



Office of Mental Health and Addiction Services

Prevention Booklet

Table of Contents

Introduction	3
How to use this document	4
Section One:	
2005 Overview of Alcohol and Other Drug Use by Adolescents	4
Using High-Risk Alcohol-Related Behaviors Data	5
Table 1: 30 day use of alcohol	5
Use of Tobacco, Alcohol, and Other Drugs by Adolescents	7
Consequences Associated with Alcohol, Tobacco or Other Drug Use	8
Age of First Alcohol Use	9
Table 2: Age of first alcohol use	9
Table 3: Perceived harm of alcohol use	11
Table 4: Perceived wrong of adolescent alcohol use	13
Table 5: 30 day use of marijuana	15
Table 6: Perceived harm of marijuana	17
Table 7: 30 day use of drugs	19
Section Two: Statewide Profiles of Risk and Protective Factors	20
Table 8: Ease of alcohol access	21
Table 9: Parental views on adolescent drinking	23
Table 10: Police knowledge of adolescent drinking	25
Table 11: Is an ID needed to buy alcohol?	27
Table 12: Would police break up a party with alcohol?	29
Table 13: An adult wants me to do my best	31
Section Three: Using Data-Driven Decision-Making to Get the Best Outcomes from Evidence-Based Practices	32
Section Four: Substance Abuse Prevention Services in Oregon	40
Appendix A: Resources	41
Appendix B: Individual Contacts	42
Bibliography	43

Introduction

Substance abuse is one of the most costly and complex social and public health issues in the nation. According to a 2001 study by the [National Center on Addiction and Substance Abuse](#), the cost of substance abuse to state budgets in 1998 was a staggering \$83.1 billion dollars—13.1% of all state government spending for that year.¹ The same study reported that substance abuse-related spending for Oregon in 1998 was more than \$902 million dollars—8.2% of the entire state budget. Of that amount, 91 cents out of every dollar went to pay for the burden of substance abuse on social programs (e.g. foster care, corrections, education services). These cost figures do not include federal or local governmental spending, private sector expenses, or financial estimates of the devastation that substance abuse causes to Oregon's families, local economies, and environment. Substance abuse is everyone's problem.

The good news is that substance abuse is preventable. Now more than ever, policy-makers and stake-holders have an array of powerful tools that—when used together—can help them effectively identify and significantly reduce substance abuse and related problems. These tools include: 1) meaningful data that can produce actionable information; 2) important research on the onset and underlying causes and contributors to substance abuse; and 3) evidence-based practices that—when carefully matched to local conditions and desired outcomes—have been proven to be effective in significantly reducing substance abuse.

The [National Institute on Drug Abuse](#) has declared addiction to be a developmental disease of childhood and adolescence. Research by the [National Institute on Alcohol Abuse and Alcoholism](#) indicates that those who begin using alcohol before the age of 15 are four times more likely to develop alcohol dependence than those who begin drinking at age 21.² Delaying the *onset* of youth alcohol, tobacco and other drug (ATOD) use, and reducing the *rates* of youth ATOD use, are two critical goals for policy-makers and stake-holders interested in reducing overall rates of substance abuse and the social and financial burdens caused by it.

¹ The National Center on Addiction and Substance Abuse, CASA Reports. January 2001, *Shoveling Up: The Impact of Substance Abuse on State Budgets*. <http://www.casacolumbia.org> <22 February 2006>.

² National Institute on Alcohol Abuse and Alcoholism, Underage Drinking: A Growing Health Care Concern. <http://pubs.niaaa.nih.gov/publications/PSA/underagepg2.htm> <22 February 2006>.

How to Use This Document

This document provides important information on youth substance abuse in Oregon, and provides guidance on how policy-makers and stake-holders can use this information to develop effective approaches and select evidence-based practices that can significantly reduce substance abuse now and into the future.

Data on substance abuse rates is important for identifying priority issues and emerging drug trends, and for monitoring the effectiveness of prevention strategies in reducing substance abuse over time. Just knowing what substances are priority issues, however, is not enough. In order to formulate effective responses, it is critical to identify and strategically target the underlying causal conditions (e.g. risk, protective and other factors) that increase the likelihood of—or protect against—substance abuse and related problems.

Section One: 2005 Overview of Alcohol and Other Drug Use by Adolescents

The information on youth substance abuse rates provided in this document is collected through a statewide survey called the Oregon Healthy Teen survey. This 2005 survey is administered in a sample of Oregon schools annually, and is weighted to be representative of all 8th and 11th graders. The survey provides an overview of state and county rates of alcohol, tobacco, and other drug use among Oregon youth.

In addition, it's important to remember that good data can raise as many questions as it answers. Survey findings should always be analyzed within the context of the assessment format and the participating population. For example, since the OHT survey is administered in schools, it only captures the responses of youth who are in school. In the Oregon Healthy Teen tables, if a specific cell has five or fewer responses, that cell will have a star (*) instead of a specific number. In the following tables, the Oregon Healthy Teen data is shown with a county weight. Some Oregon counties chose not to participate in the survey and as a result do not have results.

Using High-Risk Alcohol-Related Behaviors Data

Collecting data on High-Risk Alcohol-Related Behaviors is an extremely important component of any monitoring system for substance abuse and related problems, and information from such a system is critical for:

- * Identification of geographic areas and specific populations with elevated rates of High Risk Alcohol-Related Behaviors, and
- * Early detection of emerging trends or changes in behavior patterns.

Information on High-Risk Alcohol-Related Behaviors is also very important for selecting and implementing strategies that are most likely to achieve desired outcomes by:

- * Identifying populations in need of individually-focused strategies designed to help them protect themselves against riding with drinking drivers, and
- * Identifying geographic areas in need of environmental strategies (e.g. policy or practice changes, enforcement of laws, education and communication) designed to address High-Risk Alcohol-Related Behaviors. Examples of such strategies include: strict enforcement of underage drinking laws, sobriety checkpoints, and Responsible Beverage Service Training.

Table 1: 2005 OHT Data: On how many occasions have you had beer, wine or hard liquor to drink during the past 30 days?³

County	No use	1 to 2 times	3 to 5 times	6 to 9 times	10 or more	Total Item Responses
State Percentage	61%	20%	10%	4%	4%	75,420
Baker	57%	18%	12%	5%	8%	406
Benton	67%	20%	8%	2%	3%	1,452
Clackamas	63%	21%	10%	4%	3%	8,511
Clatsop	51%	22%	13%	8%	6%	787
Columbia	59%	22%	11%	2%	6%	1,129
Coos	64%	20%	7%	5%	3%	1,331
Crook	57%	24%	9%	6%	4%	467
Curry	55%	27%	11%	3%	4%	525

³ County weight shown.

