NEW YORK STATE | Office of Addiction Services and Supports

OASAS. Every Step of the Way.

2022 Prevention Guidelines

For OASAS Funded and/or Certified Programs

www.oasas.ny.gov

TABLE OF CONTENTS

PREFACE

The primary purpose of the 2022 Prevention Guidelines is to define and describe substance misuse and problem gambling* prevention services, strategies, and activities within the framework prescribed by the New York State Office of Addiction Services and Supports (OASAS). The 2022 Prevention Guidelines also provide minimum program performance standards in the areas of service availability and delivery, personnel and fiscal practices, recordkeeping, and data reporting. The document provides the structure for the prevention field, counties, and regulatory bodies to implement and enhance consistent prevention delivery and oversight throughout New York State. OASAS is committed to reviewing this document periodically and revising it, when necessary, as new prevention information and knowledge is gained, with input from a team comprised of provider, county, and OASAS staff.

The 2022 Prevention Guidelines replace the 2014 Prevention Guidelines and should be maintained at each program site as a reference and training guide. These guidelines will go into effect on July 1, 2023. All prevention services providers funded by OASAS are subject to these guidelines and the official compilation of Codes, Rules and Regulations set forth in Mental Hygiene Law, section 14 NYCRR 1030.3 (the Regulations) and the Part 343. The Prevention Counseling Policies and Procedures (see Section VIII) applies to all OASAS certified prevention counseling providers, whether funded by OASAS or not. OASAS recognizes that the standards set forth in these guidelines vary from those required under the Regulations. To the extent that these guidelines differ from the Regulations, OASAS intends to waive regulatory compliance. OASAS will monitor program performance and contract compliance based on the standards set forth in these Guidelines.

∗ Throughout this document, the term “substance use/misuse” will refer to alcohol, tobacco and other drugs (both legal and illegal).

SECTION I: OASAS' PREVENTION APPROACH

The New York State Division of Prevention and Problem Gambling Services (PGGS) of the Office of Addiction Services and Supports (OASAS) works to prevent substance misuse, substance use disorders, and problem gambling throughout the lifespan. The Division accomplishes this by implementing comprehensive strategies that are culturally responsive, evidence-based, and trauma-informed to strengthen individuals, families, and communities. The Division is committed to increasing health equity, reducing stigma, and building resilience for all. They collaborate and connect their work with state, regional, and local partners to amplify common goals and build a collective impact.

The main goals of OASAS funded prevention services are to:

- Reduce the prevalence of substance misuse and problem gambling in the NYS population across the lifespan.
- Delay the initiation of substance misuse and problem gambling behaviors among youth and young adults for as long as possible.
- Decrease the negative health, social, educational, and economic consequences and costs associated with substance misuse and problem gambling.
- Prevent the escalation of substance misuse and problem gambling behaviors to levels requiring treatment through early identification, brief intervention, and referral if needed.

The overall OASAS prevention approach is guided by the Risk and Protection Framework, the National Institute of Medicine (IOM) Behavioral Health Continuum of Care Model[1], the Socio-Ecological Model, and SAMHSA's Strategic Prevention Framework (SPF).

Risk and Protection Framework

The OASAS Prevention Risk and Protection Framework is based on epidemiological research that identifies specific risk factors that increase the likelihood of the development of substance misuse, substance use disorder, and/or problem gambling behavior or gambling disorder and protective factors that reduce that likelihood. OASAS looks to the modification of those factors identified through a local community needs assessment when identifying fundable programs and strategies.

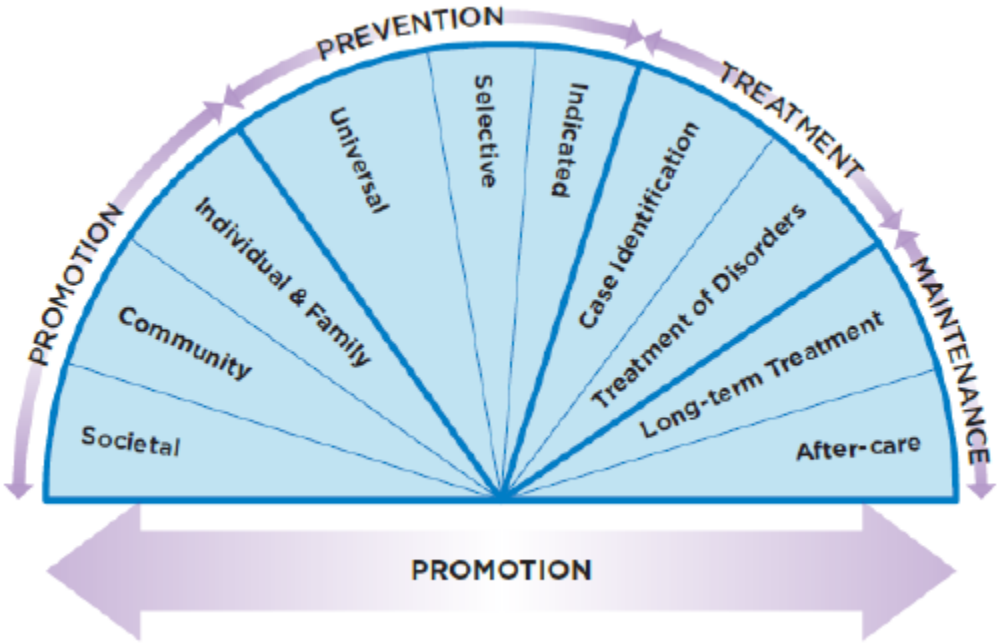
Prevention researchers have identified a subset of early and shared risk and protective factors that can be targeted to reduce the prevalence of Mental, Emotional, and Behavioral (MEB) difficulties for children (see Appendix A). These MEB health risk factors interfere with a child's ability to successfully achieve social and emotional developmental milestones, leading to more negative life trajectories, especially for children with multiple challenges. Intervening early to bolster the achievement of these critical childhood social and emotional development

[1] National Academies of Sciences, Engineering, and Medicine. (2019). *Fostering healthy mental, emotional, and behavioral development in children and youth: A national agenda*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25201.

competencies contributes to both overall mental health promotion and the prevention of both short and long-term substance misuse and other MEB health. Appendix G provides information regarding MEB evidence-based programming.

National Institute of Medicine (IOM) Behavioral Health Continuum of Care Model

In addition to the Prevention Risk and Protection Framework, OASAS follows the National Institute of Medicine (IOM) Behavioral Health Continuum of Care Model which demonstrates the scope of services before, during, and after a substance misuse problem. The Continuum of Care Model recognizes multiple opportunities for addressing behavioral health problems and disorders. Prevention focuses on interventions that occur prior to the onset of a substance use disorder, problem gambling, or gambling disorder and are intended to reduce risk and prevent the occurrence of a substance use disorder.



The National Institute of Medicine categorizes prevention as designed to meet three levels of risk: (IOM, 2009) "Universal," "Selective," and "Indicated," as defined below. Prevention activities may be subsequently categorized into those that are designed for each of these three (3) populations categories. Providers are required to choose the most effective and appropriate prevention activities for the needs of their target population, based on their needs assessment (see below for Needs Assessment description).

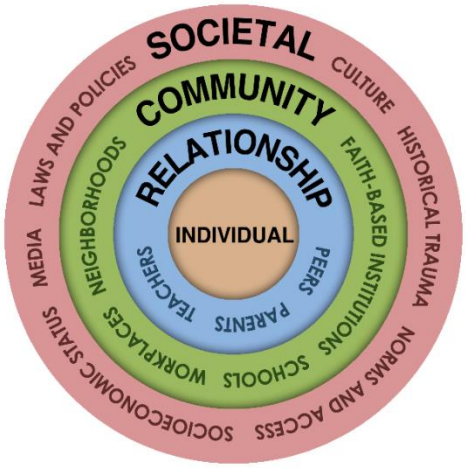
Universal – Universal prevention programs and strategies are designed for the general public or for demographic sub-populations without assessing for levels of risk or problem behaviors in that population. Some examples of providing a universal prevention service to a demographic sub-population is the delivery of an evidence-based educational program to all students a school; anti substance misuse policies in schools; parenting education program open to all families in a community.

Selective - Selective prevention programs target subsets of the total population that are deemed to be at risk for substance misuse and/or problem gambling behavior by virtue of their membership in a population segment. The selective prevention program is presented to the entire subgroup because they are at higher risk than the general population. An individual's personal risk is not specifically assessed or identified, and selection is based solely on membership in the higher risk subgroup. Some examples of selective subgroups are: children of substance users or problem gamblers; children who have dropped out of school; and children with multiple community risk factors that favor substance misuse or problem gambling.

Indicated - Indicated prevention programs are designed for those populations with elevated levels of individual risk factors, putting them at higher risk for developing substance misuse and/or problem gambling problems, and are identified as having minimal but detectable signs or symptoms but do not meet diagnostic levels of a substance use or problem gambling disorder.

Socio-Ecological Model

The socio-ecological model is a multi-level framework that considers the different contexts where risk and protective factors exist. The model also considers the various settings where an individual interacts, and posits that people are influenced not only by personal traits (i.e., genetics, attitudes, beliefs), but by their relationships with others (i.e., peers, family), the institutions and communities to which they belong (i.e., schools, faith community), and the broader society (i.e., social and cultural norms).



OASAS' prevention providers are encouraged to implement prevention programs and strategies across the socio-ecological settings. Prevention can have the greatest reach and impact by addressing multiple contexts and the constellation of risk and protective factors that influence both individuals and population substance misuse and problem gambling behavior. Examples of prevention programs and strategies at the varying levels include:

- **Individual level**: strategies that modify factors specific to the individual, such as health and psychosocial problems, which may correspond with substance use and misuse and problem gambling. Strategies may include but, are not limited to: individual one-on-one interventions such as prevention counseling, Teen Intervene, Screening, Brief Intervention, and Referral to Treatment (SBIRT) or Brief Alcohol Screening and Intervention for College Students (BASICS).

- **Relationship level**: strategies that modify the relationship dynamics within an individual's closest social circle (e.g., family members, peers). Strategies may include

but, are not limited to: small group classroom interventions that train students on peer refusal skills, or parenting-targeted programs, such as Promoting Positive Parenting (Triple P); Strengthening Families or Parenting Wisely.

- **Community level**: strategies that modify the settings where social relationships occur, such as schools, workplaces, and neighborhoods. Strategies may include but not limited to, school-wide implementation of the Positive Action or a campus-based social-norms marketing campaign.

- **Societal level**: strategies that modify broad societal factors which includes the creation or modification of health, economic, educational, and social policies; consistent and perceived enforcement of those policies, as well as broader media campaigns. Societal strategies include the implementation of Environmental Change Strategies which are described in Section 2 of these Guidelines.

OASAS uses SAMHSA's Strategic Prevention Framework (SPF) to integrate the concepts of Risk and Protection Factors, IOM Behavioral Health Continuum of Care Model, and the Socio-Ecological Model to generate an effective comprehensive prevention approach for the community. OASAS funded prevention providers are expected to use SAMHSA's Strategic Prevention Framework (SPF) model to identify relevant risk and protective factors that are driving the observed negative health outcomes such as substance use and misuse or problem gambling behaviors in an affected community. Using the IOM continuum and the Socio-Ecological model, funded prevention providers are well-informed to choose an appropriate strategy to reduce risk factors or increase protective factors through a data-driven tailored approach to prevention. The multiphase SPF blends the constructs of Risk and Protective Factor Framework, IOM continuum, and Socio-Ecological model to offer an evidence-based process to plan, implement and evaluate substance misuse and problem gambling prevention services.

SAMHSA's Strategic Prevention Framework (SPF)

SAMHSA's Strategic Prevention Framework (SPF) is a data-driven prevention planning process. The process includes five (5) steps with two underlying principles, described below. The SPF is designed to guide states, jurisdictions, tribes, and communities in the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities.

The five-step planning process includes:

- Needs Assessment: Gather and analyze data related to substance misuse (risk/ protective factors, prevalence, consequences, and community readiness to address needs and gaps);

- Capacity Building: Build state and local resources and readiness to address and engage in coordinated prevention effort;

- Strategic Planning: Use data to prioritize risk and protective factors; develop a logic model that links data-identified problems with associated factors, evidence-based strategies and anticipated outcomes; develop an actionable plan to address resource and readiness gaps; outline anticipated evaluation activities; and address cultural responsiveness;

- Implementation: Follow and process through the strategic plan;

    - Evaluation: Collect, analyze, and monitor information about activities and outcomes to reduce uncertainty, improve effectiveness, and make decisions.

The two underlying principles included in each five step-planning process:

- Cultural Competence: Consider community-based values, traditions, and customs, and work with knowledgeable persons of and from the community to plan, implement, and evaluate prevention activities; be respectful and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse population groups throughout NYS and in its communities.

- Sustainability: Provide stable infrastructure, available trainings, and community support—and work toward maintaining these factors.

In addition, the SPF emphasizes sustaining the prevention process itself, recognizing that the communities will return to each step of the process, again and again, as the problems the local communities face continue to evolve.

For more details about each SPF step and integrating the guiding principles please visit: https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

Needs Assessment

The OASAS Prevention Framework requires providers to base their selection of target populations and services on community needs assessments which is Step 1 of the Strategic

Prevention Framework. Needs assessments identify underlying causes and help to prioritize risk and protective factors (See Appendix A) that are evident in a community. The results from the needs assessment process should clearly identify and point to the specific elevated risk factors, decreased protective factors, and the problem behavior(s) to be addressed in the target community. The assessment should also identify populations within the community who are experiencing health disparities as well as assess the equity of the distribution of prevention services. Identification of prevention service gaps should be used in prevention planning to maximize prevention services reach to areas of greatest need.

Data from the Needs Assessment must be included when entering the Annual Prevention Workplan into WITNYS. The activities in the Workplan should reflect the data collected.

Needs assessment: a systematic, rational process for collecting and analyzing data to describe the needs of a specific population with regards to substance misuse, problem gambling, and related problems within that population.

For substance misuse and problem gambling prevention, a comprehensive Needs Assessment allows community planners to identify the levels of risk and protective factors operating in a community that are predictive of substance misuse, problem gambling and related problem behaviors. In addition, the data collected serve as a baseline for monitoring the effects of programs and community efforts to address the problem behaviors. OASAS recommends four methods for collecting needs assessment data:

- **Population Surveys**- systematic surveys of middle and high school students, young adults, and other populations to assess a community's risk and protective factors.
- **Archival Risk Indicators**- data collected by government agencies or service providers for administrative or planning purposes. Archival data can give an estimate of the prevalence of various risk factors, problem behaviors, and consequences.
- **Key Informant Interviews-** Structured, one-on-one interviews with a person who is familiar with the risk factors or problem behaviors in a population and whose position provides access to the needs of that population.
- **Focus Groups-** Small, interactive structured group discussion including active members of the population, led by a moderator in a controlled environment.

With the findings, service providers can then pick an evidence-based program that addresses and modifies that identified risk or protective factor and/or substance misuse issue. For example, data from local hospital discharges, trends in policy violations, and key informant interviews with community leaders indicate underage drinking is a substance misuse issue in the community. Additionally, findings from a school-based survey, identify low perceived risk of alcohol use among high school students as a potential driving factor for increased underage drinking. A service provider could choose high school students as a target population, low perceived risk of harm of alcohol use as a risk factor, and an evidenced-based program designed to raise awareness about the risks associated with alcohol use.

Providers will need to use a variety of data sources to gain a comprehensive prevention perspective in your community.

Needs Assessment data generally fall into two categories:

1. Quantitative data: based on numbers; primarily from survey questionnaires, administrative data, and statistical analyses; student and other surveys or archival risk indicators collected from government and other service organizations.

To get an understanding of the community, it is best to find and use the most local-level data as possible instead of state, county, or national-level data. Local-level could be at the zip code level, city/town, school building, classroom, school-district or organization level. Some of these data might already be available and readily accessible through relationships with community stakeholders.

Prevention providers can often obtain relevant quantitative data from a variety of sources. One source is from local schools. Some schools independently implement surveys that measure relevant risk and protective factors (See Appendix A) as well as substance use consumption and consequence data. They may share their data to ensure that their prevention programming meets their needs as highlighted in the survey findings. Some surveys that schools may implement that collect relevant data are the Communities that Care Youth Survey (CTC), Youth Risk Behavioral Surveillance Survey (YRBSS) or Youth Development Survey (YDS).

Some other archival or administrative quantitative data sources include:

- Online databases
    - Kids' Well-being Indicators Clearinghouse
    - American Community Survey
    - Health Data NY
- Local Governmental Units' (LGUs) Local County Plans
- Local hospitals (e.g., emergency room admissions, overdoses)
- Poison Control Centers (e.g., number of calls about accidental poisonings)
- Law Enforcement (e.g., number of calls about social host ordinance violations, number of minors in possession)

Archival records or administrative data may be easily accessible; however, there may be times when it will be best for providers to collect their own. Collaborative efforts with schools to administer a separate survey (i.e., CTC, YRBSS, or YDS as mentioned above) may be necessary. Additional resources may be needed to collect and analyze data. Partnerships with local universities who have students interested and willing to volunteer to gain practical experience is a good consideration.

Qualitative data can be used to fill in some missing gaps from the quantitative findings.

2. Qualitative data: gives meaning and context to quantitative data; often includes text and words and not numbers; and requires qualitative analyses of findings.

A qualitative approach can be used to describe qualities or characteristics, and often answers the questions, "how" or "why" something occurs. Qualitative approaches may include observations, key informant interviews, and focus groups. A qualitative method involves following a systematic procedure for data collection and analyses in order to generate reliable and trustworthy data. For example, a provider should describe in detail and be transparent about: the purpose for conducting the research, how it was conducted, procedural decisions, and data collection and management. Someone who reads the results should clearly be able to follow the progression of events and decisions, understand the underlying logic that led to those results, and be able to replicate the process easily.

Qualitative analysis involves coding and categorizing the data (e.g., text), which is the most important process. Qualitative analytic software exists to help organize the data for coding, but coding can be done manually with the use of colored pens and highlighters to emphasize similar content (See How to Analyze Qualitative Data for a basic process for manual coding). A provider can then subsequently cut and sort the data to figure out patterns and themes.

Coding: subdividing the raw information (e.g. text), categorizing it, and assigning the text, tags or labels that clearly identify the theme or topic (Dey, 2003).

The people who do the coding, however, make the decisions on the meaning of the data, what codes to collate, and identify thematic patterns that appear. It is best practice to involve more than one person in the coding process where there can be discussion and consensus on coding labels, patterns, and themes.

Qualitative methods are often best used in conjunction with quantitative methods. The quantitative data findings highlight the "what" (i.e., "underage youth are accessing alcohol through social connections"), and the qualitative data findings go into deeper explanation of the "how" (i.e., "youth are paying homeless adults outside liquor stores to buy them alcohol"). That data together helps a provider develop a focused prevention strategy to target those factors.

The methods and results from both categories of data for needs assessment are required to be entered into the annual Workplan in the WITNYS (Web Infrastructure for Technology New York Services) provider reporting system and updated annually. Resources and training webinars are available on the WITNYS web pages to assist in conducting annual needs assessments.

The data collected should serve as a baseline for monitoring the effectiveness of policies, programs, and community efforts to address the problem behaviors. These local needs assessments may be conducted by the provider, but resulting plans are more likely to succeed when collaborating with community coalitions and/or county and community service networks. Providers use the results of their needs assessments when developing their annual Prevention Planning Year (PPY) Workplan (see **Section IV, subsection A**). In addition, the needs assessment method and results will need to be included in the annual report narrative (see **Appendix J**).

For further instruction on conducting a needs assessment for submission with the Annual Prevention Workplan in WITNYS, please review the Needs Assessment training for providers offered on the OASAS website: https://oasas.ny.gov/providers/prevention-training.

Use of Evidence-Based Programs and Strategies (EBPS)

OASAS supports and promotes the use of Evidence-based Programs and Strategies (EBPS) which are activities that evaluation research has demonstrated to be effective. These activities can result in cost savings when delivered with fidelity to the program's design and the populations studied. OASAS-approved EBPS have been evaluated for effectiveness specifically in preventing or reducing substance misuse and related problems.

To select appropriate EBPS, providers will need to reflect on the prominent risk and protective factors identified through their needs assessment. They should pick programs and strategies that are culturally and developmentally relevant to their target populations and based on identified local need.

A list of EBPS acceptable for use with OASAS funding can be found on the OASAS website under the OASAS Registry of Evidence-based Programs & Strategies (REPS) and in the WITNYS data management system in the help resources section of the system.

