



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

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2011 Prevention Guidelines

~Requirements for All OASAS Funded Prevention
Services~

Draft

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PREFACE

The primary purpose of the 2011 Prevention Guidelines is to define and describe the minimum 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 Alcoholism and Substance Abuse Services (NYS OASAS). The 2011 Prevention Guidelines also provide minimum program performance standards in the areas of service availability and delivery, personnel and fiscal practices, recordkeeping, and data reporting. The document provides the structure for the prevention field, counties and regulatory bodies to implement and enhance consistent prevention delivery and oversight throughout New York State. OASAS will review these guidelines periodically, 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 2011 Guidelines replace the 2009 Prevention Guidelines and should be maintained at each program site as a reference guide. These guidelines will go into effect January 1, 2012. 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) and the Part 343. 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 SERVICES FRAMEWORK

The OASAS Prevention Framework is based on epidemiological research that has identified causal risk and protective factors that lead to the development of problem behaviors during adolescence, including: substance abuse; delinquency; teen pregnancy; school drop-out; and violence. Preliminary research also shows associations between risk factors and youth problem gambling. 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 and practices (EBPs) for the specific target populations identified by needs assessment. The selection of effective EBPs also fosters efficient resource management in achieving the outcomes of reducing or avoiding substance use/abuse among youths in the community. This comprehensive community planning to address the risk and protective factors through the delivery of evidence-based programs and practices (EBPs) will lead to the accomplishment of the following goals:

A. Overall Goals of OASAS Funded Prevention Services

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

B. OASAS 2010-2014 Prevention Strategic Plan Priorities

The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified prevention as the first of eight Strategic Initiatives in their national Strategic Plan for 2011 – 2014. During 2009 through 2010 OASAS conducted a state-level strategic planning process together with providers and state partners. Supported by the Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework process, OASAS developed a data driven strategic plan that included analyses of substance use risk factors, consumption levels and negative consequences as well as New York State's current prevention capacity to address the prioritized problems. Providers should be targeting these priorities in their annual Workplans, unless otherwise indicated by their community needs assessments:

- Reduce binge drinking and all underage drinking;
- Reduce illegal drug abuse to include:
 - Marijuana use;
 - Prescription painkiller abuse among youth;
- Reduce Risk Factor: Parental Attitudes Favorable Towards Problem Behavior;
- Increase Protective Factor: Family Opportunities for Prosocial Involvement;
- Reduce any gambling among youth and problem gambling among adults.

C. Needs Assessment & Planning

Providers are required to base their selection of services on a local needs assessment that identifies and prioritizes elevated risk factors, decreased protective factors, and the problem behaviors 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.

The results of the local needs assessments are entered in the Prevention Activities and Results Information System (PARIS) as part of the Annual Prevention Provider Workplan, and must be updated annually.

D. Use of Evidence-based Programs and Practices (EBPs)

The delivery of OASAS funded evidence-based prevention programs and practices (EBPs) must be across multiple domains and within multiple systems. Prevention services should be culturally relevant and include EBP educational curricula that target individual and family risk/protective factors and selected EBP environmental strategies that target community level risk factors. Section II describes the prevention service approaches funded by OASAS. Section III describes service delivery requirements and performance standards.

E. Environmental Strategies

The OASAS Prevention Framework recognizes and emphasizes the impact of utilizing environmental strategies that address population level norms towards substance use, problem gambling, 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 its negative consequences. (See Appendix D for further guidance.)

F. SAMHSA's Strategic Prevention Framework (SPF)

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) is a prevention planning process that is data driven and consists of five interactive steps including: 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

The SPF model is congruent with the OASAS Prevention Framework, and is compatible with the Logic Model that providers are required to follow in the Prevention Activities and Results Information System (PARIS).

G. Community Coalitions and Prevention Resource Centers (PRCs)

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

1. Providers & Community Coalitions

Community coalitions make 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 behavior. Providers are expected to:

- Be active participants in existing underage drinking, substance abuse and/or problem gambling prevention community coalitions;
- Lead or assist in community coalition planning efforts, including needs and resource assessment and service planning;
- Document in their annual Workplan their planned activities to support community coalitions; and
- Collaborate with the PRCs in establishing new local prevention community coalitions as needed.

