



Office of Addiction Services and Supports

2014 Prevention Guidelines

For OASAS Funded and/or Certified
Prevention Services

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PREFACE

The primary purpose of the 2014 Prevention Guidelines is to define and describe acceptable levels of prevention services, strategies and activities necessary to reduce underage drinking, alcohol misuse and abuse, illegal drug abuse, medication misuse*, and problem gambling within the framework prescribed by the New York State Office of Addiction Services and Supports (OASAS). The 2014 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. As stated when the first Guidelines were issued in 2009, OASAS is committed to reviewing this document periodically and revising when necessary, as new prevention information and knowledge is gained, with input from a team comprised of provider, county, and OASAS staff.

The 2014 Prevention Guidelines replace the 2012 Prevention Guidelines and should be maintained at each program site as a reference guide. These guidelines will go into effect January 1, 2014, with program performance standards being fully implemented by the end of the July 2013-June 2014 Prevention Planning Year (PPY) Workplan cycle (see **Section III, Prevention Performance Standards**). 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. It is the intent of OASAS to monitor program performance and contract compliance based on the standards set forth in these Guidelines.

* Throughout the rest of this document substance abuse will include alcohol, other drugs (legal and illegal), and tobacco

SECTION I: OASAS PREVENTION FRAMEWORK

The OASAS Prevention Framework is based on epidemiological research that identifies specific risk factors that increase the likelihood of the development of substance abuse and four (4) other problem behaviors during adolescence: delinquency; teen pregnancy; school drop-out; and violence. The research also identifies protective factors that reduce the likelihood of the development of those same problem behaviors. In addition, there is also now preliminary evidence that indicates the correlation of some of those same risk and protective factors to adolescent problem gambling (see **Appendix A**).

Identifying local risk and protective factors helps prevention providers better understand what they can do to promote supportive communities and healthy development for children, adolescents, and young adults. It guides the selection of evidence-based programs (EBPs) and strategies (collectively termed EBPS) for specific target populations identified by a local needs assessment. The selection of effective EBPS also fosters efficient resource management in achieving the outcomes of preventing or reducing substance use/abuse among youth in the community. This comprehensive community planning to address the risk and protective factors through the delivery of EBPS will lead to the accomplishment of the following overall goals of OASAS funded prevention services:

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

A. SAMHSA's Strategic Prevention Framework (SPF)

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) is congruent with the OASAS Prevention

Framework in that it is also a data-driven prevention planning process. The SPF focuses more on population-level changes, and is well-suited to coalitions as well as individual providers. The SPF consists of five (5) interactive steps: 1) assessment; 2) capacity; 3) planning; 4) implementation; and 5) evaluation. Cultural competence and sustainability are woven throughout the fabric of all five steps of the SPF process. The five steps of the SPF are designed to help states and communities build prevention competencies and the infrastructure necessary to implement and sustain effective prevention policies, practices, and programs.

B. Needs Assessment & Planning

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 behavior(s) to be addressed in their communities. These local needs assessments may be conducted solely by the provider or as part of a community coalition or in collaboration with the county and/or community service networks. Providers should consult with their Local Governmental Units (LGUs), as applicable, and refer to their Local County Plans (<https://cps.oasas.ny.gov/cps>) for county-specific needs.

Providers enter the results of their needs assessments into the Prevention Activities and Results Information System (PARIS) as part of their annual Prevention Planning Year (PPY) Workplan (see **Section IV, subsection A**).

C. Use of Evidence-based Programs and Strategies (EBPS)

Another important component of the OASAS Prevention Framework is the utilization of evidence-based programs and strategies (EBPS). Prevention research has produced substantial evidence that EBPS can change youth and families' risk and protective factors and community factors which in turn result in lower levels of youth problem behaviors. EBPS include educational prevention services, environmental prevention strategies, and some early intervention activities (see **Section II** for detailed descriptions of each prevention service).

Selecting appropriate EBPS (culturally relevant to their target populations and based on identified local need) helps to ensure that providers are spending their resources

on proven programs that work. A list of EBPS acceptable for use with OASAS funding can be found in the PARIS Knowledge Base, under OASAS Registry of Evidence-based Programs & Strategies (REPS).

D. Community Coalitions and the OASAS Prevention Resource Centers (PRCs)

A community coalition is a group of stakeholders who represent diverse organizations, constituencies, and community members who agree to work together to achieve the common goal of reducing substance abuse and/or problem gambling behaviors within their community. Not unlike the OASAS Prevention Framework, the community coalition model uses a data-driven and strategic planning process (e.g., SAMHSA's SPF) that results in the identification of risk and protective factors and problem behaviors at the local level and the selection of appropriately matched EBPS and policies to address the identified factors. Connecting multiple sectors of the community, which include OASAS prevention providers, in a comprehensive planning approach, community coalitions can achieve measurable outcomes in substance abuse and problem gambling behavior and make efficient use of limited resources.

OASAS recognizes the value of community coalitions as partners in combating substance abuse and problem gambling at the local level. Through the establishment of the Prevention Resource Centers (PRCs), OASAS provides support to local communities, counties, and prevention providers to establish and assist community coalition development efforts. The PRCs provide regional training and technical assistance to foster and support community coalitions (see **Appendix B** for a more detailed description, including locations for the PRCs).

Providers are expected to collaborate with the PRCs and work with community coalitions in their regions (where applicable) by:

- Being active partners in existing underage drinking, substance abuse 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.

SECTION II: REQUIREMENTS AND DEFINITIONS FOR FUNDED PREVENTION SERVICES

All OASAS funded prevention services must address individual and/or family risk and protective factors and/or community level risk and protective factors which are predictive of substance abuse and/or problem gambling behavior among youth, as identified by a local needs assessment. Target populations for recurring prevention services are youth, ages 5 – 20, and those who directly impact youth (i.e., family/parents). Other individuals aged 21 and over may be targeted through information awareness activities, community capacity building efforts, and environmental prevention strategies (see definitions below).

Prevention services may be delivered directly with youth and family/parent target populations to improve their individual and family outcomes, or they may be delivered indirectly using communication technologies, through community capacity building efforts, or with environmental prevention strategies (see **Appendix C**). Both direct and indirect prevention activities are important and are needed to achieve healthier communities. Providers should include the delivery of evidence-based programs and strategies as well as supportive programs utilizing both direct and indirect activities.

All OASAS funded prevention providers are required to implement Primary Prevention services, which include the following service approaches: prevention education; environmental strategies; community capacity building; positive alternatives; and information awareness (see **Appendix E – Primary Prevention Workplan Logic Model**). In addition, providers may choose to implement Other Prevention services as well, which are prevention counseling and early intervention services (see **Appendix E – Other Prevention Workplan Logic Model**).

Since August 2013, OASAS funded prevention providers have been required to add specific problem gambling prevention activities (i.e., Information Awareness/Problem Gambling Speaking Events) to their existing prevention services, to increase the level of public awareness of this issue and to deliver a consistent message statewide. This requirement consists of a minimum of three (3) face-to-face speaking events in the providers' communities, and is not to exceed five (5) events within any given PPY Workplan (see **Appendix D** for the specifics of this policy).

Definitions of OASAS Funded Prevention Service Approaches:

A. Education

Substance abuse and problem gambling prevention education is a direct activity that includes structured curricula and/or structured sessions that aim to decrease risk factors and increase protective factors among youth by improving pro-social attitudes, increasing understanding of the consequences of substance use and/or gambling behavior, teaching critical social skills, and improving knowledge of substance use and problem gambling consequences. Prevention education involves two-way communication and is distinguished from information awareness activities in that the interaction between the educator and the participants is required for its success. It is delivered to youth between the ages of five (5) and twenty (20) years. Social skills may include: decision making; goal setting; stress-management skills; communication skills; substance use and gambling refusal skills; and assertiveness skills.

Prevention education also includes structured curricula to assist parents and families in identifying and reducing family risk factors; learning about the effects of substance abuse and problem gambling on individuals and families; and in gaining a better understanding of child and adolescent development to improve positive parenting. Topics include parenting skills, family communications, teen supervision and monitoring, and reducing problem behaviors.

Prevention education services consist of evidence-based programs (EBPs) and non evidence-based programs (non-EBPs). See **Appendix F** for recommended best practices in the delivery of EBP education services.

B. Environmental Prevention Strategies

Environmental prevention strategies are mutually reinforcing sets of evidence-based and promising indirect activities, designed to effect population-level reductions in substance abuse and problem gambling behaviors within communities. They are primarily aimed at influencing behavior through the establishment and enforcement of laws, policies, and regulations regarding access to and availability of alcohol and other substances and gambling for underage youth, combined with the use of media to increase community support of such. Environmental prevention strategies complement services targeting youth and families. See **Appendix G** for additional information on “what is” and “what is not”

considered an environmental strategy.

As demonstrated by research, the most effective environmental prevention strategies, and therefore considered by OASAS to be evidence-based, rely on a three-pronged approach:

- Development, enhancement, or support of a policy, regulation, or law (which should include consequences for not abiding by it)
- Enforcement/compliance of a policy, regulation, or law and its consequences
- Communication/media campaigns to raise awareness and support for the policy, regulation, or law, and for the enforcement/compliance efforts

Detailed descriptions of the three (3) strategy types (Policy, Regulations, Laws; Enforcement/Compliance; Communication/Media Campaigns), and the various activities allowed by OASAS that fall under each can be found in the “Service Approaches and Activities Glossary” in the PARIS Knowledge Base, under the 2013-2014 Workplan link.

