds that compliance checks are an important element in a youth smoking prevention plan as they can reduce tobacco sales to youth (Jason et al., 1991), reduce the amount of tobacco consumed by youth smokers, and reduce the overall rates of youth smoking in a community (Ross & Chaloupka, 2004; Tutt, Bauer & DiFranza, 2009). Strong enforcement components are necessary for a compliance program to be truly successful in reducing illegal sales and smoking rates among young people (Tutt, 2009). A media component can also strengthen the effectiveness of compliance checks for tobacco sales to minors. In one community, a compliance program with strong enforcement that included regular direct contact with retailers educating them on the fines and sanctions associated with violations of the law and reminding them that they are subject to random compliance checks resulted in an over 20 percent increase in compliance (Tutt et al., 2009).

- **Product Placement**

Many states now require retail outlets in which individuals under the age of 18 are allowed on the premises to place tobacco products in a location that cannot be reached without the help of an employee. Doing this can eliminate the theft of tobacco products by underage persons which is shown to be a larger problem for retailers with self-service tobacco displays (Cummings, Hyland, Saunders-Martin & Perla, 1998-1999).

- **Tobacco Licensing Restrictions**

There is some evidence that placing restrictions on the number of outlets provided with tobacco licenses in a given area may prevent or reduce youth smoking (Novak, Reardon, Raudenbush & Buka, 2006). Some states also have policies that allow license revocation for retailers that continue to sell to minors.

Other strategies used for restricting youth access to tobacco are the use of tobacco product scanners that prompt store clerks to ask purchasers for age identification (Cummings et al., 1998-1999), penalties for selling tobacco to minors and penalties or fines for minors who attempt to purchase tobacco (Jacobson & Wasserman, 1999).

- **Establishing Smoke-Free Indoor Air Laws**

Smoke-free indoor air laws place restrictions on smoking in both public and private settings such as government buildings, restaurants, schools, health facilities and workplaces. Studies examining the enforcement of these public and private policies to reduce or eliminate second-hand exposure to tobacco smoke have had good success. The policies protect non-smokers and also appear to reduce the daily number of cigarettes smoked by employees (Bauer, Hyland, Li, Steger & Cummings, 2005). Some studies report that laws restricting smoking in public places may reduce overall cigarette consumption and demand among current smokers (Chaloupka, 1991; Chaloupka & Wechsler, 1997; Wasserman, Manning, Newhouse & Winkler, 1991). Smoke-free indoor air laws also appear to affect smoking behaviors in the youth population. For example, placing local restrictions on smoking in restaurants was found to reduce rates of smoking as well as smoking intensity among youth in the surrounding community (Ross & Chaloupka, 1994).

- **Advertising Restrictions on Tobacco Products**

Some studies suggest that advertising can influence young people to smoke cigarettes (Pucci & Siegel, 1999, Hanewinkel, Isensee, Sargent & Morgenstern, 2010). To reduce tobacco advertising, communities often place limitations on where tobacco and cigarette advertising can be posted. For example, advertising may only be allowed if it is at least 1,000 feet away from a church or school. Laws also may place limits on the size of an advertisement or billboard. Some states place similar restrictions on tobacco advertising outside of retail stores. California, for example, limits retailer ad displays to no larger than fourteen square feet. In addition, California state law limits advertising displays to no more than one-third of the square footage of glass doors and windows of any retailer (California Department of Health Services, 2005).

- **Community-Level Strategies to Address Illicit Drug Problems**

Because of the fact that illicit drug manufacture, distribution and sale occur underground, illicit drug prevention strategies often differ from strategies for legal substances such as alcohol and tobacco. However, one illicit substance that has been addressed through policy at the local level in many communities is methamphetamine. Because of the fact that the chemicals used to produce this drug are available legally, Federal, state and local laws can place restrictions on access to these chemicals as an effort to reduce local production and use of methamphetamine. The following describes such restrictions in more detail:

- **Controlling the Sale of Precursor Chemicals**

Efforts to control the sale of chemicals used in methamphetamine production as well as enforcing penalties for those who

violate the laws can increase the perceived costs and perception of risk associated with methamphetamine production (O'Connor, Chriqui, McBride, Eidson, Baker, Terry-McElrath & VanderWaal, 2007). For example, federal laws have been passed to address the problem including the Combat Methamphetamine Act passed in 2005 that set limits to the amount of over the counter pseudoephedrine products behind the counter and set limits to how much of the product can be sold to an individual (O'Connor et al., 2007). Federal law does not prevent states from drafting more strict policies and some have done so with success (O'Connor et al., 2007). In addition, many states' local efforts also can be implemented to pass laws related to methamphetamine precursors or associated criminal penalties for those in violation of the law.

Lessons learned from crime prevention efforts shed light on the role that environmental strategies can play to reduce other illicit drug problems within the community. Many of these strategies include reducing the availability of drugs in the community through supply reduction. For example there is some success in the following:

- **Reducing Drug Dealing in Private Rental Places**—There is strong research evidence that suggests drug related crimes can be decreased via implementation of appropriate management of rental properties. Civil, criminal and regulatory rules and laws can be used to force third-parties (i.e., landlords and owners) to take some responsibility in controlling crime committed on their property. Nuisance abatement efforts that threaten landlords/owners with legal action to seize properties in which drug dealing occurs have been successful at reducing drug related crimes, such as dealing and drug offenses (Eck, 1997; Mazerolle, Soole & Rombouts, 2007).

- **Crime Prevention Through Environmental Design (CPTED)**—This describes strategies targeted at crime reduction by changing aspects of the physical environment in which problems occur. CPTED aimed at drug problems may include installing surveillance cameras, adding additional lighting and eliminating bus stops or phone booths used by drug users and dealers. There is some support that CPTED aimed at reducing drug problems is successful at impacting drug and violent arrests (Mazerolle, Soole & Rombouts, 2007).

Researchers have recently developed a comprehensive intervention to prevent youth use of harmful legal products, such as inhalants, prescription drugs and over-the-counter-drugs (Johnson et al., 2007).

- **Comprehensive Prevention Intervention to Reduce Youth Use of Harmful Legal Products**—This intervention has three evidence-based substance abuse prevention components: community mobilization to support the prevention efforts, environmental strategies to reduce the availability of harmful legal products, and school-based prevention education to improve youths' behavioral and cognitive skills. The particular environmental strategies emphasized in this intervention include working with retailers to post warning labels, identify products with high-risk of being abused, developing store policies regarding sales of these high-risk products, changing how/where products are displayed, and restricting sales to youth. Strategies also engaged parents and schools in restricting access of harmful products within the home and school environments. The program has undergone a study to test feasibility of implementing the program components in four Alaskan communities. Results

from the feasibility study indicate fewer youth (12-17 years) were able to purchase harmful products (Courser, Collins, Holder, Johnson & Ogilvie, 2007) and

parents and schools adopted practices to restrict youth abuse of harmful legal products (Johnson et al., 2007).

CONCLUSION

In summary, it is clear that strong scientific evidence exists to support the effectiveness of environmental strategies, as well as evidence that coalitions can be successful at implementing the full array of prevention programs and environmental/policy strategies to address local substance abuse problems. As indicated by the socio-ecological model, effective interventions to address behavior such as substance use and abuse requires a comprehensive approach, seeking change at multiple levels (Bronfenbrenner, 1979; Sorensen, Emmons, Hunt & Johnston, 1998). Such an approach addresses the problem using both individually-focused and environmentally-focused interventions as part of a strategic plan to achieve population-level reductions in alcohol, tobacco and illicit drug use.

Additionally, by implementing a comprehensive plan addressing all levels of the ecological model, coalitions bring about key community and systems changes (e.g., new or modified programs, policies and practices brought about by the coalition related to its mission) that are considered critical intermediate outcomes needed to bring about population-level changes in substance abuse outcomes (Roussos & Fawcett, 2000). Examples of community changes include: implementing a prescription drug take-back program, expanding the practice of health clinics to screen for youth drug use and changing policy to increase the tax paid for tobacco products. These community changes represent progress toward achieving long-term goals and can be documented with reliability (Fawcett et al., 1997; Francisco, Paine, & Fawcett, 1993).

Other researchers agree that markers of intermediate outcomes toward more distal health outcomes are changes in the community environment, such as the shifts in programs, policies and practices described above (Butterfoss, 2007; Kegler, Twiss & Look, 2000).

Research examining the relationship between community changes and population-level outcomes provides indication that these community changes are important precursors of improvements in population-level health outcomes. Fawcett and colleagues (1997; Paine-Andrews et al., 2002) have demonstrated in numerous case studies that reductions in population-level health outcomes are more likely when a sufficient number of community changes have been achieved. When coalitions are effective at facilitating new or modified programs, policies and practices, such as increasing enforcement of underage drinking laws, decreasing availability of tobacco, and implementing evidence-based drug prevention programs, they are more likely to experience population-level decreases in targeted health outcomes, such as the reduction of youth substance abuse and decreases in alcohol-related crashes and fatalities. These studies provide strong examples of community changes as intermediate outcomes toward population-level outcomes.

Research on substance abuse coalitions makes a further case for coalitions and use of comprehensive, community change efforts. Project Freedom, a drug abuse prevention coalition in Wichita, Kans., (Fawcett et al., 1997) was engaged in high levels of community mobilization

and was effective at facilitating new or modified programs, policies and practices targeted at their mission of preventing substance abuse. Additionally, survey data from high school seniors showed a modest impact on reducing use of alcohol. Examination of single nighttime vehicle crashes, a population level indicator of community health, also suggests a negative relationship between this variable and the number of community changes the coalition helped bring about. The researchers discovered that rates of single nighttime vehicle crashes were more likely to decrease when a sufficient number of community changes had been achieved, suggesting that the coalition contributed to reductions in crash rates through the implementation of a variety of strategies targeting substance abuse prevention.

It is examples like the one above that show how coalitions can be the vehicles through which comprehensive prevention occurs within the community. By ensuring that a multi-level, multi-component response is implemented by the multitude of community stakeholders involved in the coalition, communities are more likely to reduce substance abuse population-wide. Research is clear that both individual-level and community-level interventions are needed to affect all individuals and sectors within the community. Coalitions are well poised to be the change agent to help the community select the right combination of evidence based programs, policies and practices to achieve population-level reductions in substance abuse/use rates.

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APPENDIX C: SAMHSA-CSAP APPROVED NOMS

National Outcome Measures Items

Domain: Abstinence	Item Description	Source
Measure: 30 Day Use		
Cigarette	During the past 30 days, on how many days did you smoke part of or all of a cigarette?	NSDUH
Other tobacco product	During the past 30 days, on how many days did you use other tobacco products?	NSDUH
Alcohol	Thinks specifically about the past 30 days. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?	NSDUH
Marijuana or hashish	Thinks specifically about the past 30 days. During the past 30 days, on how many days did you use marijuana or hashish?	NSDUH
Other illegal drugs	Thinks specifically about the past 30 days. During the past 30 days, on how many days did you use any other illegal drug?	NSDUH
Domain: Abstinence	Item Description	Source
Measure: Age of First Use		
Cigarette	How old were you the first time you smoked part or all of a cigarette?	NSDUH
Other tobacco product	How old were you the first time you used any other tobacco product?	NSDUH
Alcohol	Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you had only a sip or two from a drink.	NSDUH
Marijuana or hashish	How old were you the first time you used marijuana or hashish?	NSDUH
Other illegal drugs	How old were you the first time you used any other illegal drug?	NSDUH
Domain: Abstinence	Item Description	Source
Measure: Perception of Disapproval Attitude		
Cigarettes (use one or more packs a day)	How do you feel about someone your age smoking one or more packs of cigarettes a day? 1. Neither approve nor disapprove 2. Somewhat disapprove 3. Strongly Disapprove	NSDUH
Cigarettes (close friends feel about use)	How do you think your close friends would feel about you smoking one or more packs of cigarettes a day? 1. Neither approve nor disapprove 2. Somewhat disapprove 3. Strongly Disapprove	NSDUH
Marijuana (use once or twice)	How do you feel about someone your age trying marijuana or hashish once or twice? 1. Neither approve nor disapprove 2. Somewhat disapprove 3. Strongly Disapprove	NSDUH

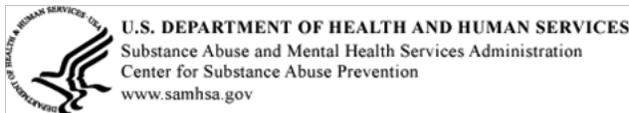
Marijuana (use once a month or more)	How do you feel about someone your age trying marijuana or hashish once a month or more? 1. Neither approve nor disapprove 2. Somewhat disapprove 3. Strongly Disapprove	NSDUH
Alcoholic beverage (use one or two drinks a day)	How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day? 1. Neither approve nor disapprove 2. Somewhat disapprove 3. Strongly Disapprove	NSDUH
Domain: Abstinence	Item Description	Source
Measure: Perceived Risk/Harm of Use		
Cigarettes (one or more packs a day)	How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day ? 1. No risk 2. Slight risk 3. Moderate risk 4. Great risk	NSDUH
Marijuana (use once or twice a week)	How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week ? 1. No risk 2. Slight risk 3. Moderate risk 4. Great risk	NSDUH
Alcoholic beverage (once or twice a week)	How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week ? 1. No risk 2. Slight risk 3. Moderate risk 4. Great risk	NSDUH
Domain: Employment and Education	Item Description	Source
Measure: Perception of Workplace Policy		
	Would you be more likely or less likely to want to work for an employer tat tests its employees for drug or alcohol use on a random basis? 1. More likely 2. Less likely 3. Would make no difference	NSDUH
Domain: Crime and Criminal Justice	Item Description	Source
Measure: Alcohol-Related Car Crashes		

and Injuries		
	During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only? 1. Yes 2. No	NSDUH
Domain: Social Support/Social Connectedness	Item Description	Source
Measure: Family Communications Around Drug Use		
	During the past 12 months , have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents we mean your biological parents, adoptive parents, stepparents, or adult guardians – whether or not they live with you. 1. Yes 2. No	NSDUH
	During the past 12 months , how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol or other drugs? 1. 0 times 2. 1 to 2 times 3. A few times 4. Many times	NSDUH
Domain: Retention	Item Description	Source
Measure: Percentage of youth seeing (read, watch, listen to) a prevention message		
	During the past 12 months, do you recall hearing, reading, or watching an advertisement about the prevention of substance use? 1. Yes 2. No	NSDUH

APPENDIX D: OVERVIEW OF THE COMMUNITY OUTCOME MEASURES PROCESS

Strategic Prevention Framework State Incentive Grant Cohorts III/IV/V

Community-Level Outcome Data Collection and Reporting Manual



Prepared by:



September 2011

Overview

This document provides information regarding the Community Outcomes data requirements for SPF-SIG Cohort III/IV/V grant recipients. The manual is broken into two general sections that separately address (1) the community-level data collection and reporting requirements for SPF- SIG Cohort III/IV/V grantees and (2) the process of submitting Community Outcomes data. Further information and additional helpful suggestions can be found in *Community Outcomes Frequently Asked Questions (FAQs)*.

