Appendix 1

PRIMARY PREVENTION

The aim of primary prevention is to prevent use and abuse of alcohol, tobacco and other drugs **before the behavior occurs.** This is done through change to an environment that is known to be conducive to substance use disorders, or by preventing exposures to identified risk factors that cause substance use. Primary prevention strategies engage schools, workplaces, and communities to establish programs and policies to improve knowledge about substance use disorders, denote effective ways to address the problems, and enhance resiliency.

Primary prevention does not seek to intervene or act on negative outcomes resulting from identified substance use disorders. The common phrase used to describe primary prevention is "going upstream" of the problem. There are various analogies to illustrate the concept of going upstream. One is as follows:

You are picnicking on a grassy slope overlooking a stream. Suddenly, you see a head bobbing in the middle of the current; a youngster waving arms and crying out for help. Lifeguards race into the river and rescue the youngster.

Soon, another drowning youngster is swept by. Then another. The lifeguards are busy pulling people out of the current. You begin to understand that there must be something further upstream that is causing these kids to get swept away. You decide to go upstream to find out what is causing the kids to fall into the stream. You identify the source of the problem on a hill above the river: a soccer field that does not have a fence around it. When a ball is kicked off the field, it rolls down hill and lands in the river. The youngsters who chase the ball into the river to retrieve it get swept away in the current.

As a primary preventionist, your actions might be to inform the kids and their parents of the dangers of chasing balls into the river, thereby altering any unsafe behavior. You may be to organize the community to build a fence to deflect the soccer balls and protect the players from impulsively chasing the ball into the stream. You may also provide a safety class to equip the youngsters on ways to save themselves when being swept away by currents. Maybe you will offer bowling as an alternative activity. **These activities are all implemented prior to when the predictable accident occurs. Each strategy supports the goal of preventing kids from drowning in the stream.**

Secondary prevention aims to reduce the impact of a problem that has already occurred. If you ask the lifeguards to buy lots of life vests and keep watch for kids who are in the current, you are engaging in secondary prevention. Likewise, activities designed to screen, test, and refer to treatment are secondary prevention/intervention efforts.

Tertiary prevention aims to soften the impact of ongoing problems. If you identify the youngsters who have nearly drowned and provide ongoing treatment to address their various

injuries, you are engaging in tertiary prevention. Activities designed to reverse or treat the effects of substance abuse or overdose are not primary prevention.

The more effective primary prevention is, the lower the need for secondary and tertiary interventions. Although for many substance use disorders a combination of primary, secondary and tertiary interventions is needed to achieve a meaningful degree of prevention and protection, **the Substance Abuse Block Grant Primary Prevention Set-Aside is intended to fund only primary prevention strategies.**

Appendix 2

SAMHSA's Strategic Prevention Framework (SPF)

Online Course: https://www.samhsa.gov/capt/tools-learning-resources/what-is-spf

The SPF is a planning model promoted by Substance Abuse and Mental Health Services Administration (SAMHSA) to support coordinated, comprehensive, data-driven planning and accountability. Designed to be long-term and evolutionary in nature, the resulting plan should build on knowledge and experience over time, and lead to measurable outcomes and system improvements. There are five (5) steps of the SPF developed to organize prevention strategies and objectives for change:

Five Steps:

Assessment: What is the problem?
Capacity: What do you have to work with? Building resources.
Planning: What works, and how do you do it well?
Implementation: Put a plan into action – deliver evidence-based interventions as needed.
Evaluation**:** Examine the process and outcomes of interventions. Is it succeeding?

All applicant coalitions are encouraged to utilize this five-step process in the organization of their prevention strategies and objectives for change, and as a guide in the development of coalitions' Comprehensive Community Prevention Plan (CCPP). These steps, if implemented well, will strengthen the coalition and enhance their risk assessment when applying for funds.

The five steps of the SPF are guided by two central principles:
Cultural competence – the ability of an individual or organization to interact effectively with members of diverse population groups.

Sustainability - the process of building an adaptive and effective system that achieves and maintains desired long-term results.

These principles must be integrated into each step to ensure an effective planning process.

Steps that can be taken to ensure cultural competence:

- Consider the terms and phrases used by your community when discussing substance abuse problems and related behaviors.
- Ask the leaders of a community to provide guidance regarding any cultural differences to be aware of.
- Look for prevention interventions that have been developed for and evaluated with an audience like your focus population.
- Develop case examples that reflect participants' life experiences to supplement a prevention strategy that is already underway.
- Conduct follow-up interviews with participants to better understand program evaluation findings.

Practitioners should consider culture at every step of the SPF to ensure than members of diverse population groups actively participate in, feel comfortable with, and benefit from prevention practices.

Steps that can be taken to ensure sustainability:

Sustainability is the process of building an adaptive and effective system that achieves and maintains desired long-term results.

Prevention practitioners must think contextually about sustainability. This means working toward maintaining effective interventions as well as the planning processes and other factors that contribute to their success.

- Think about sustainability from the beginning.
- Identify diverse resources. You may find people, partnerships, and materials to support prevention in unexpected places.
- Invest in capacity. Find ways to teach others how to assess needs, plan and deliver interventions, and more.
- Build ownership among stakeholders. The more you inform and involve people, the more likely they will be to help sustain prevention efforts.
- Identify program champions. Some people are more excited about prevention—and more influential in your community—than others.

- Track and tout outcomes. A solid evaluation can help you determine, and communicate to others, which prevention efforts are worth sustaining.

Distinctive Features of the SPF

The SPF planning process has four distinctive features. The SPF is:

Data driven: Good decisions require data. The SPF is designed to help practitioners gather and use data to guide all prevention decisions—from identifying which substance misuse issues problems to address in their communities, to choosing the most appropriate ways to address those problems. Data also helps practitioners determine whether communities are making progress in meeting their prevention needs.

Dynamic: Assessment is more than just a starting point. Practitioners will return to this step again and again: as the prevention needs of their communities change, and as community capacity to address these needs evolve. Communities may also engage in activities related to multiple steps simultaneously. For example, practitioners may need to find and mobilize additional capacity to support implementation once an intervention is underway. For these reasons, the SPF is a circular, rather than a linear, model.

Focused on population-level change: Earlier prevention models often measured success by looking at individual program outcomes or changes among small groups. But effective prevention means implementing multiple strategies that address the constellation of risk and protective factors associated with substance misuse in a given community. In this way, we are more likely to create an environment that helps people support healthy decision-making.

Intended to guide prevention efforts for people of all ages: Substance misuse prevention has traditionally focused on adolescent use. The SPF challenges prevention professionals to look at substance misuse among populations that are often overlooked but at significant risk, such as young adults ages 18 to 25 and adults age 65 and older.

Reliant on a team approach: Each step of the SPF requires—and greatly benefits from—the participation of diverse community partners. The individuals and institutions you involve will change as your initiative evolves over time, but the need for prevention partners will remain constant.

From the SAMHSA website: https://www.samhsa.gov/capt/applying-strategic-prevention-framework

Appendix 3

Comprehensive Community Prevention Plan (CCPP) Guidance Document

The purpose of this document is to provide guidance to coalitions in the development of their CCPPs. The CCPP should include the following components:

Brief Mission Statement

1. Name of organization, contact information
2. Overview of the coalition
3. Where you fit into the overall fabric of community services
   a. Members
   b. The service you provide/gap you fill
4. The community-level change you strive to accomplish

Community Assessment

1. Definition of Community
   a. Define the boundaries of community being assessed including rationale for the definition.
      i. Rationale might include geographic boundaries, sub-populations, etc.
   b. Include relevant geographic and demographic information to describe community context.

2. Community History
   a. Describe major events and forces that have affected the community and influenced targeted outcomes.

3. Needs Assessment
   a. Describe/define measures used to identify the substance use disorders in the community.
      i. Data sources and findings (most current available)
      ii. Qualitative surveys and interviews
      iii. Archival data
   b. Analyze information about the problem, goals and factors affecting them.
   c. Rationale for the naming and framing choices made for each problem statement

4. Capacity and Resource Assessment
   a. Define organizational structure and operating mechanisms.
      i. Training and technical assistance provided to staff /community volunteers.
      ii. Method for developing leadership and attracting skilled staff.
   b. Analyze strengths of existing staff and community partners working to accomplish goals.
      i. Identify gaps in staffing, and ways to address the gaps.
   c. Describe the resources
      i. Currently available for community mobilization.
      ii. Needed and necessary to address identified community problems.
      iii. Strategies for developing/sustaining funding
   d. Support capacity and resource assessment through quantifiable, qualifiable measures.

Logic Model

1. Problem Statement
   a. One problem statement for each identified community issue defined in the Needs Assessment
   b. The problems identified by the community are the ultimate goal or outcome portrayed in the logic model
   c. Prioritized
   d. Supported by measures from Needs Assessment and/or Capacity Assessment

2. Root Causes
   a. The reasons targeted problems exist are clearly identified
   b. Risk/protective factors

3. Local Conditions
   a. The local conditions that maintain risk or build protection for each problem are clearly identified

4. Goals (Impact Statement)
   a. Break-down of the parts necessary to attack the problem
   b. In-line with the identified problem to present a clear relationship between the two

5. Objectives (Intended Impact) Quantitative is Know, Do, and Feel, Qualitative is Believe, Become, and Love.
   a. Project the anticipated outcome for each goal
   b. Specific
   c. Measurable, either qualitative or quantifiable
   d. Achievable
   e. Relevant
   f. Timed

6. Strategy (Principles of change)
   a. What steps will be taken to meet the identified objectives

7. Activities
   a. Strategic activities needed to meet the identified objectives

8. Responsibility
   a. Identify partners needed to carry out the identified objectives

9. Due Dates

   a. Establish appropriate timeframes to complete the identified objectives

10. Documentation

    a. Collect and provide the appropriate documentation (data, written reports, etc.) to demonstrate the

objectives have been met.

