Resource Guide

for

FY2024 Comprehensive Prevention and Early Intervention Grant Application

State of Alaska, Division of Behavioral Health, Section of Prevention and Early Intervention

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Table of Contents

Dear Prevention Partner:

Thank you for your interest in behavioral health prevention, this **Resource Guide** was originally developed for organizations applying for community/regional funding through the Comprehensive Prevention & Early Intervention Services Request for Proposals. This guide was designed to provide information to applicants in completing the FY24 grant proposal. Given the keen interest in prevention, this **Resource Guide is being made available to anyone wishing to work in the field of behavioral health prevention or early intervention**.

The first section offers general prevention information following the five steps of the Strategic Prevention Framework (SPF). Within each step, additional information, resources, samples and templates are provided.

The information and resources provided are designed to help you develop a comprehensive prevention plan, designed to meet the unique qualities and conditions of your community. This Resource Guide is not all-inclusive; use as much or as little as you need to develop your proposal.

Please join our prevention partnership as we work together, community by community, to create a strong, healthy and positive Alaska.

Most sincerely,

DBH Prevention & Early Intervention Team

Section I: General Concepts

Table 1. Alaska Behavioral Health Prevention and Early Intervention
✉ Long Term Outcomes and their key population-level indicators✉

	OUTCOME I: All Alaskan communities, families and individuals are free from the harmful effects of substance use, dependency and addiction.
	Youth Substance Abuse Indicators
1	Youth who use alcohol, tobacco, or marijuana before age 13 [1.]
2	Youth who engage in drinking (past 30 days)* [1.]
3	Youth who use Illicit* (including prescription drug misuse) [2.]
4	Youth who receive repeat Minor Consuming charges (AS04.16.050(c)) [3.]
	Adult Substance Abuse Indicators
5	Adults who engage in heavy drinking* [4.]
6	Adults who engage in binge drinking* [1.]
7	Adults who use illicit drugs* (including prescription drug misuse) [2.]
	Fetal Alcohol Spectrum Disorders Indicators
8	Number of births per 100,000 [5.]
9	Woman who drank in last 3 months of pregnancy [6.]
10	Women who drank four or more drinks at one time during pregnancy [6.]
	OUTCOME II: Alaska children, youth and adults are mentally healthy and living successfully.
	Wellness and Mental Health Indicators
11	Days of poor mental health in past month (Adults) * [4.]
12	Youth who experienced depression during past year* [1.]
13	Youth who do not feel alone in their life [1.]
	Suicide Indicators
14	Suicide Rate per 100,000* [7.]
15	Non-fatal suicide attempts (rates per 100,000)* [7.]
16	Adults who have thought about committing suicide [4.]
17	Youth who have thought about committing suicide [1.]
	OUTCOME III: All community members are connected, resilient and have basic life skills that promote positive behavioral health and wellness.
	Resiliency and Connectedness Indicators
18	Adults with needed social and emotional support [4.]
19	Youth with supportive relationships [1.]
20	Youth with social, emotional and employability skills [8.]
21	Youth engaged in meaningful activities [1.]
22	Youth who feel like they matter to other people in the community [1.]
23	Students who feel connected to their school [8.]
24	Family Support and Connection [9.]

* Indicators are also part of the AK DHSS and Mental Health Trust's Alaska Scorecard.

Data Sources

1. YRBS (Youth Risk Behavior Survey) AK DHSS, DPH, and US CDC
2. SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health (NSDUH)
3. Alaska Court System, Minor Consuming Charges; Court View Case Management System
4. BRFSS (Behavioral Risk Factor Surveillance Survey) conducted by AK DHSS, DPH and US CDC
5. ABDR (Alaska Birth Defects Registry) conducted by AK DHSS, DPH
6. PRAMS (Pregnancy Risk Assessment Monitoring System) conducted by AK DHSS, DPH and US CDC
7. Alaska Trauma Registry managed by AK DHSS, DPH
8. SCCS (School Climate and Connectedness Survey) conducted by Association of Alaska School Boards (AASB)
9. NCHS (National Child Health Survey, Alaska Sample)

SAMHSA'S Strategic Prevention Framework

The purpose of the Strategic Prevention Framework is to build the capacity and infrastructure for States, tribal organizations, and communities to decrease substance use and abuse, promote mental health, and increase overall health and wellness. The Strategic Prevention Framework (SPF) utilizes the following five-step process. For additional information, tools, strategies or ideas on how to best utilize each step, link to the SAMHSA Prevention Platform website at: https://preventionplatform.samhsa.gov

Step 1) Assessment:

Profile population needs, resources, and data to address the problems and gaps in service delivery.

Communities must accurately assess their behavioral health-related conditions using local, regional and state data. Data should identify the magnitude of the problem to be addressed, where the problem is greatest, and risk and protective factors associated with the identified problem. Communities must also assess community assets and resources, gaps in services and readiness to act.

You should begin by using the provided section on resources and links to web sites that publicly list State and regional data that you may use in developing your needs assessment. It may be more challenging in smaller or rural communities to identify local data that further defines the conditions you wish to change. Focus groups, community surveys or key leader interviews may be helpful in gathering local data. You will also need to assess community readiness in order to determine what capacity you will have to implement strategies that you will later choose during the planning stage. Matching interventions to community's level of readiness is critical for success.

Key Milestones	Key Products
• Collaboration with advisory groups • Collection & analysis of local/regional data • Development of problem statements • Identification of potential geographic target areas/populations • Analysis of resources: programs, facilities, key individuals and leaders, potential partnerships • Assessment of organizational, fiscal and leadership capacity • Assessment of cultural capacity • Analysis of service and resource gaps	• Clear, concise and data driven priority BH issue. • Data sources for ongoing assessment • Community resource assessment(community program, resource and service base-line inventory) • Gap analysis (resources and services)

Step 2) Capacity:

Mobilize and/or build capacity to address needs.

Bringing together key stakeholders at the State, regional, and local levels is critical to plan and implement successful prevention activities that can be sustained over time. Key tasks may include, but are not limited to, convening leaders and stakeholders; building coalitions; training stakeholders, coalitions, and service providers; organizing agency networks; leveraging resources; and engaging stakeholders to help continue the activities.

Community readiness tools, assessments and strategies to increase readiness are available from the Tri-Ethnic Center for Prevention Research http://www.triethniccenter.colostate.edu/communityreadiness.shtml. You may choose to adapt this tool to meet your needs or create your own readiness tool.

Key Milestones	Key Products
• Creation and continuation of partnerships • Invitation to stakeholders who are not yet involved • Meetings and workshops with key stakeholders, coalitions and service providers • Further define level of community readiness to address identified issues • Introduction of training and education to promote readiness, cultural competence, leadership and evaluation capacity	• Directory of key stakeholders, leaders and service providers • Partnership agreements/memorandums • Capacity report with quarterly updates • Community readiness summary

Step 3) Planning:

Develop a comprehensive Strategic Plan.

Communities must develop a strategic plan that provides a vision for the prevention activities and strategies for organizing and implementing prevention efforts in their community. A strategic plan must be based on documented needs, build on identified resources/strengths, set measurable outcomes and include the performance measures and baseline data against which progress will be monitored. Plans may be adjusted as the result of ongoing needs assessment and monitoring activities. The issue of sustainability should be a constant throughout each step of planning and implementation and should lead to the creation of a long-term strategy to sustain policies, projects and practices. The strategic plans must be data-driven and focused on addressing the most critical needs in the State, region and locale.

A *Logic Model* identifies the core components of the strategic plan. These include the long-term outcome(s) of the grant project, selected risk and protective factors you wish to change, resources available or "inputs", activities you plan to implement, prevention strategies, population you intend to serve, the number or amount of delivered services or people served (outputs), and short and long term outcomes. The sequence of the *Logic Model* should flow and provide a rationale between the prioritized risk and protective factors, selected activities and prevention strategies and expected outcomes.

Key Milestones	Key Products
• Planning meetings and development sessions • Further define geographic target population • Define long-term and short-term measurable outcomes from assessment, select key strategies and performance targets • Draft strategic plan • Logic model development • Identify risk and protective factors that affect outcomes identified • Selection of policies, programs and practices • Preliminary action plan and timeline development • Creation of evaluation plan	• Comprehensive strategic plan • Logic model • Preliminary action plan and timeline • Performance outcomes • Evaluation plan and performance measures

Step 4) Implementation:

Implement evidence-based prevention policies, projects and policies and infrastructure development activities.