Community Outcome Data Reporting Requirements

This section provides a brief overview of the community-level data to be reported by SPF-SIG Cohort III/IV/V grantees and gives specific detail regarding the Community Outcomes data requirements. Because community-level National Outcome Measures (NOMs) are a primary focus of the reporting requirements as indicated by the Center for Substance Abuse Prevention (CSAP), guidance for the collection and submission of community-level NOMs data is highlighted. Descriptions and definitions are included for each of the prevention NOMs relevant to the Community Outcomes data reported by SPF-SIG Cohort III/IV/V grant recipients.

Community Outcomes Data Submission Process

This section discusses the process through which grantees will submit Community Outcomes data. Information is provided regarding how, when, and by whom Community Outcomes data are submitted through CSAP's on-line Prevention Management Reporting and Training System (PMRTS). As well, the data elements included in the Community Outcomes data submission are outlined in detail, including a description of each individual data element to be submitted.

Community Outcomes Data Reporting Requirements

SPF-SIG grantees are required to report on community-level epidemiological outcomes as a condition of their SPF-SIG award and as a part of the cross-site evaluation effort. These data are used by CSAP for showing progress on NOMs at the community level and by the SPF-SIG cross-site evaluation team to demonstrate the effectiveness of the SPF SIG program on producing population-level change. The Community Outcomes data are intended to reflect changes in the consumption, consequence, and intervening variables expected to be influenced by SPF-SIG programming at the community level.

Community Outcomes data reported to the cross-site evaluation will likely be derived from the same data sources that grantees will be using for their own local evaluations. Examples include measures derived from existing community-level surveys (of students or adults), traffic crash data, hospitalization data, and other state or local data sources that may provide more sensitive measures of change and/or more precise geographic matches to the funded communities than are available through national databases. If a grantee's existing data sources do not provide community-level outcome data that meet the criteria discussed in this manual regarding NOMs specifications, alternative means of collecting these data must be explored.

Community Outcomes data requirements involve grantees collecting and submitting data for each subrecipient community on at least one outcome measure for each targeted priority. If the targeted priority has an associated NOM indicator (see Table 1), the reported measure must correspond with the approved NOMs item. If the targeted priority does not have an associated NOM indicator, the reported measure must be a valid and reliable tool for assessing the priority. Community Outcomes data should represent the community expected to be impacted by the subrecipient's SPF-SIG programming. Grantees should enter at least one baseline assessment point that is prior to the funding of subrecipients and the implementation of SPF-funded programs and as many follow up points as possible.

Community-Level NOMs

SPF-SIG grantees are required to report on the NOMs related to prevention at the grantee (i.e., state, tribe, jurisdiction), community, and program levels. Grantee-level NOMs are generally pre-populated by estimates from existing data sources (e.g., UCR, FARS, NSDUH). Program-level NOMs are collected through the administration of the Participant-Level Instrument (PLI) and are submitted by subrecipients via the PMRTS. Program provider data (for NOMs such as Use of Evidence-Based Programs, Policies and Practices) are reported by the subrecipient through completion of the Community-Level Instrument (CLI). ***Community-level NOMs are submitted by the grantee evaluator through the Community Outcomes Module of the PMRTS.*** Table 1

shows those NOMs that are pertinent to community-level outcomes for SPF-SIG Cohort II/IV/V grantees.

Grantees are required to report community-level NOMs that are relevant to their priority programs, policies, and practices. For each subrecipient, and for each targeted priority, data for at least one NOM must be reported. For example, if a subrecipient selects drinking and driving as its targeted priority, the grantee would be required to report on at least one of the three NOM indicators specific to this priority: (1) driving while under the influence, (2) alcohol related traffic fatalities, or (3) alcohol and drug related arrests. In this example, the grantee would not be required to report on NOM indicators unrelated to drinking and driving, such as family communication around drug use. If a subrecipient selects a priority that does not have an associated NOM indicator (e.g., alcohol-related cases of domestic violence, opioid overdoses), grantees are required to collect and report at least one community-level outcome measure related to this chosen priority.

For a list of approved NOMs to be used for community-level outcome reporting, grantees should refer to Table 1, which includes the following information:

- **Indicator** – the name of the particular indicator(s) within each prevention domain, i.e., the specific concept within the domain that will be assessed by the measure
- **Measure** – the specific wording of the survey item (for survey data) and/or the explicit components of the measure calculation (for event/surveillance data)
- **Measure Response Options** – the specific wording of the possible answers for the associated survey item from which respondents can choose (not applicable for event/surveillance data)
- **Outcome Reported** –the actual result and related statistic being reported for the associated measure; the interpretation of the reported community-level statistic

CSAP requires that the item wording and response options of survey questions match verbatim the approved list of NOMs items (see Table 1), which are taken from the National Survey on Drug Use and Health (NSDUH). Although there are several nationally recognized surveys that collect similar information on substance use and related consequences, the item wording or response choices are different enough that they do not meet the criteria for federal reporting requirements. Grantees must use the NSDUH item wording.

Data Sources for Community Outcomes Data

Community Outcomes data will be population-level statistics derived from either survey data or archival data from event/surveillance data systems.

- **Survey Data** -- Community surveys should target the population expected to be impacted by the subrecipient’s SPF-SIG activities. Survey samples should be representative of the target population and can include youth or adults. Surveys to collect the community-level NOMs data must use the approved NOMs measures. The NOMs measures may be added to an existing community survey.
- **Event Surveillance Data** -- Subrecipients must collect community-level event surveillance data pertaining to school, traffic, and crime NOMs from the local jurisdictions that collect and publish these data. The data should be collected for the jurisdictions representing the geographic area defined as the community expected to be impacted by the subrecipient’s SPF SIG activities. These data must conform to the specific NOMs measure calculations.

Table 1. National Outcome Measures (NOMs) to be Used in SPF SIG Community Outcomes Data Reporting

Indicator	Measure	Measure Response Options	Outcome Reported
Domain: Reduced Morbidity - Abstinence from Drug Use/Alcohol Use			
30 Day Use	Cigarettes During the past 30 days, on how many days did you smoke part or all of a cigarette?	A number between 0 and 30.	Percent who reported having smoked a cigarette during the past 30 days (i.e., percent who responded 1 or more days)
	Other Tobacco Products During the past 30 days, on how many days did you use [other tobacco products]?	A number between 0 and 30.	Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products, such as snuff, chewing tobacco, pipe tobacco (i.e., percent who responded 1 or more days)
	Alcohol During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?	A number between 0 and 30.	Percent who reported having used alcohol during the past 30 days (i.e., percent who responded 1 or more days)
	Marijuana or Hashish During the past 30 days, on how many days did you use marijuana or hashish?	A number between 0 and 30.	Percent who reported having used marijuana or hashish during the past 30 days (i.e., percent who responded 1 or more days)
	Other Illegal Drug During the past 30 days, on how many days did you use [any other illegal drug]?	A number between 0 and 30.	Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs, such as heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders (i.e., percent who responded 1 or more days)
Age at First Use	Cigarettes How old were you the first time you smoked part or all of a cigarette?	Age of first use.	Average age at first use of cigarettes.
	Other Tobacco Products How old were you the first time you used [any other tobacco product] †?	Age of first use.	Average age at first use of tobacco products other than cigarettes.
	Alcohol Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.	Age of first use.	Average age at first use of alcohol.
	Marijuana or Hashish How old were you the first time you used marijuana or hashish?	Age of first use.	Average age at first use of marijuana or hashish.

Indicator	Measure	Measure Response Options	Outcome Reported
	Other Illegal Drug How old were you the first time you used [other illegal drugs] ‡?	Age of first use.	Average age at first use of other illegal drugs.
Domain: Reduced Morbidity - Abstinence from Drug Use/Alcohol Use			
Perceived Risk/Harm of Use	Cigarettes How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?	No risk, slight risk, moderate risk, great risk, "don't know/can't say"	Percent reporting moderate or great risk (i.e., percent reporting "moderate risk" and percent reporting "great risk" combined)
	Marijuana How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?	No risk, slight risk, moderate risk, great risk, "don't know/can't say"	Percent reporting moderate or great risk (i.e., percent reporting "moderate risk" and percent reporting "great risk" combined)
	Alcohol How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?	No risk, slight risk, moderate risk, great risk, "don't know/can't say"	Percent reporting moderate or great risk (i.e., percent reporting "moderate risk" and percent reporting "great risk" combined)
Disapproval of Substance Use (youth only)	Cigarettes How do you feel about someone your age smoking one or more packs of cigarettes a day?	Neither approve nor disapprove, somewhat disapprove, strongly disapprove, "don't know/can't say"	Percent somewhat or strongly disapproving (i.e., percent reporting "somewhat disapprove" and percent reporting "strongly disapprove" combined)
	Cigarettes How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?	Neither approve nor disapprove, somewhat disapprove, strongly disapprove, "don't know/can't say"	Percent reporting that their friends would somewhat or strongly disapprove (i.e., percent reporting "somewhat disapprove" and percent reporting "strongly disapprove" combined)
	Marijuana or Hashish How do you feel about someone your age trying marijuana or hashish once or twice?	Neither approve nor disapprove, somewhat disapprove, strongly disapprove, "don't know/can't say"	Percent somewhat or strongly disapproving (i.e., percent reporting "somewhat disapprove" and percent reporting "strongly disapprove" combined)
	Marijuana How do you feel about someone your age using marijuana once a month or more?	Neither approve nor disapprove, somewhat disapprove, strongly disapprove, "don't know/can't say"	Percent somewhat or strongly disapproving (i.e., percent reporting "somewhat disapprove" and percent reporting "strongly disapprove" combined)
	Alcohol How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?	Neither approve nor disapprove, somewhat disapprove, strongly disapprove, "don't know/can't say"	Percent somewhat or strongly disapproving (i.e., percent reporting "somewhat disapprove" and percent reporting "strongly disapprove" combined)
Domain: Employment/ Education			
Perception of Workplace Policy	Drug or Alcohol Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?	More likely, less likely, would make no difference, don't know or can't say	Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests (i.e., percent responding "more likely")
Daily School Attendance	Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	N/A	See Measure Calculation.
Domain: Crime and Criminal Justice			
Driving While Under the Influence of Alcohol*	During the past 12 months, have you driven a vehicle while you were under the influence of alcohol?	Yes, no, don't know or can't say	Percent who reported having driven a vehicle while under the influence of alcohol (i.e., percent responding "yes")
Alcohol-Related Traffic Fatalities*	Measure Calculation: The number of alcohol-related traffic fatalities (NHTSA/FARS defined) divided by the total number of traffic fatalities and multiplied by 100.	N/A	See Measure Calculation.

Indicator	Measure	Measure Response Options	Outcome Reported
Alcohol and Drug-Related Arrests	Measure Calculation: The number of drug/alcohol-related arrests [for DUI, Drug Abuse Violations, and Liquor Law Violations (UCR-FBI defined)] divided by the number of total arrests and multiplied by 100.	N/A	See Measure Calculation.
Domain: Social Support/ Social Connectedness			
Family Communication Around Drug Use	Parent During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?*	0 times, 1 to 2 times, A few times, Many times.	Percent of parents reporting that they have talked to their child at least once (i.e., percent reporting “1 to 2 times,” “a few times”, and “many times” combined)
	Child During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you.	Yes, no, don't know or can't say	Percent reporting having talked with a parent (i.e., percent responding “yes”)
Domain: Retention			
Percentage of Youth seeing (reading, watching, listening) a prevention message	During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use]**?	Yes, no, don't know or can't say	Percent reporting having been exposed to prevention message (i.e., percent responding “yes”)

Community Outcomes Data Submission Process

This section provides an overview of the process by which grantees submit community outcomes data. This includes an explanation of the data entry system and the submission timelines, as well as a description of the various data elements to be submitted. For responses to commonly asked questions, grantees should reference the document, *Community Outcomes Frequently Asked Questions (FAQs)*, which will be continually updated.

How and When to Submit

The grantee-level evaluator is responsible for gathering the relevant Community Outcomes data for all subrecipient communities and for submitting these data to via the Community Outcomes module of the PMRTS. In the PMRTS, under the Evaluation tab, there is a tab for Community Outcomes, which will put grantee evaluator directly into the Community Outcomes data entry module.

Grantee evaluators should submit Community Outcomes data into the PMRTS as soon as data become available. Baseline assessments should be submitted as soon as data are available for the last period prior to subrecipient funding and program implementation. Follow up data, as they become available, should be submitted as part of the grantee quarterly reports. It is understood that follow up data may not be available on a quarterly basis for all data sources. For example, a student survey may occur once per year, or event/surveillance data may be extracted once every six months. Grantees are asked to enter any updated data they have each quarter.

What to Submit

Several important data elements pertaining to community-level epidemiological outcomes have been identified by the cross-site evaluation team, and grantees are asked to submit data for each of these elements. The data entry process in the Community Outcomes module follows the data elements outlined below. In Appendix A, each of these data elements is described in detail and any associated terms are defined; this table is meant to act as a guide for data entry. Because the Community Outcomes data are considered the responsibility of the grantee-level evaluator, the term “evaluator” will be used in the text below to indicate the person entering data into the system.

Subrecipient Name -- Once a grantee has funded subrecipients and entered the information into the Implementation section of the PMRTS, this information will appear in the Community Outcomes data entry module. Upon opening the data entry module, the evaluator will select the name of the subrecipient for which data will be entered. Once that record is complete, the evaluator must select another subrecipient to

enter data for another community. Community Outcomes data must be entered separately for each funded subrecipient. [Note: Single-community grantees will enter data at the grantee-level only.]

Priority Information -- For each subrecipient, the evaluator must indicate the targeted SPF-SIG priorities. Priorities pertain to the aspect of substance use and related problems being targeted by the subrecipient with SPF-SIG funds. For example, a common priority is the prevention of *underage drinking*; another is the prevention of *drinking and driving*. A subrecipient can have multiple priorities, they may be mandated by the grantee or selected by the community, and all should be entered. The priorities entered by the evaluator for each subrecipient in the Community Outcomes portion of the PMRTS should be consistent with the priority areas entered by the individual subrecipients in the CLI.

The remainder of the data entry fields will pertain to this priority. To enter data for another priority, the evaluator must come back to this point and enter a new priority.

Indicator Information -- An indicator is the conceptual operationalization of the targeted priority, but is not the actual measure. For example, for the priority of *underage drinking*, an appropriate indicator could be *30-day use*. At least one NOM indicator should be chosen to represent each targeted priority. Multiple indicators may be entered for a single priority. In addition to selecting an indicator(s) for each priority in the **Indicator** field, the evaluator must also determine the type of indicator it is. This is done by selecting *consumption*, *consequence*, or *intervening variable* in the **Indicator Type** field. In the example of the *30-day use* indicator, *consumption* would be selected.

The remainder of the data entry fields will pertain to this indicator. To enter data for another indicator for this priority, the evaluator must come back to this point and enter a new indicator.

Data Source Type -- Community Outcomes data are derived from either surveys or event surveillance data systems. The specifics of the outcome data requested vary depending on the data source type. For this indicator and the set of outcome data to be entered for this record, the evaluator should select either *survey data* or *event data* in the **Data Source Type** field. The remainder of the data entry screens will depend on this choice.

Data Source and Measure Information for Survey Data -- This section provides information about the means by which the survey data were collected. This includes what survey was used, when it was administered, which survey item was used as a measure for this indicator, and whether this measure qualifies as a NOM. In the **Data Source** field, the evaluator should indicate which survey was used to collect the data (e.g., YRBS, CtC). The evaluator should indicate the date on which the survey was

administered in the **Data Collection Date** field and whether this data collection point occurred before or after SPF-SIG programs related to this priority were implemented in this community.

