

ARKANSAS 2010
STRATEGIC PREVENTION PLAN



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STATE OF ARKANSAS OFFICE OF THE GOVERNOR



To the Citizens of Arkansas:

I am pleased to share with you the updated and expanded Arkansas Strategic Prevention Plan, which addresses substance abuse and other self-destructive behaviors. In addition to providing this informative resource, the State of Arkansas offers free training sessions to community leaders, distributes free informational materials at the community level, promotes environmental change efforts in communities, and gathers and makes instructive data available throughout the State. These basic tools can help communities make improvements in their schools and neighborhoods that will positively influence families and our young people.

To bring about effective long-term change, however, a systems approach is required. Proactive substance-abuse prevention requires a serious investment focused on positive development of our citizens, rather than treatment options only. Because of the limited number of current prevention programs provided, I urge you to work with us to implement the goals and objectives of the Plan.

Thanks to the Strategic Prevention Framework State Incentive Grant (SPF SIG) Advisory Committee and its work groups for their dedicated efforts in developing this important project.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Beebe". The signature is stylized and cursive.

Mike Beebe

STRATEGIC PREVENTION CAPACITY, PARTNERSHIP, AND COLLABORATION

The Governor's SPF SIG Advisory Committee membership provided oversight and support for the development of the Arkansas Strategic Prevention Plan. The members now provide endorsement of the Arkansas Strategic Prevention Plan and commitment to collaborate in the implementation of its elements. The membership is committed to expanding coordination and collaboration among participating agencies and organizations.

The Arkansas Strategic Prevention Plan is designed as a state and local prevention system whereby participating state partners and local stakeholders can coordinate prevention funds and resources. This is based on a common vision and mission and includes an overarching goal, objectives and strategies.



Fran Flener
State Drug Director
Office of the Governor

Appointees and Contributors to the SPF SIG Advisory Committee (Strategic Prevention Framework State Incentive Grant)

- Action for KIDS
- Alcohol Beverage Control (ABC) Enforcement
- Arkansas Association of Chiefs of Police
- Arkansas Association of Substance Abuse Treatment Providers
- Arkansas Collegiate Drug Education Committee
- Arkansas Foundation for Medical Care
- Arkansas Minority Health Commission
- Arkansas National Guard
- Arkansas Prevention Network (APNet)
- Arkansas School Boards Association
- Arkansas State Board of Pharmacy
- Arkansas State Police
- Arkansas State Representative
- Arkansas State Senator
- Attorney General's Office
- Center for Substance Abuse Prevention (CSAP)
- Commission on Child Abuse, Rape, & Domestic Violence
- Department of Community Corrections
- Department of Education
- Office of Alcohol & Drug Abuse Prevention (ADAP), Division of Behavioral Health Services (DBHS) Department of Human Services (DHS)
- Department of Health
- Division of Volunteerism & Division of Youth Services, DHS
- Mothers Against Drunk Driving (MADD)
- Prevention Resource Centers
- Research Triangle Institute (RTI)
- SPF SIG Advisory Committee Management Team
- Southwest Prevention Center/CSAP's SWCAPT (Center for the Application of Prevention Technologies)
- State Epidemiological Workgroup (SEW)
- Underage Drinking Prevention Task Force
- University of Arkansas, Division of Agriculture, Cooperative Extension Service
- University of Arkansas at Little Rock, Institute for Economic Development
- University of Arkansas at Little Rock, MidSOUTH Prevention Institute
- University of Central Arkansas, Department of Health Sciences
- University of Arkansas for Medical Sciences
- U.S. Drug Enforcement Administration
- Youth Representatives from Mount St. Mary School, Little Rock

INTRODUCTION TO THE ARKANSAS STRATEGIC PREVENTION FRAMEWORK

The state of Arkansas established the Strategic Prevention Framework State Incentive Grant (SPF SIG) Advisory Committee consisting of representatives from the Governor's Office and approximately 30 state agencies and other stakeholders in prevention. The Committee's goal is to provide recommendations to the Governor for an updated and expanded "Arkansas Strategic Prevention Plan" that enhances Arkansas' prevention resources. This document was developed with funding from the Office of Alcohol and Drug Abuse Prevention.

The Arkansas Strategic Prevention Plan describes a public health approach that will guide state agencies, schools, community organizations and coalitions, networks, and families in working together to prevent not only children, but all age groups, from engaging in problem behaviors including substance abuse. The Committee used the expertise and knowledge from multiple agencies and organizations as a foundation to work toward a more cohesive and collaborative system that coordinates and maximizes resources to fill gaps in services and address unmet needs.

The Arkansas Strategic Prevention Plan is designed around elements that are part of a major prevention initiative of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). The federal initiative is called the "Strategic Prevention Framework" (SPF), and states are encouraged to use the five strategic elements of the SPF to develop individual state prevention frameworks that will contribute to a national Strategic Prevention Framework.

These elements comprise a strong and viable state prevention system and include:

- **Assessment** of Prevention Needs, Resources, and Readiness
- **Capacity** of State and Communities for Partnership and Collaboration
- **Planning** with a Prevention Mission, Vision, and Theoretical Model
- Selection and **Implementation** of Best Practices that reflect the diversity of the people in the state
- Monitoring and **Evaluation** of the state's prevention efforts

The SPF is also designed to include cultural competency and sustainability. All of these elements will guide state and local organizations to establish partnerships and implement systems to coordinate prevention resources.

The state partners who came together to develop this Arkansas Strategic Prevention Plan acknowledge the challenges associated with developing, implementing, and maintaining such a plan. Such challenges may include competing agendas, priorities, perspectives, limited state resources, and interagency fragmentation of prevention services.

The partners also recognize that the Arkansas Strategic Prevention Plan provides a unique opportunity to advance prevention and coordinate prevention funds and resources. Long-term change will be realized by pursuit of a shared vision and common goals and objectives that improve the well-being of the state's citizens, rather than directly modifying structures and budgets.

There is also a recognition that the State partners may not be able to unanimously subscribe to each strategy proposed for the Arkansas Strategic Prevention Plan. However, the partners are unanimously committed to working within their respective agencies and with other partners to put forth and implement the elements of the Arkansas Strategic Prevention Plan.



DEFINITION OF PREVENTION

—**pre-ven'tion (pri-vent'tion)** *n.* Prevention is a proactive process designed to empower individuals and communities to meet the challenges of life events and transitions throughout the lifespan by creating and reinforcing conditions that promote healthy behaviors and lifestyles.

Prevention begins with the promotion of healthy communities for youth and families. Prevention includes helping individuals to understand that they can have an impact in solving their local problems and setting local norms. Prevention emphasizes collaboration and cooperation, both to conserve limited resources and to build on existing relationships within the community. Community groups need to routinely explore new, creative ways to use existing resources.

Prevention requires multiple processes that involve people in a proactive effort to protect, enhance, and restore the health and well-being of individuals and their communities. It is based on the understanding that there are factors that vary among individuals, age groups, ethnic groups, and risk-level groups and geographic areas.

The overall goal for prevention is the development of healthy, responsible, productive citizens. To meet this goal, tailored prevention services must be made available through a variety of providers and strategies that target diverse groups (Institute of Medicine). Prevention efforts designed for specific populations are:



Universal Direct: Interventions directly serving an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, and parenting class).

Universal Indirect: Interventions supporting population-based programs and strategies that include planned and deliberate goal-oriented practices, procedures, processes, or activities that have identifiable outcomes achieved with a sequence of steps subject to monitoring and modification. Included within this definition are environmental strategies which establish or change written and unwritten community standards, codes, law, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population, one-time or single events (such as a health fair, a school assembly, or the distribution of material), and other activities intended to impact a broad population.

Selected: Activities targeted to individuals or a subgroup of a population whose risk of developing a disorder is significantly higher than average.

Indicated: Activities targeted to individuals identified as having minimal but detectable signs or symptoms foreshadowing disorder, or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.



STRATEGIC PREVENTION PLANNING

Mission

The mission of the developers and endorsers of the *Arkansas Strategic Prevention Plan* is to implement and sustain a statewide prevention framework that enhances the capacity and collaboration of key stakeholders, on both the state and community levels.

Goal, Objectives and Strategies

The *Arkansas Strategic Prevention Plan* will offer new directions with statewide and community-focused activities for addressing prevention across the lifespan. Under each objective, various strategies are identified to guide implementation of the Arkansas Strategic Prevention Plan.

Strategic Prevention Plan Goal

To provide an effective and comprehensive system of prevention services that are sustained, monitored, and evaluated.

The Goal of the *Arkansas Strategic Prevention Plan* will be:

- Implemented with evidence-based* strategies and promising approaches
 - Focused on shared short- and long-range prevention outcomes
 - Endorsed and maintained by key stakeholders
 - Driven by data for state and the community
 - Sensitive to cultural diversity
 - Accessible to all Arkansans

Objective 1: Statewide Leadership

To support the Arkansas Alcohol and Drug Abuse Coordinating Council as the lead authority for prevention in the state.