The findings of your needs assessments should be used to guide selection and implementation of policies, projects and practices that will be effective in measuring community change. Please note that community implementers should ensure

that community and culturally responsive adaptations are made, when replicating an evidence-based program, without sacrificing the core elements of the policies, projects and practices. All selected strategies need to have existing evidence of effectiveness or a clear plan to assess ongoing effectiveness of the strategy toward community change.

Key Milestones	Key Products
• Collection of process data and additional pre-implementation data • Full action plan development, timeline, identify partners responsible for each strategy • Acquisition of relevant materials for implementing evidence-based policies, programs and practices • Implementation of strategic plan • Consultation and collaboration with evaluation team • Implementation of evaluation plan	• Finalized action plan and timeline • Identified evidence-based policies, strategies and practices • Further refined evaluation plan

Step 5) Evaluation:

Monitor process, evaluate effectiveness, sustain effective programs/activities, and improve or replace those that fail.

Ongoing monitoring and evaluation are essential to know if the outcomes desired are achieved and to assess project effectiveness and service delivery quality. Communities should collect outcome data on a regular basis, so that projects can monitor, evaluate, sustain, and improve their community-based prevention activities and know they are reaching the desired target population and reaching the identified project outcomes. Key questions that you must address include how much are you doing, how well are you doing it, and is anyone better off?

Data to be collected as identified on the *Logic Model* includes *outputs* (the type and number of services delivered, and the number of persons served), and *outcomes* (the expected measurable change in attitude, knowledge, skills, conditions, and/or behaviors). If it is determined that the activities and strategies used are not meeting the desired outcomes, then modifications may be needed, or it may be necessary to revisit earlier steps in the SPF assessment process. Both assessment and evaluation are ongoing processes necessary to determine if our prevention efforts are making a difference in the population or community we are serving.

Key Milestones	Key Products
• Consultation and collaboration with evaluation team • Process evaluation • Collection of required data (outputs, participant feedback, measure change in outcomes) • Review of effectiveness of policies, projects and practices • Development of recommendations for quality improvement	• Evaluation report and updates • Recommendations for quality improvement

The Strategic Prevention Framework does not guarantee results; it does allow you to be fully aware of the important work you are doing and will help to bring clarity to your strategies, interventions and overall community change process. For additional resources, please visit The Athena Forum at https://theathenaforum.org/intro_field_prevention

Be flexible in allowing the SPF process to occur. This requires patience, a commitment to and understanding of where you are in the process, and how to use the SPF to achieve the outcomes you desire for your community. The Strategic Prevention Framework is a dynamic and integrated process and requires you to move back and forth among the five steps to implement a well-developed and effective plan. If you are open to the process, you will find that the SPF model not only provides you with clearly defined tools and strategies to plan your prevention approach, but it also enables you to build sustainable and culturally responsive strategies to meet the needs of your community.

Institute of Medicine (IOM), Prevention Classifications

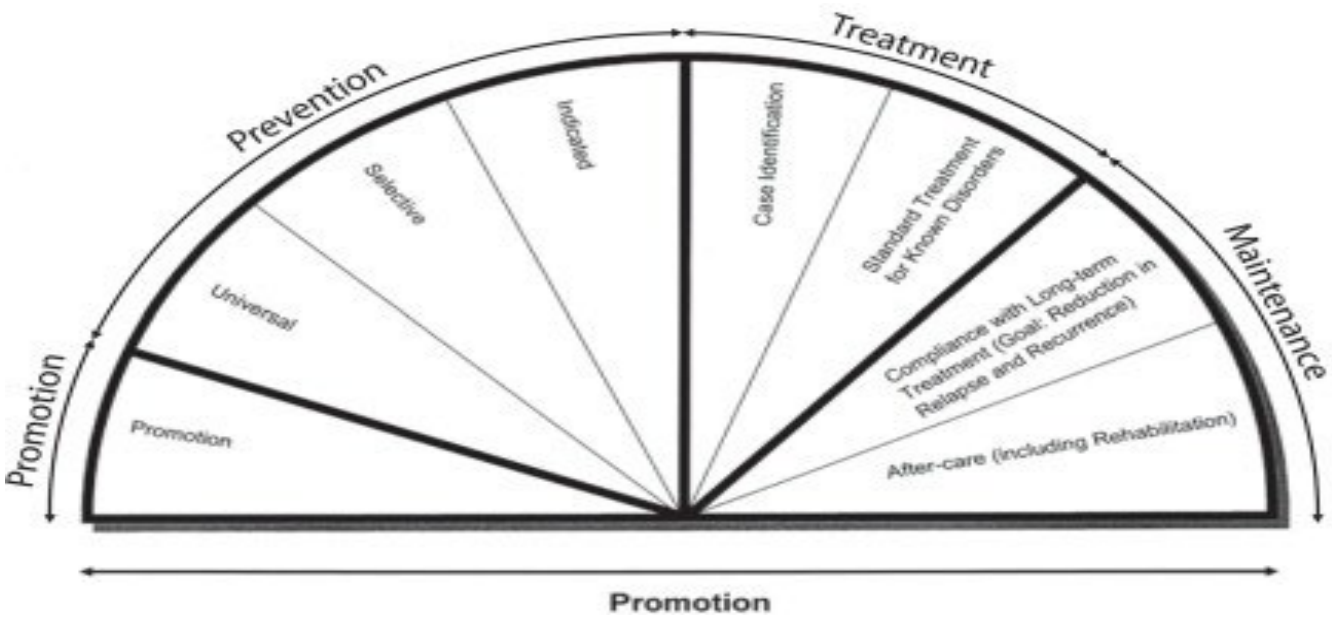
The Institute of Medicine (IOM) system classifies prevention strategies and activities according to the populations they intend to affect. Prevention strategies are divided into one of three IOM classifications:

- **Universal strategies:** (indirect or direct): target the general population
- **Selective strategies:** target people at *higher-than-average risk* for the problem behavior
- **Indicated strategies:** target people already experiencing or engaging in problem behaviors, but *may not* have been diagnosed with a disorder.

The Institute of Medicine took its prevention classification a step further by developing a *Continuum of Care* as shown in the diagram below[2]. The Continuum shows the relationship between the **Promotion** of health and wellbeing to **Prevention, Treatment** and **Maintenance** within the various stages of the health care process.

Continuum of Care

Mental Health Intervention Spectrum



Mental Health Promotion includes efforts to enhance individuals' ability to achieve developmentally appropriate tasks (developmental competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen their ability to cope with adversity.

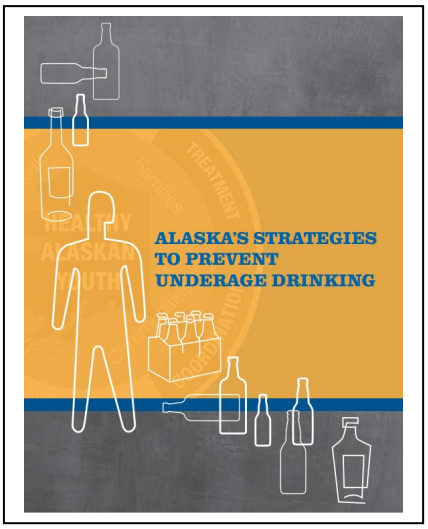
[2] Institute of Medicine Prevention Mental, Emotional, and Behavioral Disorders Among Young People (2009, pg 67).

Relevant State Plans

Alaska's Plan to Reduce and Prevent Underage Drinking

In October 2009, the Division of Behavioral Health, in partnership with the Alaska Interagency Committee to Prevent Underage Drinking (AKPUD), released the State of Alaska Plan to Reduce and Prevent Underage Drinking in response to the 2007 "Call to Action to Prevent and Reduce Underage Drinking" by the Acting Surgeon General. The AKPUD organized in 2007 to begin looking at Alaska's data and needs related to youth alcohol use. The plan developed with input from the interagency committee, 25 Town Hall meetings on Underage Drinking, and public comment from a diverse group of Alaskans.

The plan is organized to provide recommendations on three levels of interaction (national; state; and community) and eight strategy components (media campaign; alcohol advertising; limiting access; youth oriented interventions; community intervention; government assistance and coordination; alcohol excise taxes; and research and evaluation). Currently Recover Alaska in coordination with DBH is conducting focused conversations with Alaskans (providers, youth and grantees) in order to determine priorities and potential updates in the plan. Those recommendations will be incorporated into a future update of this plan.