11. Evaluation

a. Identify appropriate methodologies to evaluate the effectiveness of the project/program

LOGIC MODEL FOR PRIMARY PREVENTION FUNDING

The purpose of this model is to provide an in-line continuum for the rationale for funding, from identification of the problem through to strategies to address the problem and evaluation of outcomes. The first six columns will be contained in the Comprehensive Community Prevention Plan (CCPP) and remain static for 3 years, or until an updated CCPP is produced. The fourth through eleventh columns will be revised in the annual Scope of Work for each subgrant. They remain flexible to apply the most effective strategy to address the current problems in the community; and to plan and assign the funding stream to support each program.

1	2	3	4	5	6	7	8	9	10	11
Data/Problem	**Root Cause**	**Local Conditions**	**Goals (Impact Statement)**	**Objectives (Intended Impact) Quantitative - know, do, feel Qualitative - believe, become, love**	**IOM Strategies/ Specific Strategies (Principles of Change)**	**Activities**	**Who is Responsible?**	**When is it Due?**	**Documentation**	**Evaluation**

LOGIC MODEL FOR PRIMARY PREVENTION FUNDING

The 3-Year Community Plan will contain columns 1 through 6. Column 6, Strategies, will reflect the anticipated IOM Classifications necessary to fulfill the objectives

The annual Scopes of Work will begin with column 4 and continue through column 11. Columns 4 and 5 will be the exact goals and objectives laid out in the Community Plan, but with more specificity. Strategies will be narrowed down from the IOM classification to the specific strategy, and activities will be finalized to fulfill the short term goal. Documentation and Evaluation will become part of the documentation. The line-logic will show a defensible relationship between each element.

Appendix 5

BHWP State Priorities

These priorities were defined by the Multidisciplinary Prevention Action Committee (MPAC), SAPTA Strategic Plan 2017-2020 and by SAMHSA's Strategic Initiative #1 2011-2018 (Attachment B). It is required that applicants will choose a minimum of three (3) of the following 15 priorities areas for funding per funding stream.

Priority Area	Priority Description
1	Prevent the onset of childhood and underage drinking and other drug use, reduce the progression of substance abuse, including prescription drugs used illicitly and marijuana; prevent the relapse of substance abuse of those in recovery
2	Support earlier access to prevention by targeting students in high-risk environments needing access to after-school activities/programming for youth empowerment
3	Create or implement strategies to reduce binge-drinking and drug use in youth under the age of 18 and young adults up to age 24
4	Target substance abuse prevention on Native American communities among youth and adults
5	Target substance abuse prevention on people that are lesbian, gay, bisexual, transgender and questioning (LGBTQ)
6	Develop and/or increase collaboration and partnership with the military; active service, veterans, reservists, National Guard, and their families
7	Develop targeted prevention efforts aimed at older adults at risk of developing a dependence on opioids and alcohol
8	Target alcohol and other drug use among women of child-bearing years and women currently pregnant
9	Target substance abuse prevention on people speaking a language other than English
10	Focus prevention activities on prescription drugs used for non-medical purposes, or without a prescription
11	Develop and strengthen linkages to available resources
12	Focus prevention activities around use of e-cigarettes, including the dangers of use and changes in social norms
13	Focus prevention activities around marijuana, including medical marijuana dispensaries, recreational issues and changes in social norms
14	Engage cross-systems expertise, such as educational institutions, first responders, law enforcement, etc., to increase or leverage training and educational opportunities and promote community level change

Appendix 6

SIX PRIMARY PREVENTION STRATEGIES:

The SABG statute (45 CFR 96.125) identifies six primary prevention strategies. BHWP, as an agency, is required to ensure that among the subgrantees, funds are spent for each of the six strategies:

1. **Information Dissemination** strategies are 1-way communication from source to audience. It provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse, and addiction, and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. It is marked by one-way communication from the source to the audience, with limited contact between the two. Examples include: Clearinghouse or information resource centers; resource directories; media campaigns; brochures/pamphlets/rack cards; radio/TV public service announcements; health fairs or health promotion; information lines.

2. **Education** strategies include 2-way communication. Interaction between the educator or facilitator and participants is the basis of Education activities. Education activities aim to affect critical life and social skills, including decision making, refusal skills, critical analysis, and systematic judgment abilities. An example of critical analysis would be the interpretation of media messages. Examples include: classroom and/or small group sessions (all ages); parenting and family management classes; peer leader/helper programs; education programs for youth groups; groups for children of substance abusers.

3. **Alternatives**. This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. Examples of alternative strategies include: drug-free dances and parties; youth or adult leadership activities; community drop-in centers; and community service activities.

4. **Problem Identification and Referral** Strategy. The goal of this strategy is to identify individuals who have indulged in illegal or age-inappropriate use of tobacco or alcohol and those individuals who are using illicit drugs for the first time. This identification is made to assess if the behavior of these individuals can be reversed through education. ***Note: this strategy does not include Screening, Brief Intervention, and referral to Treatment (SBIRT) or any activity designed to determine if a person is in need of treatment.*** Examples of Problem Identification and Referral activities include: Employee assistance programs; student assistance programs; driving while under the influence or driving while intoxicated education programs.

5. **Community Based Process.** The goal of this strategy is to improve the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. It includes organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.

   Examples include:

   - Community and volunteer training

- Systematic planning
- Multiagency coordination and collaboration
- Accessing services and funding
- Community team building

6. **Environmental.** This strategy influences incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population. This is achieved by establishing or changing written and unwritten community standards, codes, and attitudes. This strategy is divided into two subcategories to permit distinction between activities that center on **legal and regulatory** initiatives and those that relate to **service and action-oriented** initiatives.

   Examples include:

   - promoting the establishment and review of alcohol, tobacco and drug use policies in schools
   - technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco and other drug use
   - modifying alcohol and tobacco advertising practices
   - product pricing strategies.
   - resource development or technical assistance to maximize enforcement procedures

Appendix 7

INSTITUTE OF MEDICINE (IOM) MODEL

The Six Strategies indicate the *type of activities planned*, while the IOM indicates the *populations served*. The three IOM Model categories are Universal, Selective and Indicated.

Universal prevention strategies are intended to reach a very large audience and are provided to everyone in a population, such as a school or community. They are not selected for participation based on individual risk factors.

- Universal direct strategies
  - Directly serve an identifiable group of participants
  - Have not been identified based on individual risk
  - Examples are school curriculums, after-school programs, parenting classes, party patrols
  - Also include interventions involving interpersonal, ongoing and repeated contact, such as coalition building.
- Universal indirect strategies
  - Support population-based programs and environmental strategies
  - Examples include establishing alcohol, tobacco and other drug (ATOD) policies

Selective prevention strategies target subgroups of the general population that are known to have specific risks for substance abuse and are recruited to participate in the prevention effort specifically because of that group's risk profile.

  - Examples include curriculum-based programs for children of substance-abusing parents, and programs for families living in high-crime or impoverished neighborhoods.

Indicated strategies are targeted to individuals who are experiencing early signs of substance use and other related problem behaviors associated with substance use, but who haven't reached the point where clinical diagnosis of substance abuse can be made. Indicated prevention approaches are used for individuals who may or may not be abusing substances but who exhibit risk factors such as school failure, interpersonal social problems, delinquency and other antisocial behaviors. These individuals may also exhibit psychological problems such as depression and suicidal behavior, which increase their chances of developing a drug abuse problem. Indicated prevention strategies target these individuals with special programs.

  - Examples include: DUI education program for individuals with a conviction for driving under the influence.

Appendix 8

EVIDENCE-BASED STRATEGIES

An Evidence-Based Practice (EBP) is defined as a prevention service (program, policy, practice) that has been proven to positively change the problem being targeted. In general, there needs to be evidence that the intervention has been effective at achieving outcomes through some form of evaluation. The evaluation process monitors outcomes to determine whether the intervention positively impacted the target problem and/or contributing condition. The type of evidence collected will vary for different types of interventions. For example, a program will track participants for a period of time after receiving the intervention and compare them to a group who did not participate in the program. An effective policy will be measured by looking at a community that has implemented the policy and the impact that was documented when they did so. Or the impact of the removal of a policy can be studied. Practices are effective if the desired behavior change is supported by everyone in the community.

NREPP (National Registry of Evidence-Based Programs and Practices) defined EBPs as:
Interventions that have shown through program evaluation using accepted scientific methods that an observed effect is the consequence of the intervention.

Evidence-based interventions are defined by inclusion in one or more of the three categories below:

1. Included in Federal registries of evidence-based interventions, such as NREPP and OJJDP;
2. Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or
3. Documented effectiveness supported by other sources of information and the consensus judgment of informed experts. When selecting a strategy in this category, ALL of the following guidelines should be met.
    - The intervention is based on a theory of change that is documented in a clear logic model;
    - The intervention is similar in content and structure to interventions that appear in registries and/or peer-reviewed literature;
    - The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
    - The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluation prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g. officials from law enforcement and education sectors or elders within indigenous cultures).

EBPs are typically accompanied by manuals that prescribe the content delivered to participants for each session and the variations that may be allowed regarding program implementation. The program must be implemented with fidelity to the prescribed delivery. If providers attempt to adjust the program to a different audience, or use a different delivery method, the program will no longer be considered evidence based.