2. Providers & PRCs

OASAS funds the PRCs to provide training and technical assistance to local prevention providers and local community coalitions in following the SPF model for planning and delivery of EBPs. The services provided by PRCs

are:

- Disseminate current prevention science and assist coalitions and prevention providers in bringing that science to practice;
- Build and sustain the capacity of existing community coalitions and increase the number of new community coalitions in the region;
- Support partnerships among providers, counties, schools and community groups in the region.
- Provide technical assistance to coalitions and providers on the Strategic Prevention Framework, including: needs assessment, capacity building, implementation evaluation, cultural competency and sustainability.

SECTION II: DEFINITIONS & REQUIREMENTS FOR FUNDED PREVENTION SERVICES

The delivery of OASAS funded prevention programs and practices must be across multiple domains and within multiple systems, with increasing emphasis on delivery of evidence-based programs and practices (EBPs). Prevention services should include EBP educational curricula that target individual and family risk/protective factors and selected EBP environmental strategies that target community level risk factors.

A. Primary Prevention Services

Primary Prevention is defined as a collaborative and community focused process to prevent or delay substance use and abuse and/or problem gambling in individuals, families and communities. The selection of prevention service activities within this category is based on a community needs assessment that identifies levels of substance use or gambling, their consequences, elevated risk factors and decreased protective factors. The following services are included in this category:

- Prevention Education: Involves two-way communication and is distinguished from information dissemination activities by the fact that the interaction between the educator and the participants and among the peer participants is the basis of its success. Activities are designed to increase ATOD knowledge, improve pro-social attitudes, increase the understanding of the consequences of substance use, decrease normative misperceptions regarding substance use and teach critical life and social skills. Developmentally appropriate social competency skills taught include: assertiveness and substance use refusal skills, self-control, conflict resolution, stress-management, communication and decision-making. Prevention Education also includes structured curricula to assist parents and families in identifying and reducing family risk factors and learning about the effects of substance abuse on families and better understanding child and adolescent development to improve positive parenting. Topics include parenting skills, family communications, teen supervision and monitoring, and reducing problem behaviors.
- Environmental Strategies: These evidence-based strategies utilize activities to affect population level change to address community norms, availability, and

policies/laws/regulations surrounding substance abuse and problem gambling behaviors. In order to change these factors, a multi-faceted approach needs to be employed, including strategies from each of the following categories:

- Policy Change;
- Enforcement/Compliance with Existing Laws;
- Media/Communications.

These are considered the best practices for planning and delivery of environmental strategies. By combining complimentary strategies from each of these categories, overall effectiveness is increased. Environmental strategies must be implemented in set of mutually reinforcing activities. (See Appendix D for further guidance.)

- 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.
- 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.*
- Positive Alternatives: Provides for the participation of target populations in constructive and healthy activities that exclude drug use and gambling and include a clear no use message. Positive alternatives also provide opportunities for social

* Information and Awareness activities alone have not been shown to be effective at preventing substance abuse or problem gambling.

bonding to positive role models who can change attitudes towards substance abuse as a lifestyle. Alternative activities alone have not been shown to be effective at preventing substance abuse. They should be linked with other prevention services. (See Appendix E for further guidance.)

B. Other Direct Prevention Services

Prevention services that are not considered Primary Prevention are the following:

- Prevention Counseling: 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 Institute of Medicine (IOM) selective and indicated youth (see below) who are considered at highest risk for developing substance abuse or gambling problems. It is limited to individuals between ages five and 20 years old.
- Early Intervention: Offered to IOM indicated individuals who have already begun to exhibit substance use or gambling behaviors but do not meet the DSM-IV criteria of substance abuse or dependence, or pathological gambling. Examples of this type of prevention service are: Teen Intervene; Alcohol Awareness Programs; BASICS.

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

The National Institute of Medicine (IOM) categorizes prevention *populations* (target 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 required to choose the most

effective and appropriate prevention activities for the needs of their target population, based on their needs assessment.

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.

D. Evidence-based Programs and Practices (EBPs)

OASAS requires that a percentage of prevention services be evidence-based programs and practices (EBPs). (See SECTION III: PREVENTION PERFORMANCE STANDARDS for more specifics on the requirements). EBPs have been evaluated to show effectiveness in preventing substance abuse and related problems, and are designed to change youth and families' risk and protective factors and community factors that drive illegal consumption and negative consequences due to substance abuse. Research has shown that appropriate use of EBPs result in a cost savings.

