# Substance Abuse Prevention Framework
# and
# FY 2005 Services Recommendations

**Developed by:**
**The Prevention Subcommittee**
**of the**
**TCADA Technology Transfer Committee**
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**Texas Commission on**
**Alcohol and Drug Abuse**

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# Charge to the Prevention Subcommittee of the Technology Transfer Committee

**A. Establish a strategic direction for prevention/Define a prevention framework**

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**B. Establish criteria for FY 2004 Contract Renewal**

**C. Establish criteria for FY 2005 Services Procurement**

# Substance Abuse Prevention Framework

## Cost-Effectiveness of Prevention

TCADA's Statewide Service Delivery Plan (2002) states that "prevention is a cost-effective strategy to reduce the incidence of alcohol, tobacco and other drug use and preclude the need for treatment." Substance abuse places an enormous burden on Texans—as individuals, as families, as communities, and as taxpayers. The economic toll alone is staggering. Total economic costs of alcohol and drug abuse were estimated at close to $26 billion in 2000 ($16.4 billion for alcohol and $9.5 billion for illegal drugs)--$1,244 for every man, woman, and child in the state. The loss and suffering associated with substance abuse, however, is immeasurable. The simple fact is that everyone knows someone whose life has been impacted by substance abuse.

Several recent studies provide detailed evidence that the multimillion-dollar drain annually on the Federal entitlement budget to pay for the health consequences of drug abuse in our society can be significantly reduced through the implementation of evidence-based prevention programs. The emerging science of drug abuse prevention, which has until recent years lagged behind that of drug abuse treatment, can now point to numerous studies that show evidence of the cost-effectiveness of prevention services and programs. These include studies focused on high-risk youth, school-based and community-based programs, and family-focused methadone treatment in conjunction with prevention programs. Evidence of the impact of two approaches -- social influence and competence enhancement -- abounds in the literature and testifies to a 30 to 50 percent reduction in drug use after the initial intervention (Botvin). Several related studies are included in: "Cost-Benefit/Cost-Effectiveness Research of Drug Abuse Prevention: Implications for Programming and Policy," Research Monograph Series No.176, National Institute on Drug Abuse, June 1998.

Cost-benefit estimates available in the literature indicate that prevention is consistently cost-beneficial, with estimates ranging from $1:2 to $1:19.64. Substance abuse prevention is also a key factor in reducing health care costs in many areas, including spinal cord and head injuries from alcohol and drug impaired driving, health, education and rehabilitation costs associated with Fetal Alcohol Syndrome and ATOD-emergency room visits (SAMSHA, 1995).

The benefits of school-based drug prevention programs in the U.S. far exceed the costs. The lifetime social benefits from one average student's participation in drug prevention are estimated at $840, while the cost of one student's participation in drug prevention is approximately $150. Thus every $1 spent on school-based drug prevention results in a cost-savings of $5.60. (Rand: MR-1459-RWJ, 2002)

## Background

### Prevalence Data and Historical Nature of the Problem

The Drug Demand Reduction Advisory Committee serves by state law as the single source of information for the governor, legislature and public about substance abuse issues. TCADA's Executive Director is the presiding officer and TCADA staff provides administrative support.

Through this responsibility, TCADA has painted a clear picture of the nature of the substance abuse problem in Texas.

The January 2003 Drug Demand Reduction Advisory Committee Report, *Toward a Drug-Free Texas: A Coordinated Demand Reduction Strategy*, clarifies the need for substance abuse prevention in Texas. The following information comes from the report and data from the *2002 Texas School Survey of Substance Use Among Students*:

> Drug-related problems have a devastating impact on public health, welfare, and safety. In 2000, the total economic cost associated with alcohol and drug abuse in Texas was estimated at $25.9 billion. Seventy-one percent of students in Grades 7-12 reported using alcohol, with 26 percent considered binge drinkers. More than 13,500 Texans died from alcohol and drug disorders, 46% of them younger than 25. Substance abuse puts young people at risk in other ways too. National data indicate parental substance abuse causes or contributes to seven out of 10 cases of child abuse and neglect and three-quarters of all foster care placements. People with substance abuse problems crowd our jails and prisons. Six out of 10 Texas prisoners have substance abuse problems. Crime related to substance abuse cost Texas nearly $4 billion in 2000 and accounted for about 48% of total expenditures in the state's criminal justice system.
>
> Substance abuse places an enormous burden on Texans—as individuals, as families, as communities, and as taxpayers. The economic toll alone is staggering. Total economic costs of alcohol and drug abuse were estimated at $1,244 for every man, woman, and child in the state. The loss and suffering associated with substance abuse, however, is immeasurable. The simple fact is that everyone knows someone whose life has been impacted by substance abuse
>
> Substance abuse impacts all aspects of personal and family life and contributes to some of our most devastating social problems. Alcohol and drugs are key factors in violence and criminal activity and contribute to many serious medical disorders, including life-long conditions, such as fetal alcohol syndrome and AIDS. Substance abuse is also associated with high rates of child maltreatment, suicide, divorce, unwanted pregnancy, domestic violence, disability, unemployment, poverty, and homelessness. While there is no way to truly quantify the damage, the pervasiveness of the problem cannot be overstated.
>
> <u>Health</u>
>
> - In 2000, drugs and alcohol caused 38 percent of the deaths among young people aged 15 to 24 and nine percent of all deaths in Texas
> - About 13,518 Texans died in 2000 from alcohol and drug disorders—46 percent of them younger than 25 years old.
> - 42 percent of automobile accidents involved alcohol or drugs. They resulted in 1,161 deaths and 27,298 injuries in 1999.
> - About 20 percent (1,457) of the new HIV and AIDS cases reported in 2000 are linked with intravenous drug use.

- In 2000, approximately 727 babies were born with fetal alcohol syndrome, bringing the total number of Texans living with fetal alcohol syndrome to 23,260.
- Texas spent more than $2 billion in health care costs associated with drug and alcohol abuse in 2000.

Families

- In three out of four cases of domestic violence, the victim reported that alcohol or drugs had been a factor.
- Parental substance abuse causes or contributes to seven out of ten cases of child abuse and neglect and three-quarters of all foster care placements.
- In 2002, 38 percent of adults receiving treatment in state-funded community programs were custodial parents; together they were responsible for close to 24,000 children. Substance abuse severely impairs or compromises a parent's ability to provide a safe and nurturing home. As a result, these children are more likely to have problems with delinquency, poor school performance, sexual promiscuity, and emotional difficulty than their peers, and one in four will experience substance abuse problems.
- In FY 2003, TCADA-funded providers admitted 28,898 adult clients to treatment. About one-third of these clients reported having a total of 20,996 children living in the same household, and 497 of the clients were pregnant.

Schools

- Early smoking and marijuana use is associated with dropping out of high school, even among youth who have nonconforming attitudes and behaviors. Adolescents who are frequent smokers are 85% more likely to drop out of high school, and those who use marijuana are 68% more likely to drop out.
- High school dropouts have higher rates of unemployment and earn less than graduates without college degrees. They also use more social services, such as welfare, medical, and unemployment assistance, and are more likely to become involved with the criminal justice system.
- Adolescents who smoke, drink, or use marijuana are more likely to have behavioral problems in school and engage in illegal activities, including use of other drugs.

Workplaces

- One fourth of the people on welfare assistance have a substance abuse problem that creates a substantial barrier to finding and keeping a job.
- Three fourths of all substance abusers are employed, but they are about 12% less productive than their peers. They are more than twice as likely to skip work or to work for more than three employers in a single year. Furthermore, the health care costs for employees with alcohol problems are double those of other employees.
- Lost productivity due to alcohol and drugs cost Texas $11.2 billion in 2000.

Criminal Justice System

- In 2000, 68 percent of youths entering Texas Youth Commission facilities abused or were dependent on alcohol or drugs in the year before their

incarceration. About one-third of them report using alcohol or drugs when they began getting into legal trouble.
- Crime related to substance abuse cost Texas close to $4 billion in 2000 and accounted for about 48% of the total expenditures in the state's criminal justice system.

Over the past century, the use of tobacco, alcohol and illegal drugs has fluctuated in response to changes in public attitudes and the political, economic, and social environment. The most dramatic change has been the drop in smoking, which began in the mid 1960s. Use of illegal drugs and alcohol peaked in the late 1970s and early 1980s, respectively, and then began a period of steady decline. This era was marked by increased awareness of health risks, significant new laws and policies, government support of prevention and treatment services, and the development of grassroots initiatives and community coalitions aimed at decreasing substance abuse.

In 1990, however, tobacco and illegal drug use among young people began to climb again. These increases have been attributed to a number of factors, including a lowered perception of the risks associated with using drugs; fewer anti-drug messages from parents, schools, and the media; positive images of drug use portrayed by the entertainment industry; and aggressive marketing by tobacco companies. The upward trend stabilized in 1998, and since then, use has fallen slowly but steadily. Among adults, past-year use of illegal drugs rose slightly between 1993 and 2000.

While current patterns of drug use are generally much lower than the peaks seen in past decades, they remain at unacceptable levels. Moreover, patterns of use for specific substances vary, and gains in one area are sometimes offset by an escalating or emerging problem in another. Despite significant gains, substance abuse continues to pose a significant threat to the state's public health and safety.

**Alcohol** is the state's number one drug problem. Although use has been declining gradually since 1990, alcohol remains the drug of choice for young people and the most widely abused drug among adults.
- About 18 percent of seventh graders and 51 percent of twelfth graders report drinking in the past month.
- Twenty-three percent of high school seniors drove a car after having a substantial amount to drink at least once during the past school year. This represents 74,000 impaired teen drivers on Texas roads each year.
- Binge drinking was reported by 26 percent of students in grades 7-12. Moreover, 29 percent of college students in Texas are binge drinkers, and 16 percent become drunk often (three or more times a month).
- About 16 percent of adults in Texas have a problem of alcohol abuse or dependence.

**Tobacco** is also a serious problem, even though adult smoking is at its lowest point since the early sixties. Decreases have been uneven among the population, and women are closing the historical gap between rates of smoking for men and

women. While tobacco use among teenagers has dropped significantly over the past four years, it remains dangerously high with nearly one in five secondary students reporting past month use. This number is particularly troublesome because tobacco use is linked with increased use and abuse of other drugs.