EBPS Review Panel

The Registry of Evidence-based Programs & Strategies (REPS) was developed to identify EBPS that meet State policy priorities and is updated periodically to include innovative and culturally responsive programs. To maintain and update the REPS, OASAS assembles an EBPS Review Panel of volunteer prevention researchers from New York academic and provider organizations as well as OASAS prevention researchers. The Review Panel's purpose is to review new and existing program research and outcome evaluation evidence developed by numerous academic, federal, state, private and provider organizations to identify programs that meet or exceed evidentiary criteria for quality research evidence of effectiveness.

Providers or curriculum developers may submit evidence of effectiveness for established EBPS or for an innovative program for special populations to the Review Panel for determination of EBPS status via prevention@oasas.ny.gov . The full Panel convenes at least twice a year or more based on the need to review applications and to consider new research on the existing EBPS. The Review Panel results on the EBPS are disseminated to providers and are used to update the WITNYS activity planning and reporting system.

Environmental Change Strategies

Prevention-focused Environmental Change Strategies (ECS) impact the community, social, and economic contexts in which people access and consume alcohol, other substances or engage in gambling behavior. These strategies are grounded in the field of public health and emphasize changing the broader physical, social, cultural, and institutional forces that contribute to health problems in the general population. The most effective prevention environmental change strategy employs a comprehensive, coordinated three-pronged approach:

1. The enacting or improving of laws, regulations and policies;
2. Enhancing enforcement of the law, regulation or policy; and
3. The use of the media to raise community awareness and support for the policy and enforcement activities.

Please visit the OASAS Prevention training page for instructional videos on designing and implementing Environmental Change Strategies for substance use/misuse prevention.

https://oasas.ny.gov/applying-comprehensive-environmental-strategy-approach

Community mobilization and promotional media are essential both to generate public support for the environmental changes and to promote their sustainability. Environmental change strategies, like all effective prevention, must be selected based on a community needs assessment identifying the specific environmental factors that lead to substance misuse and gambling related negative consequences. OASAS supports the implementation of the three environmental components as a coordinated effort, and all three must be implemented conjointly to receive credit toward the evidence-based practice standard.

POLICY

Policy is defined a "standards for behavior that are formalized and embodied in rules, regulations, and procedures (Toomey & Wagenaar, 1999; p. 193)." Often when we think of policy, we think of national policy, such as the National Minimum Drinking Age Act which strives to limit access to alcohol for persons under 21 years old; or state-level policy such as the NY state policy that requires both servers and bartenders to be 21 years old or older. These

policies can be conceptualized as “Big P” policies because they are enacted through an elected body. However, policies can be more internal and more local to a community or organization. These policies are sometimes termed, “Little p” policies and they “represent changes to internal policy, practice and or funding within an organization or system. (CADCA, 2019; p. 4)”. They do not require approval from an elected body, and often the changes can be made administratively. For example, a local pharmacy could adopt a policy to consistently serve as a medication take-back location.

ENFORCEMENT

To be effective, policies, regulations, and rules must be enforced. Enforcement traditionally involves law enforcement officers who provide consequences when laws are not followed. Law enforcement officers are often necessary partners when implementing certain enforcement strategies. For example, officers may implement sobriety checkpoints to evaluate drivers for signs of alcohol or substance impairment and enforce existing driving under the influence (DUI) or driving while intoxicated (DWI) laws. Law enforcement officers are the appropriate stakeholders to involve for this enforcement because they can screen for alcohol or other substance use, issue citations, and appropriately handle violators.

While having law enforcement involved may assist in implementing some effective-enforcement strategies, they may not be a necessary stakeholder for all strategies. In addition, it may not be feasible in your community to involve law enforcement officers, or their role might not be an appropriate fit to the policies that you are choosing to enforce. There are other ways of enforcement that may be considered.

Less traditional stakeholders can play critical roles in enforcement such as school personnel, parents, employers, and other key community enforcers. For example, school personnel, such as coaches, administrators, and teachers may be more feasible and more appropriate stakeholders to engage when enforcing school-based substance misuse policies. Apartment building owners or managers may be more appropriate when enforcing building specific housing policies related to substance use. It is important to think of the appropriate stakeholders that have the enforcement capacity required for the policy and what is feasible given your community resources.

Another consideration is that often it is the perception of enforcement that can motivate people to comply with regulations related to alcohol, tobacco, and other drugs. If there is an increase in the perceived likelihood of being caught, arrested, and/or penalized, compliance to the policy increases among the population (Birckmayer, Holder, Yacoubian, & Friend, 2004).

MEDIA

Public awareness and media campaigns can, and should, be used to support the policy and enforcement strategies selected for implementation. Use of media can bring awareness to policies, enforcement, and consequences, as well as be used to influence public support and change community norms.

**OASAS does not support the use of Scare Tactics for media content. Messages that have the intent of scaring individuals into a behavior change are not only ineffective but may be

damaging. Youth tend to not believe the message and discredit the messenger when danger is overstated or when inaccurate data or biased perspectives are presented (Beck, 1998). These messages also tend to backfire when youth have access to contrary information and experience (Golub & Johnson, 2001). Recent evidence suggests that scare tactics have been useful in other countries to yield a one-time action (or inaction); however, long-term and sustained behavior change is not met with scare tactic methods. (Esrick, Kagan, Carnevale, Valenti, Rots, & Dash, 2019).

Three main media strategies that OASAS supports are:

Media Advocacy

Media advocacy strategically uses media (e.g., radio, newspapers, TV, op-eds, blogs, social network sites) to advance a prevention initiative. It can raise awareness of AOD use and gambling problems, generate public debate about related issues, and garner support for prevention efforts. Implementation involves having a clear purpose, support from community stakeholders, research on the targeted audience, a carefully crafted message, strong relationships with media partners, and a well-thought-out dissemination plan. The term *earned media* often accompanies media advocacy work. *Earned media* refers to the free publicity and promotion the prevention initiative receives (i.e., op-ed article in the newspaper; radio interview) rather than through paid advertising.

Social Marketing

Social marketing can be used to influence community attitudes and norms regarding AOD as well as outcome expectancies of use. This approach uses techniques adapted from commercial marketing to encourage positive, voluntary behavior change. It involves disseminating messages that reinforce the benefits of engaging in a specific behavior while minimizing the perceived negative consequences typically associated with behavior change. Effective implementation of social marketing involves a comprehensive needs assessment with a clear understanding of the targeted population, the creation of a message based on formative research, and the message must be frequently disseminated through multiple communication channels. The message should be branded and marketed so it is easily recognizable. The hallmark of a successful social marketing campaign is the varied forms of media used to publicize the prevention message.

Social Norms Campaign

A Social Norms Campaign is used to correct misperceptions by disseminating actual statistics highlighting the misperception within a population. For example, young people may assume inaccurate normative beliefs such as “everybody drinks” which can lead to problem drinking behaviors among underage youth. If the needs assessment data reveal a large percentage of underage youth do not drink alcohol, a social norms campaign can be used to correct the misperception with a positive message. A social norms campaign uses data to educate the public about the actual drinking rates and it can refute community misperceptions.

Each of the strategies above have evidence-based implementation steps that should be followed. Please refer to the resources listed for guidance.

EXAMPLE OF A COMPREHENSIVE ENVIRONMENTAL APPROACH

Policy, enforcement, and media strategies should work together toward a common goal. The overall approach should be guided by problem behaviors, consequences, or risk and protective factors identified in community-based needs assessment. For example, if data indicate that the majority of underage youth are accessing alcohol through informal social events, such as house parties, then a sequence of strategies that address social access seems warranted, and this course of action could include a Social Host Ordinance (Policy), Underage AOD Party Dispersal/Party Patrols (Enforcement), and a "Parents who Host Lose the Most" Social Marketing Campaign (Media) as well as training and engagement of local law enforcement on this community focused approach to reduce alcohol use amongst youth.

Prevention-focused Environmental Change Strategies Resources:

Environmental Strategies to Prevent Underage Drinking

Environmental Strategies to Prevent the Non-Medical Use of Prescription Drugs

Prevention Tools: What works, what doesn't

Catalog of Environmental Prevention Strategies

Environmental Strategies: Selection Guide, Reference List, and Examples of Implementation Guidelines

The Coalition Impact: Environmental Prevention Strategies

Policy specific:

Community Tool Box: Influencing Policy Development

Alcohol Policy Information System

Media specific:

Understanding Social Marketing

Developing a Social Media Plan to Support Substance Misuse Prevention Efforts

Tip Sheet: Strategies for Working with the Media

Ten Steps for Developing a Social Marketing Campaign

Enforcement specific:

Tips of Engaging with Law Enforcement

Support of Community Coalitions

OASAS recognizes the value of community coalitions as partners in delivering evidence-based prevention specifically through the implementation of environmental strategies at the local level. Coalitions connect multiple sectors of the community, i.e., businesses, schools, health care providers, parents, local law enforcement, local elected officials, the faith community and OASAS prevention, treatment and recovery providers, in a comprehensive planning approach, and can achieve measurable outcomes in substance misuse and problem gambling behavior as well as make efficient use of limited resources.

Role of the Prevention Resource Center:

Through the establishment of the Prevention Resource Centers (PRCs), OASAS provides targeted training and technical assistance (TA) to communities, counties, and prevention providers in creating and sustaining prevention-focused community coalitions. PRCs are tasked with transferring prevention science and evidence-based programs and practices to communities and other partners who are engaged in population-based prevention. The PRC services are explicitly intended for developing, maintaining, and sustaining prevention-focused coalitions across the state. Their training and TA sessions concentrate on the five-step Strategic Prevention Framework (SPF) process with an emphasis on using data-driven decisions to implement effective environmental prevention strategies to support, strengthen, and maintain effective prevention services throughout the state.

Before reaching out to PRC staff for Training or TA, OASAS funded prevention providers are expected to contact their Regional Office Prevention Specialist who can provide limited Training or TA and arrange for more in-depth and targeted sessions as needed from the PRCs or from the Division of Prevention and Problem Gambling Services. OASAS funded prevention providers should keep their Regional Office Program Manager and Prevention Specialist informed of their agency's Training and TA needs to ensure regional and statewide coordination to meet these gaps.

Role of the Prevention Provider:

Providers are strongly recommended to collaborate with the PRCs and work with community coalitions in their regions by:

- Being active partners in existing underage drinking, substance use and/or problem gambling prevention community coalitions;
- Participating in community coalition planning efforts, including needs and resource assessments and service planning;
- Documenting in their annual Workplan their planned activities to support community coalitions;
- Collaborating, when possible, with the PRCs in establishing new local prevention community coalitions as needed;
- Coordinating prevention services to complement coalition and other service system strategies and activities to maximize impact and prevent duplication of effort.

See **Appendix B** for a more detailed description, including locations for the PRCs.

SECTION II: DEFINITIONS AND REQUIREMENTS FOR FUNDED PREVENTION SERVICES

All OASAS funded prevention services must address individual, family, and/or community level risk and protective factors which are predictive of substance misuse and/or problem gambling behavior, as identified by a local needs assessment. Prevention services may be delivered directly with individuals to improve their outcomes, or they may be delivered indirectly using environmental prevention strategies (see **Appendix C** for the Definition of Direct & Indirect Activities). Both direct and indirect prevention activities are needed to achieve healthier communities.

All OASAS funded prevention services are categorized as "Primary Prevention" or "Other" prevention services.

Definitions of OASAS Funded Prevention Service Approaches

A. Primary Prevention Services

Primary Prevention includes prevention education, Environmental Change Strategies, community capacity building, positive alternatives, early intervention, and information dissemination. The selection of prevention activities within these service approaches is based on a community needs assessment that identifies levels of substance misuse, its consequences, elevated risk factors and decreased protective factors. Prevention counseling, SBIRT, and problem gambling prevention services are not included as Primary Prevention Services.

1. Prevention Education -

Prevention education is a direct activity that includes implementation of a standardized curriculum and/or structured sessions that involve two-way communication. It is distinguished from information awareness activities in that the interaction between the educator and the participants is required for its success. Prevention education may be implemented in various settings including schools and other community locations.

Prevention education services consist of evidence-based programs (EBPs) and non-evidence-based programs (non-EBPs).

Evidence-Based Programs (EBPs)

Prevention providers can select an EBP from the OASAS Registry of EBPs that meets a need identified in the assessment. This registry includes a list of programs that have curricula and scripted lessons that can be implemented directly by prevention provider staff or by classroom teachers (i.e., Life Skills Training, Positive Action, PATHS, PAX, etc.). Those implemented by classroom teachers, like the [PAX] Good Behavior Game, are infused into the existing school curricula and practices. For this type of EBP, a prevention provider would support the fidelity of implementation through training, responsive coaching, and technical assistance (e.g., workshops,

webinars, websites, resource review, co-teaching/modeling sessions, presentations, data meetings).

Note about fidelity:

While cultural and other adaptations to improve participant engagement and communication of program content are beneficial to successful delivery, changes to core elements (e.g. target population, setting, "dosage" and curricula content) have been shown to reduce effectiveness. Providers who add, delete or otherwise significantly adapt the curricula content must contact the developer and get the changes approved in writing (a dated email response will suffice for documentation).

To determine whether an EBP is appropriate, consider:

1.) The Target Population age/grade groups selected match the EBP recommended age/grade groups.

2.) The other Target Population demographics (race, ethnicity, gender, other cultural factors) match the EBP recommended demographics.

3.) The Target Population Risk Factors identified from the needs assessment align with the outcomes associated with the EBP's implementation.

4.) When on-site or Internet online training is available and/or recommended based on the qualifications of delivery staff, staff are trained, and training is documented.

5.) The facilitator/group leader selected has qualifications and experience to be able to implement the EBP with fidelity.

Non-Evidence-Based Programs (non-EBPs)

A non-EBP is a program or strategy that has a standardized curricula or scripted lessons that can be implemented by prevention provider staff that meets a need identified in the needs assessment. These programs have not been formally approved by the OASAS EBPS Review Panel but may be listed as effective on other evidence-based registries. Non-EBPs need be structured and consistent; and focus on modifying the risk and protective factors OASAS supports, reducing substance misuse, and/or its consequences. For guidance on selecting a quality prevention program, see **Appendix E**.

**OASAS does not support the use of Scare Tactics in funded prevention programming. Scared Straight and other prison or parole programs which bring together inmates and students have resulted in higher rates of re-arrest and delinquent behavior than youths not involved in the intervention (Petrosino, Turpin-Petrosino, & Finckenauer, 2000).

2. Environmental Change Strategies

An environmental change strategy is a comprehensive, coordinated three-pronged approach as described above in Section I. The approaches of Policy, Enforcement, and Media need to be coordinated and focused on a common problem identified through the community needs assessment. Environmental Change Strategies that OASAS supports can be found in **Appendix F**. Providers should consider collaborating with a local substance misuse prevention coalition to support this work. For more information on designing and implementing Environmental Change Strategies visit the OASAS training page: https://oasas.ny.gov/applying-comprehensive-environmental-strategy-approach

3. EBP Community Capacity Building

Community Capacity Building activities aim to enhance the ability of prevention providers to more effectively integrate substance misuse and problem gambling prevention services in the community. EBP Community Capacity Building occurs when a prevention provider supports EBP implementation indirectly through coaching and technical assistance (TA) activities rather than through direct service. For example, the PAX Good Behavior Game (PAX GBG) is implemented by classroom teachers throughout the school day. The provider's role is to assist and support the teacher with overcoming challenges to implementation and to ensure fidelity to the EBP model. Providers are required to report on their TA efforts and coaching activities which will count towards the EBP requirement. Currently, the only EBPs with the allowed EBP Community Capacity Building designation are PAX GBG and Positive Action.

EBP Community Capacity Building does not include internal provider capacity building, nor staff training, staff meetings, management activities, or case consultations.

4. Positive Alternatives

Positive alternatives are direct activities that provide target populations with opportunities to participate in constructive, pro-social, healthy activities that exclude substance use and gambling. These activities must convey a clear no-use message.

Positive alternatives provide opportunities for pro-social bonding to positive role models who can influence attitudes toward a healthy lifestyle. Decisions about positive alternative implementation should be based on factors uncovered during the community needs assessment. They also should be used concurrently with EBPs and be used to support and reinforce key skills learned through participation in EBPs.

Positive alternatives should:

- Use interactive and experiential learning methods rather than passive lecture-style approaches;
- Incorporate activities to practice the skills taught in EBP education (e.g., anger management conflict resolution, decision making, other social skills);

- Reduce OASAS supported risk factors or enhance OASAS supported protective factors;
- Promote the self-examination of substance misuse or gambling attitudes through role plays and group discussions;
- Foster bonding with adults through opportunities and rewards for prosocial behavior;
- Reinforce a central theme (conceptual coherence);
- Be structured and consistent;
- Be delivered by staff who feel reasonably supported and empowered.

5. Information Awareness/Dissemination

This prevention service approach increases public knowledge and attention to substance misuse and/or problem gambling, and its effects on individuals, families, and communities. Information awareness activities are characterized by one-way communication from the source to the targeted populations using a variety of media technologies. Depending on the technology used, some activities are classified as direct (face-to-face), while others are indirect. Information awareness activities are also used to increase public knowledge and awareness of available and effective prevention programs and services.

These activities include:

- Presentations that advertise and promote prevention services available through the prevention provider;
- National/local substance use prevention related designation events such as SAMHSA National Prevention week, Red Ribbon week, Alcohol Awareness Month, Problem Gambling Awareness Month, etc.;
- Communication to parents/caregivers explaining prevention activities their child(ren) are engaging in or educating them on substance misuse/problem gambling facts;
- One-time presentations or events with the goal of educating on substance use/problem gambling prevention information or data.

**OASAS does not support the use of Motivational or Cautionary Speakers and assemblies as an informational awareness event. One-time multi-media events, heart wrenching stories or techniques (e.g., displaying mock DWI car crashes) can be "powerful"; however, their effects create only temporary emotional arousal and are not necessarily effective at instilling positive behavior change. When students are asked what they remember about these programs, they report what they observed and felt (i.e., sadness or horror), but they will not report modifying their future behavior or intention, making them ineffective approaches for substance use prevention. In addition, youth who are not desensitized to violence through modern media may be traumatized and block it out of their memory. Similarly, programs relying on "experts" warning students about the dangers of substance use often fail because there is little or no contextual framework, and the youth and presenter(s) have no meaningful connection (Brown, D'Emidio-Caston, & Pollard, 1997). Presentations by people with lived experience or lessons that display, categorize or show how drugs are consumed have no evidence of effectiveness (Hansen, 1997). There are guidelines for effective community forums available here.

6. Early Intervention Prevention Services

Early Intervention services are designed for individuals that meet the Institute of Medicine's (IOM) definition of "Indicated." These are individuals who are already exhibiting symptoms and behaviors of substance use or problem gambling, but do not meet the criteria for a diagnosis of substance use disorder, or a gambling disorder. The aim is to reduce levels of substance use and/or problem gambling, and to decrease the length of time the symptoms or behaviors continue and/or reduce the need to refer for treatment services.

Teen Intervene and BASICS are primary prevention Early Intervention Services. Prevention Counseling and Screening, Brief Intervention, and Referral to Treatment (SBIRT) are categorized as "other" direct prevention early intervention services. Providers delivering prevention counseling must be certified by OASAS and must adhere to specific rules and regulations set forth by OASAS (see **Section VIII**).

Primary Prevention Early Intervention Services

1. **Brief Alcohol Screening and Intervention for College Students (BASICS)**

   Brief Alcohol Screening and Intervention for College Students (BASICS) is an evidence-based prevention program for heavy-drinking college students who are at risk for alcohol-related problems. At-risk students are identified and provided two 1-hour motivational interviews and an assessment with customized feedback. More information about BASICS can be found on the developer's website: http://depts.washington.edu/abrc/basics.htm

2. **Teen Intervene**

   Teen Intervene is an evidenced-based prevention program (EBP) targeting youth 12 to 19 years of age who display the early stages of alcohol, substance use, or gambling problems. These youth do not, however, exhibit use at a level demonstrating diagnosable substance use/problem gambling disorder. Teen Intervene is an early intervention that integrates stages of change theory, motivational enhancement, and cognitive behavioral therapy. This intervention aims to help teens reduce and ultimately eliminate their substance use, and/or problem gambling.

B. "Other" Direct Prevention Services

1. **Prevention Counseling**

   Prevention Counseling is a short-term, problem-resolution focused OASAS prevention service designed to decrease risk factors and increase protective factors that are predictive of substance use and/or problem gambling.

   Prevention Counseling makes use of brief counseling and standardized brief interventions to prevent, delay, or reduce substance use, problem gambling, and the negative consequences caused by these behaviors. It includes screening, assessment of risk and protective factors, and referral of individuals with apparent symptoms of substance use,

problem gambling, physical, mental, emotional, educational, or social problems to the appropriate treatment or support services.

Prevention Counseling serves youth (4 year olds +), adults, and families across the life span who are at risk for developing substance misuse or problem gambling behaviors, and do not meet the DSM 5 criteria for substance use disorder or gambling disorder.

