

DEPARTMENT OF HEALTH

Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health

Bureau of Drug and Alcohol Programs *Prevention Manual* 7/1/2005-6/30/2010

Revised June 2008

TABLE OF CONTENTS

Overview of Prevention	iii
Part One: Performance Based Prevention	1.01
➤ The Six Major Federal Strategies and Other Prevention Categories	
➤ Three (3) Institute of Medicine Prevention Classifications	
➤ Program Types	
Part Two: Strategic Prevention Framework Requirements	2.01
➤ Needs Assessment	
➤ Capacity	
➤ Planning	
➤ Implementation	
➤ Evaluation	
Part Three: Utilizing the Performance-Based Prevention (PBPS).....	3.01
Data Management System	
Part Four: Training Requirements	4.01
Part Five: Reporting Requirements	5.01
Part Six: The Pennsylvania National Guard	6.01
Part Seven: Reduction of Youth Access to Tobacco	7.01
Part Eight: Appendices.....	8.01
➤ Appendix A – Risk Assessment Survey	
➤ Appendix B – Determining Number of Contacts	
➤ Appendix C – SCA PBPS Quarterly Review Worksheet	
➤ Appendix E – SCA Request For National Guard Services	

OVERVIEW OF PREVENTION

It is the intent of the Bureau of Drug and Alcohol Programs (BDAP) to further the advancement and implementation of substance abuse prevention policies and practices throughout the Commonwealth, based on proven methodologies. These methodologies are based on the latest research within the substance abuse field. This work is carried out in conjunction with Single County Authorities (SCAs) and their contracted providers. As a result, there is flexibility in allowing SCAs to tailor service delivery based on identified needs and risk factors in their communities. Accomplishing strategic goals and objectives and the attainment of measurable outcomes is done in collaboration with local and state partners.

PART ONE: PERFORMANCE BASED PREVENTION

- A. Prevention funds provided to the SCA shall be used to develop and implement a comprehensive system of resources that includes a broad array of prevention strategies directed at individuals not identified to be in need of treatment. The services shall be provided either directly by the SCA or through one or more public or non-profit private entities. Prevention program activities shall be provided in a variety of settings to targeted populations who are affected by risk factors associated with substance abuse, determined through a community-wide bi-annual needs assessment.
- B. The SCA must conduct one meeting each calendar quarter internally as a functional unit or with all contracted providers to discuss prevention service delivery as it relates to planning, implementation, barriers, monitoring analysis, and technical assistance. The SCA must maintain the minutes of each quarterly meeting on file at the SCA office.
- C. The delivery of comprehensive prevention services has been formalized into six (6) major Federal Strategies, three (3) Institute of Medicine (IOM) Prevention Classifications, and Evidence-Based, Innovative, and Generic Program Types. As a management agency for drug and alcohol services, the SCA shall budget for and implement prevention services under each Federal Strategy and IOM classification which shall meet the unique needs of its community identified by the needs assessment process.

The six (6) Federal Strategies shall be utilized in conjunction with the three (3) IOM Prevention Classifications in the implementation and delivery of single and recurring prevention programs.

Six Federal Strategies:

Defined below are the six (6) Federal Strategies (see BDAP's Minimum Data Sets Administration Guide for examples) that comprise the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs.

1. Information Dissemination – provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, abuse and addiction and the affects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

2. Education – involves two-way communication, which is distinguished from the Information Dissemination category by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this category are to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.
3. Alternative Activities – operates under the premise that healthy activities will deter participants from the use of alcohol, tobacco and other drugs. The premise is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs (ATOD) and would, therefore, minimize or eliminate use of ATOD. These activities must be directly linked to an educational or skill-building activity.
4. Problem Identification and Referral – targets those persons who have experienced first use of illicit/age-inappropriate use of tobacco and those individuals who have indulged in the first use of illicit drugs and alcohol in order to assess if their behavior can be reversed through education.

Prevention funds shall not be used for SAP, EAP, or DUI programs beyond the point of the educational component. Funding for assessment or any other activity directly linked to the inauguration of treatment must come from other designated funding sources.

5. Community-Based Process – aims directly at building community capacity to enhance the ability of communities to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration, coalition building and networking.
6. Environmental – establishes or changes written and unwritten community standards, codes, ordinances and attitudes thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the population. This category is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to action-oriented initiatives.

Institute of Medicine (IOM) Prevention Classifications:

Defined below are the three (3) IOM Prevention Classifications that can contain the six major federal strategies. Included are examples of activities that comprise the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs. Additional information may be found at the following website: www.samhsa.gov.