The 2002 School Survey showed that tobacco was the second most widely used substance among students. About 45 percent of all secondary students in the 2002 survey reported having used some type of tobacco product cigarettes or smokeless tobacco during their lifetime, significantly down from 51 percent in 2000. 18% reported tobacco use in the month before the survey, with 12th graders (30 percent) admitting more than triple the use of 7th graders (9 percent).

Patterns of **illegal drug use** vary over time and according to age group. Among youth, overall use has decreased slightly in recent years. Marijuana is the most popular illicit drug, accounting for three out of four adolescent treatment admissions. Levels of cocaine and crack have stabilized, but the use of Ecstasy has increased sharply at all grade levels in recent years.

- 16 percent of youth report current use of illegal drugs, and seven percent are heavy users who use illegal drugs on a daily or weekly basis.
- Inhalants use is a serious problem, particularly among students in seventh and eighth grades and among those who experience academic, attendance, and disciplinary problems at school.
- Eighteen percent of all secondary students reported lifetime use of any inhalant substance. The percent of students who reporting using inhalants during the past-month has remained constant at 7 percent during the past two school surveys.
- For 7th graders, inhalants were the third most commonly used substance, after alcohol and tobacco; while for other grades, marijuana was the third most commonly used substance.
- About 34% of all secondary students in 2002 reported using some type of illicit substance during their lifetime, and 16 percent reported past-month use.
- Some 36% of boys and 30% of girls had ever used illicit drugs. Use of illicit drugs remained stable between 2000 and 2002, but significant increases were reported for some drugs. The most dramatic rise was seen in Ecstasy use, where seventh and eighth graders reported more than double rates of use than 2 years ago.
- Marijuana was the most commonly used illicit drug and the third most prevalent substance that secondary school students reported using after alcohol and tobacco. Thirty-two percent of all secondary students in 2002 reported having smoked marijuana at some point in their lives, the same as in 2000. Past-month use of marijuana was 14.4% in 2002.

Most people with substance abuse problems began using drugs at an early age. The earlier people start using drugs, the more likely they are to develop a substance use disorder. The average age of first use for all substances is lower now than it was in 1994. On average, Texas students begin using tobacco, beer, and inhalants when they are twelve years old and illegal drugs when they are 13 years old. One factor that determines whether students use drugs is their

perception of the risks involved. Young people who believe substances are dangerous are less likely to actually use them.

## History of Prevention Funding at TCADA

Through Substance Abuse and Prevention Block Grant application, TCADA has consistently reported to the Center for Substance Abuse Prevention a prevention funding level considerably over the 20% set-aside that is required of the state.

**Prevention Set-Aside History**

**FY 1997 -FY 2004**

| Fiscal Year | Requirement |
|---|---|
| 1997 | $ 17,843,835 |
| 1998 | $ 17,843,835 |
| 1999 | $ 24,508,711 |
| 2000 | $ 24,823,606 |
| 2001 | $ 25,457,884 |
| 2002 | $ 26,529,845 |
| 2003 | $ 26,666,226 |
| 2004 | $ 26,666,226 |

## History of Prevention Service Delivery System

Since 1997, the TCADA Board of Commissioners has committed to make prevention the cornerstone of TCADA's service delivery system and directed the development of a comprehensive prevention strategy for the agency. The 1997 NIDA publication of the "red book," *Preventing Drug Use Among Children and Adolescents*, provided the research-based guide for the implementation of TCADA's prevention system that is currently in place. The "red book" provided the direction for use of the Institute of Medicine - Universal, Selective and Indicated - classifications that are targeted for prevention services.

The Statewide Service Delivery Plan (SSDP) of February 1, 1998 reflected the Board's commitment in stating that prevention "plays a critical role in the overall delivery of health services be they for physical, mental, or substance dependence problems." The 1998 SSDP provided a blueprint for the development of a system of service networks – network management organizations. The plan called for prevention to be included in the networks.

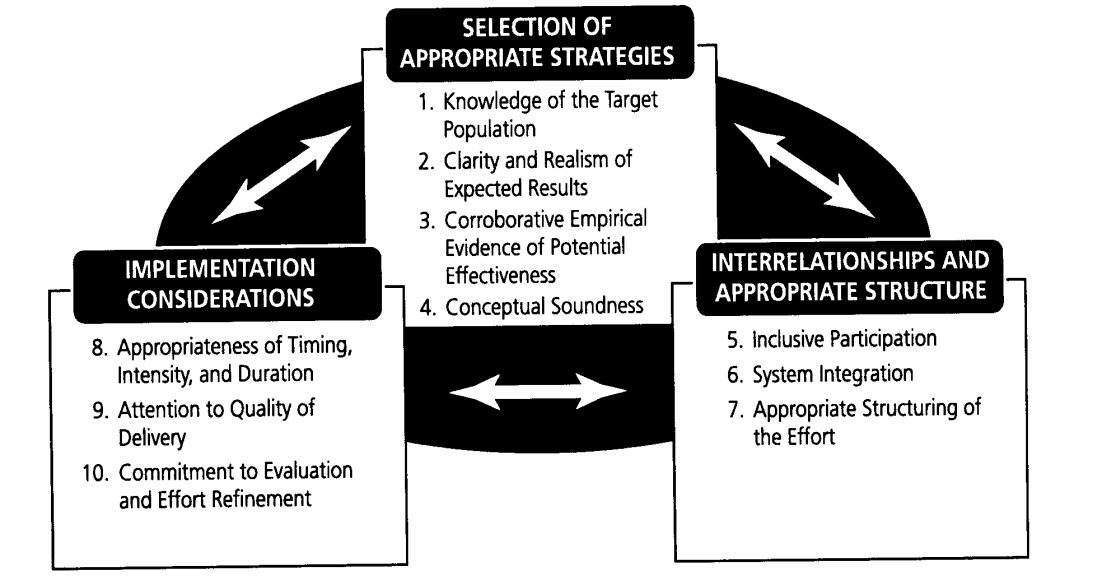
During the years since 1997, TCADA's philosophy has remained constant: "Prevention is the cornerstone of our service system. Drug abuse is a preventable behavior, and prevention is the most cost effective investment we can make."

The following chart details the Prevention/Intervention Service Delivery program strategies:

| Prevention Program Strategy | Type | Area Coverage | Description |
|---|---|---|---|
| Youth Primary Prevention | YPP | Community | Conduct prevention strategies that target universal and selective youth an families to preclude ATOD use |
| Community Coalition Program | CCP | Community | Conduct environmental/community-based activities to preclude ATOD us |
| Prevention Resource Centers | PRC | Region | Provide prevention resource center clearinghouse for information and materials and training |
| Prevention Media Campaign | PMC | Statewide | Conduct public awareness campaign/Partnership for a Drug Free Texas/R Ribbon Campaign |
| Prevention Training Service | PTS | Statewide | Prevention training to support evidence-based prevention program implementation |
| Tobacco Special Project | TOB | Statewide | Conduct annual Synar Survey |
| Tobacco Interagency Prevention | TIP | Community | Interagency contract to conduct tobacco prevention/cessation activities in selected areas |
| State Incentive Grant | SIG | Community | Federal grant to conduct science-based prevention programs targeting 12-year old youth and families through community coalitions |
| **Intervention Program Strategy** | **Type** | **Area Coverage** | **Description** |
| Youth Prevention/Intervention | YPI | Community | Conduct prevention strategies to target indicated youth and families to interrupt illegal ATOD use and other problem behaviors |
| Rural Border Intervention | RBI | Rural community | On the Texas Mexico border, target indicated youth and families to interr illegal ATOD use and other problem behavior by engaging them in prevention and treatment services |
| Pregnant/Postpartum Intervention | PPI | Community | Conduct intervention strategies that target substance abusing pregnant/postpartum women and their children to interrupt ATOD use an other problem behaviors |
| Outreach, Screening & Referral | OSR | Multi-county | Conduct outreach, screening and referral services for substance abuse and other social service needs for individuals, families and communities |
| **Other Intervention Program Strategies Not A Part of the Prevention Service Delivery System** | HEI, HIV, HTS, HTY | Selected Community | HIV Early Intervention, HIV Outreach, HIV Training Statewide and Interagency Support for Texas Integrated Funding Initiative |

The 1997 CSAP Implementation Guide, Guidelines and Benchmarks for Prevention Programming, provided the tool that TCADA used to develop rules and set standards for prevention effectiveness. Figure 2 below illustrates the processes recommended in the guidelines.

**Figure 2**



TCADA assumed leadership of the **Partnership for a Drug-Free Texas (PDFT)** in 1997. Since that time, the PDFT has won numerous national awards for its work to shape attitudes across Texas about the use of drugs. PDFT reports a total return on the TCADA investment at $44 for every $1 spent for the period September 2002 - April 2003. The total cost to TCADA was $390,525 and the total return was $17,638,520 for that same time period.

Eleven **Prevention Resource Centers** were funded in January 1997 in each of the HHSC regions to serve as a resource for local communities by providing needs assessment, resource identification, training and materials.

In February 1997, the **Prevention Model Initiative** was funded to implement a model program in each region that had been documented as researched and proven effective in the NIDA "red book." The model program initiative was a TCADA pilot to test how to shape programs to address the differing needs of the Texas population while maintaining the original effectiveness of the researched program. TCADA received national recognition from the Society for Prevention Research in June 1998 and from CSAP in March 1999 for pioneering this research-to-practice effort. The following are the models that were funded through a cooperative agreement with exemplary TCADA funded providers across the state:

- Life Skills Training Program - Botvin
- All-Stars - Hansen
- Promoting Alternative THinking Strategies (PATHS) - Kusche
- Preparing for the Drug Free Years- Hawkins & Catalano
- Communities that Care - Hawkins & Catalano
- Strengthening Families - Kumpfer
- Reconnecting Youth - Eggert

Results from the comprehensive TCADA evaluation were positive for the model programs that were implemented across the state. TCADA applied for and received the Texas Education Agency (TEA) designation as an innovative program for the Reconnecting Youth program so that students could receive school credit for taking the course that is implemented in high schools. The Strengthening Families Program in El Paso was featured along with the developer, Dr. Karol Kumpfer, on a Bill Moyers' PBS special. Aliviane, Inc. culturally adapted that program for Mexican Americans and the adaptation *Dando Fuerza (Strengthening Families Program for Mexican American Families)* has been designated a promising program by CSAP.