County	No use	1 to 2 times	3 to 5 times	6 to 9 times	10 or more	Total Item Responses
Deschutes	50%	18%	17%	5%	9%	3,176
Douglas	58%	23%	10%	5%	4%	2,533
Gilliam	53%	23%	13%	*	0%	47
Grant	50%	25%	13%	5%	6%	201
Harney	58%	21%	13%	6%	*	218
Hood River	63%	23%	8%	5%	2%	562
Jackson	62%	21%	10%	4%	4%	4,506
Jefferson	54%	26%	12%	3%	5%	526
Klamath	54%	22%	12%	5%	7%	1,481
Lake	50%	26%	12%	9%	4%	195
Lane	63%	19%	10%	3%	5%	7,492
Linn	60%	20%	10%	5%	5%	2,618
Malheur	65%	18%	9%	5%	3%	726
Marion	64%	20%	9%	3%	4%	7,765
Morrow	59%	24%	11%	2%	3%	331
Multnomah	60%	21%	10%	5%	4%	12,328
Polk	58%	22%	11%	2%	6%	674
Sherman	34%	45%	17%	*	*	53
Umatilla	57%	22%	10%	6%	5%	1,671
Union	63%	16%	10%	5%	5%	628
Wallowa	55%	17%	18%	*	7%	168
Wasco	68%	18%	7%	2%	5%	491
Washington	66%	20%	9%	3%	2%	10,266
Wheeler	69%	26%	0%	0%	*	42
Yamhill	60%	19%	11%	5%	6%	2,114

Use of Tobacco, Alcohol, and Other Drugs by Adolescents

Smoking kills an estimated 430,000 Americans each year. In addition, research shows that teens who smoke are three times more likely than nonsmokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine. Smoking is also associated with a host of other risky behaviors, such as fighting and engaging in unprotected sex. Very few people initiate smoking or become habitual smokers after their teen years. In the United States, nearly nine out of 10 current adult smokers report starting smoking before the age of 19. In 2005, 87% of 8th and 11th grade Oregon youth had not used tobacco in the past 30 days.

Research has documented that brain development in humans isn't complete until their early twenties. During that time of development, use of alcohol, tobacco and other drugs can have a profound effect, particularly on those areas of the brain that govern inhibition and impulse control and which are the last to develop. At this time, there is *no known safe amount* of alcohol, tobacco, or any other drug of abuse for a youth whose brain is still developing.

Drug Use information can be used to monitor important areas of youth substance abuse, such as:

- *Determining whether efforts to prevent or delay experimentation with alcohol, tobacco or other drugs are being successful,
- *Determining the rate at which the incidence or number of new cases of experimentation, is changing over time for each substance; and
- *Early detection of emerging trends or changes in substance abuse patterns.

Drug Use data is also very important for selecting strategies that are most likely to achieve desired outcomes by:

- *Identifying the substances for which youth are reporting the highest rates of experimentation at each grade level, and
- *Identifying shifts and transitions in substance abuse between students' grades.

Typically, reported rates of experimentation—or lifetime use—will increase with age and maturation, producing a “stair step” pattern of increased numbers of youth reporting lifetime experimentation with drugs in each successive grade. In addition, increases in reported lifetime experimentation rates over time for the same substance by the same grade level might also indicate an emerging trend in increased use. Drug use is dynamic. Careful monitoring of changes over time and looking at outcomes can inform policy makers and stake-holders that their efforts are achieving success. With this information, policy makers and stake-holders can address emerging substance abuse issues before they become significant public health crises.

Consequences Associated with Alcohol, Tobacco or Other Drug Use

Studies on the most common substances of abuse—alcohol, tobacco and marijuana—have yielded extremely important findings:

- *Youth who use alcohol before the age of fifteen are four times more likely to develop alcohol dependence as an adult; ⁴
- *Early marijuana use signals an increased risk for hard drug use by grade 10. ⁵
- *Early marijuana use is also associated with drug use problems, dependency, and treatment need. ⁶
- *Early use of alcohol predicted early use of marijuana, which in turn was predictive of early use of other illicit drugs. ⁷

⁴ Grant, B. F. “The impact of a family history of alcoholism on the relationship between age at onset of alcohol use and DSM-IV alcohol dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey.” *Alcohol Health and Research World*, Volume 22 (1998).

⁵ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Initiation of Marijuana Use: Trends, Patterns and Implications*. <<http://www.oas.samhsa.gov/MJinitiation/chapter1.htm#1.2.4>> (22 February 2006).

⁶ Ibid.

⁷ Ibid.

Age of First Alcohol Use

Age of First Use information is important because it pinpoints when youth are most likely to begin experimenting with certain substances. It provides more precise information for determining a course of action to delay onset of use than does the Lifetime Use measure, which simply reports prevalence of experimentation by grade. Age of First Use information can be used to monitor important areas of youth substance abuse, including:

- * Whether efforts to prevent or delay first experimentation with alcohol, tobacco or other drugs are achieving success, and
- * Early detection of emerging trends or changes in substance abuse patterns.

Age of First Use data is also very important for selecting and implementing strategies that are most likely to achieve desired outcomes by:

- * Identifying the age at which students begin using different substances and thereby indicating the minimum age at which interventions should begin to occur, and
- * Identifying sequencing, patterns and relationships in usage of different substances, and developing comprehensive approaches that are developmentally appropriate to the age at which those substances are first used.

Reported Age of First Use of alcohol by Oregon 8th and 11th graders is provided in Table 2. The percent of youth who have never drank alcohol, who took their first drink at age twelve or younger, or who took their first drink at age thirteen or above is shown. In 2005, 27,084 8th and 11th graders responded they had not used alcohol in their lifetime. Unfortunately, this was only 36% of the youth surveyed.

Table 2: 2005 OHT Data: How old were you when you had more than a sip or two of beer, wine, or hard liquor for the first time?⁸

County	No use	8 to 10 years old	11 to 13 years old	14 to 17 years old	Total Item Responses
State Percentage	36%	17%	24%	23%	75,451
Baker	33%	22%	26%	19%	410
Benton	46%	16%	20%	19%	1470
Clackamas	38%	15%	23%	24%	8525

⁸ County weight shown.

