



New York State
Office of Alcoholism & Substance Abuse Services
Addiction Services for Prevention, Treatment, Recovery

2009 PREVENTION GUIDELINES:

ALCOHOL, TOBACCO, OTHER DRUG ABUSE and
PROBLEM GAMBLING PREVENTION PROGRAMS

June 2009

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PREFACE

The primary purpose of these prevention guidelines is to define and describe the strategies and activities necessary to attain comprehensive and effective alcohol, tobacco, substance abuse and problem gambling prevention services within the framework prescribed by the New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS). These guidelines also seek to clarify minimum program performance standards in the areas of service availability and delivery, personnel and fiscal practices, recordkeeping, and data reporting. The guidelines will also assist the prevention field, counties and regulatory bodies to implement and enhance consistent prevention delivery and oversight throughout New York State. OASAS will review these guidelines every two years and revise as necessary as new prevention information and knowledge is gained, with input from a team comprised of providers, county, and OASAS staff.

The 2009 guidelines represent a revision to the 1995 Prevention Guidelines and should be maintained at each program site as a reference guide. These guidelines will go into effect September 1, 2009. All prevention 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). 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 document, alcohol, tobacco and other drug use or abuse will be referred to as substance use or abuse, in order to read more succinctly.

Section I:

THE PREVENTION FRAMEWORK

OASAS defines prevention as a pro-active, evidenced-based process utilizing effective programs and strategies to prevent or reduce substance use, and problem gambling in individuals, families, and communities. The OASAS Prevention Framework is grounded on research that substance abuse is preventable and that prevention is the most cost-effective element in the continuum of substance abuse services. Practitioner experience and research have shown that to accomplish substance abuse prevention goals, a range of programs and practices must be provided within a coordinated and sustainable community service system. The development of a comprehensive continuum of population level and targeted prevention services must be planned based on knowledge of a community's unique risk and protective factor profile. Research and practitioner experience have also documented that substance abuse is inter-related, in a very basic way, to a host of other social problems and health compromising behaviors.

The Prevention Framework is based upon a body of research spanning two decades that identifies risk factors and protective factors that predict youth problem behavior. This research was advanced into the Social Development Model by Drs. J. David Hawkins and Richard Catalano at the University of Washington and many colleagues over time. The model incorporates social learning theory, developmental stage theory, problem behavior theory, and the biopsychosocial model. The OASAS Prevention Framework is based on this model. A major strength of this model is that in targeting risks for substance abuse, it also addresses other problem behaviors, such as delinquency, teen pregnancy, school dropout and violence. There is now some preliminary evidence from studies that some risk and protective factors for problem youth behavior also predict problem gambling.

The OASAS Prevention Framework now identifies 20 risk and 11 protective factors that operate in four Domains, or life arenas: Individual/Peer, Family, School, and Community (see Table 1). Simply put, the risk factors increase the probability of a behavior (e.g., substance abuse) and protective factors mediate or buffer the negative effects of exposure to risk (see Table 2). Each of the four Domains can be a setting for service delivery of evidence-based programs and practices (EBPs) shown to improve the levels of the risk and protective factors. Research has shown that the most effective prevention systems use multiple strategies that operate across multiple domains. This research is why OASAS relies on data-driven planning and the strength of prevention coalitions, since no single service system or institution can effectively do this work alone.

Table 1

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. Community Laws and Norms Favorable Toward Substance Use	√	√			√
3. Transitions and Mobility	√	√		√	
4. Low Neighborhood Attachment	√	√			√
5. Community Disorganization	√	√			√
6. Extreme Economic Deprivation	√	√	√	√	√
Family					
7. Family History of the Problem Behavior	√	√	√	√	√
8. Family Management Problems	√	√	√	√	√
9. Family Conflict	√	√	√	√	√
10. Parental Attitudes Favorable Towards Drugs / Other Problem Behavior	√	√			√
School					
11. Academic Failure	√	√	√	√	√
12. Low Commitment to School	√	√	√	√	√
Individual and Peer					
13. Early Initiation of Drug Use	√	√	√	√	√
14. Early Initiation of Problem Behavior	√	√	√	√	√
15. Rebelliousness	√	√		√	
16. Friends Who Use Drugs / Engage in Other Problem Behavior	√	√	√	√	√
17. Favorable Attitudes Toward Drug Use / Other Problem Behavior	√	√	√	√	
18. Perceived Risk of Drug Use	√				
19. Peer Rewards for Drug Use	√				
20. Depressive Symptoms	√				

√ Indicates that 2 or more prospective studies have found the risk factor to predict the youth problem behavior.

Table 2

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 Prosocial Involvement
8. School Rewards for Prosocial Involvement

Individual & Peer

9. Religiosity
10. Belief in the Moral Order
11. Social Skills

Research Findings:

- All Risk and Protective factors from the research predict youth (ages 10-20) 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 academic testing scores at the school district level.
 - Risk factors increase the probability of problem behaviors.
 - Protective factors decrease the probability of problem behaviors.

Guidance to consider when applying the framework:

- Risk and protective factors operate and interact across several domains. Some are characteristics of the individual; others are those of families, peers, schools and communities.
- Different risk factors are related to different periods of development. For example, early initiation of problem behavior refers to younger children in grades K-3, however 'early initiation of substance use' is a risk for pre-teens in intermediate grades 6-8.
- When more risk factors are at higher levels, substance use prevalence is higher. Large youth population surveys in NYS have shown that in the absence of any high risk factors, current marijuana use was lower than average. But 70 percent of youth with 10 or more elevated risk factors reported current marijuana use.
- Risk and protective factors show consistency over time and across different races, cultures, and classes. While the levels of individual risk factors for different groups may vary, they do appear to operate in the same way.
- Most of the research on risk and protective factors has been conducted on youth 10 – 20 years old. However, this should not be interpreted that OASAS excludes other age groups for prevention efforts. OASAS supports prevention efforts across the life cycle when a documented need exists.