1. Universal Preventive Interventions - are activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
2. Selective Prevention Interventions – are activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
3. Indicated Preventive Interventions - are activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing a disorder or having biological markers indicating predisposition for a disorder but not yet meeting diagnostic levels.

Program Types:

1. Evidence-Based Prevention includes strategies, activities, approaches, and programs:
 - Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse
 - Grounded in a clear theoretical foundation and have been carefully implemented
 - Evaluation findings have been subjected to critical review by other researchers
 - Replicated and produced desired results in a variety of settings
2. Only programs recognized as evidence-based by the following agencies are considered evidence-based in PBPS:
 - The Substance Abuse and Mental Health Services Administration (SAMHSA)
 - Office of Juvenile Justice And Delinquency Prevention
 - Department of Education
 - Center for the Study and Prevention of Violence
3. Innovative Programs:
 - Program/principle has been identified or recognized publicly, and has received awards, honors, or mentions
 - Program/principle has appeared in a non-referenced professional publication or journal (it is important to distinguish between citations found in professional publications and those found in journals)
 - BDAP will consider programs that were purchased from a developer to be Innovative Programs (Examples of these types of programs include: Babes, Project Meds, Parent-to-Parent, etc)
4. Generic Programs:
 - Capture activities that do not fit into an evidence-based or innovative program
 - Provide basic alcohol tobacco and other drug awareness/education as well as everyday alternative prevention activities

PART TWO: STRATEGIC PREVENTION FRAMEWORK REQUIREMENTS

The SCA shall ensure that the following criteria are adhered to in the implementation of performance-based prevention:

A. Needs Assessment

This process is an assessment to determine the extent of the problem and identify existing resources, as well as additional resources needed within the local community. The assessment should profile population needs, resources, and readiness to address needs and gaps. Prevention services shall be directed towards reducing risk factors and enhancing protective factors identified by the SCA through an assessment of its service area utilizing the following criteria:

- (1) The SCA must complete a Prevention Needs Assessment at least once every two years using the Department's Risk Assessment Instrument (*Appendix A*) as per the BDAP Report Schedule.
- (2) The minimum number of Prevention Risk Assessment Surveys required to be completed by each SCA is determined by the county's population (*Appendix B*). The Division of Prevention strongly encourages SCAs to present local data to key representatives prior to the distribution of the Prevention Needs Assessment Survey.
- (3) The minimum number of completed Prevention Risk Assessment Surveys must be data entered into PBPS as per the BDAP Report Schedule.
- (4) The SCA must develop long terms goals (6 years) based on the priority risk factors identified by the assessment that significantly impact substance abuse within targeted areas. These goals must be entered into the Department's Performance Based Prevention System (PBPS) data management system.

B. Capacity

The SCA must increase efforts within their geographic areas to build capacity to address needs. Building capacity includes identifying and using the resources available, developing the resources needed, and mobilizing community members.

C. Planning

The SCA must develop a comprehensive strategic Prevention Plan for addressing identified problems:

- (1) Goal and Objective Development

- a. The SCA's Prevention Plan consisting of long-term goals (six years), annual objectives, and programs as approved by the Department, shall serve as the SCA's work statement for prevention services.
- b. At least two (2) standardized indicators within the PBPS data management system, shall be used to measure the reduction of established risk and will be utilized by the SCA annually to assess the reduction of risk factors via the Social Indicator Evaluation section within PBPS.
- c. Baseline social indicator data shall be gathered, prior to goal implementation, to determine the current level of risk factors existing within the targeted area. Based on this data, SCAs will establish a maximum achievable percentage by which the risk factor is to be reduced. Subsequent data will be gathered and entered in the PBPS each year to assess the SCAs progress in reducing the risk factor.

(2) Program Planning

The SCA shall plan prevention programming as follows:

- a. SCAs are required to implement a combination of programs addressing:
 - All six federal strategies
 - All programs types (evidence-based, innovative and generic)
- b. All evidence-based and innovative programs must demonstrate positive outcome measures and ongoing effectiveness over the course of service delivery.
- c. 25% of program services must be delivered through a combination of evidence-based and innovative programs.
- d. The SCA is required to provide 20% of services through recurring events.

D. Implementation

It is recommended that SCAs utilize the Fidelity and Adaptation (F/A) Tool to monitor the implementation of evidence-based programs in order to understand why expected outcomes may or may not have been attained due to adaptations made to programs.

The goal of the F/A Tool is to assist SCAs and those implementing evidence-based programs in understanding the importance of maintaining program fidelity. If several different groups are completed under an evidence-based program, it is recommended that the F/A Tool be completed for each group. Groups can be defined as follows:

School Group: A group can be defined as one completed cycle or program. A group can also be defined as a cohort of youth of the same target population, setting/location, and the same delivery agents that have completed the program and have been given the same delivery (overall duration of the intervention, delivery method, number of sessions, length of sessions, order of sessions, frequency of sessions and materials).