The steps to identify appropriate EBPs include:

- Identifying a problem and target population
- Finding relevant research
- Developing a logic model
- Implementing a research-informed program
- Evaluating the outcomes of your program

Program evaluation may not always show a positive outcome. This does not necessarily mean the program was a failure, but that it was not effective for the problem and target population. Less than positive evaluations provide information that will be valuable in your selection process for a replacement program.

Use of Non-Evidence Based Strategies:

While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. In addition to EBP, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program-specific data indicate they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

New strategies should be used if an EBP does not exist to meet the identified community need and there is not one that can be adapted to do so. It is recognized that there may be prevention initiatives that a community is committed to which have not gone through the process to have documented a stronger level of evidence that it is effective. In addition, many environmental interventions have limited evidence that isolate the impact of the specific intervention components of a community plan. It may also be necessary to rely on weaker evidence when no appropriate interventions are available in categories with stronger evidence. An intervention should address the targeted problem and local contributing conditions and is appropriate for the cultural and community context in which it will be implemented. Under these circumstances, it may be appropriate to select or continue to use a strategy or practice that does not meet a stronger category of evidence. The following conditions should be addressed in these situations.

1. Evaluation methodology documenting effectiveness should meet rigorous scientific standards and evaluation of local implementation should work to move the intervention further along the continuum of evidence strength. It may be appropriate to work with a

local university, researcher, evaluator, or local epidemiology workgroup in order to strengthen the evaluation plan.

2. The intervention should follow best-practice principles.
3. Documentation to justify the inclusion of a particular intervention is important. Prevention planners are encouraged to provide as many types of documentation as are appropriate and feasible in order to provide strong justification of documented effectiveness. This documentation may include:
    - documentation that clarifies and explains how the intervention is similar in theory, content and structure to an existing EBP;
    - documentation that the intervention has been used by the community through multiple iterations and data collected indicates its effectiveness;
    - documentation that indicates how the intervention adequately addresses elements of evidence usually addressed in peer-reviewed journal articles (nature and quality of the evaluation research design, consistency of findings across multiple studies, nature and quality of data collection methods);
    - documentation that explains how the intervention is based on an established theory that has been tested and empirically supported in multiple studies;
    - documentation that describes and explains how the intervention is rooted in the indigenous culture and tradition. documentation that the intervention has been used by the community through multiple iterations and data collected indicates its effectiveness;
    - documentation that indicates how the intervention adequately addresses elements of evidence usually addressed in peer-reviewed journal articles (nature and quality of the evaluation research design, consistency of findings across multiple studies, nature and quality of data collection methods);
    - documentation that explains how the intervention is based on an established theory that has been tested and empirically supported in multiple studies;
    - documentation that describes and explains how the intervention is rooted in the indigenous culture and tradition.

Note: SAMHSA terminated the NREPP contract on December 28, 2017 because some of the evidence-based practices were not current and it was not configured for accurate search results. SAMHSA is moving to EBP implementation efforts through targeted technical assistance and training that makes use of local and national experts and will assist programs with implementation. Below is a partial list of popular resources.

Resource List for Evidence-based Programs:

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)
http://nrepp.samhsa.gov/landing.aspx

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
https://www.ojjdp.gov/mpg/

National Institute on Drug Abuse
https://teens.drugabuse.gov/teachers/lessonplans#/questions
https://teens.drugabuse.gov/drug-facts/marijuana

The NCJA Center for Justice Planning (NCJP)
http://www.ncjp.org/saas/ebps/registries

National Institutes of Health
https://teens.drugabuse.gov/teachers/lessonplans#/questions (new)

https://teens.drugabuse.gov/sites/default/files/podata_1_17_14_0.pdf

https://prevention.nih.gov/resources-for-researchers/dissemination-and-implementation-resources/evidence-based-programs-practices

National Institute of Justice
https://www.crimesolutions.gov/ProgramDetails.aspx?ID=191

Network of Care – Clark County
http://clark.nv.networkofcare.org/ph/county-indicators.aspx
Refer to categories: Health Risk Factors, and Mental Health and Substance Abuse

REAL Prevention
https://real-prevention.com/

Botvin LifeSkills Training
https://lifeskillstraining.com/

Project Northland and Class Action
http://www.hazelden.org/web/go/projectnorthland

Project Towards No Drug Abuse
http://tnd.usc.edu/about.php

Too Good for Drugs
https://toogoodprograms.org/

Mind over Matter Series
https://teens.drugabuse.gov/teachers/mind-over-matter

Parenting Wisely
https://www.parentingwisely.com/

Smart Moves
https://www.bgca.org/programs/health-wellness/smart-moves

Catch My Breath
https://catchinfo.org/modules/e-cigarettes/

Appendix 9

CULTURAL COMPETENCY

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines cultural competency as: *"The ability of an individual or organization to interact effectively with people of different cultures."*

At the coalition level, cultural competence requires a set of behaviors, attitudes and policies that enable members of the organization to provide programs effectively across cultures, with the ultimate goal of improving access, utilization and effectiveness of prevention services for underserved, high need clients and communities.

Cultural competency is a fluid and ongoing process that should be embedded in every step of the Strategic Prevention Framework and reflected in your primary prevention strategies and activities. "Culture" is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. Becoming culturally competent is a dynamic process that requires cultural knowledge and skill development at all service levels, including policymaking, administration, and practice. Cultural competence is a major component of the SPF and should be weaved into coalition strategies.

These guiding principles are helpful when thinking about cultural competence:

- Cultural competence is woven through a continuum with several guiding principles that enable coalitions to have positive interactions in culturally diverse environments;
- Each group has unique cultural needs. Your coalition should work to make room for several paths that lead to the same goal;
- People have group identities and personal identities. It is important to treat people as individuals and also acknowledge their group identities;
- People are served in varying degrees by the dominant culture. Coalitions must recognize that what works well for the dominant cultural group may not work for members of other cultural groups; and

High-risk communities should be revealed in needs assessment data and discussed during early planning meetings, incorporating the National CLAS Standards which can be found on the following website: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

The principal standard is to provide effective, equitable, understandable and respectful quality programs and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

The subgrantee shall use a variety of strategies as appropriate for each target group and be prepared to report back to the state on their programs.

Further resources can be found on the SAMHSA website:
https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence

Appendix 10

HOW TO WRITE S.M.A.R.T. OBJECTIVES

(revised from CDC-RFA-DP17-1701)

For BHWP funded partners, program planning includes developing program goals that may span three years or more. Beginning with initial community assessments and continuing the process through planning, implementation and evaluation, a subgrantee's Logic Model will reflect the linear method by which a program will achieve its goals. The problems, root causes, local conditions, and even the goals may remain constant over a three-year period, but the objectives and activities implemented to target the problem may be subject to change based on current indicators.

Objectives are more immediate than goals; they represent mileposts that your program needs to achieve to accomplish its goals by the end of the funding period. Each year, your Scope of Work (or "work plan") should be based on the strategies you have selected to reach your program goals. Because strategies are implemented through objectives and program activities, multiple objectives are generally needed to address a single strategy. Objectives are the basis for monitoring implementation of your strategies and progress toward achieving your program goals. Objectives also help set targets for accountability and are a source for program evaluation questions.

Writing SMART Objectives

To use an objective to monitor your progress, you need to write it as a SMART objective. A SMART objective is:

1. **Specific**

   Objectives should provide the "who" and "what" of program activities.

   Use only one action verb, because objectives with more than one verb imply that more than one activity or behavior is being measured.

   Avoid verbs that may have vague meanings to describe intended outcomes, like "understand" or "know"; it may prove difficult to measure understanding and knowledge. Instead, use verbs that document action, like "At the end of the session, the participants will list three concerns…"

   Remember, the greater the specificity, the greater the measurability.

2. **Measurable**

   Objectives should quantify the amount of change expected. It is impossible to determine whether objectives have been met unless they can be measured.

The objective provides a reference point from which a change in the target population can be measured clearly.

3. Achievable

Objectives should be attainable within a given time frame (one year) and with available program resources.

4. Realistic

Objectives are most useful then they accurately address the scope of the problem and programmatic steps that can be implemented within a specific time frame.

Objectives that do not directly relate to the program goal will not help achieve the goal.

5. Time-Limited

Objectives should provide a time frame indicating when the objective will be measured, or a time by which the objective will be met. Using the end of the grant to complete all activities should be avoided as the purpose is to show a realistic progression towards achieving the outcome objective. Including a time frame in the objectives helps in planning and evaluating the program.

Examples of SMART Objectives

Non-SMART objective 1: Schools will be trained on the selected evidence-based LifeSkills prevention curriculum.

- This objective is not SMART because it is not *specific, measurable, or time-phased.* It can be made SMART by *specifically* indicating who is responsible for training the schools, how many people will be trained, who they are, and by when the training will be conducted.

SMART objective 1: By year two of the project, the Nevada Schools Coalition will have a statistically significant increase in the knowledge of staff **of elementary schools in districts 1, 3, and 6** on prevention of violent behaviors, substance and tobacco use.

- Training people on the LifeSkills curriculum is an activity or process. Increasing their knowledge is an outcome or SMART Objective as it measures a magnitude of change and answers more than did we train x number of people. This can be evaluated through pre-post tests.

Non-SMART objective 2: 90% of parents will participate in a parenting course.

- This objective is not SMART because it is not *specific or time-phased.* It can be made SMART by *specifically* indicating who will do the activity, by when, and who will participate in the parenting course.

SMART objective 2: By the end of the calendar year, C.I.R.C.L.E.S. will have enrolled 90% of **Hispanic parents of preteens and teens currently enrolled in city middle and high schools** in the evidence-based, **Parenting Wisely curriculum in Spanish.**

Appendix 11

OUTCOME OBJECTIVES WORKSHEET

Outcome Objective Development Worksheet:

This worksheet can assist you in writing outcome objectives for your project. For your review, we have provided a sample outcome, broken down into simple components. You can use this template by filling in outcome information in the spaces provided for your program. Then, below each table, write your outcome objective using the components identified. Please keep all objectives Simple, Measurable, Achievable, Realistic, and Time limited. This worksheet is presented for your planning use. Do not include it with your proposal.