As already stated, while focusing on the multiple **risks** that young people face, it is equally important to increase **protective** factors. Prevention programs that strengthen protective factors by providing more opportunities, skills, rewards for pro-social behavior, and by developing consistent standards for behavior across families, schools, communities are more likely to be effective.

A. Prevention Goals

As more is learned about substance abuse and problem gambling, more effective prevention strategies are being developed, tested and validated. There is general agreement that investing in prevention has a far greater return on value, in human as well as economic terms, than allowing problems to develop and attempting to treat them. While New York has a continuing commitment to treat those individuals suffering the consequences of substance abuse and problem gambling, our parallel responsibility is to intervene efficiently and effectively in the process that leads individuals to make unhealthy choices. New York's investment in prevention is an essential component of a long-term strategy and an integrated part of a larger continuum of services to reduce substance abuse and problem gambling that includes addiction treatment and recovery services.

The primary goals of substance abuse and problem gambling prevention are:

1. To reduce the prevalence of substance use and abuse and problem gambling in the New York population.
2. To delay the initiation of substance use and gambling behaviors among youth as long as possible.
3. To decrease the negative health, social and economic consequences and costs associated with substance abuse and problem gambling.
4. To prevent the escalation of substance use and gambling behaviors to levels requiring treatment through early identification, brief intervention and referral.

B. Needs Assessment and Planning

It is important that OASAS-funded providers base their selection of prevention services on a local needs assessment that identifies elevated risk factors, decreased protective factors, and the problem behaviors to be addressed. These local needs assessments may be conducted solely by the provider, but are much more efficient if conducted as part of a community coalition or in collaboration with the county and/or community service networks.

In addition to identifying and prioritizing risk factors and protective factors, the NYS OASAS Prevention Framework stresses the importance of utilizing evidence-based programs and strategies in multiple domains and working with multiple systems to deliver a consistent, cohesive message. This approach has been demonstrated by research to have the greatest impact in preventing or reducing problem behaviors and thus achieving healthy outcomes.

The framework recognizes and emphasizes the impact of utilizing environmental strategies that address population level norms towards substance use, substance availability, and regulations and policies. Many environmental strategies are evidence-based practices and research has demonstrated that these strategies can affect entire communities and result in population-level changes in substance use and abuse.

C. Evidenced-based Programs and Practices (EBPs)

As defined by OASAS, Evidenced-based Programs and Practices (EBPs) have been tested for effectiveness by research studies and found effective in reducing risk factors and enhancing protective factors that predict problem behaviors including substance use and abuse. The studies ideally employ an experimental design or at a minimum a quasi-experimental design with matched comparison groups. The studies ideally are published in peer reviewed journals, or have been reviewed by a national research review panel, such as the National Registry of Evidence-based Programs and Practices (NREPP). To be accepted, the study must have shown significant and positive effects on substance use and/or the OASAS Prevention Framework Risk and Protective factors. The framework's

emphasis is on reducing the risk factors and enhancing the protective factors (both within individualized environments and within the shared environment) that have been demonstrated by research to be predictive of substance use and problem gambling. OASAS also recognizes that while more research is needed, the prevention process is relevant throughout the life cycle and not solely applicable to youth.

NYS OASAS is updating its EBP registry of programs and practices that have been shown through research to positively affect substance use, and/or the risk and protective factors associated with substance abuse. Providers may submit innovative programs and practices that may not be currently categorized as an EBP to OASAS for review and approval as appropriate. As new programs and practices are determined to meet applicable requirements, OASAS will continue to add to our EBP tool kit. When research is available, we hope to include EBPs to reduce problem gambling behavior.

An excellent resource on EBPs for prevention comes from the federal Center for Substance Abuse Prevention (CSAP), called: *Identifying and Selecting Evidence-Based Interventions Revised Guidance Document for the Strategic Prevention Framework State Incentive Grant Program* (HHS Pub. No. (SMA)09-4205. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009). This guidance document spells out how to determine if an EBP is a good fit for your cultural contexts, population needs and how to rate the research evidence provided. Section IV of this document referenced above provides three definitions of EBPs, and the first two are used by OASAS:

1. Inclusion in Federal registries of evidence-based interventions;
2. Reported (with positive effects on the primary targeted outcome) in peer-reviewed Journals.

Section II: SERVICE SYSTEM

A. Service Approaches

The following service approach categories have been defined by the Center for Substance Abuse Prevention (CSAP) and OASAS as important elements of a comprehensive prevention service plan. NYS OASAS has adapted the CSAP framework to include problem gambling prevention strategies and prevention counseling, including early identification and brief intervention. Substance abuse and problem gambling prevention strategies include:

1. Positive Alternatives

Provides for the participation of target populations in constructive and healthy activities that exclude drug use and gambling and includes a clear no use

message. Positive alternatives also provide opportunities for social bonding to positive role models who can change attitudes towards substance abuse as a lifestyle;

2. Community-Based Process

Aims to enhance community involvement in substance abuse and problem gambling prevention by building community coalitions and training community members and agencies as partners in prevention;

3. Prevention Education

Uses activities and educational presentations to: teach family and youth the consequences of substance use; improve drug abuse and other problem behavior attitudes and teach drug refusal and other social skills;

4. Environmental Approaches

Establishes activities to change written and unwritten community standards, policies, and attitudes that tend to tolerate, accept, or support the abuse of substances and problem gambling in the general population;

5. Information and Awareness

Provides accurate information and increases knowledge and awareness of the nature and extent of problem gambling, substance use, abuse and dependence, and their effects on individuals, families, and communities; and

6. Prevention Counseling

Prevention counseling is a short term, problem resolution focused service that concentrates on resolving identified problems and/or assessing and improving the level of youth and family risk and protective factors that are predictive of substance abuse and/or problem gambling. It includes screening and referral for individuals who are abusing substances or may be developing gambling problems and require referral to appropriate treatment services. It does not include treatment for mental illnesses or addictions.