In March 1998, TCADA funded **statewide prevention training** services that today work to meet the charge of this subcommittee to improve the skills of the prevention workforce. The Statewide Prevention Training Services were funded to provide training and technical assistance to preventionists in an effort to strengthen and expand TCADA's prevention infrastructure by providing best practice training in 8 categories ranging from community mobilization to life skills training for youth. The PTS programs were re-competed in 2001, and 12 programs were funded to provide training in the following domains: individual, family, community, and school. Over 8,000 service providers were trained in evidence-based strategies in 2003. Five Texas-developed and TCADA-funded PTS programs were named as model or promising by CSAP's NREP process. These programs include: *Protecting You-Protecting Me, Peers Making Peace, Strengthening Families Program for Mexican American Families, the PAL Program and Student Assistance Program*.

The Southwest CAPT sponsored Substance Abuse **Prevention Specialist Training** to 650 people during the last two years has greatly enhanced the development of a strong prevention workforce in Texas. In fiscal year 2004, all TCADA-funded prevention program directors were required to have this training. The SWCAPT conducted the Regional Workforce Development Initiative in September in an effort to bring together key prevention stakeholders from the state to develop a strategic plan to strengthen the prevention workforce in Texas. This initiative will continue the work on the plan during FY 2004.

Training and technical assistance efforts begun during this time included a prevention track at the TCADA Institute, an expanded focus on prevention at the TCADA Best Practices Conference and regional trainings provided by TCADA's Training and Technical Assistance Division. More significantly, the first annual TCADA Prevention Conference was held in fall 1999. The Prevention Conference was focused on providing prevention best practice training to teams of community stakeholders who could take back the knowledge to a wide spectrum of community services.

**Community Coalition** funding was awarded for the first time in April 1998 with the goal of strengthening collaboration in communities and to support the existing community-based prevention/intervention and treatment infrastructure – to connect the dots in communities. Eighteen coalitions were funded in the 11 HHSC regions.

TCADA initiated **core council services** (**OSR)** in 1990. Since that time, the outreach, screening and referral services have served as a critical referral link and entry point for the public to treatment and other services. Additionally since 1996, these providers have been responsible for required minors and tobacco prevention services.

The **Border Initiative** also was developed that year with a goal of establishing a regional substance abuse prevention system along the Texas-Mexico Border. Implementation of locally developed, comprehensive prevention programs that served the diverse needs of the border was the priority. The following is a brief description of the progression of the border initiative:

- 1997- $200,000 ONDCP grant that TCADA matched with an additional $250,000 to increase prevention program capacity for the border region.
- 1998-TCADA participated in the first of four United States-Mexico Demand Reduction Conferences sponsored by the ONDCP and CONADIC as a high-level, bi-national coordinating forum for sharing information on research and best practices on the border.
- 1999-TCADA began to formulate a working relationship with the newly developed Border CAPT and to assist them in coordinating regional activities along the Texas border.
- 2000-TCADA staffed a full-time border coordinator.
- 2001-TCADA participated in the HHSC Colonia initiative.
- 2001-TCADA received a technical assistance request to Center for Substance Abuse Treatment that offered videoconferences to 8 border communities.
- 2002-TCADA developed a Border Strategic Plan.
- 2002-TCADA became a member of the Border Governor's Substance Abuse Commission.
- 2003-TCADA became a member of the Texas Secretary of State Bi-national Roundtable.
- 2003-TCADA funded intervention services in the Big Bend area and in the Valley area.

In 2000, the SSDP stated that prevention continued to form the foundation of the state's substance abuse service system. The latest SSDP, February 2002, stressed the development of an integrated system of care that makes appropriate services available and accessible to meet the needs of clients and their families by providing a continuum of high quality prevention and treatment services in each region. Collaboration was the key to improved prevention outcomes in 2002. The 2002 plan again indicated, "prevention is a cost effective strategy to reduce the incidence of alcohol, tobacco, and other drug use and preclude the need for treatment."

A $27 million shortfall at TCADA at the end of 1999 greatly impacted the provision of prevention services. The shortfall impacted prevention service capacity at both the state and community level.

In March 2002, the State of Texas, through the Governor's Office, entered into a cooperative agreement with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) to oversee the **State Incentive Grant (SIG)** Program authorized under Section 516 of the Public Health Service Act, as amended. The Governor designated the Texas Commission on Alcohol and Drug Abuse to direct the $4 million annual award to develop and implement a comprehensive substance abuse prevention strategy. To support the development of effective prevention approaches at the local level, this program will award 85 percent of the funding, or $3.4 million, to community coalitions for community planning and implementation of science-based programs. The SIG program, titled the Texas State Incentive Program (TSIP), funded 27 coalitions in 2003. SIG funding is intended to augment current prevention efforts and cannot be used to supplant TCADA prevention services.

The 2003 DDRAC report to the legislature set forth the state's mission of a generation of drug-free Texans. Fourteen state agencies signed a Memorandum of Understanding to support the development and implementation of the Texas Drug Demand strategy. The DDRAC report included goals, 10-year targets and specific recommendations that impact prevention service delivery at TCADA. The DDRAC goal for prevention is to stop use before it starts through the following strategies:

- Establish laws and policies that foster healthy individuals and communities.
- Educate the public about substance abuse and promote social norms that discourage illegal and inappropriate use of alcohol, tobacco, and other drugs.
- Support the development of community coalitions to promote, plan, and coordinate prevention activities that address specific community needs.
- Involve families, schools and community support in prevention efforts.
- Motivate and prepare teachers, health professionals, clergy, community leaders, and other citizens to serve as positive role models and mentors.
- Use media and other technology to promote prevention through clear, consistent drug-free message
- Provide research-based prevention programs to foster positive, healthy lifestyles among youth, equipping them to reject the use of alcohol, tobacco, and other drugs.

The 10-year targets are as follows:

- Reduce use of alcohol, tobacco, and other illegal drugs among adolescents age 12-17 by 25 percent.
- Reduce illegal drug use among adults by 25 percent.

- Increase by 25 percent the number of adolescents who access state-funded treatment prior to juvenile justice system involvement

In July 1992, Congress enacted a law aimed at decreasing access to tobacco products among youth under the age of 18. Named for its sponsor, Congressman Mike Synar of Oklahoma, the **Synar** amendment required states to enact and enforce laws prohibiting any manufacturer, retailer, or distributor from selling or distributing tobacco products to youth under the age of 18. The goal of the amendment was to reduce the number of successful illegal purchases by minors to no more that 20 percent of attempts in each state within a negotiated time period. In 1997, the Texas Legislature passed Senate Bill. The Texas law gave full responsibility for enforcement of the law to the Comptroller of Public Accounts. The federal penalty for non-compliance with the requirement goes to the Single State Authority for substance abuse. Through a Memorandum of Understanding with the Comptroller, TCADA has conducted the annual Synar survey to determine the rate of illegal sales to minors and prepared the annual Synar report to SAMHSA/CSAP. An additional requirement of the MOU for TCADA is the provision of community education through TCADA-funded Outreach, Screening and Referral programs. Since 1996, OSR's have been required to conduct voluntary retailer compliance visits, provide community presentations and media outreach and participate in community coalitions working on tobacco prevention. Additionally, TCADA-funded Youth Prevention Programs participate in the effort to reduce minors' access to tobacco. The historical Texas Synar rates are as follows:

- 1995 – 53%
- 1996 – 56%
- 1997 – 24% (Texas law effective 9/1/97)
- 1998 – 13%
- 1999 – 14.6%
- 2000 – 13.4%
- 2001 – 12.9%
- 2002 – 15.7%

## TCADA's Current Prevention Fiscal and Program Policies

The current TCADA prevention framework provides a continuum of services that target universal, selective and indicated populations. Definitions for these three Institute of Medicine classifications of prevention activities are as follows:

### Universal

Universal prevention strategies are designed to reach the entire population without regard to individual risk factors, and they generally are designed to reach a very large audience. Participants are not recruited to participate in the program, and the degree of individual substance abuse risk of the program participants is not assessed. The program is provided to everyone in the population (community, school, or neighborhood) regardless of whether they are at risk for substance abuse. General examples of universal preventive interventions include the use of seat belts, immunizations, prenatal care, and smoking prevention (IOM 1994). All members of a community, not just specific individuals or groups within a community, benefit from a universal prevention effort. Examples of universal preventive interventions for substance abuse include substance abuse education using school-based curricula for all children within a school district, media and public awareness campaigns within inner-city neighborhoods, and social policy changes, such as reducing alcohol availability by reducing the number of liquor outlets in a municipality.

**Selective**

Selective prevention strategies target subgroups of the general population that are determined to be at risk for substance abuse. Recipients of selective prevention strategies are known to have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group's profile, but the degree of individual vulnerability or personal risk of members of the targeted subgroup generally is not assessed. Vulnerability is presumed on the basis of their membership in the at-risk group. Knowledge of specific risk factors within the target group allows program designers to address specific risk reduction objectives. Selective programs generally run for a longer period of time and require more time and effort from participants than universal programs. General examples of selective prevention interventions include home visitation and infant day care for low birth-weight children and annual mammograms for women with a family history of breast cancer (IOM 1994). Selective prevention targets those who are at greater-than-average risk for substance use. Targeted individuals are identified on the basis of the nature and number of risk factors for substance use to which they may be exposed. Examples of selective prevention programs for substance abuse include special clubs and groups for children of alcoholics, rites of passage programs for at-risk males, and skill training programs that target young children of substance abusing parents, or families who live in high crime or impoverished neighborhoods, and mentoring programs aimed at children with school performance or behavioral problems.