Strategy 1

Review criteria and provide broad technical assistance on implementation of the Arkansas Strategic Prevention Plan elements to agency and program directors associated with substance abuse.

Strategy 2

Support funding practices based on sound prevention policies and strategies to state agencies that in turn allocate money to support local prevention services.

Strategy 3

Establish and monitor state prevention outcomes and provide guidance to state agencies to reach proposed outcomes.

STRATEGIC PREVENTION PLANNING

Objective 2: State and Community Mobilization

To mobilize state and local commitment, promote readiness, and support leadership for planning and delivery of prevention services.

Strategy 1

Engage diverse prevention providers (i.e., private, non-profit, faith-based, public) to participate in the implementation of the Arkansas Strategic Prevention Plan.

Strategy 2

Increase collaboration among organizations and agencies involved in prevention including, but not limited to, state and local government, elected officials, key stakeholders and the thirteen regional Prevention Resource Centers.

Strategy 3

Design and implement a training and technical assistance system (workforce development) that will increase and enhance skills of providers to administer effective prevention services.

Strategy 4

Maintain a pool of master preventionists available to deliver training and technical assistance to prevention providers.

Objective 3: Data to Support State and Community Prevention Efforts

To assist State agencies, organizations, and communities in: using state and local data to conduct prevention needs assessments; selecting and implementing with fidelity evidence-based prevention policies and strategies based on sound prevention data of assessed risk and protective factors of problem behaviors; and monitoring and evaluating effectiveness of prevention efforts.

Strategy 1

Include a plan for ensuring statewide participation in the Arkansas Prevention Needs Assessment Student Survey (APNA), the CORE* Survey and other identified prevention needs assessment efforts.

Strategy 2

Provide a list of resources that identifies where evidence-based strategies can be located to assist in selecting strategies based on needs identified by the APNA and other data sources to ensure that prevention efforts address the specific prevention needs of partner state agencies and their community constituents.

Strategy 3

Establish and maintain guidelines for collection of prevention data and its dissemination to state and community prevention entities.

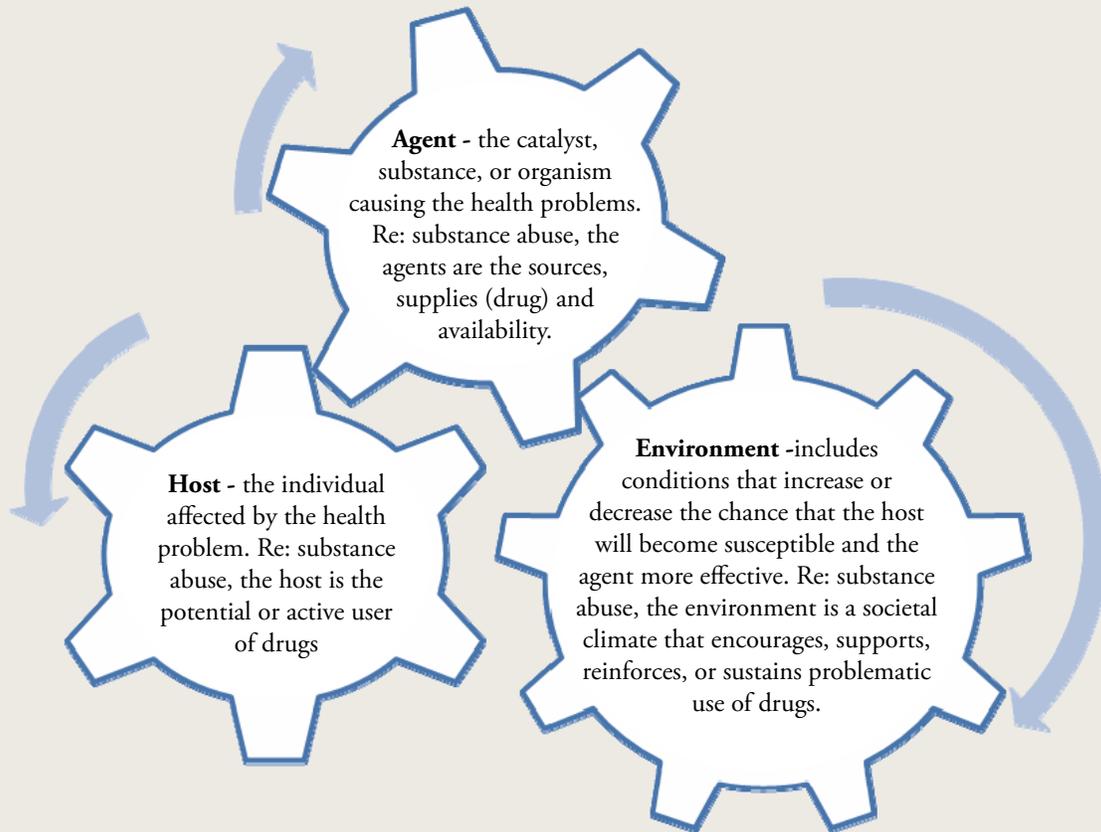
Strategy 4

Include utilization of a logic model in effective planning.

*CORE is not an acronym.

PUBLIC HEALTH MODEL OF PREVENTION

The **Public Health Model of Prevention** stresses that problems arise through the relationships and interactions among the agent, the host, and the environment.



The public health model requires an understanding of how agent, host, and environment interact and a plan of action for influencing all three:

The agent (alcohol and other drugs) must be made:

- Less attractive and/or,
- Less accessible

The environment (society) must offer more:

- Rewards for abstinence,
- Reinforcement for responsible use by adults,
- Attractive recreational and social options,
- Social and legal sanctions for misuse and abuse which cause harm,
- Culture-specific health messages, and
- Positive, healthy role models

The host (individuals and families) must be given more:

- Information on which to base decisions,
- Opportunities to develop self-esteem and insight,
- Understanding of the causes of addiction, its symptoms, and techniques to use in helping people who are addicted,
- Skills to communicate, solve problems, and resist peer pressures, and
- Knowledge about prevention theory and strategies.

STRATEGIC PREVENTION DATA SYSTEM FOR NEEDS ASSESSMENT AND OUTCOMES

The Data Collection and Needs Assessment component of the Arkansas Strategic Prevention Plan will:

- Respond to the unique prevention requirements of multiple funding resources;
- Identify risk and protective factor levels of communities;
- Identify problem behaviors associated with high risk and low protective factors including substance use and abuse, criminal justice consequences, delinquency, violence, school dropout and underachievement differences, and teen pregnancy.
- Identify geographic, ethnic, gender, cultural, and age related issues;
- Assess risk and protective factors and the consumption and consequence data to determine the target population and prevention services;
- Determine the readiness and capacity of a community to address identified problem behaviors through evidence-based prevention strategies shown to reduce related risk and increase protective factors
- Provide follow-up evaluation data to determine the effectiveness of the prevention services and policies implemented.

Recommended Data Sources

In 2005, the Advisory Committee tasked the State Epidemiological Workgroup (SEW) with identifying available data sources to assist communities in addressing the requirements noted above. In 2007, the SEW published the State Epidemiological Profile. The Epidemiological Profile is available online at <http://www.arunderagedrinking.com> or through the Office of Alcohol and Drug Abuse Prevention. Both consumption data (i.e. rates of use) and consequence data (i.e. criminal justice activity) are available. Data users should be aware that certain biases exist at all levels of data collection. The SEW considered these biases and a discussion of the data limitations is included in the Epidemiological Profile. For state, regional, and local agencies and organizations, the Advisory Committee recommends the following data sources as a foundation to address Needs Assessment, Monitoring, and Evaluation:

Arkansas Prevention Needs Assessment (APNA) Survey

The Arkansas Prevention Needs Assessment (APNA) Student Survey is conducted annually. APNA uses the Communities That Care Student Survey instrument which is based on risk and protective factors and collects information on drug use and social indicators. Arkansas public school students in 6th, 8th, 10th, and 12th grades are surveyed. Each participating district is provided its own data results in district and building level reports (providing the number of participants is large enough for student anonymity). Data results are also published at the county, region, and state levels and posted on line for public access. The APNA data has become a major planning resource for communities, schools, ADAP and other state agencies. APNA data results are (1) instrumental to the SPF SIG's epidemiological workgroup's efforts; (2) provide participating school districts with data needed for NCLB planning reporting requirements; (3) provide Drug Free Communities Grantees with data needed to satisfy federal reporting requirements; and (4) are used by Prevention Resource Centers to develop their region and county action plans, etc. APNA Reports are accessible on line at the ADAP web site at http://www.arkansas.gov/dhs/dmhs/adap_survey.htm.

Since its inception in 2002, APNA participation has grown:

Year	Districts	Students Surveyed
2002	95	28,204
2003	72	19,983
2004	128	43,784
2005	158	58,385
2006	194	74,691
2007	208	88,040
2008	219	94,684

STRATEGIC PREVENTION DATA SYSTEM FOR NEEDS ASSESSMENT AND OUTCOMES

Arkansas Traffic Crash Statistics

The Arkansas State Police Highway Safety Office publishes annual reports that include information about vehicle and motorcycle accidents in a variety of situations (e.g. involving alcohol, inclement weather, varying road conditions, and different times of day) for both fatal and non-fatal crashes. These reports also include trending for year and age of driver as well as county and city statistics. Full reports can be found at http://www.asp.arkansas.gov/hso/hso_index.html.