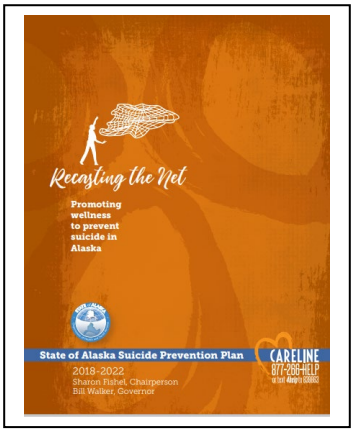
We have plenty of work to do but we are headed in the right direction. Utilizing the strength-based approach of the Strategic Prevention Framework, community coalitions and inter-departmental collaboration we will continue to have an impact on the negative consequences related to underage drinking.

Copies of the Plan are available at:
https://health.alaska.gov/dbh/Documents/Prevention/UnderagedrinkingUpdated.pdf

Alaska Suicide Prevention Plan

In September 2004, the Statewide Suicide Prevention Council in coordination with the Department of Health and Social Services released the Alaska Suicide Prevention Plan. The plan was developed based upon recommendations from the National Strategy for Suicide Prevention: Goals and Objectives for Action released by the U.S. Department of Health and Human Services in 2001. The plan now titled Recasting the Net was updated in 2018 along with the valuable Alaska Postvention Guide both available at https://health.alaska.gov/SuicidePrevention/Pages/default.aspx.

The Alaska Suicide Prevention Plan outlines 13 goals with recommended strategies for individuals, groups and communities to "*reduce the incidence of suicide and non-lethal suicide behavior in Alaska*". The Division of Behavioral Health strongly encourages communities to utilize the plan to support development of these strategies including additional resources supported by the Statewide Suicide Prevention Council as well as other state and national resources to address the high rate of suicide in Alaska. The Council is currently revising and updating the five-year plan which will be released later, in 2011.



What is Resiliency?

Resiliency is the ability to "bounce-back" and successfully overcome life challenges and problems. **People who are resilient have supportive family and friends, possess skills to cope with life successfully, and are engaged in activities that give their life meaning and purpose.**

Increasing Resiliency

Resiliency is nurtured through supportive relationships and being involved in activities that:
1) Have meaning and purpose; 2) Teach and practice life skills and social competencies (sometimes called Social Emotional/ Employability Skills). Three factors contribute to resiliency:*

- Connectedness – Connectedness is experienced as connection to people or a positive affiliation to "places". Emotional support is provided by being close to, or attached to other people. Support provides assistance in working through problems, and guidance in taking on new challenges. Throughout the relationship, high expectations are maintained.

  Connectedness also refers to a sense of "belonging" or identity" to a place or organization (i.e. feeling connected to school, a club, a team, a cause, or their culture.) Activities that increase supportive caring relationships and/or a sense of belonging to positive pro-social organizations, contribute to resiliency.

- Meaningful Engagement – Involvement in activities that give life meaning and purpose contribute to resiliency. Meaningful engagement efforts often include helping others or improving local conditions (i.e. subsistence, or cultural activities, community service, education, organizing or advocacy efforts). Meaningful *Youth Engagement* focuses on involving youth in decision-making and all phases of planning, organizing and evaluation of projects.

- Life Skills and Social Competencies - People who are resilient have the personal awareness, social and life skills to make positive choices, maintain healthy relationships, and succeed in life. *(Sometimes called Social, Emotional and Employability Skills.)*
  - ✓ Life skills include the ability to make decisions, solve problems, resolve conflicts, think critically, manage stress and make healthy decisions
  - ✓ Social Competencies include abilities to communicate, resolve conflict, get along with others, empathize, and be culturally sensitive.

** Building Developmental Assets ™ is another way to increase resiliency and connectedness.*

Measuring Resiliency and Connectedness

Resiliency can be measured by how much someone reports being supported, connected, meaningfully engaged and having the life skills and social competencies to maintain their heath and wellness.
Short-term outcomes related to resiliency:

1. Having positive supportive relationships
2. Feeling like I belong to ….*name of place, organization etc*
3. Being engaged in meaningful activities
4. Having life skills and social competencies

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[3] National Research Council and Institute of Medicine. (2002). *Community Programs to Promote Youth Development*. J. Eccles & J.Goodman, eds. www.nap.edu/catalog/10022.html. This list is consistent with the Critical Elements of Successful Youth programs cited in the *Alaska Adolescent Health Plan* 1995.

[4] B. Bernard. (2004) *Resiliency: What We Have Learned*. WestEd.

Culture is Prevention . . .

Cultural Identity - **Cultural Connectedness** is a protective factor and a strengths-based approach associated with the prevention of substance abuse and suicide and an increase in overall well-being.

Culture is the sum total of ways of living, including values, beliefs, traditions, protocols, rituals, language, behavioral norms, ways of knowing and styles of communication.[5]

One's **Cultural Identity** is the extent to which someone connects to and practices the values, beliefs, and traditions of their identified culture.

Ways to Measure Cultural Identity and Connectedness

Communities desiring to increase cultural identity or connectedness can evaluate their efforts in many ways, examples include:[6]

Knowledge:	Increased knowledge of their identified culture
Attitudes:	Increased appreciation and connection to their identified culture
Behavior:	Increased skills in specified cultural/traditional practices

Threats or Risk Factors associated with Cultural Identity

Alaska Native and American Indian (ANAI) persons or groups may experience higher levels of psychological and social stress due in part to historical or generational trauma, oppression and imposed cultural change. These adverse experiences or risk factors are associated with suicide and high rates of alcohol and other drug use.[1.] *Other groups defined by ethnicity, age, ability, religious affiliation, or sexual orientation, may experience similar risk factors.*

Strengths and Resources

Additional recourses can be found at the UAF **Alaska Native Knowledge Network (ANKN), Native Educator Associations Regional and statewide associations, the Center for Alaska Native Health Research and First Alaskans Institute**

[5] U.S. DHHS *To Live to See the Great Day that Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults,* SAMHSA (2010). http://www.sprc.org/library/Suicide_Prevention_Guide.pdf

[6] Adapted from Caroline Cruz, CSAP Western Region, 11.2010, communications

Section II: Resources for SPF Steps 1-5

Step 1: Assessment Resources

For a community to understand its problems and the underlying factors affecting those problems, information must be collected at the local and or regional level. A community assessment determines the needs and identifies the gaps (and any duplication) in the services or resources. Since problems do not happen in isolation of community social norms and practices, an assessment may include a review of local public and/or organizational policies.

A local needs assessment can answer such questions as: *What are the behavior problems facing our community and how significant are they*? *How prevalent are the risk factors or protective factors associated with the problems in the community*? *To what extent are people aware of the community resources and services?* A local needs assessment may include any of the following:

- A community profile: population statistics (demographics, cultures etc), local economy, transportation government, schools, public facilities, major regional organizations etc. **Alaska Community Database** has some of this information: https://maps.commerce.alaska.gov/dcra-cdo/home
- Data related to areas of concern: examples major causes of death or injuries; prevalence of problematic behaviors (tobacco/ alcohol/drug use; suicides and suicide attempts; delinquency or violence related data ; teen births, etc)
- Prevalence of risk factors and protective factors associated with the problems

Data may come from local or regional sources (health departments, law enforcement, schools, etc.) Additionally, *community opinion surveys* may be useful to further understand community perceptions of major problems. Note: Data collection and analysis takes time! Planning team members must be prepared to make a commitment that may take several months.

Community Resource Assessment
This type of assessment focuses on your community's strengths and resources. Briefly describe your resources. *Remember, resources can include many things in a community!* After you make your list decide if there are gaps that need to be addressed. Below are a few examples of resources*:*

- Schools: pre-k through 12 grade, college and/or technical schools for all ages
- Health and social services available
- Key businesses, corporations or foundations that provide support or services to your community
- Faith-based or Culture-based groups and organizations
- Informal groups, clubs or affiliations (e.g. Rotary, Lions, Elks, Moose etc.)
- Key individuals that are supportive of your efforts and can make things happen!
- Other significant agencies, organizations programs and services available to children, youth, and their families in prevention, early intervention and or treatment of behavioral or public health

Resources:

- **Alaska State Library** http://library.state.ak.us/ has numerous resources
- **Alaska's Epidemiologic Profile Consumption and Consequences (2019):** https://health.alaska.gov/dph/Epi/injury/Documents/sa/SubstanceAbuseEpiProfile_2019.pdf This document provides a baseline epidemiological profile on substance use, abuse, dependence and consequences.