County	No use	8 to 10 years old	11 to 13 years old	14 to 17 years old	Total Item Responses
Clatsop	27%	20%	25%	28%	782
Columbia	35%	18%	28%	19%	1130
Coos	37%	17%	23%	22%	1335
Crook	29%	24%	27%	20%	468
Curry	30%	23%	26%	22%	517
Deschutes	25%	23%	27%	25%	3168
Douglas	34%	19%	24%	22%	2524
Gilliam	15%	30%	30%	26%	47
Grant	23%	14%	36%	27%	202
Harney	37%	21%	24%	17%	211
Hood River	34%	20%	21%	25%	572
Jackson	37%	15%	25%	24%	4529
Jefferson	29%	24%	30%	17%	526
Klamath	30%	18%	25%	26%	1477
Lake	25%	27%	24%	25%	199
Lane	37%	19%	25%	19%	7518
Linn	36%	20%	22%	22%	2610
Malheur	42%	19%	18%	21%	721
Marion	36%	17%	24%	23%	7787
Morrow	29%	23%	27%	21%	325
Multnomah	36%	15%	24%	26%	12359
Polk	30%	12%	35%	23%	660
Sherman	24%	18%	33%	24%	49
Umatilla	32%	22%	25%	22%	1681
Union	36%	20%	24%	20%	630
Wallowa	24%	22%	34%	20%	171
Wasco	43%	18%	18%	22%	493
Washington	40%	15%	22%	23%	10223
Wheeler	53%	15%	20%	*	40
Yamhill	32%	21%	26%	21%	2092

Table 3: 2005 OHT Data: How much do think people risk harming themselves if they take one or two drinks of an alcoholic beverage nearly every day? ⁹

County	No risk	Slight risk	Moderate risk	Great risk	Total Item Responses
State Percentage	15%	26%	32%	27%	72,750
Baker	18%	29%	27%	26%	403
Benton	13%	24%	32%	31%	1,402
Clackamas	13%	24%	32%	31%	8,286
Clatsop	16%	28%	29%	26%	727
Columbia	19%	30%	29%	23%	1,053
Coos	17%	29%	29%	26%	1,247
Crook	15%	32%	30%	24%	450
Curry	16%	33%	29%	22%	506
Deschutes	23%	28%	30%	19%	3,122
Douglas	16%	28%	32%	24%	2,439
Gilliam	19%	21%	47%	13%	47
Grant	19%	34%	35%	12%	194
Harney	14%	28%	32%	26%	211
Hood River	17%	25%	32%	26%	549
Jackson	15%	26%	35%	24%	4,403
Jefferson	20%	30%	27%	22%	483
Klamath	20%	27%	27%	26%	1,417
Lake	19%	34%	32%	16%	199
Lane	17%	29%	30%	23%	7,280
Linn	17%	27%	28%	28%	2,517
Malheur	20%	21%	31%	28%	704
Marion	14%	25%	31%	30%	7,535
Morrow	20%	28%	27%	26%	317
Multnomah	13%	25%	33%	28%	11,828
Polk	16%	28%	40%	15%	659
Sherman	19%	27%	37%	17%	52

⁹ County weight shown.

County	No risk	Slight risk	Moderate risk	Great risk	Total Item Responses
Umatilla	15%	27%	32%	26%	1,600
Union	17%	24%	28%	30%	620
Wallowa	24%	33%	30%	14%	168
Wasco	14%	20%	26%	40%	469
Washington	13%	21%	33%	32%	9,853
Wheeler	18%	*	65%	*	40
Yamhill	21%	26%	26%	26%	1,970

Table 4: 2005 OHT Data: How wrong do you think it is for someone your age to drink beer, wine, or hard liquor regularly?¹⁰

County	Very wrong	Wrong	A little bit wrong	Not wrong at all	Total Item Responses
State Percentage	45%	25%	21%	9%	72,404
Baker	39%	23%	25%	13%	407
Benton	51%	22%	20%	7%	1,389
Clackamas	47%	25%	20%	7%	8,234
Clatsop	34%	25%	30%	11%	689
Columbia	41%	29%	23%	7%	1,075
Coos	39%	29%	22%	11%	1,257
Crook	37%	33%	18%	12%	462
Curry	38%	30%	21%	12%	516
Deschutes	34%	22%	28%	15%	3,081
Douglas	43%	26%	21%	10%	2,399
Gilliam	22%	22%	50%	*	46
Grant	26%	30%	24%	19%	197
Harney	45%	29%	18%	7%	217
Hood River	43%	28%	22%	7%	548
Jackson	47%	25%	20%	9%	4,393
Jefferson	38%	29%	23%	10%	493
Klamath	41%	22%	22%	15%	1,372
Lake	34%	28%	27%	11%	197
Lane	46%	25%	19%	10%	7,333
Linn	46%	23%	19%	11%	2,517
Malheur	53%	25%	15%	7%	710
Marion	47%	26%	20%	8%	7,452
Morrow	39%	32%	21%	7%	318
Multnomah	42%	26%	23%	9%	11,773
Polk	45%	32%	16%	6%	631
Sherman	28%	22%	28%	22%	54

¹⁰ County weight shown.

County	Very wrong	Wrong	A little bit wrong	Not wrong at all	Total Item Responses
Umatilla	43%	25%	25%	8%	1,640
Union	47%	21%	20%	12%	617
Wallowa	39%	17%	35%	9%	172
Wasco	49%	22%	19%	10%	476
Washington	50%	24%	18%	7%	9,754
Wheeler	54%	*	17%	22%	41
Yamhill	42%	22%	24%	12%	1,944

Table 5: 2005 OHT Data: During the past 30 days, how many times did you use marijuana?¹¹

County	No use	1 or 2 times	3 to 9 times	10 to 19 times	20 to 39 times	40 or more	Total Item Responses
State Percentage	84%	6%	4%	2%	1%	2%	74,515
Baker	83%	5%	3%	2%	2%	5%	407
Benton	92%	5%	1%	1%	1%	*	1434
Clackamas	86%	6%	4%	1%	1%	2%	8435
Clatsop	76%	8%	5%	5%	3%	2%	752
Columbia	86%	5%	3%	2%	2%	2%	1093
Coos	81%	7%	5%	3%	1%	3%	1314
Crook	84%	6%	5%	3%	*	2%	462
Curry	84%	7%	4%	1%	*	3%	515
Deschutes	73%	10%	6%	4%	2%	5%	3156
Douglas	83%	6%	4%	3%	2%	2%	2501
Gilliam	93%	*	0%	0%	0%	0%	46
Grant	89%	6%	*	*	*	*	201
Harney	95%	4%	0%	*	0%	0%	217
Hood River	86%	5%	4%	1%	*	3%	564
Jackson	82%	7%	5%	2%	2%	3%	4497
Jefferson	78%	8%	6%	3%	1%	3%	507
Klamath	82%	5%	5%	3%	1%	4%	1424
Lake	86%	9%	3%	0%	*	*	198
Lane	86%	5%	3%	2%	2%	2%	7454
Linn	84%	6%	4%	2%	1%	4%	2590
Malheur	90%	5%	3%	1%	*	1%	719
Marion	88%	5%	3%	1%	1%	2%	7699
Morrow	86%	6%	3%	2%	*	*	325
Multnomah	81%	8%	5%	3%	1%	2%	12156
Polk	83%	4%	4%	2%	4%	2%	676
Sherman	84%	*	*	*	0%	*	51
Umatilla	88%	4%	4%	1%	1%	1%	1662

¹¹ County weight shown.