**Indicated**

Indicated prevention interventions identify individuals who are experiencing early signs of substance abuse and other related problem behaviors associated with substance abuse and target them with special programs. The individuals identified at this stage, though showing signs of early substance use, have not reached the point where a clinical diagnosis of substance abuse can be made. Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors -- such as school failure, interpersonal social problems, delinquency and other antisocial behaviors, and psychological problems such as depression and suicidal behavior -- that increase their chances of developing a substance abuse problem. Indicated prevention approaches require a precise assessment of an individual's personal risk and level of related problem behaviors rather than relying on the person's membership in an at-risk group as in the selected approach. Programs are frequently extensive and highly intensive; they typically operate for longer periods of time, at greater frequency of contact and require greater effort on the part of the participant than do selective or universal programs. General examples of indicated prevention in the health field include training programs for children experiencing early behavioral problems, medical control of hypertension, and regular examinations of persons with a history of basal cell skin cancer (IOM 1994). In the field of substance abuse, an indicated prevention intervention would be a substance abuse program for high school students who are experiencing a number of problem behaviors, including truancy, failing academic grades, juvenile depression, suicidal ideation, and/or early signs of substance abuse.

CSAP Prevention Strategies

All TCADA-funded programs implement one or more of the following six CSAP Prevention Strategies in the delivery of the prevention program:

- **Information Dissemination:** These activities provide awareness and information on the nature and effects of alcohol, tobacco and drug use, abuse and addiction and their impact on individuals, families and communities. Activities include the development and dissemination of educational and informational materials to provide public information (through the media and otherwise) for the purpose of reducing alcohol, tobacco and other drug abuse.

- **Prevention Education and Skills Training:** These activities involve two-way communication and are distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, and critical analysis.

- **Problem Identification and Referral**: Activities are directed at 1) the *identification* of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have indulged in the first use of illicit drugs, and 2) *referral* for appropriate screening/assessment.

- **Alternatives:** These activities provide for the participation of target populations in activities that exclude alcohol, tobacco and other drug use, including activities that promote the awareness of alternatives to alcohol, tobacco, and drug abuse including service learning projects that encourage drug-free lifestyles. More successful (in reducing risk or increasing protective factors) alternative activities are those that are integrated with skills-based or other learning initiatives. Alternative activities alone have not been shown to reduce substance use or abuse.

- **Community-Based Process:** These services are intended to enhance the ability of the community to more effectively provide prevention, intervention and treatment services for alcohol, tobacco, and other drug abuse through community mobilization and empowerment. Community-based strategies include activities, such as training parents, school staff, law enforcement officials, judicial officials, social service providers, health service providers and community leaders; collaborating with community-based organizations, schools and other local agencies in the planning and implementation of drug and alcohol abuse services; and linking community resources.
- **Environmental and Social Policy:** These activities establish or change written and unwritten community standards, codes and attitudes, thereby reducing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population. Activities include such things as promoting the establishment of a review process for alcohol, tobacco, and other drug use policies in schools; community initiatives to establish ordinances to reduce public drinking or smoking; and various social and public policy initiatives directed at the improvement of health conditions in the community such as zero-tolerance policies for youth drinking and driving.

## Current Service Delivery System Funding

**Universal/Selective/Indicated Funding - FY 2003** (See Appendix 4 U/S/I Maps)

Universal

- FY03 total number of funded YPP programs serving the universal populations: 64

- FY03 total dollars expended - YPP programs serving the universal populations: $15,273,325

Selective
- FY03 total number of funded YPP programs serving the selective populations: 34
- FY03 total dollars expended - YPP programs serving the selective populations: $4,721,381

Indicated
- FY03 total number of funded YPI programs serving the indicated populations: 52
- FY03 total dollars expended - YPI programs serving the indicated populations: $18,362,805

**Funding By CSAP Prevention Strategies – FY 2004**
- Information Dissemination: $3,210,514.43
- Prevention Education and Skills Training: $24,381,098.61
- Problem Identification and Referral: $4,954,952.68
- Alternative Activities: $4,427,217.73
- Community Based Processes: $3,733,340.09
- Environmental/Social Policy: $1,986,539.19

**Funding for Minors and Tobacco Activities - FY 2003**
YPP
- FY03 total number of YPP programs implementing Minors and Tobacco Activities: 98
- FY03 total YPP dollars (estimated) for Minors and Tobacco Activities: $1,108,275.00

OSR
- FY03 total number of OSR programs implementing Minors and Tobacco Activities: 41
- FY03 total OSR dollars (estimated) for Minors and Tobacco activities: $457,818

## Key Concepts Underlying the Prevention Framework

**TCADA Vision**

A bright Texas where individuals, families, and communities may reach their full potential away from the shadows of addiction.

**TCADA Mission**

The mission of the Texas Commission on Alcohol and Drug Abuse (TCADA) is to provide a continuum of complementary alcohol and other substance abuse services in an efficient, effective and fiscally responsible manner that includes prevention, intervention, treatment and rehabilitation, and to improve access to these services across the state.

**Guiding Principles**

The Prevention Subcommittee relied on the Research and Best Practice work group of 2002 as a guide for developing the recommendations of this strategic plan. The report from the work group included this guiding statement: "The following basic principles, developed by NIDA, represent the knowledge gained through research and evaluation conducted over the past two decades. These principles articulate current best practices in the field of substance abuse prevention. A number of national agencies have identified promising, effective, and model substance abuse prevention programs that incorporate these principles and have achieved positive results. Even though various agencies use a variety of criteria for selection as a promising, effective or model program, all have criteria that contain a requirement for proof of positive outcomes. Using these recognized programs is a strategy to improve prevention outcomes."

1. Prevention programs should be designed to enhance protective factors and move toward reversing or reducing known risk factors.
2. Prevention programs should target all forms of drug abuse, including the use of tobacco, alcohol, marijuana and inhalants.
3. Prevention programs should include skills to resist drugs when offered, strengthen personal commitments against drug use, and increase social competency, in conjunction with reinforcement of attitudes against drug use.
4. Prevention programs for adolescents should include interactive methods, such as peer discussion groups, rather than didactic teaching techniques alone.
5. Prevention programs should include a parent or caregiver component that reinforces what the children are learning—such as facts about drugs and their harmful effects—and that opens opportunities for family discussions about use of legal and illegal substances and family policies about their use.
6. Prevention programs should be long-term, over the school career with repeat interventions to reinforce the original goals.
7. Family-focused prevention efforts have greater impact than strategies that focus on parents only or children only.

8. Community programs that include media campaigns and policy changes, such as new regulations that restrict access to alcohol, tobacco, or other drugs, are more effective when they are accompanied by school and family interventions.
9. Prevention programs need to strengthen norms against drug use in all settings, including the family, the school, and the community.
10. Schools should offer opportunities to reach all populations.
11. Prevention programs should be adapted to address the specific nature of the drug abuse problem in the local community.
12. The higher the level of risk of the target population, the more intensive the drug abuse effort must be and the earlier it must begin.
13. Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive.

## Theoretical Basis for Prevention

**Risk and protective factor-focused prevention** is based on a simple premise: To prevent a problem from happening, we need to identify the factors that increase the risk of that problem developing and then find ways to reduce the risk. At the same time, we must also identify those factors that buffer individuals from the risk factors present in their environments and then find ways to increase the protection.

Risk and protective factor-focused prevention is based on the work of J. David Hawkins, Ph.D., Richard F. Catalano, Ph.D., and a team of researchers at the University of Washington in Seattle. In the early 1980s, they conducted a review of 30 years of youth substance abuse and delinquency research and identified risk factors for adolescent drug abuse and delinquency. They have continually updated this review. Other researchers—including Joy Dryfoos, Robert Slavin and Richard Jessor—have reviewed the literature on behavior problems, such as school dropout, teen pregnancy, violence and the identified risk factors of these problems. Young people who are seriously involved in juvenile delinquency, substance abuse, school dropout, teenage pregnancy or violence are more likely to engage in one or more of the other problem behaviors. Furthermore, all of these teen problems share many common risk factors.

The primary focus of substance abuse prevention programs is reducing substance abuse; however, since problem behaviors—including substance abuse, violence, delinquency, teenage pregnancy and school dropout—share many common risk factors, reducing common risk factors is likely to reduce multiple problem behaviors.

### Risk Factors

Generalizations about Risks

- Risks exist in multiple domains.
- Risk factors exist in all areas of life. If a single risk factor is addressed in a single area, problem behaviors may not be significantly reduced. Communities should focus on reducing risks across several areas.
- The more risk factors are present; the greater is the risk.
- While exposure to one risk factor does not condemn a child to problems later in life, exposure to a greater number of risk factors increases a young person's risk exponentially.

Even if a community cannot eliminate all the risk factors that are present, reducing or eliminating even a few risk factors may significantly decrease problem behaviors for young people in that community.
- Common risk factors predict diverse problem behaviors. Since many individual risk factors predict multiple problems, the reduction of risk factors is likely to affect a number of different problems in the community.
- Risk factors show consistency in effects across different races and cultures. While levels of risk may vary in different racial or cultural groups, the way in which these risk factors work does not appear to vary. One implication for community prevention is to prioritize prevention efforts for groups with higher levels of risk exposure.

The following is a summary of the research-based **risk factors** and the problem behaviors they predict (in parentheses).

Community Risk Factors
- Availability of Drugs (Substance Abuse and Violence)
- Community Laws and Norms Favorable toward Drug Use, Firearms and Crime (Substance Abuse, Delinquency and Violence)
- Community norms—the attitudes and policies a community holds about drug use and crime—are communicated in a variety of ways: through laws and written policies, through informal social practices and through the expectations parents and other members of the community have of young people.
- Extreme Economic Deprivation (Substance Abuse, Delinquency, Violence, Teen Pregnancy and School Dropout)

Family Risk Factors
- Family History of the Problem Behavior
- Family Management Problems (Substance Abuse, Delinquency, Violence, Teen Pregnancy and School Dropout)
- Family Conflict (Substance Abuse, Delinquency, Violence, Teen Pregnancy and School Dropout)
- Parental Attitudes and Involvement in Drug Use, Crime and Violence (Substance Abuse, Delinquency and Violence)

School Risk Factors
- Early and Persistent Antisocial Behavior (Substance Abuse, Delinquency, Violence, Teen Pregnancy and School Dropout)
- Academic Failure Beginning in Elementary School (Substance Abuse, Delinquency, Violence, Teen Pregnancy and School Dropout)
- Lack of Commitment to School (Substance Abuse, Delinquency, Violence, Teen Pregnancy and School Dropout)

Individual/Peer Risk Factors
- Alienation/Rebelliousness (Substance Abuse, Delinquency and School Dropout)
- Friends Who Engage in the Problem Behavior (Substance Abuse, Delinquency, Violence, Teen Pregnancy and School Dropout)
- Favorable Attitudes toward the Problem Behavior (Substance Abuse, Delinquency, Teen Pregnancy and School Dropout)

- Early Initiation of the Problem Behavior (Substance Abuse, Delinquency, Violence, Teen Pregnancy and School Dropout)
- Constitutional Factors (Substance Abuse, Delinquency and Violence)

**Protective Factors**

Protective factors may buffer exposure to risk. Protective factors are conditions that buffer young people from the negative consequences of exposure to risks by either reducing the impact of the risk or changing the way a person responds to the risk. Consequently, enhancing protective factors can reduce the likelihood of problem behaviors arising.