C. Community Capacity Building

This prevention service approach aims to enhance the skills and abilities of coalition members, volunteers, other impactors, and community groups to more effectively collaborate in improving and integrating substance abuse and problem gambling prevention services within the community. It may take the form of assisting with community coalition building, delivering other impactor training, and/or providing technical assistance to agencies and organizations to improve non-provider prevention efforts. It is **not internal** provider capacity building, staff meetings, management activities, or case consultations.

D. Information Awareness

This prevention service approach increases public knowledge and attention to substance abuse and/or problem gambling, and their 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. See **Appendix C** for activities within each category.

Information awareness activities are also used to increase public knowledge and awareness of available and effective prevention programs and services.

E. Positive Alternatives

Positive alternatives are direct activities that provide target populations with opportunities to participate in constructive, pro-social, healthy activities that exclude substance abuse and underage gambling. These activities must also convey a clear no-use message. Positive alternatives also provide opportunities for pro-social bonding to positive role models who can influence attitudes toward a healthy lifestyle.

Positive alternative activities may be more successful when they support and strengthen the skills learned in educational EBPs. See **Appendix I** for recommended best practices when delivering positive alternative activities.

F. Prevention Counseling

Prevention counseling is a short-term, problem-resolution-focused prevention service approach that is designed to assess and improve the levels of youth and family risk and protective factors to prevent or reduce substance use, problem gambling, and the negative consequences of such behaviors. It is offered to youth that meet the Institute of Medicine's (IOM) definition of "Selective" and "Indicated" (see **subsection H**), and is limited to individuals between five (5) and twenty (20) years of age.

Providers delivering prevention counseling services must be certified by OASAS, and must adhere to specific rules and regulations set forth by OASAS (see **Section VIII**).

G. Early Intervention

Early Intervention services are designed for individuals under twenty-one (21) years of age* that meet the Institute of Medicine's (IOM) definition of "Indicated" (see **subsection H**). These are individuals who are already exhibiting symptoms and behaviors of substance use or gambling, but do not meet the criteria for a diagnosis of substance use disorders, or a gambling disorder. The aim is to not only reduce levels of substance use

* An exception is BASICS (Brief Alcohol Screening and Intervention for College Students) – an evidence-based program for college students between the ages of 18 and 25.

and/or gambling, but also to decrease the length of time the symptoms or behaviors continue and/or reduce the need to refer for treatment services.

H. Prevention Activities and Institute of Medicine (IOM) Population Categories

The National Institute of Medicine (IOM) categorizes prevention *populations* (target populations) into three (3) classifications: “Universal”, “Selective”, and “Indicated,” as defined below. Prevention *activities* may be subsequently categorized into those that are designed for each of these three (3) population 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.

1. Universal – Universal prevention programs and strategies are designed for the general public or for demographic sub-populations without selecting for levels of risk or problems behaviors in that population. An example of providing a universal prevention service to a demographic sub-population is the delivery of an evidence-based educational program to all students in first grade at a particular elementary school.
2. Selective - Selective prevention programs target subsets of the total population that are deemed to be at risk for substance use, abuse and/or problem gambling behavior by virtue of their membership in a particular population segment. Some examples of selective subgroups are: children of substance abusers or problem gamblers; school dropouts; and children with multiple community risk factors that favor substance abuse or gambling. The selective prevention program is presented to the entire subgroup because as a whole 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.
3. Indicated - Indicated prevention programs are designed for those with elevated levels of individual risk factors, putting them at high risk for developing substance abuse and/or gambling problems, or who have already begun to exhibit substance use or gambling behaviors but do not meet the diagnostic criteria for substance use disorders or a gambling disorder.

I. Evidence-based Programs and Strategies (EBPS)

Evidence-based Programs and Strategies (EBPS) are sets of prevention activities that evaluation research has shown to be effective. These activities result in cost savings when delivered with fidelity to the program’s design and the populations studied.* Some of these prevention activities help individuals develop the intentions and skills to act in a healthy manner while others focus on creating an environment that supports healthy behavior. OASAS-approved EBPS have been evaluated for effectiveness specifically in preventing or reducing substance abuse and related problems, and are designed to change youth and families’ risk and protective factors and those community factors that drive illegal consumption and negative consequences due to substance abuse.** Ongoing research may eventually identify effective EBPS for problem gambling.

OASAS requires that a percentage of prevention services be OASAS-approved EBPS. See **SECTION III** for more specifics on this requirement.

J. OASAS Registry of Evidence-based Programs & Strategies (REPS) and EBPS Review Panel

The OASAS Registry of Evidence-based Programs & Strategies (REPS) was developed to support providers in identifying EBPS that meet OASAS policy priorities, evidence criteria and to update the providers’ “toolbox” with innovative and culturally competent programs. The OASAS REPS is available to providers in the Prevention Activities and Results Information System (PARIS) as a drop-down box for Workplan development, and in the PARIS Knowledge Base under “OASAS Registry of Evidence-based Programs & Strategies (REPS).”

To maintain and update the REPS, OASAS assembled 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 generated sources to identify programs that

* See **Appendix F** for recommended best practices for EBP education.

** A list of EBPS that are approved by OASAS can be found in the PARIS Knowledge Base-OASAS Registry of Evidence-based Programs and Strategies (REPS).

meet OASAS EBPS criteria.

Providers may submit evidence of effectiveness for an established EBPS or for an innovative program for special populations to the Review Panel for determination of EBPS status. The Panel convenes twice a year to review applications from OASAS providers and to consider new research on the existing EBPS grandfathered into the Registry from the former CSAP Model Program registry. Review Panel results are disseminated to the provider submitting the EBPS Review Application, and to their OASAS Field Office Program Manager. If requested, their County or City Local Governmental Unit (LGU) is also notified of the results. If the program attains EBPS status approval the results are posted in the PARIS Knowledge Base and the program is added to the EBPS (Model Program and Environmental Prevention Strategies) list available for selection during annual Workplan development. More information on the EBPS application and review process can be found in the PARIS Knowledge Base by clicking “New EBPS Application & Process.”

SECTION III: PREVENTION PERFORMANCE STANDARDS

This section describes the eight (8) minimum performance standards to be met by providers in their planning and delivery of OASAS funded prevention services. This section also describes the annual program performance review process.

A. Prevention Performance Standards

The eight (8) prevention performance standards were developed by stakeholder workgroups, approved by OASAS and published in the 2012 Prevention Guidelines. These performance standards are the provider-accountability measures used by OASAS program managers during the Workplan approval and program performance review processes. One (1) standard, for planned resource allocation for EBPS, was published in the 2009 Prevention Guidelines and has been in effect since 2011. The seven (7) additional standards were applied beginning with the first unified OASAS Prevention Planning Year (PPY) Workplan (July 1, 2013 - June 30, 2014).

The definitions below will assist providers in understanding the computation of all eight (8) performance standards:

Performance Standard 1: Planned Percentage of EBPS Staff Allocation

All providers are required to allocate a percentage 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 documented in the PARIS Knowledge Base. Effort is defined as direct services Full Time Equivalent (FTE) staffing, with 1.0 equaling one full-time worker (see full definition of FTE in the PARIS User Manual). The standard increases by five percent (5%) each subsequent PPY until reaching 70% in 2018.*

* Since the first year of 2011, when the standard was set at 35%, this standard has been met or exceeded in statewide averages each year. In 2013, with the standard set at 40%, the statewide average was 60%.

Required Standard (Minimum EBPS FTE % per Prevention Planning Year):

2009	0%	2014-15	50%
2010	0%	2015-16	55%
2011	35%	2016-17	60%
2012	40%	2017-18	65%
2013-14	45%	2018-19	70%

Score Calculation:

$$\% \text{ EBPS FTE} = \frac{\text{Total EBPS FTE (Primary + Other Prevention Workplans' EBPS FTE)}}{\text{Total FTE (Primary + Other Prevention Workplans' Total FTE)}}$$

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

Performance Standard 2: Percent Planned Direct Services Delivered:

This standard measures the provider's performance in delivering their planned direct services. All planned direct service activities in the approved Workplan are compared to the actual activity delivery counts entered during the Workplan year. Indirect service activities, such as those delivered through mass media, environmental prevention strategies and capacity-building activities are not included in this measure. All sessions and events that were delivered during the year and entered into PARIS are counted, even those that were initially unplanned (not in the approved Workplan). All recurring classroom and group sessions delivered are counted, even when the groups were not completed.

The following prevention services are included in this standard:

- All recurring education classroom/group sessions (EBPS & non-EBPS)
- All positive alternatives (both single and continuing sessions)
- All direct information/awareness activities (Health Promotion Event, Speaking Event, Walk-in Information Services and Telephone Information Services)
- All prevention counseling sessions (Assessment and Counseling)
- All early intervention sessions

Required Standard:

At least 80% of total annual planned direct services must be delivered and entered into PARIS.