Community Group: A group can be defined as one completed cycle or program.

Note: These definitions of group do not change or impact how groups are defined for PBPS.

E. Evaluation

The SCA shall evaluate their comprehensive prevention strategic plan.

- (1) The SCA will collect data through the implementation of the Prevention National Outcome Measures (NOMs) for individuals 12 years of age and older.
- (2) The SCA/provider will administer, collect and enter into PBPS the developer's pre/post tests and/or surveys for all evidence-based and innovative programs, for the purposes of capturing outcomes.

However, if the SCA feels that the developer's instrument is inappropriate for administering, collecting, and entering into PBPS, (or) obstacles inhibit the SCA/provider from administering the developer's instrument, the SCA **must submit an alternate instrument choice** to use with the program. The alternate instrument can be a modification of the developer's instrument or any of the available core measure instruments found within PBPS. All alternate instruments **MUST** be submitted and approved by your assigned Program Analyst prior to use with the program.

- (3) The SCA shall evaluate the PBPS data monthly. This evaluation is to determine compliance in meeting its annual objectives and develop methods for improvements in program services.
- (4) The SCA shall conduct a quarterly review of PBPS administrative and contracted provider data utilizing the Quarterly Review Worksheet (*Appendix C*).
- (5) The SCA shall complete Objective and Social Indicator Evaluations annually utilizing the PBPS evaluation module.
- (6) Each SCA will ensure an Annual Outcome Evaluation is submitted electronically to the assigned Prevention Program Analyst according to the BDAP Report Schedule.

**PART THREE: UTILIZING THE PERFORMANCE BASED PREVENTION (PBPS)
DATA MANAGEMENT SYSTEM**

- A. The SCA shall ensure that all prevention and early intervention services, including but not limited to SAP Services, funded by the SCA are included in the SCA's Prevention Plan to deliver performance based prevention services, and recorded into the PBPS data management system (see a complete description of BDAP's MDS Service Codes in the BDAP's MDS Administration Guide).
- B. The SCA shall plan, monitor, evaluate and analyze prevention service delivery using BDAP's PBPS.
- C. The SCA shall ensure that pre and post test results are recorded in the PBPS within 4 weeks of the pre and post test completion dates. Effective July 1, 2007, SCAs and their providers are required to administer the Adult and Youth NOM survey once to selected (as determined by the SCA) single services that count attendees and recurring service participants from October 1 through November 30 of each year. The survey is administered once per attendee/participant (it is not a pre/post test). Survey results must be entered into PBPS no later than January 31st of each year.
- D. Effective July 1, 2008, the SCA/providers shall be required to use the developer's pre/post tests and/or surveys for all evidence-based and innovative programs for the purposes of capturing outcomes. Alternate instrument options may be requested and submitted for prior approval, if the SCA/provider feels that the developer's instrument is inappropriate for use with their particular program situation. The results from each pre/post test and/or survey administered with these evidence-based and innovative programs must be entered into PBPS.

All alternate instrument options that are either modified from the developer's tool or created by the SCA/provider MUST be submitted to the Bureau of Drug and Alcohol Programs for prior approval. Once approved, the alternate instrument will be entered into PBPS for SCA/provider use. Program Analysts will approve all instrument choices while reviewing Program Plans.

- E. The SCA shall ensure that data associated with all prevention and early intervention services, including but not limited to SAP Services, funded by the SCA are entered into the PBPS system according to BDAP data entry requirements, timelines, and in an accurate manner to ensure data integrity.
- F. The SCA shall enter prevention service data into the PBPS when the SCA delivers their own prevention services. If an SCA contains a "functional unit" that provides

direct prevention services, the SCA shall establish a PBPS-generated provider Organization ID, and enter the prevention services under the functional unit's provider Organization ID (6-digit number).

All contracted providers that deliver prevention services shall enter their own prevention service data into PBPS. If any contracted provider cannot enter their own data into PBPS, the SCA may enter the provider's prevention service data into PBPS on their behalf

The SCA shall continue to enter each prevention provider's organization information in PBPS, and assign each prevention provider all programs that the provider is expected to deliver. The SCA shall enter the provider's service data into PBPS under the provider's PBPS-generated Organization ID (6 digit number), not under the SCA's Organizational ID. (Note: SCA data entry staff shall be added to the provider's organization as staff member[s] to access the organization's information and make entries. The actual staff at the provider organization who deliver prevention services shall also be added to the provider organization in PBPS so they can be attached to services.)