EBPs fall under the Primary Prevention category of services, and include prevention education activities (currently labeled Model Programs in PARIS), and environmental strategies. OASAS funding supports EBPs delivered in the classroom, in group and family programs, and selected environmental strategies that target community factors. (See Appendix C for further guidance.)

E. EBP Review Panel and the New York - Registry of Evidence-based Programs & Practices (NY-REPP)

An EBP Review Panel of prevention researchers has been assembled to update and maintain the New York Registry of Evidence-based Programs & Practices (NY-REPP) and was developed to assist providers in identifying other EBPs that may be culturally specific, meet OASAS's criteria, and are not currently on that list. The panel's purpose is

to review the new and existing prevention outcome research and rate the evidence of effectiveness available for programs and practice. The panel includes volunteer prevention researchers from New York academic and provider organizations as well as OASAS prevention researchers.

Providers may submit evidence of effectiveness for an EBP or a promising program or practice for special populations to the EBP Review Panel for review and determination of EBP status. The EBP Panel convenes twice a year to review applications from providers and consider new research on the existing EBPs in PARIS. EBP Review Panel results will be disseminated to the provider submitting the NY-REPP application, the Field Office, the Local Governmental Unit (LGU) and will be posted on PARIS. If a submitted program attains EBP Status, the program becomes a part of NY-REPP and will be added to the drop down list of available EBPs (Model Programs) found in PARIS. More information on NY-REPP and the EBP application and review process can be found in the PARIS Knowledge-base under EBP Review.

SECTION III: PREVENTION PERFORMANCE STANDARDS

This section describes the minimum performance standards to be met for providers in their planning and delivery of OASAS funded prevention services. These performance standards are the measures for which providers will be held accountable during the Workplan Approval process and during the Performance Review process.

A. Overall Service Delivery Performance Standard

Comprehensive prevention plans for effective prevention services cannot succeed unless they are implemented with their selected target populations. This standard requires that at least 80% of all planned direct services be delivered to at least 80% of planned participants each year. The standard will be applied within each direct Service Approach

approved in the annual Workplan. The annual Workplan may be revised up until the end of the third quarter of each year. Details on the measurement of this Standard is provided in Appendix B. Capacity building activities, including other impactor training, technical assistance, coalition work, and indirect approaches using mass media such as environmental strategies and information dissemination will not be measured by this standard. Both a Program Reporting Unit (PRU) and a Provider level score will be produced for all providers with multiple PRU's. (See Appendix B for further guidance.)

B. Standards for Delivery of EBPs

A primary goal for the New York State prevention service system is to increase the delivery of effective EBPs in communities. Prevention EBPs currently include multi-component model programs, educational programs and environmental strategies. Beginning in 2011 (January 1st for calendar year providers; July 1st for NYC providers), and increasing each year, all providers are required to dedicate a percentage of their OASAS funded prevention services to the delivery of EBPs, according to the following schedule:

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

C. Standards for Delivery of Recurring Prevention Education Services

Service Delivery Goal:

1. All required class/group sessions should be completed.

Performance Standards:

1. For EBP Educational curricula delivery (Model Programs) with nine (9) sessions or less, all sessions as designed by the EBP developer must be completed. The standard will be applied to all Class/Groups that are initiated.
2. For EBP Educational curricula with ten (10) sessions or more, 80% of sessions as designed by the EBP developer must be completed. The standard will be applied to all Class/Groups that are initiated.
3. For Non-model Education programs with nine sessions or less planned, all planned sessions must be delivered. The standard will be applied to all Class/Groups that are initiated.
4. For Non-model Education programs with 10 sessions or more, 80% of sessions must be delivered. The standard will be applied to Class/Groups that are initiated.

D. Standards for Delivery of Prevention Counseling Services

Service Delivery Goals:

1. All youth who are admitted to Prevention Counseling with no current substance use will maintain and strengthen their healthy behavioral choices and remain free of substance use at discharge.
2. All Individual Service Plan (ISP) Objectives will be achieved.