Behavioral Risk Factor Surveillance System (BRFSS)

The Centers for Disease Control (CDC) designed the BRFSS to collect information on health conditions and risk behaviors in the United States. It is currently the primary source of data for states and the nation on the health-related behaviors of adults. The BRFSS is administered by the Arkansas Department of Health with assistance from the CDC. All states ask a set of core questions and have the option of adding modules designed by the CDC or asking their own (state-designed) questions. Households are selected randomly by the CDC, data are collected monthly through telephone interviews with adults (aged 18 or older), and data are analyzed and reported on by both the CDC and designated state agencies. Annual Arkansas BRFSS information can be found online at <http://brfss.arkansas.gov/>.

CORE

The CORE Alcohol and Drug Survey was developed in the late 1980s by the U.S. Department of Education and advisors from several universities and colleges to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four-year institutions. The survey is now administered by the CORE Institute at Southern Illinois University - Carbondale (SIUC). The survey includes several types of items about drugs and alcohol. One type deals with the students' attitudes, perceptions, and opinions about alcohol and other drugs, and the other deals with the students' own use and consequences of use. There are also several items on students' demographic and background characteristics as well as perception of campus climate issues and policy. More information on the CORE survey is available online at http://www.siu.edu/departments/coreinst/public_html/.

Monitoring the Future (MTF) is an ongoing study of the behaviors, attitudes, and values of American secondary school students, college students, and young adults. Each year, a total of approximately 50,000 8th, 10th and 12th grade students are surveyed (12th graders since 1975, and 8th and 10th graders since 1991). In addition, annual follow-up questionnaires are mailed to a sample of each graduating class for a number of years after their initial participation. MTF reports are available online at <http://www.monitoringthefuture.org/>.

National Survey on Drug Use and Health (NSDUH)

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds the NSDUH, is an agency within the U.S. Public Health Service, a part of the U.S. Department of Health and Human Services. Supervision of the project comes from SAMHSA's Office of Applied Studies (OAS). Data from the NSDUH provide national and state-level estimates of the past month, past year, and lifetime use of tobacco products, alcohol, illicit drugs, and non-medical use of prescription drugs. More information on the NSDUH is available online at <http://www.oas.samhsa.gov/states.htm>.

Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas (ARF)

The Risk Factors for Adolescent Drug & Alcohol Abuse in Arkansas is a compilation of data reported by various state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Division of Youth Services, etc). Approximately 46 archival data indicators are collected annually and organized according to the following categories: Demographic data, Community Domain, Family Domain, School Domain, Peer/Individual Domain, and Consequences. The publication reports the data at the state, region, and county levels. To depict data trends, the annual publication includes data for each of the most recent five years and for the 10th year back (six years of data). This compilation provides ADAP and communities, schools, agencies, and organizations with readily accessible data needed for effective planning of prevention efforts. It has also proven to be a valuable resource for other fields, including treatment, youth services, etc. This report is published annually for dissemination purposes and is also posted online at http://www.arkansas.gov/dhs/dmhs/adap_survey.htm.

WHAT DOES EVIDENCE-BASED MEAN?

Today, the term “evidence-based” is part of the vernacular of prevention science. In general, the term “evidence-based” and similar terms – “research-based”, “science-based”, “model” programs and “effective” programs – are used interchangeably to describe programs that have demonstrated empirical success in preventing problem behaviors (www.findyouthinfo.gov).

After thoroughly reviewing state, federal and national data on prevention resources and programs, the SPF SIG Advisory Committee has determined that Arkansas’ at-risk children and young adults would benefit greatly by prevention providers offering the best evidence-based prevention programming available, based on the needs of the appropriate target populations. Utilization of evidence-based practice is a common requirement in most federal and state grant opportunities.

The Committee recommends that state agencies involved with youth implement evidence-based programs in their prevention efforts, particularly the Department of Human Services’ (DYS), Division of Children and Family Services (DCFS), and the Division of Behavioral Health (DBHS), the Department of Health (ADH) and the Department of Education (ADE) use evidence-based programs.

Resource Guide

SAMHSA (National Registry of Evidence-based Programs and Practices): <http://nrepp.samhsa.gov>

The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions for youth and other populations that has been reviewed and rated by independent reviewers.

Other websites which are components of the SAMHSA Health Information Website which could be helpful are the “Identifying and Selecting Evidence-Based Interventions Revised Guidance for Strategic Prevention Framework State Incentive Grant Program”, <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17983>, which provides guidance on how to identify and select evidence-based interventions that address local needs and reduce substance abuse problems.

Also, www.samhsa.gov/ebpwebguide/index.asp the SAMHSA Guide to Evidence-Based Practices (EBP) on the Web. This site is designed to assist the public with simple and direct connections to web sites that contain information about the interventions to prevent and/or treat mental and substance use disorders.

Blueprints for Violence Prevention Model Programs, Center for the Study and Prevention of Violence:

<http://www.colorado.edu/cspv/blueprints/>

Colorado Best Practices www.colorado.gov/bestpractices/

National Institute on Drug Abuse <http://www.nida.nih.gov/prevention/examples.html>

Office of Juvenile Justice and Delinquency Prevention (OJJDP), Programs guide <http://www.dsgonline.com/mpg/>

Office of Safe and Drug Free Schools <http://www.ed.gov/about/offices/list/osdfs/programs.html>

Promising Practices Network on Children, Families and Communities http://www.ojp.usdoj.gov/commprograms/field_tested_programs.htm

Find Youth Info web site: www.findyouthinfo.gov This is an online resource to help communities assess their needs and resources and link them to effective programs to help at-risk youth in their neighbors and towns.

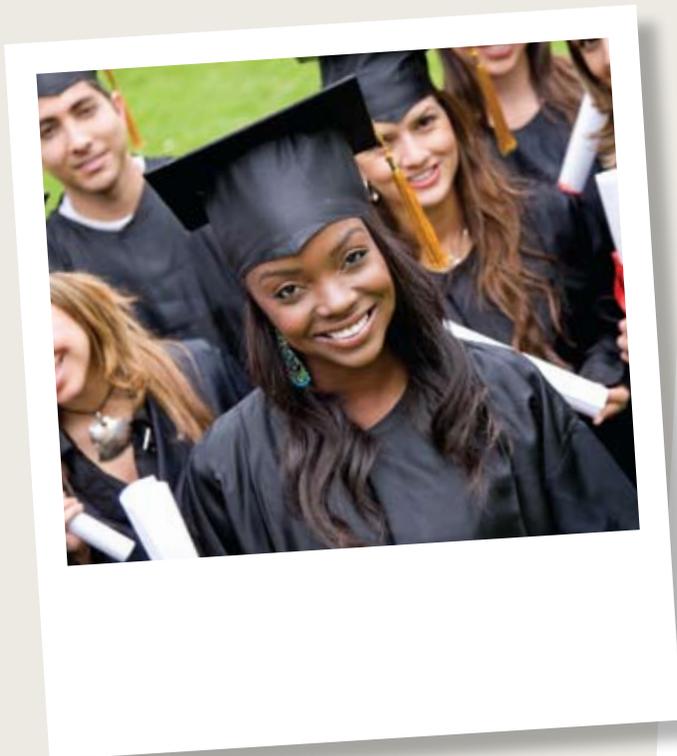
What Works Clearinghouse (WWC): <http://www.whatworks.ed.gov> The clearinghouse collects, screens, and identifies studies of effectiveness of educational interventions (programs, products, practices and policies). It provides educators, policymakers, researchers, and the public with a central and trusted source of scientific evidence on what works in education.

Center for Substance Abuse Prevention (CSAP): <http://prevention.samhsa.gov/about/default.aspx>.

STRATEGY SELECTION GUIDE

The SPF SIG Advisory Committee recommends the following selection criteria to be of primary concern when choosing an evidence-based prevention program for the federally or state-funded school, state agency, or community:

- Conduct a planning process to ensure communities' risk and protective factors and other needs have been identified prior to deciding which program is right. (www.findyouthinfo.gov)
- Selected programs should address identified risk factors and offer a community the needed protective factors.
- Determine which local resources are available in the community. A program must match the needs of the community and not duplicate other services in that community.
- Ensure the program is evidence-based (scientific, research-based and replicated) and recognized as a successful prevention program as addressed in the U.S. Department of Education's Principles of Effectiveness.
- Determine that the program is well designed, the agency/organization can implement it with fidelity, and training and on-going technical assistance will be provided to assure proper delivery of the program. It is important to implement a program as closely as possible to the way it was designed. Programs that are poorly implemented may not have the desired positive effect on behavior, and it may be better not to implement a program at all than to implement it poorly. It will generally take time, funding and effort to implement a program and train staff on the program model. Coalitions must secure adequate funding and have staff in place for proper program implementation.
- Determine the cost-effectiveness of training, materials, staffing, and other expenses compared to number of people served.
- Ensure that the program has an evaluation plan that includes measurable objectives with identified and appropriate measures.