County	No use	1 or 2 times	3 to 9 times	10 to 19 times	20 to 39 times	40 or more	Total Item Responses
Union	87%	6%	4%	1%	1%	1%	624
Wallowa	82%	6%	9%	0%	0%	*	172
Wasco	87%	5%	3%	*	2%	2%	489
Washington	88%	5%	3%	2%	1%	1%	10061
Wheeler	93%	*	*	0%	0%	0%	41
Yamhill	82%	7%	4%	2%	1%	4%	2073

Table 6: 2005 OHT Data: How much do think people risk harming themselves if they smoke marijuana regularly?¹²

County	No risk	Slight risk	Moderate risk	Great risk	Total Item Responses
Total	10%	14%	25%	52%	72,061
Baker	16%	14%	17%	53%	406
Benton	7%	12%	23%	59%	1,383
Clackamas	9%	12%	24%	55%	8,194
Clatsop	9%	17%	27%	47%	727
Columbia	12%	14%	22%	53%	1,044
Coos	12%	21%	28%	40%	1,250
Crook	6%	15%	23%	56%	439
Curry	10%	18%	29%	43%	502
Deschutes	17%	18%	23%	41%	3,067
Douglas	9%	17%	26%	48%	2,423
Gilliam	*	*	28%	52%	46
Grant	6%	11%	25%	58%	194
Harney	*	8%	27%	62%	210
Hood River	11%	16%	26%	46%	540
Jackson	9%	14%	27%	51%	4,339
Jefferson	15%	15%	26%	44%	479
Klamath	12%	18%	24%	46%	1,383
Lake	10%	9%	23%	59%	199
Lane	12%	16%	24%	48%	7,262
Linn	13%	11%	23%	53%	2,480
Malheur	14%	9%	16%	60%	707
Marion	9%	10%	21%	61%	7,505
Morrow	12%	7%	20%	60%	313
Multnomah	8%	16%	28%	48%	11,628
Polk	9%	13%	29%	49%	659
Sherman	21%	15%	23%	40%	52

¹² County weight shown.

County	No risk	Slight risk	Moderate risk	Great risk	Total Item Responses
Umatilla	10%	10%	21%	59%	1,596
Union	12%	10%	21%	57%	610
Wallowa	5%	11%	26%	58%	164
Wasco	9%	12%	15%	64%	469
Washington	7%	12%	27%	54%	9,814
Wheeler	*	15%	*	76%	41
Yamhill	14%	14%	22%	50%	1,936

Table 7: 2005 OHT Data: 30 day drug use of marijuana, inhalants, prescription drugs, stimulants, cocaine, heroin, MDMA (ecstasy) and/or LSD.¹³

County	No use	One or more occasions of use	Total Item Responses
State Percentage	80%	20%	72,124
Baker	80%	20%	383
Benton	89%	11%	1,389
Clackamas	82%	18%	8,260
Clatsop	73%	27%	725
Columbia	81%	19%	1,040
Coos	74%	26%	1,253
Crook	79%	21%	447
Curry	78%	22%	488
Deschutes	69%	31%	3,101
Douglas	78%	22%	2,419
Gilliam	74%	26%	46
Grant	84%	16%	194
Harney	86%	14%	206
Hood River	80%	20%	540
Jackson	78%	22%	4,311
Jefferson	73%	27%	480
Klamath	77%	23%	1,373
Lake	85%	15%	190
Lane	82%	18%	7,163
Linn	79%	21%	2,504
Malheur	86%	14%	700
Marion	84%	16%	7,465
Morrow	83%	17%	315
Multnomah	77%	23%	11,723
Polk	78%	22%	674
Sherman	76%	24%	51

¹³ County weight shown.

County	No use	One or more occasions of use	Total Item Responses
Umatilla	84%	16%	1,619
Union	83%	17%	609
Wallowa	77%	23%	167
Wasco	83%	17%	479
Washington	84%	16%	9,763
Wheeler	93%	*	41
Yamhill	78%	22%	2,006

Section Two: Statewide Profiles of Risk and Protective Factors

Just as there is a medical model for assessing the risk and protective factors for heart disease, there is also a scientifically validated model for assessing the risk and protective factors that promote or protect against substance abuse. The risk and protective factor approach to prevention assesses factors that increase the risk of problems developing and employs strategies to reduce those risks. At the same time, this approach also assesses and seeks to increase the levels of protective factors that buffer individuals from engaging in problem behavior. Risk and protective factors fall into four domains: community, family, school, and individual/peer. The greater the number of elevated risk factors a youth is exposed to in each domain, the more likely the youth will engage in substance abuse. Prevention and intervention can help to reduce these risk factors.

Simply knowing what kinds of substances are being abused is not enough. To prevent substance abuse, it is important to identify and strategically target the underlying causal conditions (e.g. risk and protective factors) that promote substance abuse and the related consequences. The Oregon Healthy Teens survey is an important tool for identifying State and county-level risk and protective factors. The remainder of this Section provides an overview of key State-level risk and protective factors.

Table 8: 2005 OHT Data: If you wanted to get some beer, wine or hard liquor, how easy would it be for you to get some?¹⁴

County	Very easy	Sort of easy	Sort of hard	Very hard	Total Item Responses
State Percentage	44%	25%	13%	17%	74,386
Baker	44%	27%	13%	16%	403
Benton	43%	23%	17%	17%	1,448
Clackamas	42%	26%	13%	19%	8,389
Clatsop	42%	34%	13%	10%	765
Columbia	54%	20%	13%	14%	1,104
Coos	42%	30%	9%	18%	1,298
Crook	45%	23%	16%	16%	457
Curry	53%	23%	11%	13%	506
Deschutes	49%	24%	12%	16%	3,150
Douglas	45%	25%	13%	17%	2,483
Gilliam	48%	30%	13%	*	46
Grant	36%	38%	10%	16%	195
Harney	44%	22%	13%	22%	216
Hood River	41%	26%	16%	17%	570
Jackson	44%	25%	15%	16%	4,443
Jefferson	40%	24%	14%	22%	517
Klamath	48%	22%	14%	15%	1,452
Lake	41%	33%	15%	11%	199
Lane	44%	24%	13%	19%	7,446
Linn	43%	24%	15%	18%	2,596
Malheur	46%	20%	12%	23%	712
Marion	43%	23%	15%	19%	7,664
Morrow	34%	30%	19%	17%	325
Multnomah	45%	28%	13%	14%	12,143
Polk	46%	24%	17%	13%	660
Sherman	54%	31%	*	*	52

¹⁴ County weight shown.