Sample outcome objective components

Who **(or what)**	**What** **(desired effect)**	**How** **(expected results)**	**When** **(by when)**
The person, place or thing in which the objective will cause some change. **Example:** The number of pregnant women receiving substance abuse treatment.	This should illustrate some change in either a positive or negative direction, i.e. increase or decrease. **Example:** will increase	This should depict the magnitude of the desired change, i.e. a change in percentage, a change in raw numbers, or a statistical measure. Be as specific as possible and make sure it is realistic. **Example:** By 10% from the previous year October 1, 2015 to September 30 2016	This depicts the target date for the objective to be achieved. Don't confuse this with deadlines for activities. This should be your final deadline for the objective. **Example:** by September 30, 2017

Sample outcome objective: By September 30, 2019, the number of pregnant women receiving substance abuse treatment will increase by 10% from the previous year - October 1, 2017 to September 30, 2018.

Who	What	How	When
Final outcome objective:			

Outcome #1
Objective components
Outcome #2
Objective components

Who	What	How	When
Final outcome objective:			

CSAP PREVENTION SERVICE CODES

Service Title	CSAP Code	Strategy	Preferred Entity	Description
1. Alcohol, tobacco and other drug-free activities	STA01	Alternative Activities	Service Provider or Coalition	Social and recreational activities for youth and adults that specifically exclude the use of alcohol, tobacco, and other drugs, e.g., Project Graduation, PromPromise, events done as part of annual special campaigns, Red Ribboon Campaign, Drunka nd Drugged Driving Awareness Week, National Family Month, etc. and locally initiated events
2. Coalition Building	STC05C	Community Process	Coalition	Activities to build the membership of a coalition or build the capacity of that membership to conduct the steps of the Strategic Prevention Framework: Assessment, Coalition Building, Strategic Planning, and Progress monitoring
3. Coalition Coordination	STC05D	Community Process	Coalition	Basic organizational activities to assure a sustained coalition effort, e.g., meeting coordination, record keeping, communication, etc.
4. Coalition Participation	STC04	Community Process	Service Provider	Service provider participation in coalition meeetings and other events; non leadership participation
5. Coalition Support: Community Awareness	STC05A	Community Process	Service Provider	Activities conducted by service provider staff in support of a coalition sponsored community awareness initiiative, e.g., activities related to a media campaign, development of presentation material, etc.,
6. Coalition Support: Needs & Resource Assessment	STC02	Community Process	Service Provider	Activitities conducted by service provider staff in support of a coalition needs assessment and resource assessmentc e.g., data gathering, report writing, data analysis, etc.

CSAP PREVENTION SERVICE CODES

Service Title	CSAP Code	Strategy	Preferred Entity	Description
7. Coalition Support: Environmental Strategies	STV01A	Community Process	Service Provider	Activities conducted by provider staff in support of a coalition-driven environmental initiative, e.g., representing (not just attending) public policy making meetings, developing materials, making presentations on behalf of the coalition.
8. Coalition Support: Strategic Planning	STC10	Community Process	Service Provider	Activities conducted by provider staff in support of community strategic planning for substance abuse prevention, e.g., participating in meetings, plan writing, etc.
9. Community needs assessment	STC02B	Community Process	Coalition	Activities related to developing a written understanding of the substance abuse prevalence and related risk and protective factor profile of the local community.
10. Community resource assessment	STC01	Community Process	Coalition	Activities related to developing a written understanding of the prevention resources of a community.
11. Community resource directory development & maintenance	STN09	Information Dissemination	Coalition	Activities related to the development and updating of a community directory of substance abuse- and other behavioral health-related resources
12. Community resource dissemination	STN15	Information Dissemination	Coalition or Service provider (in the absence of a coalition)	Activities related to the effective dissemination of a community directory.

CSAP PREVENTION SERVICE CODES

Service Title	CSAP Code	Strategy	Preferred Entity	Description
13. Community-wide Awareness	STN16	Information Dissemination	Coalition or Service provider (in the absence of a coalition)	Activities directed to the community at large or other large community subgroups and across multiple sectors – this activity is not classroom drug education – and is mostly the conveyance of information about the community drug problem, the community risk and protective factor profile, community norm information about priority prevalence or risk or protective factor issues, community resources, the coalition's strategic plan, and progress being made toward strategic goals.
14. Consultation on organizational environmental strategies	STV01B	Environmental Strategies	Service Provider or Coalition	Activities that provide guidance to a community group or coalition to maximize the development of and/or enforcement of healthy substance abuse norms and standards.
15. Children of Substance Abusers (COSA) Groups	STE01	Education & Training	Service Provider	Substance abuse prevention educational services targeted to youth and adults who are children of substance abusers.
16. Drug Education - Schools	STE02	Education & Training	Service Provider	Substance abuse prevention education presentations to youth in school settings.
17. Drug Education - Youth Groups	STE03S	Education & Training	Service Provider	Substance abuse prevention education presentations to groups of youth in non-school settings.
18. Employee Assistance	STP01	Problem ID & Referral	Service Provider	Activities intended to provide information to individuals experiencing substance abuse-related problems that are interfering with work performance, e.g., workplace prevention education, risk reduction education, health education and promotion, supervisor training, screening and referral.

CSAP PREVENTION SERVICE CODES

Service Title	CSAP Code	Strategy	Preferred Entity	Description
19. Environmental Strategies related to underage alcohol sales prvention	STV03	Environmental Strategies	Coalition or Service provider (in the absence of a coalition)	Activities intended to prevent the sale of alcoholic beverages to minors, to track activities such as the placement of legally required signs in bars, restaurants, stores, or other establishments regarding the dangers of alcohol use, or efforts to educate retailers and law enforcement personnel about these issues, e.g., retail outlet server and management education, working with Division of Alcoholic Beverage and Tobacco field agents to monitor underage sales, etc.
20. Environmental strategies related to illegal drug abuse prevention	STV01C	Environmental Strategies	Coalition or Service provider (in the absence of a coalition)	Activities intended to prevent the use and trafficking of illegal drugs, e.g., working with local law enforcement and neighborhoods to establish neighborhood watch programs, making drug trafficking an enforcement priority, establishing a drug court, etc.
21. Environmental strategies related to prescriptio or OTC drug abuse prevention	STV01D	Environmental Strategies	Coalition or Service provider (in the absence of a coalition)	Activities intended to prevent illicit use of prescription and OTC drugs, e.g., physician education, pharmacist education, law enforcement education, support of laws and policies to assure adequate control over the distribution of these drugs, etc.
22. Environmental strategies related to tobacco sales prevention	STV02	Environmental Strategies	Coalition or Service provider (in the absence of a coalition)	Activities intended to prevent the sale of tobacco products to minors, to track activities such as the placement of legally required signs in bars, restaurants, stores, or other establishments regarding the dangers of tobacco use, or efforts to educate retailers and law enforcement personnel about these issues, e.g., retail outlet cashier and management education, working with Division of Alcoholic Beverage and Tobacco field agents to monitor underage sales, etc.
23. Health Promotion	STN03	Information Dissemination	Service Provider or Coalition	These activities address the indirectly ATOD related risk and protective factors in a community, e.g., promoting good nutrition, healthy relationships, stress reduction, displays at community events, etc.
24. Mentoring	STE06M	Education & Training	Service Provider	An older or more skilled person provides guidance to a younger or less skilled person for the purpose of reducing risk for substance abuse and strengthening protective factors.

CSAP PREVENTION SERVICE CODES

Service Title	CSAP Code	Strategy	Preferred Entity	Description
25. Newsletter development	STN07	Information Dissemination	Coalition or Service Provider	Gathering information, formatting and producing an organizational newsletter.
26. Newsletter dissemination	STN13	Information Dissemination	Service Provider	Activities related to the distribution of an organizational newsletter.
27. Parenting/Family Support	STE04S	Education & Training	Service Provider	Structured activities intended to assist parents and families in addressing family domain risk factors and protective factors, and learning about the effects of substance abuse on individuals and families.
28. Peer leader activities	STE05S	Education & Training	Service Provider	Structured prevention activities that use people of a similar rank or standing (peers) to provide guidance, support, and other risk reduction activities.
29. Peer leading training	STE05S	Education & Training	Service Provider or Coalition	Activities intended to prepare peer leaders to conduct peer leader activities, including training and supervised practice experiences.
30. Prevention assessment & referral	STP06	Problem ID & Referral	Service Provider	Activities intended to provide a risk screening assessment and referral to prevention services or further social/treatment service assessment.
31. Prevention media message development	STN08	Information Dissemination	Service Provider or Coalition	Activities related to the development of a media message or campaign, the message is usually less than five minutes long, e.g., television and radio Public Service Announcements, no-cost newspaper ads, billboard ads, theater slide shows.