Performance Standards:

1. Among youth who report no substance use in the past 30 days at admission, 90% will remain free of substance use in the past 30 days at discharge. This standard will be applied to admissions whose length of service exceeds 30 days.
2. Successful ISP Completion is defined as the accomplishment of a majority (51% or more) of the objectives in the ISP.

E. Standards for Delivery of Environmental Strategies

Performance Requirements:

1. Needs assessment and a population data-based logic model must be used when selecting Environmental strategies.
2. At least one Policy change or one Enforcement strategy must be selected and supported by appropriate Media/Communications strategies.
(See Appendix D for further guidance.)

F. Performance Reviews

If, after a review, providers have not met these EBP standards and/or other areas of required performance, the OASAS Field Office program manager will prepare a Management Plan* recommending the next steps to be taken by OASAS, the

(Local Services Bulletin No. 2000-03: Annual Program Performance Reviews – NYS OASAS-Funded Treatment Programs)

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, 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 web based automated OASAS prevention reporting system designed to support three major functions:

- The annual OASAS Prevention Workplan development and approval process;
- Monthly data collection and reporting of OASAS funded prevention activities;
- Results reporting/provider performance.

A manual and instructions for navigating PARIS can be found in the Support Module of the system. Questions regarding PARIS and the following sections should be directed to the appropriate Field Office and/or the PARIS Help Desk. Periodically OASAS will conduct PARIS trainings for new staff and to update the field on changes to the system. All OASAS funded prevention providers are required to attend such trainings as requested.

A. OASAS Workplan Development and Approval

All providers are required to submit an annual prospective Workplan of planned

prevention services, and the expected results of their prevention activities. Management, supervision, staff development, travel, document preparation (handouts, workbooks, and educational materials), etc. are not entered in the Workplan. Once submitted, the Workplan is approved by the provider's Local Governmental Unit (LGU) (if applicable) and their OASAS program manager. During the Workplan review and approval process, the provider, LGU (if applicable), and OASAS must agree that the expected results identified in the Workplan increase the probability of achieving the prevention goals stated in Section I – Prevention Framework - A. Overall Prevention Goals.

Draft Workplans for the upcoming year are usually made available to providers in PARIS in August for calendar-year providers, and in March for New York City providers. Completed calendar-year Workplans are due to LGUs for approval by September 15th and to OASAS Field Offices by October 15th; completed NYC Workplans are due April 15th and May 1st. All State Approved Workplans for the upcoming year are considered as part of the Performance Review process discussed in Section III.

B. Monthly Data Collection and Reporting

Providers are responsible for accurate and timely data reporting. PARIS is the primary source of information that OASAS draws from to inform the community, as well as Local, State and Federal Government officials regarding the types of funded prevention services delivered, to whom, and where. PARIS data drives OASAS's policy decisions.

1. Responsibility for Accurate Data Reporting

Providers are required to:

- Revise their Workplan when circumstances arise that cause a change in their planned services;

- Ensure that FTE and CPP counts in PARIS are current as Field Offices utilize this information during yearly program review;
- Update contact information in the PARIS Admin section in order for OASAS to communicate effectively with the provider system.

2. Responsibility for Timely Data Reporting

The following are the timeframes for reporting prevention activity data in PARIS:

- 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.
- 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 below).

Again, for assistance in ensuring accurate and timely PARIS reporting, providers should contact their respective Field Office and/or the PARIS Help Desk.

C. 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 request for a waiver must be approved by the applicable OASAS Field Office Program Manager. 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 waiver per fiscal year will be granted.

SECTION V: FISCAL POLICY 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.

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:

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

Each provider must have adequate space, which is clean, safe, and accessible, available for all staff providing prevention services.

D. Filling Vacancies

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. Non-Prevention Functions

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

F. 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.

G. 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 the prior approval of the 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.

H. OASAS Contractual Requirements

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

I. Prevention Materials and Curricula (Service Standards)

1. 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.
2. 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.
3. 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.

J. PREVENTION STAFFING REQUIREMENTS

Effective July 2010*, all OASAS funded prevention providers are required to demonstrate that:

1. The individual who oversees prevention services in a NYS OASAS-funded prevention program meets the staffing qualifications described in the section 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 agency).