MONITORING PROGRESS AND EVALUATING RESULTS

The Importance of Evaluation

Evaluation describes an entity's planned and careful use of information. It also ensures that data is gathered and reported accurately and appropriately to key stakeholders/partners. The powerful ways people can use the results, not merely the process of collecting statistics, makes evaluation so important. A high-quality evaluation ensures that people have the right information.

Five Functions of Evaluation

- Improvement** – The first, and most important, function of information gathered through evaluation is improvement. Volunteers, leaders and supporters should get better at the work of problem solving because of what can be learned.
- Coordination** – Prevention entities are made up of many partners working on different parts of an overall response to problems. Keeping these partners and activities pointing in the same direction can be difficult unless the entity's evaluation fosters coordination. The information should help members know what others are doing, how this work fits with their own actions and goals, and what opportunities exist for working together in the future.
- Accountability** – Volunteers want to know if their gifts of time and creativity make a difference. Funders want to learn if and how their contributions foster community improvements. Everyone involved in the work wants to see outcomes. A good evaluation allows the prevention entity to describe its contribution to important population-level outcomes.
- Celebration** – A stated aim of any evaluation process should be to collect information that allows the prevention entity to celebrate genuine accomplishments. The path to reducing drug use at the community level is not easy. Regular celebration of progress is needed to keep members motivated and encouraged in the face of difficult work.
- Sustainability** – The path to reduced negative behavior can be long, often requiring years of hard work to see movement in population-level indicators. Likewise, new community problems emerge, requiring renewed response. Evaluation should help a prevention entity stay “in the game” long enough to make a difference by sharing information with key stakeholders and actively nurturing continued support.



ACCOUNTABILITY FOR PREVENTION RESULTS

The Arkansas Strategic Prevention Plan provides guidance for state and community agencies and organizations to effectively evaluate their prevention efforts. Evaluation provides feedback to help prevention planners stay on course, identifies the most effective strategies for each population served, and demonstrates the benefits realized to both the funding source and community served. Training and technical assistance in evaluation is often necessary to appropriately evaluate the community's efforts.

Population Level Indicators

It is important to acknowledge that the federal government is now holding state governments accountable for making measurable change in population level indicators (e.g. number of alcohol-related car crashes, age of first use, etc.). When applying this to the Public Health Model, prevention evaluation efforts focus on changes to the environment where the host lives (community) rather than the changes to the host (individual). As a result, a paradigm shift has occurred in the prevention field. This affects the way prevention is being evaluated at the state level and, in turn, impacts what and how a state expects funded programs to deliver services and evaluate results.

The most effective strategies for achieving change at the population-level are environmental. Hence, the prevention focus has shifted from one of creating change in individual participants to one that concentrates on changing the systems within a community in order to impact community level measures. Such an approach requires a data-driven plan specifically structured to effect systemic change. A well-designed plan will be tailored to the unique needs (data driven) and resources of that community and will contain an evaluation plan that includes population-level indicators as measures of its success.

Systemic Change

Creating systemic change within a community requires a comprehensive approach utilizing various means to create that change (e.g. public information dissemination, media, education, training, public forums/town hall meetings, etc.). Because positive change within groups of individuals can contribute toward change at the community level, it is possible for a participant-based program to be part of the communitywide prevention effort. However, services being provided by such a program must be an integral part of the community's comprehensive plan striving to change community-level measures. Otherwise, that program is an isolated effort that makes no purposeful contribution to the community's effort. In a systems approach, all components are interdependent and synchronized to effectively and efficiently create desired changes at the community-level.

Prevention results have a chain reaction starting with the progress achieved by individual programs that then collectively contributes to changes in community level measures. When communities improve their population level measures, they will, in turn, impact countywide results. And, when county level measures see positive change, the statewide population shows improvement. Thus, in order to achieve progress toward national outcome measures and satisfy federal funding requirements, states are ultimately dependent upon changes occurring within communities that can impact population-level measures. In response to Congressional concerns and to assure funding accountability, most federal agencies have established national outcome measures targeting population-level change specific to their unique indicators.

NATIONAL OUTCOME MEASURES

National Outcome Domains and Performance Management Measures

SAMHSA's CSAP has identified specific outcome measures that were required of discretionary grant recipients with full implementation by the end of the Federal Fiscal Year (FFY) 2007. These National Outcome Measures (NOMs) relate to youth ages 12 to 17 and to adults ages 18 and older. The following table shows measures for youth aged 12 to 17 only.

For more information, go to www.nationaloutcomemeasures.samhsa.gov/outcome/index_2007.asp.

Substance Abuse and Mental Health Services Administration National Outcome Measures (NOMs)

DOMAIN	OUTCOME	MEASURES	
		SUBSTANCE ABUSE PREVENTION	YOUTH DATA (12-17 YEARS OLD)
Reduced Morbidity	Abstinence from Drug/Alcohol Use	<p>30-day substance use (nonuse/reduction in use)</p> <p>Measures are for:</p> <ol style="list-style-type: none"> The average number of days of use in the past 30 days by those who use— <ul style="list-style-type: none"> Alcohol Cigarettes Marijuana or hashish The prevalence of use, that is, the percentage of persons reporting— <ul style="list-style-type: none"> Any alcohol use in the past 30 days Any cigarette use in the past 30 days Any illegal drug use other than marijuana in the past 30 days Any marijuana or hashish use in the past 30 days Any tobacco product use other than cigarettes in the past 30 days¹ 	<p>Nationally, 2006 data indicate that 12- to 17-year-olds who used alcohol averaged 4.5 days of alcohol use during the past 30 days.</p> <p>For data on adults, go to http://www.nationaloutcomemeasures.samhsa.gov/outcome/index_2007.asp</p>
		Perceived risk/harm of use	Nationally, 2006 data indicate that 78 percent perceived moderate or great risk of harm from having five or more drinks of an alcoholic beverage once or twice a week.
		Age of first use*	Nationally, 2006 data indicate that the average age of first use among those who reported using: <ul style="list-style-type: none"> Alcohol – about 13 years old Cigarettes –about 13 years old Any illegal drug other than marijuana – about 13 years old Marijuana – 14 years old Any tobacco product other than cigarettes – about 13 years old.³

**Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)**

DOMAIN	OUTCOME	MEASURES	
		SUBSTANCE ABUSE PREVENTION	YOUTH DATA (12-17 YEARS OLD)
		Perception of disapproval/attitude*	<p>Peers – Nationally, 2006 data indicate the percentages of those who somewhat or strongly disapproved of someone their age):</p> <ul style="list-style-type: none"> • 86% – having one or two drinks of an alcoholic beverage nearly every day • 89 % smoking one or more packs of cigarettes a day • 82% – trying marijuana or hashish once or twice • 83% – using marijuana once a month or more <p>Peers disapprove – Those who perceive that their close friends disapprove:</p> <ul style="list-style-type: none"> • 86.5% – smoking one or more packs of cigarettes a day
Employment/ Education	Increased/ Retained Employment or Return to/Stay in School	Perception of workplace policy	<p>Nationally, 2006 data indicate for employment—</p> <ul style="list-style-type: none"> • 25% of persons aged 15 to 17 who were employed would be more likely to work for an employer who randomly tests for drugs and alcohol.
		Substance-related suspensions/ expulsions	
		Attendance and enrollment	<p>Nationally, fiscal year (FY) 2004 data indicate for education:</p> <ul style="list-style-type: none"> • 93% percent of students in prekindergarten through 12th grade attended school daily.
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Alcohol-related car crashes and injuries	<p>Nationally, 2006 data indicate that 41% of all traffic fatalities were alcohol related.</p>
		Alcohol- and drug-related crime	<p>Nationally, there was a 7% increase in the number of drug- and alcohol-related arrests from 2000 to 2006</p>
Social Connectedness	Increased Social Supports/Social Connectedness²	Family communication around drug use	<p>Nationally, 2006 data indicate:</p> <ul style="list-style-type: none"> • 92% of parents talked to their child about ATODs during the past 12 months. • 60% of youth aged 12 to 17 talked to at least one parent about ATODs during the past 12 months.
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race, and ethnicity	
Retention	Increased Retention in Treatment – Substance Abuse	Total number of evidence-based programs and strategies	

**Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)**

DOMAIN	OUTCOME	MEASURES	
		SUBSTANCE ABUSE PREVENTION	YOUTH DATA (12-17 YEARS OLD)
		Percentage of youth seeing, reading, watching, or listening to a prevention message	Nationally, 2006 data indicate that 91% reported exposure to prevention messages.
Cost Effectiveness	Cost Effectiveness (Average Cost)³	Services provided within cost bands (Universal, Selected, and Indicated)	2008 is the first year these data are being reported, and there is no AR or U.S. average.
Use of Evidence-Based Practices	Use of Evidence-Based Practices³	Total number of evidence-based programs and strategies	2008 is the first year these data are being reported, and there is no AR or U.S. average.