Measure pertains to the specific survey item used to operationalize the indicator. The cross-site evaluation is charged with aggregating data across multiple subrecipients and multiple grantees, which is only possible with detailed information about the measures used by each grantee and subrecipient. In the **Measure: Source Item** field, the evaluator should enter the specific survey item for which data will be entered. The survey item should be entered exactly as it is worded on the survey. In the **Measure: Response Options** field, the evaluator should enter the response options for the survey item exactly as they appear on the survey. The evaluator should also indicate the coding schema (i.e., the numeric code associated with each response options) for the response options that would be used for analysis. This information is necessary for the cross-site evaluation team to make sense of reported outcomes that are, for instance, means or medians.

Two examples of measure information follow: (1) A subrecipient with a priority of *underage drinking* and an indicator of *30-day use* is using the measure/source item, *During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?*, for which the response options are *a number between 0 and 30*; and (2) A subrecipient with a priority of *underage drinking* and an indicator of *perceived risk/harm of use* is using the measure/source item, *How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?*, for which the response options and associated codes are *0=no risk, 1=slight risk, 2=moderate risk, 3=great risk, 99=don't know/can't say*.

After entering the measure information above (i.e., source item and response options), the evaluator must indicate in the **NOMs Item** field whether the subrecipient measure qualifies as a NOM. This determination should be made after reviewing the criteria outlined earlier in this manual and in Table 1. As a reminder, a measure can only be considered a NOM if the wording of the source item and the response options match the approved NOMs (NSDUH) item exactly.

Data Source and Measure Information for Event Data -- This section provides information about the means by which the event data were collected. This includes what event surveillance data system was used, what time period the archived data reflect, how the event was defined, how the measure was calculated for this indicator, and whether this measure calculation qualifies as a NOM. In the **Data Source** field, the evaluator should indicate which event surveillance data system was used to collect the data (e.g., FARS, UCR). The evaluator should indicate the begin and end dates of the data extract used to calculate the outcome the **Data Source Time Frame** fields. For example, if the data file includes data from January 1, 2007 through December 31, 2007, these dates

should be entered as the begin and end dates. The evaluator should also indicate whether this data collection point occurred before or after SPF-SIG programs related to this priority were implemented in this community.

Measure pertains to the specific event and associated calculation used to operationalize the indicator. The cross-site evaluation is charged with aggregating data across multiple subrecipients and multiple grantees, which is only possible with detailed information about the measures used by each grantee and subrecipient. In the **Measure: Event Definition** field, the evaluator should enter a detailed description of the event being reported; this definition should correspond to how the event is defined in the database from which the data are pulled. In the **Measure: Measure Calculation** field, the evaluator should enter the specific calculation used to derive the measure, including the specification of all elements of the equation such as numerator, denominator, multiplier, and divisor. This information is necessary for the cross-site evaluation team to make sense of reported outcomes that are, for instance, rates.

For example, a subrecipient with a priority of *drinking and driving* might specify an indicator of *alcohol-related traffic fatalities*. For this indicator, the event definition might be *fatalities resulting from alcohol-related motor vehicle crashes within county xxx*. The associated measure calculation could be *the number of alcohol-related traffic fatalities in the county xxx divided by the total number of traffic fatalities in county xxx and multiplied by 100*.

After entering the measure information above (i.e., event definition and measure calculation), the evaluator must indicate in the **NOMs Item** field whether the subrecipient measure qualifies as a NOM. This determination should be made after reviewing the criteria outlined earlier in this manual and in Table 1. As a reminder, a measure can only be considered a NOM if the measure calculation matches the approved NOMs measure calculation exactly.

Population Information for Survey Data -- This section provides information about the population intended to be represented by the survey data. In this section, the evaluator should enter a text description of the population in the **Population from which Survey Sample was Drawn** field and provide further detail about age or grade parameters as well as the overall number of persons (i.e., **N of Population** field) in the targeted population. Whenever the statistics are available, the evaluator should also provide information (estimates, if necessary) regarding the population demographic characteristics, such as the breakdown of gender, race, and ethnicity.

Survey Sample Information for Survey Data -- This section provides information regarding the survey sample and survey participants. The evaluator should use the **Sampling Strategy** field to explain how the survey sample was drawn from the population (e.g., a random sample, a convenience sample, a full census). The number of persons who were drawn for the survey sample should be entered in the **N of Sample**

field, and the number of person who actually participated in the survey should be entered in the **Number of Respondents** field. The evaluator must provide information regarding the demographic characteristics of the survey respondents, such as the breakdown of gender, race, and ethnicity.

Population Information for Event Data -- This section provides information about the population intended to be represented by the event surveillance data. In this section, the evaluator should enter a text description of the population in the **Population on which the Event Data is Based** field and provide further detail about age range as well as the overall number of persons (i.e., **N of Population**) in the targeted population. The evaluator must indicate at what level (state, county, service area, etc.) the data are being reported in the **Geographic Unit of Event** field. The evaluator should also provide information regarding the population demographic characteristics, such as the breakdown of gender, race, and ethnicity.

Outcome Data Information for Survey Data -- This section contains the actual outcome data that is being reported for the associated priority, indicator, and measure. The **Reported Outcome for Survey Data** pertains to the actual result and related statistic being entered for this measure. In this field, the evaluator should provide a detailed text description of the reported outcome. Because multiple reported outcomes can be derived from a single measure, and multiple measures can give rise to a single reported outcome, it is important to provide the cross-site evaluation team with sufficient information to interpret the results being entered.

In the earlier example of a subrecipient with a priority of underage drinking, an indicator of 30-day use, and a measure/source item, During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?, the reported outcome might be the percentage of high school students who report drinking any alcohol in the past 30 days. Alternatively, the reported outcome might be the mean numbered days high school students report having used alcohol in the past 30. (Note: The first reported outcome satisfies a NOM reporting requirement, whereas the second reported outcome does not.)

After describing the reported outcome, the evaluator should enter the outcome data. This includes entering the statistic in the **Calculated Value** field and the type of statistic (e.g., mean, median, percentage) in the **Value Type** field. Whenever possible, the evaluator should enter the associated **Standard Error** and **Standard Deviation**, as well as the **Upper and Lower Bounds of the 95% Confidence Interval**. These latter fields are strongly requested but not required, because it is understood that such estimates are not always available in secondary datasets. Because the number of persons on which the reported statistic is based can differ from the number of survey respondents, due to missing data and/or legitimate skip patterns in the survey, the evaluator is asked to provide information about the **Actual Number of Valid Responses for the Specific Survey Item** being reported as well as the

Possible Number of Valid Responses for the Specific Survey Item being reported.

Outcome Data Information for Event Data -- This section contains the actual outcome data that is being reported for the associated priority, indicator, and measure. The **Reported Outcome for Event Data** pertains to the actual result and related statistic being entered for this measure. In this field, the evaluator should provide a detailed text description of the reported outcome. Because multiple reported outcomes can be derived from a single measure, and multiple measures can give rise to a single reported outcome, it is important to provide the cross-site evaluation team with sufficient information to interpret the results being entered.

After describing the reported outcome, the evaluator should enter the outcome data. This includes entering the number of times the defined event occurred in the community in the time frame of the data collection in the **Number of Events** field. This number would be a simple frequency count. The evaluator should enter the reported statistic in the **Calculated Value** field and the type of statistic (e.g., rate, percentage) in the **Value Type** field. Because the calculated value is likely to be a rate, percentage, etc., the cross-site evaluation team would benefit from understanding the additional components used in the computation. Thus, the evaluator is asked to describe the denominator in the **Denominator Definition** field and to provide the value of denominator in the **Denominator Value** field. The information in both of these fields should correspond with the information provided in the **Measure: Measure Calculation** field.

Additional Information

For content questions relating to the Community Outcomes data elements contact the DACCC SPF SIG III/IV Cross-site Evaluation Team:

- Kelly Vander Ley (kvanderley@rmccorp.com)
- Kelly Jarvis (kjarvis@rmccorp.com)
- 1-800-788-1887

For technical questions relating to the navigation of the PMRTS Community Outcomes Data Entry System contact DITIC Support Help Desk:

- DITICSupport@kitsolutions.net
- 1-888-DITIC-4-U (1-888-348-4248)
- To find training videos and support information, go to the DITIC support site: <http://kitusers.kithost.net/support/diticsupport/Home/tabid/782/Default.aspx>
- To log in and enter data, go to the Prevention Management Reporting and Training System: <https://www.pmrts.samhsa.gov/pmrts/>

Appendix A: Community Outcomes Data Elements Table

The table below displays and provides a detailed explanation for each data element requested in the Community Outcomes data entry module.

Data Element	Explanation
Subrecipient Information	
Subrecipient Name	Name of subrecipient receiving SPF SIG funding from the grantee. Response options will appear as a drop-down list generated from Subrecipient section on MRT.
Priority Information	
Priority	<p>A priority pertains to the aspect of substance use and related problems that is being targeted by the subrecipient with SPF SIG funds. For example, a subrecipient might identify <i>Prevention of Underage Drinking</i> as a priority to target with SPF-SIG funded programming.</p> <p>Select from the drop down menu the priorities that have been assigned to (or selected by) this subrecipient. This information should be consistent with what you entered as priority areas in the CLI, specifically items 50a, 52, and 57. Multiple priorities may be entered for each subrecipient, where applicable.</p> <p>Priorities are typically consumption patterns or consequences. Consumption patterns are the way in which people drink, smoke and use drugs. Consumption includes overall consumption, acute or heavy consumption, consumption in risky situations (e.g., drinking and driving) and consumption by high-risk groups (e.g., youth, college students, and pregnant women). Consequences are defined as the social, economic and health problems associated with the use of alcohol and illicit drugs (e.g., illnesses related to alcohol, such as cirrhosis and fetal effects, drug overdose deaths, crime, and car crashes or suicides related to alcohol or drugs).</p> <p>Intervening variables are factors that have been identified through research as being strongly related to and influencing the occurrence and magnitude of substance use and related risk behaviors and their subsequent consequences (e.g., retail access, social norms, individual risk and protective factors). These variables are often the focus of prevention strategies, changes in which are then expected to affect consumption and consequences. If a subrecipient is focusing on an intervening variable that relates to a consumption or consequence variable already entered as a priority, information about that intervening variable should be entered in the Indicator Information section for the associated priority. If a subrecipient is focusing on an intervening variable that is not linked to a consumption or consequence variable already entered as a priority, information for that intervening variable should be entered as its own priority.</p>

Data Element	Explanation
Indicator Information	
Indicator	<p>An indicator reflects a conceptual operationalization of the targeted priority, but is not the actual measure. For example, if a subrecipient is targeting the <i>Prevention of Underage Drinking</i> as a priority, <i>30-Day Use</i> might be an indicator of this priority.</p> <p>Select from the drop down list the indicator being used to represent the stated priority. Multiple indicators can be selected for a given priority, where applicable. For example, if a subrecipient is targeting the <i>Prevention of Underage Drinking</i> as a priority, both <i>30-Day Use</i> and <i>Age at First Use</i> might be indicators of this priority. If the indicator being used is not in the drop down menu, select <i>Other</i>. If <i>Other</i> is selected, you will be asked to describe the indicator in the <i>Other Indicator</i> field.</p> <p>Indicators may be either direct or indirect representations of each priority. You should include indicators identified as Intervening Variables linked with the stated consumption/consequence priority. For example, the subrecipient illustrated above with the <i>Prevention of Underage Drinking</i> as a priority may have identified <i>Enforcement Levels</i> as a key intervening variable. This subrecipient would list <i>30-Day Use</i>, <i>Age at First Use</i>, and <i>Enforcement Levels</i> as indicators of this priority.</p>
Indicator Type	<p>For each indicator, specify whether the indicator is a Consumption pattern, Consequence, or an Intervening Variable. For example, for a subrecipient with a priority of <i>Prevention of Underage Drinking</i>, the indicator <i>30-Day Use</i> would be a Consumption pattern, while the indicator <i>Enforcement Levels</i> would be an Intervening Variable.</p>
Data Source Type	
Data Source Type	<p>For this indicator, are you reporting data from a survey or from an event/surveillance system?</p> <p>Data Source Type pertains to whether the data reported for this indicator are derived from a survey or from an event/surveillance system (e.g., state traffic data archives, court records, hospital records). For each indicator, select the appropriate data source type from the drop down list. Multiple data sources may be entered for each indicator, where applicable. For example, if <i>Driving under the Influence</i> is an indicator, it is possible that a subrecipient would report data from a community survey as well as DUI arrest data from an event/surveillance data system for that indicator.</p>
Data Source and Measure Information for Survey Data	
Data Source	<p>Which survey are you using to collect data for this indicator?</p> <p>Select from the drop down list the survey used to collect the data for the indicator. Response options will include YRBS, BRFSS, state/grantee student survey, etc.</p> <p>If a local data source (e.g., state/grantee student survey) or <i>Other</i> is selected under Data Source, you will be asked to insert the specific name of the survey (e.g., "California Healthy Kids Survey") in the Data Source Name field.</p>
Data Collection Date	When were these data collected?