AND

* LSB 2008-04

2. If a prevention program is staffed by four or more full-time equivalent professional staff (excluding the individual who oversees prevention services-described above), at least 25 percent of the 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

Qualifications that satisfy the above staffing requirements are:

1. Credentialed Prevention Professionals (CPP);
- Credentialed Prevention Specialists (CPS) who have an additional year of qualifying prevention work experience (minimum total of 2 years) and have

completed an additional 150 hours of OASAS approved education and training (minimum total of 250 hours); 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)

K. 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 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:

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).

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

1. hiring notice/letter;
2. résumé 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. Program staff have the right to review their personnel file.

D. Time and Accrual

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

E. Restriction on Governing Board

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

F. Mandated Child Abuse Reporting

In accordance with LSB 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 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 VIII: PREVENTION COUNSELING POLICIES & PROCEDURES

Prevention counseling is a 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; and to refer to appropriate treatment or support services those individuals with apparent symptoms of substance abuse or dependence, pathological gambling, or physical, mental, emotional educational, or social problems. Upon admission, prevention counseling

is not to exceed 120 days without supervisory approval. Prevention Counseling is limited to individuals between 5 – 20 years of age.

A. Policies and Procedures

The provider is required to 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 (OASAS, LGU) and shall address, at a minimum, the following:

1. supervision of prevention counseling staff;
2. admission, retention, and discharge criteria;
3. problem identification and initial screening determination, risk factor assessment, and service plan development;
4. 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;
5. 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);
6. the identification of appropriate referral sources applicable for participant needs; and
7. child abuse reporting protocol.

B. Required Services/Activities

Prevention counseling services include the following activities:

1. assessment of substance use and problem gambling behavior;
2. risk factor assessment;
3. service plan development;
4. individual counseling;
5. group counseling;
6. family involvement;
7. referral to other necessary prevention, treatment, and/or support services;
8. crisis intervention

C. Referral Services

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:

1. substance abuse treatment and crisis services;
2. problem gambling treatment and crisis services;
3. mental health and developmental disability services;
4. vocational and/or educational services;
5. health care services;
6. education, risk assessment, supportive counseling and referral services concerning HIV and AIDS and other communicable diseases; and
7. family counseling services.

D. Admission Procedures

1. Assessment and 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 should be used.*

*Standardized screening instruments can be found in the PARIS Knowledge Base under Prevention Counseling Screening Instruments.

The assessment is documented on the Assessment/Admission Record (PAS-64) form.

2. Admission Criteria: To be admitted to Prevention Counseling, the assessment must document:

- a. current (within the last 30 days) substance use or gambling; or
- b. consequences related to substance use or gambling; or
- c. a high level of risk on at least two risk factors.

The risk factors for admission to prevention counseling are:

- Family history of substance abuse or problem gambling;
- Peers engaged in substance use or gambling;
- Favorable attitudes toward substance use or gambling;

- Early initiation of substance use, or gambling;
- Depressive symptoms;
- Family management problems; and
- Family Conflict.

3. Criteria for Referral: 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.)

4. Refusal of Referral: 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 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.

Note: an individual may not be enrolled in prevention counseling services and in an early intervention service at the same time.

5. Personal History Record: The Personal History Record (PAS-64A) should be initiated 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.

E. Participant Service Plans

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 should be used, e.g., GAIN-Q.

The Participant 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, and the results of the referral.

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

3. The Participant Service 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 service plan update is completed. (The new assessment data must be added in PARIS.)
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 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.
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 involvement in all significant services that are provided. Progress notes shall be written after each counseling session. For those individuals participating in group counseling, staff shall complete the Group Counseling Participation Record (PAS-67) and Group Process Summary (PAS 67a) forms as well.
12. 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 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).
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; or
 - b. has received maximum benefit from the service; or
 - c. refuses counseling services; (voluntarily left, dropped out) or
 - d. refuses referral; or

- e. is disruptive to the service and/or fails to comply with the service's reasonably applied behavioral expectations; or
- f. has had no face-to-face counseling contact in 30 calendar days; or
- g. 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. The discharge plan may include referrals for continuing care and 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.

Discharge data should be entered into PARIS within forty-five (45) days of 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 30 days from the last face-to-face.

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. 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.

19. All prevention providers who are legally required to disclose information regarding an individual must complete 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.

F. 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 (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.
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.