Providers must be certified by OASAS to deliver Prevention Counseling.

2. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based approach offered to adolescents or adults who are at risk for developing a substance use disorder. The goal of SBIRT is to reduce and prevent substance use disorders and related health consequences, disease, accidents, and injuries. SBIRT can be delivered in multiple settings such as medical settings, behavioral health settings, senior settings, community-based settings, etc. SBIRT incorporates screening for substance use with brief, tailored feedback and advice known as the Brief Intervention. Simple feedback, utilizing Motivational Interviewing, about risky behavior is one of the most important influences on changing behavior. If the screening indicates "high risk" substance use, the individual is referred for an assessment.

Prevention professionals who wish to implement SBIRT must be trained prior to implementation. SBIRT Training information can be found at: https://oasas.ny.gov/providers/screening-brief-intervention-and-referral-treatment-sbirt

3. Problem Gambling Prevention Services

As OASAS continues to focus efforts on integrating problem gambling prevention into statewide prevention services, trained staff are required to deliver a minimum of 1, but no more than 5, Underage Problem Gambling information awareness presentations per year, in the form of face-to-face or virtual speaking events within their communities. At least one staff must attend a Training of Trainer session prior to delivering the presentation. The staff that attends the Training of Trainer session may, in turn, train other staff to provide the training. These presentations are to be given to adults such as parents, caregivers, school personnel, human service professionals, community members etc. The presentation is not meant for dissemination to students in the schools. The minimum number of participants recommended for each session is ten. If the agency has no other trained staff, the agency must notify their OASAS program manager and identify another staff member to be trained within 30 days of the vacancy. Direct questions about the Training of Trainers to prevention@oasas.ny.gov

For providers who deliver prevention counseling services, it is required that they utilize an OASAS approved gambling screening tool and administer Teen Intervene if indicated. OASAS approved gambling screening tools are found on the OASAS website.

SECTION III: PROGRAM PERFORMANCE REVIEWS

This section describes the annual program performance review process, including the eleven (11) prevention performance standards to be met by providers in their planning and delivery of OASAS funded prevention services.

All OASAS funded providers are subject to an annual Program Performance Review. As part of this process, program administrative and fiscal compliance is reviewed along with compliance with the Performance Standards (described below). The general administrative requirements reviewed include timeliness of budget, claims, and workplan submissions; completion of the annual OASAS County Planning Surveys; and submission of monthly data reporting.

If, after a review, a provider has not met applicable Performance Standards and/or other areas of required performance, the Regional Office Program Manager will prepare a Management Plan recommending the next steps to be taken by OASAS, the LGU and/or the provider. This Plan will include written notification to the provider (if a direct contractor) or to the LGU with a copy to the provider and will:

- Describe the problem(s) identified;
- Offer technical assistance, if necessary, to correct these problems;
- Include specific dates when the Regional Office will follow up with the LGU and/or provider to ensure the problems are being addressed; and
- Provide notice that failure to correct the problems may negatively impact future funding.

Performance Standard 1: Needs Assessment Completed

All providers are required to conduct a current needs assessment to identify relevant substance use and problem gambling issues for the communities they serve. In their needs assessment, they should include substance use consumption, gambling behaviors, consequence, and risk/protective factor data associated with subsequent substance use and gambling. See Needs Assessment section above for more detailed information on the process. The needs assessment should include:

- Consumption data that is not older than 5 years
- Risk/protective factor data that is not older than 5 years
- Consequence data that is not older than 5 years
- Comparisons made between Nation, state, community, school/local data indicators
- Quantitative data (e.g., surveys, archival, etc.) and qualitative data (e.g., focus groups or informant interviews)

Score Calculation:

This standard is met if the provider meets at least 4 out of the 5

Performance Standard 2: 60% of FTEs Allocated to Planned EBPS

All providers are required to allocate a portion of their OASAS funded prevention efforts to the delivery of evidence-based programs and strategies (EBPS) in their Workplans each year. EBPS are approved by the OASAS EBPS Review Panel and are listed in the Registry of Evidence-based Programs and Strategies (REPS) for Prevention and can be found here. Effort is defined as direct services Full Time Equivalent (FTE) staffing, with 1.0 equaling one full-time worker. The full definition of FTE is located in the WITNYS Workplan User Manual under the **Help Resources** tab on the WITNYS Home Page.

Requirement:

At least 60% of the total budgeted FTE effort must be dedicated to delivering EBPS.

Score Calculation:

$$\text{Planned Percent of FTEs Allocated to EBPS} = \frac{\text{Total EBPS FTE (Primary + Other Prevention Workplans' EBPS FTE)}}{\text{Total FTE (Primary + Other Prevention Workplans' Total FTE)}}$$

Note: Total EBPS FTE = EBP Educ. FTE + EBP Comm. Cap. Building FTE + EBP Env. FTE + EBP Early Intervention FTE + EBP Prevention Counseling FTE.

Performance Standard 3: 80% of Planned Primary Direct Services Must be Delivered

This standard uses the percent of a provider's total annual planned Primary Prevention direct services that are delivered during the Workplan year. Indirect services, such as those delivered through mass media, environmental prevention strategies, and capacity-building activities, are not included in this measure.

The following prevention services are included in this standard:

- EBP Education and Non-EBP Education class/group sessions
- Positive Alternatives – Recurring group sessions and Positive Alternatives – onetime events
- Information Awareness direct activities (Health Promotion Event, Speaking Events, Walk-in Information Services, and Telephone/Virtual Information Services)

Requirement:

Deliver at least 80% of the total annual planned Primary Prevention direct services.

Score Calculation:

Percent of Planned Primary Prevention Direct Services Delivered	=	Total Planned Direct Service Sessions & Events Delivered* / Total Direct Service Sessions & Events in Approved Primary Workplan

* All sessions, even when the classes/groups were not completed, and events that were delivered and reported during the year are counted, even those not in the approved Workplan.

Performance Standard 4: 80% of Planned Direct Services Participants Must be Served with Direct Services

This standard uses the percent of a provider's total annual planned direct services participants who received a direct service during the Workplan year. Participants served through indirect services, such as those delivered through mass media, environmental prevention strategies and capacity-building activities, are not included in this measure.

The following prevention services are included in this standard:

- EBP Education and Non-EBP Education classes/groups
- Positive Alternatives – Recurring groups and Positive Alternatives – One-Time events
- Prevention Counseling and EBP Prevention Counseling clients assessed
- EBP Early Intervention clients admitted

Requirement:

Deliver direct services to at least 80% of the planned direct services participants.

Score Calculation:

Percent of Planned Direct Services Participants Served	=	Total Participants Served by Direct Services* / Total Direct Services Participants in Approved Workplan(s)

* All participants served in classes/groups that had at least one session, even when the classes/groups were not completed, and events that were delivered and reported during the year are counted, even those not in the approved Workplan.

Performance Standard 5: 80% of Planned EBP Education Classes/Groups Completed

This standard uses the percent of a provider's total annual planned EBP Education classes/groups that are completed during the Workplan year. Class/group completion means that at least 80% of the minimum required sessions are delivered, based on the research study(s) for which EBP status was approved. The minimum required sessions for all EBPs are in **Appendix G**. At least

one participant must be reported for a session to be counted. A few EBPs do not use curricula sessions (e.g., Olweus Bullying Program). For these EBPs, a minimum of 1 is used as the criterion.

Requirement:
Complete at least 80% of the planned EBP Education classes/groups (as defined above).

Score Calculation:

$$\text{Percent of Planned EBP Education Classes/Groups Completed} = \frac{\text{Total Planned EBP Education classes/groups completed}}{\text{Total EBP Education classes/groups planned}}$$

Performance Standard 6: 80% of Planned Non-EBP Education Classes/Groups Completed

This standard uses the percent of a provider's total annual planned Non-EBP Education classes/groups that are completed during the Workplan year. Class/group completion means that at least 80% of the sessions specified by the provider at class/group initiation are delivered. At least one participant must be reported for a session to be counted.

Requirement:
Complete at least 80% of the planned Non-EBP Education classes/groups (as defined above).

Score Calculation:

$$\text{Percent of Planned Non-EBP Education Classes/Groups Completed} = \frac{\text{Total Planned Non-EBP Education classes/groups completed*}}{\text{Total Non-EBP Education classes/groups planned}}$$

Performance Standard 7: Prevention Counseling - % Substance Use or Gambling Activity Prevented

For all youth who report no substance use or gambling activity in the past 30 days when admitted to prevention counseling, a core OASAS Prevention goal is to help them stay substance use and/or gambling free or to delay the initiation of such behaviors. For these Prevention Counseling participants, 90% will remain free of substance use and free of gambling activity in the past 30 days at the time of their discharge from prevention counseling. This standard will be applied only to admissions for students in grades 6-12 and whose length of admitted counseling services exceeds 30 days. This standard will not be applied at the elementary school level. Students with "OASAS Administrative Discharges" will not be included in the measure. Performance Standard 7 is applicable only to providers who are certified by OASAS to deliver Prevention Counseling Services.

Requirement:
At least 90% of participants who reported no substance use and/or no gambling activity during the past 30 days at prevention counseling admission will report no past 30-day substance use/gambling activity at prevention counseling discharge.

Score Calculation:

Percent of Youth with Current Substance Use/Gambling Prevented* = Total Participants with No Past 30-Day Substance Use/Gambling at Discharge** / Total Participants with No Past 30-Day Substance Use/Gambling at Admission

* Among participants who were admitted and discharged during the Workplan year and whose length of admitted counseling services exceeds 30 days.

** Participants without a valid WITNYS Admission/Discharge record are not included.

Performance Standard 8: Youth Who Successfully Complete Prevention Counseling
For providers certified by OASAS to deliver prevention counseling services, this standard requires that the percent of participants who have successfully completed prevention counseling be at least 60%. Successful completion of prevention counseling is defined in WITNYS as the Completion Reason of "Service Plan Completed (achieved all/majority of objectives)."

Requirement:
All or most of the objectives in the Participant Services Plan were accomplished for at least 60% of the participants at discharge.

Score Calculation:

Percent of Youth Who Successfully Complete Prevention Counseling* = Total Participants Discharged Who Accomplished All or a Majority of Objectives** / Total Participants Discharged***

* Among participants who were admitted and discharged during the Workplan year and had valid WITNYS data entered.

** Identified in the Participant Services Plan and specified in the Discharge Record (PAS-64B) and WITNYS.

*** Participants discharged due to extended illness or school transfer are not included. Participants discharged due to failure to complete counseling (no face-to-face counseling contact within a thirty (30) calendar-day period) or those without a Discharge Record are included. Links to all Prevention Counseling forms can be found below in section VIII (section H).

Performance Standard 9: All Three Components of Planned Environmental Prevention Strategies must be delivered

Performance Standard 9 requires that service providers deliver the three components of an Environmental Change Strategy, policy, enforcement, and media activities to receive credit. For more details about environmental prevention, providers are encouraged to view the OASAS Environmental Change Strategies webinar (2020).

To be successful in a community-wide effort to reduce or delay substance use, providers should work with their community partners to assess new policy and enforcement activities or to strengthen the existing policy and enforcement activities for prevention. Providers may play a supportive role to community coalitions by delivering appropriate communications/media campaigns, but the provider must demonstrate their contribution towards the policy and enforcement elements of the strategy.

The planning or data entry for standalone media campaigns will not be accessible in WITNYS beginning with the 2022-2023 workplan. A prevention provider, ideally with their community partners, must plan and deliver complementary Policy and Enforcement components to receive credit for the service. For example, a provider indicates that their target community has a new or existing Social Host law, but the residents are not aware of the new law. The provider would select "Social Host Ordinance" under Environmental Policy, Regulations and Laws, and select "Media Advocacy Campaign" to increase community awareness to support the new law, and an enforcement approach they expect to use in the process

Requirement:
When planning environmental prevention strategies during Workplan development, at least one policy/regulation/law strategy, one enforcement/compliance strategy, and one communication strategy must be selected for delivery. Providers may indicate that they are not delivering the policy or enforcement directly but are supporting it through activities selected under the communication/media campaign strategy. Providers must identify the enforcement activities that will support or strengthen the effectiveness of the policy. Detailed descriptions of the three (3) strategy types (Policy, Regulations, and Laws; Enforcement/Compliance; Communication/Media Campaigns), and the various activities under each strategy can be found in **Appendix F**.

Score Calculation:
For providers implementing environmental prevention strategies, this standard is met if the provider delivers or can demonstrate community collaboration to deliver at least one policy, one enforcement approach, and one media strategy for substance use/misuse prevention.

Performance Standard 10: Annual Report Submission
All OASAS prevention providers are required to submit an annual report that evaluates direct service prevention activities conducted in the previous prevention plan year July 1-June 30th. The report must follow the report template as disseminated by the Division.

Requirement:
Each provider must submit the report on September 30th of each year by close of business to receive credit for successfully meeting this standard.

Performance Standard 11: Underage Problem Gambling Prevention Information Awareness Events

All OASAS funded prevention providers are required to provide at least one (1) and no more than five (5) underage problem gambling prevention information awareness events to their community each workplan year. The minimum class number is ten.

Requirement:
Each provider will receive credit for conducting at least one underage problem gambling prevention information awareness event in their community.

SECTION IV: PREVENTION REPORTING REQUIREMENTS

Providers that receive State funds through OASAS to provide Primary Prevention and Other Prevention services (see Section II) are required to submit, for each Program Reporting Unit (PRU), an annual workplan for review and approval plus monthly delivered services data using WITNYS (Web Infrastructure for Technology (New York) Services).* This submitted information is then available in WITNYS to generate workplan and delivered services standard reports for providers and reviewers.

Help is available to WITNYS users through User Guides and training videos posted in the WITNYS 'Help Resources' links. There is also an OASAS WITNYS Help Desk that can be reached by toll-free phone at 866-438-3789 or email at WitnysHelpDesk@oasas.ny.gov.

OASAS and/or the WITNYS contractor conduct trainings annually for new provider staff or when there are significant system upgrades to WITNYS. These trainings also serve as a refresher for existing provider staff. OASAS strongly encourages attendance at these trainings to

help ensure proper use of WITNYS. Trainings are recorded and posted in the WITNYS 'Help Resources' links.

*Providers who have been approved by OASAS to deliver Alcohol Awareness Programs (AAPs) submit a separate annual report directly to the Division of Prevention via a standard form (see Section XI).

A. Workplan Submission, Review, and Approval

OASAS-funded providers are required to submit a WITNYS workplan annually that includes the planned prevention services and planned staff FTE allocations. The workplan and the delivered services data form the basis for OASAS Regional Office review and approval of OASAS funding commitments. The planned services should be based on a formal needs assessment of the population(s) being served. Provider administrative and managerial support activities, such as staff supervision, internal staff development, travel time, and resource preparation (handouts, workbooks, and educational materials), etc., are normally not to be included in the WITNYS workplan or the delivered services data. EBP Community Capacity Building (as stated in Section 2), and support activities for local prevention coalition work may be included in the WITNYS workplan. All planned prevention services included in the workplan submitted for review and approval in WITNYS must be representative of the total expenses (both revenue and deficit funding) approved by OASAS.

Once a provider submits a workplan, it is reviewed by the provider's LGU (unless the provider is funded directly by OASAS) and then by its OASAS Regional Office Program Manager. During the workplan review and approval process, the provider, LGU (if applicable), and OASAS must agree that the expected results identified in the workplan increase the probability of achieving the prevention goals stated in Section I (Prevention Framework - Overall Prevention Goals).

Note: It is imperative that the Workplan FTEs and budgeted FTEs being are the same or within 10% of each other.

Key workplan dates:

March 1	Providers can begin to draft new workplans in WITNYS
April 15	Allocated provider workplans due to County LGUs NYC DOE District workplans due to DOE Central Office Direct NYC provider workplans due to NYC Regional Office Program Managers
May 15	County LGU workplan approvals due NYC DOE Central Office workplan approvals due
July 1	Regional Office Program Managers workplan approvals due (workplans become 'active')

B. Delivered Services Data Submission

OASAS prevention providers are required to submit delivered services data monthly in WITNYS. The delivered services data and workplan form the basis for OASAS' Regional Office review and approval of OASAS funding commitments. Additionally, delivered services data are the primary source of information that OASAS uses to inform local, state and federal government officials with required services reporting. The data are routinely used by OASAS staff when a request is received for information concerning a provider's prevention activities. The data also drive OASAS' prevention policy decision making process; thus, it is vital that data submission is accurate and timely. Providers are required to submit each month's delivered services data by the 15th of the following month or by the first business day after the 15th if the 15th falls on a non-business day.

C. Other Reporting Requirements

Providers are required to:

- Inform the applicable LGU (unless funded directly by OASAS) and OASAS Regional Office of significant changes to its funding, staff resources, or services delivered;
- Ensure that FTE and staff credential information is current;
- Maintain their contact information by communicating changes to their OASAS Program Manager and with the WITNYS Help Desk;
- Submit an Annual Report (see **Appendix J** for template).

D. Problem Gambling Reporting

Providers will enter any data related to problem gambling prevention services in the "Problem Gambling" facilities in WITNYS. This includes the required Information Awareness Speaking Event(s) and any type of problem gambling focused environmental strategy. All providers will have a "Problem Gambling" Facility for each county in which they have a Primary Facility.

You will not enter problem gambling information awareness events or problem gambling environmental strategies in your workplan.

SECTION V: FISCAL POLICIES AND PROCEDURES

All OASAS funded Prevention providers must have a Fiscal Policy and Procedure Manual governing the financial operation of the program.

All fiscal policies and procedures of OASAS funded prevention providers must be in accordance with New York State Mental Hygiene Law; New York State Finance Law; the Not-for-Profit Corporation Law; Consolidated Budgeting Reporting and Claiming Manual; Consolidated Fiscal

Reporting Manual: OASAS Funding Requirements; Contract Documents; Administrative and Fiscal Guidelines; Local Services Bulletins; all other applicable Federal and State laws and regulations as well as local school/community agency board and/or County/LGU requirements and policies.

Please see **Administrative and Fiscal Guidelines for OASAS Funded Providers** for reference to all applicable fiscal requirements and Local Services Bulletins.

SECTION VI: ADMINISTRATIVE AND OPERATIONAL REQUIREMENTS FOR OASAS FUNDED PROVIDERS

A. Foundational Staff Training Requirements

Starting with the 2023-2024 workplan, newly hired staff will be required to take OASAS approved foundational training courses within one year. Existing staff will need to verify they have completed the foundational coursework within the past three years or will need to re-take the coursework. Staff only need to complete SAMHSA's Substance Abuse Prevention Skills Training (SAPST) once. Certificates of Completion should be added to the employee's personnel file. The following are the foundational training requirements:

1. SAMHSA's Substance Abuse Prevention Skills Training (SAPST)
    a. The SAPST course is a requirement for all prevention staff (excluding support staff). There are two parts to the SAPST: an online prerequisite course, "Introduction to Substance Abuse Prevention: Understanding the Basics," followed by a 4-day training either in person or through a virtual platform. This course is approved by OASAS for thirty-one hours that can be used for CPP/CPS credentialing (section 2) and re-credentialing and for CASAC re-credentialing. SAPST training information can be found on the OASAS website.
2. Prevention Ethics (6 hours): required every three years
3. Cultural Responsiveness (12 hours): twelve hours initially and 6 hours every three years thereafter

B. Staffing Requirements

1. **Prevention Director/Supervisor**: Each prevention provider must designate a supervisor whose responsibilities are overseeing administrative, programmatic, prevention counseling/Teen Intervene (if applicable), and day-to-day operations.

The individual who is directly responsible for the administration of prevention services in an OASAS-funded prevention program (who may be the Executive Director, Director of Prevention, Supervisor or Manager of Prevention Services or their equivalent, depending upon the job titles used and division of responsibilities in any given agency) must meet **one (1)** of the following qualifications and provide supporting documentation to the Regional Office:

(a) Credentialed Prevention Professional (CPP) or;

(b) Credentialed Prevention Specialist (CPS) who has an additional year of qualifying prevention work experience (minimum total of 2 years) and has completed an additional 150 hours of OASAS approved education and training (minimum total of 250 hours) or;

(c) Licensed, certified, or credentialed in a *related discipline, has completed a minimum of 30 hours of prevention specific education and training and has two years of qualifying prevention work experience or;

(d) Is approved at the discretion of the Office.

***Related Disciplines include**: CASAC, CPGC; CPHA (Certified Public Health Administrator), NY State Education Licensed or Certified Teacher, Health Educator, Guidance Counselor, Rehabilitation Counselor, Social Worker, Licensed Mental Health Practitioner, Registered Nurse, Physician, National Board-Certified Counselor or Certified Health Education Specialist.