CSAP PREVENTION SERVICE CODES

Service Title	CSAP Code	Strategy	Preferred Entity	Description
32. Disseminating electronic media	STN14	Information Dissemination	Coalition or Service Provider	Activities related to the appearance of the media messages in the community.
33. Prevention Information Clearinghouse	STN01	Information Dissemination	Service Provider or Coalition	Activities related to a central repository and dissemination point for current, factual, and culturally competent written and audiovisual information and materials regarding substance use and abuse.
34. Prevention print material	STN05	Information Dissemination	Service Provider or Coalition	Activities related to the design and production of written materials to inform community members about the effects of substance abuse and local provider and/or coalition activities, e.g., brochures, flyers, fact sheets, posters, pamphlets, etc.
35. Disseminating print material	STN11	Information Dissemination	Coalition or Service Provider	Activities for the purpose of distributing printed substance abuse prevention materials.
36. Prevention Technical Assistance	STC08	Education & Training	Service Provider or Coalition	Activities intended to strengthen an organization's or individual preventionist's capabilities and skills for providing high quality prevention services, including assistance on understanding prevention, program evaluation, program planning, data interpretation, etc.
37. Prevention Training	STC06	Education & Training	Service Provider or Coalition	Activities that present information or develop skills related to improving the readiness of the local community to support substance abuse prevention or to improve the quality of the local substance abuse prevention workforce.
38. Prevention Policy Development	STV06	Environmental Strategies	Coalition (for community-wide & single-sector policies) Service Provider (for single sector policies, e.g., a school or school district)	Activities intended to change public and organizational policy about ATOD use/abuse, e.g., changing local and state environmental codes, ordinances, regulations and legislation and organizational policies and procedures. Examples of targets for public policy efforts: law enforcement priorities, access to alcohol or tobacco products by minors, zoning ordinances to reduce the number of retail alcohol distributors, drug-free school zones, workplace policy

CSAP PREVENTION SERVICE CODES

Service Title	CSAP Code	Strategy	Preferred Entity	Description
39. Recreation Support	STA07A	Alternative Activities	Service Provider	This allows provider staff to participate in the planning and conduct of recreational activities that are part of a local effort that has a stated goal to prevent alcohol and other drug use.
40. Service Learning	STA06	Alternative Activities	Service Provider or Coalition	These activities are a coordinated effort to link learning and community service, i.e., participants learn about the issues related to a community need and then apply that learning and their general intellectual and physical skills into planning and conducting a community service project.
41. Speaking Engagements	STN17	Information Dissemination	Service Provider or Coalition	Community awareness on local risk and protective factors Community awareness on local prevention resources Community awareness on local prevention services gaps Community awareness on local prevention accomplishments Community awareness of local drug problems.
42. Strategic Planning	STC10B	Community Process	Coalition	This includes 1) needs assessment for a defined community: neighborhood, municipality, county, DCF district and 2) facilitation of a planning process based on the results of the needs assessment.
43. Student Assistance	STP03	Problem ID & Referral	Service Provider	Activities conducted in cooperation with a school to assist students with personal problems that are detrimentally affecting school performance and making appropriate referrals.
44. Support Group	STE06A	Education & Training	Service Provider	Open group activities, i.e., a participant may join or leave the group at any time, for participants who do not need substance abuse treatment and generally have not participated in substance abuse treatment (this is not a relapse prevention activity), that address issues that threaten a substance abuse-free lifestyle.
45. Telephone Information Service	STN18	Problem ID & Referral	Service Provider	Activities for responding to telephone inquiries to identify an individual's substance abuse prevention issues that cannot be adequately addressed by the provider's prevention programs or services and to make appropriate referrals for other services.

CSAP PREVENTION SERVICE CODES

Service Title	CSAP Code	Strategy	Preferred Entity	Description
46. Training Curriculum Development	STN06	Education & Training	Service Provider	This activity is the development of training curriculum and materials on substance abuse prevention related topics. The training topics should be related to the prevention needs of the community.
47. Tutoring	STA07B	Alternative Activities	Service Provider	This activity needs to be a part of a local effort that has a stated purpose or goal of reducing substance abuse. It includes the coordination of tutors, training of tutors, supervision of tutors, and direct tutoring.
48. Volunteer Coordination	STC03	Community Process	Service Provider	This activity allows staff to coordinate, train, and supervise volunteers who are conducting substance abuse prevention activities.
49. Youth Group Support	STA07C	Alternative Activities	Service Provider	This activity allows staff to assist local youth groups, e.g., faith-based groups, clubs, scouts, etc., in planning and conducting substance abuse prevention activities.
50. Other prevention activities/services: Prevention Counseling	STE06P	Problem ID & Referral	Service Provider	Activities conducted with individuals seeking guidance for remaining drug free for the purpose of determining the extent of the presenting problem, giving guidance, and, if necessary, making a referral to a prevention program or other appropriate service; usually no more than three sessions; this is not a service for a person who needs substance abuse treatment; this service is not drug treatment screening.
51. Other prevention activities/services	STC05B	Community Process	Coalition	Activities that recognize the contribution of local individuals and groups to the prevention of substance abuse.

APPENDIX II

SCOPE OF WORK INSTRUCTIONS

INSTRUCTIONS

EXAMPLE SCOPE OF WORK

APRIL 5, 2017

BEHAVIORAL HEALTH, WELLNESS AND PREVENTION
DIVISION OF PUBLIC & BEHAVIORAL HEALTH
STATE OF NEVADA

Cover Sheet Instructions: Please us the attached cover sheet template.

BACK

1. **Coalition Name:** Please fill in your organizations name.
2. Contact Name and Title: Please provide the name and title for the primary contact for this project. This is the individual to be contacted if Bureau staff have any questions.
3. Contact Phone: Please provide a valid phone number for the person listed in two above.
4. Contact email: Please provide a valid email address for the person listed in two above.
5. Physical Address: Please provide the current address of your organization. Please include the street number, street name, City, and zip code.
6. Mailing address: Please provide the mailing address for your organization. If the mailing address is the same as your physical address, just indicate "Same address."
7. EIN: Please provide your Employer Identification Number as issued by the IRS.
8. Vendor#: Please provide your State of Nevada assigned vendor number. If you do not have a current State of Nevada vendor number, please contact the Nevada State Purchasing Division to request one (http://purchasing.nv.gov/Vendors/Registration.)
9. DUN & Bradstreet: Please provide your 9 digit Data Universal Number.
10. Attachments Checklist: Please mark all attachments that are included with your proposal. (All listed attachments are required.)

Example Cover Sheet:

COALITION NAME:

CONTACT NAME AND TITLE:

CONTACT PHONE (including extension):

CONTACT EMAIL:

PHYSICAL ADDRESS (City, State, Zip):

MAILING ADDRESS IF DIFFERENT:

EIN:

VENDOR #:

DUN & BRADSTREET:

ATTACHMENTS CHECKLIST:

- ☐ **SOW for SFY 19 (Including the Outcomes and Objectives worksheet)**
- ☐ **Budget for SFY 19**
- ☐ **Logic Model for SFY 19**

Section B – Scope of Work Instructions
State of Nevada, Division of Public & Behavioral Health
SUBSTANCE ABUSE BLOCK GRANT – PRIMARY PREVENTION SET-ASIDE
Coalition: Please fill in your name here
HD#

Scope of Work Instructions:

Please use the attached Scope of Work Template (not the example template).

1. **Coalition/ Provider Name:** Please fill in the name of your organization.
   Example: Second Chances, Inc.,

2. **HD #:** The 5-digit HD (Health Division number). Please leave this space blank. Number will be filled in by state staff.

3. **Purpose/Title -** Please fill in the purpose or title (project name) and then a brief description.
   Example: Purpose: To implement a community-based intervention that is designed to prevent, delay & reduce high-risk and underage alcohol use.

4. **Brief Description of program** - Please provide a short description of the program/ project.
   Example: This is a comprehensive community-based primary prevention plan for reducing high-risk and underage alcohol use in a community. This plan is 1) focused on primary prevention, 2) community-based, and 3) comprehensive. The objectives in this plan will help achieve the goal of reducing high-risk and underage drinking & is designed to flow logically.

5. **Problem Statement:** Briefly describe the problem or the gap that is being addressed through this scope of work. This should correspond to your CCPP assessment.
   Example: High-risk alcohol use, including underage use, causes numerous public health and public safety problems in Washoe County.

6. **State Priority Number(s):** Please indicate which state priority you are addressing. There may be one to multiple goals per each priority area.

Example: Priority 10 – Prevent the onset of childhood and underage drinking and other drug use, reduce the progression of substance abuse, including prescription drugs used illicitly and marijuana; prevent the relapse of substance abuse of those in recovery.

7. **Goal:** Description of a broad goal. The Goal does not need to be measurable e.g. improve the health of women, reduce IVDU, etc. The goal is the broadly stated purpose of the program. A goal may be stated as reducing a specific behavioral health problem or as improving health & thriving in some particular way. It should be a very broad result that you are looking to achieve. The goal does not need to be measurable. Goals can be one or many. However, each goal must have its own Outcome Objectives and Activities and may include the target population to be served.
   Example: To reduce high-risk and underage alcohol use, among 12 – 20 year olds, in Washoe County.

8. **Outcome Objective 1: (S.M.A.R.T.)** Please enter a description of measurable Outcome Objective which are Specific, Measurable, Achievable, Realistic, Time limited. Outcome objectives are specific statements describing the strategies you will employ, the subrecipients you will fund, the **evidence-based programs** you hope to accomplish which must be measurable and should include:
   - Who: Target population
   - What: Strategies and Evidence based programs utilized to effect change
   - Where: Area
   - When: By when will the change occur
   - How much: Measurable quantity of change
     Example: By March 30, 2018, decrease social youth access to alcohol use in Washoe County by 10% as compared to the baseline number established in 2016. OR By 2018, reduce the overall number of DUI crashes in Washoe County by 10%, as compared to the baseline number established in 2016. (The number of DUI crashes in 2016 is taken as the baseline on which measurements are based.)

   Outcome Objectives can be Qualitative or Quantifiable:
   Example: Qualitative: To reduce the reported access to alcohol by youth at public events in Washoe County by 2018
   Example: Quantifiable: To reduce the number of establishments offering a Happy Hour in Washoe County by 60% by 2018.
   Refer to Outcome Objectives Worksheet for further guidance.
   There may be several objectives under one goal.