Score Calculation:

This performance standard is calculated as the sum of total Workplan and non-Workplan direct service activity sessions and events, divided by the sum of total direct service activity sessions and events that appear in the approved Workplan.

$$\begin{array}{l} \% \text{ Planned} \\ \text{Direct} \\ \text{Services} = \\ \text{Delivered} \end{array} = \frac{\text{Total Reported Activities (Workplan + Non-Workplan entered)}}{\text{Total Workplan Activities (from Primary + Other Workplan(s))}}$$

Performance Standard 3: % Planned Direct Services Participants Served

This performance standard is the percent of the total annual planned direct service participants who received a direct service activity during the Workplan year. Total participants include both planned (Workplan) direct services participants and non-planned (non-Workplan) direct services participants served during the year. Participants served through indirect service activities, such as those delivered through mass media, environmental prevention strategies and capacity-building activities, are not included in this measure.

Participants receiving the following services are included:

- All recurring EBP and non-EBP education programs (all participants are counted here, even those for partially-completed class/groups).
- All positive alternative activities (single-session and continuing-session activities).
- All direct information/awareness activities (Health Promotion + Speaking Events + Telephone Information + Walk-in Information Services)

- Prevention counseling (total Assessments planned)
- Early intervention (total Assignments planned).

Required Standard:

At least 80% of the total planned participants are served as reported in PARIS.

Score Calculation:

This performance standard is calculated as the sum of Workplan and Non-Workplan direct service activity participants served during the Workplan year, divided by the sum of Workplan direct service activity participants planned in the approved Workplan.

$$\begin{array}{l} \% \text{ Planned} \\ \text{Direct Service} = \\ \text{Participants} \\ \text{Served} \end{array} = \frac{\text{Total Workplan + Non-Workplan Participants served}}{\text{Total Planned Participants}}$$

Note: All participants in sessions and events that were delivered during the year and entered into PARIS are counted, even those that were unplanned (not in the Workplan) and those participants whose recurring class/groups were only partially completed.

Performance Standard 4: % EBP Class/Group Completion:

This performance standard measures the percentage of a provider’s EBP class/groups that are completed after they are initiated. 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 on the PARIS Knowledge Base under the “OASAS Registry of Evidence-based Programs & Strategies (REPS)” folder. At least one participant must be reported as attending for a session to be counted. This standard applies to all class/groups that are initiated (i.e., session one is completed and data is entered in PARIS). A few EBPs do not use curricula sessions (e.g., Olweus Bullying Program). For these EBPs the minimum sessions required is listed as “NA,” and the number of sessions is entered by the provider at initiation and is used as the criterion. Non-Workplan class/groups that are added and initiated during the

year are included in the measurement of this standard.

Required Standard:

At least 80% of the minimum sessions required (as defined above) for all EBP Education class/groups that are initiated during the Workplan year are completed.

Score Calculation:

This performance standard is calculated as the percentage of all initiated EBP education class/groups that are completed. Completion status means that at least 80% of the minimum required sessions were delivered and entered in PARIS.

$$\begin{array}{l} \% \text{ EBP} \\ \text{Class/Groups} = \frac{\text{Total EBP class/groups completed}}{\text{Total EBP class/groups initiated}} \\ \text{Completed} \end{array}$$

Performance Standard 5: % Non-EBP Education Class/Group Completion:

This performance standard measures the percentage of a provider's Non-EBP (Non-Model) class/groups that are completed after they are initiated. The standard requires that at least 80% of Non-EBP education programs (Non-Models) that are initiated are completed. For OASAS, class/group completion means that at least 80% of the sessions planned by the provider at class/group initiation are delivered and that at least one participant is reported for a session. The number of sessions specified by the provider at initiation is used as the criterion. Both planned and unplanned class/groups are included in this standard once they are initiated.

Required Standard:

At least 80% of all Non-EBP education class/groups (Non-Model programs) that are initiated during the Workplan year are completed as defined above.

Score Calculation:

This performance standard is calculated as the percentage of all initiated Non-EBP education class/groups that are completed. Completion status

means that at least 80% of the total class/group sessions entered at initiation were delivered and entered in PARIS.

$$\begin{array}{l} \% \text{ Non-EBP} \\ \text{Class/Groups} = \\ \text{Completed} \end{array} = \frac{\text{Total Non-EBP class/groups completed}}{\text{Total Non-EBP class/groups initiated}}$$

Performance Standard 6: % Current Substance Use Prevented:

For all youth who report no substance use in the past 30 days when admitted to prevention counseling, a major OASAS goal is to help them stay drug free or to delay the initiation of substance use. For these drug-free counseling participants, 90% will remain free of substance use 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” (no discharge data reported in PARIS) cannot be included in the measure.

Required Standard:

At least 90% of participants who reported no substance use during the past 30 days at prevention counseling admission will also report no past 30 day substance use at prevention counseling discharge.

Score Calculation:

This performance standard is calculated as the percentage of admitted prevention counseling participants as defined above who report no past 30 day substance use at admission and at discharge.

$$\begin{array}{l} \% \text{ Current} \\ \text{Substance Use} = \\ \text{Prevented} \end{array} = \frac{\text{Total Participants with no Past 30 Day use at discharge}}{\text{Total Counseling Admissions with no Past 30 Day use}}$$

Performance Standard 7: % Successful Completion of Prevention Counseling:

For providers that deliver prevention counseling services, this performance standard measures the percentage of participants who are judged to have successful counseling outcomes. Successful completion of prevention counseling is defined as the accomplishment of all or a majority of the objectives identified in the Participant Services Plan.

- Provider is defined here as certified counseling provider within a county.
- The cohorts for this performance standard are prevention counseling participants who were admitted and discharged during the Workplan year.
- Participants discharged due to extended illness or school transfer are **not** included in this standard.
- Participants discharged due to failure to complete counseling (no contact in 30 days) or those administratively discharged from OASAS due to no discharge record **are** included in the standard.

Required Standard:

All or a majority of the objectives in the Participant Services Plan were accomplished for at least 60% of the participants at discharge.

Score Calculation:

This performance standard is calculated as the percentage of participants admitted to prevention counseling who have successfully achieved all or a majority of the objectives identified in the Participant Services Plan at discharge as specified on the OASAS Form PAS- 64B – Discharge Record.

$$\begin{array}{l} \% \text{ Successful} \\ \text{Counseling} \\ \text{Completion} \end{array} = \frac{\text{Total discharges of participants who accomplished all/a majority of objectives}}{\text{Total all discharges, except those due to extended illness or school transfer}}$$

Performance Standard 8: Planned Environmental Prevention Strategies Meeting Evidence-based Guidelines:

This performance standard provides information on whether environmental prevention strategies are planned to include policy and enforcement activities and are supported by appropriate media campaign strategies. To be successful, communities must assess and improve new environmental policy and enforcement activities and/or increase needed supports for their existing substance use policy and enforcement activities. Providers may play a supportive role by delivering appropriate communications/media campaigns, but the policy and/or enforcement-compliance strategies to be supported must be identified in the annual Workplan. For example, a provider indicates that a new Social Host law has been enacted in a community they serve, 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 and support of the new law.

Required Standard:*

When planning environmental prevention strategies during Workplan development, at least one (1) policy/regulations,/laws strategy or one (1) enforcement/compliance strategy must be selected for delivery, or for support through the activities under the communication/media campaign strategies. 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 the “Prevention and Early Intervention Service Approaches and Activities Glossary”, in the PARIS Knowledge Base, under the “2013-2014 Workplan.”

Calculation:

This performance standard is calculated as a categorical measure. For those providers planning environmental prevention strategies, this standard is met if the provider plans to deliver or support at least one policy or one enforcement strategy that is supported by at least one communication/media campaign strategy, Evidence of service delivery implementation for the above must be documented in PARIS to pass this standard.

* For providers not planning any environmental prevention strategies, this standard is not applicable.

Once this planning standard has been met (i.e. a policy or enforcement strategy and supportive media activities are planned), other additional communication/media campaign activities, such as Social Marketing Campaigns, may be selected as needed. One media activity, Social Norms Misperception Campaign, has been shown to be effective when based on recently measured youth norms (e.g., school-based youth survey). It can be selected independently for environmental EBPS credit provided that all components of this campaign are followed, and that the campaign is about alcohol use.

B. Performance Reviews

All OASAS funded providers are subject to an annual Program Performance Review ([OASAS Local Services Bulletin No. 2000-03](#)). As part of this process, a review of program administrative and fiscal compliance is reviewed along with compliance with the Performance Standards (see preceding **subsection A**). The general 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 Field 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 performance deficiencies identified
- Offer technical assistance to correct these problems
- Include specific dates when the provider will submit a plan for improving performance with milestones to ensure that the performance targets are met
- Provide notice that failure to correct these problems will negatively impact on the future funding of the program.