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

The National Institute of Medicine (IOM) categorizes prevention populations into three classifications: universal, selective and indicated, as defined below. Prevention activities may be subsequently categorized into those that are designed for each of these three population categories. Providers are not required to deliver services in all three service categories, but they are required to choose the most effective and appropriate for the needs of their target population.

1. Universal

Activities designed for universal populations prevent the onset of substance use

and gambling, by reaching entire populations (whether national, local community, school, or neighborhood in scope) with messages and programs aimed at preventing the use of substances and gambling behavior. These universal prevention strategies increase public awareness, change community norms and help develop the social and other life skills necessary to prevent initiation of the problems.

2. Selective

Selective prevention activities 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; or older adults who take medication and consume alcohol. 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 is based solely on membership in the at-risk subgroup.

3. Indicated

Indicated prevention strategies are designed to reduce individually assessed risk factors and/or the use of substances and gambling behaviors. Indicated populations do not meet DSM-IV criteria for substance abuse or dependence, or pathological gambling, but they are exhibiting symptoms, such as substance use and/or gambling behaviors. The aim of indicated prevention programs is not only reduction in levels of substance use or gambling, but also the decrease in the length of time the signs continue, and/or reducing the need to refer to treatment services.

C. Need for Comprehensive and Integrated Community Prevention

Providers can help to increase the understanding of substance abuse and problem gambling issues in communities and improve the use of community resources for substance abuse and problem gambling prevention through their participation in community coalitions. Providers can, in addition to offering planning and prevention science expertise, support coalitions and communities by training *Other Impactors*, such as social services staff, teachers, health professionals, parents, youth groups, citizen volunteers, etc., who will help to improve the Risk and Protective factors prioritized by counties, coalitions and in provider workplans. To successfully build community coalitions, deliver environmental strategies and many other services, prevention professionals' work with *Other Impactors* to help achieve our goals in the prevention framework and EBPs. Substance abuse and problem gambling are a persistent and complex public health concern requiring a comprehensive multi-faceted prevention approach. Communities that employ multiple

strategies, across multiple domains, and that are implemented throughout the life cycle will realize the greatest impact. Prevention services have a broader reach when they can be integrated within existing support services for families, in schools and other community institutions.

Providers select prevention activities and initiatives based on a prioritization of risk and protective factors identified in their needs assessment, and documented in the Prevention Activities and Results Information System (PARIS). These needs assessments are required to be updated annually in PARIS. OASAS encourages shared needs assessment and planning processes with community coalitions, other service providers and their counties for a more comprehensive and efficient approach. Shared planning is not easy, but it can result in greater community acceptance and support for prevention strategies.

D. Coalition and Integration Support from Regional Prevention Resource Centers

The OASAS Regional Prevention Resource Centers (PRC's) provide training and technical assistance to community coalitions and prevention providers to improve planning and build capacity for expanding EBPs. Working in partnership with counties and OASAS prevention providers, the PRC's help communities by strengthening existing coalitions and collaborating with community stakeholders in a multi-county area. The focus on EBPs will lead to changes in community attitudes, norms and behaviors that will better address community factors that drive alcohol, other drug abuse and problem gambling behavior.

1. The goals of the PRCs' are twofold:

- To facilitate the building of partnerships between counties, prevention providers, schools, and communities to increase delivery of EBPs.
- To align the services and resources among the OASAS-funded prevention network and counties, and to better address the needs of the communities by transferring essential prevention knowledge across systems while integrating current prevention science to practice.

2. The Regional PRC services include:

- Disseminating current prevention science;
- Assisting coalitions and prevention providers in bringing that science to practice;
- Building and sustain the capacity of community coalitions and increase the number of community coalitions in the region;

- Supporting partnerships among providers, counties, schools and community groups in the region.

E. Activity Reporting - Prevention Activities and Results Information System (PARIS)

PARIS is the OASAS prevention data reporting system for all direct prevention services. PARIS was developed with the input and feedback of providers, counties and OASAS for the purpose of collecting and sharing information on the direct services delivered by OASAS service providers. Management, supervision, needs assessment, staff development, travel, document preparation (handouts, workbooks, educational materials) and other provider activities not related to the actual delivery of direct services are not reported in PARIS. The following service approach categories and their activities are further defined in the PARIS Library reference documents (Activity Codes and Environmental Strategies Definitions).

1. Substance Abuse Education - Evidence-Based Programs (EBP - Models)

These group programs use multi-session curricula alone or within a comprehensive multi-component approach to increase youth and/or family understanding of the consequences of substance use, improve attitudes towards drug abuse and other problem behaviors and teach drug refusal and other social skills. These programs appear on federal EBP registries and have been researched and shown to reduce youth substance use and/or risk and protective factors when implemented as designed.

2. Substance Abuse/Problem Gambling/Other Education Programs (Non-EBP)

These programs are similar to the EBP education programs described above, but do not have evidence of effectiveness from research studies. Some have been locally developed, adapted from the evidence-based models, or purchased from outside developers. Many local programs have been developed to meet local school or community needs.