2. **Prevention Staff:** To promote a competent and skilled workforce, all OASAS funded providers must adhere to the table below to determine the number of prevention professional staff required. OASAS will exercise discretion in determining compliance with this staffing requirement for larger providers that operate a range of services at multiple locations.

# of Full Time Equivalent (FTE) Professional Staff (not including the Prevention Director)	# of Professional Staff (this <u>may</u> include the Prevention Director) who must meet the Prevention Staffing requirement
1-3	1
4-7	2
8-11	3
12-15	4
16-19	5

Prevention professional staff must meet the staffing qualifications below:

(a) Credentialed Prevention Professional (CPP) or;

(b) Credentialed Prevention Specialist (CPS), or;

(c) Licensed, certified, or credentialed *in a related discipline** (see above) has two (2) years of qualifying prevention work experience and has completed at least 60 hours of prevention-specific education and training.

3. **Prevention Counseling Staff:** Prevention Counseling must be conducted by staff who are either licensed, certified and/or credentialed in a related discipline - CASAC, CPP, Credentialed Problem Gambling Counselor, Certified Teacher, Certified Health Educator, Certified School Counselor, Certified Rehabilitation counselor, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Registered Professional Nurse, Licensed Physician, and National Board-Certified Counselor, or holds a Bachelor's Degree with 1 year of work experience with youth and 1 year of counseling work experience.

Prevention Counselors who do not meet the aforementioned criteria on the effective date of these guidelines will be allowed to continue providing prevention counseling services through the WAIVER process.

4. **Teen Intervene Staff:**

a. <u>Licensed, Certified or Credentialed Professionals</u>

If delivery staff are licensed, certified, or credentialed in a related discipline, they are approved to deliver Teen Intervene.

b. <u>Non-Licensed, Non-Certified or Non-Credentialed Professionals</u>

If staff are <u>not</u> licensed, certified, or credentialed in a related discipline, providers must document in the employee file that staff have successfully met <u>all</u> the following education, training, and experience requirements in order to be approved by OASAS to implement Teen Intervene:

- The equivalent of a minimum of one (1) year of full-time counseling experience
- A minimum of six (6) hours of counseling skills or motivational interviewing training (MI)
- A minimum of six (6) hours of adolescent alcohol and other drug addiction training
- Teen Intervene training

<u>Related disciplines include</u>: CASAC, CPP, Credentialed Problem Gambling Counselor, Certified Teacher, Certified Health Educator, Certified School Counselor, Certified Rehabilitation counselor, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Registered Professional Nurse, Licensed Physician, and National Board-Certified Counselor.

C. Supervision Requirements:

Starting 2023-2024 workplan, all prevention staff shall receive regular supervision according to the educational background and professional status of the employee:

Staff without a license/credential and a bachelor's degree or less: weekly individual supervision with the Prevention Director/Supervisor, or a CPP, or a Licensed, certified, or credentialed professional *in a related discipline** that has two (2) years of qualifying prevention work experience and has completed at least 60 hours of prevention-specific education and training.

Staff with a non-prevention specific credential: biweekly individual supervision with a Prevention Director/Supervisor or a CPP.

Staff with a CPS: biweekly individual or group supervision with a Prevention Director/Supervisor, or a CPP.

Staff with a CPP: monthly individual or group supervision with a Prevention Director/Supervisor.

Ethical Standards
Every substance misuse prevention staff member shall be expected to uphold high ethical standards and be responsible to their service recipients, themselves, and other professionals. A Credentialed Prevention Professional (CPP) or a Credentialed Prevention Specialist (CPS) has a professional duty to adhere to the CPP/CPS Cannon of Ethical Principles and report through appropriate channels, any unethical conduct of which he or she is aware. (To read more about 14 NYCRR Part 853 - Credentialing of Addictions Professionals, click here).

Non-Prevention Functions
Funded prevention staff members are not permitted to perform non-prevention functions (e.g., act as lunchroom or hall monitors; provide substitute classroom coverage unrelated to substance misuse prevention services) except in emergency situations.

Filling Vacancies
Prior approval by OASAS is required to fill a prevention provider's Chief Executive Officer or Executive Director, Chief Financial Officer/Comptroller and Prevention Director (if applicable) vacancies. Any service provider sub-contracted through a County/LGU must meet the County/LGU's guidelines for hiring any positions that may require prior approval. Providers are responsible for ensuring that all staff hired meet OASAS' guidelines and meet qualifications as stated in their organization's written job descriptions. Refer to the Administrative and Fiscal Guidelines for OASAS-Funded Providers for additional information.
In addition to the above, it is strongly recommended that providers notify their Regional Office and County/LGU regarding changes of key (i.e., managerial, supervisory) personnel. Changes in management staff contact information must be made in the OASAS Provider Directory system (PDS). Keeping the PDS up to date allows OASAS and the public to have the correct contact information for your program.

B. Policy Manual

Each provider must develop, maintain, and make available to all staff the following information regarding its program operations, which has been approved by its Governing authority:

- Organizational chart;
- Organizational purposes/goals;
- Program days/hours of operation;
- Site locations, including hours of operation;
- Description of services provided;
- Incident reporting procedure (NYS Operating Regulations, Part 836-Incident Reporting in OASAS Certified or Funded Services);*
- Description of supervisory process;
- Copies of all forms (internal/external) used by the program (e.g., evaluation tools, data collection forms, etc.);
- Copies of all curricula being used by the provider;
- Child abuse reporting procedure;
- Description of confidentiality and/or privacy procedures;**
- Approved NYS OASAS Workplan;
- Most recent Annual Report;
- Procedure for complying with Justice Center requirements;
- Emergency Management Plan.

* NYS Operating Regulations, Part 836.3: OASAS requires compliance by all providers of OASAS services that are: certified, licensed, operated, or funded by OASAS. If a Prevention program is either certified or funded, then incident reporting is a requirement.

**Prevention providers that do not provide prevention counseling services should be aware that non-counseling services are not covered by the confidentiality requirements contained in 42 CFR Part 2. However, these providers are encouraged to develop procedures to protect the privacy of all program participants where appropriate and follow their local program policies and procedures.

C. Adequate Space

Each provider must have adequate space, which is clean, safe, accessible, and available for all staff providing, and consumers receiving, prevention services.
See NYS Operating Regulations, Part 814.3 for additional requirements.***

*** NYS Operating Regulations, Part 814 has general requirements for all facilities that have OASAS certified or funded services. Part 814.3 has general language for all facilities while much of the remaining sections are specific to types of facilities. For prevention, 814.3 is applicable.

D. Lease Renewal/Relocation Requirements

Each provider must receive prior approval by OASAS before entering a new or renewed lease. The provider is responsible for notifying their OASAS Regional Office ninety (90) days prior to the expiration of their current lease, and for arranging a fair market rent study to be done before entering a new or renewed lease. Please see the Administrative and Fiscal Guidelines for OASAS-Funded Providers for more information regarding the process.

E. Hours of Operation (Service Availability)

The hours of operation for providers with full-time staff must be no less than 35 hours per week. Alternative arrangements require prior written approval from OASAS. The hours of operation may be flexible in accordance with applicable employee contractual requirements, County/LGU policies, and the needs of the population to be served. Providers who are not operational during all 12 months of the prevention planning year (July 1 to June 30th) must indicate the non-service months in WITNYS in Facility Profile, "Operating Hours."

F. OASAS Contractual Requirements

Prevention services must be provided in accordance with OASAS contractual requirements and approved Workplans.

G. Prevention Materials and Curricula (Service Standards)

Prevention providers are responsible for the following:

- Implementing the requirements of the Evidence-Based Programs and Strategies (EBPS) selected. Providers must ensure fidelity to the EBPS core elements such as: service description; target population; setting; curricula content, participant number, number of sessions, etc. to maximize delivery effectiveness.
- Ensuring that all materials and/or curricula used in the provision of prevention services are accurate, current, age-appropriate, and culturally relevant to the target population being served.
- Selecting/using material/curricula that will contribute to the comprehensive approach in achieving the desired results as stipulated in the annual Workplan.
- Annually reviewing and updating, as needed, all material/curricula used, to ensure it addresses the requirements of the Workplan and meets the needs of the target population.

Prevention services should be provided to an identified target population at a level of intensity and frequency sufficient to ensure adequate knowledge and skill building in accordance with the comprehensive approach to providing prevention services.

H. Voluntary Termination of Authorized Prevention Services

A provider of prevention services that is OASAS funded and/or has been issued an OASAS operating certificate for Prevention Counseling must notify the Regional Office at least six (6) months prior to the voluntary termination of any authorized service as stated in 14 NYCRR Part 810 here.

The provider should also notify the County/LGU (if applicable) of the proposed closing. The Notice of Termination should include a comprehensive description of clearly defined actions that shall be taken. Certified prevention providers should, at a minimum, adhere to the following:

- Assure appropriate referral of prevention counseling participants as necessary;
- Preserve the confidentiality of service recipient records;
- Ensure appropriate access to financial records and accounts.

Implementation of the termination process shall not commence until the termination plan has been deemed satisfactory by the Regional Office. Please contact the Regional Office for the appropriate form to begin the process.

SECTION VII: PERSONNEL POLICIES AND PROCEDURES

All personnel policies and procedures must be in accordance with established NYS OASAS policy and/or, where appropriate, local school/community agency board, and/or County/LGU policy.

A. Employee Manual

All prevention providers must provide a copy of their employee manual to each employee upon his/her employment and obtain a signed statement that the employee has read the manual. The employee manual shall include, but is not limited to:

- Organizational purposes and goals;
- General personnel policies;
- Employment, promotion, separation policies;
- Employee orientation and training, to include foundational training requirements, Teen Intervene training for employees implementing Teen Intervene, and SBIRT training for employees implementing SBIRT;
- Employee appraisal (probationary and regular);
- Time and attendance;
- Salary and job title structure;
- Employee benefits;
- Affirmative action/non-discrimination policies;
- Sexual harassment policies;
- Violence in the workplace policy;

- Emergency preparedness policies and procedures;
- Grievance procedures;
- Conflict of interest policies;
- Substance Free Workplace (including Nicotine) policy;
- Employee travel policy (if not included in Fiscal Manual);
- Incident Reporting/Justice Center policy;
- Mandated Reporting of Suspected Child Abuse or Maltreatment policy.

B. Listing of Job Descriptions

Providers must have a job description, with specific written criteria detailing minimum qualifications of staff and job responsibilities for each position. These criteria must be in accordance with OASAS staff qualification standards.

C. Employee Personnel File

Providers must maintain a personnel file for each employee which includes, but is not limited to the following:

- Hiring notice/letter;
- Resumé or employment application which includes prior work history;
- Annual salary information, promotions etc.;
- Copy of job description and qualifications;
- Copies of performance evaluations;
- References, with documentation of written or oral verification;
- Professional licenses/certification/ credentials;
- Income tax withholding forms (W-4 and IT-2104);
- Records of training/staff development courses;
- Certificates of completion for required hours of foundational and prevention specific training;
- An individualized professional development plan appropriate to employee's job duties which must be signed and dated by the supervisor and employee;
- Employee benefit records, (e.g., health insurance pension, etc.);
- Copies of letters of commendation, if any;
- Copies of supervisory counseling memoranda, if any;
- Disciplinary actions, if any;∗
- Grievance matters, if any;
- Separation records, if any;
- Other pertinent correspondence

∗ Disciplinary actions should be included only when there is a final determination warranting such action. If there was not a sufficient basis for proceeding with the disciplinary action, the records of such action should be maintained in a separate file. Program staff have the right to review their personnel file.

D. Time and Accrual

In accordance with the County/LGU, Board of Directors or local school district policy, each employee must document the use of time expended in the program. Such documentation must include a record of sick, vacation, and personal time.

E. Restriction on Governing Board

No person receiving compensation as an employee of a prevention provider may serve on the governing board of that provider.

F. Mandated Child Abuse Reporting

In accordance with Mandated Reporting of Suspected Child Abuse or Maltreatment all OASAS funded providers are mandated to report suspected child abuse or maltreatment.

1. Mandated reporters who have direct knowledge of any allegation(s) of suspected child abuse or maltreatment, must personally make a report to the Statewide Central Register and then notify the person in charge of the institution or his/her designated agent that a report has been made. The person in charge, or the designated agent of such person, is then responsible for all subsequent internal administration necessitated by the report. This may include providing follow-up information (ex., relevant information contained in the child's educational record) to CPS.

Note: Notification to the person in charge or designated agent of the medical or other public or private institution, school, facility or agency does not absolve the original mandated reporter of his or her responsibility to personally make a report to the Statewide Central Register.

2. Within 48 hours, the prevention program director or designee or staff member shall submit a written report to the local child protective service of the suspected child abuse or maltreatment on the established forms.

3. Such reports shall be submitted without regard to whether the participant who is alleged to have abused or maltreated or neglected a child consents to such reporting and without regard to whether such alleged abused or maltreated child who may be receiving services consents.

4. Additional information beyond initial reports may only be disclosed with proper consent or an appropriate court order.

G. Justice Center Requirements

The Justice Center for the Protection of People with Special Needs became effective June 30, 2013. The law applies to OASAS service providers that are operated, certified, licensed or funded by the Office (“covered providers”). Provisions are incorporated into 14 NYCRR Part 836*.

The Justice Center is a state oversight agency charged with receiving reports of alleged abuse, neglect and other significant incidents involving patients and program related personnel who interact with patients on a “regular” basis and in a “substantial” “and unsupervised” manner

during the course of their duties. The Justice Center investigates and prosecutes cases of abuse and neglect. The Justice Center affects OASAS prevention service providers in the following areas:

- Incident and Death Reporting;
- Fingerprinting and checking criminal history of:
    - Prospective employees, contractors and/ or volunteers *if they have the potential to or may be permitted to have regular and substantial unsupervised or unrestricted physical contact with service recipients;*
    - All applicants for an OASAS credential (or renewal of a credential);
    - All applicants for an operating certificate;
    - Mandated Reporters (Persons who have "regular and substantial contact" with program participants);
- Incident management plan and incident review committee;
- Code of Conduct for Mandated Reporters.

All providers must check the Staff Exclusion List (SEL) developed by the Justice Center and the State Central Register for Child Abuse and Maltreatment prior to hiring any employee, contractor, and/or volunteer who has the potential for "regular, substantial, and unsupervised" contact with clients.

Background checks by OASAS are required for staff in prevention counseling programs certified or funded by the Office. Prevention programs that only provide group or classroom-based prevention services where employees do not have, or even have the potential for, regular and substantial unsupervised or unrestricted physical contact with clients will not need to undergo criminal background checks. However, service providers who may not be certified programs but work for, or in, school districts may be required by the school district to complete a background check based on State Education Department requirements. For any questions about staff fingerprinting requirements, please send an email to cbc@oasas.ny.gov

Certified Prevention Providers are obligated to comply with incident and death reporting requirements as defined in Part 836. The regulations and additional guidance on reportable incidents can be found at https://www.oasas.ny.gov/regulations.

SECTION VIII: PREVENTION COUNSELING POLICIES AND PROCEDURES

Prevention Counseling is a short term (maximum of 15 sessions), problem-resolution focused activity/intervention aimed at decreasing risk factors and increasing protective factors that are predictive of substance misuse and/or problem gambling.

Prevention Counseling makes use of *brief counseling and standardized brief interventions to prevent, delay, or reduce substance use, problem gambling, and the negative consequences caused by these behaviors. It includes screening and assessment of risk and protective factors, and referral of individuals with apparent symptoms of substance use, problem gambling, physical, mental, emotional, educational, or social problems to the appropriate treatment or support services.

Prevention Counseling serves youth, adults, and families across the life span. It is not for any individual who has already been diagnosed with an SUD or Problem Gambling Disorder.

Providers must be certified by OASAS to deliver Prevention Counseling.

*Brief Counseling is defined as time limited face to face (or virtual) provision of age-appropriate assistance and/or guidance related to risk and protective factors, decision making, conflict resolution, educational awareness and discussion on consequences of alcohol and substance use, and problem gambling activity. While it is not treatment or therapy, the goal is to impact and/or modify behavior through raising awareness and helping an individual to make informed decisions.

A. Policies and Procedures

The provider is required to establish written policies, procedures, and methods governing the provision of Prevention Counseling services. The policies shall include a description of each activity provided, including procedures for making appropriate referrals to and from other services, when necessary. These policies, procedures, and methods shall address, at a minimum, the following:

- Supervision of prevention counseling staff, to include frequency, type, and location;
- Copy of assessment/screening instruments used;
- Admission, retention, and discharge criteria - to include provisions for implementing short term counseling;
- Problem identification and initial screening determination, risk and protective factor assessment, and service plan development;
- The identification and list of appropriate referral sources applicable for participant needs;
- Record-keeping procedures that ensure that documentation is accurate, timely and prepared by appropriate staff, and that the maintenance and/or storage of active and inactive records, the release or disclosure of information and the destruction of records are performed in conformance with the Federal Confidentiality Regulations (42 CFR Part 2);
- Record-keeping procedures for problem gambling prevention counseling that ensure that documentation is accurate, timely, prepared by appropriate staff, and in conformance with the confidentiality regulations contained in the Health Insurance Portability and Accountability Act (HIPAA);

- Ensure and document that Prevention Counseling staff receive training in: a) mandated reporting; b) suicide prevention; c) Motivational Interviewing (or an equivalent training) at least every three years.
- Mandated reporting protocol;
- Incident reporting in accordance with Part 836 - Incident Reporting in OASAS Certified, Licensed, Funded, or Operated Services.

B. Administrative Operations

Each provider must designate a supervisor whose responsibilities are to provide supervision for Prevention Counseling and ensure that prevention counselors understand the parameters within which OASAS required services/activities are delivered (See **Section C below**).

1. Participation in Prevention Counseling services is voluntary, and participants should be so informed by posting a notice in each site where services are provided. In the case where the local school board or community board policy requires parental permission, the permission must be obtained within the guidelines of the Federal Confidentiality Regulations (42 CFR Part 2).
2. There shall be at least one full-time equivalent (1 FTE) counseling staff member for every thirty-five (35) admitted Prevention Counseling participants who are regularly receiving individual counseling services.
3. Prevention provider records must be maintained separately from other school/agency records.
4. Where possible, participant records should be maintained at the site where services are provided.
5. All participant counseling and administrative program records must be kept by the provider for a period of six (6) years from the date of the last payment made for that contract period.
6. Adequate space is required for the provision of Prevention Counseling services. Adequate space is defined as: clean, safe, accessible, and complies with confidentiality standards.

C. Required Services/Activities

Prevention counseling services must include the following activities:

- Age-appropriate screening for substance misuse and or problem gambling behaviors using OASAS approved tools;
- Assessment of risk and protective factors related to the presenting problem behavior(s) (reason for referral);
- Referral to Teen Intervene or Brief Alcohol Screening and Intervention for College Students (BASICS) where appropriate.

- Participant Services Plan development for admitted participants, documenting active participation and with projected timeframes for completion of goals;
- Referral to other necessary prevention, treatment, and/or support services when needed;
- Compliance with all OASAS documentation and reporting requirements;
- Disposition.

Prevention counseling activities may include:

- Individual prevention counseling;
- Group prevention counseling;
- Parent/Family sessions.

D. Screening, Assessment, and Disposition

An individual who seeks or has been referred for Prevention Counseling services shall undergo an initial screening for risk and protective factors associated with substance use and/or problem gambling and an assessment of the presenting problem to identify the circumstances contributing to the participant's referral to Prevention Counseling and to reach a disposition regarding the appropriateness of admission to Prevention Counseling and/or other types of provider prevention or referral services. This required screening and assessment should include the use of OASAS approved standardized tools and may include up to three (3) sessions over a twenty (20) school/work/business day period, at which point a disposition must be made. The assessment is documented on the Assessment Admission Record (PAS-64). The Personal History Record (PAS-64A) should be initiated during the assessment period. All completed assessments for individuals not admitted into counseling must be maintained in a central file in a secure manner on-site.

E. Admission Criteria

To be admitted to Prevention Counseling, an assessment of risk and protective factors is completed based on the presenting problem behavior(s)and is limited to no more than three sessions.

Opened cases are based on the youth having a minimum number of risk factors that must be supported with a detailed explanation of the problem behavior, justifying the risk factor. Admission to Prevention Counseling requires a minimum of four (4) risk factors identified with at least 2 required from the individual and/or family domains. *If the needs are beyond the scope of the prevention counseling service, appropriate referrals are made and documented.* (See **Appendix H** for Risk Factors Assessment and Definitions).

The Personal History Record (PAS-64A) should be initiated prior to the admission of an individual into Prevention Counseling and maintained in the participant's program record. (See **subsection H- Program Records** below).