Data Element	Explanation
	<p>Indicate the month and year in which the survey was conducted. If multiple years of data (e.g., 2004 and 2005) were combined into a single estimate due to low <i>Ns</i>, please insert the month and year of the most recent survey date and note the details in Data Source Comments.</p>
Strategies implemented prior to data collection?	<p>Were any SPF-funded strategies related to this priority implemented in this community prior to this data collection date?</p> <p>Indicate whether any SPF strategies related to this priority had been implemented in this community before the data collection date (i.e., before the date the survey was administered).</p>
Start Date for Strategies Related to this Priority	<p>During what quarter were strategies related to this priority first implemented in this community?</p> <p>Indicate in the drop down menu the quarter when SPF-funded strategies, related to this priority, were first implemented in this community. This date refers to when the strategies were first <i>implemented</i> (e.g., when direct services were provided) and does not include the planning stages. If multiple SPF strategies are being implemented in this community for the same priority, indicate the earliest implementation date among them.</p>
Measure: Source Item (exact wording)	<p>For which survey item are you reporting data?</p> <p>Measure pertains to the survey item used to operationalize the indicator. Enter the survey item used for this measure. Type out the source item verbatim, exactly as it appears on the survey instrument. For example, a subrecipient with a priority of <i>Prevention of Underage Drinking</i> using an indicator of <i>30-day Use</i> may be using the measure/source item: <i>During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?</i> The response options for this item should be entered in the corresponding text field.</p>
Measure: Response Options (exact wording)	<p>Enter the response options for the survey item used for this measure. Type out the entire set of response options verbatim, exactly as they appear on the survey instrument. If applicable, include the associated codes for each response that were used in analyses. The coding schema is necessary for the cross-site team to understand reported outcomes that are means, medians, etc. For example, a subrecipient with a priority of <i>Prevention of Underage Drinking</i> using an indicator of <i>30-day Use</i> may be using the measure/source item <i>During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?</i> for which the response options are: <i>a number between 0 and 30</i>. In another example, the measure/source item <i>How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?</i> would require the listing of the response options and their associated codes, such as: <i>0=no risk, 1=slight risk, 2=moderate risk, 3=great risk, 99=don't know/can't say</i>.</p>
NOMs Item	<p>Does this measure qualify as a NOMs item?</p> <p>Indicate whether the Source Item above qualifies as a NOMs item. Note: In order for the Source Item to be considered a NOMs item, the item wording must match the approved NOMs item exactly. Please refer to the NOMs Definitions document for clarification.</p>

Data Element	Explanation
Data Source/Measure Comments	Enter any explanatory comments needed to clarify any of the information provided in the fields related to Data Source and Measure.
Data Source and Measure Information for Event Data	
Data Source	<p>Which event/surveillance system are you using to collect data for this indicator?</p> <p>Select from the drop down list the surveillance system used to collect the data for the indicator. Response options will include Fatality Analysis Reporting System (FARS), Uniform Crime Report (UCR), state/grantee agency reporting system, etc.</p> <p>If a local data source (e.g., state/grantee agency reporting system) or <i>Other</i> is selected under Data Source, you will be asked to insert the specific name of the surveillance system (e.g., "Colorado Department of Transportation") in the Data Source Name field.</p>
Data Source Time Frame	<p>When were these data collected?</p> <p>Indicate the time frame during which data for this measure were collected. You will be asked to insert a begin date and end date (e.g., 1/1/2005 to 12/31/2005) for the time period of the data you are submitting. If multiple years of data (e.g., 1/1/2004 to 12/31/2005) were combined into a single estimate due to low Ns, please note the details in Data Source Comments.</p>
Strategies implemented prior to data collection?	<p>Were any SPF-funded strategies related to this priority implemented in this community prior to the dates during which the event data were collected?</p> <p>Indicate whether any SPF strategies related to this priority had been implemented in this community before the data collection time period.</p>
Start Date for Strategies Related to this Priority	<p>During what quarter were strategies related to this priority first implemented in this community?</p> <p>Indicate in the drop down menu the quarter when SPF-funded strategies, related to this priority, were first implemented in this community. This date refers to when the strategies were first <i>implemented</i> (e.g., when direct services were provided) and does not include the planning stages. If multiple SPF strategies are being implemented in this community for the same priority, indicate the earliest implementation date among them.</p>
Measure: Event Definition	<p>Specifically what event is being used to represent this indicator?</p> <p>Define the incident or event that comprises the operationalization of this indicator. Be specific in your description. For example, an event definition might be <i>Alcohol-related motor vehicle crashes involving a single driver and occurring between the hours of 10 pm and 4 am.</i></p>
Measure: Measure Calculation	<p>How is the event you are reporting being calculated?</p> <p>Measure pertains to the calculation used to operationalize the indicator. Describe in detail how the measure is calculated, specifying all elements of the equation including numerators, denominators, divisors, and multipliers. For example, for the reported outcome of <i>Percent of traffic fatalities that were alcohol-related among all drivers in county xxx</i>, the measure calculation would be <i>the number of alcohol-related traffic fatalities in county xxx divided by the total number of traffic fatalities in county xxx and multiplied by 100.</i></p>

Data Element	Explanation
	Counts should be unduplicated.
NOMs Item	<p>Does this measure qualify as a NOMs item?</p> <p>Indicate whether the measure calculation above qualifies as a NOMs item. Note: In order for the measure calculation to be considered a NOMs item, the equation must match the approved NOMs equation exactly. Please refer to the NOMs Definitions document for clarification.</p>
Data Source/Measure Comments	Enter any explanatory comments about any of the information provided in the fields related to Data Source and Measure.
Population Information (Will appear if data source type is Survey Data)	
Population from which Survey Sample is Drawn	<p>From what population was the survey sample drawn?</p> <p>Describe the population that the survey was designed to represent for this measure. For example: <i>Public school students in grade 9 attending school in xxx county</i>. Note that “xxx county” could be either larger or smaller than the actual service area of the community grantee. Disaggregated populations are preferred. For example, if a survey is administered to grades 9 and 11 for a measure of high school drinking, grade 9 and grade 11 data should be reported separately when possible. In this case, grade 9 and grade 11 would be entered as separate populations.</p>
Population Age or Grade	<p>Was the survey population defined by age or grade level?</p> <p>Choose from the drop down menu whether the survey population was defined by age (e.g., 18-25 year olds) or by grade (e.g., 9th grade students).</p> <p>If Age is chosen, you will be asked to enter the applicable age range by indicating minimum and maximum ages (see below).</p> <p>If Grade is chosen, you will be asked to enter the applicable grade levels by indicating the grades involved in the survey (see below).</p>
Survey Population Age Range Minimum	<p>What was the minimum age of members of the survey population?</p> <p>Insert the lower bound for the age range for the population represented by the survey. For example, if the survey was given to young adults between the ages of 18 and 25, then 18 should be entered as the minimum age. If the population age range is bound at the lower but not the upper end (e.g., age 16 and over), then 16 should be entered as the minimum age.</p>
Survey Population Age Range Maximum	<p>What was the maximum age of members of the survey population?</p> <p>Insert the upper bound for the age range for the population represented by the survey. For example, if the survey was given to young adults between the ages of 18 and 25, then 25 should be entered as the maximum age. If the population age range is bound at the lower but not the upper end (e.g., age 16 and over), then 99 should be entered as the maximum age.</p>
Survey Population Grade Range	<p>What grade levels were targeted by the survey?</p> <p>Insert the grade(s) of the population represented by the survey. When possible, data for each specified grade should be reported separately.</p> <p>If the survey was administered to students in one grade level, choose that grade from the drop down menu. For example, if the survey was</p>

Data Element	Explanation
	<p>administered to Grade 7 students only, then select 7. If the survey was administered to multiple grades, but the data are able to be disaggregated and reported by each grade level, choose the grade corresponding to the data being reported from the drop down menu. For example, if the survey was administered to students in Grades 9 and 11 and the current data being reported are for Grade 9 students, then select 9. If the survey was administered to students in multiple grades and the data are not able to be disaggregated, then choose all of the relevant grades from the drop down menu. For example, if the survey was administered to students in grades 9 and 11, and the data are being reported together, select both 9 and 11. You may select more than one option from the drop down menu by holding down the Cntrl key.</p>
N of Population	<p>Approximately how many persons were part of the survey population?</p> <p>Enter the number of persons in the population from which survey is drawn. For example, if the population is grade 9 students in xxx county, indicate the overall number of grade 9 xxx county students.</p>
Population Characteristics	<p>In the fields that follow, insert the demographic characteristics (where known) of the population from which the survey is drawn. Be sure to report demographic characteristics from the overall population (e.g. all students in grade 9 in xxx county), <u>not</u> the characteristics of the actual survey respondents (e.g. the students in grade 9 in xxx county who actually completed the survey).</p> <p>Note that the total percentages for gender, race, and Hispanic ethnicity each may not total to more than 100.</p>
Gender	
Percent Female	<p>Insert as a whole number the percentage of females in the specified population.</p>
Percent Male	<p>Insert as a whole number the percentage of males in the specified population.</p>
Race	
Percent American Indian/Alaska Native	<p>Insert as a whole number the percentage of American Indian/Alaska Native individuals in the specified population.</p>
Percent Asian	<p>Insert as a whole number the percentage of Asian individuals in the specified population.</p>
Percent Black or African American	<p>Insert as a whole number the percentage of Black or African American individuals in the specified population.</p>
Percent Native Hawaiian or Other Pacific Islander	<p>Insert as a whole number the percentage of Native Hawaiian or Other Pacific Islander individuals in the specified population.</p>
Percent White	<p>Insert as a whole number the percentage of White individuals in the specified population.</p>

Data Element	Explanation
Percent Multiracial	Insert as a whole number the percentage of Multiracial individuals in the specified population.
Percent Other	Insert as a whole number the percentage of individuals of other races in the specified population.
Hispanic Ethnicity	
Percent Hispanic/Latino	Insert as a whole number the percentage of Hispanic/Latino individuals in the specified population.
Percent Non-Hispanic/Latino	Insert as a whole number the percentage of Non-Hispanic/Latino individuals in the specified population.
Survey Sample Information (Appears if data source type is Survey Data)	
Sampling Strategy	<p>What sampling strategy was used for this survey?</p> <p>Select from the drop down list the sampling strategy for this survey. Examples include whether the survey was conducted with a full census of the specified population, a randomly selected sample, a convenience sample, or a targeted or purposive sample of the specified population.</p> <p>If <i>Other</i> is selected, you will be asked to define the sampling strategy and provide enough detail for the cross-site evaluation team to understand the strategy.</p>
N of Sample	<p>How many persons were drawn as part of the survey sample?</p> <p>This pertains to the number of persons who were drawn for the survey sample, or the number of persons who were recruited for participation in the survey. For example, if a survey was mailed to 1000 adults in the community, but only 300 completed and returned the survey, the N of Sample would be 1000.</p>
Number of Respondents	<p>How many persons participated in the survey?</p> <p>This pertains to the number of persons who actually participated in the survey. For example, if a survey was mailed to 1000 adults in the community, but only 300 completed and returned the survey, the Number of Respondents would be 300.</p>
Characteristics of Survey Respondents	<p>In the fields that follow, insert the demographic characteristics (where known) of the survey respondents.</p> <p>Note that the total percentages for gender, race, and Hispanic ethnicity each may not total to more than 100.</p>
Gender	
Percent Female	Insert as a whole number the percentage of survey respondents who were female.
Percent Male	Insert as a whole number the percentage of survey respondents who were male.
Race	

Data Element	Explanation
Percent American Indian/Alaska Native	Insert as a whole number the percentage of survey respondents who were American Indian/Alaska Native.
Percent Asian	Insert as a whole number the percentage of survey respondents who were Asian.
Percent Black or African American	Insert as a whole number the percentage of survey respondents who were Black or African American.
Percent Native Hawaiian or Other Pacific Islander	Insert as a whole number the percentage of survey respondents who were Native Hawaiian or Other Pacific Islanders.
Percent White	Insert as a whole number the percentage of survey respondents who were White.
Percent Multiracial	Insert as a whole number the percentage of survey respondents who were multiracial.
Percent Other	Insert as a whole number the percentage of survey respondents who were of other races.
Hispanic Ethnicity Percent Hispanic/Latino	Insert as a whole number the percentage of survey respondents who were Hispanic/Latino.
Percent Non-Hispanic/Latino	Insert as a whole number the percentage of survey respondents who were not Hispanic/Latino.
Survey Sample/Respondent Comments/ Concerns	Please comment on the information provided in the fields related to the survey sample and/or survey respondents. Please indicate any concerns about representativeness or response rates.
Event Population Information (Appears if data source type is Event/Surveillance Data)	
Population on which Event Data is Based	<p>Who constitutes the population for the event data being reported for this measure?</p> <p>Describe the population that the event data were designed to represent for this measure. For example: <i>All licensed drivers in xxx county</i>. Note that “xxx county” could be either larger or smaller than the actual service area of the subrecipient grantee.</p>
Geographic unit of event	<p>What is the geographic unit of the data being reported?</p> <p>Indicate at what level data are being reported: State/Grantee, Subrecipient community, Service area, or Other. If <i>Other</i> is chosen, you will be asked to specify.</p>
Event Census Population Age Range Minimum	<p>What is the minimum age of the population on which the event data is based for this measure?</p> <p>Insert the lower bound for the age range for the population specified in the Event Definition. For example, if the Event Definition is alcohol-related motor vehicle crashes among young adults aged 18 to 25 years, the minimum</p>

Data Element	Explanation
	would be 18. If the population age range is bound at the lower but not the upper end (e.g., age 16 and over), the minimum age would be 16.
Event Census Population Age Range Maximum	<p>What is the maximum age of the population on which the event data is based for this measure?</p> <p>Insert the upper bound for the age range for the population specified in the Event Definition. For example, if the Event Definition is alcohol-related motor vehicle crashes among young adults aged 18 to 25 years, the maximum would be 25. If the population age range is bound at the lower but not the upper end (e.g., age 16 and over), the maximum should be entered as 99.</p>
N of Population for Event Data	<p>How many persons comprise the population on which the event data is based for this measure?</p> <p>Estimated number of persons in the population from which the event data were collected. For example, if the event definition is <i>alcohol-related motor vehicle crashes among young adults aged 18 to 25</i>, then the <i>N</i> of the population would be the total number of drivers in the community between 18 and 25 years of age.</p>
Event Census Population Characteristics	<p>In the fields that follow, insert the demographic characteristics (where known) of the sample population specified in the event definition.</p> <p>Note that the total percentages for gender, race, and Hispanic ethnicity each may not total to more than 100.</p>
Gender	
Percent Female	Insert as a whole number the percentage of females in the specified population.
Percent Male	Insert as a whole number the percentage of males in the specified population.
Race	
Percent American Indian/Alaska Native	Insert as a whole number the percentage of American Indian/Alaska Native individuals in the specified population.
Percent Asian	Insert as a whole number the percentage of Asian individuals in the specified population.
Percent Black or African American	Insert as a whole number the percentage of Black or African American individuals in the specified population.
Percent Native Hawaiian or Other Pacific Islander	Insert as a whole number the percentage of Native Hawaiian or Other Pacific Islander individuals in the specified population.
Percent White	Insert as a whole number the percentage of White individuals in the specified population.
Percent Multiracial	Insert as a whole number the percentage of Multiracial individuals in the specified population.