SECTION IV: PREVENTION REPORTING REQUIREMENTS

The Prevention Activities and Results Information System (PARIS) is the OASAS data system for providers of prevention services. PARIS supports the key functions of:

- An annual OASAS Prevention Planning Year (PPY) Workplan development, review, and approval process
- Monthly service data collection for OASAS funded prevention activities
- Reports for providers and management for service delivery and provider performance, including those for the Prevention Performance Standards detailed in these Guidelines

Providers who receive state funding from OASAS to provide Primary Prevention or Other Prevention services (see **Section II**) are required to use PARIS. Providers who have been approved by OASAS to deliver Alcohol Awareness Programs (AAPs) submit a separate annual report directly to the Bureau of Prevention Services via a standard form (see **Section X**).

Use of PARIS is supported in a number of ways that include:

- A User Manual with instructions for navigating the system (found in the Support Module of PARIS)
- A Knowledge Base library of documentation and descriptive 'how-to' resources
- On-line instructional tools
- The PARIS Help Desk

Questions concerning PARIS should be directed to the PARIS Help Desk (1-866-438-3789 or PARISHelpDesk@OASAS.NY.gov) or to the appropriate Prevention Bureau Liaison.

Periodically OASAS will conduct PARIS trainings for new staff and provide updates about changes to the system. OASAS funded prevention providers are required to attend such trainings when requested.

A. OASAS Workplan Development and Approval

All OASAS funded providers are required to submit a prospective Workplan annually for their planned prevention services. The Workplan, combined with prior provider performance, forms the basis for OASAS Field Office review and approval of OASAS funding commitments. The planned services are based on a formal assessment of the needs of the population being served which is documented within the Workplan. The Workplan includes only direct services. Administration and overhead support activities such as management, supervision, staff development, travel, resource preparation (handouts, workbooks, and educational materials), etc., are not included in the Workplan as separate activities.* All prevention services entered into the Workplan and submitted for approval in PARIS must be representative of total expenses (both revenue and deficit funding) approved by OASAS.

The capability to create new Workplans is available to providers each spring. If appropriate, providers can copy forward their previous Workplan and then make the necessary modifications. Once submitted, the Workplan is reviewed by the provider's LGU (unless the provider is directly funded by OASAS) and then reviewed by their OASAS Field Office Program Manager. During the Workplan review and approval process, the provider, the 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).

The timeline for Workplans is as follows:

- March 1st New Workplans for next Prevention Planning Year (PPY, July 1st – June 30th) become available to providers in PARIS.
- March 31st Deadline for providers to submit current approved Workplans for revisions.
- April 1st Providers submit completed Workplans for next PPY.
- July 1st Data collection for next PPY Workplans begins.

Specific guidance for Workplan revisions is provided in the PARIS Knowledge Base. Approved Workplans may not be revised after March 31st of the current PPY.

B. Monthly Data Collection and Reporting

* Direct Service covers all tasks directly related to the provision of specific prevention services to Target Populations. Included within that are those support activities directly related to those services: travel, staff supervision related to direct service activities, materials production and other preparation tasks associated with the service.

OASAS funded/certified prevention providers are responsible for accurate and timely data reporting.

PARIS is the primary source of information from which OASAS draws to inform local, state and federal government officials, as well as the communities served, regarding the types of funded prevention services delivered, to whom, and where. PARIS data is routinely used by OASAS staff when a request is received for information concerning a provider's prevention services and activities. As PARIS data also drives the OASAS prevention-related policy decision process, it is vital that data reporting is kept current.

1. Responsibility for Accurate Data Reporting

Providers are required to:

- Inform their OASAS Field Office and LGU of significant changes to their funding, staff resources or services delivered. These changes may require a revision to their Workplan.
- Ensure that FTE and staff credential information in PARIS is current.
- Update contact information as necessary in both the PARIS Admin module and the [OASAS Provider Directory System](#) (PDS).

2. Responsibility for Timely Data Reporting

The following due dates apply for reporting prevention activity data in PARIS:

- Monthly: Each month's activities must be entered 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.
- Annually: All data for activities in the prior Workplan cycle (that ends June 30th) must be entered into PARIS by September 1st.

Note: Data collection for each PPY Workplan will be closed two (2) months after the end of the Workplan year (on September 1st) in order to generate the Prevention Performance Measures reports used by the Field Office for the annual Program Performance Review process (see **Section III, subsection B**).

Any specific questions about PARIS reporting should be directed to the PARIS Help Desk at 1-866-438-3789 or PARISHelpDesk@oasas.ny.gov.

C. Requests for Waiver for Delinquent Data Reporting

Requests for a waiver to enter delinquent data after the PARIS annual data collection deadline (September 1st) will be granted only for emergency situations. A request for a waiver must be approved by the appropriate OASAS Field Office. If the waiver is granted, the data collection module will be reopened for a period of two (2) weeks from the approval notification date. Only one (1) waiver per fiscal year will be granted.

SECTION V: FISCAL POLICIES AND PROCEDURES

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 Programs](#) for reference to all applicable fiscal requirements and Local Services Bulletins.

SECTION VI: ADMINISTRATIVE AND OPERATIONAL REQUIREMENTS FOR OASAS FUNDED PROVIDERS

A. Prevention Director/Supervisor

Each prevention provider must designate a supervisor whose responsibilities are overseeing day-to-day operations, that include administrative, programmatic and prevention counseling (if provided).

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

* 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.

- Procedure for complying with [Justice Center](#) requirements
- [Emergency Management Plan](#)

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.***

D. [Lease Renewal/Relocation Requirements](#)

Each provider must receive prior approval by OASAS before entering into a new or renewed lease. The provider is responsible for notifying their OASAS Field 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 into a new or renewed lease. Please see the [Administrative and Fiscal Guidelines for OASAS-Funded Programs](#) for more information regarding the process.

E. [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 Clinical Director (if applicable) vacancies. Any service provider sub-contracted through a County/LGU must meet the County/LGU's guidelines for hiring for any positions that may require prior approval. Providers are responsible for insuring that all staff hired meet OASAS guidelines and meet qualifications as stated in their organization's written job descriptions.

[\(State Aide Bulletin No. 1994-01: Changes in Administrative Procedures for Funded Local Services\)](#)

In addition to the above, it is strongly recommended that providers notify their Field Office and County/LGU regarding changes of key (i.e. managerial, supervisory) personnel.

*** 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.

F. Non-Prevention Functions

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

G. Operational Months of Service Delivery

If a provider is approved by OASAS to operate less than 12 months (i.e. service delivery is less than 12 months), they should identify in the PARIS Workplan the months they are not operational (Found in PARIS in Administration/PRU Operational months). This section of PARIS should be updated as their status changes.

H. 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.

I. OASAS Contractual Requirements

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

J. Prevention Materials and Curricula (Service Standards)

- Prevention providers are responsible for 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, etc. to maximize delivery effectiveness.
- Prevention providers must ensure that all materials and/or curricula utilized in the provision of prevention services are accurate, age-appropriate, and culturally relevant to the target population being served.

- Each provider is responsible for selecting/utilizing material/curricula that will contribute to the comprehensive approach in achieving the desired results as stipulated in the annual Workplan.
- Each prevention provider is responsible for annually reviewing and updating, as needed, all material/curricula utilized, 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.

K. Prevention Staffing Requirements

All OASAS funded prevention providers need to meet both requirements below:

1. The individual who oversees 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 staffing qualifications described following the table on the next page.
2. If a prevention program is staffed by four (4) or more full-time equivalent professional staff (not counting the individual who oversees prevention services as described above), at least **25 percent** (25%) of the staff must also meet the staffing qualifications described (following the table on the next page).

The table below illustrates how the staffing requirement will be applied based on the number of full-time professional staff. 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 (excluding the Director of Prevention)	# of Professional Staff (excluding the Director of Prevention) who must meet the Prevention Staffing requirement
1-3	0
4-7	1
8-11	2
12-15	3
16-19	4

Staffing Qualifications:

- 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) Prevention professional who is licensed, certified or credentialed in a ***related discipline*** (see below); has two (2) years of qualifying prevention work experience, and has completed 60 hours of prevention-specific education and training.

Related disciplines include: Credentialed Alcoholism and Substance Abuse Counselor (CASAC), 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, Licensed Creative Arts Therapist and National Board Certified Counselor.

L. Ethical Standards

Every substance abuse prevention staff member shall be expected to uphold high ethical standards and to 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 report, through appropriate channels, any unethical conduct of which he or she is aware ([14 NYCRR Part 853 - Credentialing of Addictions Professionals](#)).

M. 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 Field Office at least six (6) months prior to the voluntary termination of any authorized service ([NYS Operating Regulations, Part 810.16: Voluntary Termination of Authorized Services](#)).

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. For certified prevention providers it should, at a minimum, do following:

- Assure appropriate referral of patients as necessary
- Preserve the confidentiality of patient 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 Field Office. Please contact the Field Office for the appropriate form to begin the process.

SECTION VII: PERSONNEL POLICIES AND PROCEDURES

All personnel policies and procedures of prevention providers 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 should include, but is not limited to:

- Organizational purposes and goals
- General personnel policies
- Employment, promotion, separation policies
- Employee orientation and training
- 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
- Tobacco-free policy ([14 NYCRR, Part 856](#))
- Employee travel (if not included in Fiscal Manual)

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
- Résumé 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 and credentials
- Income tax withholding forms (W-4 and IT-2104)
- Records of training/staff development courses
- 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

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.