9. **Percent Funding:** Please enter the estimated percent of the budget allocated to this objective. Total sum of the percentages allocated to the following budget categories - Personnel, Travel, Equipment, Operating, Consultant/Contracts, Training and Other - should equal 100%.

   Example: 5% (For this particular Outcome Objective)

10. **Activities:** List the steps planned to achieve the stated Outcome Objective.

    Example:
    1. Provide information about why adults should not provide alcohol to youth.
    2. Institute social host ordinances.
    3. Publicize the consequences for adults who provide alcohol to youth.
    4. Work with law enforcement, prosecutors and the judiciary to enforce the consequences.
    5. Institute keg registration.
    6. Collect information about sources of alcohol when charging youth with alcohol-related offense.

11. **CSAP Code:** Please indicate the code or codes which describe the services, strategies and descriptions of your activities.

12. **Date due by:** Please indicate the expected date by which the activity will be accomplished. The end of the grant period may suffice in some cases, but using the end of the grant to complete all activities should be avoided as activities should show progression towards achieving the objective. Please make these realistic dates that show a progression towards achieving the outcome objective.

    Example: December 30, 2018.

13. **Documentation:** please list any documentation or process evaluation documents that will be produced to track the completion of the activities.

Example:

1. Copies of flyers, ads & newspaper articles, social media & TV ads used in this effort.
2. Informational brochures on laws that impose liability against individuals (social hosts) responsible for underage drinking. Documentation of efforts to increase public awareness of this issue.
3. Informational brochures, TV & radio ads, newspaper articles
4. Meeting minutes, memoranda of understanding, records of efforts to influence public opinion.
5. Meeting minutes with stakeholders, public workshops, small business impact questionnaires, records of efforts to raise public awareness & influence public opinion relating to Keg registration, which is a tool to identify and punish adults who buy beer kegs for underage youth.
6. Records of interviews, surveys, reports, focus groups, local law enforcement data

14. **Evaluation:** please explain how you will evaluate if you have met your objectives or not. The evaluation plan should clearly explain what data will be used, where and how you will collect the data, and any analysis, e.g. simple rate comparison, statistical tests of significance, etc. If you are using an evidence bases program, many times the evaluation criteria is provided and should be used to preserve fidelity with the evidence based methods.

Example:

Evaluation: Data will be collected on how youth obtain alcohol through compliance check surveys and will be examined and compared to the baseline collected in 2014 to determine if there is the desired 10% decrease in youth social access to alcohol. Law enforcement and anecdotal reports of parents and other adults providing alcohol to youth will be examined and compared to the baseline to assess the impact.

BACK

References:
1. A Community-based Primary Prevention Plan to Reduce High-Risk and Underage Alcohol Use http://www.health.state.mn.us/divs/hpcd/chp/cdrr/alcohol/alcpdf/communitypreventionplanreducealcohol.pdf
2. Creating Goals & Objectives for CAST – CAST Evaluation Team Webinar: *ncweb.pire.org/scdocuments/documents/**CAST_GoalsObjectives_Webinar**.ppt*

EXAMPLE SCOPE OF WORK:

BACK

Coalition/Provider Name: Second Chances, Inc.
Grant Name: State Substance Abuse Primary Prevention (SAPP)
HD #: To be assigned – please leave blank.

Purpose/ Title: To implement a community-based intervention that is designed to prevent, delay & reduce high-risk and underage alcohol use.
Brief Description of program: This is a comprehensive community-based primary prevention plan for reducing high-risk and underage alcohol use in a community. This plan is 1) focused on primary prevention, 2) community-based, and 3) comprehensive. The objectives in this plan will help achieve the goal of reducing high-risk and underage drinking & is designed to flow logically. There are strategies/activities/tasks; short-term, intermediate, and long-term outcomes; and methods for measuring outcomes for each of the twelve objectives
Problem Statement: High-risk alcohol use, including underage use, causes numerous public health and public safety problems in Washoe County.

State Priority: 12 Environmental strategy to reduce underage drinking.

Goal 1: Reduce high-risk and underage alcohol use and the problems associated with it in Washoe County.

Outcome Objective 1a: By May 30, 2018, reduce commercial youth access to alcohol by 10% as compared to the baseline established in 2016. Second Chances Inc. will work with Mothers Against Underage Drinking to present "Check IDs", an EBP, to all liquor merchants in the county.		**Percent Funding:**	25 %
Activities	**Date due by**	**Documentation**	
1. Build relationships with merchants, law enforcement, prosecutors, the judiciary and local decision-makers to stop commercial access to alcohol by youth.	2/28/2018	Before/After Survey results, Meeting minutes, records of workshops , records of liaison efforts	
2. Work with merchants to implement beverage server training	3/10/2018	Training records, memorandum of understanding	

3. **Work with local decision-makers and law enforcement to institute compliance checks and administrative penalties.**	3/15/2018	Meeting minutes, opinion surveys, newspaper articles to influence public opinion, local law enforcement records, any memoranda of understanding
4. **Publicize compliance check results.**	3/30/2018	Copies of flyers, public service announcements, advertisements on radio, tv & social media
5. **Work with local decision-makers to prohibit alcohol service and sales to 18-20 year-olds and youth nights in bars and ban home delivery of alcohol.**	5/30/2018	Meeting minutes, progress notes, workshops
6. **Work with prosecutors, the judiciary, local decision-makers and law enforcement to enforce penalties for selling to youth and for youth who use false identification.**	5/30/2018	Meeting minutes, public opinion surveys, Small Business Impact Questionnaires, Public Workshops to assess impact
7. **Support an increase in alcohol excise taxes.**	5/30/2018	Flyers, Radio & TV ads, public service announcements, social media
Evaluation: **The coalition will track policies implemented in the community/state to reduce commercial alcohol sales to youth. Compliance check data will be collected and regularly publicized. Data on how youth obtain alcohol will be examined. Data will be examined to determine the effects of raising the price of alcohol through an excise tax. If necessary, surveys of youth will be conducted. Commercial youth access to alcohol will be compared to the baseline established in 2016.**		

Outcome Objective 1b: **By March 30, 2018, reduce social youth access to alcohol by 10% as compared to the baseline established in 2016. Second Chances Inc. will work with Mothers Against Underage Drinking to present "What Were You Thinking?" an EBP, to parents of high school students in Washoe County.**	**Percent Funding:**	25 %
Activities	**Date due by**	**Documentation**
7. **Provide information about why adults should not provide alcohol to youth.**	3/30/2018	Copies of flyers, ads & newspaper articles, social media & TV ads used in this effort.

8. **Institute social host ordinances.**	3/30/2018	Informational brochures on laws that impose liability against individuals (social hosts) responsible for underage drinking. Documentation of efforts to increase public awareness of this issue.
9. **Publicize the consequences for adults who provide alcohol to youth.**	3/30/2018	Informational brochures, TV & radio ads, newspaper articles
10. **Work with law enforcement, prosecutors and the judiciary to enforce the consequences.**	3/30/2018	Meeting minutes, memoranda of understanding, records of efforts to influence public opinion.
11. **Institute keg registration.**	3/30/2018	Meeting minutes with stakeholders, public workshops, small business impact questionnaires, records of efforts to raise public awareness & influence public opinion relating to Keg registration, which is a tool to identify and punish adults who buy beer kegs for underage youth.
12. **Collect information about sources of alcohol when charging youth with alcohol-related offenses.**	3/30/2018	Records of interviews, surveys, reports, focus groups, local law enforcement data
Evaluation: : Data on how youth obtain alcohol will be examined and compared to the baseline to see if there is the desired 10% decrease in youth social access to alcohol. Law enforcement and anecdotal reports of parents and other adults providing alcohol to youth will be examined and compared to the baseline to assess the impact.		

Outcome 1c: By August 30, 2018, reduce the acceptability of underage youth alcohol use by 10% as compared to the baseline established in 2016.		**Percent Funding:**	20 %
Activities	**Date due by**	**Documentation**	

1. **Work with law enforcement, prosecutors, the judiciary, decision-makers, school administrations, Park and Recreation Departments, employers, faith community leaders, and parents to enforce policies regarding youth use.**	8/31/2018	[Meeting minutes, written policies, memoranda of understanding, records of efforts to influence public opinion.]
2. **Promote zero tolerance of underage use.**	8/31/2018	Informational brochures, TV & radio ads, social media & newspaper articles
3. **Enforce school, community and organization policies.**	8/31/2018	Written policies, meeting minutes, memorandum of understanding
4. **Institute a media plan about the dangers of youth use.**	8/31/2018	Workshops, meeting minutes, written policies
5. **Assure that evidence-based school curricula are being implemented.**		Curricula
6. **Assure that effective parenting skills are being taught.**	8/31/2018	Informational brochures, public service announcements, TV & radio ads, social media & newspaper articles
Evaluation: Long-Term: A community opinion survey will evaluate the attitudes of adults concerning the acceptance of youth alcohol use. The survey will be compared with a baseline survey completed in 2016, and the variables will be analyzed using a two tailed student t-test to assess any significant differences.		