G. 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 factor assessment;
 - d. personal history record;
 - e. the individual participant's service plan and all reviews and updates thereto;

- f. 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 the first assessment session.
4. The same identification number must be used for the participant among all of 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 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's identification number, the name of the individual assigned to the number, emergency contact information, 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. A copy of the central admissions log should also be maintained at the provider's administrative office.

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. 120 Day Service Plan Review/Justification (OASAS Form PAS-65b), when applicable;
 - g. Participant Progress Summary (OASAS Form PAS-66);
 - h. Discharge Record (OASAS Form PAS-64b)

8. For those individuals participating in group counseling, staff shall complete both of the following:
 - a. Group Counseling Participation Record (OASAS Form PAS-67);
 - b. Group Process Summary (OASAS Form 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. 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 IX: TEEN INTERVENE POLICIES & PROCEDURES

Teen Intervene is an Early Intervention program targeting 12- to 19-year-olds 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.

Note: An individual may not be enrolled in Teen Intervene and prevention counseling at the same time.

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, require review and approval by the governing authority (OASAS, LGU) and shall address, at a minimum, the following:

1. Designated supervision of Teen Intervene facilitators;
2. 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;
3. Identification of appropriate referral sources for participants who display evidence of more serious substance abuse issues and/or mental health issues;
6. Consent to release information;
7. Child abuse reporting protocol.

B. Required Services/Activities

Teen Intervene was designed to be implemented in three sessions, with the third session including a parent/caregiver. Teen Intervene should be administered in two or three sessions of 60 -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. If the individual has not made progress after six sessions, a referral for an evaluation for substance abuse treatment is likely indicated.

The following are required activities:

1. risk factor assessment;
2. problem identification and initial screening determination, using an evidenced-based standardized screening instrument developed for adolescents (e.g., CRAFFT)
3. a minimum of at least two sessions to deliver the program content;
4. the last session should include the adolescent and a parent and/or a caring adult identified by the adolescent. The adolescent has the right to not involve the parent or caring adult if they so choose.
5. all sessions except the last are individual sessions;
6. referral to other necessary prevention, treatment, and/or support services.

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 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:

1. 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
2. Results from a standardized AOD screening instrument (e.g., CRAFFT, POSIT, or Part 1 of Teen Intervene - Client Questionnaire;
3. Part 2 of Teen Intervene - Client Questionnaire;
4. Teen Intervene - Pros and Cons Worksheet;
5. Teen Intervene - Readiness to Change Worksheet(s);
6. Teen Intervene - Establish Goals Worksheet(s);
7. Teen Intervene - Parent/Guardian Worksheet (if parent/guardian session delivered);
8. Teen Intervene - Parent/Guardian Questionnaire;
9. 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 including demographics, referral source, service delivery information and level of substance use. This data will not contain individually identifying information. 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 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 (see Local Services Bulletin No. 2008-04: Prevention Credential and Staffing Requirements, for list of approved professionals*) then staff 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, Certified or 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 the following education, training and experience requirements in order to be approved by OASAS to deliver Teen Intervene:

- a. The equivalent of a minimum of one year of full time counseling experience; and
- b. Counseling skills or motivational interviewing training (MI), (minimum of 6 hours); and
- c. Adolescent alcohol and other drug addiction training (minimum of 6 hours); and
- d. Teen Intervene training.

SECTION X: ALCOHOL AWARENESS PROGRAMS – POLICIES & PROCEDURES

Pursuant to Sections 19.07 and 19.25 of the Mental Hygiene Law and Sections 65-B and 65-C of the Alcohol Beverage and Control Law, the NYS Office of Alcoholism and Substance Abuse Services (OASAS) is charged with the responsibility to develop and implement Alcohol Awareness Programs (AAP) for Youth.