* 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.

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 [Local Services Bulletin No. 2007-08](#), all OASAS certified providers are mandated to report suspected child abuse or maltreatment.

1. Any staff member of a prevention program who has reasonable cause to suspect that a child coming before him or her is an abused or maltreated child or where the parent, guardian, custodian or other person legally responsible for such child comes before him or her in his or her professional or program capacity and states from personal knowledge, facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, shall immediately report such suspected child abuse or maltreatment to the prevention program director or his or her designee. If the staff member is him or herself a mandated reporter, he or she must personally make a report as required by law.
2. The prevention program director, or designee, or staff member (if a mandated reporter) shall immediately report by telephone the suspected child abuse or maltreatment to the Statewide Central Register of Child Abuse and Maltreatment unless the appropriate local plan for the provision of child protective services provides for oral reports to the local child protective service. The prevention program director or designee or staff member shall submit within 48 hours 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”).

The Justice Center is a new state oversight agency charged with investigating and prosecuting allegations of abuse, neglect and other significant incidents involving patients and program related personnel who interact with patients on a “regular” basis and in a “substantial” manner during the course of their duties. 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
 - All applicants for an OASAS credential (or renewal of a credential)
 - All applicants for an operating certificate
- Mandated Reporters
- Code of Conduct

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.

Background checks by OASAS are required for staff in prevention counseling programs certified 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

SECTION VIII: PREVENTION COUNSELING POLICIES AND PROCEDURES

Prevention counseling is a short-term, problem-resolution focused activity that concentrates on resolving identified problems and improving the level of youth and family risk and protective factors that are predictive of substance abuse and/or problem gambling. It is limited to individuals between five (5) and twenty (20) years of age.

The goals are to prevent, delay or reduce substance use and problem gambling, and the negative consequences caused by substance use and gambling behaviors, and to refer to appropriate treatment or support services those individuals with apparent symptoms of substance abuse or dependence, problem gambling, or physical, mental, emotional educational or social problems.

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
- Admission, retention, and discharge criteria
- Identification of assessment/screening instruments used
- Problem identification and initial screening determination, risk factor assessment, and service plan development
- 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)
- The identification of appropriate referral sources applicable for participant needs
 - Child abuse reporting protocol
 - Incident reporting protocol to OASAS Field Office, and/or Justice Center as applicable

B. Required Services/Activities

Prevention counseling services must include the following activities:

- Assessment of substance use and problem gambling behavior
- Risk factor assessment
- Disposition
- Referral to other necessary prevention, treatment, and/or support services when needed

Prevention counseling activities may include the following activities:

- Participant Services Plan development for admitted participants
- Individual counseling
- Group counseling
- Family sessions

C. Assessment and Disposition

An individual who seeks or has been referred for Prevention Counseling services shall undergo an initial assessment 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 prevention or referral services. Standardized screening instruments should be used.*

This required assessment may include up to three (3) sessions over a twenty (20)

* Standardized screening instruments can be found in the PARIS Knowledge Base under 2012 Prevention Guidelines-Related Links.

school/work/business day period, at which point a disposition must be made.

The assessment is documented on the Assessment/Admission Record (PAS-64) form. The assessment is also entered into PARIS and must include documentation of “30_Day Use at Admission” for grades six (6) through twelve (12).

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.

D. Admission Criteria

To be admitted to Prevention Counseling, the assessment must document at least one of the following:

- Current (within the last 30 days) substance use or gambling
- Consequences related to substance use or gambling
- Family history of substance abuse or problem gambling
- A high level of risk on at least two of the following risk factors:
 - Peers engaged in substance use or gambling
 - Favorable attitudes toward substance use or gambling
 - Early initiation of substance use, or gambling
 - Early initiation of the problem behavior (grades K-5)
 - Depressive symptoms
 - Family management problems
 - Family conflict

The Personal History Record: 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**).

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*, 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

* Refer to DSM-5 for criteria

substance abuse or problem gambling treatment service for an evaluation, the individual may be referred for an early intervention service (e.g. Teen Intervene or BASICs). If early intervention services are not available, the individual can then be admitted to Prevention Counseling for brief motivational counseling focused on accepting the referral for an evaluation for substance abuse or problem gambling treatment.

E. Referral Services

Each Prevention Counseling provider must make arrangements 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 abuse 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.

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 approved by supervisory staff. Standardized assessment instruments, where appropriate, 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.
- Take into account cultural and social factors, as well as the particular 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.
4. For those participants readmitted into the service within sixty (60) days of discharge, the initial Assessment/Admission Record (PAS-64) form may be utilized provided that a new Participant Services Plan update is completed. The new assessment data must be added in PARIS.
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.
7. Duration of an individual's participation in counseling shall not exceed one hundred and twenty (120) calendar days without justification for a longer period.
8. All participants receiving Prevention Counseling in a school setting must be discharged at the end of the school year, unless services continue over the summer.

9. A participant shall be retained in the Prevention Counseling service 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.

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. 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, must be reviewed with supervisory staff. Any resulting decisions made must be documented in the participant record and the Participant Services Plan must be revised accordingly.

12. 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.

13. Counseling staff must have face-to-face counseling contact with each participant at least once a week (excepting school vacations, holidays and examination periods). If the frequency of counseling is determined to be needed less than weekly, a rationale must be documented in the Participant Services Plan. Any

interruption to the weekly 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 (Referral Record PAS-64C) which have been identified in the assessment and over the course of counseling.
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 twenty (20) 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) days from the last face-to-face.

18. Discharge data should be entered into PARIS by the fifteenth (15th) of the next month following the date of the last counseling contact. The date of discharge should be either the date of the last face-to-face contact or at the end of thirty (30) days from the last face-to-face.
19. For all discharges of participants in grade six (6) and above, counselors must collect and enter into PARIS the past 30 day substance use data.
20. No participant shall be discharged without a Discharge Plan that has been reviewed by 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.
21. All Prevention Counseling providers making referrals for any support or auxiliary services must document these services on the Referral Record (PAS-64C).
 - a. 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.
 - b. 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 those individuals who have been diverted (or referred) to Prevention Counseling through the Criminal Justice system, a [Criminal Justice Consent to Release Information](#) (TRS-4) must be completed.

G. Administrative Operations

1. Each provider must designate a supervisor whose responsibilities are to provide clinical supervision for Prevention Counseling.
2. 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).
3. 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.
4. Prevention provider records must be maintained separately from other school/agency records.
5. Where possible, participant records should be maintained at the site where services are provided.
6. 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.
7. Adequate space is required for the provision of Prevention Counseling services. Adequate space is defined as: clean, safe, accessible, and complies with confidentiality standards.

H. Program Records

1. Providers must keep individual records for each individual who is assessed, whether they are admitted to Prevention Counseling services or not. All records, at a minimum, must include:
 - The source of referral
 - Issues precipitating referral

- Initial screening findings and recommendations
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
 - 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. Each participant must have a unique identification number as assigned by the provider and recorded in PARIS (Participant Identifier Code). This unique identification number is assigned at the first assessment session.
 4. 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.
 5. 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.

6. Services utilizing electronic record keeping protocols and subject to HIPAA oversight, shall administer said record keeping protocols accordingly.
7. All prevention providers must maintain participant records for each individual admitted to 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
 - 120 Day Service Plan Review/Justification (PAS-65B), when applicable
 - Participant Progress Summary PAS-66)
 - Discharge Record (PAS-64B)
8. For those individuals participating in group counseling, staff shall complete both of the following:
 - Group Counseling Participation Record (PAS-67)
 - Group Process Summary (PAS-67A)

Note: OASAS Prevention Counseling forms PAS-64 – PAS-67B can be found in the PARIS Knowledge Base.

9. 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 Field 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 alcohol or drug use problems (e.g., using or possessing drugs) but do not use these substances daily or demonstrate a diagnosable substance use disorder. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, this intervention aims to help teens reduce and ultimately eliminate their alcohol and other drug use.

Abstinence 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 that individual's severity of their alcohol and drug problem 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.

A. Policies and Procedures

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 abuse issues 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 abuse treatment is likely indicated.

The following are required activities:

- Problem identification and initial screening determination, using an evidenced-based standardized screening instrument developed for adolescents (e.g., Teen Intervene Client Questionnaire, CRAFFT)
- A minimum of at least two (2) sessions (with the youth) to deliver the program content
- 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 (42CFR Part 2).
2. Each provider must designate a supervisor whose responsibilities are to provide

clinical supervision for staff delivering Teen Intervene.

3. Adequate space is required for the delivery of Teen Intervene. Adequate space is defined as clean, safe, 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 and entered into PARIS 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 PARIS 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 screening instrument (e.g., CRAFFT, POSIT, or Part 1 of Teen Intervene - Client Questionnaire)
- Part 2 of Teen Intervene - Client Questionnaire
- Teen Intervene - Pros and Cons Worksheet
- Teen Intervene - Readiness to Change Worksheet(s)
- Teen Intervene - Establish Goals Worksheet(s)
- Teen Intervene - Parent/Guardian Worksheet (if parent/guardian session delivered)
- Teen Intervene - Parent/Guardian Questionnaire
- Completed Release of Information Concerning Alcoholism/Drug Abuse Patient's (TRS-2), Criminal Justice Consent to Release Information (TRS-4) or HIPAA form (if applicable)

Required data for this service approach must be entered into PARIS. See PARIS User's Manual for instructions.