Outcome 1d: By May 30, 2018, improve alcohol use role modeling by adults in the community and in the media by 5% as compared to the baseline in 2016.	**Percent Funding:**	20 %
Activities	**Date due by**	**Documentation**

1. Institute a communication plan about adult role modeling.	5/31/2018	Written policies, meeting minutes
2. Institute "no use" chaperone policies for school and youth activities.	5/31/2018	Written policy, Records of signed Chaperone "No use" Policy & agreement
3. Institute policies prohibiting or restricting alcohol use in public areas and at community events.	5/31/2018	Written policy, informational brochures, agreements
4. Raise awareness about how alcohol is promoted and portrayed in the media and in the community.	5/31/2018	Written policy, informational brochures, articles & ads on TV, radio & social media.
Evaluation: A pre & post surveys will be used to determine if there is any change in the number of adults who understand how their alcohol use role modeling impacts youth as compared to a baseline survey conducted in 2016. In addition, community events will be observed and documented to see if they are either alcohol-free or have adults-only areas where alcohol can be consumed. Police and anecdotal neighborhood reports of community events will be examined for alcohol-related problems and compared to the baseline established in 2016.		

References:
1. A Community-based Primary Prevention Plan to Reduce High-Risk and Underage Alcohol Use http://www.health.state.mn.us/divs/hpcd/chp/cdrr/alcohol/alcpdf/communitypreventionplanreducealcohol.pdf
2. Creating Goals & Objectives for CAST – CAST Evaluation Team Webinar: *ncweb.pire.org/scdocuments/documents/**CAST_GoalsObjectives_Webinar**.p*

Appendix 14

BUDGET INSTRUCTIONS

Budget Development Instructions:
The following budget development instructions and budget example have been prepared to help you develop a complete and clear budget to ensure delays in processing awards are minimized.

Funding Details and Requirements:
This funding announcement is for the Substance Abuse Primary Prevention Program Project. You will complete an individual scope of work (SOW), budget and budget narrative for each one-year cycle of the project period. All funding is subject to the availability of funding.

Detailed Budget Building Instructions by Line Item:
Budget building is a critical component of the application process. The budget in the application is going to be the budget used for the subgrant. The budget must be error free and developed and documented as described in the instructions.

1. **Under the "Category" section of the line item;** there is nothing to be filled out or completed by the applicant. **Please see the Example Budget for reference**

2. **Under the "Total Cost" section of the line item;** the total cost identified should represent the sum of all costs represented in the "Detailed Cost" section associated to the line item. **Please see the Example Budget for reference**

3. **Under the "Detailed Cost" section of the line item**; the detailed costs identified should represent the sum of all costs represented in the "Details of expected expenses" section associated to the line item. **Please see the Example Budget for reference**

4. **Under the "Details of Expected Expenses" section of the line item;** the details of expected expenses identified here should represent the fiscal/mathematical representation of all costs that are outlined in the budget narrative. The expenses should represent a projection of the expenses that will be charged to the subgrant that directly support the work necessary to complete the tasks that are required to meet the goals and objectives as outlined in the scope of work (SOW) for this subgrant. **Please see the Example Budget for reference.**

Example Budget for reference with instructions below.

Category	Total Cost	Detailed Cost	Details of Expected Expenses
1. Personnel	**$ 77,280**	**Personnel: The costs that are allowed to be included in this budget line item are personnel costs only. This does not include any form of temporary staff, contract employees and/or volunteers.** The following details must be included in the details of expected expenses sections of the line item. 1. The positions title must be included. **NOTE:** Do not put an individual name. 2. The number of staff that will be charged to the grant under a specific position title. **NOTE:** If your organization charges multiple staff that share the same projected allocation of time, then group them together. See Project Coordinators **NOTE:** If your organization charges multiple staff that do not share the same projected allocation of time, then separate them. See Administrative Assistant 3. The total annual salary of the position per year. 4. The percentage of time they will be contributing to the project. 5. The sum total of 1 through 4. 6. The fringe benefits line must be represented as an average percent of the total salaries being charged to the grant. **Example:** \$7,000 + \$22,500 + \$35,000 + \$3,000 + \$1,500 = \$69,000. The average cost of fringe benefits for all staff being charged to the grant is 12%. Fringe benefits are calculated as \$69,000 X 12% (0.12) = \$8,280. **Salaries:** (FTE X Annual Salary X % of Effort = Salary Charged) **Fringe:** (Total Salary Charged X Average Fringe Benefit Rate = Fringe Benefit Cost) **NOTE:** Please see the example below.	
		$ 7,000	Executive Director, 1 X $70,000 per year X 10% = $7,000
		22,500	Project Manager, 1 X $45,000 per year X 50% = $22,500
		35,000	Project Coordinators, 2 X 35,000 per year X 50% = $35,000
		3,000	Administrative Assist, 1 X $15,000 per year X 20% = $3,000
		1,500	Administrative Assist, 1 X $15,000 per year X 10% = $1,500
		8,280	Fringe Benefits equals 12% of total salaries charged - $69,000 X 12% = $8,280

<table>
<tr><th>Category</th><th>Total Cost</th><th colspan="2">Details of Expected Expenses</th></tr>
<tr><td>2. Travel</td><td>$ 8,160</td><td colspan="2">Travel: The costs that are allowed to be included in this budget line item are all travel costs.
The following details must be included in the details of expected expenses sections of the line item. All rates must be reflective of actual GSA approved rates at the time budget development.
1. Mileage should reflect GSA approved rate and total projected miles to be driven.
2. A brief description of the trip.
3. The destination of the trip.
4. The number of staff that will be traveling.
5. An estimated trip cost per staff traveling.
6. The projected trip total.
Mileage: (GSA Rate X Number of Miles = Cost)
Trips: (Number of staff X estimated cost per staff X number of trips = Cost)
NOTE: Please see the example below</td></tr>
<tr><td colspan="2"></td><td>$ 1,070

3,000

4,000
90</td><td>Mileage for local meeting and events - $.535 X 2000 miles =$1,070
1 SAMHSA Conference, Washington DC, April 2017, 2 Staff, $1,500 each = $3,000
4 Quarterly Meetings, Statewide, 2 Staff, $500 each = $4,000
1 “Prevention Training” travel only, Reno, 6 staff, $15 each = $90</td></tr>
<tr><td>3. Operating</td><td>$ 7,075</td><td colspan="2">Operating: The costs that are allowed to be included in this budget line item are all operating costs. Operating costs may include but are not limited to; building space, utilities, telephone, postage, printing and copying, publication, desktop/consumable office supplies, drugs, biologicals, certification fees and insurance costs. If applicable, indirect costs are not included in this section. Organizational costs that do not reasonably contribute the accomplishments of project tasks, goals and objectives of the scope of work cannot not be charged to the grant.
The following details must be included in the details of expected expenses sections of the line item.
1. A brief description of the item being charged.
1. The monthly average cost of the item.
2. The number of months that the budget encompasses.
3. If the item of cost is split between funding sources, then include the percentage of split being charged to this grant.
NOTE: if one item of cost is split at 25% then all other items of cost should share the same percent of the split.
Supplies: (Per Month Cost X number of months charged X Rate of Allocation = Cost)
NOTE: Please see the example below</td></tr>
<tr><td colspan="2"></td><td>$ 900

4,500

300

375

1,000</td><td>Office Supplies (paper, pencils, pens, etc.) - $75 per month X 12 months = $900
Rent - $1,500 per month X 12 Months = $18,000 X 25% allocation.
Phone - $100 per month X 12 months = $1,200 X 25% allocation.
E-mail - $125 per month X 12 months = $1,500 X 25% allocation.
1 Computer for the project manager X $1000 per computer</td></tr>
</table>

<table>
<tr><th>Category</th><th>Total Cost</th><th colspan="2">Details of Expected Expenses</th></tr>
<tr><td>4. Equipment</td><td>$ 16,500</td><td colspan="2">Equipment: The costs that are allowed to be included in this budget line item are equipment costs. Per federal regulation; §200.33 Equipment. Equipment means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or $5,000 per unit
The following details must be included in the details of expected expenses sections of the line item.
1. Include a brief description of the item being charged.
2. Include the cost of the item, per unit.
3. Include the number of units that are being purchased.
4. If the item of cost is split between funding sources, then include the percentage of split being charged to this grant.
NOTE: if one item of cost is split at 25% then all other items of cost should share the same percent of the split.
Equipment: (Per Unit Cost X Number of Units = Cost)
NOTE: Please see the example below</td></tr>
<tr><td colspan="2"></td><td>$ 16,500</td><td>Examination Table, $5,500 per unit X 3 units – 16,500 (this is almost never used; most expenditures will fall under Operating costs)</td></tr>
<tr><td>5. Contractual Consultant</td><td>$ 99,575</td><td colspan="2">Contractual: The costs that are allowed to be included in this budget line item are contract costs. List all sub-grants, consultants, contract, personnel/temporary employees and/or vendors that will be procured through a competitive process. (Travel and expenses of consultants and contractor should be incorporated into the contracts and included in this section as a part of the estimate contract cost.)
The following details must be included in the details of expected expenses sections of the line item.
1. Include a brief description of the intended future contract that is being considered.
2. Include the estimated cost of the contract.
3. If applicable, include the cost of and number of deliverables that will be the result of the completed contract.
4. If applicable, include the per hour rate of the contract and the number of hours the project is going to take.
5. For subgrant funding; provide a brief description of the sub-grant project or projects and the total estimated pass-through amount.
NOTE: Do not list the actual names of contractors, consultants, vendors or subgrantees in the budget.
NOTE: Please see the example below</td></tr>
<tr><td colspan="2"></td><td>$ 20,000
4,375
15,200

60,000</td><td>Contract to provide 4 regional prevention training courses; $5,000 X 4 Courses = $20,000
Media consultant - $35 per hour X 125 hours = $4,375
Contract for the development of a community needs assessment = $95.00 per hour X 160 hours - $15,200
Sub-grants for community primary prevention programs = $60,000</td></tr>
</table>