The SCA shall maintain a policy and procedure for entering prevention service data into PBPS on behalf of a prevention provider(s), and make it available upon request.

- G. At least 70% of prevention service data must be entered into the PBPS within two (2) weeks of the date the service was delivered. The expectation is to maintain an 70% monthly average. The data entered monthly must be monitored for accuracy and analyzed for progression toward outcomes by the 30th of the following month.
- H. All previous fiscal year service data is to be entered into the PBPS by July 21st.

PART FOUR: TRAINING REQUIREMENTS

A. 2-Day Web-Based PBPS

SCA and provider staff who enter data into PBPS or who are directly responsible for monitoring data entered into PBPS, and their supervisors, **must** attend the 2-Day Web-Based PBPS Training.

B. Additional required courses, as applicable.

- **Program/MDS Service Codes**

SCA staff directly involved with prevention assessment, planning, monitoring, service delivery or data entry, as well as contracted providers' supervisors, direct service and data entry staff must be trained in the Program/MDS Service Codes Training. Exemptions to requirement:

- Part-time SCA and provider staff that provide prevention services in the evening and weekends, and have full-time day employment elsewhere.
- Volunteers who deliver and/or support prevention programs.
- Individuals such as nurses, police officers and school teachers who provide direct prevention services as a component of their jobs.

- **Needs Assessment**

SCA and contracted provider staff involved in the facilitation of the Needs Assessment process must complete the Needs Assessment course. The SCA must identify, in writing, SCA and contracted provider staff required to complete this course and have this information available upon request.

- **Goal and Objective Evaluation**

SCA and contracted provider staff involved in the Goal and Objective Evaluation must complete the Goal and Objective Evaluation course. The SCA must identify, in writing, SCA and contracted provider staff required to complete this course and have this information available upon request.

- **Program Fidelity/Adaptation**

SCA and contracted provider staff that have responsibility for implementation and/or evaluation of evidence-based programs and practices must complete the Program Fidelity/Adaptation course. The SCA must identify, in writing, SCA and contracted provider staff required to complete this course and have this information available upon request.

C. Optional course

- **Goals and Objectives Development**

This course is complementary to the 2 day PBPS course. It is recommended for SCAs and contracted provider staff involved in the goal and objective development process.

SCA and contracted provider staff required to complete any of the aforementioned courses must receive certificates of completion from the Department. Copies of SCA and contracted provider staff certificates must be maintained at the SCA office and be available upon request.

All staff hired after July 1, 2006 will have twelve (12) months from hire date to complete the mandatory courses.

PART FIVE: REPORTING REQUIREMENTS

The SCA must submit reports to the Department at such times and in such form as the Department requires and in accordance with the BDAP Report Schedule.

PART SIX: THE PENNSYLVANIA NATIONAL GUARD

The Pennsylvania National Guard Drug Demand Reduction Program started in 1995 and is a joint venture with the Pennsylvania Department of Health. Their mission is to support Community-based Drug Demand Reduction (DDR) coalitions and educational institutions in their efforts to disseminate anti-drug messages to the public and provide youth with alternatives to drug use and substance abuse.

The Pennsylvania National Guard Drug Demand Reduction Program offers a variety of no-cost services such as:

- **National Guard Stay on Track (SOT)** - prevention program for middle school students (6th through 8th) to reduce future substance abuse through cognitive development, social skills development and emotional development.
- **Youth Leadership Camps**- focused on youth by educating children on substance abuse and violence, and providing positive alternatives. Some of the many team building activities include an obstacle course, leadership reaction course, physical training, climbing wall, swimming, etc., hosted at Fort Indiantown Gap or in your communities.
- **After School Activities** – homework clubs at community centers; a video production program that allows students of SOT to work on their anti-ATOD end- of-year activity video, and collaborating with different agencies such as the Boys and Girls Club and YMCA in their health fairs or drug prevention programs.
- **Challenge Training**- consists of team building, problem solving, and trust building games provided for special events or as part of organizational activities.
- **Presentations**- healthy choices; information on the effects of drugs, alcohol, and tobacco for youth programs, parent groups and ATOD Conferences.
- **Static Displays**- anti-drug, anti-smoking and anti-alcohol resources, publications and demonstrations.

Appendix D contains specific information on the process to request Pennsylvania National Guard Drug Demand Reduction services.

PART SEVEN: REDUCTION OF YOUTH ACCESS TO TOBACCO

In addition to addressing other alcohol and drug related issues, the SCA shall address the reduction of tobacco use among youth as a part of its prevention plan. These activities shall be included in the SCA's goals, objectives and provisions of services for reducing identified risk factors, even if the assessment of risk factors does not indicate tobacco use as a high risk factor.

PART EIGHT: APPENDICES