3. Environmental Strategies (EBP)

Researchers have identified three interrelated environmental factors that predict population levels of alcohol, and tobacco usage, i.e., community norms regarding substance abuse, the availability of alcohol and other drugs and substance abuse policies and regulations. Environmental strategies were developed to: 1) improve substance use regulations and policies; 2) increase compliance with regulations and policies to reduce the availability of alcohol, tobacco and other substances; and 3) change community norms regarding substance abuse. Examples of environmental activities include alcohol outlet compliance checks, alcohol outlet server training, social norms marketing, and the

development and implementation of policies to reduce the availability and public use of alcohol and underage gambling.

These strategies were successfully employed by governments and coalitions over the last decade and have resulted in record decreases in the population prevalence of tobacco use. These strategies can be applied to other problem behaviors, including underage drinking, other substance use and gambling. Additional environmental activities may be used if they are evidenced-based.

4. Prevention Counseling

Prevention counseling is a short-term, problem-resolution focused activity that concentrates on resolving identified problems and/or assessing and improving the level of youth and family risk and protective factors that are predictive of substance abuse and/or problem gambling. Goals include delaying first use of substances and gambling; reducing substance use and problem gambling and the negative consequences caused by substance use and gambling behaviors. Prevention Counseling is for those individuals who are considered at highest risk for developing substance abuse or gambling problems, as well as for individuals who have already begun to experience substance abuse or gambling problems and for those who may require referral to treatment or other more intensive services. Prevention counseling components include Assessment and Referral, Individual Counseling, Group Counseling and Family Counseling.

5. Positive Alternative Activities – (Single Session Continuing in PARIS)

Positive alternatives offer opportunities for pro-social interaction and improving social skills. They include after-school programming such as: fitness-sports, arts and multicultural activities that help to develop a healthy lifestyle. Positive alternatives also provide opportunities for social bonding to positive role models who can change attitudes towards substance abuse as a lifestyle. Clear, consistent, no-use messages are an important component.

6. Information Dissemination – (Single Session Activity in PARIS)

Information Dissemination activities are intended to inform the general and specific populations about the issues of substance use or abuse and/or problem gambling. Information Dissemination activities provide knowledge of the nature and extent of substance abuse and/or problem gambling and their effects on individuals, families, and communities as well as increase awareness of available prevention programs and services. They can be provided directly at community or school meetings or events. Examples include prevention training, technical assistance to schools, social service providers, law enforcement, community organizations or other groups.

7. Community Coalition Development

The use of prevention science helps prevention providers, communities, and programs build capacity to identify and address risk and protective factors and environmental conditions related to substance use/abuse and problem gambling. The most effective way of engaging these multiple systems in prevention efforts is through local community coalitions. More than any other entity, community coalitions are poised to connect multiple sectors, including businesses, parents, media, law enforcement, schools, faith organizations, health providers, social service agencies, and government. Acting in concert, coalition partners gain a more complete understanding of the community's problems and together engage in a process to identify problems and implement evidence-based solutions. The result is a comprehensive, community-wide approach that promotes the healthy development of young people while decreasing problem behaviors such as substance abuse, problem gambling, delinquency, teen pregnancy, school drop outs and violence. Coalition building additionally makes efficient use of limited community resources. By connecting multiple sectors of the community in a comprehensive approach, community coalitions can achieve measurable outcomes in substance abuse and problem gambling prevention.

NYS OASAS funded Prevention Providers are expected to:

1. Assist communities in establishing prevention coalitions, where needed;
2. Be active participants in existing substance abuse and/or problem gambling community coalitions;
3. Lead or assist in community coalition planning efforts, including needs and resource assessment and service planning;
4. Document in their OASAS annual Workplan their planned activities to support community coalitions; and
5. Cooperate with Prevention Resource Centers (PRCs).

Section III. RESULTS-ORIENTED PROGRAMMING

- A. In their annual Workplans, prevention providers must identify the expected results of their prevention activities. During the Workplan review and approval process, the prevention provider, County 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 - A. Prevention Goals. As a part of local

county planning for prevention services, County - LGU's and OASAS review the providers' Workplans and either approve them or request modifications.

Each prevention provider must define their expected results as Workplan "Performance Targets." Performance targets are the specific changes in behavior, risk and/or protective factors or environmental conditions for a specified number or percentage of participants or populations. The format for writing Performance Targets is specified in PARIS.

B. Providers must have at least one performance target for each of the following service approaches selected, i.e.:

- Substance Abuse Education – EBPs (Model Programs);
- Substance Abuse/Problem Gambling/Other Education (Non-Model Programs);
- Prevention Counseling; and
- Environmental Strategies.

C. In an effort to continually improve performance, providers should review their output and outcome data on a regular basis, i.e., at least annually, and make necessary changes to their service approaches, service locations and/or service levels projected in the Workplan. Providers should, on an annual basis, analyze and compare their actual output to what was projected in the Workplan and make necessary changes to the upcoming year's Workplan based on that comparison/analysis.

D. Providers are requested to utilize evidenced-based programs and strategies whenever possible. Providers should conduct those evidenced-based prevention programs with the highest possible level of program fidelity. Program fidelity is measured in PARIS for Substance Abuse education – EBPs (Model Programs). Sampling methods will be defined in PARIS in the future.

E. Standards for Delivery of Evidence Based Programs (EBPs)

Prevention EBPs currently include multi-component model programs, educational programs and environmental strategies. A primary mission outcome for OASAS is to increase EBP services in communities, but resource constraints have limited their implementation. The following minimum standards were developed taking into account current economic realities. Additional time has been allowed for cooperative planning within the system and identification of resource allocation options that will support the expansion of EBPs. OASAS will convene a committee of stakeholders to develop an EBP capacity building plan with state partners, counties and providers.