Step 2: Capacity Building Resources

What is an effective coalition?

Coalition building is a proactive strategy that promotes coordination and collaboration, and makes efficient use of limited community resources. By connecting multiple and diverse sectors of a community and developing a comprehensive approach to a common issue (such as driving under the influence, domestic violence, or suicide prevention), coalitions can achieve amazing and sustainable outcomes—much more than could ever be achieved alone.

Building capacity within your coalition involves increasing membership to include a diverse mix of community members with different skills, resources, and experiences. Coalitions must engage stakeholders of all ages from youth to Elders, as well as build cultural responsiveness. Members of the public should hold leadership positions, not substance abuse professionals. Effective leaders are vital to the success of a coalition; a leader must be able to keep the vision and goals of the coalition alive and motivate the community to take action. Coalitions must have a clear plan of cooperation and division of responsibilities amongst coalition members.

Additional Resources:

- **Community Anti-Drug Coalitions of America (CADC**A) http://www.cadca.org/ Resources, training, or free technical assistance for coalitions. Note the Capacity Building Primer at, https://www.cadca.org/resources/capacity-primer.

- **The Prevention Institute** – Promotes primary prevention policies, organizational practices, and collaborative efforts that improve health and quality of life. See section and guide on Coalition Building https://www.preventioninstitute.org/publications/developing-effective-coalitions-an-eight-step-guide

Community Readiness

The State of Alaska's Division of Behavioral Health understands the importance of knowing if your community is "ready" to make social change. The *Community Readiness Overview* will help you identify ways you can assess your community for its readiness to begin a social change process. The basic premise of looking at your community's readiness is to help match an intervention or strategy to a community's readiness for change.

Community Readiness Overview

Identify your issue/what you want to change in your community.

1. Identify your "community" with respect to the identified issue-- this may be a geographical area, a group within that area, an organization or any other type of identifiable "community.

2. Ask questions to determine your community's level of readiness to address the identified issue.

3. Select strategies/conduct workshops based on your community's readiness: there are several strategies appropriate for each stage of readiness.

4. Review how effective your efforts have been.

Six Questions to Ask About Your Community's Readiness

1. **Community Efforts**: To what extent are there efforts, programs and policies to address the identified issue?
2. **Community Knowledge of the Efforts**: To what extent do community members know about local efforts? Are the efforts available to all segments of the community?
3. **Leadership**: To what extent are community leaders and active community members supportive of the issue?
4. **Community Climate**: What does the community know about the issue? Is there interest in the issue; is the community ready to take action?
5. **Community Knowledge about the Issue**: How well do community members understand the causes of the problem and how it impacts the community?
6. **Resources Related to the Issue**: Are local resources- people, time, money, space, etc- available to support change efforts

What Level of Readiness Does Your Community Fall Under?

1. **No Awareness**: The community or leaders do not generally recognize Issue as a problem (or it may truly not be an issue).
2. **Denial Resistance**: At least some community members recognize that it is a concern, but there is little recognition that it may be occurring locally.
3. **Vague Awareness**: Most feel that there is a local concern, but there is no immediate motivation to do anything about it.
4. **Preplanning**: There is clear recognition that something must be done, and there may be a group addressing it. However, efforts are not focused or detailed.
5. **Preparation**: Active leaders begin planning in earnest. Community offers modest support of efforts.
6. **Initiation**: Enough information is available to justify action. Activities are underway.
7. **Stabilization**: Administrators or community decision makers support activities. *Staff are trained an experienced.*
8. **Confirmation/Expansion**: Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
9. **High Level of Community Ownership**: Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

Additional Community Readiness Resources:

- **Tri-Ethnic Center** model resources and be found at, https://communityreadiness.org/ (The originators of the Community Readiness model)

Step 3: Planning Resources

Risk and Protective Factors

Careful identification of community-specific risk and protective factors is a critical step in selecting the best strategies to impact the behavioral health conditions in your community. The factors listed below are research-based, but not an exhaustive list. It is important to select factors that truly impact the health and wellness of your community.

PROTECTIVE FACTORS	RISK FACTORS
Characteristics within the individual or conditions in the family, school or community that help youth cope successfully with life challenges & existing risk factors.	Characteristics within the individual or conditions in the family, school or community that increase the likelihood youth will engage in problem behavior.
FAMILY • **Family connectedness** (attachment & bonding)* • Positive parenting style • Living in a two parent family • Higher parent education • High parental expectations about school	**FAMILY** • **Experienced child abuse (physical, sexual) or other family violence*** • Family history of the problem behavior • Family management problems • Family conflict • Favorable parental attitudes and involvement in problem behaviors • Household access to substances or guns
SCHOOL • **Connected to school*** • Caring school climate • Student participation in extracurricular activities • Early intervention and support services	**SCHOOL** • Academic failure • Lack of personal commitment to school
COMMUNITY • **Positive connection to *other* adults*** • Safe, supportive, connected neighborhood • Strong community infrastructure (services for those in need) • Local, state policies and practices that support healthy norms and child-youth programs • Range of opportunities *in the community* for meaningful youth engagement	**COMMUNITY** • **Availability of alcohol/other drugs*** • **Community norms and laws*** • Availability of firearms • Transitions and mobility (*moving a lot*) • Low neighborhood attachment & community disorganization • Poverty
INDIVIDUAL - PEERS • **Engagement in meaningful activities** • **Life skills and social competence*** *(Social Emotional/Employability Skills)* • **Cultural identity and connection*** • Positive personal qualities • Positive self concept • Positive peer role models • Religious identity • High grade point average	**INDIVIDUAL - PEERS** • **Early initiation of the problem behavior*** • **Feeling depressed or suicidal*** • **Loss of cultural identity and connection*** • Constitutional factors (see definition) • Childhood media exposure to violence and alcohol • Early and persistent antisocial behavior • Friends who engage in the problem behavior • Favorable attitudes toward the problem behavior (low perceived-risk of harm) • Older physical appearance than peers • Paid work more than 20 hrs/week • Perceived risk of untimely death

CSAP Prevention Strategies

There are six broad prevention strategies that address risk behaviors (e.g. alcohol/tobacco/drug use, suicide etc.) and can increase resiliency. A community coalition or planning team must decide which strategy(s) work best to address their needs or issues. Communities at different *levels of readiness* may need to use different strategies. For example, a community at the beginning stage of readiness may use strategies one and two (information and education). After the community is "more ready" to address the issues more deeply, other strategies may be selected**.** *Community efforts are most effective when combinations of strategies are used, together.*

1. DISSEMINATION OF INFORMATION

This strategy provides information about the nature and extent of the problem, its warning signs or its solutions. It may provide information about available prevention programs and activities within an agency. Dissemination of information is characterized by one-way communication between the source and the audience, with limited contact between the two. *Examples include:*

- Resource centers
- Pamphlets, posters, flyers
- Motivational events or speakers[1]
- Newspaper and newsletter articles
- Radio and television PSAs (public service announcements)
- Community resource directories
- Health fairs & some wellness gatherings
- Website information
- Information-based media campaigns

2. EDUCATION*

This strategy involves two-way communication. It is different from strategy one (disseminating information) in that it's based on the interaction between the educator and the participants. Activities under this strategy often focus on life skills (e.g. problem solving, decision making, communication skills, stress management and coping strategies.) This strategy may also provide training in critical thinking skills and media literacy. *Examples include:*

- Classroom and small group sessions
- Peer leader and peer helper programs
- Education programs for youth groups
- Social, emotional/employability skills
- Parenting and family management classes
- Cross-age teaching or peer education
- Interactive technologies
- Life skills (bullying prevention, conflict resolution, refusal skills, media literacy or subsistence skills)
- Staff, volunteer or community workshops on prevention or early intervention topics

3. "ALTERNATIVE" (MEANINGFUL) ACTIVITIES*

This strategy provides for the active engagement of the target audience in several phases of the project including: planning organizing, implementation and evaluation. These efforts are most effective when used with other prevention strategies. *Examples include*:

- Community service activities
- Youth centers & community drop-in centers
- Intergenerational events and celebrations
- Leadership activities
- Mentoring programs
- Job shadowing, internships, workplace experiences
- Culturally-based activities (subsistence activities, language, dance, arts instruction etc.)
- *Some* social & recreational activities (e.g. drug-free dances and parties)
- Recognition events that celebrate individual or group accomplishments

** These strategies lend themselves to building protective factors, resiliency and Developmental Assets.*

1. The list of six strategies was developed by Center for Substance Abuse Prevention (CSAP)
2. Motivational speakers can have a powerful short-term impact but within 72 hours research has shown that it's usually gone.