The Alcohol Awareness Program is designed to provide an educational experience for under-age youth who are referred through the courts, schools, family members or other agencies for violation of the underage drinking laws. These violations include: possession of alcoholic beverages with intent to consume; purchase of alcoholic beverages with intent to consume; attempt to purchase an alcoholic beverage with intent to consume; or attempt to purchase an alcoholic beverage through fraudulent means, such as a forged or altered driver's license. *(We can also provide more legal-specific language as follows* The alcohol awareness program for youth is an alternative sentence that may be imposed upon youth under 21 years of age found

guilty of violating section 65-b (fraudulent use of identification to purchase alcohol) or 65-c (underage possession of alcohol) of the Alcoholic Beverage Control Law. Furthermore, this program can be used as an alternative condition of dismissal for a youth under 21 years of age who has been charged with a misdemeanor other than section 1192 of the Vehicle and Traffic Law (driving while intoxicated or with ability impaired), where the record indicates that the consumption of alcohol may have been a contributing factor in the commission of the offense) The programs also provide a mechanism to determine whether or not a youth may need to be evaluated for their alcohol and other drug use, and a means to involve family/significant others in the education and support process –We need to discuss further and may need different wording. The educational experience provided by the Alcohol Awareness Program for Youth gives attendees valuable information about the negative consequences of alcohol use. Such education can have a positive impact on their future behavior and the health and well-being of the communities in which they live.

The alcohol awareness program for youth is a valuable sentencing alternative for youths who may be at high risk of developing serious problems with alcohol and who have gotten into trouble with the law because of alcohol. By providing such youth with information vital to their well-being while also requiring investment of enough of their time to serve as a deterrent to alcohol and other drug use; the alcohol awareness program for youth is an important resource n addressing youthful alcohol abuse.

The AAP may be an evidence based program approved by the Office or if not must indicate how it addresses requisite learning objective in each of the following categories:

- (i) laws and the criminal justice system;
- (ii) characteristics of alcohol and other drugs;

- (iii) characteristics of gambling
- (iv) understanding alcoholism/addiction;
- (v) family dynamics and issues regarding children of alcoholics and substance abusers;
- (vi) societal issues;
- (vii) youth issues;
- (viii) choices and alternatives;
- (ix) screening and self assessment; and
- (x) community resources;
- (xi) incorporate a stress management component.

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:

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. Releases of Information: 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 (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 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 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.

APPENDICES

Appendix A

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 longitudinal studies link the risk factor to the youth problem behavior.* 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 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.

Appendix B

Measurement of SECTION III: PREVENTION PERFORMANCE STANDARDS

A. Overall Service Delivery Performance Standard

1. For all recurring direct services including EBP Education, Non-EBP Education, Positive Alternatives (Single Session Continuing), Prevention Counseling and Early Intervention, at least 80% of planned participants will received the service planned as reported in PARIS.

2. A minimum of 80% of Counseling Assessments will be completed.

Total Assessment Episodes

WP Total Planned Assessments

3. A minimum of 80% of Counseling Admissions will be completed.

Total Admissions

WP total Planned Admissions

4. A minimum of 80% of EBP Education (Model program) Class/Groups will be initiated.

Total EBP Class/Groups Initiated

Total Planned EBP Class/Groups

5. A minimum of 80% of Non-EBP Education (Non-Model) Class/Groups will be initiated.

Total # Non-EBP sessions delivered

Total Planned Non-EBP Class/Groups

6. A minimum of 80% of Positive Alternatives (Single Session Continuing will be delivered.

Total # SSC sessions delivered

Total # planned SSC sessions

Activity Codes Included:

Fitness-Sports Activities

Cultural-Multicultural Activities

Arts Activities

Community Volunteer Activities

Other Pro-social Activities

7. A minimum of 80% of Single Session Activities for direct Information Dissemination will be delivered.

Total # Direct Information Activities delivered

Total # Planned Occurrences

Activity Codes Included

Telephone Information Services

Walk-in Information Services

Health Promotion Event

Speaking Events

8. Single Session Activities: Positive Alternatives =

Total # SSC sessions delivered

Total # planned SSC sessions

Activity Codes Included:

Fitness-Sports Activities

Cultural-Multicultural Activities

Arts Activities

Community Volunteer Activities

Other Pro-social Activities

Appendix C

Best Practices for Delivery of EBP Education Services

1. The Target Population age/grade groups selected must match the developers' EBP recommended age/grade groups.
2. The other Target Population demographics (Race, ethnicity, gender, other cultural factors) must match the developers' EBP recommended demographics.
3. The Target Population Risk Factors identified in the needs assessment must match the developers' EBP Risk Factors outcomes reported in the PARIS Knowledge-base.
4. Providers who adapt the curricula must contact the developer and get the changes approved in writing (a dated email response will suffice for documentation).
5. If on-site or Internet online training is required by the EBP developer, delivery staff must be trained and that training must be documented.