Data Element	Explanation
Percent Other	Insert as a whole number the percentage of individuals of other races in the specified population.
Hispanic Ethnicity	
Percent Hispanic/Latino	Insert as a whole number the percentage of Hispanic/Latino individuals in the specified population.
Percent Non-Hispanic/Latino	Insert as a whole number the percentage of Non-Hispanic/Latino individuals in the specified population.
Event Census Comments	Please comment on any of the information provided in the fields related to event data, including any concerns related to the event population.
Outcome Data Information for Survey Data	
Reported Outcome for Survey Data	<p>What is the result you are reporting for this measure?</p> <p>Reported outcome pertains to the actual result and related statistic you are reporting for this measure. For example, if a subrecipient is using a survey item measure that reads, <i>How many days in the past 30 days have you had an alcoholic beverage?</i>, a possible reported outcome could be 1) <i>Mean Number of Days in the Past 30 on which Alcohol was Used by Grade 9 Students</i> or another could be 2) <i>Percentage of Grade 9 Students who Used Alcohol in the Past 30 Days</i>. The reported outcome description should correspond with the statistical information reported on the outcome data section.</p> <p>Provide a brief but detailed description of the outcome being reported from the data collected by this measure and, thus being used to track changes in the related indicator. In this description, please be specific about the behavior being assessed. It is possible that a single measure could yield data for multiple reported outcomes (as shown above). It is also possible for a single reported outcome could be derived from multiple measures. For example, the reported outcome of <i>Percentage of grade 9 students who report using alcohol in the past 30 days</i> could be computed from multiple measures, including: 1) During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage? Response options: 0-30 days; 2) Have you had one or more alcoholic drinks in the past 30 days? Response options: yes/no; and 3) On how many days in the past 30 have you had an alcoholic beverage? Response options: 0 days, 1-4 days, 5-9 days, 10 or more days.</p> <p>Be specific in the reported outcome description and make sure the reported outcome text field corresponds to the outcome data provided. For example, if your reported outcome is <i>Mean number of days in the past 30 days on which Grade 9 students report using alcohol</i>, then a mean should be reported in the Calculated Value and Value Type fields.</p>
Calculated Value	Enter the value of this measure for the community. For example, this may be a prevalence rate expressed as a percentage (e.g., percentage reporting haven driven drunk in past 30 days); it may be a mean (e.g., number of days used alcohol in the past 30).
Value Type	Select from the drop-down list the type of number reported (e.g., percentage, mean, rate) in the Estimated Value. If none of the listed number

Data Element	Explanation
	types apply, select <i>Other</i> and specify the value type in the Specify Other field.
Standard Error	Enter the standard error for the calculated value, computed in light of the sampling design used (e.g., simple random, two-stage cluster design, etc.).
Standard Deviation	Enter the standard deviation for the calculated value, computed in light of the sampling design used (e.g., simple random, two-stage cluster design, etc.).
95% Confidence Interval Lower Bound	Enter the lower bound of the 95% confidence interval of calculated value. This will typically be the calculated value minus ~2 s.e.. The interval could be asymmetrical if calculated for very low prevalence rates.
95% Confidence Interval Upper Bound	Enter the upper bound of the 95% confidence interval of calculated value. This will typically be the calculated value plus ~2 s.e. The interval could be asymmetrical if calculated for very low prevalence rates.
Actual number of valid responses for specific survey item	<p>How many respondents provided a valid response (i.e., not missing) to the survey item of interest?</p> <p>Indicate the actual number of valid responses received for the specific survey item of interest. For example, if 130 adults responded to the survey item out of the 140 adults participating in the survey, the actual number of valid responses is <i>130</i>.</p>
Possible number of valid responses for specific survey item	<p>How many respondents could have provided a valid response to the survey item of interest?</p> <p>Indicate the possible number of valid responses for the specific survey item of interest. For example, if 130 adults responded to the survey item out of the 140 adults participating in the survey, the possible number of responses is <i>140</i>. However, if the specific survey item is part of a legitimate skip pattern, the possible number of valid responses could be less than the total number of survey respondents. For example, consider a case where the stem question asks whether the respondent has had alcohol in the past 30 days. Of the 140 survey respondents, 40 say “no” to this question and skip the following question (i.e., the specific survey item of interest). The other 100 say “yes” to the stem question and then are asked to answer the following question (i.e., the item of interest) about how many days in the past 30 days they have had alcohol. In this situation, the number of possible valid responses for the specific survey item would be <i>100</i>.</p>
Validity Comments/ Concerns	Please comment on any concerns regarding how well each measure actually provides an accurate and unbiased assessment of the priority at the community level. Please indicate any concerns about missing data and how they were addressed.
Outcome Data Information for Event Data	
Reported Outcome for Event Data	<p>What is the result you are reporting for this measure?</p> <p>Reported outcome pertains to the actual result and related statistic you are reporting for this measure. For event data, the reported outcome should be consistent with information provided for the event definition and measure calculation. The reported outcome description should also correspond with the statistical information reported on the outcome data section.</p>

Data Element	Explanation
	<p>Provide a brief but detailed description of the reported outcome being derived from this measure and, therefore, being used to track changes in the related indicator. In this description, please be specific about the event being assessed and make sure the reported outcome text field corresponds to the measure calculation and the outcome data provided. For example, if the reported outcome is <i>Percentage of car accidents in County xxx that were alcohol-related</i>, then the measure calculation would show the computation of a percentage of the total number of car accidents and the reported outcome (i.e., calculated value) would be a percentage.</p>
Number of Events	<p>How many times did this event occur in the community? Enter the number of events identified in community.</p>
Denominator Definition	<p>How is the denominator defined for this measure calculation and reported outcome?</p> <p>This information should be consistent with the denominator listed in the measure calculation field.</p> <p>For example, if the reported outcome is the number of alcohol-related motor vehicle crashes occurring among drivers aged 25 or younger, the denominator would be defined as the number of drivers in the community between ages 16 and 25. If the reported outcome is the percent of motor vehicle crashes attributed to alcohol, the denominator would be defined as the total number of motor vehicle crashes in the community.</p>
Denominator Value	<p>What is the value of the denominator for this measure calculation?</p> <p>Indicate the denominator value. This could be the number of persons for the specified population (e.g., all drivers aged 16-25) or the total number of events of which the smaller subset of events is based (e.g., all motor vehicle crashes).</p>
Calculated Value	<p>The value of this measure for the community. For example, this may be a calculated rate or percentage (e.g., number of alcohol-related motor vehicle crashes per 1,000 people).</p>
Value Type	<p>Select from the drop down list the type of number reported in the Calculated Value field (e.g., percentage, mean, rate). If none of the listed number types apply, select <i>Other</i> and specify the number type in the Specify Other field.</p>

APPENDIX E: CULTURAL COMPETENCE PRIMER

Cultural Competence Primer: Incorporating Cultural Competence into Your Comprehensive Plan



**Community Anti-Drug Coalitions of America
National Community Anti-Drug Coalition Institute**

CADCA's National Coalition Institute, developed in 2002 by an act of Congress, serves as a center for training, technical assistance, evaluation, research and capacity building for community anti-drug coalitions throughout the United States.

In 2005, the Institute started a series of primers to help coalitions navigate the Strategic Prevention Framework (SPF). The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services, developed the SPF for use by community coalitions in their efforts to reduce substance abuse at the population level. Each primer is designed to both stand alone and work with the others in the series. While we have focused on the inclusion of cultural competence in the elements of the SPF, any community coalition can adapt the materials in this primer to its own needs.

CADCA's Institute designed this primer to provide anti-drug coalitions with a basic understanding of cultural competence and its importance in achieving substance abuse reduction that is both effective and sustainable. If you know how to include all major sectors of your community in your efforts to develop a plan to create population-level change in community rates of substance abuse, then you will likely increase your chances of success.

You will find additional information on cultural competence, the SPF's primary components and all of the published primers on the Institute's Web site, www.coalitioninstitute.org.

Arthur T. Dean

Major General, U.S. Army, Retired

Chairman and CEO

CADCA (Community Anti-Drug Coalitions of America)

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INTRODUCTION

Drug Free Communities Support Program

In 1997, Congress enacted the Drug Free Communities Support Program (DFC) to provide grants to community-based coalitions to serve as catalysts for multi-sector participation to reduce local substance abuse rates. By 2008, more than 1,600 local coalitions received funding to address two main goals:

- Reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse.
- Establish and strengthen collaboration among communities, private nonprofit agencies, and federal, state, local, and tribal governments to support the efforts of community coalitions to prevent and reduce substance abuse among youth.

Strategic Prevention Framework

This is one of a series of primers based on the Strategic Prevention Framework (SPF).¹ CADCA utilizes the SPF to assist

Cultural competence

What you need to know:

- Basic understanding of the key principles of cultural competence and how to integrate them into your coalition's work
- How to integrate cultural competence into the Strategic Prevention Framework

What your community needs to do:

- Acknowledge the diversity in your community
- Reach out to diverse organizations in your community and invite them to join the coalition
- Commit to the development of a culturally competent coalition
- Create an entity responsible for ensuring cultural competence

The products your community needs to create:

- A culturally competent comprehensive community plan to reduce substance abuse

Sample materials related to cultural competence are available on the CADCA National Coalition Institute's Web site, www.coalitioninstitute.org.

¹ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) developed the SPF to facilitate implementation of prevention programming.

community coalitions in developing the infrastructure needed for community-based, public health approaches that can lead to effective and sustainable reductions in alcohol, tobacco, and other drug (ATOD) use and abuse. The elements shown in Figure 1 include:

- **Assessment.** Collect data to define problems, resources, and readiness within a geographic area to address needs and gaps.
- **Capacity.** Mobilize and/or build capacity within a geographic area to address needs.
- **Planning.** Develop a comprehensive strategic approach that includes

A word about words

What is your goal? Your aim? Your objective? Perhaps more importantly, what is the difference? At times, the terms seem interchangeable. Often, the difference depends on who is funding your efforts.

To minimize confusion, we have added a chart (see page 38) that highlights terms often used to describe the same or similar concepts.

Figure 1. The Strategic Prevention Framework



policies, programs, and practices creating a logical, data-driven plan to address problems identified in assessment.

- **Implementation.** Implement evidence-based prevention strategies, programs, policies, and practices.
- **Evaluation.** Measure the impact of the SPF and the implementation of strategies, programs, policies, and practices.

Cultural competence and the SPF

This primer focuses on the process that the Institute suggests community coalitions use to incorporate cultural competence as they work through the elements of the SPF. SAMHSA lists cultural competence as a cross-cutting aspect of the SPF. Likewise, we believe that cultural competence affects all aspects of coalition building, and include it as one of the 15 core competencies for achieving community change. These research-based core competencies align closely with the SPF. Notice that cultural competence is listed under the capacity element of CADCA's core competencies.

Although cultural competence affects all elements of the SPF, coalitions should emphasize it when developing capacity. Individuals and organizations can increase their cultural competence because the skills and knowledge required can be learned and implemented in a fairly reasonable time frame.

The SPF process can help people collaborate by enabling them to better understand the coalition's mission, vision and strategic plan, as well as their individual roles in helping the group achieve its goal of a safe, healthy and drug-free community. Coalitions that merely conduct a string of activities without fitting them into a strategic plan perpetuate the trend of coalition members working in isolation, because individual members do not understand how their contributions relate to the greater goal.

We encourage your coalition to *think* comprehensively, even if it cannot *act* comprehensively at the moment. Maintain a strong focus on your community and its needs, and avoid "borrowing" another group's cultural competence plan and using it as your own. You can incorporate ideas and concepts from others to

This primer seeks to answer four key questions:

- WHAT** is cultural competence, and why is it of critical importance as you develop and implement a comprehensive community plan to reduce substance abuse?
- WHAT** does your coalition need to do to build cultural competence as it moves through the elements of the SPF?
- WHAT** products should you develop to create a culturally competent coalition?
- WHAT** can your coalition do if it experiences problems?

jump-start your own efforts; but you should custom design a plan that matches your community's unique characteristics.

A word about sustainability as it relates to cultural competence

Sustaining initiatives to bring about population-level changes in substance abuse rates requires a strong coalition that can unite all sectors of a community. Starting to work on sustainability without involving key segments of your community can lead to serious problems. Indeed, many funders will want your coalition to clearly demonstrate that it has the commitment and participation of diverse sectors of your population, especially those acutely affected by substance abuse.

Sustaining an initiative over time also requires a combination of diverse internal and external nonfinancial resources. Necessary internal resources include sound leadership; committed, well-trained partners and members; and strong administrative and financial management systems. Critical external resources include public and key stakeholders and the engagement of community-based organizations, parents and other residents.

Learn more about the SPF

This primer focuses on cultural competence and how to integrate this concept into each element of the SPF. You can learn more about the SPF from the Institute's primer series and Web site (www.coalitioninstitute.org). Additional discussion of cultural competence is included in the Institute's Capacity Primer.

Actions to ensure cultural competence for your coalition

Every coalition's planning for cultural competence will look different because each community is unique. When you develop your coalition's plan for incorporating cultural competence into every phase of its work, ask **DOES OUR COALITION...**

Assessment

- Include diverse populations, cultures, ethnicities, gender, sexual orientation, disability and age groups in our data gathering?
- Encourage participation of bi-lingual community members to support the development and implementation of our assessment?
- Use multiple forms of data collection; both qualitative and quantitative (key informant interviews, focus groups, listening sessions and surveys)?
- Recognize that diverse communities view alcohol and drugs differently and that culture influences how they should be addressed (i.e., drinking as an accepted form of socializing)?
- Recognize and include formal and informal community leaders in all aspects of building your coalition?
- Consider how community "institutions" and history-keepers can contribute to prevention efforts?
- Involve community in all aspects of data analysis (impacts buy-in in prevention strategies)?
- Incorporate community strengths as well as problems in our assessment?

Capacity

- Ensure that coalition staff reflects composition of community.
- Train staff and members on concepts of cultural competence.
- Establish principles and strategies that lead to diverse community leadership.
- Encourage participation of members that represent the cultural, linguistic, and ethnic composition of the community.
- Meet in different community settings and ask local cultural organizations to host at their site.

Planning

- Ensure broad community participation in planning process
- Review and discuss planning process with community to increase understanding of planning
- Broaden work and action plans to reflect input and outreach by diverse populations, cultures, ethnicities, and age groups to include in data gathering
- Incorporate community in selection of strategies and seek methods to assure buy-in is present

Implementation

- Ensure activities include members of impacted communities (i.e., people involved should include target audiences and people in treatment, recovery, rehabilitated, ex-offenders).
- Seek unique and creative methods to ensure all communication materials reflect “community” –brochures and posters, reports, etc.
- Continuously review, assess and select strategies for implementation that reflect local environments and problems.
- Ensure all communication materials are reviewed (tested) for appropriateness by target community prior to distribution (content, reading level, visual and distribution method?)
- Conduct appropriate prevention programs for the composition of our community

Evaluation

- Involve community in collection, interpretation and dissemination of information (including youth)
- Ensure evaluation process and products are relevant to diverse communities
- Consider applying awareness of race and culture specific linguistic and community attributes and relevance to measure all coalition prevention efforts
- Include various qualitative methods in your evaluation (e.g. interviews informal/formal)
- Select an evaluation team with experience and expertise working in diverse communities and be diverse (age, education, gender, ethnicity, etc.)
- Disaggregate data to lowest level

CHAPTER 1. WHAT DEFINES A CULTURALLY COMPETENT COALITION?

Multiculturalism is an acknowledgment that the United States is a diverse nation and does not assume that any cultural tradition is ideal or perfect. It looks to the equitable participation of all individuals in society. It assumes that our nation can be both united and diverse, that we can be proud of our heritage and of our individual group identities while at the same time working together on common goals. It is a reciprocal process based on democratic principles and a shared value system.

– Elizabeth Pathy Salett, President,
National Multicultural Society,
Washington, D.C., 2004

Effective anti-drug coalitions recognize the need to include a broad cross section of the population in their work and give importance to including organizations that represent various cultural groups. They know, for example, that they must focus on young people as one target of prevention efforts, but they also make a place for youth at the coalition table. They understand that different racial and ethnic groups need viable roles in the coalition to help determine and support anti-drug strategies. In short, effective coalitions make a concerted effort to ensure that cultural competence permeates all aspects of their work.

We define a coalition as a formal arrangement for collaboration among groups in which each retains its identity but all agree to work together toward a common goal: a drug-free community. To serve as catalysts for population-level change, coalitions need deep connections into all major sectors of the community. Coalition building, collaborative problem-solving and community development constitute some of the most effective interventions for change available. Prevention programs or human service organizations are different than effective coalitions, which involve agencies, the public sector and individuals as equal partners.

Coalition leaders readily acknowledge that working with diverse cultural groups is necessary, incredibly rewarding and often difficult. Efforts to bridge cultures and encourage communitywide participation often run counter to prevailing sentiments. At times, residents blame drug problems on particular cultural groups,

youth or people from certain neighborhoods. Some people do not readily trust what they consider the dominant culture or government institutions. Others feel isolated by language, low socioeconomic status or the frustration of trying to be understood.

Remember, substance abuse is a tough issue. It crosses all racial and economic lines and disproportionately affects certain populations. The coalition can help foster community reconciliation. For example, coalitions can bring together a range of organizations and agencies to create a positive environment for reintegrating former prisoners. Research indicates that approach is critical to successful, sustainable outcomes. Re-entry implementation is easier through a coordinated effort.