Beginning in 2011, all providers will be required to dedicate a percentage of their OASAS resources to the delivery of EBPs. The EBP delivery standards will go into effect January 1, 2011 for calendar year providers and July 1, 2011 for NYC providers.

<u>Year</u>	<u>EBP Minimum Standard</u>
2011	35%
2012	40%
2013	45%
2014	50%
2015	55%
2016	60%
2017	65%
2018	70%

F. Method to Calculate Percentage EBPs

NYS OASAS will calculate the EBP percentage of services delivered to measure providers' progress in meeting the new EBP Standard. The calculation method will be developed and published in PARIS before the applicable 2011 EBP Standard start date as noted above. Evidence-Based Programs currently include:

1. Comprehensive multi-component programs (e.g. Project Success, Project Northland);
2. Substance abuse education (EBP) (e.g., Life Skills Training, Project Alert); and
3. Environmental strategies.

G. Management Plan

If, after a review, providers have not met these EBP standards and/or other areas of required performance, the OASAS Field Office will prepare a Management Plan recommending the next steps to be taken by OASAS, the County/LGU and/or the provider. This Plan will include written notification to the direct contractor or to the LGU, with copies to its provider, that:

- describes the performance deficiencies identified;
- offers technical assistance to correct these problems;
- includes specific dates when the provider will submit a plan for improving performance with milestones to ensure that the performance targets are met;
- gives notice that failure to correct these problems will negatively impact on the future funding of the program. (Local Services Bulletin No. 2000-03:

Annual Program Performance Reviews – NYS OASAS-Funded Treatment Programs)

H. Federal Center for Substance Abuse Prevention (CSAP) National Outcome Measures (NOMs)

Providers should be familiar with CSAP's National Outcome Measures (NOMs) and are encouraged to positively impact these outcomes for the target populations they deliver services to. The CSAP NOMs are:

- Past 30-day substance use/gambling;
- Binge drinking;
- Perceived risk/harm of substance use;
- Age of first substance use;
- Perception of disapproval/attitude of substance use;
- Substance abuse/gambling-related suspensions, expulsions and attendance;
- Family communication around substance use/gambling; and
- Youth seeing, reading, watching or listening to a prevention message.

Further information on the CSAP National Outcome Measures can be found at:

http://www.nationaloutcomemeasures.samhsa.gov/outcome/index_2007.asp

Section IV. ADMINISTRATIVE OPERATION

- A. Each provider must designate a supervisor whose responsibilities are overseeing day-to-day operations, that include administrative, programmatic and prevention counseling (if provided).
- B. Each provider must have this information for program operations approved by its governing authority. These items should be made available to all staff. These should include the following:
1. Organizational chart;
 2. Organizational purposes/goals;
 3. Program days/hours of operation;
 4. Site locations, including hours of operation;
 5. Description of services provided;
 6. Incident reporting procedure;
 7. Description of supervisory process;
 8. Copies of all forms (internal/external) used by the program (e.g. evaluation tools, data collection forms, etc.);

9. Copies of all curricula being used by the provider;
10. Child abuse reporting procedure;
11. Description of confidentiality* and/or privacy procedures and
12. Approved NYS OASAS Workplan.

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

- C. Adequate space, which is clean, safe, and accessible, should be available for all staff providing prevention services.
- D. Prior approval is required by OASAS to fill 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)
- E. Funded prevention staff working at school locations shall not be required to perform non-prevention functions (i.e., act as lunchroom or hall monitors; provide substitute classroom coverage unrelated to substance abuse prevention services, etc.).
- F. If a provider does not deliver services year round, they should identify in the PARIS Workplan the months they are not operational (Found in PARIS in Administration/PRU Operational months).

Section V. SERVICE AVAILABILITY

- A. The hours of operation for providers with full-time staff must be no less than 35 hours per week. Alternative arrangements require the prior approval of OASAS.
- B. 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.
- C. Prevention services must be provided in accordance with OASAS contractual requirements and approved Workplans.

Section VI. SERVICE STANDARDS

- A. 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.
- B. 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 also 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.
- D. It is recommended that prevention services 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.

Section VII. PROVIDER REPORTING - PREVENTION ACTIVITIES AND RESULTS INFORMATION SYSTEM (PARIS)

A. Responsibility for Timely Data Reporting

All OASAS-funded providers must attend PARIS training as requested and are responsible for ensuring that all required data is entered into PARIS on a monthly basis.

B. Time Frames for Data Collection

All OASAS-funded providers' prevention activity data must be entered 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.

C. Annual Data Collection Deadlines

Any delinquent (late) data reporting for the previous fiscal year must be entered into PARIS by March 1 for calendar year providers and by September 30 for New York City fiscal year providers. After this reporting deadline date, PARIS data collection will be closed to allow for cleaning, analysis and annual reporting. In case of unforeseen and emergency situations, providers may request a waiver to enter data after the deadline (see D. below).

D. Requests for Waiver for Delinquent Data Reporting

Requests for a waiver to enter delinquent data after the PARIS annual data collection deadline will only be granted for emergency situations. A waiver request must be sent by email to the OASAS PARIS Helpdesk, ParisHelpDesk@oasas.state.ny.us with a copy sent to the applicable OASAS Field Office Program Manager. OASAS will inform the provider of the disposition of their waiver request within one (1) week. If the waiver is approved, the data collection module will be reopened for a period of two (2) weeks from the approval notification date. Only one waiver per fiscal year will be granted.

Section VIII. FISCAL POLICY AND PROCEDURES

- A. All fiscal policies and procedures of 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.

Section IX. PREVENTION STAFFING REQUIREMENTS

While these staffing requirements do not go into effect until July 2010, all funded prevention providers are encouraged to work toward and demonstrate compliance on a voluntary basis prior to the effective date.