County	Very easy	Sort of easy	Sort of hard	Very hard	Total Item Responses
Umatilla	44%	21%	16%	18%	1,655
Union	39%	29%	12%	21%	619
Wallowa	35%	42%	12%	11%	165
Wasco	43%	25%	12%	20%	486
Washington	47%	25%	12%	16%	10,094
Wheeler	33%	19%	43%	*	42
Yamhill	44%	25%	12%	20%	2,086
Total	33,044	18,773	9,949	12,606	74,386

Table 9: 2005 OHT Data: How wrong do your parents feel it would be for you to drink beer, wine, or liquor regularly?¹⁵

County	Very wrong	Wrong	A little bit wrong	Not wrong at all	Total Item Responses
State Percentage	64%	22%	11%	3%	72,643
Baker	57%	22%	18%	4%	408
Benton	68%	19%	10%	3%	1,399
Clackamas	66%	23%	9%	3%	8,252
Clatsop	56%	26%	15%	3%	696
Columbia	57%	26%	15%	1%	1,068
Coos	61%	24%	11%	4%	1,285
Crook	55%	28%	13%	4%	461
Curry	58%	26%	14%	2%	511
Deschutes	57%	22%	16%	5%	3,103
Douglas	63%	23%	12%	2%	2,415
Gilliam	40%	34%	21%	*	47
Grant	45%	32%	18%	5%	195
Harney	65%	26%	9%	0%	217
Hood River	65%	23%	10%	3%	545
Jackson	66%	22%	10%	2%	4,400
Jefferson	59%	23%	16%	3%	498
Klamath	64%	20%	12%	3%	1,379
Lake	58%	25%	13%	4%	196
Lane	65%	20%	12%	4%	7,349
Linn	65%	19%	12%	5%	2,528
Malheur	69%	20%	10%	*	713
Marion	64%	22%	11%	2%	7,474
Morrow	54%	27%	16%	3%	319
Multnomah	64%	23%	11%	2%	11,818
Polk	61%	28%	9%	2%	631
Sherman	55%	26%	11%	*	53

¹⁵ County weight shown.

County	Very wrong	Wrong	A little bit wrong	Not wrong at all	Total Item Responses
Umatilla	61%	22%	12%	5%	1,640
Union	60%	22%	16%	2%	618
Wallowa	52%	34%	13%	*	173
Wasco	64%	22%	12%	2%	476
Washington	66%	24%	9%	2%	9,793
Wheeler	68%	*	*	15%	41
Yamhill	61%	23%	13%	3%	1,942

Table 10: 2005 OHT Data: If someone your age drank some beer, wine or hard liquor in your neighborhood, he or she would be caught by the police.¹⁶

County	Very much true	Pretty much true	A little true	Not at all true	Total Item Responses
State Percentage	14%	16%	39%	30%	71,424
Baker	14%	15%	40%	31%	408
Benton	16%	21%	36%	28%	1,373
Clackamas	17%	17%	38%	28%	8,160
Clatsop	9%	17%	43%	31%	676
Columbia	13%	17%	42%	28%	1,058
Coos	16%	15%	38%	32%	1,263
Crook	14%	15%	39%	32%	457
Curry	13%	16%	40%	31%	502
Deschutes	16%	12%	36%	36%	3,060
Douglas	12%	16%	38%	34%	2,355
Gilliam	13%	*	56%	24%	45
Grant	12%	15%	52%	20%	196
Harney	14%	13%	49%	24%	215
Hood River	15%	19%	34%	33%	535
Jackson	15%	18%	40%	28%	4,318
Jefferson	16%	16%	38%	29%	486
Klamath	10%	19%	37%	34%	1,331
Lake	11%	18%	48%	23%	193
Lane	13%	14%	38%	34%	7,235
Linn	19%	18%	37%	27%	2,477
Malheur	18%	23%	39%	20%	707
Marion	17%	19%	38%	26%	7,378
Morrow	16%	23%	42%	19%	316
Multnomah	12%	15%	39%	34%	11,585
Polk	2%	10%	40%	48%	632
Sherman	18%	*	36%	38%	50

¹⁶ County weight shown.

County	Very much true	Pretty much true	A little true	Not at all true	Total Item Responses
Umatilla	16%	21%	41%	23%	1,604
Union	18%	17%	44%	21%	615
Wallowa	9%	15%	55%	22%	172
Wasco	16%	16%	40%	29%	478
Washington	11%	17%	42%	30%	9,614
Wheeler	*	*	49%	39%	41
Yamhill	18%	18%	37%	28%	1,889

Table 11: 2005 OHT Data: If someone your age tried to purchase alcohol at a store in your neighborhood, he or she would be asked for ID or proof of age.¹⁷

County	Very much true	Pretty much true	A little true	Not at all true	Total Item Responses
State Percentage	58%	30%	9%	3%	71,205
Baker	62%	27%	8%	3%	403
Benton	63%	27%	7%	4%	1,356
Clackamas	58%	29%	9%	3%	8,115
Clatsop	64%	26%	7%	3%	672
Columbia	56%	30%	11%	2%	1,059
Coos	59%	28%	9%	5%	1,266
Crook	55%	35%	8%	2%	457
Curry	55%	34%	8%	3%	501
Deschutes	54%	28%	12%	5%	3,044
Douglas	58%	31%	9%	3%	2,329
Gilliam	73%	20%	*	0%	45
Grant	47%	37%	11%	4%	196
Harney	48%	39%	8%	5%	214
Hood River	64%	26%	7%	3%	539
Jackson	62%	30%	7%	2%	4,324
Jefferson	54%	26%	12%	8%	486
Klamath	54%	32%	11%	3%	1,335
Lake	50%	35%	11%	5%	197
Lane	60%	29%	8%	4%	7,220
Linn	60%	25%	11%	5%	2,462
Malheur	57%	29%	10%	4%	702
Marion	58%	28%	10%	3%	7,360
Morrow	65%	26%	6%	3%	313
Multnomah	58%	31%	9%	2%	11,553
Polk	44%	44%	12%	0%	632
Sherman	62%	20%	14%	*	50

¹⁷ County weight shown.