It is important to acknowledge that some coalition members may see solutions in terms of decreasing racism and poverty, while others will consider solutions in terms of getting people clean and sober. There is a place at the table for all, but the coalition needs to have a clearly articulated logic model so members and supporters will understand what success will look like in measurable terms, both short and long term.

Despite these and many other challenges, coalitions across the country actively serve as catalysts for better understanding and collective work. They gain vital community support through their efforts to include, validate and respect diverse populations in the common goal of healthier, drug-free communities. Effective coalitions recognize and honor the strengths and resources inherent in diverse groups.

Because achieving cultural competence requires time and effort, your coalition must demonstrate how achieving it helps contribute to reducing substance abuse rates. Following are reasons commonly cited for devoting resources to cultural competence:

Rapidly changing demographics. The 2000 U.S. Census indicates the country is undergoing rapid demographic change. Significant numbers of immigrants are settling in traditional and new communities. Far fewer culturally homogeneous communities exist now than in past decades.

The widespread reach of substance abuse. The negative consequences of substance abuse affect all segments of society, regardless of income, gender, ethnic origin, sexual orientation, disability, age, etc. It is not enough to reduce rates in one segment of a community; a comprehensive approach is necessary.

Aim for a custom fit

The Institute aims to develop effective anti-drug coalitions. We do not believe in a “one size fits all” model. However, we recognize that while coalitions will differ in many aspects, all can share a core approach. Successful coalitions will take the key concepts of cultural competence and modify them to custom-fit their communities—making an adjustment here, placing more emphasis there and adapting essential ideas to local practice.

The value of group strengths and protective factors. Research demonstrates that each group has strengths and protective factors that can buffer the negative effects of substance abuse. Communities must identify, strengthen and include these factors in their strategies to reduce substance abuse rates.

The value of group representation. The coalition table must reflect the diversity of the community. Residents want to see respected individuals who understand their needs occupying leadership roles. Otherwise, your coalition will not gain widespread community buy-in.

What defines culture?

The most commonly cited aspects of culture are the most visible: language, music and food. Anthropologists and other social scientists study additional qualities that help us develop a deeper understanding of culture—the shared values, traditions, norms, customs, arts, history, folklore and institutions of a people unified by race, ethnicity, language, nationality, religion or other factors. For example, culture affects people’s perceptions about alcohol use, abuse and related problems.

Culture pervades all aspects of identity—whether individual or group. Coalitions must first understand a culture before attempting to alter systems, policies or group norms. And they need to recognize that an individual can identify with multiple groups. Diversity encompasses much more than racial or ethnic

identification. Researchers have identified the following factors, which may be present in any number of combinations:

- National origin
- Gender
- Sexual orientation
- Religion
- Location (rural, urban, suburban)
- Socioeconomic status
- Age

What is cultural competence?

The U.S. Department of Health and Human Services defines cultural competence as a “set of behaviors, attitudes and policies that come together in a system, agency or program or among individuals, enabling them to function effectively in diverse cultural interactions and similarities within, among and between groups.”

Other experts view cultural competence as a point on a continuum representing the policies and practices of an organization, or the values and behaviors of an individual, which enable that organization or individual to interact effectively in a culturally diverse environment (see Figure 2).

When coalitions incorporate cultural competence into their work, they

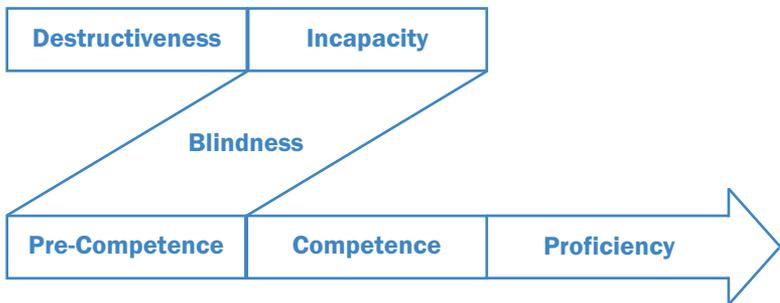
- Invest time and resources in training staff and volunteers in cultural competence.
- Carefully examine their structure, practices and policies to ensure that these elements truly facilitate effective cultural interactions.
- Display respect for differences among cultural groups.
- Expand cultural knowledge and pay attention to the dynamics of culture.

Understanding culture is a process

- 1. Cultural Knowledge**—Knowledge of some cultural characteristics, history, values, beliefs and behaviors of a different group
- 2. Cultural Awareness**—Openness to the idea of changing cultural attitudes
- 3. Cultural Sensitivity**—Knowledge of cultural differences without assigning values to the differences
- 4. Cultural Competence**—Ability to bring together different behaviors, attitudes and policies and work effectively in cross-cultural settings to produce better results

Figure 2.

Cultural Competence Continuum



-
- Solicit advice from diverse communities regarding activities.
 - Hire employees who respect unique aspects of varied cultures.

Coalitions that embody these qualities create an atmosphere that encourages cultural competence in individuals and member organizations. Some of the guiding principles of cultural competence that your coalition may incorporate include the following:

Culture: first, last and always. Culture has an impact on how a person thinks, believes and acts. Acknowledge culture as a predominant and effective force in shaping behaviors, values and institutions.

One goal—many roads. Each group has something to share. Acknowledge that several paths can lead to the same goal.

Diversity within diversity. Recognize the internal diversity and complexity of cultural groups. Remember that one individual cannot speak for all.

People are unique. Acknowledge people's group and personal identities and treat people as individuals.

Viewpoint shift. The dominant culture serves the community with varying degrees of success. Acknowledge that what works well for the dominant group may not serve members of other cultural groups. Try viewing issues from alternative viewpoints.

CHAPTER 2. CULTURAL COMPETENCE AND COALITION BUILDING

Community work is bigger than any one organization or group. At its best, it transcends organizational boundaries and encompasses all members and groups, including diverse populations, within a community. For such collective work, members of all community sectors must realize that what happens in one part of town affects everyone. This perspective focuses, justifiably, on the interconnectedness of problems and issues. Successful coalitions practice self-determination and democratic principles. They recognize that it is never acceptable for one group or individual to impose its solutions to problems on another.

As cultural issues affect all aspects of coalition development and operations, your group should address cultural competence on multiple levels: in your community interactions, within your partnerships, within the host organization (if applicable) and so on. Effective collaborations highlight cultural issues and integrate them as core aspects of building communitywide support. To work through the elements of the SPF before inviting members of diverse communities to the coalition table is a mistake and likely will offend the people you need to include.

To transform a focus on cultural competence into effective action, coalitions need to take steps to ensure broad support of the concept. Following are examples of some things your coalition should consider:

Write it down. Make including diverse populations part of your mission and vision statements. Incorporate these concepts into your logic model, strategic plan and action plan.

Commit from the top. Coalition governance should officially commit to enhancing its cultural competence as it works to reduce substance abuse.

Do not assign and forget. Do not delegate work on cultural issues to one individual or department. Focus and responsibility must remain with the coalition.

Action steps for achieving cultural competence

- 1. Develop support for change throughout the organization (who wants change and who does not?).** Is this a top-down mandate? How deep is the “buy-in”? Do you need a committee to work on this issue?
- 2. Identify the cultural groups to be involved.** Who needs to be involved in the planning, implementation and reinforcement of the change?
- 3. Identify barriers to cultural competence at work in your organization.** What is not working? What will slow you down or stop you?
- 4. Assess your current level of cultural competence.** What knowledge, skills and resources can you build on? Where are the gaps?
- 5. Identify the resources needed.** How much funding is required to bring about the changes? Where can you find the resources?
- 6. Develop goals and implementation steps and deadlines for achieving them.**
- 7. Commit to an ongoing evaluation of progress (measuring outcomes) and be willing to respond to change.** What will success look like? How do you know you are on the right track?

Significant benefits accrue to a coalition that focuses on cultural competence. You will see an *increase* in:

- Respect and mutual understanding.
- Unity and civility in problem-solving.
- Participation and involvement of diverse cultural groups.
- Trust and cooperation.
- Inclusion and equity.

Your coalition will see a *decrease* in:

- Unwanted surprises that might slow coalition progress.
- Mistakes, competition or conflict.

Following are some of the most commonly cited indicators of cultural competence to help your coalition assess whether you are heading in the right direction:

Outreach efforts. You encourage outreach to diverse groups, have made it part of your strategic plan and have assigned responsibilities to coalition members.

Inclusive language. You use inclusive language when referring to groups in your community (“we” and “our community” rather than “those people” or “those kids”). Coalition members and staff demonstrate an understanding of cross-cultural concepts.

Committed leadership. Your coalition leaders support cultural competence and demonstrate commitment to the concept.

Coalition composition. Your coalition—members and leaders—reflects the diversity in your community.

Training and development. Your coalition provides or facilitates cultural competence training for community and coalition members, staff and volunteers.

Shared responsibility and accountability. Coalition and community members, staff and volunteers work together and share responsibility for developing effective strategies.

Overarching principles of cultural competence

Individuals who work in various areas of substance abuse prevention served on the SAMHSA Center for Substance Abuse Prevention’s Racial and Ethnic Specific Knowledge Exchange and Dissemination Project committee, which drafted the following overarching principles that define cultural competence:

- **Ensure** community involvement at all levels.
- **Use** population-based definitions of community (let the community define itself).
- **Stress** the importance of relevant culturally appropriate approaches.
- **Support** the development of culturally specific services.
- **Adhere** to Title VI of the 1964 Civil Rights Act (42 U.S.C. 2000d et seq.), which prohibits discrimination on the basis of race, color and national origin in programs and activities receiving federal financial assistance.
- **Use** culturally relevant outcomes and indicators.
- **Employ** culturally competent evaluators.
- **Engage** in asset mapping—identify resources and start from this point.
- **Promote** organizational cultural competence—staff should reflect the community it serves.
- **Allow** the use of indigenous knowledge in the body of “evidence-based” research.
- **Include** target population(s) (e.g., youth, consumers, participants, elders).

CHAPTER 3. INCORPORATING CULTURAL COMPETENCE INTO YOUR COMPREHENSIVE APPROACH

As noted earlier, cultural competence should never be an afterthought or something to worry about after your coalition has been formed and has developed activities. Addressing issues of diversity and cultural competence from the coalition's inception increases the likelihood of establishing a firm foundation to build on in later years.

We will use the SPF as the basis for a discussion of how to incorporate cultural competence into your efforts to develop population-level approaches to substance abuse. In this chapter, we will take a closer look at how the first element—assessment—relates to your coalition. Note that we present substantial information on the assessment and capacity-building elements of the SPF. Simply stated, you should incorporate key concepts of cultural competence from the very beginning. If in your initial coalition meeting, you look around the room and see that significant groups are not present, take immediate steps to change that situation. Your credibility—indeed, the success of your entire effort—may hang in the balance.

As you work through the elements, you will notice that each encompasses a kind of mini-SPF—that is, each element includes a certain amount of assessment, capacity building, planning, implementation and evaluation. Your coalition might start to feel as if it is doing the same thing over and over. That is a natural part of the process, because as you get into the work, you will start to see areas that you need to revisit, generate more data for or fine-tune.

Assessment

A community assessment is a comprehensive description of your target community. It involves systematically gathering and analyzing community data to identify and address local ATOD problems. Generally, coalitions conduct community assessments early in their formation. However, because a community's strengths, needs, resources and makeup continually change and

evolve, ongoing assessment is critical. Effective community assessment includes five elements:

- **Creating** a community description
- **Assessing** community needs
- **Discerning** community resources
- **Documenting** community history
- **Developing** a problem statement (or statements)

Cultural issues affect all of these components, highlighting the need for cultural competence when you begin to assess the problems in your community.

Data collection tips

To ensure a culturally appropriate and responsive data collection process, follow these guidelines:

Data collectors should be diverse. They should reflect the makeup of your community.

Edit data collection questions. Be sure your questions are not potentially too personal or offensive.

Make sure you are understood. Employ competent translators, interviewers or group facilitators who mirror the community.

Use focus groups. A skilled moderator can help you unearth information you will not get from a broad survey.

Listen to local experts. Invite community experts to share their thoughts with coalition members.

Be sensitive to group norms. Learn what is and what is not acceptable to your target group. Which actions or words cause alarm; which open doors?

Be alert to group concerns. Some groups may feel quite vulnerable or defensive about discussing substance abuse with people they consider outsiders.

Conduct key informant interviews. In one-on-one interviews, a skilled interviewer can gather insights to flesh out your quantitative data.

Host a town hall meeting. Work with partners from different cultural groups to host town hall meetings in a variety of community settings. Employ a skilled moderator (and translators if needed) to focus participants on generating information to decrease substance abuse.

Creating a community description

To develop a complete community description, your coalition must gather the basic demographic data that define your community. Factors to consider include such variables as size, population, ethnic or racial groups, economic status, primary language and so on. You can get this information from the most recent U.S. Census.

Coalition leaders often find that data from national or state sources, usually presented in the aggregate, provide an overly broad picture of their community and its substance abuse problems. Similarly, state- or federal-level data are often too general to adequately define a community's specific concerns or needs.

Whenever possible, aim for data sorted by gender, age, race and/or ethnicity, so you can determine which groups are more affected by ATOD problems. However, if you can only amass aggregate data, your coalition may need to disaggregate them—that is, divide them into constituent parts—to help you better understand the dimensions of the problem.

Your group might turn to a city or county planning department, economic development office, tribal council or chamber of commerce for more precise data. In describing your community, your group also must consider cultural heterogeneity, assimilation and acculturation, and hidden communities.

Cultural heterogeneity

While many large population groups such as Asian Americans, Native Americans or Hispanics possess many similarities, they also differ by national origin, language, tribe, geography and culture. For example, the traditional approach to studying the extremely diverse Asian American population as a homogeneous group hides important intergroup differences. Likewise, the Hispanic population of the United States includes a number of nationality groups that vary from each other and have different rates of alcohol and drug abuse. Consequently, simply saying “drug use among Asian American or Hispanic youth” probably will not be sufficient for your purposes. Acknowledging these disparities by disaggregating data can help your coalition avoid a culturally insensitive approach.

Acculturation and assimilation

Immigrant groups bring traditional cultural values, such as strong family ties, which have served for generations as protective factors. Acculturation and assimilation tend to decrease the strength of these cultural values and with them their protective value. This phenomenon is seen among youth, who tend to adapt more readily to a new culture. For example, research shows that among Hispanic/Latino immigrants, more men than women consume alcohol. However, within two generations a cultural shift occurs, and the consumption rates between the genders tend to equalize.

Hidden communities

For a variety of reasons, some groups prefer to maintain a low profile, and finding good data about them may be difficult. For example, individuals who have learned to fear negative consequences as a result of their sexual orientation often shun contact with government agencies and have been historically undercounted. Coalitions may find it challenging to identify these hidden communities, but should make every effort to reach out to them.

One source of data that you might investigate is diversitydata.org, a project of the Harvard School of Public Health. The Web site incorporates data on a diverse range of social measures that may be helpful to your coalition.

Assessing community needs

Your coalition naturally will want to deploy its limited resources to the areas of greatest concern and will want as much community input as possible when developing a list of community needs. Coalition members can agree that not all needs may be met at the same time; however, they must at least make it onto your list. Compiling a comprehensive list helps build trust and ensures that when resources become available, you can quickly match them to identified needs. As you or some other entity conduct a needs assessment, do not be surprised if you find that diverse communities have different priorities.