Effective July 2010, all NYS OASAS-funded community-and-school-based prevention programs will be required to demonstrate that:

- A. The individual who oversees prevention services in a NYS OASAS-funded prevention program meets the staffing qualifications described below. Such person 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 program).
- B. If they are staffed by four or more full-time equivalent professional staff (excluding the individual in item A., at least 25 percent of their staff must meet the staffing qualifications described below). The table below illustrates how the staffing requirement will be applied based on the number of full-time professional staff. NYS 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

It is NYS OASAS' expectation that, given the timeframe for implementation, prevention providers will have sufficient time to recruit qualified staff or assist existing staff to attain the credentials that will satisfy the staffing requirement.

Prevention practitioners who meet the staffing qualifications to satisfy the staffing requirement are:

- Credentialed Prevention Professionals (CPP);
- Credentialed Prevention Specialists (CPS) who have two years of qualifying prevention work experience and have completed 250 hours of OASAS approved education and training; or
- Prevention professionals who are licensed, certified or credentialed in a related discipline*, have two years of qualifying prevention work experience and have 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. (LSB No. 2008-04 Prevention Credential and Staffing Requirements)

- C. 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. (Part 853 - Credentialing of Addictions Professionals).

Section X. PERSONNEL POLICIES AND PROCEDURES

- A. 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.
- B. All providers must have an employee manual which includes, but is not limited to, information about the following items:
1. organizational purposes and goals;
 2. general personnel policies;
 3. employment, promotion, separation policies;
 4. employee orientation and training;
 5. employee appraisal (probationary and regular);
 6. time and attendance;
 7. salary and job title structure;
 8. employee benefits;
 9. affirmative action/non-discrimination policies;
 10. sexual harassment policies;
 11. violence in the workplace policy;
 12. emergency preparedness policies and procedures;
 13. grievance procedures;
 14. conflict of interest policies;

15. tobacco-free policy (OASAS Operating Regulations Part 856); and
 16. employee travel (if not included in Fiscal Manual).
- C. Providers must provide a copy of the employee manual to each employee upon his/her employment and obtain a signed statement that the employee has read the manual.
- D. 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.
- E. Providers must maintain for each employee a personnel file which includes, but is not limited to the following:
1. hiring notice/letter;
 2. resumé or employment application which includes prior work history;
 3. annual salary information, promotions etc;
 4. copy of job description and qualifications;
 5. copy of performance evaluations;
 6. references, with documentation of written or oral verification;
 7. professional licenses/certification and credentials;
 8. income tax withholding forms (W-4 and IT-2104);
 9. records of training/staff development courses;
 10. An individualized professional development plan appropriate to employee's job duties which must be signed and dated by the supervisor and employee;
 11. employee benefit records, e.g., health insurance pension, etc;
 12. copies of letters of commendation, if any;
 13. copies of supervisory counseling memorandum, if any;
 14. disciplinary actions*, if any;
 15. grievance matters, if any;

16. separation records, if any; and
17. other pertinent correspondence.

*Disciplinary actions should be included only when there is a final determination warranting such action. If there was not a sufficient basis for proceeding with the disciplinary action, the records of such action should be maintained in a separate file.

- F. 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.
- G. No person receiving compensation as an employee of a prevention provider may serve on the governing board of that provider.
- H. Child Abuse Reporting
 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 or 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.

Section XI. PREVENTION COUNSELING

A. Purpose of Prevention Counseling

Prevention counseling is a short-term, problem-resolution focused activity that concentrates on assessing and 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. The goals are to prevent, delay or reduce substance use and problem gambling, and the negative consequences caused by substance use and gambling behaviors.

Providers may utilize a case management approach, that includes identifying participant service needs, developing linkages with appropriate service providers who can meet these needs, and arranging referrals (e.g., public assistance, medical, child care, legal, family treatment, mental health, vocational/educational, etc.), as appropriate, for the participant and/or his/her significant others.

B. Policies and Procedures

1. The provider shall establish written policies, procedures and methods governing the provision of prevention counseling that 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, require review and approval by the governing authority and shall address, at a minimum, the following:
 - a. admission, retention, and discharge criteria;
 - b. problem identification and initial screening determination, risk and protective factor assessment, and service plan development;
 - c. record-keeping procedures that ensure that documentation is accurate, timely and prepared by appropriate staff. The maintenance of active and inactive records, release, disclosure and destruction of records are to be performed in conformance with the federal confidentiality regulations, 42 CFR Part 2;
 - d. 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)

- e. screening and referral for associated physical, mental, emotional, social or other treatment or support services including methods for ongoing coordination of care, e.g., telephone communications, mailings of reports, meetings with said providers, etc.;
- f. identification of chemical dependence and/or problem gambling treatment service providers and other providers of services as applicable that the participant may need;
- g. supervision; and
- h. child abuse reporting.

C. Goals - Prevention Counseling

- 1. A provider that offers prevention counseling services shall have among its goals:
 - a. the identification and resolution of identified problems; reduction of risk factors and the augmentation of protective factors for those at risk for developing substance abuse and/or gambling problems; and
 - b. the referral to appropriate treatment or support services for individuals with apparent symptoms of substance abuse or dependence, pathological gambling or physical, mental, emotional, educational, or social problems.

D. Required Services/Activities

- 1. The prevention counseling program must include the following activities where applicable:
 - a. problem behavior screening;
 - b. risk and protective factor assessment;
 - c. service plan development;
 - d. individual counseling;
 - e. group counseling;

- f. referral to other necessary prevention, treatment, and/or support services; and
 - g. crisis intervention.
- 2. The prevention counseling program may also provide as applicable:
 - a. family counseling services. The involvement of the family is strongly encouraged.