4. COMMUNITY-BASED PROCESSES

This strategy aims to enhance community capacity to more effectively provide prevention, early intervention and treatment services. Activities in this strategy include organizing, planning, training, building coalitions, networking and enhancing the effectiveness of programs. Examples include:

- Coalitions, collaborations and/or wellness teams
- Community team-building activities
- Needs assessments & community readiness surveys
- Cross-systems planning (e.g. schools, health, police)
- Youth-Adult partnerships addressing community issues
- Efforts to decrease barriers to services (e.g. scholarships, transportation, child-care; assure cultural sensitivity)

5. "ENVIRONMENTAL" APPROACHES*

This strategy seeks to change the conditions around people. Specific strategies aim to change community social norms/attitudes and practices or, its policies and laws (ordinances, codes or standards). Additionally, it may include changes made at the organizational level (its own policies and practices) that promote healthy behaviors. *Examples include:*

- Review and modify policies related to tobacco or alcohol **prices, taxing or advertising**
- Establish and/or **review local ordinances and practices** related to alcohol/drugs and firearms. Examples: Number, location, hours of operation or criteria for licensing liquor stores or outlets
    1) Purchasing of liquor or firearms
    2) Underage drinking, curfew hour, etc.
- Increase local **enforcement and judicial sentencing** related to:
    1) Availability or distribution of tobacco, alcohol or other drugs
    2) Underage drinking
    3) Driving while intoxicated
    4) Family and dating violence or juvenile delinquency offenses
- Change **norms or attitudes** about alcohol, tobacco or illegal drugs, drinking and driving, violence or bullying behavior, mental health, sexual orientation, cultural beliefs, etc. Examples:
    1) Drinking while pregnant
    2) Storing firearms safely (to prevent unintended injuries and suicide among depressed individuals)
    2) Assisting a child/youth in need (cold, hungry, not adequate clothing)
    3) Changing **public perceptions** and norms about youth and their capabilities
    4) Promoting a community's "social responsibility" to supporting all children & youth
- Change **school norms,** policies, programs and practices to increase a positive school climate
- **Media strategies** to assure safe, responsible reporting about suicide, mental illness and substance abuse
- Media strategies addressing underage or drinking while pregnant, or balanced reporting about youth
- Vendor **education** or business practices promoting health (e.g. smoke-free policies, always-checking identification, or youth-friendly practices)

6. INDIVIDUAL SUPPORT AND REFERRAL

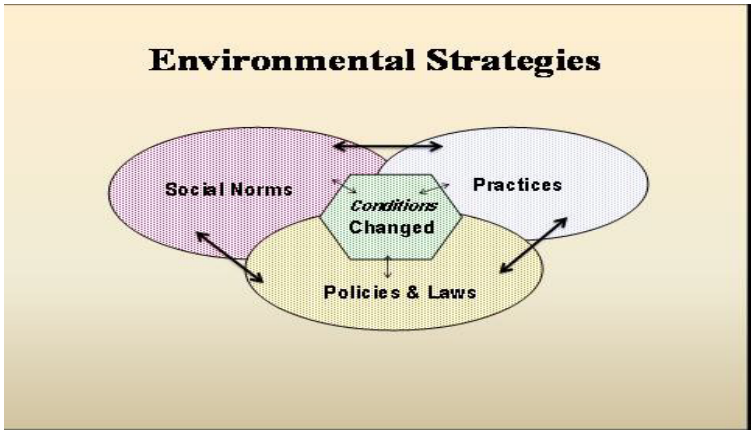
This strategy identifies those who have begun displaying the warning signs or are experiencing problems as a result of engaging in risk behaviors (e.g. use of tobacco, alcohol or other drugs, skipping school, late to work, isolating themselves, giving personal items away). This strategy also assesses if concerning behavior can be reversed through education or referral of services. *Examples:*

- Support groups, talking/healing circles
- Suicide survivors groups
- Driving while intoxicated education programs
- Alcohol information schools
- Student & employee assistance programs
- Crisis Lines or hotlines
- Depression and mental health screening programs
- Nicotine use and addiction screening

Adapted from the Center for Substance Abuse Prevention,
Alaska Division of Behavioral Health, Section of Prevention & Early Intervention, 2010

Environmental Strategies

The Division of Behavioral Health strongly urges all applicants to consider Environmental Strategies as part of their prevention efforts.



Environmental Approaches:
Environmental approaches are the intentional efforts to change the conditions around people to ensure greater health, safety and wellness. Specific environmental strategies seek to change a community's social norms, practices, policies or laws. http://hss.state.ak.us/dbh/prevention/publications/default.htm

Perceptions/Social Norms: The way people think and feel about something or someone. Many communities use social marketing approaches to change social norms or perceptions. Examples: Youth perception of parent's approval or disapprove tobacco or alcohol use; beliefs/attitudes about certain groups of people (i.e. kids these days, attitude)

Social Norms: The *collective* thinking/attitudes or behaviors about what is normal or acceptable. **Examples**: Students belief that everyone is doing "it". The belief to NOT drink while pregnant

Practices: The way people do things *intentionally*; customs, traditions, protocols.
They may be formal or informal.

Informal practices are typically the way individuals interact. *Examples***:** the way people greet each other; the naming of a child; the rituals around death, the way neighbors may respond to a child when there is a problem.

Formal practices are typically within an organization or group (rules or procedures.) They come from figures of authority (e.g. coaches, directors, school principals), or may evolve over time as, "the way things are done."

Examples: Discipline procedures, teaching strategies; how a school or classroom is managed; how customers are treated; how a leader evokes youth engagement.

Policies: the way an organization governs or manages itself and its employees; policies institutionalize an organization's values and practices.

Examples: No smoking within the restaurant; background checks for everyone working with children; random drug testing of student athletes.

Laws or local ordinances: A set of "rules" to govern a community/state/country. They are created by the legislative body and enforced by the administrative branch of government.

Examples: Curfews, taxes on tobacco or alcohol, bar hours of operation, parent permission for teens to get services; mandatory reporting of child abuse.

Additional Resources:
The Coalition Impact: Environmental Prevention Strategies https://www.cadca.org/resources/coalition-impact-environmental-prevention-strategies

Prevention Principles

Prevention principles include the common elements [found in research] that identify effective prevention practices. This list may be used to guide the thinking, planning, selection, and delivery of your efforts. If a community already has a prevention program or strategy in place, these principles may be used to assess the program's potential effectiveness. The following principles have emerged from research supported by the National Institute of Drug Abuse (NIDA) and the National Research Council.

1. Prevention efforts must address the risk and protective factors associated with the problem (e.g. substance use)

2. Prevention efforts must begin early before problems arise; they anticipate times of challenge and crisis. Intervene early and plan for life and school transitions.

3. Prevention efforts need to be reinforced over time. Consider duration of exposure (time), the dosage (how often) and follow-up efforts.

4. Information alone doesn't change behavior. (Showing consequences in a "scare tactic" format has only a short-term impact.) Information needs to be combined with other prevention strategies, see number 10.

5. Prevention planning needs to involve "stakeholders" (people who care about the issue) -- in ways that have meaning for them.

6. Prevention efforts must include the community - family, schools, business, faith, community groups & individuals, not just one organization.

7. People at different levels of risk, need different kinds of prevention or intervention strategies.

8. Prevention efforts need to be appropriate for age, gender and cultural backgrounds.

9. Prevention efforts that incorporate resiliency and positive youth development approaches emphasize:
   - Supportive relationships and connectedness
   - Activities that have true meaning to the participants
   - Skill building and some recognition of success

10. Community prevention efforts are most effective when combinations of strategies are used:
    - Public Information
    - Alternative, meaningful activities
    - Environmental approaches*
    - Education/skill building
    - Community capacity building
    - Individual support and referral

Environmental Approaches aim to change conditions: norms, perceptions, policies, practices or laws within an organization or community.

Logic Models

A logic model is a planning tool to help you address your key prevention efforts. Below is an outline of the elements to include in a logic model; in addition, a template and logic model example are provided to assist you in developing your own logic model. We recognize that there are many different logic model styles—please pick the model that best meets your needs and planning style—this template is only one example.