¹ The Center for Substance Abuse Prevention used data from the National Survey on Drug Use and Health (NSDUH) to estimate these measures.

² For ATR “Social Support of Recovery” is measured by client participation in voluntary recover or self-help groups, as well as interaction with family and/or friends supportive or recovery.

³ Required by 2003 OMB PART Review.

* The tables below show performance indicators that use APNA data as measures for the Safe and Drug Free Schools and Communities (SDFSC) funds from the U.S. Department of Education.

PERFORMANCE INDICATOR	INSTRUMENT/ DATA SOURCE	FREQUENCY OF COLLECTION	TARGET YEAR	BASELINE Established 2002	ACTUAL PERFORMANCE (All grades combined)
A 2% increase in the age of first use of cigarettes, alcohol and marijuana	APNA 2007 Survey for grades 6, 8, 10, and 12	Annually	2007-08	Cigarettes: 11.96 Alcohol: 12.51 Marijuana: 13.52	Cigarettes: 12.1 Alcohol: 12.6 Marijuana: 13.6

PERFORMANCE INDICATOR	INSTRUMENT/ DATA SOURCE	FREQUENCY OF COLLECTION	TARGET YEAR	BASELINE Established 2002	ACTUAL PERFORMANCE (All grades combined)
A 2% decrease in favorable attitudes toward antisocial behavior	APNA 2007 Survey for grades 6,8, 10, and 12	Annually	2007-08	Grade 6: 40.4 Grade 8: 32.0 Grade 10: 43.6 Grade 12: 39.9	Grade 6: 37.5 Grade 8: 33.3 Grade 10: 41.7 Grade 12: 39.0

STATE OUTCOMES AND TARGETED MEASURES

The matrix on the following pages identifies desired state-wide outcome objectives for reducing and preventing illegal drug, alcohol, and tobacco use; reducing factors that put youth at risk for substance abuse; increasing factors that protect or buffer youth; objectives targeting school achievement; and objectives targeting the consequences of substance abuse including alcohol-related traffic crashes and youth crime. State agencies involved in substance abuse prevention have supported the objectives as part of the Arkansas Strategic Prevention Framework and have selected specific objectives to target with prevention funds and other resources.

Description of Matrix Headings

Background

In 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA) created a matrix management system that outlines and guides the agency's activities in pursuit of its mission to build resilience and facilitate recovery for people with or at risk for substance use and/or mental disorders. SAMHSA has developed and is implementing a data strategy in order to measure the agency's success in meeting its mission. The National Outcome Measures (NOMs) is a key component of the data strategy. Developed in collaboration with the States, the 10 NOMs include domains that are designed to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities. See pages 15, 16, and 17 for the SAMHSA NOMs Matrix.

In 2009, the Advisory Council undertook the revision of the Arkansas Strategic Prevention Plan. The original plan stressed youth and substance abuse. In the revised plan, every effort was made to expand the scope of the plan to include Arkansans of all ages. In addition to expanding the scope to a wider age range, new consequence target outcomes, i.e. alcohol/drug related car crashes, were identified and included in the plan.

Headings

The Arkansas Strategic Prevention Plan is organized to reflect the organization of the SAMHSA NOMs. Arkansas Target Outcomes have been grouped according to **Domain, National Outcome Measure, and Measure.**

Targeted Substance/Consequence: Identifies the specific substance targeted by the measure, i.e. alcohol, cigarettes, or the specific consequence related to substance abuse, i.e. alcohol/drug related crash fatalities.

Age Group: The age group from whom the consumption or consequence data was taken, i.e. APNA data is collected through surveys administered to 6th, 8th, 10th, and 12th graders at Arkansas public schools.

Years: The plan currently includes data collected for the years 2003, 2005, and 2007. Trend data is collected every other year up to the Target Outcome Date of 2015. Data collected in 2003 is used as the baseline data for establishing the original target outcomes.

Target Outcome Set in 2005: The Arkansas Strategic Prevention Plan was originally developed and published in 2005. At that time, target outcomes were developed and a date for reaching the target was established. Those original target outcomes are identified under this matrix heading.

Revised Target Outcome for 2015: The Arkansas Strategic Prevention Plan was updated in 2009. At that time, target outcomes were evaluated and revised as necessary. If it was determined that a new target outcome was required, the new target outcome appears under this matrix heading. The determination for revising a target outcome was made based on trend data.

STATE OUTCOMES AND TARGETED MEASURES

Domain: Reduced Morbidity

National Outcome Measure: Abstinence from Drug/Alcohol Use

Measure: 30-Day Substance Use

Targeted Substance/ Consequence	Age Group	2003	2005	2007	Target Outcome set in 2005	Revised Target Outcome for 2015
Alcohol	Grade 6 ¹	6.6%	4.8%	3.6%	1.6%	1.6%
	Grade 8 ¹	19.7%	16.9%	15.5%	14.7%	11.3%
	Grade 10 ¹	37.2%	33.6%	30.3%	32.2%	25.3%
	Grade 12 ¹	48.0%	42.8%	40.3%	43.0%	35.3%
	18-20 ²	34.3%	38.4%	28.4%	N/A	23.4%
	21-25 ²	59.0%	56.2%	46.5%	N/A	41.5%
	26-64 ²	46.5%	41.0%	43.7%	N/A	38.7%
	65 + ²	33.2%	24.2%	28.1%	N/A	23.1%
Cigarettes	Grade 6 ¹	3.6%	2.7%	1.9%	1.6%	1.0%
	Grade 8 ¹	11.7%	10.1%	8.1%	6.7%	6.7%
	Grade 10 ¹	21.8%	17.4%	15.3%	16.8%	10.3%
	Grade 12 ¹	30.0%	24.9%	23.5%	25.0%	18.5%
	18-25 ³	46.5%	44.9%	N/A	N/A	39.9%
	26 + ³	29.2%	28.5%	N/A	N/A	23.5%
Marijuana	Grade 6 ¹	1.5%	0.8%	0.5%	0.5%	0.25%
	Grade 8 ¹	5.9%	5.3%	4.1%	2.9%	2.9%
	Grade 10 ¹	15.2%	11.8%	10.4%	12.2%	5.4%
	Grade 12 ¹	20.6%	15.9%	15.3%	17.6%	10.3%
	18-25 ³	16.1%	14.4%	N/A	N/A	9.4%
	26 + ³	3.6%	3.9%	N/A	N/A	1.6%
Any Illicit Drug ⁴	Grade 6 ¹	5.9%	7.5%	5.9%	2.9%	2.9%
	Grade 8 ¹	11.5%	14.8%	12.2%	8.5%	8.5%
	Grade 10 ¹	19.1%	21.1%	17.1%	16.1%	13.1%
	Grade 12 ¹	22.8%	23.9%	20.6%	19.8%	17.6%
	18-25 ³	19.0%	19.7%	N/A	N/A	16.0%
	26 + ³	5.0%	5.9%	N/A	N/A	2.5%

Notes: ¹ Source: Arkansas Prevention Needs Assessment (APNA) Student Survey (2003, 2005, 2007).

² Source: Arkansas Behavior Risk Factor Surveillance System (BRFFS) (2003, 2005, 2007).

³ Source: National Survey Drug Use and Health (NSDUH), CDC. (2003/2004 and 2005/2006).

⁴ "Any illicit drug" includes marijuana for all age groups.

STATE OUTCOMES AND TARGETED MEASURES

Domain: Reduced Morbidity

National Outcome Measure: Abstinence from Drug/Alcohol Use

Measure: Perceived Risk/Harm of Use

Targeted Substance/ Consequence	Age Group	2003	2005	2007	Target Outcome set in 2005	Revised Target Outcome for 2015
Alcohol ^a	Grade 6 ¹	46.7%	39.1%	38.0%	51.5%	51.5%
	Grade 8 ¹	38.7%	31.3%	32.4%	43.7%	43.7%
	Grade 10 ¹	33.8%	27.8%	29.3%	38.8%	38.8%
	Grade 12 ¹	33.1%	30.0%	29.9%	38.1%	38.1%
Binge Drinking ^b	Grade 6 ¹	N/A	52.9%	53.6%	N/A	58.6%
	Grade 8 ¹	N/A	49.2%	51.1%	N/A	56.1%
	Grade 10 ¹	N/A	43.7%	45.5%	N/A	50.5%
	Grade 12 ¹	N/A	41.8%	42.7%	N/A	47.7%
	18-25 ²	31.4%	34.5%	N/A	N/A	39.5%
	26 + ²	46.9%	45.0%	N/A	N/A	50.0%
Cigarettes ^c	Grade 6 ¹	65.5%	63.7%	64.5%	75.5%	75.5%
	Grade 8 ¹	62.9%	63.6%	67.2%	72.9%	72.9%
	Grade 10 ¹	60.9%	64.8%	67.6%	70.9%	70.9%
	Grade 12 ¹	61.8%	67.6%	67.1%	71.8%	71.8%
	18-25 ²	63.8%	66.9%	N/A	N/A	76.9%
	26 + ²	73.4%	72.7%	N/A	N/A	82.7%
Marijuana	Grade 6 ^{1,d}	77.9%	75.0%	73.9%	82.9%	82.9%
	Grade 8 ^{1,d}	73.6%	73.3%	73.3%	78.6%	78.6%
	Grade 10 ^{1,d}	59.4%	61.9%	62.3%	64.4%	64.4%
	Grade 12 ^{1,d}	50.9%	55.7%	52.7%	55.9%	55.9%
	18-25 ^{2,e}	27.6%	26.6%	N/A	N/A	31.6%
	26 + ^{2,e}	49.5%	50.2%	N/A	N/A	55.2%

Notes: ¹ Source: Arkansas Prevention Needs Assessment (APNA) Student Survey, (2003, 2005, 2007).