E. Staffing Requirements – Minimum Qualifications

Teen Intervene is designed for professionals including teachers, school counselors, social workers, psychologists and other youth-serving professionals who are working with alcohol or drug abusing teenagers. Users of the Teen Intervene model should have formal training in basic counseling skills, as well as a basic understanding of the etiology, course and treatment of adolescent alcohol and other drug addiction.

1. Licensed, Certified or Credentialed Professionals

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

Related disciplines include: 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.

2. Non-Licensed, Non-Certified or Non-Credentialed Professionals

If delivery staff are not licensed, certified or credentialed in a related discipline (see list above), providers must document in the employee file that staff have successfully met all of the following education, training and experience requirements in order to be approved by OASAS to deliver 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

SECTION X: ALCOHOL AWARENESS PROGRAM POLICIES AND PROCEDURES

An Alcohol Awareness Program (AAP) is a specific prevention service governed by OASAS under Section 19.25 of the Mental Hygiene Law. Prevention providers who deliver an AAP 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 PARIS.

A. Definition of an Alcohol Awareness Program (AAP)

An [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, family members or other agencies for violation of the underage drinking laws. It may be an alternative sentence that is imposed upon youth younger than twenty-one (21) 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.

Additionally this education program may also be modified and used for those 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 law, local or state, that would benefit the public by having the offender receive education about youth and alcohol.

The program may also provide a mechanism to determine whether or not a youth may need to be evaluated for their alcohol and other drug use, 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 alcoholism/addiction
- Family dynamics and issues regarding children of alcoholics and substance abusers
- Societal issues
- Youth issues
- Choices and alternatives
- Screening and self assessment
- Community resources
- Stress management

C. Application/Approval Process

Organizations interested in delivering an AAP must complete an application and submit to the Bureau of Prevention Services. Information regarding the physical location of the AAP, referral sources (e.g. courts, local magistrates, and schools), program content and budgets are required. Each application will be reviewed and applicants will be notified by the Bureau of Prevention Services regarding the outcome or need for additional information.

D. Reporting Requirements

All AAPs are required to submit annual reports for the time period of July 1st - 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.

SECTION XI: CONFIDENTIALITY

Federal Law guarantees the strict confidentiality of all persons (including youth) who have applied for or received any alcohol or substance abuse-related services. Participant records maintained by the prevention counseling 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 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.

A. 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 Written Participant Consent.
 - 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 E** - 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.

2. Disclosure is permitted without written participant consent in certain instances (see **Appendix J**).

C. 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.

D. 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 alcohol or substance abuse-related services to the participant. Absent consent, disclosures for non-treatment purposes are not permitted.

E. 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) (20 U.S.C. §1232g, 34 CFR 99) 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:

1. The program can ask participants to sign a consent to disclose information to their parents' when a parents request specifically includes access to a child's prevention counseling records.
2. 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](#).

APPENDICES

APPENDIX A

NYS OASAS Risk Factors That Inhibit Healthy Youth Development

RISK FACTORS	Problem Behaviors				
	Substance Abuse	Delinquency	Teen Pregnancy	School Drop-Out	Violence
Community					
*1. Availability of Alcohol and Other Drugs	√				√
*2. Insufficient Laws and Policies to Reduce Substance Use	√	√			√
*3. Social Norms Favorable Toward Substance Use	√	√			√
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 to problem gambling.

Protective Factors That Promote Healthy Youth 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:

- All Risk and Protective factors from the research predict youth substance use and the other problem behaviors.
- Research from Univ. of Washington, Social Development Research Group provides evidence that the Risk and Protective factor scores also 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 main purpose of a regional Prevention Resource Center (PRC) is to build and sustain capacity for community coalition development by providing training and technical assistance and by supporting partnerships between prevention providers, counties, schools, and the community.

Primary responsibilities of the PRCs include:

- Assisting providers and other stakeholders in the development of community coalitions
- Training prevention provider staff and coalitions on Evidence-based Programs and Strategies (EBPS), including needs assessments and all components of the federal Strategic Prevention Framework
- Identifying and addressing technical assistance and training needs of new and existing community coalitions and local prevention providers
- Improving county and program planning

LISTING OF REGIONAL PREVENTION RESOURCE CENTERS

Western PRC

<http://gcasa.net/Prevention/WNYPreventionResourceCenter/tabid/102/Default.aspx>

Host Provider: Genesee Council on Alcohol and Substance Abuse in Batavia

Counties Covered:

Niagara	Cattaraugus	Wyoming
Erie	Orleans	Alleghany
Chautauqua	Genesee	

Finger Lakes PRC

<https://ncadd-ra.org/programs-services/finger-lakes-prevention-resource-center>

Host Provider: DePaul’s National Council on Alcoholism and Drug Dependence - Rochester Area

Counties Covered:

Monroe	Ontario	Seneca
Livingston	Yates	Tompkins
Steuben	Schuyler	Tioga
Wayne	Chemung	Broome

Central PRC

<http://www.cr-prc.org>

Host Provider: The Prevention Network in Syracuse

Counties Covered:

Cayuga	Oswego	Jefferson	St. Lawrence
Cortland	Onondaga	Lewis	
Chenango	Madison	Oneida	
Delaware	Otsego	Herkimer	

Mid-Hudson PRC

<http://www.adacinfo.com>

Host Provider: ADAC of Orange County in Goshen

Counties Covered:

Sullivan	Rockland	Dutchess	Westchester
Orange	Ulster	Putnam	

NYC PRC

<http://www.childrensaidsociety.org/prevention-resource-center>

Host Provider: Children's Aid Society in Manhattan

Counties Covered:

Bronx	Richmond	Queens
New York	Kings	

Suffolk County PRC

<http://www.liprc.org>

Host Provider: South Oaks Hospital

Counties Covered:

Suffolk

Counties with NO PRC

Albany	Franklin	Montgomery	Schenectady
Clinton	Fulton	Nassau	Schoharie
Columbia	Greene	Rensselaer	Warren
Essex	Hamilton	Saratoga	Washington
Franklin			

APPENDIX C

Definition of Direct and 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:
 - Health Promotion Event
 - Speaking Events
 - Telephone Information Services
 - 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:
 - Audio/Visual Materials
 - Newsletters
 - Public Service Announcements
 - Resource Directories
 - Other Printed Material
 - Internet-Site Content
 - Internet-Social Media
 - Newspaper-Content
 - Television-Radio-Content

APPENDIX D

OASAS Problem Gambling Prevention Policy

Since 2005 OASAS has had statutory oversight for problem gambling prevention, treatment, and recovery services. OASAS' oversight of problem gambling services is reflected in the 2012 Prevention Guidelines.

OASAS is focusing efforts on integrating problem gambling prevention into our statewide addiction services system. Beginning in 2013, all OASAS funded prevention providers integrated problem gambling prevention activities into their existing prevention services. Public Awareness is the current focus of this initiative. At least one person per agency will be trained by March 2014. Once a staff member has attended the training, they will be required to deliver the problem gambling information awareness presentation provided to them, in the form of face-to-face speaking events within their communities. Providers are to provide no less than three (3), and not to exceed five (5), information awareness presentations per Workplan cycle. This will be captured in PARIS as:

Service Approach: Information Awareness
Activity Code: Problem Gambling Speaking Events
Activity Name: *Write-In, Identified population*

This does not require a Workplan revision for the 2013-2014 Workplan. The activities should be entered as non-Workplan activities in the data collection module. Beginning with the 2014-2015 Workplan, problem gambling prevention activities should be planned and included during Workplan development.

If an agency experiences staff turnover and loses the person trained to present the problem gambling information awareness speaking events, then the agency must notify their OASAS Program Manager and identify another staff member to be trained within thirty (30) days of the vacancy.

For those providers who deliver Prevention Counseling services, it is required that they utilize an approved gambling screening/assessment tool when assessing individuals for need of services. These forms are found in the PARIS Knowledge Base under 2012 Prevention Guidelines – Related Links; then Screening Instruments; then Standardized Screening Instruments.

APPENDIX E



APPENDIX F

Recommended Best Practices for Delivery of EBP Education Services

The guidance below is intended to maintain and strengthen the fidelity of EBP implementation. While cultural and other adaptations to improve participant engagement and communication of program content are beneficial to successful delivery, changes to core elements such as target population, setting, “dosage” and curricula content have been shown to reduce outcome 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).

1. The Target Population age/grade groups selected match the developers’ EBP recommended age/grade groups.
2. The other Target Population demographics (race, ethnicity, gender, other cultural factors) match the developers’ EBP recommended demographics.
3. The Target Population Risk Factors identified in the needs assessment match the developers’ EBP Risk Factors outcomes reported in the PARIS Knowledge Base.
4. When on-site or Internet online training is recommended by the EBP developer and/or recommended based on the qualifications of delivery staff, staff are trained and training is documented.

Appendix G

Environmental Prevention Strategies

Environmental substance abuse prevention strategies were designed to impact the community, social, and economic contexts in which people access and consume alcohol, tobacco, or other drugs. 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 environmental prevention strategies employ a 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.