F. Participant Services Plans

1. A Participant Services Plan (PAS-65) shall be developed within twenty (20) school/work/ business days of admission, based on a comprehensive risk and protective factor assessment. It shall be developed and signed by the single member of the counseling staff responsible for coordinating and managing the participant's services, and their supervisory staff. The participant should be involved in the development of their Service Plan, but their signure is not required. Standardized, age-appropriate assessment instruments, should be used (e.g., GAIN-Q).

   The Participant Services Plan shall:

   - Establish behavioral indicators which address each identified problem, and/or risk factor and/or protective factor identified during the comprehensive risk and protective factor assessment;
   - Specify the behavioral results/outcomes to be achieved which shall be used to measure progress toward attainment of the stated behavioral indicators;
   - Indicate the expected time frame for accomplishment of the stated behavioral indicators and results/outcomes;
   - Consider cultural and social factors, as well as the circumstances for each participant;
   - Include a record of referral for any ancillary service to be provided by any other facility, a description of the nature of the service, and the results of the referral.

2. The participant shall participate in the service planning process.

3. The Participant Services Plan must include the signature and date of the authorized staff person completing the planning process and their supervisor.

4. For those participants readmitted into the service within sixty (60) calendar days of discharge, the initial Assessment/Admission Record form may be utilized provided that a new Participant Services Plan update is completed.

5. The responsible counseling staff member shall ensure that the Participant Services Plan is included in the participant's record and that all services are provided in accordance with the service plan.

6. The entire Participant Services Plan, once established, shall be thoroughly reviewed, and revised, at least every ninety (90) calendar days by the responsible counseling staff member in consultation with the participant. Any revisions to the Participant Services Plan shall be documented using the Services Plan Update (PAS-65A).

7. Duration of an individual's participation in counseling shall not exceed fifteen sessions. Extended services may be provided with justification and supervisory approval to be documented in the case record using the Services Plan Update (PAS-65A).

8. A participant shall be retained in the Prevention Counseling service beyond fifteen sessions only if the participant:

    - Continues to meet the admission criteria;
    - Can benefit from continued Prevention Counseling;
    - Is on a waiting list for admission into a treatment program.

    Justification for retaining a participant beyond fifteen sessions must be documented in the case record and indicated in the Participant Services Plan accordingly.

9. All participants receiving Prevention Counseling in a school setting must be discharged at the end of the school year, unless services are justified and have supervisory approval to continue over the summer. If it is not possible to continue services over the summer, the participant shall be referred to an appropriate service provider if necessary.

10. There must be a notation in the case record that upon admission, the service provider's rules, standards for admission, retention and discharge, and confidentiality regulations (42 CFR Part 2 for substance abuse, HIPAA for problem gambling) were reviewed with the participant and that the participant indicated that he/she understood them. Program participants must receive written notice informing them of the existence of 42 CFR Part 2 and HIPAA and be advised how the program will use and disclose the information collected about them. A Notice of Privacy/Confidentiality form can be found on the OASAS website.

11. Progress notes (Participant Progress Summary PAS-66) shall be written, signed, and dated by the responsible counseling staff member, and shall provide a chronology of the participant's progress related to the behavioral indicators established in the Participant Services plan. It shall clearly delineate the course and results of service and shall indicate participant's involvement in all significant services that are provided. Progress notes shall be written after each counseling session. For those individuals participating in group counseling, staff shall complete the Group Counseling Participation Record (PAS-67) and Group Process Summary (PAS-67A) forms as well.

12. Supervisory staff must be consulted in the case of any participant who is not responding to counseling, not meeting the behavioral indicators defined in the individual's Participant Services Plan, or who is disruptive to the service. Any resulting decisions made must be documented in the participant record and the Participant Services Plan must be revised accordingly.

13. Counseling staff must have face-to-face counseling contact with each participant at least twice a month (except for school vacations, holidays, and examination periods). If the frequency of counseling is determined to be needed less than twice a month, a rationale must be documented in the Participant Services Plan. Any interruption to the bimonthly, face-to-face contact must be documented in a progress note.

14. To remain active, a Prevention Counseling participant must have at least one (1) face-to-face counseling contact within a thirty (30) calendar-day period, unless prior arrangements have been made between the participant and program staff (e.g. rehabilitation, hospitalization, staff leave of absence, etc.).

15. Discharge Planning: The Discharge Plan shall be developed in collaboration with the participant and shall begin upon admission, be closely coordinated with the Participant Services Plan, and be included in the participant record. The Discharge Plan shall include, but not be limited to, the participant's need for any continued services and/or other referrals for any specific needs which have been identified in the assessment and over the course of counseling. Referrals should be indicated on the Referral Record (PAS-64C).

16. Discharge Categories: An individual shall be discharged from the Prevention Counseling service when any of the following occurs:

    - Participant has accomplished the behavioral results/ outcomes identified in the individual service plan and subsequent service plan updates;
    - Participant has received the maximum benefit from the service;
    - Participant has an extended illness;
    - Participant refuses referral;
    - Participant is disruptive to the service and/or fails to comply with the service's reasonably applied behavioral expectations;
    - Participant refuses counseling services (e.g., voluntarily left, dropped out);
    - Participant has had no face-to-face counseling contact in thirty (30) calendar days;
    - Participant has finished the school year (if in a school setting).

17. A Discharge Summary, which includes a narrative description of the course and results of counseling, must be prepared and included in each participant's record within thirty (30) calendar days of discharge. The date of discharge should be either the date of the last face-to-face contact or at the end of thirty (30) calendar days from the last face-to-face.

18. Admission and discharge data should be entered into WITNYS by the fifteenth (15^{th}) of the next month.

19. No participant shall be discharged without a Discharge Plan that has been reviewed by the participant, assigned staff, and approved by a supervisor prior to the discharge of the participant. This does not apply to participants who stop attending, refuse continuing care, or otherwise fail to cooperate. The Discharge Plan may include referrals for continuing care and shall be offered to the participant upon discharge.

20. All Prevention Counseling providers making referrals for any support or auxiliary services must document these services on the Referral Record. The results of the referral (i.e. whether the participant appeared at the referral site for assessment, or whether the participant was admitted) should be documented whenever possible.

21. The Referral Record (PAS-64C) must be kept in the participant's record if a referral is made. If referrals are made for individuals not admitted into counseling, those referral records must be maintained in a confidential manner in a central file on-site.

22. All Prevention Counseling providers who are legally required to disclose information regarding an individual must complete a Consent for Release of Information Concerning Alcoholism/Drug Abuse Patients (TRS-2). For individuals who have been diverted (or referred) to Prevention Counseling through the Criminal Justice system, a Criminal Justice Consent to Release Information must be completed.

G. Referral Services

Each Prevention Counseling provider must plan to address additional services to meet participant needs that cannot be met by the prevention counselor. Written policies and procedures that identify methods for coordination of services are required for:

- Substance use treatment and crisis services;
- Problem gambling treatment and crisis services;
- Mental health and developmental disability services;
- Vocational and/or educational services;
- Health care services;
- Education, risk assessment, supportive counseling and referral services concerning HIV and AIDS and other communicable diseases;
- Family counseling services.

Criteria for Referral to Evaluation for Treatment: If a participant displays the characteristics consistent with the criteria for substance use disorders or a gambling disorder (Refer to DSM 5 for criteria) a referral for an evaluation for treatment should be made.

Refusal of Referral: In a case where an individual is unwilling to accept a referral to a substance misuse or problem gambling treatment service for an evaluation, the individual may be referred for an early intervention service (Teen Intervene or BASICS). The individual can be admitted to Prevention Counseling for brief motivational counseling that is focused on accepting the referral for an evaluation for substance misuse or problem gambling treatment.

H. Program Records

1. Providers must keep individual records for each participant who is assessed whether they are admitted to Prevention Counseling services or not. All records, at a minimum, must include:
    - The source of referral;
    - Presenting problem behavior(s) precipitating the referral;
    - Initial assessment findings and recommendations, including referrals for additional services or supports.

2. Records for all admitted participants must include, at a minimum, the following:

    - Current substance use or gambling, if any;
    - Consequences related to substance use or gambling, if any;
    - Documentation of the comprehensive risk factor assessment based on presenting problem behaviors;
    - Personal history record;
    - The individual's Participant Services Plan and all reviews and updates thereto;
    - Correspondence regarding the participant;
    - Discharge plan and summary, including the circumstances of the discharge;
    - Documentation of contacts with participant's family, significant other(s), teachers, counselors, and other service providers;
    - Progress notes.

3. **Participant Identifier Code:** Each participant must have a unique identification number as assigned by the provider and recorded in a central admissions log. This unique identification number is assigned at the first assessment session.

The same Participant Identifier Code must be used for the participant among all of the provider's Program Reporting Units (PRUs) and for all transactions. The same Participant Identifier Code should be used for the same individual even if the participant was re-admitted in different contract years. Within each PRU, the number can never be reused for another participant.

4. A **Central Admissions Log** shall be maintained for newly assessed participants and shall include, at a minimum:

    - The Participant Identifier Code;
    - The name of the individual assigned to the Participant Identifier Code;
    - Emergency contact information;
    - The admission date;
    - The program reporting unit (PRU) admitted to;
    - The discharge date.

    An alphanumeric cross-reference to the central log must also be maintained and stored in a secure manner. The Participant Identifier Code may be up to ten (10) characters long and may include any combination of alphabetic letters or numbers. A copy of the central admissions log should also be maintained at the provider's administrative office.

Note: If the participant already has a Participant Identifier Code due to receiving Teen Intervene services, that same Participant Identifier Code should be used.

5. Services utilizing electronic record keeping protocols and subject to HIPAA oversight, shall administer said record keeping protocols accordingly.

6. All prevention providers must maintain participant records for each individual admitted to prevention counseling services components. An individual counseling record must include:

    - Assessment/Admission Record (PAS-64)
    - Personal History Record (PAS-64A)
    - Referral Record, (PAS-64C), when applicable
    - Participant Services Plan (PAS-65)
    - Services Plan Update (PAS-65A), when applicable
    - Participant Progress Summary (PAS-66)
    - Discharge Record (PAS-64B)

7. For individuals participating in group counseling, staff shall complete both of the following:

    - Group Counseling Participation Record (PAS-67)
    - Group Process Summary (PAS-67A)

Note: All OASAS Prevention Counseling forms can be found on the OASAS website Forms page.

8. Redesign of OASAS approved forms:

A provider may redesign OASAS Forms PAS-64 through PAS-67 to meet their special needs, provided all the required data elements of the NYS OASAS forms are included in the proposed equivalent form.

The proposed equivalent form(s) must be approved in writing by OASAS Regional Office. This approval letter must be maintained on file for review purposes. The approval exists as long as no further modifications are made to the approved form(s).

SECTION IX: TEEN INTERVENE POLICIES AND PROCEDURES

Teen Intervene is an Early Intervention, evidence-based program (EBP) targeting youth between twelve (12) and nineteen (19) years of age who display the early stages of substance use or gambling problems (e.g., using or possessing drugs), but do not use substances or gamble daily or demonstrate a diagnosable substance use or gambling disorder. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, this intervention aims to help teens reduce and ultimately eliminate their substance use and gambling.

Preventing addiction and reducing harm is the long-term goal of Teen Intervene. As with most early intervention models, Teen Intervene goals are developed by the adolescent in conjunction with the counselor. The goals of the intervention reflect the individual's severity of substance misuse or gambling and their willingness to change. Thus, intervention goals will vary across

clients. Non-abstinence goals common to early interventions (e.g., harm reduction, risk reduction) may not be suitable for some settings and/or a counselor's clinical orientation. By using individualized goals and personalized feedback, the counseling can be more directly focused for each adolescent's specific needs.

Teen Intervene is designed for professionals including teachers, school counselors, social workers, psychologists, and other youth-serving professionals who are working with adolescents who use substances or gamble. Users of the Teen Intervene model should be trained in the delivery of the model, and have formal training in basic counseling skills, as well as a basic understanding of the etiology, course and treatment of adolescent substance use and gambling disorders. Refer to the Staffing Requirements in Section VI: Administrative and Operational Requirements for OASAS Funded Providers.

A. Policies and Procedures

Polices in the school and/or other settings can assist in successful implementation of Teen Intervene (TI) by supporting referrals to the program and continued engagement by participants. It is rare for young people to self-refer into Teen Intervene; therefore, a policy that encourages referrals from administrators, teachers and coaches may help reach youth who could benefit from early intervention. For example, the program will be more successful if there are policies in place, (e.g., screen every student when an alcohol or other drug (AOD) or gambling problem is suspected), when the screen is positive, or when there are indications that the student is gambling or using substances.

The provider is required to establish written policies, procedures and methods governing the provision of Teen Intervene that shall include procedures for making appropriate referrals to and from other services, when necessary. These policies, procedures, and methods shall address, at a minimum, the following:

- Designated supervision of Teen Intervene facilitators;
- Record-keeping procedures that ensure that documentation is accurate, timely, and prepared by appropriate staff;
- The maintenance and/or storage of active and inactive records, the release or disclosure of information and destruction of records are to be performed in conformance with the Federal Confidentiality Regulations (42 CFR Part 2);
- Identification of appropriate referral sources for participants who display evidence of more serious substance use issues, problem gambling and/or mental health issues;
- Consent to release information;
- Child abuse reporting protocol.

B. Required Services/Activities

Teen Intervene was designed to be implemented in three (3) sessions, with the third session including a parent/caregiver. Teen Intervene should be administered in two (2) or three (3) sessions of sixty (60) to seventy-five (75) minutes in duration. However, in many settings providers may not have access to the adolescent for that amount of time per session. In those cases, the provider can increase the number of sessions up to six (6). If the individual has not

made progress after six (6) sessions, a referral for an evaluation for substance misuse or problem gambling treatment is likely indicated.
The following are required activities:

- Problem identification and initial screening determination, using an evidenced-based screening instrument developed for adolescents (e.g., Alcohol and Other Drug Use History, CRAFFT, S2BI, Brief Adolescent Gambling Screen etc.). Examples can be found on the OASAS SBIRT website under Adolescent Screening Instruments;
- A minimum of at least two (2) sessions (with the adolescent) to deliver the program content. Where appropriate, Teen Intervene booster sessions may be offered to the adolescent;
- An optional third (3rd) session should include both the adolescent and a parent and/or a caring adult identified by the adolescent. However, the adolescent has the right to not involve the parent or caring adult if they so choose;
- All sessions except the last are individual sessions;
- Referrals to other necessary prevention, treatment, and/or support services, if needed.

C. Administrative Operations

1. Participation in Teen Intervene is voluntary, and participants should be so informed by posting a notice in each site where services are provided. In the case where the local school board or community board policy requires parental permission, the permission must be obtained within the guidelines of the Federal Confidentiality Regulations (42 CFR Part 2).
2. Each provider must designate a supervisor whose responsibilities are to provide supervision for staff delivering Teen Intervene. {Refer to Section VI (B) Staffing Requirements}

3. Adequate space is required for the delivery of Teen Intervene. Adequate space is defined as clean, safe, and accessible and complies with confidentiality standards.

D. Program Records

Records for all Teen Intervene participants must include, at a minimum, the following information:

- A Participant Identifier Code that is created by providers should be used on all Teen Intervene questionnaires, worksheets, and other paper or electronic records. The participant's name or any other identifying information should not be entered into any reporting system or used on questionnaires and worksheets.

Note: If the participant already has a Participant Identifier Code due to Prevention Counseling services, that same identifier should be used.

- Results from a standardized AOD or problem gambling screening instrument (e.g., Alcohol and Other Drug Use History, CRAFFT, 2SBI, Brief Adolescent Gambling Screen)
- Part 2 of Teen Intervene - Client Questionnaire
- Teen Intervene - Pros and Cons Worksheet

- Teen Intervene – Triggers and Cravings Worksheet
- Teen Intervene - Readiness to Change Worksheet(s)
- Teen Intervene - Establish Goals Worksheet(s)
- Teen Intervene - Parent/Guardian Questionnaire (if parent/guardian session delivered)
- Teen Intervene - Parent/Guardian Worksheet (if parent/guardian session delivered)
- Six Steps Worksheet (if parent/guardian session delivered)
- Family Rules on Alcohol and Other Drug Use (if parent/guardian session delivered)
- Parent/Guardian Goals (if parent/guardian session delivered)
- Completed Release of Information Concerning Alcoholism/Drug Abuse Patient
- Criminal Justice Consent to Release Information or HIPAA form (if applicable)

Required data for this service approach must be maintained by the provider and entered, as relevant, into WITNYS.

SECTION X: CONFIDENTIALITY

Federal Law guarantees the strict confidentiality of all persons (including youth) who have applied for or received any alcohol or substance misuse-related services. Participant records maintained by the prevention counseling, Teen Intervene, or SBIRT service are confidential and may only be disclosed in conformity with federal regulations governing the confidentiality of alcohol and drug abuse participants' records as set forth in Federal Confidentiality Regulations (42 CFR Part 2). The records of problem gambling program participants are protected from disclosure by New York State law and HIPAA.

Records protected from unauthorized disclosure include any data or information, whether written or oral, that would identify a person as an individual that has applied for or received prevention counseling, Teen Intervene, or SBIRT services. Unrecorded data, including memories and impressions of program staff, are "records" protected by the regulation. Unless a program applicant/participant has consented or disclosure is otherwise permitted by law, all data pertaining to an applicant/participant, from the time of the initial contact with the provider through all subsequent involvement in program activities and discharge, must remain permanently confidential.

Provider Requirements:

Each provider must:

- Develop written procedures that regulate and control access to and use of records which are subject to these regulations;
- Maintain written records in a secure room, locked file cabinet, safe or other similar depository that is separate from other school and/or modality/environment records;
- Maintain and store the central log of Participant Identifier Codes for each participant admitted to the program, and the alphanumeric cross-reference log in a secure room,

locked file cabinet, safe or other similar depository that is separate from other school and/or modality/environment records;

- Educate all provider staff about the confidentiality requirements, restrictions on re-disclosure and program procedures for ensuring compliance with federal regulations;
- Provide each participant with a written summary of his/her confidentiality rights in accordance with federal regulations.

B. Releases of Information

Service providers may release information to a person or organization only if one (1) of the following conditions is met:

1. The provider has obtained a sufficient Consent to Release Protected Information

   a. Any written Consent to Release Protected Information must include the following nine (9) elements (as required by the federal regulations):

      - The name or general designation of the service provider or person authorized to disclose information;
      - The identity of the person or organization to which a disclosure will be made;
      - The name of the participant;
      - The purpose or need for the disclosure;
      - The extent or nature of the information disclosed/released;
      - A statement that the consent may be revoked at any time, except to the extent that action has been taken in reliance on it (this statement should be eliminated where participation in counseling is a condition of release from a judicial matter and a TRS-4 is used);
      - A specific description of the date, event or condition upon which the consent will expire, without express revocation;
      - The date the consent is signed;
      - The signature of the participant.

   b. Even if the participant is a minor, his/her signature is required prior to making any disclosure, including disclosures to parents or guardians. For additional information and clarification whether participants' records can be released to their parents without a signed release of information or court order, see **subsection F below- Family Educational Right and Privacy Act**.

   c. Each written participant consent must be filed permanently in the participant's record together with a record of all information released with it.

d. Any disclosure made with written participant consent must be limited in scope to that information that is necessary to accomplish the need or purpose for the disclosure.

C. Disclosures Made Without Written Participant Consent

Under 42 CFR Part 2, disclosure without written participant consent is otherwise permitted by law in the following instances:

1. Medical Emergency

Disclosure may be made to medical personnel only and is limited to information that is necessary to treat an emergency medical condition which poses an immediate threat to the health of any individual and requires immediate medical attention. Immediately following disclosure, the provider must document in the participant's record: the name and affiliation of the medical personnel to whom disclosure was made, the name of the individual that made the disclosure, the date and time the disclosure was made and the nature of the emergency.

2. Scientific Research

Disclosure may be made for the purpose of scientific research if the recipient of the information is qualified to conduct research and has provided proof of the existence of protocol that ensures participant information will be adequately protected in accordance with federal confidentiality regulations.

3. Audit and Evaluation

Disclosure may be made to the following entities for audit and evaluation activities:

- a government agency which aids, or regulates, the provider;
- a third-party payer to the provider;
- a peer review organization;
- Medicaid or Medicare personnel.

4. Court-ordered Disclosures

A subpoena, search warrant, arrest warrant or court order standing alone, is not sufficient to require or permit a provider to disclose information. Disclosure may be made as directed by a court order when the order is accompanied by a subpoena mandating disclosure and is issued after the provider and participant have had an opportunity to be heard at a hearing in court.

5. Qualified Service Organization Agreement (QSOA)

Disclosure may be made to an outside service provider that has entered into a Qualified Service Organization Agreement for support services. The information disclosed must be limited to that which is needed to effectively support the functioning of the program.