1. **Activities:** Activities are what you do to reduce risk factors or increase protective factors. These are the processes or events you undertake using the resources available. List your major programmatic activities by what is being done by when. Some logic models will include a timeline or provide a separate timeline that identifies a detailed list of activities or milestones to be achieved with who is responsible. *Examples:*

- Provide 5 training sessions by Nov. 2011
- Develop Wellness Plan by Feb
- Sponsor 1 Parent Training by Feb 2011
- Host at least 8 youth-led events by June 2011

2. **Target Population:** The people you are focusing your prevention efforts on. As a result of your efforts you hope to see changes in this population. *Examples: parents, teachers, students, children, youth, whole community.*

3. **Outputs:** The number of activities, events, or participants served. It could include the duration of events, or products produced by your activities. *Examples:*

- 20 HS students receive 1 hour of monthly life skills sessions.
- 1,200 newsletters mailed to families

4. **Short Term Outcomes:** Short-term outcomes are what you cause to happen. They describe changes in attitudes, knowledge, skills, behaviors or conditions that the program produces. *In some cases the short term outcomes could be your selected risk or protective factors.* Identify the appropriate, measurable outcomes for your program. This can be at the individual, organizational, or community level. *Examples:*

- Increase the age of first use of alcohol by high school students.
- Increase life skills among club participants
- Increase the perception of the harmful effects of alcohol among middle school students
- Increase cultural identity and subsistence skills among participating students

Hint: structure your outcome statements using the following format:

The Desired Effect	IN WHAT	For Whom
Increase	Attitude	Program Participant
Decrease	Perception	Client
Maintain	Knowledge	Individual
Improve	Skill	Family
Reduce	Behavior	Neighborhood
Expand	Condition	Organization
Etc.	Etc.	Community

5. Long Term Outcomes: Long-term outcomes are what your program expects to achieve over time. These impacts are influenced by *other* community efforts, in addition to your program. Applicants must select from the following:

- All Alaskan communities, families and individuals are free from the harmful effects of substance use, dependency and addiction.
- Alaska children, youth and adults are mentally healthy and living successfully.
- All community members are connected, resilient and have basic life skills.

Logic Model *(Template)*

Logic Model for: _____ _____
Project Name & Organization Date

Two Risk /Protective Factors addressed by this project: _____
* Short term outcomes *could be* your selected risk or protective factors

Activities Activities selected are based on your Risk & Protective factors. Describes what by when (timeline)	**Target Population**	**Outputs** Number of activities, events, products, participants	**Short Term Outcomes*** Changes in attitude, knowledge, skills, behavior or external condition	**Long Term Outcome** Select from three given in RFP

Logic Model *(filled out)*

Project Name and Organization: "Ankorak" / Kyeea Youth Services

Two Risk or Protective Factors addressed: Supportive adults & Engagement in meaningful activities

Activities Activities selected are based on your Risk & Protective factors. Describes what by when (timeline)	**Target Population**	**Outputs** Number of activities, events, products, participants	**Short Term Outcomes*** Changes in attitude, knowledge, skills, behavior or external condition	**Long Term Outcome**
1. Provide staff training three times in the year	Providers and volunteers	# of trainings # of people attend	Increase in adult leader skills	All Alaskan communities, families and individuals are free from the harmful effects of substance use, dependency and addiction. All community members are connected, resilient and have basic life skills.
2. Implement the silent mentoring project *from Oct.-April*	Middle and High School age youth	# of students mentored	*Activities 2-7 together will impact all three outcomes:* • Increase supportive youth-adult relationships • Increase in life skills and social skills • Increase engagement in meaningful activities	
3. Teach life skills *through weekly* group sessions	Middle and High School age youth	# of lessons taught # of students		
4. Support youth-led service projects, *throughout the year.*	High school age youth	# of youth participating # of projects		
5. Host cultural activities at least monthly	All community members	# of youth & community members participating # of sessions held		
6. Host student support group *twice a month*	Middle and High School age youth	# of youth attending # of sessions		
7. Conduct post-survey of participants in May 09.	Middle and High School age youth	# of completed surveys		

The Evaluation Plan for this *sample project* may be found on page 29-30 of this document.

NOTE: Your short-term outcomes need to relate *in some way* to at least one of the key statewide population indicators, in Table 1, which can be found on page 4 of this document.

Step 4: Implementation Resources

Evidence-Based Interventions

In the healthcare field, evidence-based interventions, also called EBI, generally refer to approaches to prevention or treatment that are validated by some form of documented evidence. What counts as "evidence" varies. Evidence often is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well. Evidence-based interventions stand in contrast to approaches that are based on culture, tradition, belief, or anecdotal evidence.

One concern is that too much emphasis on EBIs may in some cases restrict practitioners from exercising their own judgment to provide the best care for individuals. For this reason many organizations have adopted definitions of evidence-based practice that emphasize balancing the "research" with the "practical." For the purposes of this resource guide and related material, evidence based programs and interventions are left to users to make their own judgments about which interventions are best suited to their particular needs.

Below is a list of Evidence-Based categories the Substance Abuse and Mental Health Services Administration (SAMHSA) uses for identifying evidence-based interventions. Work continues towards establishing clear definitions and criteria for evidence-based interventions with the overall goal of disseminating information and guidelines for selecting evidence-based interventions that are both, outcome-based and practical. The value and status of EBIs continues to mature and grow—moving toward a balance between "research" and innovation.

NOTE: *In earlier resource guides, prevention practices and interventions were identified as either evidence-based, model or promising programs. SAMHSA is no longer maintaining a listing of model and promising programs and will only be referenced as "Legacy" programs as a historical reference. It is recommended that users contact these program sources directly to determine their effectiveness as identified below.*

1. Peer-Reviewed Journals include primary research literature that identifies potential prevention interventions and presents findings on what works and what doesn't work. However, peer-reviewed journals still require a critical assessment of the quality of research presented and the conceptual model on which it is based. Critical consumers must be prepared to read the material thoroughly to understand the background of the intervention, conceptual model used, the study population including the baseline in which intervention will be measured, quality of the study design, if the intervention was able to measure up to the study's expectations, and finally the summary and discussion of the study's implications for future use. ***Prevention Principles*** (see page 20) that have already been reviewed and identified as "what works" falls under this category. Furthermore, for those applicants choosing to address suicide reduction, the Alaska Suicide Prevention State Plan and the Alaska Plan to Reduce and Prevent Underage Drinking, falls under this category and any strategies used must be congruent with that plan.

2. Documented Effectiveness refers to interventions and strategies that have shown to be effective in the field of prevention and are important to our development of prevention programs and services. Formerly, these were identified as *Model and Promising Programs*. These programs were listed on national registries; however, they did not meet the criteria for listing as evidence based programs. Many prevention projects and programs may not have the resources, technical expertise or extra funding to support extensive research efforts to be listed as an evidence-based program, however, they have implemented strategies based on solid theory, is supported by a documented body of knowledge and shows a strong consensus of effectiveness in the field of prevention.

This approach also validates and incorporates the culture and values of a community that may otherwise be overlooked by traditional research methods. This is especially true among smaller rural or ethnic communities that are not representative of larger population groups.

Sample Timeline

The following timeline describes the tasks and timing for a project. This is just a sample of how to organize your project. Some timelines can be very lengthy depending on the type and scope of project. Some timelines may also include a broad overview of the project on an annual basis, as shown in this example or they may be broken up by year and indicate task completion by month. Timelines will vary depending on the person creating it and the project.

The format below is a sample timeline; you are not required to use this format.

Project: Youth Engage!		**Year 1**				**Year 2**				**Year 3**			
		Quarter				Quarter				Quarter			
		1	2	3	4	1	2	3	4	1	2	3	4
Objective 1: Conduct inter-agency collaboration to determine the barriers that prevent youth ages 5-18 from participating in after school and summer programs, develop plans to mitigate those barriers and collaborate on joint programming as appropriate.													
Objective 1c: Replicate Youth Council model													
Task 1	Identify what works and possible improvements	X	X										
Task 2	Establish agreements with additional high schools and middle schools			X	X								
Task 3	Recruit a staff liaison at each additional school identified					X	X						
Task 4	Conduct orientation for new staff liaisons					X	X	X	X	X		X	
Task 5	Recruit youth at schools identified					X	X	X	X	X	X	X	X

Step 5: Evaluation Resources

Evaluation Plan

Applicants are required to submit an evaluation plan that answers the following questions:

What do you <u>ultimately</u> hope to achieve?

Select one or more of the **long-term Behavioral Health outcomes:**

- All Alaskan communities, families and individuals are free from the harmful effects of substance use, dependency and addiction.
- Alaska children, youth and adults are mentally healthy and living successfully.
- All community members are connected, resilient and have basic life skills.