E. Referral Services

- 1. Each prevention counseling provider must make arrangements to address additional services to meet participant needs that cannot be met by the prevention counseling provider. Written policies and procedures that identify methods for coordination of services are required for the following:
 - a. substance abuse treatment and crisis services;
 - b. problem gambling treatment and crisis services;
 - c. mental health and developmental disability services;
 - d. vocational and/or educational services;
 - e. health care services;
 - f. education, risk assessment, supportive counseling and referral services concerning HIV and AIDS and other communicable diseases; and
 - g. family counseling services.

F. Admission Procedures

- 1. Admission Determination: An individual who seeks or has been referred for prevention counseling 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.

This required assessment may include up to three (3) sessions over a twenty (20) school/work/business-day period, at which point a disposition must be made. Standardized screening instruments*, are encouraged to be used e.g., CRAFFT, Lie/Bet, ASSIST, AUDIT, GAIN-SS, POSIT, SOGS-RA, etc.

* Standardized screening instruments can be found in the PARIS Knowledge Base

under Prevention Counseling Screening Instruments.

2. Admission Criteria: To be admitted to Prevention Counseling, the assessment must document:
 - a. current (within the last 30 days) substance use or gambling; (Current use of alcohol does not apply as a criterion for individuals 21 or older, and/or current use of tobacco does not apply as criterion for individuals 18 or older) or
 - b. consequences related to substance use or gambling; or
 - c. a high level of risk on at least two risk factors. (These criteria (risk factors) do not apply for individuals 21 and older.)

The risk factors for admission to prevention counseling are:

- i. Family history of substance abuse or problem gambling; (This risk factor is sufficient alone to be admitted to prevention counseling)
 - ii. Rebelliousness;
 - iii. Peers engaged in substance use or gambling;
 - iv. Favorable attitudes toward substance use or gambling;
 - v. Early initiation of substance use, or gambling;
 - vi. Academic failure;
 - vii. Depressive symptoms;
 - viii. Family management problems; and
 - ix. Family Conflict.
3. If a participant displays the characteristics consistent with the criteria for substance abuse, dependence or problem/pathological gambling, a referral for an evaluation for treatment should be made. (Criteria for substance abuse and pathological gambling can be found in PARIS Knowledge Base under Prevention Counseling Screening Instruments).
 - a. In a case where an individual is unwilling to accept a referral to a substance abuse or problem gambling treatment service for an evaluation, the individual may be admitted to prevention counseling for brief motivational counseling focused on accepting the referral for an evaluation for substance abuse or problem gambling treatment. This brief motivational counseling shall be for a maximum of twelve (12) visits after which the individual must be referred for an evaluation to substance abuse or problem gambling treatment or receive a discharge of “refuses referral.”

4. The assessment is documented on the Assessment/Admission Record (PAS-64) form.
5. The Personal History Record (PAS-64A) shall be completed prior to the admission of an individual into prevention counseling. The completed assessments for individuals not admitted into counseling must be maintained in a central file in a secure manner on-site.

G. Participant Service Plan

1. A Participant Service Plan (OASAS Form 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, are encouraged to be used, e.g., GAIN-Q. The service plan shall:
 - a. 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;
 - b. specify the behavioral results/outcomes to be achieved which shall be used to measure progress toward attainment of the stated behavioral indicators;
 - c. indicate the expected time frame for accomplishment of the stated behavioral indicators and results/outcomes;
 - d. take into account cultural and social factors, as well as the particular circumstances for each participant;
 - e. include a record of referral for any ancillary service to be provided by any other facility, a description of the nature of the service, the results of the referral, and the procedures for ongoing coordination of care.
2. The participant shall be included and actively participate in the service planning process.
3. The initial decision to admit an individual shall be made by a staff member who is authorized by the provider's policy to admit individuals. The name of the staff that made the decision, along with the date of admission, must be documented in the case record.
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 it is reviewed and updated.

5. The responsible counseling staff member shall ensure that the plan is included in the participant's record and that all services are provided in accordance with the service plan.
6. The entire service plan, once established, shall be thoroughly reviewed and revised at least every ninety (90) calendar days and every 90 days thereafter by the responsible counseling staff member in consultation with the participant. Any revisions to the individual development plan shall be documented in writing.
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. Such justification must be noted in the case file and approved by a supervisor.
8. A participant shall be retained in the prevention counseling service only if the participant:
 - a. Continues to meet the admission criteria; and,
 - b. Can benefit from continued prevention counseling services.
9. 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. (Notice of Privacy/Confidentiality form can be found on OASAS website - Search for Sample HIPAA forms)
10. The case of any participant who is not responding to counseling, not meeting behavioral indicators defined in the individual service plan, or is disruptive to the service, must be reviewed with supervisory staff. Any decisions made must be documented in the participant record and the service plan must be revised accordingly.
11. Progress notes (Participant Progress Summary PAS-66) shall be written, signed, and dated by the responsible counseling staff member, and shall provide a chronology of the participant's progress related to the behavioral indicators established in the service plan. It shall clearly delineate the course and results of service, and shall indicate participant's participation in all

significant services that are provided. Progress notes shall be written after each counseling session. For those individuals participating in group counseling, staff shall complete the Group Counseling Participation Record (PAS-67) and Group Process Summary (PAS 67a) forms as well.