Some youngsters who are exposed to multiple risk factors do not become substance abusers, juvenile delinquents, school dropouts or teen parents. Balancing the risk factors are protective factors—aspects of people's lives that counter or buffer risk. Research has identified protective factors that fall into three basic categories: individual characteristics, bonding and healthy beliefs and clear standards.

Individual Characteristics
Research has identified four individual characteristics as protective factors. These are characteristics children are born with and are difficult to change: gender, a resilient temperament, a positive social orientation and intelligence. Intelligence, however, does not protect against substance abuse.

Bonding
Positive bonding makes up for many other disadvantages caused by other risk factors or environmental characteristics. Children who are attached to positive families, friends, school and community and who are committed to achieving the goals valued by these groups are less likely to develop problems in adolescence. Studies of successful children who live in high-risk neighborhoods or situations indicate that strong bonds with a caregiver can keep children from getting into trouble. To build bonding, three conditions are necessary: opportunities, skills and recognition. Children must be provided with opportunities to contribute to their community, family, peers and school.

Healthy Beliefs and Clear Standards
The people to whom youth are bonded need to have clear, positive standards for behavior. The content of these standards is what protects young people. When parents, teachers and communities set clear standards for children's behavior, when they are widely and consistently supported and when the consequences for not following the standards are consistent, young people are more likely to follow the standards.

Actively Creating Healthy Communities
- Research supports the importance of a community focus.
- Risk and protective factors are found in all aspects of the community: schools, families, individuals and the community. Community efforts can affect the entire local environment, including community norms, values and policies.
- Because substance abuse is a phenomenon influenced by multiple risk factors, its prevention may be most effectively accomplished with a combination of interventions.

- A community-wide approach promotes the development of strong bonds to family, community and the school.
- Because community approaches are likely to involve a wide spectrum of individuals, groups and organizations, they create a base of support for behavior change. The firm support of community leaders and their involvement in a prevention effort is likely to lead to long-term behavior change. This reallocation of resources to reduce risk factors and enhance protective factors becomes feasible with support from community leaders.
- Programs and strategies gradually become integrated into the regular services and activities of local organizations and institutions. The community-wide focus creates a synergy; the whole is more powerful than the sum of its parts.
- Because many attempts to change families, schools and other institutions have operated in isolation, they have had limited success. For meaningful change to occur, multiple interconnected forces of the community must begin to share a common vision and agenda.

# Services Recommendations for Prevention FY 2005

## Analysis of Current TCADA Service Delivery System Needs

The Prevention Subcommittee has determined that the current system provides for a comprehensive array of prevention services that function at three vital levels – statewide, regional and local. Services are targeted to universal (both individual and environmental), selective and indicated youth and their families.

The universal strategies are implemented to affect both environmental and individual youth outcomes. Development of a strong workforce through the statewide prevention training programs is a need that remains fundamental to a competent workforce. Continuation of participation in the Partnership for a Drug-Free America/Texas (PDFT) campaign is needed to maintain an awareness of prevention efforts for the state. The influence of the Prevention Resource Centers (PRC) should be strengthened at the regional level with funding to meet the increased responsibilities that will be assumed by moving the Outreach Screening and Referral (OSR) function to serve as an access and coordination entity for treatment (OSAR). Increased funding (information dissemination strategy funding from OSR) will provide additional prevention materials, evidence-based curricula, curricula training and information on regional resources for prevention and treatment. Providing centralized support for the PRC's through the TCADA library and clearinghouse will be a priority for additional funding for much requested prevention materials.

In recent years, community coalitions have emerged as a critical element in successful substance abuse prevention systems. Community coalition programs (CCP) have the ability to unite diverse stakeholders, address a problem from multiple perspectives, and draw upon resources from all sectors of the community to create an integrated strategy for change. Recommendations from the Drug Demand Reduction Advisory Committee (DDRAC) strongly support all three of these service delivery strategies. The need for youth prevention universal (YPU) programs that provide universal educational curricula for children and youth in community and school settings also remains crucial.

Treatment and prevention programs must become partners working to heal the entire family. The subcommittee is recommending that the children of substance abusing parents in TCADA-funded treatment programs be specifically targeted through selective educational programs (YPS) for children and youth with special emphasis placed on evidence-based programs that serve families. Adult treatment programs and YPS providers will be required to coordinate services. Other high-risk groups will also be targeted with selective prevention programs (YPS).

Any use of tobacco, alcohol, or other drugs by an adolescent is a serious issue that should result in immediate intervention. Youth need to be screened for participation in indicated prevention programs, their risk factors assessed and strategies prioritized for the children and youth and their families. The line between prevention and treatment has been defined by the Prevention Subcommittee for youth following CSAP's definition of indicated prevention. The NIH *Drug Abuse Prevention for At-Risk Individuals* publication states that indicated prevention strategies are designed to prevent the onset of substance abuse in specific individual youth who do not meet the Diagnostic and Statistical Manual- Fourth Edition (DSM-IV) criteria for addiction but

who are showing early danger signs, such as falling grades and the use of alcohol and other gateway drugs. Individuals identified at this stage who may show signs of early, experimental use have not reached the point of a clinical diagnosis of substance abuse as defined by DSM IV.

Screening for Youth Prevention Indicated (YPI) program indicated services should remain with the YPI program type. Referral for youth meeting specific indicators for abuse or dependency should be made to the Outreach Screening Assessment and Referral (OSAR) programs for assessment of substance abuse or chemical dependency. The OSAR will make the appropriate referrals for treatment. The specific indicators will be defined by TCADA for the "intervention assessment" for YPI programs. The intervention assessment score will indicate the need for referral for further screening by the OSAR.

Maintaining a significant level of funding for the selective and indicated population is a priority supported by the DDRAC report to the Legislature. The DDRAC policy recommendation is as follows: "give priority to individuals impacted by multiple risk factors, especially children of substance abusers, while continuing to give priority to legislatively-mandated populations, including: youth who have abused or at risk for abusing substances; youth referred by the juvenile justice system" etc. YPI services will intervene early with high-risk youth (including children of substance abusers) and will serve to reach youth before they need treatment or become involved in the juvenile justice system.

Providing culturally appropriate, accessible services to children and youth and their families on the Texas-Mexico Border remains a strong recommendation for continuation of the rural border services. The border plan should be the reference criteria for FY05 border prevention services.

Along with the OSAR services, which will focus on assessment and appropriate referral for chemical dependency treatment, PPI services should also be moved out of the primary prevention strategies. The principal intervention in the PPI programs is for the substance abusing woman. The children of these women are the secondary target population and appropriate referrals for children would remain as a requirement and selective prevention services would be available, if appropriate. Funding for OSAR and PPI would remain in the intervention category, but would not be considered part of the prevention service delivery system.

**Specific Recommendations**

1. Apply a common and uniform assessment method to determine needs and resources (that applies social indicators) at the local, regional and state levels as described in *Need Estimate for Substance Abuse Prevention in Texas*.

   See Appendix 1, 2, 3:
   - *Need Estimate for Substance Abuse Prevention in Texas* (Appendix 1)
   - U, S, I Prevention Needs Estimate FY 2005 Chart (Appendix 2)
   - Universal, Selective, Indicated Prevention Needs Maps (Appendix 3)

2. Continue to use and promote the risk and protective factor theoretical framework as the unifying approach that will describe TCADA-funded prevention services. (See Theoretical Basis for Prevention, page 19.)

The FY 2005 RFP should require applicants to develop a Logic Model to ensure that communities define local risk and protective factors and address them with evidence-based programs that address the need in the six life or activity domains in which risk and protective factors chiefly occur. Risk and protective factors exist at every level of individual interaction in society. The individual brings a set of qualities or characteristics to each interaction, and these factors act as a filter, coloring the nature and tone of these interactions – whether positive or negative. The interactions are organized by CSAP in six life domains (and subcategory of risks):

- Individual: (biological and psychological dispositions, attitudes, values, knowledge, skills, problem behaviors)
- Peer: (norms, activities, bonding)
- Family: (function, management, bonding)
- School: (bonding, climate, policy, performance)
- Community: (bonding, norms, resources, awareness/mobilization)
- Society/Environmental: (norms, policy/sanctions)

3. Effective multi-component prevention systems combine individual and environmental change strategies across multiple settings to promote well-being in a defined local community. The Subcommittee recommends targeting the universal population with both environmental and individual strategies. The Subcommittee recommends supporting the development and use of environmental strategies that seek to reduce or eliminate substance abuse and related problems by changing the overall context within which substance use occurs. Environmental strategies have the ability to reach entire populations and reduce collective risk. They complement individual prevention strategies and have the potential to generate larger effects than individual prevention strategies by impacting greater numbers of people and producing sustainable results at lower costs.

The most effective vehicle for the implementation of environmental strategies is the community coalition. By mobilizing individual citizens, entire neighborhoods, and local systems, community coalitions have the ability to impact local policy, community norms, access to and availability of alcohol, tobacco, and other drugs (ATOD), local media norms, citizen surveillance, school drug policies, police enforcement policies, availability of ATOD at community events, among many other issues.

The subcommittee recommends the continuation of current funding for universal environmental strategies including community coalitions, Partnership for a Drug-Free Texas (PDFT), Red Ribbon campaign, and Synar activities as well as universal youth educational (YPU) strategies. PDFT is a nationally recognized media effort that has broad effect in shaping the attitude of children, youth and their families across the state. The cost effective return on the PDFT investment is reported to be 44:1. The Red Ribbon Campaign, managed by PDFT, is the most recognizable environmental strategy in the state. Red Ribbon Week is a broad campaign implemented in many school districts across the state and nation. It is a model collaborative effort between TCADA/PDFT, National Guard, DEA, and numerous community organizations and private sector entities.