Appendix D

Environmental Strategies

Strength of the Research Evidence: EBP rating Table

Environmental substance abuse prevention strategies are those that shape the community, social, and economic context in which people access alcohol, tobacco, or other illicit drugs. They are primarily aimed at influencing behaviors through the establishment of laws, regulations and policies (referred to as “policies,” hereafter). The most effective environmental strategies employ a three-pronged approach: the implementation of a policy (which should include consequences for not abiding by the policy), media to raise awareness and support for the policy and its consequences, and enforcement of the policy and its consequences.

The table of environmental strategies below includes the “intervening variables” and “community context” factors that indicate a need for the strategy. The table is organized by the primary intervening variables. The Pacific Institute for Research and Evaluation (PIRE) researchers supporting the New York SPF-SIG project evaluation have reviewed environmental outcome studies and rated the level of evidence of effectiveness for each strategy from “High” to “Low/No data available”. The studies reviewed reported outcomes relevant to alcohol use and related negative consequences. The table includes Policy Change and Enforcement strategies, as well as Media/Communications efforts to support those strategies. *Prevention First-NY!* grantees (i.e., those funded by the NY SPF-SIG) are required, at a minimum, to select strategies within the Policy Change category that have a High or Medium level of evidence, and to support that policy through appropriate Enforcement and Media/Communications efforts. *Prevention First NY!* grantees may also select strategies at the “Low/No data available” level of evidence if those strategies complement the High and Medium evidence strategies. “High” level of evidence strategies are color coded green, “Medium” are yellow, and “Low” or “Data not available” are red.

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

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 misuse and/or are a common source of beer for minors	Medium
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
8. College/University Policies	Policies (and their enforcement) on college campuses can include many of those cited above (e.g., restrictions on retail sales, mandatory merchant training, keg registration, and restricting consumption where heavy drinking occurs, such as parking lots and campus stadiums). Additional policies that have some level of evidence include dry campuses (no alcohol consumption allowed on campus), as well as substance-free residence halls and fraternity/sorority houses,			High
9. School District Substance Use Policies	We did not find many studies on the effectiveness of school alcohol policies, other than drug testing (in which the evidence of effectiveness is mixed). Nevertheless, a University of Minnesota website suggests the following: <ul style="list-style-type: none"> • Prohibiting alcohol at school-related events, even if off school campus • Adopting practices to prevent bringing alcohol into schools or events (e.g., requiring mesh or see-through bags instead of backpacks, monitoring parking lots and school events, prohibiting re-entry into events) 			Low

Strategy	Strategy Description	Primary Targeted Intervening Variable	Consider the Strategy When...	Level of Evidence of Effectiveness
10. Workplace Substance Use Policies	Not much success in identifying workplace alcohol policies (other than policies prohibiting alcohol during business hours and drug testing); even less on the effectiveness of such policies. The U of Minnesota website lists some policies for preventing underage drinking in the workplace, similar to some of the strategies cited already (e.g., liability education and restricting/monitoring access to alcohol at workplace events).			Data not available.
11. Family Substance Use Policies	Not much success in identifying studies on the effectiveness of family-based alcohol policies. Nevertheless, some options might include Safe Homes (pledges to host safe, supervised, and substance free gatherings) and Lock it Up (pledges to keep alcohol and other drugs in a locked, secured location).			Data not available.

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 "Unsung 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
4. Social Marketing	Social marketing uses standard marketing techniques to persuade people to reduce harmful behaviors or increase socially positive behaviors.	Social/Community Norms	Attempting to change community attitudes; supports all strategic efforts	Medium
5. 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.epi.umn.edu/alcohol/policy/index.shtm>
- Underage Drinking Enforcement Center: <http://www.udetc.org>

Appendix E

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 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:

1. Used interactive and “experiential learning methods rather than passive lecture-style approaches”,
2. Fostered bonding with adults through opportunities and rewards for prosocial behavior,
3. Promoted the self-examination of substance use attitudes through role plays and group discussions,
4. Used the activities to practice the skills taught in EBP education – anger management, conflict resolution, decision making, other social skills,
5. Planned the activities to reinforce a central theme (conceptual coherence),
6. Maintained a structured and consistent delivery of planned activities at set times,
7. 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.