County	Very much true	Pretty much true	A little true	Not at all true	Total Item Responses
Umatilla	67%	25%	4%	4%	1,600
Union	66%	22%	10%	2%	611
Wallowa	56%	31%	11%	*	172
Wasco	58%	29%	9%	4%	477
Washington	53%	36%	9%	2%	9,604
Wheeler	90%	0%	*	*	40
Yamhill	58%	28%	8%	5%	1,871

Table 12: 2005 OHT Data: If there was a party in your neighborhood where people your age were drinking, the police would come and break it up.¹⁸

County	Very much true	Pretty much true	A little true	Not at all true	Total Item Responses
State Percentage	24%	28%	34%	14%	71,019
Baker	25%	26%	33%	16%	407
Benton	27%	27%	31%	15%	1,358
Clackamas	27%	27%	33%	13%	8,083
Clatsop	18%	29%	37%	17%	673
Columbia	23%	28%	34%	15%	1,056
Coos	24%	27%	34%	16%	1,254
Crook	25%	31%	32%	13%	456
Curry	22%	27%	39%	12%	500
Deschutes	26%	22%	33%	19%	3,049
Douglas	24%	25%	35%	16%	2,317
Gilliam	27%	38%	27%	*	45
Grant	21%	29%	38%	12%	196
Harney	33%	23%	31%	13%	215
Hood River	23%	31%	34%	13%	529
Jackson	27%	29%	31%	12%	4,311
Jefferson	25%	25%	32%	18%	486
Klamath	20%	26%	40%	14%	1,335
Lake	21%	21%	48%	10%	194
Lane	20%	26%	34%	20%	7,186
Linn	28%	28%	31%	13%	2,455
Malheur	29%	32%	29%	10%	705
Marion	27%	29%	32%	13%	7,354
Morrow	27%	31%	33%	9%	312
Multnomah	21%	31%	37%	11%	11,536
Polk	8%	20%	43%	28%	631
Sherman	18%	14%	39%	29%	51

¹⁸ County weight shown.

County	Very much true	Pretty much true	A little true	Not at all true	Total Item Responses
Umatilla	32%	26%	29%	13%	1,610
Union	24%	34%	31%	11%	614
Wallowa	15%	37%	40%	8%	170
Wasco	23%	33%	32%	12%	476
Washington	23%	28%	37%	13%	9,539
Wheeler	*	37%	39%	20%	41
Yamhill	28%	24%	32%	16%	1,875

Table 13: 2005 OHT Data: Outside of my home and school, there is an adult who always wants me to do my best.¹⁹

County	Very much true	Pretty much true	A little true	Not at all true	Total Item Responses
State Percentage	69%	19%	8%	4%	71,994
Baker	71%	22%	4%	3%	412
Benton	71%	19%	7%	3%	1,374
Clackamas	68%	20%	9%	4%	8,148
Clatsop	72%	18%	8%	2%	676
Columbia	71%	15%	11%	2%	1,074
Coos	71%	17%	7%	5%	1,278
Crook	73%	16%	7%	4%	459
Curry	68%	23%	8%	1%	518
Deschutes	68%	19%	7%	5%	3,074
Douglas	74%	15%	9%	2%	2,371
Gilliam	47%	47%	*	0%	47
Grant	61%	29%	6%	4%	196
Harney	76%	18%	3%	3%	215
Hood River	70%	16%	8%	7%	541
Jackson	71%	17%	8%	4%	4,401
Jefferson	66%	23%	8%	3%	492
Klamath	70%	22%	6%	3%	1,364
Lake	70%	21%	6%	4%	197
Lane	68%	18%	10%	4%	7,303
Linn	72%	16%	8%	5%	2,504
Malheur	69%	20%	6%	5%	710
Marion	67%	19%	9%	5%	7,454
Morrow	63%	25%	9%	3%	317
Multnomah	69%	20%	8%	3%	11,749
Polk	72%	14%	9%	4%	632
Sherman	66%	24%	*	*	50

¹⁹ County weight shown.

County	Very much true	Pretty much true	A little true	Not at all true	Total Item Responses
Umatilla	68%	20%	8%	3%	1,640
Union	72%	19%	7%	2%	619
Wallowa	76%	16%	8%	0%	172
Wasco	66%	23%	9%	3%	470
Washington	67%	21%	9%	3%	9,582
Wheeler	66%	32%	*	0%	41
Yamhill	70%	16%	9%	5%	1,914

Section Three: Using Data-Driven Decision-Making to Get the Best Outcomes from Evidence-Based Practices

In 2003, the Oregon Legislature passed Senate Bill 267, which requires that increasing amounts of state funds are allocated to the implementation of evidence-based practices (EBP). For 2005-07, the statute requires that at least 25 percent of state substance abuse and mental health funds be used for the provision of evidence-based practices. In 2007-09, the percentage of funds to be spent on EBPs increases to 50 percent, and in 2009-2011 to 75 percent.

Funding only those practices proven to be effective in reducing substance abuse is good policy and sound stewardship of public resources. The shift to the delivery of services based on scientific evidence of effectiveness, however, is a major transition for those working in the mental health and substance abuse systems. The Office of Mental Health and Addiction Services is using this transition as an opportunity to work with policy makers and stakeholders to restructure the mental health and substance abuse delivery systems for adults and youth.

The Oregon Healthy Teen survey provides critical information that can help decision makers and stakeholders strategically select and invest in those evidence-based practices that are most likely to achieve the best results. Substance abuse is dynamic and highly impacted by local conditions. The data provided by the survey provides a mechanism for careful assessment and diagnosis at the state and county levels, ensuring that

funds can be invested in evidence-based practices most closely aligned with priority substance abuse issues, elevated risk factors, and lower than desired protective factors.

Ensuring that selected strategies are locally and culturally appropriate for each community's level of readiness for change is also important. In addition, because research has shown that no one strategy can—in and of itself—produce significant reductions in substance abuse. It is also extremely important to use comprehensive approaches that include both environmental and individual strategies to address all key underlying causal factors. Every community needs a comprehensive plan.

Research has shown that prevention strategies are most effective when they:

- *Focus on reducing risk factors known to increase the risk of substance abuse and increase protective factors known to protect youth against substance abuse;
- *Address risk factors at the appropriate developmental stages;
- *Address problems early, before the behavior becomes a habit;
- *Target individuals and communities who are at greatest risk; and
- *Are culturally competent.

There are a number of important considerations that go into the selection of evidence-based practices. The Oregon Healthy Teen survey provides important information. The remainder of Section Three provides a concise overview of each of the following considerations:

- *Identified substance abuse problem;
- *Priority risk and protective factors, as well as other underlying causal conditions;
- *Level of community readiness for change;
- *Community resources;
- *Target population;
- *Cultural competency;
- *Developmental appropriateness;
- *Fidelity and adaptation challenges;
- *Comprehensiveness of approach;
- *Individual and Environmental approaches;

*Evaluation; and

*Sustainability of outcomes.