² Source: National Survey Drug Use and Health (NSDUH), CDC, (2003/2004 and 2005/2006).

(a) Perceive great risk in drinking one or two alcoholic beverages nearly every day, (b) Perceive a great risk from drinking 5 or more drinks once or twice a weekend, (c) Perceive a great risk from smoking one or more packs per day, (d) Perceive a great risk from smoking marijuana regularly, (e) Perceive a great risk from smoking marijuana once a month

STATE OUTCOMES AND TARGETED MEASURES

Domain: Reduced Morbidity

National Outcome Measure: Abstinence from Drug/Alcohol Use

Measure: Age of First Use

Targeted Substance/ Consequence	Age Group	2003	2005	2007	Target Outcome set in 2005	Revised Target Outcome for 2015
First Alcohol Sip or More ¹	N/A	12.7	12.5	12.6	14.0	14.0
First Cigarette Use ¹	N/A	11.9	12.0	12.1	13.0	13.6
First Marijuana Use ¹	N/A	13.6	13.5	13.6	15.0	15.0

Domain: Reduced Morbidity

National Outcome Measure: Abstinence from Drug/Alcohol Use

Measure: Perception of Disapproval/Attitude

Favorable attitude toward drug use ¹	Grade 6	22.4%	20.8%	17.9%	17.4%	12.9%
	Grade 8	26.6%	25.5%	22.8%	21.6%	17.8%
	Grade 10	37.7%	35.4%	33.1%	32.7%	28.1%
	Grade 12	38.8%	32.2%	32.9%	33.8%	27.9%

Domain: Employment/Education

National Outcome Measure: Return To/Stay in School

Measure: ATOD Suspensions & Expulsions

High school infractions related to alcohol ^{2,3}	N/A	2.6	3.1	2.4	1.3	1.3
High school infractions related to tobacco ^{2,3}	N/A	22.0	21.0	20.3	11.0	11.0
High school infractions related to other drugs ^{2,3}	N/A	6.0	7.7	7.9	3.0	3.0

Domain: Employment/Education

National Outcome Measure: Return To/Stay in School

Measure: Attendance & Enrollment

High school drop-out rate ²	N/A	3.9%	3.3%	3.3%	1.9%	1.9%
Low commitment to school ¹	Grade 6	41.4%	41.9%	42.0%	36.4%	36.4%
	Grade 8	38.7%	35.7%	35.3%	33.7%	33.7%
	Grade 10	41.5%	38.0%	39.5%	36.5%	36.5%
	Grade 12	43.5%	41.5%	42.2%	38.5%	38.5%
Suspended from school ¹	Grades 6, 8, 10, & 12	10.2%	12.7%	13.4%	5.1%	5.1%

Notes: ¹ Source: Arkansas Prevention Needs Assessment (APNA) Survey (2003, 2005, 2007).

² Source: Archival Risk Factors for Adolescent Drug and Alcohol Abuse (ARF) in Arkansas (2004, 2006, 2007)

³ Rates per 1,000 total enrollment

STATE OUTCOMES AND TARGETED MEASURES

Domain: Crime & Criminal Justice

National Outcome Measure: Decreased Criminal Justice Involvement

Measure: Alcohol-Related Car Crashes & Injuries

Targeted Substance/ Consequence	Age Group	2003	2005	2007	Target Outcome set in 2005	Revised Target Outcome for 2015
Alcohol/Drug related fatalities⁴	0-17	19	14	43	N/A	17
	18-20	24	19	31	N/A	22
	21-25	49	37	33	N/A	24
	26-64	167	162	154	N/A	149
	65 +	13	15	13	N/A	12
Crash injuries & deaths; underage drinking drivers²	< 21 years of age	390	626	519	N/A	351
Traffic crashes involving underage drinking drivers²	< 21 years of age	363	512	457	N/A	327

Domain: Crime & Criminal Justice

National Outcome Measure: Decreased Criminal Justice Involvement

Measure: Alcohol/Drug-Related Crime

Drunk or high at school¹	Grades 6, 8, 10, & 12	11.7%	11.1%	10.1%	5.85%	5.85%
Sold illegal drugs¹	Grades 6, 8, 10, & 12	4.7%	4.3%	4.1%	2.35%	2.35%
Stolen a vehicle¹	Grades 6, 8, 10, & 12	2.5%	2.6%	2.4%	1.25%	1.25%
Been arrested¹	Grades 6, 8, 10, & 12	5.3%	5.5%	5.4%	2.65%	2.65%
High school assaults on other students or staff^{2,3}	High school students	18.3	18.4	16.4	9.15	9.15
High school weapons/ explosives infractions^{2,3}	High school students	1.5	1.9	1.8	0.75	0.75
High school vandalism^{2,3}	High school students	6.0	4.1	5.0	3.0	3.0

Notes: ¹ Source: Arkansas Prevention Needs Assessment (APNA) Survey (2003, 2005, 2007)

² Source: Archival Risk Factors for Adolescent Drug and Alcohol Abuse (ARF) in Arkansas (2004, 2006, 2007)

³ Rate per 1,000 total enrollment

⁴ Source: Arkansas State Police, Annual Traffic Crash Statistics (2003, 2005, 2007)

STATE OUTCOMES AND TARGETED MEASURES

Domain: Social Connectedness

National Outcome Measure: Family Communication Around Drug Use

Measure: Family Conflict

Targeted Substance/ Consequence	Age Group	2003	2005	2007	Target Outcome set in 2005	Revised Target Outcome for 2015
Family risk factor¹	Grade 6	33.1%	39.9%	36.2%	28.1%	28.1%
	Grade 8	42.3%	51.3%	47.6%	37.3%	37.3%
	Grade 10	36.9%	41.9%	39.4%	31.9%	31.9%
	Grade 12	33.7%	38.4%	35.4%	28.7%	28.7%

Domain: Social Connectedness

National Outcome Measure: Family Communication Around Drug Use

Measure: Family Attachment

Family protective factor¹	Grade 6	59.2%	56.5%	57.0%	64.2%	64.2%
	Grade 8	55.9%	52.5%	52.6%	60.9%	60.9%
	Grade 10	48.3%	43.9%	45.3%	53.3%	53.3%
	Grade 12	58.8%	56.7%	56.2%	63.8%	63.8%

Domain: Social Connectedness

National Outcome Measure: Family Communication Around Drug Use

Measure: Rewards/Opportunities for Prosocial Involvement

Family protective factor¹	Grade 6	57.6%	56.0%	55.8%	62.6%	62.6%
	Grade 8	66.2%	64.6%	64.2%	71.2%	71.2%
	Grade 10	57.2%	55.5%	54.7%	62.2%	62.2%
	Grade 12	55.7%	55.1%	54.4%	60.7%	60.7%

Notes: ¹ Source: Arkansas Prevention Needs Assessment (APNA) Survey (2003, 2005, 2007)

APPENDICES

Appendix A: Risk and Protective Factor Framework

Appendix B: Logic Models

Appendix C: Recommendations for Colleges and Universities

Appendix D: Prevention Resources

Appendix E: SAMHSA Strategic Prevention Framework Model

Appendix F: Glossary and References

Risk and Protective Factor Framework

The following graphic supports a public health model using a theoretical framework of risk reduction and protection enhancement. Developments in prevention and intervention science have shown that there are characteristics of individuals, their families and their environment (i.e., community, neighborhood, school) that affect the likelihood of negative outcomes including substance abuse, delinquency, violence, and school dropout. Other characteristics serve to protect or provide a buffer to moderate the influence of the negative characteristics. These characteristics are identified as risk factors and protective factors. (Arthur, Hawkins, et al., 1994), (Hawkins, Catalano, Miller, 1992).