To improve outcomes for the minors and tobacco activities currently implemented by YPP and OSR program types, the Subcommittee recommends redirecting the environmental

strategies funds used by these two program types for competition among Prevention Resource Centers. The regional center would collaborate with the Community Coalition Programs and may subcontract with other entities in each region, as appropriate. Maintaining implementation of this strategy at the local level rather than just at the regional level is important to maintain the level of coverage needed for Synar compliance.

4. Continue to provide a system of training, workforce development and technical assistance by providing statewide prevention training for evidence-based prevention programs in the 6 domains that will strengthen and expand the prevention infrastructure. These services provide vital training on the latest prevention technology, research and best practice approaches to encourage and support effective implementation of evidence-based prevention programs at the local level. Much of the training is provided for community-based organizations or school district staff that delivers the curricula in schools; thus, giving TCADA an opportunity to affect school drop-out rates, which is one of the social indicators used in the needs assessment, as well as other risk factors measured in TCADA's school survey. Prevention is strengthened when school staff receive the training and the school districts implement the curriculum directly. Staff turnover at the community level indicates a continuing need for the training in model programs. The prevention training services are instrumental in improving the skills of the prevention workforce. Considering the Substance Abuse Prevention and Treatment block grant move to outcomes/performance management, TCADA will be providing an essential vehicle for improved outcomes for prevention services with the provision of this statewide training. The Subcommittee recommends funding an array of evidence-based curricula that meet regional and cultural needs and using curricula that are currently available and accessible.

   Currently, $1.4 million is awarded to statewide prevention training contractors to deliver training in the following curricula:
   - Protecting You/Protecting Me, which is a CSAP model program developed in Texas with PTS support
   - Strengthening Families Program for Mexican Americans, Peers Making Peace, and PAL: Peer Assistance and Leadership - three CSAP promising programs developed in Texas
   - Strengthening Families Program (CSAP Model)
   - Botvin's Life Skills Training, (CSAP Model)
   - All Stars (CSAP Model)
   - Preparing for Drug Free Years (CSAP Model)
   - Community Mobilization (uses evidence-based model)
   - Rainbow Days curricula - Parent Connection, Kids' Connection, Youth Connection, Faith Connection, and Kids' Connection, Too for homeless children – in the NREP application process

   The committee has recommended the following strategy for purchasing statewide prevention training services:

   TCADA will contract with a single entity to provide statewide model program training either directly or through subcontracts. This contractor will coordinate with Prevention Resource Centers and Educational Service Centers to provide appropriate regional trainings as determined by local/regional training needs assessments. The contractor would subcontract with the developer of curricula or designee to provide training locally

and designate local curricula trainers for the region or service area. The contractor would need to have the ability to facilitate bringing national issues and trainings to the state. Emphasis will be placed on providing appropriate trainings and technical assistance to the border area. This contractor must have the expertise and experience with Texas needs and capacity to provide extensive services to meet the needs of providers, schools and communities within the state.

RFP Criteria recommendations for statewide training:

- match TCADA funding percentages for Universal, Selective and Indicated direct service targets for funded training curricula
- fund evidence-based curricula/approaches in the same domains funded for prevention services: individual, family, peer, school, community and environmental
- requirements for adaptation for cultural appropriateness should be included
- the RFP/or subcontract would require additional criteria requiring applicants to meet regional needs

5. Support innovative prevention strategies that have proven outcomes by funding a small percentage of prevention providers who implement innovative prevention programs that meet the following criteria:
   - Grounded on a theory of individual and/or community change. These programs should have as a goal the reduction of recognized risk factors and/or the enhancement of protective factors
   - Appropriate to the need of the target population
   - Activities that are appropriate for the developmental stages of the target groups and are replicable in different sites for the programs that target the individual
   - Guided by needs assessment results in the case of community change
   - With outcomes whose effectiveness has been/is being researched and evaluated with sufficient fidelity to allow for eventual NREP listing

6. The U, S, I allocations for each region are based on an effort to balance best practices, effective prevention principles, resources and needs.

   Analysis reflects the following direct service need per target population:
   - Universal: 51.3%
   - Selective: 29.6%
   - Indicated: *14%

   Given the total available funding for prevention services per HHS region (after the regional allocation formula and the strategy allocations for each region are made), the Prevention Subcommittee is recommending the following allocation of resources to target universal, selective and indicated populations:

   Direct Service Programs

| Funding Recommendation Based on FY03 $ Amount | | (FY03 % Expended) |
|---|---|---|
| • Universal: | 38.8% | (31.9%) |
| • Selective: | 26.3% | (13.9%) |
| • Indicated: | 34.9% | (54.2%) |

The direct service calculations are based on needs and FY 2003 expenditures for unduplicated services. See maps in the appendix for FY03 array of services

*Formula for Indicated does not include 5% Youth Treatment Need

The committee recommends the funding percentages above as TCADA increases the capacity for youth treatment across the state. Based on indicators for need as shown in the needs assessment data for universal, selective, indicated and treatment, 5 percent of the indicated population need, which is shown in the need column, has been deducted because the need is met through youth treatment services.

As the youth treatment capacity and referral for youth outpatient treatment is implemented, the recommended percentages would be based on needs for indicated population only, numbers served unduplicated count, and expenditures.

Universal/Environmental Programs

In addition to the direct service array, 15% of the total prevention dollars should be set aside for universal/environmental program types – PMC, CCP, PRC, and statewide training services.

Other Service Delivery Recommendations:

- Continue to contract using 6 CSAP Prevention Strategies to define services (See page 14 for strategy descriptions)
- Fund the following program types: YPU, YPS, YPI, RBI (Renewal), CCP, PRC, PMC and statewide training services
- Establish separate category for TIFI contract

7. Changes Needed to Implement FY05 Recommendations
    - Change Program Types:
    - YPP to YPU = youth prevention universal
    - YPP to YPS = youth prevention selective
    - YPI, which is currently "intervention," to YPI youth prevention indicated
    - YPS services include special RFP requirement to serve children of TCADA-funded parents in treatment in addition to other selective sub groups.
    - OSR to OSAR - services should be moved to intervention/treatment funding with the addition of the assessment for chemical dependency
    - PPI services to intervention as primary focus of services is for the adult pregnant, post-partum woman not on the child
    - Some aspects of OSR ($457,818 for FY03) and all YPP ($1,108, 275 for FY03) minors and tobacco dollars should be competed under the PRCs to require evidence-based programs in addition to contacting retailers. Prevention Resource Centers (PRC) would subcontract with other entities in the region to cover counties/cities, including local prevention providers and collaborate with Community Coalition programs to provide the level of coverage that is needed for Synar compliance.

8. Certified Prevention Specialist Designation

Program Directors of prevention programs will be required to attain the Certified Prevention Specialist designation within the first 2 years of the contract start date.

# APPENDIX A

# Need Estimate for Substance Abuse Prevention in Texas

# APPENDIX A

## Need Estimate for Substance Abuse Prevention in Texas

The purpose of this document is to provide the internal agency procedures/steps used to estimate youth substance use prevention needs. This need estimate can be used as a planning component to provide the rationale for selecting a strategy, to assess the service gap between needs and resources, to support rational allocation of funding, to improve coordination of services, to promote evaluation of program effectiveness, and to understand the epidemiology of substance use and risk/protection in the state.

Based on survey and other social indicator data, the need for prevention services can be properly estimated for the state as a whole, or for substate regions or demographic groups at a given time. For the youth population in Texas, the statewide in-school survey of secondary students is conducted to provide the data needed for current and future planning of prevention resource allocation. To date, the most recent survey report published by TCADA is the *Texas School Survey of Substance Use Among Students: Grades 7-12, 2002*.

### Estimates of Youth Prevention Needs

Because the school survey sampling is not designated within regional strata, the percentages of youths who need prevention in each of the 11 regions and/or 29 subregions can not be directly provided. Instead, two methods to disaggregate the statewide prevention need estimate (which can be derived from the school survey) are used: census-based synthetic estimation and social dysfunction scale method.

The following parameters derived from the statewide school survey are used for selective and indicated prevention needs:

- *Selective Prevention (SP).* Youths are defined as in need of selective prevention if they were at risk in environments (that is, including youths who feel unsafe at school/home/neighborhood; have all/most of peers who carry weapons, drop out of school, or belong to a gang; have no peers who feel close to their parents or care about good grades; perceive parents' approval of using beer/marijuana; perceive no/less danger of using marijuana; or perceive easy availability of marijuana).

- *Indicated Prevention (IP).* Youths are defined as in need of indicated prevention if they were at high risk in environments (that is, including youths who have used any substance during the past school year PLUS have at least one alcohol- or drug-related social problem during the past school year, such as attending class high, driving while high on substances, getting into trouble with teachers/police/peers/dates due to substance use).

Since the school survey results can be generalized only to in-school students, the fact that school dropouts may have a higher prevalence of substance use and behavioral problems will be taken into account when estimating the prevention needs of youth population in Texas. It has been

suggested that the dropouts may be fairly similar to the students with high rates of absenteeism. The *SP* or *IP* rate among *students at high risk of dropping out* (those who had been absent ten or more days during the past school year for truancy, illness, or other reasons) based on the school survey will be used as a proxy for the *SP* or *IP* rate of dropouts, respectively.

***Phase I: Census-Based Synthetic Estimation***
***(The following is using the SP parameter as an example)***

*A. Statewide SP Estimate*

(1) In each of six grades, the *adjusted SP* rate at the state level
= [*SP*% among *students at high risk of dropping out*]*[cumulative dropout %] +
[*SP*% among overall in-school students]*[1-(cumulative dropout %)]; then,

(2) the *youth prevention needs* in each grade are estimated by multiplying the [*adjusted SP* rate] by [population size in each grade/age (age 12 to 17)]; then,

(3) the statewide youth prevention needs are estimated by summing up the youth prevention needs in each grade.

*B. Small Area (County) SP Estimate*

With a multi-stage probability design for the school survey sampling, the percentages of youth *SP* by county or region level cannot be directly provided. The method of census-based synthetic estimation is applied to measure the needs in small area.