6. Child Abuse Reporting

Disclosure may be made as required by Social Services Law Sections 412 through 415 but is limited by 42 CFR Part 2 to an initial report of suspected child abuse or neglect. Absent a proper consent or court order/subpoena, providers may not respond to follow-up requests information.

7. Crimes on Provider Premises or Against Provider Personnel

Disclosure may be made to law enforcement officers and is limited to circumstances related to crimes or threats to commit crimes on provider premises or against provider personnel, and the participant's name, address and last known whereabouts.

D. Disclosures Made by a Provider

Any disclosure made by a provider must be accompanied by a written statement that all information disclosed is protected by federal law and that the recipient cannot make any further disclosure unless permitted by federal regulation. Where disclosure is made verbally, a written statement must still be provided.

E. Internal Program Communications

Internal program communications may be made within the program or to those in direct administrative control, but such information must be limited to that information necessary to facilitate the provision of substance misuse or gambling related services to the participant. Absent consent, disclosures for non-treatment purposes are not permitted.

F. Family Educational Right and Privacy Act (FERPA)

Prevention providers who operate prevention counseling programs in a school should be aware that the Family Educational Right and Privacy Act (FERPA) requires the disclosure of personally identifying student data upon a parent's request. FERPA gives the parents of students who are under the age of eighteen (18) the right to inspect and review their children's education records as well as some control over the disclosure of information from those records. FERPA therefore directly conflicts with the confidentiality protections afforded a student under 42 CFR Part 2. Nonetheless, under FERPA a prevention counseling program in a school is legally required to comply with a parent's request to inspect their child's educational records – whether or not the child consents.

Under FERPA, Student Assistance Program (SAP) records are considered educational records. A parent has the right to access the educational records of their child, even if those records are normally protected by 42 CFR Part 2. Prevention providers may be faced with a situation where compliance with FERPA creates a violation of 42 CFR Part 2 and vice versa.

The following actions should be considered in resolving this conflict between the two (2) federal laws:

- The program can ask participants to sign a consent to disclose information to their parents when a parent's request specifically includes access to a child's prevention counseling records.
- Alternatively, where a parent is seeking information regarding their child's participation in prevention counseling, and the child refuses to consent to such disclosure, the school, the program, or the parent, can apply for a court to issue an order directing the program as to whether or not the requested information should be disclosed. A court will balance the competing federal requirements and determine whether it is in the child's best interest to release the child's prevention counseling records to the parent.

FERPA does not apply to records or informal notes of instructional, supervisory or administrative staff that are kept in the sole possession of the maker of the record. However, these notes lose their exemption if they are shown to anyone else.

FERPA does not apply to the records of community-based prevention counseling programs that are not administered by, affiliated with, or located in a school. FERPA only applies to the records of prevention counseling programs that are administered by, affiliated with, or located in a school.

If providers have further questions regarding the requirements of either FERPA or 42 CFR Part 2 or require assistance in resolving an actual issue regarding the disclosure of confidential information, please contact OASAS' Counsel's Office legal@oasas.ny.gov.

SECTION XI: ALCOHOL AWARENESS PROGRAM POLICIES AND PROCEDURES

The Alcohol Awareness Program (AAP) is a specific prevention service governed by OASAS under Section 19.25 of the Mental Hygiene Law. AAP providers must be approved by OASAS and must follow specific rules for delivery and reporting of activities (see below).

Note: Prevention providers who deliver AAPs do not include the AAP in their Prevention Workplans and therefore do not report AAP data in WITNYS.

A. Definition of an Alcohol Awareness Program (AAP)

The Alcohol Awareness Program (AAP) is an Early Intervention prevention service designed to provide an educational experience for underage youth who are referred through the courts, schools/colleges, family members or other agencies for violation of the underage drinking laws. It may be an alternative sentence that is imposed upon youth under twenty-one (21) years old who are found guilty of violating the Alcoholic Beverage Control Law. Furthermore, this program can be used as an alternative condition of dismissal for a youth under twenty-one (21) who has been charged with a misdemeanor where the record indicates that the consumption of alcohol may have been a contributing factor in the commission of the offense.

This education program may also be modified and used for individuals charged under a local ordinance commonly referred to as a Social Host Law or a violation of the ABC law related to

serving alcohol to minors, as well as any other local or state laws that would benefit the public by having the offender receive education about alcohol.

The program may also provide a mechanism to determine whether or not a youth may need to be evaluated for their substance misuse, and as a means to involve family/significant others in the education and support process. AAPs must conform to federal regulations governing the confidentiality of alcohol and drug abuse participants' records as set forth in Federal Confidentiality Regulations (42CFR Part 2).

B. Components of an AAP

An AAP must address the following categories:

- Laws and the criminal justice system;
- Characteristics of alcohol and other drugs;
- Characteristics of gambling;
- Understanding addiction;
- Family dynamics and issues regarding children of parents with a substance use disorder or problem gambling diagnosis;
- Societal issues;
- Youth issues;
- Choices and alternatives;
- Screening and self-assessment;
- Community resources;
- Stress management.

C. Application Process

Any organization interested in delivering an AAP should contact the Division of Prevention and Problem Gambling Services at prevention@oasas.ny.gov for more information.

D. Reporting Requirements

All AAPs are required to submit annual reports for the time period of July 1st to June 30th to the Bureau of Prevention Services, using a standard reporting form provided by OASAS. The reports collect data on numbers of participants served, referral sources, ages of participants, FTE allocation, and other relevant program information. The submission deadline for the annual report is August 15th.

APPENDICES

APPENDIX A

OASAS Risk & Protective Factor Chart

Risk Factors That Inhibit Healthy Youth Development

RISK FACTORS	Problem Behaviors				
Community	**Substance Misuse**	**Delinquency**	**Teen Pregnancy**	**School Drop-Out**	**Violence**
*1. Availability of Alcohol and Other Drugs	√				√
*2. Insufficient Laws, Policies, Compliance to Reduce Substance Misuse	√	√			√
*3. Social Norms Favorable Toward Substance Misuse	√	√			√
4. Community Disorganization	√	√			√
5. Extreme Economic Deprivation	√	√	√	√	√
Family					
*6. Family History of the Problem Behavior	√	√	√	√	√
*7. Family Management Problems	√	√	√	√	√
*8. Family Conflict	√	√	√	√	√
9. Parental Attitudes Favorable Towards Drugs	√	√			√
*10. Parental Attitudes Favorable Towards Other Problem Behavior	√	√			√
School					
11. Academic Failure	√	√	√	√	√
12. Low Commitment to School	√	√	√	√	√

Individual and Peer					
13. Early Initiation of Drug Use	√	√	√	√	√
14. Early Initiation (K-5) of Problem Behavior	√	√	√	√	√
15. Perceived Risk of Drug Use	√				
16. Favorable Attitudes Toward Drug Use	√	√	√	√	√
*17. Friends Who Use Drugs / Engage in Other Problem Behavior	√	√		√	
18. Peer Rewards for Drug Use	√				
19. Depressive Symptoms	√				

√ Indicates that at least two longitudinal studies have found the risk factor to predict the problem behavior.

* Indicates some preliminary evidence of correlation with problem gambling.

Protective Factors That Promote Healthy Young Development

Community

1. **Community Opportunities for Prosocial Involvement**
2. **Community Rewards for Prosocial Involvement**

Family

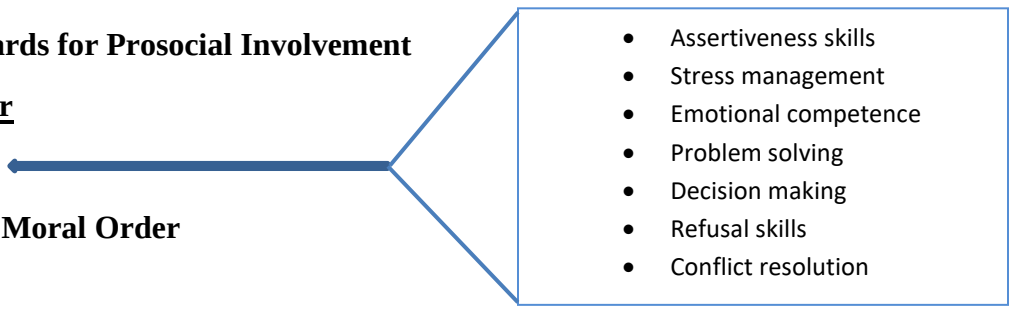
3. **Family Opportunities for Prosocial Involvement**
4. **Family Rewards for Prosocial Involvement**
5. **Family Attachment**

School

6. **School Opportunities for Prosocial Involvement**
7. **School Rewards for Prosocial Involvement**

Individual & Peer

8. **Social Skills**
9. **Belief in the Moral Order**
10. **Religiosity**



11. Prosocial Involvement

Research Findings:

- The Risk and Protective factors from the research predict levels of prevalence of youth substance misuse and the other problem behaviors listed.

- Research from Univ. of Washington, Social Development Research Group provides evidence that Risk and Protective factor scores predict statewide standardized academic test scores at the school district level.

  - **Risk factors** increase the probability of problem behaviors.
  - **Protective factors** decrease the probability of problem behaviors.

APPENDIX B

OASAS Regional Prevention Resource Centers

The Prevention Resource Center (PRC) provides focused training and technical assistance on following the five step
Strategic Prevention Framework (SPF) process as well as implementing environmental prevention strategies to support, strengthen, and develop sustainable and effective prevention services throughout the state. In six regions, OASAS has instituted a PRC, to transfer knowledge of prevention science and engage multiple systems in prevention efforts through community coalitions and its network of providers. The PRCs support community coalition work throughout New York State, and each PRC is responsible for a specific catchment area.
The Purpose of a Regional Prevention Resource Center is to:

- Support New York State's Prevention infrastructure in implementing effective alcohol, other drug, and problem gambling prevention strategies. The PRCs disseminate the current prevention science, through training and technical assistance to community coalitions, prevention providers and community-based organizations to bring science to practice.
- Increase the number of prevention-focused community coalitions operating in each region and the number reaching underrepresented communities.
- Maintain sustainable coalitions in each county that are risk and protection-focused, data-driven, research-based, and implementing AOD evidence-based prevention initiatives, with an emphasis on environmental change strategies.
- Strengthen the capacity and sustainability of existing coalitions.
- Provide technical assistance to coalitions and providers on the SPF, including needs assessment, capacity building, planning, implementation, evaluation, cultural competency, sustainability, and current prevention science.

Listing of Regional Prevention Resource Centers (PRC)

***Western PRC** - http://www.wnyprc.com/
Counties Covered: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming
Host Provider: Genesee Council on Alcohol and Substance Abuse in Batavia
430 East Main Street
Batavia, NY 14020
585-815-1844

***Finger Lakes PRC -** https://ncadd-ra.org/services/finger-lakes-prevention-resource-center/
Counties Covered: Broome, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Yates
Host Provider: DePaul's National Council on Alcoholism and Drug Dependence - Rochester Area
1931 Buffalo Road
Rochester, NY 14624
585-719-3482

***Central PRC** - https://www.preventionnetworkcny.org/central-region-prc/coalitions/
Counties Covered: Cayuga, Chenango, Cortland, Delaware, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, St. Lawrence
Host Provider: The Prevention Network in Syracuse
906 Spencer Street
Syracuse, NY 13204
315-471-1359

***Mid-Hudson PRC -** http://www.adacinfo.com/programs-services/mid-hudson-prevention-resource-center-mhprc/
Counties Covered: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Host Provider: ADAC of Orange County in Goshen
224A Main Street P.O. Box 583
Goshen, NY 10924
845-294-9000

***NYC PRC -** http://www.childrensaidsociety.org/preventon-resource-center
Counties Covered: Bronx, Kings, New York, Richmond, Queens
Host Provider: Children's Aid Society in Manhattan
4 W 125th Street, 4th Floor
New York, NY 10027
212-949-4800
***Long Island PRC -** http://www.liprc.org/
Counties Covered: Nassau, Suffolk
Host Provider: Family Service League of Long Island
1444 Fifth Avenue
Bayshore, New York, 11706
631-650-0135

APPENDIX C

Definition of Direct & Indirect Activities

Prevention services may be delivered directly with youth and family target populations to improve their individual and family outcomes, or they may be delivered indirectly using communication technologies, through community capacity building efforts, or by environmental systems change efforts. Both direct and indirect prevention activities are important and needed to achieve healthier communities. OASAS is subject to Federal reporting requirements that include providing annual statistics on the numbers of direct vs. indirect prevention services delivered.

Direct activities have two properties: 1) they involve interactive or "live" contact between the prevention staff and the participant, **and** 2) they are intended to directly reduce risk factors, increase protective factors, or reduce negative health behaviors in the activity's participants.

Direct activities include:

- All recurring Educational curricula delivery activities
- All other recurring Educational (non-curricula) activities
- All Positive Alternative activities
- All Prevention Counseling activities
- All Early Intervention activities
- Four (4) Information/Awareness activities:
    1.) Health Promotion Event
    2.) Speaking Events
    3.) Telephone Information Services
    4.) Walk-in Information Services

Indirect activities are either: 1) delivered indirectly through media such as social media, Internet websites, television radio, newspaper or other recorded or printed media, and do not involve direct face-to-face or in-person "live" contact; **or** 2) work indirectly through community systems change efforts, such as improving policies, training alcohol retail outlet clerks in underage drinking law compliance or training other professionals in evidence-based prevention. In this case the participants are "other impactors" who will help to increase our prevention efforts, but the indirect activity is not designed to improve their own risk and protective factors.

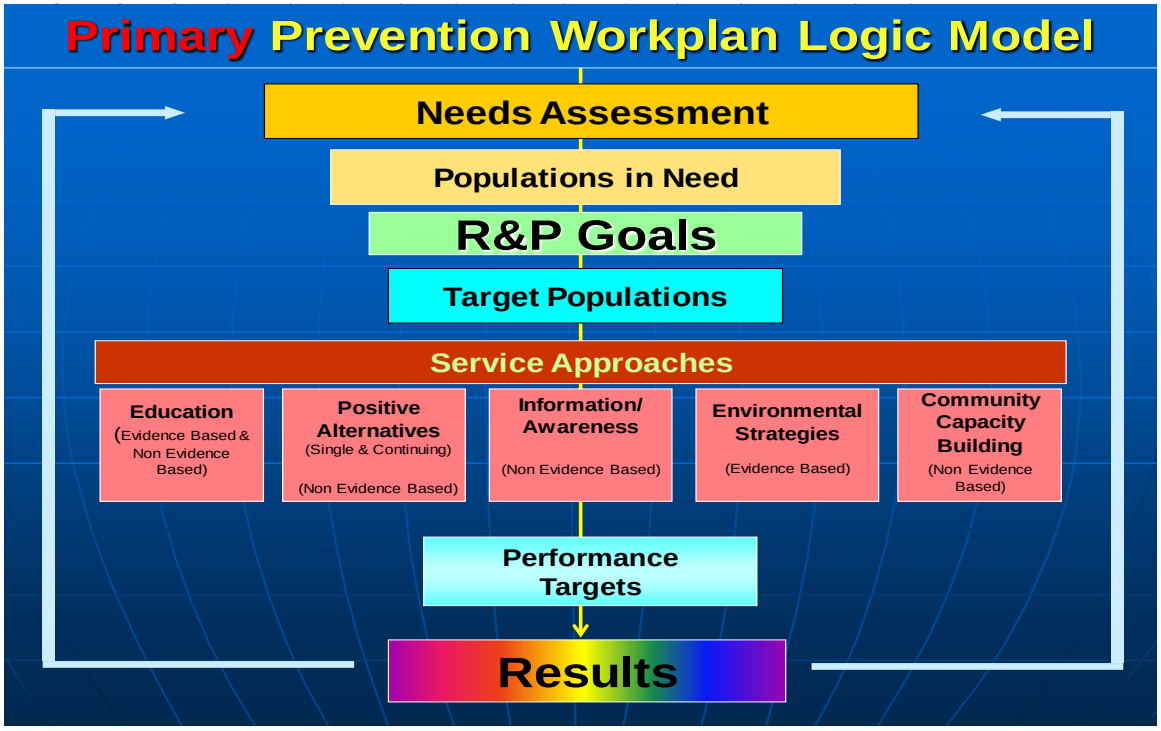
Indirect activities include:

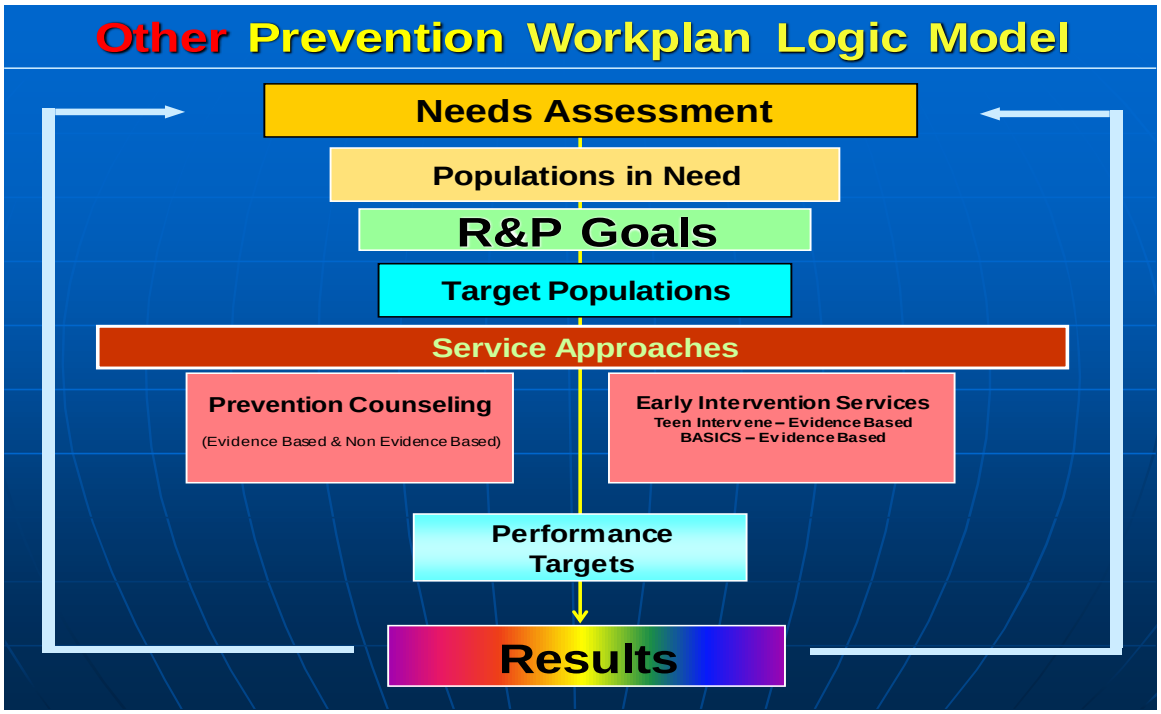
- All Environmental Prevention Strategies activities
- All Community Capacity-building activities

- Nine (9) Information/Awareness activities:
  1.) Audio/Visual Materials
  2.) Newsletters
  3.) Public Service Announcements
  4.) Resource Directories
  5.) Other Printed Material
  6.) Internet-Site Content
  7.) Internet-Social Media
  8.) Newspaper-Content
  9.) Television-Radio-Content

APPENDIX D

Prevention Workplan Logic Model





APPENDIX E

Elements to Consider When Selecting non-EBP Curricula

Select programs that:

- Enhance protective factors and/or neutralizes or reduces known risk factors;
- Targes social-emotional learning and protective factors (elementary school ages);
- Focus on competence via prosocial skills (Middle/High school ages);
- Hels individuals realize that use of alcohol, tobacco, and other drugs is not the norm (Normative education);
- Help youth develop ease in handling social situations;
- Help youth recognize and resist external pressure (e.g., advertising, media, role models, peer attitudes) to use substances;
- Help youth understand the risks and short- and long-term consequences of substance use;
- Support and encourages the development of positive aspects of life—such as helping, caring, goal setting;
- Teach ways to refuse substances effectively and still maintain friendships
- Addresses skills to:
    - Resist drugs when offered
    - Strengthen personal commitment against substance misuse taking into account peer influence
    - Increase social competency to affect behavior change in the short-term and long-term;
- Have documented efficacy in the research;
- Include corresponding fidelity and outcome tools (i.e. pre-/post-);
- Employ interactive and sound instructional methods;
- Address the specific substance misuse concerns in the local community and offers information about community resources;
- Are age-specific, developmentally appropriate, and culturally sensitive;
- Are adaptable in developer-approved ways while maintaining fidelity.