	Risk Factors	Adolescent Problem Behavior						Protective Factors	Social Development Model (SDM)
Domains	<i>Risk factors are characteristics of individuals, their family, school, and community environments that are associated with increases in alcohol and other drug use, delinquency, teen pregnancy, school dropout, and violence. The following factors have been identified that increase the likelihood that children and youth may develop such problem behaviors.</i>	Substance Abuse	Depression & Anxiety	Delinquency	Teen Pregnancy	School Drop-Out	Violence	<i>Factors associated with reduced potential for drug use are called protective factors. Protective factors encompass family, social, psychological, and behavioral characteristics that can provide a buffer for the children and youth. These factors mitigate the effects of risk factors that are present in the child or youth's environment.</i>	<i>SDM is a synthesis of three existing theories of criminology (control, social learning, and differential association). It incorporates the results of research on risk and protective factors for problem behaviors and a developmental perspective of age, specific problem, and prosocial behavior. It is based on the assumption that children learn behaviors.</i>
Community	Availability of alcohol/other drugs	√					√	Opportunities for prosocial involvement in community	
	Availability of Firearms			√			√	Recognition for prosocial involvement	
	Community laws and norms favorable to drug use, firearms, and crime	√		√			√		
	Transitions and mobility	√	√	√		√			
	Low neighborhood attachment and community disorganization	√		√			√		
	Media Portrayals of Violence						√		
	Extreme economic deprivation	√		√	√	√	√		
Family	Family history of the problem behavior	√	√	√	√	√	√	Bonding to family with healthy beliefs and clear standards.	
	Family management problems	√	√	√	√	√	√	Attachment to family with healthy beliefs & clear standards	
	Family conflict	√	√	√	√	√	√	Opportunities for prosocial involvement	
	Favorable parental attitudes and involvement in problem behaviors	√		√			√	Recognition for prosocial involvement	
School	Academic failure beginning in late elementary school	√		√	√	√	√	Bonding and Attachment to School	
	Lack of commitment to school	√		√	√	√	√	Opportunities for prosocial involvement Recognition for prosocial involvement	
Individual / Peer	Early and persistent antisocial behavior	√	√	√	√	√	√	Bonding to peers with healthy beliefs and clear standards.	
	Rebelliousness	√		√		√		Attachment to peers with healthy beliefs & clear standards	
	Friends who engage in the problem behavior	√		√	√	√	√	Opportunities for prosocial involvement	
	Favorable attitudes toward the problem behavior (including low perceived risk of harm)	√		√	√	√		Increase in Social skills	
	Early initiation of the problem behavior	√		√	√	√	√		
	Constitutional factors	√	√	√			√		

Logic Models

Coalitions and/or other organizations work to improve their communities in many ways. These changes usually take the form of new or modified programs, policies and practices needed by the community. The logic model is a framework format that is suggested to use in the process of the planning phase. It is a straightforward and a graphic approach to planning that ensures that no vital step will be overlooked from goal setting to measuring outcomes. Below is a sample logic model that programs, agencies, organizations, coalitions and/or individuals are encouraged to use.

What is a Logic Model?

- A logic model is like a road map that shows that the organization is on the right track
- It presents a picture of how the initiative is suppose to work
- It explains why the strategy setting chosen is a good solution to the problem
- It is a brief, logical series of statements linking needs and resources of the community to strategies and activities that address the issues and what the expected results will be.

Benefits of a Logic Model:

- Develops understanding
- Helps monitor progress
- Serves as an evaluation framework
- Helps restrain over-promising

Sample Logic Model I

Theory of Change

Problem Statement			Strategies	Activities	Outcomes		
Problem	Interven- ing Variable	Contributing Factors			Short-Term	Intermediate	Long-Term ¹
Prescription Drug Abuse among the elderly As many as 17% of adults 60 and over abuse prescription drugs. Source: National Clearinghouse for Alcohol and Drug Information	Idle time and loneliness	Retirement After retirement, some seniors find difficulty in adjusting to the change of lifestyle. This is causing the likelihood of increase in prescription drug abuse.	To live a productive and socially active life	Community Service Volunteer Hobbies Travel A part-time job	The seniors will explore and find new hobbies and/or activities that are enjoyable to them.	Steady activities and involvement have been found to keep seniors active and busy	After retirement, seniors find a relaxed but busy schedule that still provides a good quality of life.

Sample Logic Model II

Problem Statement			Strategies	Activities	Outcomes		
Problem	Intervening Variable	Contributing Factors			Short-Term	Intermediate	Long-Term ¹
Underage Drinking	Social Norms	Adults	Communities mobilizing for change	Communicate clear message to communities that underage drinking is inappropriate	Change in community and adult perception about underage drinking	Change in youth access	Reduce DUI arrest rate

¹ The long-term outcomes are affected not by any single strategy, but by ALL of the strategies and activities.

Alcohol Abuse Program for Arkansas Colleges and Universities As Recommended by the Arkansas Collegiate Drug Education Committee (ACDEC)

Arkansas colleges and universities deal with diverse needs and populations. The model process identified below provides guidance for establishing effective goals and policies for the campus.

Step 1: Establish a Committee...Solving the “alcohol problem” requires the efforts of the entire campus. All areas of the campus affected by alcohol abuse should be brought together to address policies and their implementation; curriculum; awareness and information; support and intervention; enforcement; assessment and evaluation; training; staffing and resources. (Task Force Planner, Promising Practices: Campus Alcohol Strategies, David Anderson & Gale Gleason Milgram, 1998)

Step 2: Establish an Office...While an oversight committee is a good source of ideas and resources, an individual or office should be given an assigned responsibility for oversight and coordination of the campus program.

Step 3: Assessment...Decisions should be data driven. What are the problems? What are the patterns of use? The Arkansas Collegiate Drug Education Committee (<http://arcdec.net>) offers the CORE survey free of charge.

Step 4: Goals...A college/university needs to identify quantitative goals early in the process. It should focus on research proven strategies for addressing alcohol abuse. The NIAAA suggests focusing on the following 5 areas:

- 1) Enforcement of the 21 minimum legal drinking age,
- 2) Implementation and enforcement of laws to reduce drunk driving,
- 3) Restrictions on alcohol retail outlet density,
- 4) Higher prices and excise taxes for alcoholic beverages, and
- 5) Responsible service policies to reduce alcohol sales to minors and intoxicated patrons.
 (“Removing the Barriers to Effective Prevention on Campus”, William DeJong & Robert Saltz, Prevention File, May 2007, pp. 2-8)

Step 5: Actions...Colleges and Universities should focus on research proven intervention strategies. Research has identified 5 strategic areas for action:

- 1) Providing alcohol-free activities,
- 2) Social norm marketing,
- 3) Limiting alcohol availability,
- 4) Restricting the marketing of alcoholic beverages, and
- 5) Development and enforcement of campus policies of local and state laws regarding alcohol.
 (Safe Lanes on Campus: A Guide for Preventing Impaired Driving and Underage Drinking, Robert Zimmerman & William DeJong, <http://www.higheredcenter.org/pubs/safelanes/>, 2003.

Step 6: Policies...Colleges and Universities should identify policies which effect alcohol use and evaluate their effectiveness and impact. For example, colleges can notify parents of alcohol policy violation on the first violation, prohibit open beverage containers at events, or prohibit alcohol advertisements in its athletic programs.

Step 7: Evaluation...A college/university should establish an annual review date to assess the effectiveness of its actions. This should include reuse of the assessment tool. Effectiveness can only be measured when quantitative goals are in place.

Prevention Resources

The state agencies and programs listed below represent the majority of prevention resources provided through state government. Private prevention service providers have not been included. This list is representative and is not intended to be all-inclusive as resources may have been underreported when this information was collected. Through the process of collecting this information, the SPF SIG Advisory Committee ascertained that the Federal Government and the Tobacco Master Settlement Agreement (MSA) provide the majority of funding for state administered prevention services while very little general state revenue is committed specifically for prevention services.

Identified Prevention Resources*

State Agencies/Commissions that allocate resources for community prevention:

- Arkansas Department of Health (ADH)
 - Abstinence Education
 - HIV Prevention
 - STD Programs
 - TPEP: Tobacco Prevention
 - Hometown Health
- Arkansas Department of Human Services (DHS)
 - Division of Youth Services (DYS)
 - Division of Behavioral Health Services (DBHS)
 - ◆ Office of Alcohol and Drug Abuse Prevention (ADAP) Drug & Alcohol Safety Educational Program (DASEP) Regional Prevention Resource Centers (PRCs)
 - ◆ DBHS Systems of Care
- Arkansas Department of Education (ADE),
 - Safe and Drug Free Schools (SDFS)
- Department of Finance and Administration (DFA),
 - Alcohol and Beverage Control (ABC) Enforcement
 - Office of Intergovernmental Services – OJJDP Funds
- Arkansas Tobacco Settlement Commission
- Arkansas Tobacco Control Board

State Agencies and Organizations that provide some type of prevention support services:

- Arkansas Department of Human Services (DHS)
 - Division of Child and Family Services
- Attorney General's Office
- University of Arkansas for Medical Sciences
 - Commission on Child Abuse, Rape and Domestic Violence
- Game & Fish Commission (with the Governor's Office & ADE)
 - Hooked on Fishing – Not on Drugs
- Criminal Justice Institute -- Arkansas Safe Schools Initiative

Additional Agencies and Organizations that provide some type of local prevention support services:

- U.S. Department of Education Safe Schools/Healthy Students
- U.S. Department of Justice
 - Weed & Seed
 - COPS (Community Oriented Policing Services)
 - Byrne Grant Program – Drug Task Force
 - Safe Kids/Safe Schools
 - Local Law Enforcement Block Grants
 - Drug Courts

- U.S. Department of Health & Human Service
 - CSAP/SAMHSA
 - ◆ Drug Free Communities Support Program
- U.S. Department of Housing & Urban Development (HUD)
 - Arkansas Department of Economic Development
 - ◆ Community Development Block Grants
- Arkansas National Guard
- MADD (Mothers Against Drunk Driving)
- PRIDE Youth Programs
- Community Development & Crime Prevention Institute
- Community Anti-Drug Coalitions of America (CADCA)
- National Highway Traffic Safety Administration
 - Arkansas Department of Transportation
- University of Arkansas Division of Agriculture
 - Cooperative Extension Service
 - ◆ 4-H Youth Development Programs
- First Lady Ginger Beebe Initiatives:
 - Leadership to Keep Children Alcohol Free
 - National Center for Addiction & Substance Abuse
- Washington County Sheriff's Office – High Intensity Drug Trafficking Areas program (HIDTA)

* Note: The Prevention Resources Workgroup of the SPF SIG Advisory Committee identified these prevention resources through telephone surveys and interviews with various state agency and prevention provider personnel seeking information on agency funding amounts, sources, and types of services provided. Prevention was broadly defined as "activities and programs in which an agency is involved to prevent negative behaviors from occurring."

SAMHSA Strategic Prevention Framework Model

The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services created the Strategic Prevention Framework (SPF). It is designed to build on science-based theory and evidence-based practices. To be effective, the SPF supports that prevention programs must engage individuals, families, and entire communities.



Glossary

Alcohol and Drug Abuse Coordinating Council:

A body created by legislation with the responsibility for overseeing all planning, budgeting, and implementation of expenditure of state and federal funds allocated for alcohol and drug education, prevention, treatment, and law enforcement. (www.state.ar.us/dhs/dmhs)

ATOD: Alcohol, Tobacco, and Other Drugs.

Centers for the Application of Prevention Technology (CAPT): Five centers nationwide are supported by CSAP to serve as regional sources of technical assistance on the application of science-based prevention at the state and community levels. Arkansas is served by the Southwest CAPT (SWCAPT).

Center for Substance Abuse Prevention (CSAP):

The prevention center under the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services. CSAP is the lead federal agency for substance abuse prevention and the funding source for the SPF State Incentive Grant (SIG) project.

Coalition: A formal arrangement for cooperation and collaboration between groups or sections of a community in which each group retains its identity but all agree to work together toward a common goal of building a safe, healthy, and drug-free community.

Contributing Factor: A set of community specific issues that compromise the intervening variables. They are the key link to identifying prevention strategies.

Consequence Data: Identifies the prevalence and incidence of substance use. It is the data we use to determine who, what, when, where, and how often.

Consumption Data: Identifies the impact of substance use on the individual and society. Substance use consequence data includes impacts on health (e.g. hospital admissions), criminal justice (e.g. arrests, traffic crashes), and children and adolescents (e.g. school performance).

Efficacy & Effectiveness: There are different standards of proof for establishing the efficacy of an intervention as opposed to its effectiveness. (e.g., Howard et al., 1996) Efficacy is a necessary, but not sufficient, condition for effectiveness and is ideally established through randomized, controlled, experimental studies (e.g., Campbell & Stanley, 1966)

Efficacy: Refers to whether the intervention can be successful when it is properly implemented under controlled conditions

Effectiveness: Refers to whether the intervention typically is successful in actual clinical practice.

Evidence-based Education: Usage of the best available empirical evidence in making decisions about education.

Evidence-based Programs: Successful, well-implemented, and well-evaluated programs that have been reviewed by the National Registry of Effective Programs and Practices (NREPP) according to rigorous standards of research. (www.modelprograms.samhsa.gov)

Evidence Based Strategies: Successful, well-implemented and well-evaluated programs, practices or policies that address contributing factors and their related risk behaviors.

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

EpiGram: A monthly publication of the SEW, the Epi-GRAM provides timely analyses of data to assist in the ongoing assessment of substance use consumption and consequences in Arkansas. The Epi-GRAM is available online at <http://www.arkansas.gov/dhs/dmhs/Epi-Grams.htm>

Epidemiology: The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems. Source: Last JM, editor. Dictionary of epidemiology 4th ed. New York: Oxford University Press; 2001, p. 61.

Fidelity: In the context of prevention programming, fidelity means maintaining the core components, framework, program elements, delivery schedule, and dosage/exposure as intended by the program developer. Ensuring programs maintain those core elements will enhance the likelihood that those original positive outcomes are achieved in a replication.

Intervening Variables: Factors that have been identified to influence the occurrence and magnitude of substance use and their consequences.

Logic Model: A picture of how the effort or initiative is supposed to work. It explains why the strategy is a good solution to the problem at hand and makes an explicit, often visual, statement of activities and results. It keeps participants moving in the same direction through common language and points of reference. As an element of work itself, the logic model can energize and rally support by declaring what will be accomplished, and how. Source: CADCA

NREPP: SAMHSA's Center for Substance Abuse Prevention (CSAP) created a National Registry of Effective Programs and Practices (NREPP). NREPP is a resource to review and identify evidence-based strategies. Toward identifying strategies, NREPP seeks candidate prevention strategies from the practice community and from the archival scientific literature.

Office of Alcohol and Drug Abuse Prevention (ADAP): Arkansas' state office designated as the lead agency responsible for substance abuse prevention and treatment, which is located within the Arkansas Department of Human Services (DHS), Division of Behavioral Health Services (DBHS). (www.state.ar.us/dhs/dmhs)

Prevention: A proactive process designed to empower individuals and communities to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles.

Preventionist (general description): One who routinely practices prevention in his/her existing societal role, whether paid or volunteer, acting in a personal or professional capacity. Includes parents, clergy, teachers, law enforcement, business owners, etc.

Preventionist (specific to substance abuse): One who provides knowledge and skills as well as promotes the development of healthy attitudes and behaviors in order to prevent the use, misuse and abuse of alcohol and other drugs and prevent behaviors harmful to human beings.

Prevention Resource Center (PRC): The focus of the Arkansas Regional Prevention Resource Center System is capacity development of communities to address prevention. Collectively, thirteen Regional Prevention Resource Centers form a statewide infrastructure to promote and increase alcohol, tobacco, and other drugs (ATOD) prevention efforts at the regional, county and community levels. Contact ADAP at (501) 686-9030 or at <http://www.arkansas.gov/dhs/dmhs/> to find your regional PRC.

Promising Approaches (Practices): (www.modelprograms.samhsa.gov) A label used in SAMHSA's former NREPP system to refer to science-based programs that showed at least some positive outcomes. SAMHSA no longer uses this designation.

Protective Factor: Characteristics or attributes of persons, their families, their peers, their environment, their schools, etc., that may help protect or provide a buffer for a person from problems such as substance abuse and which can strengthen the person's determination to reject use of alcohol, tobacco, marijuana, and other drugs.

Risk Factor: Characteristics or attributes of persons, their families, their peers, their environment, their schools, etc., that have been associated with a higher susceptibility to alcohol and other drug abuse and other problems.

Risk and Protective Factor Framework: Body of research giving direction to communities about how to design strategies to prevent youth from developing substance abuse problems. The research focuses on risk/protective factors which increase/decrease the likelihood youth will develop problem behaviors such as substance abuse.

Strategic Prevention Framework: The Strategic Prevention Framework (SPF) is a major SAMHSA initiative and includes five components: needs assessment, capacity, planning, implementation, and evaluation in an effort to encompass the state and all sectors of the community. This is the planning approach adopted by SAMHSA that is a required logic model process for grants supported by their funds. See Appendix D. (www.preventionplatform.samhsa.gov)

SPF SIG Stakeholder: Individuals or groups which can influence the outcome of the SPF SIG or which can be affected by SPF SIG activities including clients or program recipients, governmental agencies, and community coalitions and organizations. They have or should have a vested interest in a particular issue that has potential impact on them.

State Incentive Grant (SIG): A series of federal planning and development grants awarded to state governors supporting the costs for planning collaboratively and developing a state strategic prevention plan that provides guidance and direction to state and local agencies for

prevention efforts. Various SIGs have had differing focuses, amounts, and timeframes. Arkansas received a one-year planning and development SIG. The Arkansas Strategic Prevention Plan document (March 2005) was developed with SIG funding.

Substance Abuse and Mental Health Services

Administration (SAMHSA): An administration unit located within the U.S. Department of Health and Human Services housing the Center for Substance Abuse Prevention; the Center for Substance Abuse Treatment, and the Center for Mental Health Services. (www.samhsa.gov).

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Additional Information may be obtained from:
Office of Alcohol and Drug Abuse Prevention (ADAP)
305 S. Palm Street
Little Rock, AR 72205
(501) 686-9030
www.state.ar.us/dhs/dmhs