12. 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 services plan. Any interruption to the weekly face-to-face contact must be documented in a progress note.
13. To remain active, a prevention counseling participant must have at least one face-to-face contact within a thirty (30)-calendar-day period, unless prior arrangements have been made between the participant and program staff, i.e., rehabilitation, hospitalization, etc.
14. Discharge Planning: The discharge plan shall be developed in collaboration with the participant and shall begin upon admission, be closely coordinated with the service 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 referral for any specific needs (Referral Record PAS-64c) which have been identified in the assessment and over the course of counseling.
15. Discharge Categories: An individual shall be discharged from the prevention counseling service when he or she:
 - a. has accomplished the behavioral results/outcomes identified in the individual service plan and subsequent service plan updates;
 - b. has received maximum benefit from the service;
 - c. refuses counseling services; (voluntarily left, dropped out)
 - d. refuses referral;
 - d. is disruptive to the service and/or fails to comply with the service's reasonably applied behavioral expectations;
 - e. has no face-to-face contact in 30 calendar days; or
 - f. has an extended illness.
16. 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. That portion of the discharge plan that includes the referrals for continuing care shall be offered to the participant upon discharge.

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 forty-five (45) calendar days of discharge.
18. All prevention providers making referrals for any support or auxiliary service must document these services on the Referral Record (PAS -64C).
 - a. The results of the referral, i.e. whether the participant appeared at referral site for assessment; and 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. With consideration given that referrals may be made for individuals not admitted into counseling, all other referral records must be maintained in a confidential manner in those records for individuals seen but not admitted into the service or in a central file on-site.
19. All prevention providers who must disclose information regarding an individual must complete a Consent for Release of Information Concerning Alcoholism/Drug Abuse Patients (TRS-2). For those individuals mandated to the service, a Criminal Justice Consent to Release Information (TRS-4) must be completed.

H. Administrative Operations

1. Each provider must designate a supervisor whose responsibilities are to provide supervision for the prevention counseling services.
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 (42CFR 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, i.e., individual

scheduled at least two times per month.

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 should be available for all staff providing prevention services. Space should be clean, safe, accessible and comply with confidentiality standards.

I. 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:
 - a. the source of referral;
 - b. issues precipitating referral; and
 - c. initial screening findings and recommendations.
2. Records for all admitted participants must include, at a minimum, the following:
 - a. current substance use or gambling, if any;
 - b. consequences related to substance use or gambling, if any;
 - c. documentation of the comprehensive risk and protective factor assessment;
 - d. current health status;
 - e. the individual participant's service plan and all reviews and updates thereto;
 - f. any correspondence regarding the participant;
 - g. discharge plan and summary, including the circumstances of the discharge;

- h. documentation of contacts with participant's family, significant other(s), teachers, counselors, and other service providers; and
 - i. progress notes.
- 3. Each participant must have a unique identification number as assigned by the provider and recorded in PARIS. The unique identification number is assigned at assessment.
- 4. The same identification number must be used for the participant among all the provider's Program Reporting Units (PRUs) and for all transactions. The same identification number should be used for the same individual even if participant was admitted in different contract years. The same ID number should be used for a readmission in the same school district. 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's identification number, the name of the individual assigned to the number, the admission date, the program reporting unit (PRU) admitted to, and the discharge date. An alphanumeric cross-reference to the central log must also be maintained and stored in a secure manner. The participant identification number may be made up of up to ten (10) characters long and may include any combination of alphabetic letters or numbers.
- 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 service components. An individual counseling record must include:
 - a. Assessment/Admission Record (OASAS Form PAS-64);
 - b. Personal History Record (OASAS Form PAS-64a);
 - c. Referral Record, (OASAS form PAS-64c); when applicable
 - d. Participant Services Plan (OASAS Form PAS-65);
 - e. Services Plan Update (OASAS Form PAS-65a); when applicable;
 - f. Participant Progress Summary (OASAS Form PAS-66);
 - g. Discharge Record (OASAS Form PAS-64b)
- 8. For those individuals participating in group counseling, staff shall complete the:
 - a. Group Counseling Participation Record (OASAS Form PAS-67); and
 - b. Group Process Summary (OASAS Form PAS 67a)

OASAS prevention counseling forms, PAS-64 – PAS-67b can be found on the OASAS website – Search for PAS forms

9. Redesign of OASAS approved forms
 - a. A provider may redesign OASAS Forms PAS-64 through PAS-67 to meet its special needs, provided all the required data elements of the NYS OASAS forms are included in the proposed equivalent form.
 - b. The proposed equivalent form(s) must be approved in writing by OASAS. 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 XII. 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:
 1. develop written procedures that regulate and control access to and use of records which are subject to these regulations;
 2. 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;

3. maintain and store the central log of participant identification numbers 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;
 4. educate all provider staff about the confidentiality requirements, restrictions on re-disclosure and program procedures for ensuring compliance with federal regulations; and
 5. provide each participant with a written summary of his/her confidentiality rights in accordance with federal regulations.
- B. Service providers may release information to a person or organization only if one 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 elements (as required by the federal regulations):
 - (1) the name or general designation of the service provider or person authorized to disclose information;
 - (2) the identity of the person or organization to which a disclosure will be made;
 - (3) the name of the client/participant;
 - (4) the purpose or need for the disclosure;
 - (5) the extent or nature of the information disclosed/released;
 - (6) a statement that the consent may be revoked at any time, except to the extent that action has been taken in reliance on it;
 - i. this statement should be eliminated where participation in counseling is a condition of release from custody;
 - (7) a specific description of the date, event or condition upon which the consent will expire, without express revocation;
 - (8) the date the consent is signed; and
 - (9) the signature of the client/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 section E. Family Educational Right and Privacy Act (FERPA), pg. 37.
 - 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. Those examples can be found in the PARIS Knowledge Base under "Disclosures Made without Written Participant Consent".
- C. 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 can not 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 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 parents request. FERPA gives the parents of students who are under the age of 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 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.