Elements to Avoid When Selecting a non-EBP

Avoid programs or activities that:

- Use Scare tactics to change behavior in the long-term;
- Appeal to morals and/or focuses only on values clarification;
- Include one-time trainings, assemblies, workshops, events, pamphlets, or testimonials that are isolated from behavior change strategies;
- Teach only the identifying information or characteristics about substances;
- Teach only the adverse consequences of substance misuse;
- Focus only on raising self-esteem;
- Are not selected or align with the needs identified through needs assessment;
- Are not grounded in research or an effective theory of change.

APPENDIX F

Environmental Change Strategies

OASAS supports the implementation of a coordinated comprehensive three component environmental approach that encompasses policy, enforcement, and media strategies. This Appendix provides additional guidance to assist providers in selecting appropriate environmental prevention strategies. It includes a table that highlights the Environmental Change Strategies that OASAS supports. The table is divided according to the three components: Policy, Enforcement, and Media efforts. It gives a brief description of each strategy, the primarily targeted root cause(s) as well as some considerations on when to choose the strategy which should be determined by analysis of needs assessment data.

POLICY			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
Minimum age of purchase	Prohibit minors from buying or attempting to buy alcohol or other regulated substances.	Retail Access; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	High rates of underage drinking; Underage youth are buying alcohol or other substances from retailers
Public Advertising Restriction Policy	Any policies that limit the advertising of AOD[2] product use, particularly advertising that exposes young people to positive substance use messages. Restrictions can be in the form of local ordinance or can be implemented voluntarily by a business, event, or organization.	Community Norms Favorable Toward Substance Use; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	High rates of positive attitudes toward AOD; AOD advertising is commonly seen throughout the community and at public events
Policies that limit Sponsorship of Public Events	Restricts AOD sponsorship of community events. Restrictions can be in the form of local ordinance or can be implemented voluntarily by a business, event, or organization.	Community Norms Favorable Toward Substance Use; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	High rates of positive attitudes toward AOD; AOD sponsorship is used to support community events
School Substance Use Policies	Policy that a school or school district adopts to address substance use on	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Lack of effective school response to AOD; Students

[2] AOD refers to alcohol and other drugs

POLICY			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
	school property and/or students' use of substances.		engage in substance misuse
Workplace Substance Use Policies	Policy that businesses and organizations can adopt to address substance use on the property and employee use of substances	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Lack of effective workplace response to AOD; employees engage in substance misuse
Policies to Require Outlet Server/Seller Training to Obtain or Renew License/Permit	Educating owners, managers, servers and sellers at retail establishments about strategies to avoid illegally selling AOD to underage youth or intoxicated patrons. Training can be required by local or state law, or a law/ordinance may provide incentives for businesses that undergo training. Some individual establishments may voluntarily implement training policies in the absence of any legal requirements or incentives.	Retail Access; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Retail outlets oversell AOD to patrons and/or sell to minors
Social Host Ordinance	Adults who serve or provide AOD at their premises to minors or persons who are obviously intoxicated can be held liable.	Social Access; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Adults over-serve alcohol in their homes and/or provide AOD to minors

POLICY			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
Minor in Possession	Policy that addresses people under the age of 21 years old who are caught with AODs.	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Minors are observed using AOD in public places
Restrict AOD Merchandise/Paraphernalia Sales at Public Events	Policy that does not allow or limits the use of AOD merchandise/paraphernalia sales at public events	Community Norms Favorable Toward Substance misuse; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Underage youth obtain AOD merchandise or paraphernalia from public events
Take Back Days Policy	Policy that designates certain days where community members can drop off their unused medication to be properly disposed.	Social Access; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	High levels of NMUPD[3]; Community members have unused prescription medication in their homes and do not have access to a method of disposal
Drop Box Policy	Policy that designates a secured permanent location where community members can drop off their unused medication to be properly disposed.	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	High levels of NMUPD; Community members have unused prescription medication in their homes and do not have access to a method of disposal

[3] NMUPD = Non-Medical Use of Prescription Drugs

POLICY			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
Prescription Drug Destruction Bag Policy	Policy that designates a permanent source of drug destruction bags where community members can access the destruction bags to make their unused medication inert.	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	High levels of NMUPD; Community members have unused prescription medication in their homes and do not have access to a method of disposal
Medication Lock boxes policy	Policy that designates a permanent source of medication lock boxes where community members can access the boxes to safeguard their prescription medications.	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	High levels of NMUPD; Community members have unused prescription medication in their homes and do not have access to properly secure it
AOD Use Restrictions at Public Events	Restricts AOD use and sales at community events. Examples include beer gardens, sale of tokens for purchase, limiting number of drinks purchased, container size, etc.	Retail Access; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	AOD is over-sold at events and/or is accessible to minors
Hours/days of Sale Restrictions	Limits AOD consumption on premises (e.g., bars and restaurants). Examples include restricting hours of sale and AOD promotions (e.g., happy hours and two-for-one drink specials).	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Patrons are able to purchase high quantities of AOD in one sitting; DWI in tourist/entertainment corridors is high

POLICY			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
Open Container Ordinance	Policy limiting the presence of open containers of alcohol and active consumption on public property or certain areas to control the availability and use of AOD at parks, beaches and other public spaces. Restrictions can range from total bans on AOD consumption to restrictions on the times or places at which substances can be consumed.	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Substance misuse is apparent in public places and/or minors bring substances to public places
Home Delivery Restrictions	Prohibit or limit the ability of AOD retailers to deliver substances to personal residences	Retail Access; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Ability of AOD to be delivered to personal residences
Limit Location of AOD Outlets	Limits the location of outlets within a community where AOD may be legally sold for the buyer to consume on-premise (e.g., bars, restaurants) or off-premise (e.g., liquor stores, dispensaries).	Retail Access; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Outlets located in areas conducive to substance misuse
Limit Density of AOD Outlets	Limits the density (i.e., number within a geographic area) of outlets within a community where AOD may be legally sold for the buyer to consume on-premise (e.g., bars, restaurants) or off-premise (e.g., liquor stores, dispensaries).	Retail access; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	High number of outlets within a geographic area

POLICY			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
I-STOP (Prescription Drug Monitoring Program) Use	Prescribers are required to consult the I-STOP/PMP (Internet System for Tracking Over-Prescribing - Prescription Monitoring Program) Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The I-STOP provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients.	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	High levels of addictive forming medications available through prescription; Inconsistent use (or lack) of I-STOP by prescribers
Other Availability/Access	Policy that addresses and limits the availability or access of AOD but does not fit within the other choices of policies listed on this table.		
Keg Registration	Beer kegs are marked with a unique identification number that alcoholic beverage retailers register along with information about the keg's purchaser. This process enables police officers to identify the keg purchaser at parties where underage individuals are drinking beer from kegs.	Social Access; Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Beer kegs are a common source of alcohol for minors and large quantity encourages binge drinking and alcohol misuse

POLICY			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
Prescriber Education Requirement	Policy that requires prescribers to attend a training about the benefits and risks of prescribing opioids, including strategies to prevent abuse, while maintaining legitimate and appropriate access to opioids.	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	Prescribers routinely prescribe medications with addiction potential
OTHER Organizational	A policy that an organization can adopt to address substance use issues	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	
Environmental Policy Consultation/Planning	Working with another agency or entity that is taking the lead in policy implementation OR Working toward a policy strategy but in the planning stages to determine policy focus	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	
Environmental Policy Development/Design	Working on developing and designing an appropriate policy that fits local need	Insufficient Laws, Policies, Compliance to Reduce Substance misuse	

ENFORCEMENT			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
Outlet Compliance Checks (On[4] -off[5] Premise)	A tool to identify establishments that sell AOD to underage youth. The practice can be mandated by a local ordinance that outlines standards for conducting the checks, people or agencies responsible for conducting the compliance checks, and penalties for establishments, servers and sellers who illegally sell or serve to underage youth. They can also be voluntarily implemented by law enforcement or licensing authorities.	Insufficient Compliance to Reduce Substance misuse	Minors can readily purchase (or perceive they can readily purchase) AOD at off-premise locations
Outlet Compliance Surveys (On - Off Premise)	Similar to compliance checks, but they typically use a decoy who is 21 or older but who looks younger than 21. Thus, if a retailer sells to the decoy, no law is actually broken. As such, these surveys are a way to educate retailers about their practices, without giving them a citation.	Insufficient Compliance to Reduce Substance misuse	Minors can readily purchase (or perceive they can readily purchase) alcohol at off-premise locations
Compliance Checks (Other)	A method of checking compliance that does not follow traditional compliance	Insufficient Compliance to Reduce Substance misuse	Minors can readily access alcohol or other drugs

[4] Outlets that are "on premise" refers to locations where alcohol is sold and consumed, such as bars and restaurants.
[5] Outlets that are "off premise" refers to retail stores where AOD substances are sold, and consumption occurs at a separate location.

ENFORCEMENT			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
	checks or compliance surveys as listed on this table		
Retail Outlet Recognitions	Publicizing or otherwise rewarding outlets that do not sell to minors. An example is "Unstung Heroes," a periodic newspaper article with listings of the outlets that did not sell to minors, thanking them for being responsible contributing to community health and safety.	Community Rewards for Prosocial Involvement	
Retail Outlet Compliance Reporting Hotlines	Increasing awareness and citizen use of toll-free tip phone hotlines to report retail outlets that sell alcohol to minors.	Insufficient Compliance to Reduce Substance misuse	Minors can readily purchase (or perceive they can readily purchase) AOD at off-premise locations
Sobriety Checkpoints to Enforce Impaired Driving Laws	Traffic stops where law enforcement officers systematically select drivers to assess their level of AOD impairment. The goal of these interventions is to deter AOD-impaired driving by increasing drivers' perceived risk of arrest.	Insufficient Compliance to Reduce Substance misuse	Drinking/Drugging and driving is common (or perceived to be common)

ENFORCEMENT			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
Shoulder Tap Surveillance	Similar to compliance check programs except that they target the non-commercial supplier. A young decoy approaches adults outside an substance retail outlet and requests that the adult purchase on the decoy's behalf. It uses the same guidelines for the decoy's actions as in compliance checks.	Social Access	Minors can readily obtain, or perceive they can readily obtain AOD from unknown adults who purchase it for them
Underage AOD Party Dispersal/Party Patrols	A tool to reduce unruly parties hosted in residential areas. Party patrols are meant to work via general deterrence aimed at potential party hosts. The aim is to have sufficient consequences through enforcement and publicity targeting hosts of nuisance parties to encourage hosts to exercise more control over their guests (e.g., by reducing the number of invitations, lowering noise, and curtailing obnoxious behavior) while also encouraging guests (via publicity) to reign in their own behavior and cooperate with the host.	Social Access	Unruly parties are common and/or parties are a common source of AOD for minors

ENFORCEMENT			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
High visibility enforcement	Combines enforcement, visibility elements, and a publicity strategy to educate the public and promote voluntary compliance. For example, DWI checkpoints or an outside bar bouncer using an electronic scanner. Although forewarning the public might seem counterproductive, it increases deterrence.	Insufficient Compliance to Reduce Substance misuse	Low perception of risk of negative consequences
Administrative Penalties	Sanctions for non-compliance by the authoritative administrator	Insufficient Compliance to Reduce Substance misuse	Low perception of risk of negative consequences
Informal Enforcer related to policy	Working with an informal entity (e.g., school administrators, coaches, bar managers, etc) to provide consequences for individuals not adhering to policy	Insufficient perception or lack of enforcement of policy	
Environmental Enforcement Consultation/Planning	Working with another agency or entity that is taking the lead in the enforcement strategy implementation OR Working toward an enforcement strategy but in the planning stages to determine best fit with policy		

ENFORCEMENT			
Strategy	**Description**	**Root Cause(s)**	**Consider the strategy when…**
Environmental Enforcement Development/Design	Working on developing and designing an appropriate enforcement strategy that fits the policy and the local need		

MEDIA/COMMUNICATION			
Strategy	**Description**	**Root cause(s)**	**Consider the strategy when…**
Social Norms Misperceptions Campaigns	Aims to alter the perceptions that people have about how much their peers actually use substances. Typically, data must be collected about actual consumption patterns and perceptions of substance use (whereby it is often found that people perceive there to be much higher levels of substance use than is actually reported). Media efforts are then implemented to educate people that their peers really do not use as much as they think. This, in turn, leads to reduced levels of overall substance use.	Normative misperception of peer AOD use	Data on perceptions about substance use frequency/amount are higher than data on actual frequency/ amount of substance use
Counter-Advertising	Involves disseminating information about AOD, its effects, and the advertising that promotes it, to decrease its appeal and use. Counter advertising strategies directly address AOD marketing and includes the placement of health warning labels on product packaging, and media literacy efforts to raise public awareness of the advertising tactics employed in marketing.	Favorable Attitudes Toward AOD Use; Community Norms that Favor AOD Use	Minors have positive prosocial views of substance use due to marketing advertisements
Social Marketing	Uses standard marketing techniques to promote healthier community norms,	Community Norms that Favor AOD Use	

	persuade people to reduce harmful behaviors and/or increase socially positive behaviors.		
Media Advocacy / Earned Media	Involves the use of unpaid media ("earned media") to highlight a community issue and to educate the community for change in policies. Examples include letters to the editor, newspaper articles, press releases, and radio talk shows. Even more so than the other media strategies, media advocacy must be used in conjunction with policy change and enforcement.	Insufficient Laws, Policies, Compliance to Reduce Substance misuse; Favorable attitudes toward drug use; perceived risk of drug use	Lack of education about substance use prevention policies and behavior
OTHER Communication Campaign			
Environmental Communication Consultation/Planning	Working with another agency or entity that is taking the lead in media strategy implementation OR Working toward a media strategy but in the planning stages to determine media content		
Environmental Communication Development/Design	Working on developing and designing an appropriate policy that fits local need		

Appendix G

Development of the MEB EBP Guidance

In May 2015, OASAS initiated an inter-agency Mental, Emotional and Behavioral (MEB) Health Disorder Prevention Workgroup. The workgroup was comprised of representatives from NYS OASAS's Bureau of Prevention Services, Office of Mental Health (OMH), Department of Health (DOH), State Education Department (NYSED), the NYC Department of Health and Mental Hygiene (DOHMH), and OASAS prevention service providers. The workgroup's purpose was to identify evidence-based prevention programs that could impact a broader array of MEB conditions, concurrent with their substance misuse outcomes. Although OASAS prevention providers are not funded to provide mental health services to youth, it was believed that some of the programs listed on the OASAS Prevention *Registry of Evidenced-based Program and Strategies* (REPS) might also have shown positive impacts on anxiety, aggression, depression, and suicidality prevention outcomes. The current OASAS Registry served as the foundation for investigating the EBP's effectiveness of these other MEB outcomes. The program outcome studies were then reviewed to identify those with substantial effects on these mental health outcomes in addition to their influence on substance misuse prevention outcomes.

MEB Program Research Rating

The initial efforts of the Work Group were undertaken by OASAS Research Scientists and Bureau of Prevention Services staff members to identify the EBPs from the OASAS Registry of approved EBPs. After identifying the programs with the additional MEB outcomes sought, the workgroup established the rating and selection criteria for the research results that follows.

Study Rating and EBP Selection Criteria:

1.) Program is listed on the OASAS Registry of Evidence-based Programs and Strategies (REPS);

2.) Program has at least one published peer-reviewed study;

3.) Study must have at least a quasi-experimental design;

4.) Study must document a statistically significant prevention outcome for substance misuse or abuse and either anxiety, depression, suicidality, or conduct-aggressive disorders;

5.) Study must show a substantial magnitude of effects on outcomes (e.g., approaching at least a medium effect size with Cohen's *d* of at least .45 for anxiety, aggression, depression, or suicidality outcomes).*

EBP Scoring Results

The application of the rating criteria resulted in selection of four EBPs with medium to large positive effects on one or more of the MEB outcomes. The work group determined that the four programs identified below met all of the MEB rating criteria for selection.

The programs selected by the MEB workgroup all have a theoretical and conceptual basis in Social Emotional Development and Learning (SEDL). Reflective of skills related to protective factors, SEDL focuses on helping children develop the social, emotional regulation, and self-management skills required for healthy child development and educational success. These skills represent protective factors. SEDL-based EBPs have been shown to be effective for both mental health promotion and for achieving MEB disorder prevention outcomes when implemented with Institute of Medicine (IOM) universal and selective populations of young children.

More specifically, these programs met the EBP selection criteria that included evidence of significant reductions in MEB disorder risk factors that also had medium to large magnitude of effect sizes. Ultimately, the earlier promotion of healthy social and emotional development and the prevention of specific risk factors for substance misuse and other MEB problems will result in more positive child outcomes now and throughout their lives.

1. **Focal EBPs for Prevention of Mental, Emotional and Behavioral (MEB) Health Disorders The [PAX] Good Behavior Game:** A primary school-based prevention program integrated into school curricula and frameworks that trains and supports classroom teachers in implementing the EBP. This set of skills assists in improving students' social development, emotional intelligence, and behavioral self-regulation. This EBP has outcomes for improved academic and student behavior in addition to increases in teacher self-efficacy in the short-term and to prevent substance misuse, crime, and reduces over-reliance on support systems among young adults over the long term. This program has met the MEB standard for reducing aggression. This is a universal program that specifies vetted adaptations for meeting the needs of students accessing selective and indicated levels of support as well.

   http://www.air.org/topic/p-12-education-and-social-development/good-behavior-game

   http://paxis.org/products/view/pax-good-behavior-game

2. **Positive Action**: Positive Action is an integrated and comprehensive curriculum-based program that is designed to improve academic achievement; school attendance; and problem behaviors such as substance misuse, violence, suspensions, disruptive behaviors, dropping out, and sexual behavior. It is also designed to improve parent–child bonding, family cohesion, and family

conflict. Its concepts are universal and effective for all populations and socioeconomic levels and agesThis program has met the standard for reducing aggression.

https://www.positiveaction.net

3. **Promoting Alternate Thinking Strategies (PATHS):** Promoting Alternative Thinking Strategies (PATHS) is a school-based EBP for children in elementary school or preschool. The interventions are designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skill concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations. This program has met the standard for reducing depression.

   http://www.pathstraining.com/main/

4. **Incredible Years**: Incredible Years is a set of three interlocking, comprehensive, and developmentally based training programs for children, their parents and teachers. These programs are guided by developmental theory on the role of multiple interacting risk and protective factors in the development of conduct problems. The three programs are designed to work jointly to promote emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children. The parent version of this program was tested only with students who had ADHD and/or Oppositional Defiant Disorder and met the MEB outcome standards by reducing aggression. The Classroom Dinosaur Curriculum can be implemented in classrooms as a universal intervention, and the Small Group Dinosaur version can be used with students accessing selective and indicated levels of support.

   http://incredibleyears.com/

Program	Grade Levels	Minimum Lessons	Approximate Duration of Each Lesson	Associated Outcomes Addressed
PAX Good Behavior Game (PAX GBG)	K 1 2	N/A (increasing kernels and amount of time	Start of school year: "Game" is played 1-2 minutes and increase in length as students consistently "win"	• Initiation/ likelihood of substance misuse • Self-regulation

1 full day of training each year; classroom teacher implements with support of a trained PAX Partner	3 4 5 6	game is played in conjunction with other instruction)	12 out of 15 games each week (equivalent to 85% of the time). End of school year: 30-45 minutes or longer/ daily	• Learning/ classroom environments • Conduct and problem behaviors • Engaged learning time • Academic success (reading) • Mental health service utilization • Need for special services • Staff stress and burnout/ turnover
Positive Action (PA) *1 full day of training each year*	K 1 2 3 4 5 6 7 8	50 50 50 50 50 50 50 35 35	15-20 minutes 15-20 minutes 15-20 minutes 15-20 minutes 15-20 minutes 15-20 minutes 15-20 minutes 15-20 minutes 15-20 minutes	• Substance misuse • Social-Emotional mental health • Problem behaviors (violence, substance misuse, disciplinary referrals, suspensions, and bullying) • Academic achievement (math, reading) • Absenteeism

				• Family functioning
Promoting Alternative Thinking Strategies (PATHS) *2 full days (6-8 weeks apart) of training each year*	K 1 2 3 4 5 6	39 40 40 40 35 32 32	30 minutes 30 minutes 30 minutes 30 minutes 30 minutes 30 minutes 30 minutes	• Substance use disorders • Emotional knowledge • Internalizing behaviors • Externalizing behaviors • Depression • Neurocognitive capacity • Learning environment • Social-emotional competence
Incredible Years *Multi-day trainings, depending on what type of training desired* Child Dinosaur (Whole Class)	3-8 years 3-8 years	20	2-3 times per week; 20-30 minutes Small group weekly 2-hour session	• Parenting skills • Child externalizing problems • Child emotional literacy, self-regulation, and social competence • Teacher classroom management skills • Parents' involvement with the school and teachers

Small Group Dinosaur Parent Program	Parents of children ages 0-12 years	20 12	Weekly 2-3 hour sessions	

Implications for Practice

The four EBPs above can be considered on a continuum in terms of who implementation the program. For PAX Good Behavior Game, there is integration of evidence-based kernels and cues into existing curricula, lessons, and routines; therefore, [PAX] GBG must be implemented by classroom teachers. For Incredible Years, the content for the Classroom Dinosaur (e.g., whole group) consists of established curricula and lessons that can be delivered by any adult, but teachers should facilitate the implementation to ensure developmental appropriateness. The Small Group Dinosaur version should be implemented by a facilitator with clinical expertise (e.g., usually a counselor or a therapist). The Parent Program version can be implemented by a trained facilitator, which can be the classroom teacher or prevention provider. Positive Action and PATHS can be implemented by a classroom teacher or prevention provider because the lessons are provided. Cost- benefit information for many programs, including those above, have been documented through the Washington State Institute for Public Policy (WSIPP) and the 2016 Surgeon General's Report.