Assessing community resources

Your community assessment should include a list of key institutions that serve diverse populations and describe their role in reducing substance abuse rates. Incorporate organizations with direct, historic links to their populations. Black churches, for instance, have long served as both places of worship and social and health services providers to African Americans. Community centers, such as those run by Filipino Americans in some parts of the United States, help keep cultural traditions alive. These community-based entities and other grassroots organizations provide access to local expertise and knowledge that are invaluable in community mobilization efforts.

Documenting community history

Every community has a history of the events and forces that have affected and helped to shape it. It is not uncommon for people in diverse ethnic or cultural groups to interpret the same event differently. Being unaware of or insensitive to the community's history can lead to a variety of problems. For example, consider:

- Failing to account for key events that help explain current conditions can result in misinterpreting what those events really mean to community members.
- Misunderstanding the context of a situation can cause loss of credibility for the coalition.
- Failing to build on the community's past successes can result in duplication of efforts.
- Inappropriately claiming credit for progress attributable to other factors or historic trends can result in mistrust from the community.

History includes existing research

When reviewing community history, include existing research literature. You can gain valuable insight when analyzing substance abuse data among various groups. For example, Dr. Marilyn Aguirre-Molina of Columbia University in New York has studied patterns of alcohol consumption among Hispanics/ Latinos. She describes how, for this population, drinking is often associated with family-centered celebrations, and thus is a normative behavior.

Developing a problem statement

Recruit individuals familiar with substance abuse issues within the target community to help evaluate the data your coalition gathers. Avoid using a deficit model when analyzing issues. This model tends to focus on “fixing” what appears to be the source of the problem, to the detriment of the community. If a coalition identifies youth methamphetamine use as the problem, resultant strategies tend to focus on “fixing” young people and may ignore underlying issues. Some communities of color express alarm when they see a strong focus on their risk factors without equal emphasis on their protective factors or assets. Coalition leaders should not be surprised when groups who feel they have been unfairly characterized in the past balk at the use of deficit models.

Therefore, your coalition needs to develop a functional problem statement early in the assessment phase. (See the Institute’s *Assessment Primer*.) This exercise will set the stage for both your community assessment and the strategies you develop. Recognize that existing community tensions can add challenges to this process. Following are some guidelines to help your coalition navigate this exercise and develop a culturally appropriate problem statement.

- **Begin** the process with a purpose statement to focus the discussion.
- **Be alert to** community tensions and draw key community members into the process.
- **Name** only one problem at a time, and define it by its behaviors and conditions.
- **Avoid** making blaming statements.
- **Avoid** naming specific solutions.
- **Define** the problem in measurable terms.
- **Revise** the problem statement as needed to reflect community concerns.
- **Solicit** group consensus regarding the final version of the statement.

CHAPTER 4. CAPACITY BUILDING

Capacity building is the process of developing the human resources your coalition needs to achieve its aim. True capacity development involves finding people in your community who are ready, willing and able to contribute.

Building your coalition

To ensure success, you will want to create a well-balanced mix of member stakeholders and community representatives. Remember, to the extent possible, your coalition should mirror your community. The following guidelines will help you in this task:

- **Create** a formal plan for seeking coalition candidates, review who is at the table and identify gaps to fill.
- **Define** the skills, knowledge and resources coalition members need to implement your community plan effectively.
- **Plan** to recruit candidates for your coalition from both formal and informal sources.
- **Look** for leaders with strong ties to the community.
- **Create** a “job description” for coalition members outlining their responsibilities and level of commitment. Remember that you want coalition members who will actively work to bring about change, not just come to meetings, eat and listen to staff reports.
- **Avoid** recruiting “one of each type” of individual from your community. This approach can smack of tokenism.
- **Recruit** members face-to-face. This method gives you the opportunity to assess interest, skills and competence levels, and describe the level of involvement you seek.
- **Share** a compelling description of what your coalition wants to accomplish and why participation can contribute to your success.

Skill building is key

When focusing on skills your coalition may need to build, consider this quote from the University of Kansas Community Tool Box: “Organizations have a ‘culture’ of policies, procedures, programs, and processes, and incorporate certain values, beliefs, assumptions and customs. An organizational culture may not lend itself to cultural competence, so that’s where skill building comes in.”

Recognize that not everyone in the community can or should be a full-fledged coalition participant. You can manage this resource gap by establishing relations with organizations and institutions that represent diverse populations. Schedule a visit to explain the purpose of your coalition and to determine other ways that these organizations might be of assistance.

Managing your coalition

Coalitions, by their nature, are always evolving; some members will come and go. However, basic management and ongoing recruitment techniques will help keep core members focused and on track.

Match members to outreach efforts. Coalition leaders should consider member skills and attributes such as established relations with the community, language skills, business contacts and faith. For example, you might ask a person who is “faith friendly” to reach out to local congregations.

Acknowledge barriers to full community participation. Community members might not be able or might not want to participate in your coalition. Consider why certain groups or individuals cannot participate and, if appropriate, determine whether your coalition and the reluctant party can mutually work around the barrier. For example, if you wish to have genuine youth involvement, holding meetings during school hours will be a barrier. However, recognize that some community members cannot be brought into the process. Whatever the reason—trust issues, turf issues—your coalition should respect them. Continue to provide information to these groups and individuals, because they may change their minds at a later date.

Develop leaders. Many groups lose their community leaders when they immigrate to this country. Other groups may be isolated from traditional leaders. Therefore, your coalition should develop a plan for leadership development and commit resources for leadership training and conference attendance. When seeking the established leaders in your community, consider the term “leader” from the community’s point of view. A community leader might be a member of the town council, but could just as easily be “the lady

in the corner house” whom everyone knows and trusts. Indeed, the term “leader” includes all of the following and more:

- Heads of institutions or organizations
- Elected or appointed officials
- Those who oversee sweat lodge rituals
- Those who oversee ceremonial rituals
- Heads of tribal councils
- Elders
- Residents with extensive social family networks
- Youth

Teen leaders: Unique challenges

Teens often express reluctance to join a coalition of adults because they feel they will not be respected or listened to. One way to address the issue is to provide leadership training to youth.

The CADCA Institute’s National Youth Leadership Initiative is one program that can be helpful in developing young leaders. Another successful strategy is to create a youth council. CADCA coalition member the Vallejo Fighting Back Partnership in Vallejo, Calif., established such a program with youth leaders meeting separately and making recommendations to the coalition’s board.

To learn more, visit the Institute’s Web site, www.coalitioninstitute.org.

Increasing the cultural capacity of your coalition

To achieve a culturally competent coalition, you need to take a look at your existing practices and policies. Use these guidelines to help guide your efforts:

Assess your level of cultural competence. Determine the knowledge, skills and resources you have now and identify any gaps. How well do your staffing, training and materials reflect the community you serve? Do you regularly evaluate your programs in terms of cultural competence?

Fill resource gaps. Fill any gaps you identified in your assessment. Do you need staff, volunteer or coalition member training? Do you need to work with partner organizations?

Develop support for change throughout the coalition.

Consider naming a committee to develop a plan for enhancing cultural competence.

Involve community groups. Involving individuals from community groups will provide needed insights.

Identify barriers for achieving cultural competence. Identify what is not working and what barriers impede your efforts. Resist laying blame or rehashing past “mistakes.”

Develop goals and define steps required to achieve them. Your coalition leaders should formally endorse the community’s goals and implementation steps. Ensure that they know about and understand the goals and strategies of the coalition and that you have methods for informing the community in place.

Commit to ongoing evaluation and be willing to change. Evaluation enables your coalition to determine how well the plan is working, take corrective action and, if appropriate, change course.

Why is this not working?

You will encounter many challenges on your path to cultural competence. Working your way through them is part of the process. Following are typical challenges:

- The learning curve
- Lack of resources, leadership commitment or training
- Staff resistance
- Communication problems—verbal and nonverbal
- Different languages or dialects
- Class-related values
- Culture-related values
- Stereotyping
- Racism
- Ethnocentricity

CHAPTER 5. STRENGTHENING YOUR EFFORTS

The previous chapter provided you with information relevant to initial measures your coalition can take as it embarks on a journey that will lead to a healthier community. Clearly, cultural competence and diversity issues can and should be embedded in your work in the assessment and capacity-building phases of your development. This chapter will focus on how you can continue to evolve toward a culturally competent coalition as you work through the next three elements of the SPF: planning, implementation and evaluation. It finishes with a brief discussion of some corrective actions you can take if you experience problems.

Planning

“Coalitions don’t plan to fail, they fail to plan.”

Community leaders need to pay considerable attention to the planning process as they initiate efforts to build an effective coalition. They should design a process that embodies the concept that strong participation of all segments of the community will be a key determinant of the success of their efforts to reduce substance abuse. Research shows that truly effective coalitions engage residents and partners and thus develop more resources and achieve greater results. Active involvement in a planning process can empower communities as coalitions reach out to all residents and welcome them as participants in efforts to solve their problems.

While no one model planning process exists, coalitions should keep several key principles in mind. First, the process should be *open* to all who wish to participate. The planning process can be of singular importance in building a broad base of community support, and the people who participate in it support the coalition over the long haul. This does not mean that large numbers of people need to be involved in all aspects of the development of a community plan, but there should be points at which they can provide input and help build consensus.

Your planning process constitutes a significant opportunity to reach out to potential members, so to be truly inclusive and diverse, the process should involve a large number of community

sectors. For example, participation in the planning process can provide your coalition with great ideas, help get youth buy-in and give the coalition credibility in the community. For a variety of reasons, you may not get representatives from diverse cultural groups in your planning process. You may need to reach out to those groups and invite them to the table.

Your plan should include a logical sequence of strategies and steps that lead to the reduction of substance abuse in your community. A well-constructed plan includes development of an evaluation process at the start of your project (rather than at the end). In addition, a good plan:

- **Allows** you to wisely allocate current dollars and resources and secure future funding.
- **Defines** “success” in measurable terms.
- **Helps** you select interventions targeted to root causes of substance abuse in your community.
- **Assigns** accountability and timetables.
- **Emphasizes** cultural competence at every stage—involving community members at the coalition table for assessment, capacity building, planning, implementation and evaluation.

Creating a workable plan of action is challenging for any entity. For an organization that also strives to be culturally competent, it may be necessary to modify the planning process to reflect the target community. Coalitions should be open to planning and thinking that more closely aligns itself with traditions of various community groups. For example, American Indians often prefer planning processes that are circular and reflect their respect for the sacred circle. Faith-based organizations may believe action-oriented plans are secondary to the understanding of doctrine or sacred texts. Listening to and incorporating different viewpoints results in a plan that is culturally competent and therefore more likely to succeed.

Regardless of the approach or approaches you take, most coalition members will come to the table with different levels of understanding of substance abuse and the basic planning process. For example, many may not be familiar with the inner workings of effective logic models. You might need to conduct several

sessions to get everyone to a baseline of understanding. Coalition members may need time to work out any disconnects between a formal logic model process and their own approaches. Ideally, you will not start work on a logic model until all coalition members understand and are comfortable with the process. When most members start from more or less the same place, you will have a setting that generates fruitful discourse and consensus building.

Learn more about logic models

To learn more about facilitating change in organizations and to view sample logic models, visit the Coalition Resources section of the Coalition Institute's Web site at www.coalitioninstitute.org.

Cultural competence in a coalition does not just happen. You need to take concrete, coherent steps to ensure that you are on the right path. If you apply for federal grants such as the DFC, you will be required to demonstrate the inclusion of diverse groups in your coalition. Cultural competence and diversity issues should be interwoven in an explicit manner throughout. For example, if the aim of your logic model is to reduce substance abuse among youth, you should outline the steps your coalition will take to have youth from diverse backgrounds as full participants in your coalition. Make youth the subject rather than the object of your activities.

It is surprising that many coalitions develop detailed plans for everything except how to become more culturally competent. As noted above, a cultural competence plan is one method of assessing whether you are on the right track. Such a plan should have measurable goals and objectives with concrete timelines. For example, you might develop an outreach goal that your coalition will contact 30 different community organizations within six months with the goal of recruiting 12 to become members of the coalition. A cultural competence plan also should indicate who is responsible for the proposed action and outline some of the potential resources needed. The entire coalition should periodically review the cultural competence plan.

Note that a cultural competence planning process may reveal several areas of discord among coalition members. Such differ-

ences are better dealt with early in the formation of the coalition; if not, they may resurface later to derail the coalition's work.

Implementation

Community coalitions should select and implement strategies that will produce communitywide changes in substance abuse rates. Remember that while substance abuse affects entire communities, its causes, impacts and manifestations may differ significantly in diverse neighborhoods. For example, you may find that some areas of your community have a number of high-risk environments. You must tailor your approaches to address the unique problems of each locale and involve residents in crafting and carrying out solutions.

To select or develop an effective intervention, it is worthwhile to understand the basic components and elements generally present in successful community interventions. (These interventions are fully outlined in the Institute's *Implementation Primer*.) Research indicates seven essential approaches for achieving community change. We have included example interventions with each of the seven strategies.

- 1. Providing information**—Ensure that printed materials (brochures, flyers, etc.) consider the community's linguistic differences, average reading level, and how different groups are portrayed in the materials, and determine how to distribute the materials to reach the largest number of community members. Translate materials into languages used widely in your community. Disseminate publications and advertising through non-mainstream media and through a variety of channels (i.e., church bulletins, cultural organization newsletters, etc.).
- 2. Enhancing skills**—Develop an educational plan for employees, coalition members and volunteers to improve competencies required for effective cross-cultural work. Select and pay for coalition members to attend training.

- 3. Providing support**—Review your coalition’s policies and practices and confirm that your mission, vision and goals align with and are served by a diverse membership and inclusive practices. Provide child care during coalition meetings and hold meetings in the evenings when the majority of members are not at school or work.
- 4. Enhancing access/reducing barriers**—Engage local hospitals and treatment centers and collaborate to provide low-cost or free substance abuse treatment for low-income, uninsured individuals.
- 5. Changing consequences (incentives/disincentives)**—Establish a Teen Court for youth involved in minor drug offenses.
- 6. Physical design**—Work to place alcohol and tobacco products in areas of retail outlets not accessible to youth.
- 7. Modifying/changing policies**—Advocate for a policy to eliminate advertising of alcohol products near places of worship.

Choosing several of these strategies—with particular emphasis on approaches 4 through 7, referred to as environmental and systems changes—ranks high among the most important decisions your coalition will make. The methods selected must correspond to the problems identified in your logic model. After selecting one or more activities related to a particular strategy, your coalition should consider the following issues:

The challenge of changing a community

Many diverse groups live in high-risk environments. Research shows that a higher concentration of liquor outlets, alcohol and tobacco advertising, and public drinking exists in low-income and minority areas. Often, the residents have little say over land-use policies such as zoning ordinances. Research also shows that the alcohol and tobacco industries:

- Market heavily to minority communities.
- Saturate minority neighborhoods with advertising.
- Misuse minority culture to market the products.
- Oppose attempts to reduce or modify their advertising efforts.

If your coalition wants to mobilize segments of your community that are disproportionately affected, it must take these factors into account.

- Do you have broad-based support for the intervention?
- Has the intervention been successfully attempted with other diverse populations?
- Will the coalition be able to promote ownership of the intervention?
- Is it doable?