The basic logic of this form of synthetic estimation is extrapolation from estimated rates of demographic groups at the state level to the same demographic groups at the small area (e.g. county) levels of analysis. The synthetic estimate for the county is then calculated as the weighted average of the state rates for each demographic group (the weights being the relative size of each demographic group within the county).

In the analysis, 48 demographic subgroups are defined in terms of a multi-way classification of youths on the basis of variables such as age (age 12 to 17), gender (males and females), and ethnicity (Anglos, African Americans, Hispanics, and others). The TCADA school survey first provides data on the percentages of youth *SP* (either overall in-school students or *students at high risk of dropping out*) in each of the 48 demographic subgroups at the state level. Then,

(1) in each of 48 subgroups, the *adjusted SP* rate at the state level
= [*SP*% among *students at high risk of dropping out*]*[cumulative dropout %] +
[*SP*% among overall in-school students]*[1-(cumulative dropout %)];

(2) the *youth prevention needs* in each of the 254 counties are estimated by multiplying the [*adjusted SP* rate in each 48-subgroup] by [population size in each 48-subgroup in a county];

(3) if necessary, a simple proportional adjustment by population size in each subgroup can be done in order to match the summation of the estimated county-level prevention needs to the number of statewide prevention needs by six-grade group (from Phase I - Section A above). One reason for doing this is that the statewide estimate of prevention needs directly derived from the school survey data would be more accurate than the summation of county-level estimates using the synthetic method.

***Phase II: Social Dysfunction Scale Method***

The other method for Phase II estimates is social dysfunction scale (SDS) method. The SDS approach covers various county-level social indicators in the analysis. For *SP* estimate, the indicators could include school dropouts (Var1), children below poverty level (Var2), children of substance abusers (V3), and students with disruptive behaviors (Var4).

A. *Un-Weighted SDS*
   First, for each indicator, any observed value is divided by the maximum value for that indicator, providing an index with a max value of 1.0 and a min value of 0.0. Each indicator thus remains ratio-scale, with a meaningful zero point. Second, summing across all four scale-index of the indicators in a given county provides a (un-weighted) SDS score. Third, dividing the county-level SDS score by the statewide summation of SDS scores yields a corresponding *SDS mean proportion* for each county. Finally, the county-level *SDS mean proportion* is multiplied by the total statewide youth prevention needs (presented in Phase I - Section A above) to generate the county-level (un-weighted) youth prevention needs.

B. *Weighted SDS*
   First, for each indicator, any observed value is divided by the maximum value for that indicator, providing an index with a max value of 1.0 and a min value of 0.0. Each indicator thus remains ratio-scale, with a meaningful zero point. Second, summing across all four weighted scale-indices of the indicators in a given county provides a weighted SDS score. The weights for the indicators can be mathematically derived from the correlation matrix. For example, if the weights were 0.31 for Var1, 0.15 for Var2, 0.22 for Var3, and 0.32 for Var4, then the weighted SDS score for each county would be [0.31*Var1+0.15*Var2+0.22*Var3+0.32*Var4]. The weights are subject to change based on the available annual data of those indicators. Third, dividing the county-level weighted SDS score by the statewide summation of weighted SDS scores yields a corresponding weighted *SDS mean proportion* for each county. Finally, the county-level weighted *SDS mean proportion* is multiplied by the total statewide youth prevention needs (presented in Phase I - Section A above) to generate the county-level weighted youth prevention needs.

Usually, the weighted SDS prevention needs can be directly presented for the Phase II estimates. However, if no preference exists for using either un-weighted SDS prevention needs or weighted SDS prevention needs, a more conservative estimate for Phase II can be done by taking an average of un-weighted and weighted SDS prevention needs for each county.

***Final Need Estimate***

After estimating the Phase I and Phase II needs by county, take an average of both estimates to have the final selective prevention needs (mainly for population aged 12-17) by county. Then, the corresponding 11-region and/or 29-subregion codes for each county can be used to generate the regional preventions needs for resource allocation.

For universal and indicated estimates:

1. Universal prevention needs are simply the population size in a given age group.
2. Indicated youths in prevention needs can be measured by first applying the *IP* parameter from school survey to the Phase I method. Six social indicators -- dropout numbers, children in poverty, children of substance abusers, students with disruptive behaviors, teenage pregnancies, and juvenile substance-related arrests are then used for the Phase II estimate. After estimating the Phase I and Phase II needs, take an average of both estimates to yield the final indicated prevention needs by county.

If youths aged 6-17, for example, are the target, it would be proper to use the prevalence rate of grade 7 as the proxy rate for those youths under age 12.

# APPENDIX B

# U, S, I Prevention Needs Estimates FY 2005

# APPENDIX B

**U_S_I Prevention Need Estimates FY05 (based on 2004 population projection):**

| Universal Prevention | | | |
|---|---|---|---|
| 29-SubReg | Age 6-17 | 11-Region | Age 6-17 |
| 01a | 74,889 | 1 | 141,379 |
| 01b | 66,490 | 2 | 91,518 |
| 02a | 38,418 | 3 | 1,064,863 |
| 02b | 53,100 | 4 | 174,391 |
| 03a | 683,855 | 5 | 128,758 |
| 03b | 350,694 | 6 | 960,795 |
| 03c | 30,314 | 7 | 404,990 |
| 04a | 46,248 | 8 | 414,028 |
| 04b | 52,869 | 9 | 97,588 |
| 04c | 75,274 | 10 | 149,509 |
| 05a | 60,667 | 11 | 391,122 |
| 05b | 68,091 | | |
| 06a | 860,364 | Total | 4,018,941 |
| 06b | 44,894 | | |
| 06c | 55,537 | | |
| 07a | 237,456 | | |
| 07b | 70,413 | | |
| 07c | 55,760 | | |
| 07d | 41,361 | | |
| 08a | 345,611 | | |
| 08b | 33,482 | | |
| 08c | 34,935 | | |
| 09a | 25,339 | | |
| 09b | 72,249 | | |
| 10a | 149,509 | | |
| 11a | 103,748 | | |
| 11b | 65,864 | | |
| 11c | 140,459 | | |
| 11d | 81,051 | | |
| | | | |
| Total | 4,018,941 | | |

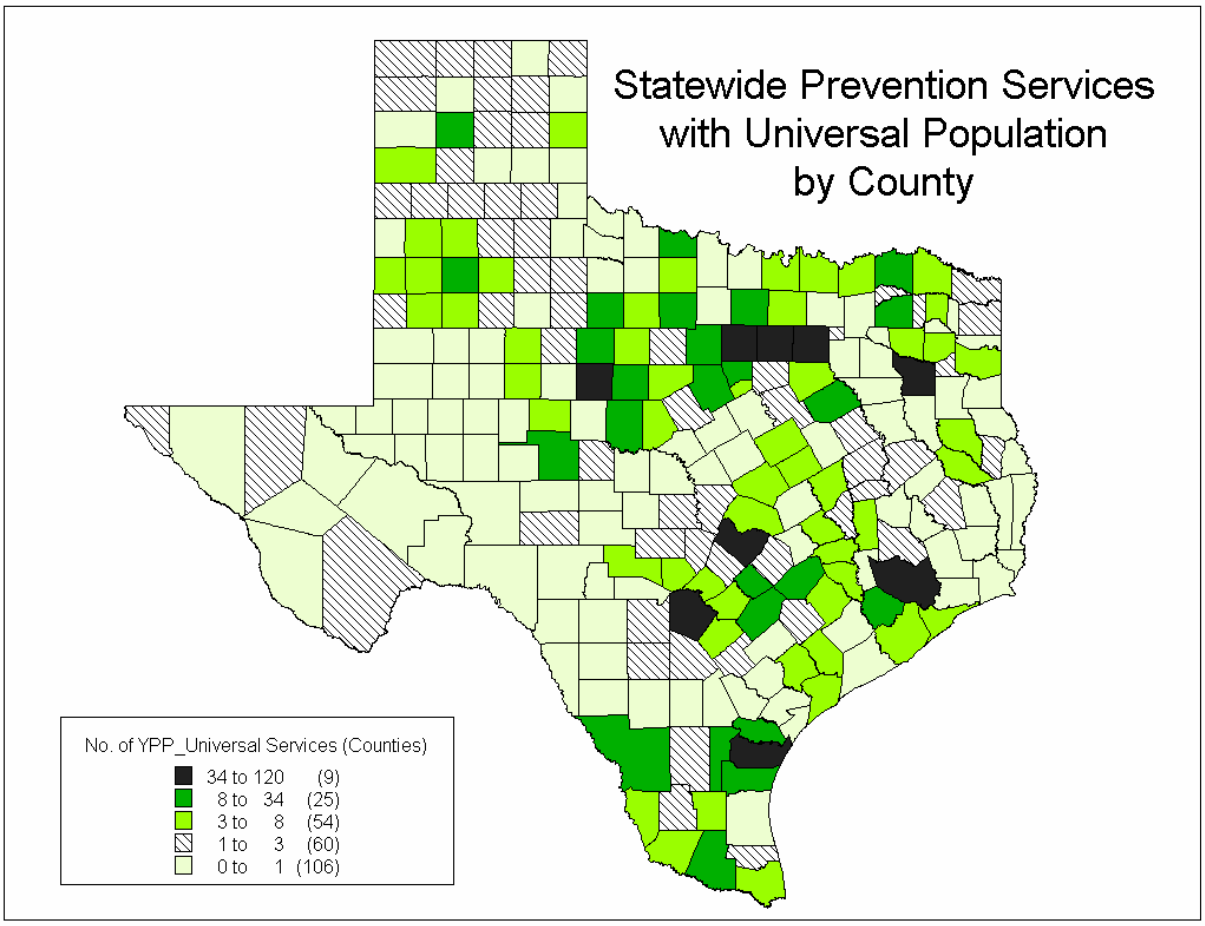
| Selective Prevention | | | |
|---|---|---|---|
| 29-SubReg | Agg 6-17 | 11-Region | Age 6-17 |
| 01a | 36,998 | 1 | 75,281 |
| 01b | 38,283 | 2 | 45,449 |
| 02a | 18,284 | 3 | 460,742 |
| 02b | 27,165 | 4 | 83,043 |
| 03a | 290,927 | 5 | 67,697 |
| 03b | 157,023 | 6 | 458,976 |
| 03c | 12,792 | 7 | 184,300 |
| 04a | 22,155 | 8 | 215,206 |
| 04b | 27,732 | 9 | 49,267 |
| 04c | 33,156 | 10 | 85,792 |
| 05a | 28,832 | 11 | 233,033 |
| 05b | 38,865 | | |
| 06a | 408,243 | Total | 1,958,787 |
| 06b | 26,070 | | |
| 06c | 24,663 | | |
| 07a | 101,603 | | |
| 07b | 31,256 | | |
| 07c | 31,185 | | |
| 07d | 20,256 | | |
| 08a | 177,567 | | |
| 08b | 17,270 | | |
| 08c | 20,369 | | |
| 09a | 12,190 | | |
| 09b | 37,077 | | |
| 10a | 85,792 | | |
| 11a | 59,741 | | |
| 11b | 40,789 | | |
| 11c | 85,239 | | |
| 11d | 47,263 | | |
| | | | |
| Total | 1,958,787 | | |