For any EBP that is implemented by a classroom teacher, rather than direct service, a prevention provider's role is to assist and support the program through coaching and technical assistance to the teachers. These support functions may also include establishing relationships with school stakeholders so as to increase capacity in the programming for sustainability purposes. Providers are required to report on their TA efforts with the teachers and capacity building activities that support the implementation of this EBP. As approved by Prevention Liaisons, technical assistance and coaching activities related to implementation of EBPs with fidelity can be documented as a ***Capacity Building*** "Service Approach", which will count towards the EBP requirement. In the OASAS reporting system, enter data by "Activity Type" and "Local Description" that specifies the types and quantity of coaching/TA support you provided to support this EBP implementation.

As outlined in the OASAS Prevention Guidelines, a major component of the OASAS Prevention Framework requires providers to base their selection of services on a local needs assessment that identifies and prioritizes elevated risk factors, decreased protective factors, and the specific problem behaviors in their communities. One such resource to assist with MEB needs assessment is the MEB Health Indicators data by county and school district on the Kids Well-being Indicators Clearinghouse (KWIC) website. This resource contains county- and school district-level information for multiple indicators across multiple years related to MEB risk factors. If providers identify elevated levels of risk factors for MEB disorders during their needs assessments, the OASAS Bureau of Prevention Services recommends that prevention providers consider the four EBPs described above to prevent MEB disorders such as substance misuse, aggression, and depression.

Appendix H

NEW YORK STATE | Office of Addiction Services and Supports

OASAS Prevention Counseling Risk Factors for Assessment

Individual	Family	Peer	School	Community
1. Genetic pre-disposition to substance addiction due to biological parent(s) with a substance addiction	10. Family substance abuse among parents, caregivers, siblings	14. Social isolation and dis-connectedness due to peer rejection and/or poor social skills	17. Academic failure (i.e. decline in grades, sudden poor performance)	19. Poverty
2. Low self-regulation, sensation seeking, impulsivity, attention deficit and hyperactivity	11. Persistent family conflict	15. Friends engaged in substance Use	18. Low commitment to school (i.e. frequent absenteeism, drop out, disinterest in clubs)	20. Availability of and access to alcohol and other drugs
3. Anxiety Disorder Diagnosis and/or its Related Symptoms	12. Family management problems (i.e. inadequate supervision, lack of or inconsistent discipline)	16. Friends engaged in other problem behaviors (i.e. fighting, stealing, other delinquency)		21. Laws and norms favorable towards alcohol and substance use
4. Depressive Disorder Diagnosis and/or its Related Symptoms	13. Parental attitudes favorable towards alcohol and/or drug use			
5. Early Initiation of alcohol/substance use, and/or gambling activity				
6. Early and persistent anti-social and aggressive behavior problems				
7. Low perceived risk and harms due to substance use				
8. Favorable attitudes towards substance use and/or problem gambling				
9. Favorable attitudes towards anti-social behavior (i.e. fighting, stealing, other delinquency)				

Prevention Counseling Admission Criteria

4 Risk Factors are required for admission to Prevention Counseling, 2 of which must be **Individual** or **Family** Risk Factors

Appendix I

OASAS Prevention Counseling Assessment

Risk Factors Definitions

<u>Individual Risk Factors</u>

Constitutional Factors

Constitutional factors are individual traits or characteristics that have a genetic and physiological basis. Evidence has been found for a genetic predisposition for substance addiction and for other personality and neurobiological risk factors that can increase the likelihood of both drug abuse, addictions and other youth problem behaviors. These other traits include: low self-regulation; sensation seeking, impulsivity, attention deficit and hyperactivity. These constitutional factors can increase the risk that young people will abuse drugs or engage in delinquent behavior. However, the family, school, peer, community and other environmental factors (including prevention services) in a young person's life interact with the constitutional factors to shape future development.

1. **Genetic predisposition to substance misuse and addiction** has been estimated to account for a large percentage (30-70%) of the prevalence of these disorders, depending on the substance and the populations studied.
2. **Other Constitutional factors related to substance initiation, abuse and other problem behaviors:**

Low Self-Regulation – reflects a decreased capacity to control oneself, actions, emotions, and interpersonal interactions. Both low behavioral and emotional self-regulation are predictive of substance misuse and other problem behaviors. While inability to self-regulate is a neurobiological trait, self-regulation can be improved through services that promote social and emotional development.

Sensation Seeking – a personality trait with a neurobiological basis defined by the "seeking of varied, novel, complex, and intense sensations and experiences, and the willingness to take physical, social, legal, and financials risks for the sake of such provide intense experience". Sensation seeking has been associated with participation in a number of risky activities including unhealthy behaviors such as problem gambling, smoking, heavy drinking, drug abuse and driving under the influence of alcohol.

Impulsivity – closely related to low self-regulation, impulsivity is characterized by engaging in behaviors suddenly and without planning. Hasty actions that occur in the moment without first thinking about them can increase the likelihood for harmful consequences. An impulsive person may be socially intrusive, excessively interrupt others or make important decisions without considering the consequences. Nine genes have been identified as playing a role in levels of

impulsivity. All nine are also related to predisposition for regular alcohol use and three of these genes are also related to opiate addiction.

Attention Deficit – **Hyperactivity Disorders** – Attention Deficit Disorder (ADD) is characterized by difficulty attending or focusing on a specific task. People with Attention Deficit Disorder may become distracted within a matter of minutes. Inattentive behavior may also cause difficulties with staying organized (e.g., losing things), keeping track of time, completing tasks, and making careless errors. Hyperactivity is a much higher than normal level of activity. Individuals who are hyperactive always seem to be in motion, moving about constantly, including in situations in which it is not appropriate. Examples include excessively fidgeting, tapping fingers, or talking incessantly. Youth may have attention deficit, hyperactivity, or both (ADHD). Adolescents with ADD or ADHD are at increased risk of nicotine use, cocaine and other stimulants, and developing an alcohol or other drug use disorder.

3. **Anxiety Disorder Diagnosis and/or its Related Symptoms –** youth *diagnosed with anxiety disorder may exhibit excessive nervousness, embarrassment, or fear of being negatively judged by others. Some studies have shown that children and youth who are diagnosed with a generalized anxiety disorder are at higher risk for substance misuse, and may also have difficulties forming attachments with family, peers and school. Social anxiety has been found to predict alcohol and cannabis dependence. Estimates are that about seven percent of the population has a social anxiety disorder, and that half of those will have an alcohol use disorder in their lifetime. A large scale longitudinal study has produced evidence that when other pre-existing risk factors, including child abuse, other trauma, family conflict, friends' problem behavior and depression are controlled for, anxiety is no longer a causal predictor of substance addiction. However, as anxiety disorders often precede substance misuse, and as information on early trauma and family dysfunction are not always available, youth with an anxiety disorder should be assessed for additional risk factors.

**Diagnosis must be made by those able to diagnose based on their legal scope of practice.*

4. **Depressive Disorder Diagnosis and/or its Related Symptoms** – youth *diagnosed with these disorders are characterized by sadness, hopelessness, lack of motivation, difficulty with thinking and concentration, and for some, suicidal thoughts or attempts. Studies have shown that children and youth who are diagnosed with these disorders area at higher risk for substance misuse, and may also have greater difficulties forming attachments with family, peers and school. The co-occurrence of depression and substance use is associated with mental health problems such as early onset of drug use, delayed recovery among drug users, longer depressive episodes and risk of suicide.

**Diagnosis must be made by those able to diagnose based on their legal scope of practice.*

5. **Early Initiation of Substance Use** – Early substance use initiation is the consumption of alcohol or other drugs of abuse including tobacco and marijuana prior to age 15. Early substance use is associated with negative outcomes such as substance use disorders, delinquency, crime, violence, dropping out of school and/or unsafe sexual activity. For

example, teens who began drinking prior to age 15 were seven times more likely to develop alcohol dependency after age 21.

6. **Early and Persistent Antisocial Behavior** – Antisocial behavior is characterized by aggression, hostility and defiance. Children who are aggressive in primary school grades are at higher risk of substance misuse and juvenile delinquency as adolescents. Antisocial behavior may include, but is not limited to, bullying, stealing, misbehaving in school, skipping school, and fighting with their peers and authority figures. The earlier young people begin these behaviors the greater the likelihood that they will abuse substances and experience negative consequences later in life.

7. **Low Perceived Harm of Substance misuse (Adolescents)** – Research on youth drug use prevalence has shown that teens' perception of the harmfulness of substance misuse predicts their levels of use. When teens believe that marijuana or alcohol use is not very risky or harmful their prevalence of use will increase. When teens begin to perceive higher levels of harm, the substance misuse prevalence decreases. The perception of harm that adolescents hold is very important since the health-compromising behaviors that can follow have long-term health and social consequences.

8. **Favorable Attitudes towards Substance misuse** – During the elementary school years, children usually express anti-drug, anti-crime, and pro-social attitudes. They have difficulty imagining why people use drugs, commit crimes, and drop out of school. By middle school, as some peers participate in activities such as fighting, stealing and other delinquency, attitudes often shift toward greater acceptance of these behaviors. Youth attitudes that are favorable toward drugs are a strong predictor of substance misuse involvement.

9. **Favorable Attitudes towards Anti-Social Behavior (Adolescents)** – Antisocial behaviors exist along a severity continuum and include repeated violations of social rules, defiance of authority and of the rights of others, deceitfulness, theft, and reckless disregard for self and others. Antisocial behaviors also include alcohol and other drug use and high-risk activities involving self and others. Adolescents who express favorable attitudes toward alcohol and other drug use and other anti-social behaviors, are more likely to engage in a variety of problem behaviors.

Family Risk Factors

1. **Family History of Substance misuse among Parents, Caregivers, Siblings** – If children are raised in a family with a history of alcohol/ drug addiction, it increases the likelihood that children will also have alcohol and other drug problems. The potential for genetic inheritance of a predisposition to addiction, for negative behavioral role modeling and increased substance availability are all mediators that increase youth risk for substance misuse.

2. **Persistent Family Conflict** – Persistent conflict between primary caregivers or between caregivers and children appears to increase children's risk for all of the problem behaviors, whether or not the child is directly involved in the conflict. For example, domestic violence in a family increases the likelihood that young people will engage in substance misuse and delinquent behaviors, as well as become pregnant or drop out of school.

3. **Family Management Problems** – Poor family management practices include lack of, unclear or unrealistic expectations for child behavior. This can lead to inconsistent or excessive discipline. Inadequate supervision, failure of parents to monitor their children – knowing where they are and whom they are with is also a family management problem.

4. **Parental Attitudes Favorable Toward Alcohol and/or Drug Use** – Parental attitudes and behaviors toward drugs, crime, and violence influence the attitudes and behaviors of their children. Parental approval of young people's moderate drinking, even under parental supervision, increases the risk that the young person will use alcohol. Similarly, children of parents who excuse them for breaking the law are more likely to develop problems with juvenile delinquency.

Peer Risk Factors

1. **Social Isolation** – Social isolation during adolescence is often a very painful emotional experience. The effect of social isolation on youth substance misuse is an important, complicated, yet often overlooked area of study. Adolescents who desire greater bonding with peers but do not have close friendships and are alienated or rejected by their peers, have an increased likelihood of substance misuse, depression, and suicide. However, youth who have social skills and have friends who offer to socialize, but choose to be isolated, showed no differences in drunkenness and cigarette use than connected peers.

2. **Friends Engaged in Substance misuse** – Young people who associate with peers who engage in substance misuse are more likely to engage in the same problem behavior. This is one of the most consistent predictors that research has identified. Even when young people come from well-managed families and do not experience other risk factors, just hanging out with friends who engage in the problem behavior greatly increases the child's risk of that behavior.

3. **Friends Engaged in Other Problem Behaviors** – Young people who associate with peers who engage in other problem behaviors-fighting, stealing, or other delinquency, violent activity; sexual activity; or dropping out of school—are more likely to engage in the same problem behavior. This is also one of the most consistent predictors that research has identified. In additions, even when young people come from well-managed families and do not experience other risk factors, just hanging out with friends who engage in the problem behavior greatly increases the child's risk of that behavior.

School Risk Factors

1. **School Failure** – Research shows that academic failure in the late elementary grades (grades 4-6), increases the risk of teen pregnancy, school dropout, as well as drug abuse, delinquency, and violence throughout life. This is also true for a student who has repeated one or more grades. Children fail for many reasons, social as well as academic. The experience of failure, not necessarily lack of ability, appears to increase the risk of problem behaviors. This can include youth in grades 9-12.

2. **Low Commitment to School** – Low commitment to school means the young person has ceased to see the role of student as a valuable one. Those who do not have commitment to school are at higher risk for substance misuse, delinquency, teen pregnancy, and school dropout. Leaving school before age 15 has been found to correlate with increased risk. Lack of enjoyment of school, perceiving coursework as not important or meaningful and greater truancy all indicate a lower commitment to school and an increased likelihood of substance misuse.

Community Risk Factors

1. **Poverty -** Children who live in deteriorating and crime-ridden neighborhoods characterized by extreme poverty are more likely to develop problems with delinquency, teen pregnancy, school dropout, and violence. Children who live in these areas, and have behavior and adjustment problems early on, are also more likely to have problems with drugs later in life.

2. **Availability of and Access to Alcohol and Other Drugs** – The more available alcohol/other drugs are in a community, the higher the risk that young people will abuse drugs. Perceived availability of drugs is also associated with risk of substance misuse. In schools where children think that drugs are more available, a higher rate of drug use occurs.
3. **Laws and Norms Favorable Toward Substance misuse** – The laws and norms that a community holds about drug use are communicated in a variety of ways: *formally* through laws, regulations, written policies, and enforcement (examples: alcohol taxes, liquor licenses, drunk driving laws, infractions for selling to minors, laws regulating the sale of firearms), and *informally* through the expectations members of the community have of young people via social practices, norms, and expectations by parents and the community which may communicate a climate of acceptance, approval or tolerance of problem behaviors. Research has shown that legal restrictions on alcohol and tobacco use, such as raising the legal drinking age, restricting sales to minors, restricting smoking in public places, and increased taxation have been followed by decreases in youth consumption and injuries. National studies of high school students have shown that shifts in normative attitudes toward substance misuse have preceded changes in prevalence of use.

APPENDIX J

Annual Reports for Prevention Programs

NYS OASAS is committed to offering effective substance misuse prevention programming. To gain a better understanding of the outcomes associated with OASAS funded prevention programming and to improve the delivery of services to communities who need it most, the Division of Prevention and Program Gambling Services (DPPGS) requires providers to evaluate their program effectiveness. The annual report provides an avenue for funded prevention providers to demonstrate the impact of their prevention services for youth, families, and/or the communities they serve. These results can be used to make sure that prevention providers impact their community as intended and make data-driven decisions regarding modifications to their workplan to ensure that they are meeting ever changing community needs. It also allows providers to demonstrate their positive outcomes and market their findings to current and potentially future collaborators.

- Reports should be submitted on or before September 30th of each year. The report should also describe the direct service prevention activities conducted in the previous prevention plan year July 1-June 30th.
- Email the completed annual report as an attachment to: The Division of Prevention and Problem Gambling Services at prevention@oasas.ny.gov with a copy to your OASAS Regional Office (RO) Program Manager, as well as to your designated Local Government Unit (LGU) representative.
- Use this electronic file name when submitting:
    - [InsertYourProviderNameHere]_AnnualReport_[Insert Year].doc
- Evaluation design should include at least a pre and posttest design using the same survey at each time period. More rigorous evaluation designs (i.e. experimental design with control or comparison group) are encouraged, but not necessary.
- Adhere to the report template below with each section clearly delineated in the report by subheadings.

All reports should:

- Include a cover page, page numbers, and appendices;
- Be no longer than 10 pages (not including the title page or appendices).

Annual Report Template

Cover page

- Include:
    - Agency name;

- Prevention plan year (PPY);
- Date submitted;
- Names of the Director and/or the person(s) who prepared the report with email addresses.

Current Needs Assessment (Approximately 1 page)

- Use data to describe the needs of the local community with regards to substance misuse and related problems. The reader should get a clear understanding of the what, where, when, why, and how of substance use in your community.
- Include data and sources within the last 3 years and be sure to mention:
  - Consumption data;
  - Consequences data;
  - Risk and protective factors associated with substance use. The risk and protective factors associated with substance (mis)use as stated in the 2014 Prevention Guidelines.

Prevention Program(s) (Approximately ½ page)

- Identify and briefly summarize the prevention programs (EBPs and non-EBPs) that were evaluated;
- The summary should describe how the risk and protective factors identified in the Needs Assessment are aligned with the programs selected.
  - **Example:** if the needs assessment data demonstrate a low perception of harm, then the programmatic content should include implementation of a program to modify that perception;
- Describe how fidelity was monitored.

Evaluation Methods (Approximately 1 page)

- Describe the evaluation method (i.e., pre-post design; quasi-experimental design using a comparison group, etc.);
- Describe the survey(s) used, include content covered, number of items, format of items (i.e., true/false; likert scale; yes/no, etc.);
- Briefly explain data collection procedures. The description should include the method for survey administration (i.e., surveys read out loud; Paper/pencil; Online)
- Provide an explanation and description of the data analysis

Results (Approximately 6 pages)

- Include participant information and demographics (# of participants, # surveys collected; gender; age; etc.);
- Use clearly labeled Tables and Figures (i.e., graphs or charts) and describe concisely what is contained or shown;
- Focus on presenting data and findings related to the risk and protective factors that are listed in the 2014 Prevention Guidelines, or on substance use consumption;
- The meaning or interpretation of data should not be included in this section.

Discussion & Conclusion (Approximately 1 page)

- Summarize main findings;
- Interpret the positive, negative, or no change results. Describe possible reasons for those results.
- Describe how the findings will impact your future workplan and delivery of prevention services. **Example:**
    - What did you learn in general about your programming and evaluation design?
    - How are you going to use those findings to plan for next year?

Appendices

- **Measures.** Include copies of survey instruments used.

References

Beck, J. (1998). 100 years of" just say no" versus" just say know" reevaluating drug education goals for the coming century. *Evaluation Review, 22*(1), 15-45.

Birckmayer, J.D., Holder, H.D., Yacoubian, G.S., & Friend, K.B. (2004). A general causal model to guide alcohol, tobacco, and illicit drug prevention: Addressing the research evidence. *Journal of Drug Education, 34*(2), 121-153

Brown, J. H., D'Emidio-Caston, M., & Pollard, J. A. (1997). Students and substances: Social power in drug education. *Educational Evaluation and Policy Analysis*, *19*(1), 65-82.

Community Anti-Drug Coalitions of America (CADCA) (2019). *The coalition impact: Environmental prevention strategies*. Alexandria, VA: CADCA's National Coalition Institute.

Dey, I. (2003). *Qualitative data analysis: A user friendly guide for social scientists*. Routledge.

Esrick, J., Kagan, R. G., Carnevale, J. T., Valenti, M., Rots, G., & Dash, K. (2019). Can scare tactics and fear-based messages help deter substance misuse: A systematic review of recent (2005–2017) research. *Drugs: Education, Prevention and Policy*, *26*(3), 209-218.

Golub, A. & Johnson, B.D. (2001). Variation in youthful risks of progression from alcohol and tobacco to marijuana and to hard drugs across generations. *American Journal of Public Health, 91*, 225-232

Hansen, W.B. (1997). Prevention programs: Factors that individually focused programs must address. In *Resource Papers for the Secretary's Youth Substance Abuse Prevention Initiative* (pp. 53–66). Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol

and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, *112*(1), 64.

Institute of Medicine. (2009). *Preventing emotional, and behavioral disorders among young*

people: Progress and possibilities, risk and protective factors for mental, emotional, and behavioral disorders across the life cycle. Washington, DC: The National Academies Press.

National Academies of Sciences, Engineering, and Medicine. (2019). *Fostering healthy mental, emotional, and behavioral development in children and youth: A national agenda*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25201.