1. **How much will you do?**
   This will measure the number (quantity) of people served and services offered.
   <u>Example, describe:</u>
   a) How many people do you aim to serve? How often will your prevention efforts take place?

   b) How will you collect this information?

2. **How well did you (will you) provide your prevention efforts?**
   This will measure the **quality of your prevention efforts**.
   <u>Example, describe:</u>
   a) How will you get feedback from your participants? Or, how will you assess your capacity and efficiency?

   b) How you will use that information to improve your program or services?

3. **Will anyone be better off, because they participate in your prevention efforts?**
   Fill out the template on the following page or submit the one you are using.
   a) Identify two to four **short-term outcomes** from your logic model that you will measure. *In some cases the short-term outcomes could be your selected risk or protective factors.*

   b) Describe how you will collect information related to each of your outcomes. (Examples include: surveys, interviews, focus groups, direct observations, client records, etc.) Please provide the actual evaluation tool (s), if you have them already.

   c) Identify the statewide prevention indicator(s) that most relate to your short-term outcomes see *(Table 1. On page 3)*

Note: if the target audience is between the ages of 10-18 the applicant is strongly encouraged to work with their school district to participate in the YRBS or SCCS surveys.

Evaluation Plan *Template* (collecting short term outcomes)

Program **Date**

Short Term Outcomes List 2-4 measureable outcomes from your logic model	**Data gathering strategy** Identify the tools, surveys or way you will get this information	**Statewide Prevention Indicator** related to your outcome
Special Notes:		

Evaluation Plan and Sample Indicators

1. How much service/programming is being provided? *This relates to how much is being done. It's most often reported as a number (#).*

Examples:
# of participants (by age, ethnicity)
# of activities offered (by activity)
# of hours volunteered
# of times PSA is aired
# of locations information is posted

2. How well are programs/services being delivered? *This relates to how satisfied your participants are with your services. It also addresses the capacity, efficiency and infrastructure of your organization or coalition.*

Examples of satisfaction measures:
% of satisfied participants
% of client suggestions implemented
% of students who feel supported by staff
% of youth who attend most activities

Examples of organizational capacity measures:
% of staff who complete *Gatekeeper* training
% staff turnover or retained after two years
% staff/participant ratio

3. Is Anyone Better Off
What impact have you had on your target audience?

This relates to: the measurement of your short term outcomes. What impact have you had on your target audience? Short term outcomes identify change in either: attitudes/perception, knowledge, skills, behavior or conditions, as a result of your prevention work. (It's typically reported as a percentage.)

Examples of short term outcomes:

- Increase youth perception of the harmful consequences of alcohol use
  Indicator: % of youth who believe alcohol use by teens, is harmful, compared to baseline
- Decrease youth perception that most of their peers regularly use alcohol
  Indicator: % of youth who believe most of their peers are not using alcohol, compared to baseline.

Other examples..:

- Increase community's awareness of suicide intervention/prevention services
- Increase participant's knowledge of FASD.
- Decrease the number of injuries resulting from driving while intoxicated (behavior)
- Increase workshop participants decision making and problem solving skills
- Improve students social/emotional skills
- Reduce the purport ion of retail outlets that sell liquor to people underage (conditions)
- Increase the percent of youth who have 3 or more supportive adults (behavior)
- Increase the percent of adults who reach out and support youth (behavior)
- Decrease youth access to alcohol (conditions)
- Increase a school's positive school climate (conditions)

Evaluation Plan *sample*

Based on the logic model for the project:
Ankorak *(see page 23)*

What do you <u>ultimately</u> hope to achieve?
Identify one or more of the **long-term outcomes**

Our long-term outcomes are:

- All Alaskan communities, families and individuals are free from the harmful effects of substance use, dependency and addiction.
- All community members are connected, resilient and have basic life skills.

1. **How much will you do?**
   How many people you aim to serve? How often will your efforts take place?
   We hope to serve 250 youth between the ages of 6-18; we will do this by:
   - Providing staff training ,*three times in the year*
   - Implementing the silent mentoring project, *throughout the year.*
   - Teaching life skills using the "Mallory Thompson" program *through weekly* group sessions
   - Sponsoring youth-led service projects, *at least once per quarter*
   - Hosting cultural activities, *monthly*
   - Conducting a student support group, *every other week.*

   How will you collect this information?
   - We will keep logs of how many people participated and how many sessions were held and when for each activity.

2. **How well did you provide your prevention efforts or services?**

   How will you get feedback from your participants? Or, how will you assess your capacity and efficiency?
   - We will measure the quality of our activities in three ways:
     - We have a suggestion box for our youth to give us input.
     - Our youth leader will hold feedback sessions every quarter, for students to tell us what they like and don't like about our activities.
     - We will review on an annual basis the percent of youth leaders that have participated in 8 or more hours of professional development training.

   How you will use that information to improve your program or services?
   - Twice a year our staff and volunteers have a special lunch where we discuss what is going well and not going well with our programs. The suggestions and feedback provided by the participants are used to make improvements. Additionally we have youth participants join us on our interview committees when hiring a new staff person.

Evaluation Plan *sample (continued)*

3. **Will anyone be better off? (**Because they participated in your prevention efforts?)
    - Identify two to four short term outcomes* from your logic model that you will measure, and be held accountable for.
    - Describe how you will collect information related to each of your outcomes.
    - Identify the statewide prevention indicators that most relate to your selected outcomes.

Our plan for collecting the project's short-term outcomes:

Short Term Outcomes List 2-4 measureable outcomes from your logic model	**Data gathering strategy** Identify the tools, surveys or way you will get this information	**Statewide Prevention Indicator** related to your outcome
Increase supportive youth-adult relationships	Youth Risk Behavior Survey*	Percent of youth reporting supportive relationships
Increase in life skills	Mallory Thompson Skill Inventory*	Percent of students who feel they have social, emotional/employability skills
Increase engagement in meaningful activities	Youth Risk Behavior Survey*	Percent of youth reporting engagement in meaningful activities
**School Climate and Connectedness Survey measures each of these outcomes as well.*		

Section III: Reporting Documentation (for Grantees)

Quarterly and Biannual Reports

Grantees will be required to submit quarterly narrative and fiscal reports on the progress of their prevention efforts, including measurable outcomes. Reports are submitted through the DHSS GEMS system. Once an applicant is successful, training in GEMS is available.

A year-end evaluation of each grantee's prevention efforts is required with the 4th quarter report.

The Division of Behavioral Health utilizes Performance Based Funding to determine annual continuation funding based on progress made by each grantee. All grantees will be assessed annually regarding their progress to date at the conclusion of the 3rd quarter reporting period. Assigned Program Coordinators will complete a Performance Assessment Review, prior to continuation funding for the next year. Individual reviews will be shared with grantee staff to determine if there are needs for training and technical assistance to continue to improve project outcomes.

Prevention National Outcome Measures (NOMS)

Like all states receiving federal dollars, the State of Alaska adopted, as required for funding the substance abuse prevention National Outcome Measures (NOMs). These measures are designed to enhance prevention efforts by tracking and identifying key substance abuse indicators that will inform us on whether we are meeting community-based needs with public funds. The Department of Health and Social Services is required to report on these outcomes on a state level. NOMs reporting items are included in the state's quarterly program reports.

Desired Outcome/Domain	Performance Measure
Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race, and ethnicity.
Use of Evidence-Based Practices	Total number of evidence-based programs and strategies

Glossary

Adaptation: The degree to which a program undergoes changes in its implementation to fit the needs of a situation or community. Adaption may include making culturally responsive adjustments and addressing regional differences. Although there are benefits to program adaption, implementers need to be careful. An adapted program may lose the components that made the original program successful; a heavily adapted program could be unrecognizable from its original model.

ATOD: Alcohol, Tobacco and Other Drugs

Coalition/Planning Team: A coalition/planning team is a group of individuals representing different perspectives who come together to promote and support change. Coalitions can address a variety of community issues including, but not limited to, substance abuse prevention, violence prevention, community wellness, suicide prevention, obesity, homelessness, community justice issues and many other community concerns.

Community: a unified body of individuals linked by common interests or an interacting population of various kinds of individuals.

Community Readiness: The degree of support for, or resistance to, identifying specific issues as problems in the community. This also includes the current success the community is experiencing in planning, implementing, and sustaining effective prevention and early intervention strategies. The readiness identification tool can also include treatment programs that impact the behavioral health issues to be decreased or eliminated.