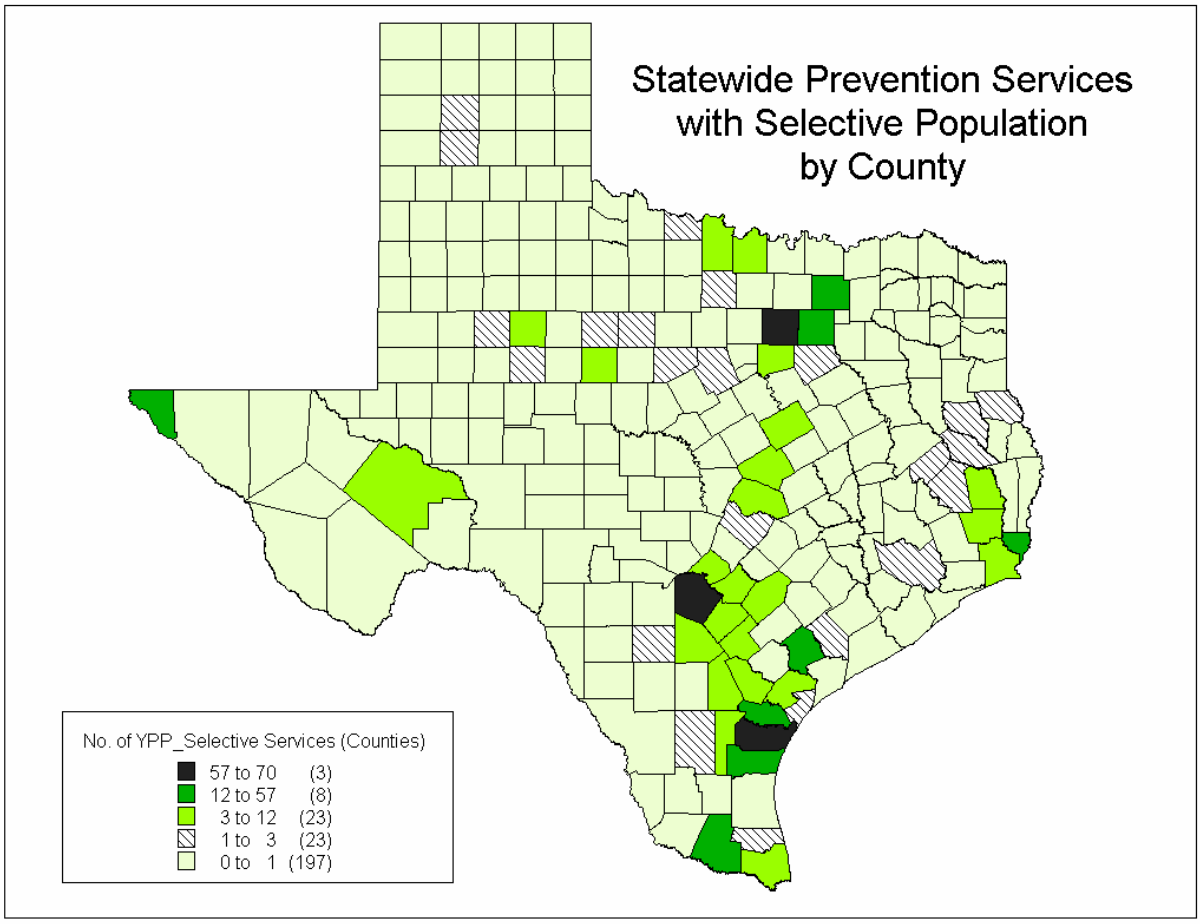
| Indicated Prevention | | | |
|---|---|---|---|
| 29-SubReg | Agg 6-17 | 11-Region | Age 6-17 |
| 01a | 15,300 | 1 | 30,381 |
| 01b | 15,080 | 2 | 18,731 |
| 02a | 7,475 | 3 | 181,372 |
| 02b | 11,257 | 4 | 31,791 |
| 03a | 112,533 | 5 | 24,538 |
| 03b | 63,299 | 6 | 172,146 |
| 03c | 5,540 | 7 | 74,234 |
| 04a | 8,537 | 8 | 84,703 |
| 04b | 9,814 | 9 | 21,978 |
| 04c | 13,440 | 10 | 35,335 |
| 05a | 10,880 | 11 | 92,805 |
| 05b | 13,657 | | |
| 06a | 152,676 | Total | 768,013 |
| 06b | 9,326 | | |
| 06c | 10,144 | | |
| 07a | 42,713 | | |
| 07b | 11,812 | | |
| 07c | 11,931 | | |
| 07d | 7,778 | | |
| 08a | 69,765 | | |
| 08b | 6,851 | | |
| 08c | 8,087 | | |
| 09a | 5,302 | | |
| 09b | 16,676 | | |
| 10a | 35,335 | | |
| 11a | 24,287 | | |
| 11b | 16,101 | | |
| 11c | 33,148 | | |
| 11d | 19,268 | | |
| | | | |
| Total | 768,013 | | |

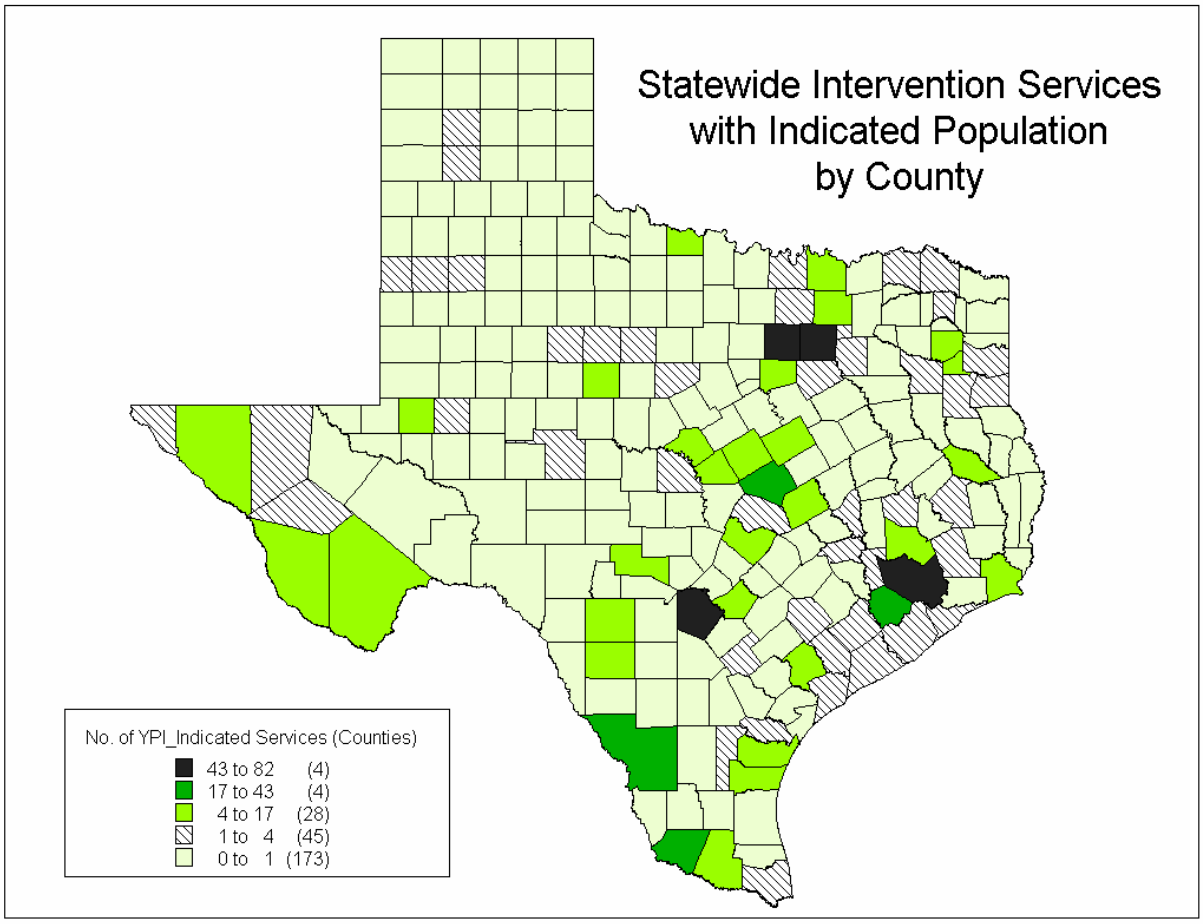
# APPENDIX C

# Universal, Selective, Indicated Prevention Needs Maps

# APPENDIX C


Statewide Prevention Services
with Universal Population
by County
No. of YPP_Universal Services (Counties)
34 to 120 (9)
8 to 34 (25)
3 to 8 (54)
1 to 3 (60)
0 to 1 (106)


Statewide Prevention Services
with Selective Population
by County
No. of YPP_Selective Services (Counties)
57 to 70 (3)
12 to 57 (8)
3 to 12 (23)
1 to 3 (23)
0 to 1 (197)


Statewide Intervention Services
with Indicated Population
by County
No. of YPI_Indicated Services (Counties)
43 to 82 (4)
17 to 43 (4)
4 to 17 (28)
1 to 4 (45)
0 to 1 (173)