Most challenging to attain are changes in policies, environments, barriers or consequences. Because these types of changes have a wide impact, your coalition will need to mobilize broad sections of the community.

Prevention program or coalition?

One significant issue affecting community change involves coalitions that manage prevention programs. In recent years, various federal agencies have encouraged coalitions to use model programs, which have been studied and found effective. We encourage coalitions to develop comprehensive strategies to reduce substance abuse rates, and acknowledge that prevention programs may form part of a comprehensive community plan. Some coalition members may operate programs and ask for coalition support of their efforts. However, it is important to keep in mind that a prevention program by itself, no matter how effective, is less likely to achieve the population-level change that a true coalition accomplishes.

Your coalition members may want to consider selecting an existing model program and fine-tuning it to meet your community's needs. To help you determine if the program is appropriate for your community, consider the following questions:

- **Who** conducted the research and program development? How knowledgeable were they in working with diverse populations?
- **What** populations were involved in the research study? How effective will the program be if the study did not include the populations with which you work?
- **Has** the original research and program been repeated with diverse populations?
- **Who** evaluated the program? Was it the program developer? Was there an independent review? Were representatives of diverse groups included on the evaluation team?

- **Are** the materials available in other languages? Do you have the resources to get necessary translations?
- **Are** translations available? Who did the translations? Were the translations tested in a target population and found effective?
- **Was** cultural competence integrated into the design of the program? If so, how?
- **Will** the program developer or local experts work with your coalition on the adaptation?
- **Have** you created a way to involve the community in the adaptation?

In most cases, you will need to adapt the model program to meet the needs of your diverse community—not necessarily an easy process.

Evaluation

To evaluate your program, your coalition will collect, analyze and interpret information on its implementation, impact and effectiveness. Evaluation should tell the story of your coalition’s work—what it did to try to change the community for the better, and how effective it was at achieving change.

An evaluation plan is like a trip itinerary. It should:

- **State** clearly where you are going.
- **Describe** how you will get there.
- **Describe** success in measurable terms (your destination).
- **Allow** your group to check short-term outcomes in measurable terms and make adjustments if necessary.

At one time, an evaluator—typically a researcher from a university—would observe coalition efforts from a detached perspective and produce a report. Today’s evaluator, however, also acts as a facilitator who helps organizations identify and improve the skills they need for success. Consequently, most evaluations now engage coalition members in the process of formulating, conducting, interpreting and using the findings of the evaluation. This approach improves communication, involves community representatives and stakeholders at each stage of evaluation and results in a more well-informed analysis of the project.

Data collection in evaluation and selection of an evaluator

Your evaluation strategy is incomplete without baseline information and a complete data collection plan. You need good data sources to interpret events in your community, and sometimes primary data sources produce information that is too broad. To put some meat on the bones of a broader survey, your coalition may need to create questionnaires, conduct key informant interviews or set up focus groups at the local level. Keep cultural competence at the forefront of this process. Ask your key constituents, which data-gathering methods will resonate in a positive way with your community? Which data-gathering methods will the community view with suspicion or alarm?

You also will want cultural competence to guide your selection of an evaluator or evaluation team. Get your community involved in the search and selection process; solicit their insights and local knowledge. When reviewing the qualifications for evaluation candidates, consider these questions:

- **How** much experience does the candidate have in working with culturally diverse groups?
- **What** experience does the candidate have in working with community coalitions?
- **How** will the candidate involve members of the community at all stages of the evaluation?
- **How** will the candidate incorporate cultural competence into the evaluation?
- **How** will the candidate manage communication issues (e.g., language)?

Getting your message out

The worst thing that can happen to your evaluation is for it to be printed, bound and placed on a shelf. Your coalition needs a strategy for getting your message out. Consider these questions:

Who cares about your work? Coalitions routinely share their results with key stakeholders: school districts, police departments and public health departments. The culturally competent coalition gets the message out to the entire network—formal and informal—that makes up the community. Have your coalition draft a list that includes civic and social organizations, ethnic or racial

groups, youth programs, senior citizens—in short, the residents of the community.

What do they care about? Many organizations complete a comprehensive report and consider the job done. However, a bound, formal report will not work for everyone. Your coalition may need to break its big report into smaller sections that highlight information important to various constituents in your community. For example, statistical summaries will resonate with police or health departments, but not, perhaps, with a youth group. Another community partner may be more interested in your process than your outcomes. To determine how best to present your information, consider your community's needs. Your organization's goals should match these needs. If you are trying to reach a particular group, providing summary information directed to its concerns is a powerful outreach tool. Consider the following additional ideas for getting your message out:

- **Invite** reporters from foreign-language newspapers to a press conference or information session.
- **Ask** teachers of graphics courses at the high school or local college to help you create colorful, eye-catching graphics to simplify information.
- **Contact** local media and ask if they need interview subjects for local public information shows. Send coalition members to talk about your initiatives.
- **Create** a “vision for our community” game by conducting a brainstorming session with coalition members.
- **Plan** a regularly scheduled “good news” report about successes in your community.
- **Create** a blog, e-mail blast system or Web page designed especially for community members (separate from your official Web page) that serves as an electronic town hall.
- **Participate** in community festivals and hand out suitable information.
- **Organize** a community pride day to recognize and honor those working for change.
- **Create** a cartoon book in which the “superheroes” are community leaders.

- **Continue** to brainstorm, and give unconventional ideas a fair hearing (no matter how outlandish they may sound at first).

Troubleshooting

Coalitions often contact CADCA's Institute with requests for training and technical assistance to help them work with diverse populations in their communities. They frequently indicate that they have difficulty reaching out to diverse groups, particularly immigrants, or have not received support from target populations. Many seek a quick fix to a complex problem. Coalition leaders who have not paid close attention to cultural competence issues often find themselves in a quandary as to what steps they can take. Here are some general suggestions that your coalition may consider if you feel that you need to make improvements in this area:

Place the issue on the agenda of an upcoming coalition meeting. Coalitions often experience difficulty when dealing with racial, ethnic, gender, sexual orientation or other differences that impact their work. Such coalitions need to air out their issues rather than continuing to hope that they will disappear. Have the group engage in an honest, constructive discussion about the current situation. Take steps to ensure that this discussion does not degenerate into a grousing or finger-pointing session. Focus on ways to improve your coalition, not to blame previous leadership or members of underrepresented communities.

Get coalition members to take ownership of the issue. In many instances, cultural competence, diversity and outreach issues are made the purview of paid staff, often an "outreach" worker. However, for your coalition to make progress on this issue, the coalition members need to take ownership of the issue and identify solutions. For example, if representation of diverse populations is a problem, then coalition members, not just staff, should be involved in identifying, reaching out to and recruiting prospective members.

Establish a subcommittee or task force to deal with cultural competence. Often, a coalition board will form a committee to probe the issue, meet with community members and make recommendations back to the entire board. Such groups can initiate action and plan concrete next steps. Research shows that such committees must have appropriate authority to be truly effective.

Develop a plan. Coalitions should consider the development of an action plan that will identify measurable outcomes and a blueprint for steps to achieve them. This plan should include goals, strategies and activities; persons responsible; and resources needed. For example, if lack of diversity in the coalition is an issue, the plan could contain the following: “Coalition will contact 24 organizations and agencies representing diverse groups in our community within the next six months with the goal of recruiting four new board members and signing six memoranda of understanding between the groups/agencies and the coalition.” Decide who will be responsible for implementing the plan. Periodically evaluate all aspects of your plan and make adjustments as necessary.

Finally, consider hiring a skilled facilitator if a situation blows up and threatens to undo the good work that your coalition has completed.

CONCLUSION

This primer presents information to help your coalition incorporate cultural competence into each step of the Strategic Prevention Framework. We hope that the ideas and concepts presented here will help you meet the challenges involved in becoming a culturally competent organization. Keep in mind as you move forward that you have entered a marathon. You are attempting to change yourself, your coalition and your community—no small task, but certainly one well worth doing.

You know, perhaps better than anyone, how difficult it is to create positive change within a community that may itself be changing in unpredictable ways. A sudden influx of new immigrants, an increase in gangs or gang-related violence, a new economic development plan, the closing or opening of a local business and even events at the national level continually buffet your community. That is why it is so important to create a healthy community that can weather these constant challenges. What all this means, of course, is that your work is never truly done. However, your coalition does not have to struggle alone. You have resources available not only at the local level but at the Institute as well. We offer training, technical assistance, publication resources and more. If you need help, contact us, as we are always ready to assist.

A WORD ABOUT WORDS

As noted at the beginning of this primer, there are a number of terms that sometimes are used interchangeably. Often, the difference depends on who is funding your efforts or the field from which you come. The following chart highlights terms that often are used to describe the same or similar concept.

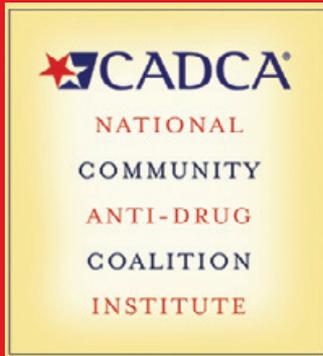
A Word about Words			
Assess	Plan/Implement	Evaluate	
<p>“The problem is... But why? But why here?”</p>			
What you want	What you do to get there	Are you getting there?	Did you get there?
<ul style="list-style-type: none"> • Aim • Goal • Objective • Target 	<ul style="list-style-type: none"> • Activity • Approach • Initiative • Input • Method • Policy • Practice • Program • Strategy 	<ul style="list-style-type: none"> • Benchmark • Indicator • Intermediate Outcome • Input/Output • Measure • Milestone • Short-term Outcome • Output 	<ul style="list-style-type: none"> • Impact • Outcome • Results
<p>Build Capacity Sustain the Work Increase Cultural Competence</p>			

GLOSSARY

- Acculturation.** The process of adopting the cultural traits or social patterns of another group. In immigrant groups, traditional cultural values and the protective value they provide may be weakened as a result.
- Activity.** Thing that you do—planned event(s) or project(s) used to implement a program.
- Aim.** A clearly directed intent or purpose, an anticipated outcome that is intended or that guides your planned actions, the goal intended to be attained.
- Approach.** The method used in dealing with or accomplishing: a logical process to solving an identified problem.
- Assimilation.** An intense process of integration in which members of an ethno-cultural group, typically immigrants, or other minority groups, are absorbed into an established, generally larger community. This presumes a loss of many characteristics which make the newcomers unique.
- Community assessment.** A comprehensive description of your target community (however your coalition defines community). The assessment process is a systematic gathering and analysis of data about your community.
- Community-level change.** This is change that occurs within the target population in your target area.
- Cultural awareness.** Being open to the idea of changing cultural attitudes.
- Cultural competence.** A set of behaviors, attitudes and policies that come together in a system, agency, or program or among individuals, enabling them to function effectively in diverse cultural interactions and similarities within, among, and between groups. A culturally competent organization has the capacity to bring into its system many different behaviors, attitudes, and policies and work effectively in cross-cultural settings to produce better outcomes.
- Cultural diversity.** Differences in race, ethnicity, language, nationality, religion, etc. among various groups within a community. A community is said to be culturally diverse if its residents include members of different groups.
- Cultural heterogeneity.** The differences within a cultural group. Large population groups, such as Asian Americans, Native Americans or Hispanics possess many similarities, but also differ by tribe, national origin, language, geography and culture.
- Cultural knowledge.** An understanding about some cultural characteristics, history, values, beliefs, and behaviors of another ethnic or cultural group.
- Cultural sensitivity.** Knowing that differences exist between cultures, but not assigning values to the differences (better or worse, right or wrong). Clashes on this point can easily occur, especially if a custom or belief in question goes against the idea of multiculturalism. Internal conflict (intrapersonal, interpersonal, and organizational) is likely to occur at times over this issue.
- Culture.** The shared values, traditions, norms, customs, arts, history, folklore and institutions of a group of people that are unified by race, ethnicity, language, nationality, or religion or other major factors (i.e., gender, sexual orientation, faith, etc.)
- Demographic data.** Data that describes a place and the people living in a community. Commonly collected demographic data include size, population, age ethnic/cultural characteristics, socio-economic status, and languages spoken.

- Disaggregated data.** Statistics or other information that is separated into its parts, such as separating data by race, ethnicity, language, sexual orientation, geography or culture.
- Diversity.** Diversity is “otherness” or those human qualities that are different from our own and outside the groups to which we belong, yet are present in other individuals and groups.
- 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 the societal climate that encourages, supports, reinforces, or sustains problematic use of drugs.
- Ethnocentricity.** The belief in the inherent superiority of one’s own ethnic group or culture, or a tendency to view alien groups or cultures from the perspective of one’s own.
- Framework.** A framework is a structure that is used to shape something. A framework for a strategy or approach supports and connects the parts.
- Goal.** A goal states intent and purpose, and supports the vision and mission statements. For example: “To create a healthy community where drugs and alcohol are not abused by adults or used by youth.”
- Initiative.** A fresh approach to something; a new way of dealing with a problem, a new attempt to achieve a goal or solve a problem, or a new method for doing this.
- Logic model.** Presents a diagram of how the effort or initiative is supposed to work by explaining why the strategy is a good solution to the problem at hand and making an explicit, often visual, statement of activities and results. It keeps participants moving in the same direction through common language and points of reference. Finally, as an element of the work itself, it can rally support by declaring what will be accomplished, and how.
- Multiculturalism.** The preservation of different cultures or cultural identities within a unified society, as a state or nation.
- Objective.** Objectives are the specific, measurable results a coalition plans to accomplish and serve as the basis by which to evaluate the work of the coalition. Each objective should have a timeframe by which it will be accomplished. “To reduce the number of youth in our community who smoke at age 15 from 18.5 percent to 10 percent by 2007.”
- Outcome.** Outcomes are used to determine what has been accomplished, including changes in approaches, policies, and practices to reduce risk factors and promote protective factors as a result of the work of the coalition. An outcome measures change in what you expect or hope will happen as a result of your efforts.
- Policy.** A governing principle pertaining to goals, objectives, and/or activities. It is a decision on an issue not resolved on the basis of facts and logic only. For example, the policy of expediting drug cases in the courts might be adopted as a basis for reducing the average number of days from arraignment to disposition.
- Practice.** A customary way of operation or behavior.
- Program.** Any activity, project, function, or policy with an identifiable purpose or set of objectives.
- Protective factors.** The factors that increase an individual’s ability to resist the use and abuse of drugs, e.g., strong family bonds, external support system, and problem-solving skills.

- Readiness.** The degree of support for, or resistance to, identifying substance use and abuse as a significant social problem in a community. Stages of community readiness for prevention provide an appropriate framework for understanding prevention readiness at the community and state levels.
- Resources.** A resource is any or all of those things that can be used to improve the quality of community life: the things that can help close the gap between what is and what ought to be.
- Results.** The consequences and outcomes of a process or an assessment. They may be tangible such as products or scores, or intangible such as new understandings or changes in behavior.
- Risk factors.** Those factors that increase an individual's vulnerability to drug use and abuse, e.g., academic failure, negative social influences and favorable parental or peer attitudes toward involvement with drugs or alcohol.
- Strategy.** Identifies the overarching plan of how the coalition will achieve intended results.
- Sustainability.** The likelihood of a strategy to continue over a period of time, especially after specific funding ends.
- Targets.** Defines who or what and where you expect to change as a result of your efforts.



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