Community mobilization and media support are essential both to generate community support for the environmental changes and to promote their sustainability. These relatively new, effective EBPS and promising prevention strategies, like all effective prevention, must be based on a community needs assessment of the specific environmental factors that lead to substance related negative consequences. To be successful, multiple and reinforcing strategies must be planned and staged carefully.

What is not Environmental Prevention?

Providing information about substances of abuse or raising awareness of substance abuse and its health and social consequences through the media does not necessarily affect individual behavior. For example, the numerous public health awareness efforts to reduce heart disease and obesity have advised Americans to avoid high cholesterol foods, eat more fruits and vegetables, get more exercise and reduce alcohol and tobacco use. This information is widespread, familiar and repeated often, yet heart disease and obesity remain major public health problems. Informing individuals through the media about the negative consequences of a high cholesterol diet (an information/awareness activity) is not environmental prevention. Removing high fat food options from school lunch menus, thus making poor diet choices less available, would be an environmental prevention strategy.

Environmental prevention at its core involves reducing the availability of substances that cause health and social problems. General community mobilization and awareness of substance abuse issues is important, but as part of an environmental prevention plan, the community mobilization and communications/media activities are designed to support the specific environmental policy and enforcement improvement efforts in the community.

The regional OASAS Prevention Resource Centers (PRCs) have been trained in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) process to support community planning and delivery of environmental prevention strategies. They can provide training and technical assistance in needs assessment and in planning for effective use of environmental prevention strategies. See **Appendix B** for a listing of the PRCs, including locations, websites, and counties covered.

APPENDIX H

Environmental Prevention Strategies Evidence Rating Table

The Pacific Institute for Research and Evaluation (PIRE) researchers have reviewed the research literature on the outcome effectiveness of environmental prevention strategies on efforts to reduce the negative consequences related to alcohol use. The table following rates the level of evidence of effectiveness for each strategy/activity from “High” to “Low/No data available”. “High” level of evidence strategies are color-coded green, “Medium” are yellow, and “Low” or “Data not available” are red. *The studies reviewed reported only outcomes relevant to alcohol use and its related negative consequences.* The table includes Policy Change and Enforcement strategies, as well as Media/Communications efforts to support those strategies. The “intervening variables” factors are categories of the causal factors that are targets for the environmental strategy.

Following the Evidence Rating Table is another table, Environmental Prevention – EBP/Model Programs, that describes four (4) programs that utilize multi-component environmental prevention strategies that have been proven effective *in reducing alcohol use and its negative consequences.*

This appendix is provided as additional guidance to assist providers in selecting environmental prevention strategies. While some of the strategies listed have low levels of evidence and may be considered promising, OASAS is designating all environmental activities that meet the Performance Standards for planning as evidence-based strategies. The research on environmental efforts is relatively new, but their potential for achieving population level health improvement changes is high. The federal Center for Substance Abuse Prevention (CSAP), PIRE and OASAS are working together to promote the use of these strategies and to continue the research into their effectiveness.

Policy Change

Strategy	Strategy Description	Primary Targeted Intervening Variable	Consider the Strategy When...	Level of Evidence of Effectiveness
1. On-Premise Alcohol Outlet Use Regulations	Alcohol restrictions at establishments that allow alcohol consumption on premises (e.g., bars and restaurants). Examples include restricting hours of sale and alcohol promotions (e.g., happy hours and two-for-one drink specials). [Note: Although restricting retail outlet density is an effective strategy, it can only be regulated at the state level in NY by the State Liquor Authority.]	Retail Access	Patrons are able to purchase high quantities of alcohol in one sitting, DWI in tourist/entertainment corridors is high	High
2. Policies to Require Alcohol Outlet Server/Seller Training to Obtain or Renew License/Permit	Server/seller training refers to educating owners, managers, servers and sellers at alcohol establishments about strategies to avoid illegally selling alcohol 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. In addition, some individual establishments may voluntarily implement training policies in the absence of any legal requirements or incentives.	Retail Access	Alcohol outlets over-sell alcohol to patrons and/or sell alcohol to minors	Medium
3. Community Event Alcohol Use Regulations	Community event alcohol-use regulations are concerned with how and when alcohol use is regulated and can be sold at community events. Examples include beer gardens, sale of tokens for purchase, limiting number of drinks purchased, container size, etc.	Community Access	Alcohol is over-sold at events and/or is accessible to minors	High
4. Public Availability Policies	Alcohol restrictions on public property to control the availability and use of alcohol at parks, beaches and other public spaces. Restrictions can range from total bans on alcohol consumption to restrictions on the times or places at which alcohol can be consumed.	Community Access	Alcohol misuse is apparent in public places and/or minors bring alcohol to public places	Medium

Policy Change (cont.)

Strategy	Strategy Description	Primary Targeted Intervening Variable	Consider the Strategy When...	Level of Evidence of Effectiveness
5. 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	Beer kegs are a common source of alcohol for minors and large quantity encourages binge drinking and alcohol misuse	Low
6. Social Host Ordinance	Under social host liability laws, adults who serve or provide alcohol at their premises to minors or persons who are obviously intoxicated can be held liable if the person who was provided alcohol is killed or injured, or kills or injures another person.	Social Access	Adults over-serve alcohol in their homes and/or provide alcohol to minors	Low
7. Advertising Restrictions	Restrictions on alcohol advertising include any policies that limit the advertising of alcoholic beverages, particularly advertising that exposes young people to alcohol messages. Restrictions can be in the form of local ordinance or can be implemented voluntarily by a business, event or organization. Such restrictions can also include restrictions on alcohol sponsorship and advertising at events.	Alcohol Advertising	Alcohol advertising is commonly seen in community and at events.	Medium

Enforcement Strategies

Strategy	Strategy Description	Primary Targeted Intervening Variable	Consider the Strategy When...	Level of Evidence of Effectiveness
1. Alcohol Outlet Compliance Checks (Off- Premise)	A compliance check is a tool to identify alcohol establishments that sell alcohol to underage youth. The practice of conducting compliance checks 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 alcohol to underage youth. Compliance checks can also be voluntarily implemented by law enforcement or licensing authorities. Generally, compliance checks are implemented by the following procedures: (1) Alcohol licensees are informed that compliance checks will occur at various times throughout the year and about potential penalties for selling alcohol to underage youth; (2) While an enforcement agent (police officer or other authorized person) waits outside the premises, a person under age 21 attempts to purchase or order an alcoholic beverage; (3) If the alcohol establishment sells alcohol to the young person, the enforcement agent issues a citation either to the seller/server or to the establishment.	Retail Access	Minors can readily purchase (or perceive they can readily purchase) alcohol at off-premise locations	High
2. Alcohol Outlet Compliance Checks (On- Premise)		Retail Access	Minors can readily purchase (or perceive they can readily purchase) alcohol at on-premise locations	High

Strategy	Strategy Description	Primary Targeted Intervening Variable	Consider the Strategy When...	Level of Evidence of Effectiveness
3. Alcohol Outlet Compliance Surveys (On - Off Premise)	Alcohol outlet surveys are 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, alcohol surveys are a way to educate retailers about their practices, without giving them a citation. Communities conduct alcohol surveys in cases where compliance checks are not legally permitted by the state, when communities want to educate rather than penalize establishments, or when they have difficulty gaining the cooperation of law enforcement.	Retail Access	Minors can readily purchase (or perceive they can readily purchase) alcohol at off-premise locations	High
4. Cops in Shops	The program places law enforcement officers behind the counter of participating establishments, posing as clerks, and outside the store, to deter adults from purchasing alcohol for minors. The program includes warning signs prominently displayed in the establishments, and local media coverage to increase young people's perception that they will be apprehended if they attempt illegal purchases.	Retail access	Minors can readily purchase (or perceive they can readily purchase) alcohol at off-premise locations	Low
5. 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.	Retail Access	Minors can readily purchase (or perceive they can readily purchase) alcohol at off-premise locations	Data not available

Strategy	Strategy Description	Primary Targeted Intervening Variable	Consider the Strategy When...	Level of Evidence of Effectiveness
6. Sobriety Checkpoints to Enforce Impaired Driving Laws	Sobriety checkpoints are traffic stops where law enforcement officers systematically select drivers to assess their level of alcohol impairment. The goal of these interventions is to deter alcohol-impaired driving by increasing drivers' perceived risk of arrest. Two types of sobriety checkpoints exist. Selective breath testing (SBT) checkpoints are the only type used in the United States. At these checkpoints, police must have a reason to suspect that drivers have been drinking before testing their blood alcohol levels.	Driving Laws	Drinking and driving is common (or perceived to be common)	High
7. DWI Tip Lines to Enforce Impaired Driving Laws	Increasing awareness and citizen use of toll-free tip phone hotlines to report impaired driving to law enforcement.	Driving Laws	Drinking and driving is common (or perceived to be common)	Data not available
8. Shoulder Tap Surveillance	Shoulder-tap enforcement programs are similar to compliance check programs except that they target the non-commercial supplier. A young decoy approaches adults outside an alcohol outlet and requests that the adult purchase alcohol on the decoy's behalf. It targets the program to locales where problems have been reported and 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) alcohol from unknown adults who purchase it	Medium
9. Party Patrols	Neighborhood "party patrols," tailored to address unruly parties hosted in residential areas, can be a tool in reducing problems associated with these gatherings. 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 alcohol for minors	Low
10. Enforcement of open container laws	Activities by law enforcement to patrol public places for the use of alcohol.	Social/Community Norms	Alcohol misuse is apparent in public places	Data not available