Identified Problem: The first step in selecting an evidence-based practice is to analyze assessment data to identify the priority problems and substance(s) of abuse that most compromise the health and well-being of the population to be served. Although some strategies have a broader focus and address multiple substances at once, many focus on a specific substance such as alcohol or tobacco. As you review potential strategies, ask yourself: “Does this strategy specifically address the substance or substances that data shows causes the biggest problems in my community?”

Priority Risk and Protective Factors and Other Causal Conditions: Knowing what substances are priority issues is not enough. In order to formulate effective responses, it is critical to identify and strategically target the specific underlying causal conditions (e.g. risk, protective and other factors) that increase the likelihood of substance abuse. After you have identified evidence-based practices that have been proven to produce positive outcomes in addressing your priority substance abuse areas, ask yourself this: “Which of these practices have also proven effective at addressing the risk and protective factors and other causal conditions that data show are priorities in my community?” Refine your strategy selection process by eliminating practices that don’t align with those priority risk, protective and other factors.

Level of Community Readiness: Community readiness is the degree to which a community is prepared to plan for—and take action on—an issue. For example, community social norms may be such that a community is much more ready to address one particular issue (e.g. methamphetamine use) over another (e.g. underage drinking). Community readiness also impacts the degree to which a community may be prepared to implement a particular strategy at a given point in time. For example, a community may be supportive of practices designed to change the individual attributes of youth (e.g. a school-based curriculum), but not at all supportive of adopting policies that would change the environment of the community (e.g. a municipal ordinance designed to restrict density of retail alcohol outlets). Community readiness is a particularly important consideration for strategy selection, since different prevention strategies are appropriate for different stages of community readiness. If you try to implement a strategy that is beyond the readiness of your community, it is likely to fail no matter how well it is suited to your priority substance abuse issues and risk and protective factors.

Community Resources: Community resources are another important consideration in selecting evidence-based prevention practices. There are at least two key questions to ask. The first is “Are there sufficient resources to support the implementation of this strategy?” In other words, do you have the capacity to carry out this strategy? Some of the strategies specify training and evaluation components that might require greater time and resources than you have the capacity to provide at this time. Some strategies include substantial costs for training, staffing, program materials, and evaluation. Furthermore, you will need to examine any requirements related to the number of staff, as well as locations required for activities that are part of the overall strategy in which you are interested. Some strategies are more complicated and involved than others, and require greater resources and expertise to implement.

The second question is “Does this strategy duplicate something that already exists in the community?” For example, if the priority risk factors are family conflict and poor family management, but several local programs already offer parenting classes aimed at the general population (i.e. “universal” strategies), then you may want to look at implementing a strategy that targets a more specified risk population (i.e., a strategy that targets a “selected” or “indicated” population).

Target Population: In analyzing data, it’s important to identify the specific population(s) experiencing the problems, and therefore in need of prevention. This is the target population. Characteristics of a target population include age, gender, developmental stage, ethnicity and culture. Most evidence-based practices have been evaluated for their effectiveness with certain target populations. When selecting strategies, it’s important to ask “Has this strategy been found to have a measurable impact upon the people we are trying to reach?”

Another important consideration is whether the target population represents a broad sector of the community, or a specifically identified segment of the community. If you need a strategy that affects the larger community, you will want to implement a “universal” strategy. If you need to reach a specific population with common identified risks, then a “selected” strategy will be more appropriate. If the population is individuals with multiple identified risks, then an “indicated” strategy will be most appropriate. Evaluations of evidence-based practices will include documentation of the target populations for which the practices have been found effective.

Cultural Competency: Contextual conditions for substance abuse prevention in Oregon include diverse populations that are widely and unevenly dispersed throughout the state in settings ranging from intensely urban to extremely frontier. Ensuring that all evidence-based practices selected are culturally and linguistically appropriate is critical for achieving community substance abuse prevention outcomes. Prevention strategies must always be accessible to, inclusive of, and appropriate for the unique qualities of the populations to be served.

Assessment data—combined with detailed research about the implementation and validity of each evidence-based practice—can provide important information about the appropriateness of each practice with regard to:

- *Target populations to be served (i.e. age and gender);
- *Target settings appropriate for strategy implementation (e.g. rural, urban, suburban, and other localized locations of strategy implementation);
- *Validated cultural adaptations of the strategy, if available; and
- *Ethnic populations for which the strategy is appropriate, including distinctions between whether the strategy has been validated for a culturally-specific setting versus merely replicated in a setting that included members of a specific culture, race or ethnicity.

It's important to carefully analyze the appropriateness of strategies with regard to the age, gender, setting and ethnic and cultural composition of the selected target population. In addition, you should ensure that your implementation plan includes the use of culturally competent staff, as well as budgeted amounts for any prospective costs associated with ensuring culturally competent strategy implementation. Such costs could include, but are not limited to, the following: interpretation and/or translation services, close captioning, special training or materials development, and increased mileage expense for travel in rural areas.

Developmental Appropriateness: When the target population is youth, it's important to think carefully about their stage of development and use only those practices most appropriate for that stage. There are key differences in developmental stages between youth in elementary, junior high or middle school, and high school, and these

differences impact the success that different approaches will have.

- *Elementary grades: children are more influenced by parents and teachers than by peers. Practices that focus on parental involvement, provide accurate information, and develop competency in decision-making and social skills may be most appropriate for this age group;
- *Junior high or middle school: peers and role models become increasingly important to students, and social pressures begin to play a much larger role in shaping behavior. Strategies that focus on building skills to strengthen the ability of a child to be aware of—and resist—external pressures, and that include cooperative learning or peer education, may be most effective for this target age range; and
- *High school: students are primarily concerned with individual identity and are most oriented to peers and role models. The most effective strategies for these students often: 1) include booster sessions to reinforce skills learned earlier in social influence approaches; 2) incorporate youth input; and, 3) offer alcohol- and drug-free, pro-social activities. The value of such strategies is increased when peers who model “no-use” norms lead them.

Developmental stages and life transitions can involve biological, psychological, or social circumstances that can increase the risk of substance abuse. Whether the stages or transitions are expected (e.g. puberty, adolescence, or graduation from school) or unexpected (e.g. parents divorce, the sudden death of a loved one), they should be addressed by preventive interventions as soon as possible—even before each stage or transition—whenever feasible. For example, because transitions—such as going from elementary to middle school or middle school to high school—can be very stressful times, strategies planned around these transitional points can be particularly effective, provided of course that the activities are appropriate to the age and stage of the child’s development.