Connectedness: A significant protective factor. Connectedness is experienced as connection to people or a positive affiliation to "places". Emotional support is provided by being close to, or attached to other people. Support provides assistance in working through problems, and guidance in taking on new challenges. Throughout the relationship, respect and high expectations are maintained. Connectedness also refers to a sense of "belonging" or identity" to a place or organization (i.e. feeling connected to school, a club, a team, a cause, or their culture.) Activities that increase supportive relationships and/or a sense of belonging to positive places, contribute to resiliency.

Contributing Factors: Another term for risk and protective factors, see their definitions.

Core Components: Those elements or main ingredients of a program that analysis shows are most likely to account for its positive outcomes.

CSAP: The Center for Substance Abuse Prevention provides national leadership in the Federal effort to prevent alcohol, tobacco, and other drug problems under the Substance Abuse and Mental Health Services Administration (SAMHSA).

Cultural Identity: is the extent to which someone connects to and practices the values, beliefs and traditions of their identified culture.

Cultural Sensitivity: Understanding and appreciating the cultural differences and similarities within a population, and being sensitive to the need for program adaptations amongst ethnic, racial, and social groups.

Developmental Assets™ the key building blocks in children's lives that help them grow strong, capable and caring. The Asset framework, used by many schools and communities identifies what kids succeed in school and life. The framework was developed by the Search Institute and captured in the book, *Helping Kids Succeed ~ Alaskan Style, see Alaska ICE website.* The framework overlaps the concepts of resiliency and protective factors.

Developmental stages: The age range of the target audience. Strategies are typically tailored to specific age groups or developmental stages. Examples: 0-5 years of age; 6-10 (elementary ages); 11-14 (early adolescents); 15-19(older adolescents); 20- 24 (young adult), etc.

Domains: Areas where prevention opportunities can take place, or where risk and protective factors, might occur; namely community, family, school, peer, and individual.

Early Intervention: Services designed to identify individuals who are at high risk for developing permanent or long-term behavioral health problems. These services are also directed toward persons who are experiencing adverse effects of alcohol or other drug use but are not dependent. The services most often target from the IOM classification system as an indicated group or audience.

Effective Programs: Programs which are well implemented, well evaluated, and produce consistently positive patterns of results (across domains and /or replications).

Environmental Strategies: Environmental strategies/approaches are the intentional efforts to change the conditions around people to ensure greater health, safety and wellness. Specific environmental strategies seek to change community social norms, practices, policies or laws.

Evaluation: The process of determining the impact of your efforts. Evaluation for the purposes of this RFP, asks applicants to measure the effectiveness of their prevention efforts in three ways: How much was done? How well was it done? Is anyone better off? See SPF, Step. 5.

Fidelity: The extent to which the delivery of a strategy/program conforms to the guidelines for implementing the original strategy/program. Example: A strategy delivered exactly as intended by its originator has high fidelity; a project delivered with considerable adaptations has low fidelity. A project carried out with absolute fidelity is considered a replication.

Indicator: A way to measure (quantify) an outcome. Your prevention efforts must lead to measureable short-term outcomes. Indicators are way of measuring your success. (e.g. Percent of students who graduate; Percent of workshop participants who score 90% or more; rate of out-of-home placements).

Indirect Cost Rate Agreement: Indirect Cost Rate Agreement refers to overall agency administrative overhead and is an agreement reached between the agency and the federal Internal Revenue Service. If a grantee applies an Indirect Cost Rate Agreement to the grant budget for their project, they cannot apply additional administrative costs to the grant budget.

Intervening Variables: Another term for risk and protective factors, see their definitions.

IOM (Institute of Medicine, Prevention Classifications: The Institute of Medicine (IOM) system classifies prevention strategies and activities according to the target population. There are three classifications

- **Universal strategies:** (indirect or direct): target the general population
- **Selective strategies:** target people at *higher-than-average risk* for the problem behavior
- **Indicated strategies:** target people already experiencing or engaging in problem behaviors, but *may not* have been diagnosed with a disorder.

Logic Model: A flowchart or graphic display of your prevention efforts. It identifies your strategies, target audience, outputs, and measureable short-term outcomes that lead to long-term outcomes.

Needs Assessment: A process by which the community collects data and examines its needs in specific areas. The assessment identifies the severity of problems and the resources available (and gaps) to address the issues.

Outcomes: Short-term outcomes let you know if anyone is better off because of your prevention efforts. They are measureable changes in attitudes, perceptions, knowledge, skills, behavior or external conditions. Long-term outcomes are typically a result of multiple, coordinated strategies over time, the measure is typically population-based.

Outputs: The number of activities, events, or participants served, may include duration of events, or products produced by your activities. *Examples:* 20 students receive 1 hour session, weekly.

Performance Measure: A term used to describe the way an organization evaluates the effectiveness of its services. (Program) performance measures typically will gauge the impact of specific services or programs on a specified target group. The target group is usually smaller (or a subset of) than the whole population.
Also see "population measures" definition below.

Population Measure: A term used to describe the impact multiple programs and services are having collectively on a defined population. Population measures include ALL community members, or all students, or all adults v.s. only the adults or students served in a specific program. Also see "performance measures" definitionabove.

Prevention: The proactive process of developing personal attributes and creating environments that promote the health, safety, and well-being of people. Research demonstrates that the most effective prevention strategies reduce personal, social, and environmental risk factors and increase/develop personal, social, and environmental protective factors.

Prevention Principles: The *common* elements of effective prevention practices, identified through research. Principles may guide the thinking, planning, selection, and delivery of prevention efforts. If a community already has a program or strategy in place, these principles can assess its potential effectiveness. (*Emerging research supported by the National Institute of Drug Abuse (NIDA) and the National Research Council.)*

Program: A planned and coordinated set of activities for a specific population, for a measureable purpose. Examples: service learning, mentoring, or life skills programs.

Project: A specific plan or undertaking to address a problem for a target population within a broader system.

Promising Programs: Projects or strategies that show some evidence of positive outcomes, but are not ready to be classified as effective programs.

Promotion: A strategy within IOM spectrum of behavioral health services. It emphasizes promoting the supporting the positive behaviors you wish to see.

Protective Factors: Characteristics within the individual or conditions within the family, school or community that help people cope with life challenges. When people successfully negotiate their problems and deal with pre-existing risk factors, they are less likely to be involved in problematic behaviors (i.e. substance abuse, violence, suicide, or early pregnancy.) Protective factors are instrumental in healthy development; they build resiliency, skills and connections.

Resiliency: The ability to successfully adapt (bounce back) from personal crisis, tragedies or life challenges (e.g. growing up in an alcoholic family). Resilient personal qualities include an easy-going temperament, being optimistic, having social emotional skills, problem solving skills and sense of autonomy and purpose. The concept of resiliency overlaps with protective factors and the Developmental Assets framework.

Resource Assessment: A list of a community's strengths and resources available to support a prevention effort. (may include people, organizations, facilities, etc.)

Risk Factors: Characteristics within the individual or conditions in the family, school or community that increase the likelihood youth will become involved in problem behaviors such as substance use, violence, suicide and early pregnancy. The more a community can reduce its risk factors, the less likely people will develop health and social problems later in life.

Social Norms: The way people think and feel about something or someone. It is the collective thinking, attitudes or behaviors about what is normal or acceptable. (Examples: Students belief that everyone is doing "it"; the belief you should NOT drink while pregnant; youth perception of parent's approval or disapprove tobacco or alcohol use.) Several communities have used social marketing approaches to change social norms or perceptions.

School climate: The quality and character of school life. Positive school climate and connections to schools are powerful protective factors. School climate is based on patterns of students', parents' and school personnel's experience of school life and reflects norms, goals, values, interpersonal relationships, teaching and learning practices, and organizational structures. National and Alaska research has demonstrated a link between a student's perception of a positive school climate and higher grades and less risk behaviors.

Strategy: A combination of activities working together toward an intended outcome. CSAP has identified six prevention strategies.

Target Audience/Population: The people a strategy intends to reach. Selection of target audience/population should reflect the area of need prioritized through your community needs, resources and readiness assessment. See Institute of Medicine (IOM) further clarification.

Wellness: Defines strategies, activities, actions, and environmental conditions that promote a healthy happy lifestyle across the age spectrum.

Youth Development: Youth development is a natural process of growth that is enhanced in the presence of supportive relationships, and meaningful, challenging experiences. The concept of youth development is captured in the overlapping protective factor, resiliency, and Developmental Assets frameworks.