Media/Communication Strategies

(must be used in addition to a Policy Change Strategy or in support of Policy Change Strategy)

Strategy	Strategy Description	Primary Targeted Intervening Variable	Consider the Strategy When...	Level of Evidence of Effectiveness
1. Alcohol Warning Signs	Alcohol warning posters are notices or signs located in alcohol establishments that provide information related to the legal, social, and health consequences of alcohol use. Posters may be required by local ordinance, or used voluntarily by alcohol establishments	Retail Access	Supporting retail policy and enforcement	Low
2. 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.	Retail Access	Supporting retail policy and enforcement	Data not available
3. Social Norms Misperceptions Campaigns	Social norms misperceptions campaigns aim to alter the perceptions that people have about how much their peers actually drink. Typically, data must be collected about actual drinking and perceptions of drinking (whereby it is often found that people perceive there to be much higher levels of drinking than is actually reported). Media efforts are then implemented to educate people that their peers really do not drink as much as they think. This, in turn, leads to reduced levels of overall drinking. An example of this is the "Most of Us" campaign.	Social/Community Norms	Data on perceptions about alcohol use frequency/amount are higher than data on actual frequency/amount of alcohol use	Medium
4. Counter-Advertising	Counter-advertising involves disseminating information about alcohol, its effects, and the advertising that promotes it, to decrease its appeal and use. Counter-advertising strategies directly address alcohol 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 alcohol marketing.	Social/Community Norms	Attempting to change community attitudes; supports all strategic efforts	Medium

Strategy	Strategy Description	Primary Targeted Intervening Variable	Consider the Strategy When...	Level of Evidence of Effectiveness
5. Social Marketing	Social marketing uses standard marketing techniques to promote healthier community norms, persuade people to reduce harmful behaviors and/or increase socially positive behaviors.	Social/Community Norms	Attempting to change community attitudes; supports all strategic efforts	Medium
6. Media Advocacy	Media advocacy involves the use of unpaid media to highlight a community issue and to advocate 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. <i>The whole point of media advocacy is to advocate for policy change and/or policy enforcement.</i>	Social/Community Norms	Supporting all strategic efforts	Data not available

Resources used to develop this guidance document:

- Birkmayer, J.D., Boothroyd, R.I., Fisher, D.A., Grube, J.W., & Holder, H.H. (2008). Prevention of Underage Drinking: Logic Model Documentation. PIRE, Calverton, MD.
- CADCA (2010). Research Support for Comprehensive Community Interventions to Reduce Alcohol, Tobacco, and Drug Use and Abuse. CADCA, Alexandria, VA.
- South Dakota SPF SIG Evidence Based Prevention Selection Guide (2011).
- Toomey, T.L., Lenk, K.M., & Wagenaar, A.C. (2007). Environmental policies to reduce college drinking: An update of research findings. *Journal of Studies on Alcohol and Drugs*, 68, 208-219).
- University of Minnesota, Alcohol Epidemiology Program: <http://www.aep.umn.edu>
- Underage Drinking Enforcement Center: <http://www.udetc.org>

Environmental Prevention – EBP/Model Programs

Curriculum	Target Population	Key Strategies	Key Outcomes/ Findings	Resources/Trainings
<p>Border Binge-Drinking Reduction Program is a coordinated effort focused on reducing cross-border teen and binge drinking in the San Diego-Tijuana region through a policy-focused, public health, prevention model. This project is a partnership of the PIRE, responsible for the border crossers survey and project evaluation, and the IPS, responsible for project interventions and newsmaking to mobilize support for policy change. Further descriptions of the nature of cross-border binge-drinking problems and the impact of the San Diego-Tijuana Border Program are available on the PIRE Web site.</p>	<p>Alcohol Focused •Ages 24 and under •Male and Female •Multiple ethnic groups •Rural & Urban Communities</p>	<p>Environmental Strategies: •Community Involvement •Information Sharing •Media Education Other Strategies: •Skill Development</p>	<p>•Reduced number of young Americans returning to the US with illegal BACs after night of drinking in Mexico •Reduced number of alcohol-related injury crashes among underage drinkers •Reduced number of arrests for violence and other problems •Increased awareness of new enforcement program.</p>	<p>• No formal training or materials</p>

Curriculum	Target Population	Key Strategies	Key Outcomes/ Findings	Resources/Trainings
<p>Challenging College Alcohol Abuse Challenging College Alcohol Abuse (CCAA) is a social norms and environmental management program that reduces high-risk drinking and related negative consequences in college students (18 to 24 years old). Under CCAA, the campus health service uses new and innovative methods to communicate public health information to students, the campus community, and the surrounding community.</p>	<p>Alcohol Primarily Focused, Illegal Drugs</p> <ul style="list-style-type: none"> •Ages 18-24 and parents •Male and Female •African American American Indian/Alaska Native Asian American Hispanic/Latino Native Hawaiian and Other Pacific Islander (NHOPI) White •Rural, Suburban, and Urban college and university campuses and communities 	<p>Environmental Strategies:</p> <ul style="list-style-type: none"> •Social norms media marketing campaign •Environmental management •Alcohol-Specific prevention program <p>Other Strategies:</p> <ul style="list-style-type: none"> •Moderation skills training 	<ul style="list-style-type: none"> •Reduced negative consequences of alcohol & illegal drug use •Decreased positive perceptions of alcohol use •Reduction in alcohol and illegal drug-related crimes •More accurate perceptions of students alcohol & illegal drug use •More accurate perception of negative consequences 	<p>Requires training on environmental prevention techniques such as social norms and social marketing. Costs dependent upon assessment and individual consultation. Materials vary given the needs of the school and local environment.</p>

Curriculum	Target Population	Key Strategies	Key Outcomes/ Findings	Resources/Trainings
<p>Communities Mobilizing for Change on Alcohol (CMCA) CMCA employs a range of social organizing techniques to address legal, institutional, social, and health issues in order to reduce youth alcohol use by eliminating illegal alcohol sales to youth by retailers and obstructing the provision of alcohol to youth by adults.</p>	<p>Alcohol Focused •Ages 13-20 •Male and Female •Multiple Ethnic Groups •Rural, Suburban, and Urban communities</p>	<p>Environmental Strategies: •Limits minors' access to alcohol by focusing on community mobilization efforts.</p>	<p>•Reduction in sales to minors •Increased identification checks by vendors •Community mobilization</p>	<p>• No formal training or materials</p>

Curriculum	Target Population	Key Strategies	Key Outcomes/ Findings	Resources/Trainings
<p>Community Trials Intervention to Reduce High-Risk Drinking (RHRD) is a multi-component, community-based program developed to alter alcohol use patterns of people of all ages (e.g., drinking and driving, underage drinking, acute (binge) drinking), and related problems. The program uses a set of environmental interventions including: The program's aim is help communities reduce various types of alcohol-related accidents, violence, and resulting injuries.</p>	<p>Alcohol Focused •All ages within a community •Male and Female •Multiple Ethnic Groups •Rural, Suburban, & Urban communities</p>	<p>Environmental Strategies: •Community awareness •Responsible Beverage Service (RBS) •Preventing underage alcohol access •Enforcement •Community mobilization</p>	<p>•Reduced driving when over the legal limit •Reduced amount consumed per drinking occasion •Reduced traffic crashes in which driver had been drinking •Reduced assault injuries</p>	<p>Materials available at a reproduction cost. Also available in Spanish. Initial telephone consultation is provided at no-cost. Additional technical assistance is negotiated.</p>

Source: The Center for Applied Research and Solutions (CARS), California SIG Resource Binder.

APPENDIX I

Recommended Best Practices for Planning and Delivery of Positive Alternatives

Research supported by SAMHSA has produced evidence that Positive Alternative activities can be an effective addition to EBP's for selective and indicated youth. This research with high-risk youth in forty-six (46) after-school programs found that only interactive, well structured programs with engaged staff were able to decrease the progression to more frequent substance use for high-risk youth who had initiated use. The evaluation summary found that Positive Alternatives were only effective when they:

- Used interactive and experiential learning methods rather than passive lecture-style approaches
- Fostered bonding with adults through opportunities and rewards for prosocial behavior
- Promoted the self-examination of substance use attitudes through role plays and group discussions
- Used the activities to practice the skills taught in EBP education – anger management conflict resolution, decision making, other social skills
- Planned the activities to reinforce a central theme (conceptual coherence)
- Maintained a structured and consistent delivery of planned activities at set times
- Were delivered by staff who felt reasonably supported and empowered

Looking at all the above elements needed for Positive Alternative programs to be successful, it may make sense to select an EBP Education model and then add Positive Alternatives to complement and reinforce the EBP educational components.

APPENDIX J

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 provides assistance to, 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.