Category	Total Cost	Details of Expected Expenses	
6. Training	**$ 1,650**	**Training: The costs that are allowed to be included in this budget line item are training costs. This line item may include registration fees/conference fees and training costs. This line item can be used to budget for training that will be attended by staff and for the costs of training and educational materials being provided to targeted populations as identified in accordance to the proposed SOW.** The following details must be included in the details of expected expenses sections of the line item. 1. Include a brief description of the intended training cost being considered. 2. Include the estimated cost of the training. 3. If developing educational materials for hosting a training. 4. Include the "per unit" cost and number of units being developed for the training. **NOTE:** Please see the example below	
		$ 500	SAMSHA Conference registration fees, 2 staff X $250 each = $500
		150	Prevention Training registration fees, 6 staff X $25 each = $150
		1,000	Printing cost for education books for addiction prevention seminar = $20 per book X 50 books = $1000
7. Other/Indirect	$ 27,469	**Other/Indirect: The costs that are allowed to be included in this budget line item are indirect costs and if applicable audit costs.** The following details must be included in the details of expected expenses sections of the line item. 1. Include a brief description of the intended cost being considered. 1. For audit costs include the total annual of the audit and the rate of allocation. **NOTE:** the rate of allocation should be the same as the rates of allocation in the operating section. If not, provide a justification as why the rate of allocation is different. 2. If applicable, include the total direct costs being charged for indirect. 3. If applicable, include the federally approved indirect rate total direct costs being charged for indirect. **Audit Cost:** (Annual audit cost X Rate of Allocation = Cost) **Indirect Cost:** (Total Direct Costs being charged X Federally Approved Indirect Rate = Indirect Cost) **NOTE:** Please see the example below	
		$ 2,000	Annual audit cost: $8,000 X 25% = $2,000
		25,469	Indirect Costs: $210,228 X 12% = 25,468.80
Total Cost	$ 237,709		

Note #1: Totals listed must match totals on Cover Page.
Note #2: Indirect Costs: 2 CFR 200.414 allows any non-Federal entity that has never received a negotiated indirect cost rate with an agency of the federal government to charge a de minimis rate of 10% of modified total direct costs, which may be used indefinitely as a Federally-negotiated rate.

Appendix 15

FAQ on ALLOWABLE AND UNALLOWABLE EXPENSES UNDER THE PRIMARY PREVENTION SET-ASIDE (PX) GRANT

Screening, Brief Intervention, Referral to Treatment (SBIRT): All activities regarding testing, screening, brief interventions and referral to treatment are not allowable under the Primary Prevention Set-Aside dollars (SABG-PX). Education on SBIRT is also not allowed.

Naloxone/Narcan: Purchase of naloxone and the necessary materials to assemble overdose kits and to cover the costs associated with the dissemination of such kits are not allowable under the Primary Prevention Set-Aside Funds.

Overdose Prevention Education and Training: if the purpose of the training is to provide hands-on skills for first response, practice on dummies, or demonstration on use of tools to reverse overdose, it is unallowable under the PX grant. The purpose of any education or training must be primary prevention of substance use disorder, consistent with 42 U.S. Code section 300x-22(a) and 45 CFR section 96.125.

Participation in Conferences or Trainings: If the purpose or primary focus of the conference or training is not specific to primary prevention of or education about alcohol, tobacco and other drugs, it is not allowable under this grant. If in doubt, please contact the Agency for approval. The name of the conference selected to attend should be included the scope of work and budget at the of submission for approval. If there is indecision at that time, please notify the Agency via email once plans for out-of-State conference participation have been finalized.

Incentives and Gift Cards: All incentives and rewards must be necessary to meet the programmatic and evaluation goals of the grant. They must be justifiable as a component of an initiative, activity or event. Examples of allowable incentives include movie passes, tee shirts or hats; or coupons for services such as manicures or car washes. Gift cards used for rewards or incentives must have prior approval from BHWP. Gift cards, coupons and incentives are unallowable if they can be turned into cash or used to purchase gas, groceries, alcohol or tobacco products.

Enforcement of alcohol, tobacco or drug laws: Subgrantees may not use primary prevention set-aside subgrant dollars to fund the enforcement of alcohol, tobacco or drug laws, including compensation for law enforcement officials' time. However, resource development or technical assistance to maximize enforcement procedures is allowed.

Also prohibited:

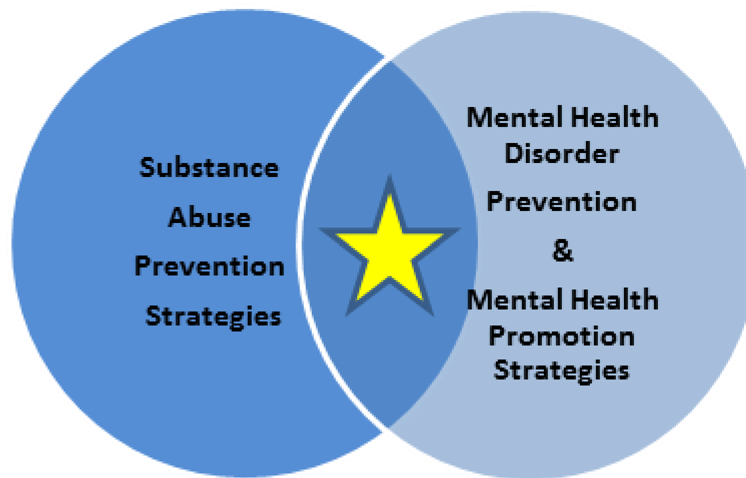
- Provide inpatient hospital services, except in specific circumstances outlined in the regulation;
- Make cash payments to intended recipients of health services. (This includes gift cards used as an incentive for participation in activities);
- Purchase or improve land;
- Purchase, construct or permanently improve a building (other than minor re-modeling);
- Purchase major medical equipment;
- Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
- Provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (unless the Surgeon general of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with HIV/AIDS); or
- Provide financial assistance to any entity other than a public or nonprofit private entity. This means that if the grantee provides sub-grants to community-based or intermediary organizations, these organizations cannot be for-profit entities.
- Savings accounts for excess or unspent funds
- Submission of reimbursement requests prior to expense of funds

Can primary prevention set-aside funds be used to fund mental health promotion or mental disorder prevention strategies?

Primary prevention set-aside funds can only be used to fund strategies that are intended to prevent substance use disorder. However, we know that many strategies that prevent substance use disorder also positively impact mental health because they target risk and protective factors that are common to both issues.

Specifically, substance use disorder and mental illness share many of the same modifiable risk and protective factors. For example, poor academic achievement and a family history of substance use disorders are risk factors for both substance abuse and mental health problems. Similarly, parental support and bonding and participation in social activities are protective factors for both substance abuse and mental health problems. This means that strategies that target those risk and protective factors would be expected to reduce both substance use disorder and mental health problems.

If you imagine two overlapping circles (see below), with one circle being substance use disorder prevention strategies and one being mental health promotion and mental disorder prevention strategies, the area of overlap is those strategies that target risk and protective factors that are common to both substance use disorder and mental health disorders.



Substance Abuse Mental Health Services Agency (SAMHSA) encourages grantees to fund strategies that address shared risk and protective factors (the star area) AND those that are specific to substance use disorder prevention.

Some examples of strategies that address shared risk and protective factors include:

- School-based substance use disorder prevention education programs that promote positive self-esteem and work to decrease bullying, which are risk factors for both substance use disorder and mental health problems; and
- Parenting and family management classes that increase the ability of parents to bond with their children and discipline effectively, which are protective factors common to both substance use disorder and mental health.

Some examples of strategies that are specific to substance use disorder prevention include:

- Promoting the establishment or review of alcohol, tobacco, and drug use policies in schools
- Guidance and technical assistance on monitoring enforcement governing the availability and distribution of alcohol, tobacco, and other drugs, and
- Modifying alcohol and tobacco advertising practices

Appendix 16

RISK ASSESSMENT CRITERIA

The Division of Health and Human Services is in the process of developing a risk assessment tool that will be used uniformly across the division. It will be made available upon completion. The new tool will be based upon the tool developed by the AGA Partnership for Intergovernmental Management and Accountability which can be accessed online here:
https://www.agacgfm.org/AGA/Intergovernmental/documents/riskassessmentmonitoringtool.pdf

Risk assessment examines a subgrantees compliance with and adherence to the rules and supplements for the program. The standards apply to every level of expenditure of funding from the grant source, regardless of the level of pass through. A part of the risk assessment will include evaluating how thoroughly the subgrantee assesses the level of risk of their subrecipients.

Factors in the assessment of risk include but are not limited to:

1. Verification of eligibility in the federal System for Award Management (SAM)
2. Legal history / history of potential risk areas / audit reports/ previous high-risk assessment
3. Primary Prevention Grant Experience
4. Effective internal controls and procedures
5. Organized record keeping and retention
6. Staff turnover/reorganization
7. Subrecipient monitoring and assessment
8. Current, accurate and comprehensive CCPP
9. Data-driven programs consistent with the data indicators in the CCPP
10. Staff training and experience with proposed implementation
11. Timely submissions of:
    a. Changes to required copies of internal documents such as insurance or policies and procedures
    b. Scopes of Work
    c. Budgets
    d. Logic model/CCPP
    e. Amendments to Budget or Scope of Work
    f. Quarterly reporting
    g. Amendments/revisions
    h. Requests for reimbursement
    i. Reporting requirements
12. Accuracy on the above items (or, frequency of errors)
13. Program consistency with Scope of Work/approved goals and objectives
14. Program Planning/ Implementation/Fidelity/Evaluation/data gathering
15. Conformance to federal, state and community priorities of the funding source
16. Capacity and outreach
17. Responsiveness to communication
18. Ability to collaborate with community partners, planning and implementation