Finally, developmental appropriateness is important in selecting both environmental and individual strategies. While most environmental strategies are directed at the community at large, there may be components that are intended to reach specific sub-populations. For example, some components of a media campaign may be aimed at teens while other components are targeted at parents. In this case, it’s important to make sure that the media message is effective (i.e. developmentally appropriate) for the specific group targeted. With individual strategies, the target population may be more narrowly focused (e.g. a specific age group, adjudicated youth, or children of

alcoholics). In these cases, it's important to ensure the strategy is appropriate to the developmental stage of the specific group that is targeted.

Fidelity and Adaptation: In order to select the most appropriate strategy or strategies, it's also important to consider fidelity and adaptation issues. Fidelity refers to the extent to which the core components of a substance abuse prevention strategy are faithfully implemented. Adaptation refers to adding or subtracting any components of a strategy, making any changes in those components, or changing the way a strategy is administered. As you examine the strategies you are interested in implementing, consider the degree to which you are able to implement the strategy as intended by the developer. If you believe that adaptations will be necessary in order for a strategy to fit your needs, ask the following questions: 1) "Is this strategy really the best choice for our needs?" and 2) "Can the strategy be implemented with fidelity, so we can be confident it will have the intended effects?"

Comprehensiveness of Approach: Prevention research has shown that comprehensive approaches using multiple strategies are the most effective in reducing substance abuse. This means that the best chance of achieving desired outcomes occurs when strategies are implemented in as many of the four domains (i.e. individual/peer; school; family; community) as possible, and address each of the risk and protective factors pertinent in the population. To assess comprehensiveness, ask "Does the strategy we're interested in address multiple domains and risk and protective factors using multiple approaches?" If not, you may need to identify additional strategies that can be incorporated into your overall plan.

Individual and Environmental Substance Abuse Prevention Strategies: A plan that combines environmental strategies with individual strategies is much more likely to be more successful than one that focuses on just one or the other.

Individual approaches define substance abuse as a personal decision. The goal of individually focused prevention approaches is to change the attitudes or behaviors of particular individuals, decreasing the chance that they will engage in substance abuse. These goals are achieved by changing the personal attributes of the individual (e.g. improve an individual's decision-making or resistance skills). An individual strategy focuses only

on individual risk and protective factors and does not include efforts to change risks that might be present in the individual's environment. While individual approaches are an important component of successful prevention efforts—particularly with high-risk populations—prevention efforts are most effective when they include strategies that take an environmental approach as well.

Environmental approaches define substance abuse as a social issue as well as an individual decision.

Environmental strategies focus on changing aspects of the environment that contribute to the use of alcohol and other drugs. Specifically, environmental strategies seek to decrease the social and health consequences of substance abuse by limiting access to substances and changing social norms that are accepting and permissive of substance abuse. Environmental approaches change public laws, policies, practices and social norms to create environments that decrease the probability of substance abuse.

In general, individual strategies are short-term actions focused on changing individual behavior, while environmental strategies involve longer-term, potentially permanent changes that have a broader reach (e.g., policies and laws that affect all members of society). Many environmental strategies tend to be inherently sustainable because they frequently involve one-time policy or practice changes. Individual strategies may be more resource-intensive to sustain because they tend not to be time-limited, and frequently include significant staffing and other resource requirements. The most effective prevention plans will use both environmental and individual substance abuse prevention strategies.

Evaluation: It is important to carefully consider your ability to implement the evaluation requirements associated with an evidence-based practice. If you cannot evaluate the short-term, intermediate-term, and long-term outcomes, the practice is not a good choice. As you select evidence-based practices, also consider how you will monitor and evaluate the practice through its implementation process to achieve continuous improvement and monitor whether outcomes are being achieved.

Sustainability of Outcomes: It's important to remember that sustaining desired substance abuse prevention outcomes may or may not involve continuing any one particular strategy over time. Drug use is dynamic and community needs may change over time. It's important to think about how you will monitor evolving community

needs and contextual conditions, and how approaches may have to be adapted or changed over time to maintain desired substance abuse prevention outcomes into the future. For example, an environmental approach might focus initially on the adoption of changes in policies or laws, with activities likely including mobilization, education, communication and advocacy. If the effort is successful, activities under the new policy or law will likely focus on enforcement and compliance. Even individual strategies may need to change over time as shifts in population or drug trends occur.

Section Four: Substance Abuse Prevention Services in Oregon

Oregon has a well-developed system that ensures substance abuse prevention services are provided within each County and Tribe. The Policy and Program Development Unit of the Oregon Office of Mental Health and Addiction Services has several Prevention Coordinators. Each prevention coordinator oversees prevention programs in counties and tribes throughout Oregon. Prevention coordinators:

- *Provide technical assistance in prevention related activities (writing prevention plans, etc.)
- *Conduct site visits to ensure the prevention programs are in compliance with the [Oregon Administrative Rules](#) in conducting prevention services, and
- *Manage funding contracts for each county and tribe.

Collaboration with other state agencies is crucial for effective substance abuse prevention services. Additional state agencies collaborating with the Policy and Program Development unit are the [Department of Education](#), the [Commission on Children and Families](#) and [Public Health](#).

Appendix A: Resources

Center for Substance Abuse Prevention, Centers for the Application of Prevention Technologies, Structure of Oregon's Prevention System.

<http://captus.samhsa.gov/Western/oregon-details.cfm>

Center for Substance Abuse Prevention, Western Center for the Application of Prevention Technologies, Oregon

<http://casat.unr.edu/westcapt/oregon2.htm>

Monitoring the Future

<http://www.monitoringthefuture.org/>

Oregon Center for Health Statistics

<http://www.oregon.gov/DHS/ph/chs/index.shtml>

Oregon Commission on Children and Families

http://egov.oregon.gov/OCCF/about_us.shtml

Oregon Department of Education

<http://www.ode.state.or.us/>

Oregon Department of Education, Office of Student Learning and the Oregon Office of Mental Health and Addiction Services, joint position paper on Effective Approaches to Substance Abuse Prevention

<http://www.oregon.gov/DHS/addiction/pos-statement.pdf>

Oregon Office of Mental Health and Addiction Services

<http://www.oregon.gov/DHS/addiction/index.shtml>

Oregon Office of Mental Health and Addiction Services, Evidence Based Practices

<http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml>

Oregon Office of Mental Health and Addiction Services, Resources and Data

http://www.oregon.gov/DHS/addiction/resource_center.shtml

Oregon Office of Mental Health and Addiction Services, Underage Drinking

<http://www.oregon.gov/DHS/addiction/underage-drinking/main.shtml>

Oregon Tobacco Prevention and Education Program

<http://www.oregon.gov/DHS/ph/tobacco/>

Oregon Partners for Children and Families

<http://www.oregonpcf.org/>

Oregon Partnership

<http://www.orpartnership.org/>

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