*Substance Abuse Prevention Skills Training*

Session 3 Handouts

Agenda

* Review Key Concepts from Session 2
	+ Step 1: Assessment
	+ Step 2: Capacity (Assessing Capacity)
* Strategic Prevention Framework
	+ Step 2: Capacity (Building Capacity)
	+ Building Capacity: The Role of Cultural Competence
	+ Step 3: Planning

Learning objectives

By the end of this session, you will be able to:

* Explain how a community can build its capacity to prevent the problems identified in its assessment
* Describe culture and how to apply cultural competence to prevention and promotion
* Explain how to prioritize risk and protective factors

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information sheet 3.1 – Building Capacity

SPF Step 2 involves (1) improving a community’s readiness to address the substance use problem and its risk or protective factors identified in the assessment; and (2) increasing the resources that are available to do substance abuse prevention.

Increasing resources and improving readiness often go hand-in-hand—in many cases, building resource capacity also contributes to greater community readiness. For example, when key stakeholders are engaged in solving problems (human resources), they often mobilize other community members, thereby preparing more people in the community to take action.

Described below are **three key areas to build capacity:**

1. Engage stakeholders and form partnerships

2. Strengthen collaborative groups

3. Increase community awareness

**Engage Stakeholders and Form Partnerships**

**Stakeholders** are the people and organizations in the community who have:

* A “stake” in prevention because they care about promoting health and well-being
* Something to gain or lose by your prevention or promotion efforts

Look in the following sectors for potential stakeholders:

* Population groups that the intervention serves
* Mental health
* Primary care
* Suicide prevention
* Behavioral health treatment and recovery
* Tobacco control
* School safety and health
* Highway safety
* Injury prevention
* Violence prevention
* Reproductive, maternal and child health
* HIV/AIDS prevention

Stakeholders may be reluctant to get involved in substance abuse prevention. Therefore, it is extremely useful to identify the “**WIIFM**”(*What’s In It For Me*) for each of the stakeholders you want to engage so that they can see the value and benefit to their own work and interests.

**Levels of Involvement.**1 Different sectors and stakeholders may want or need to be involved in your prevention activities to different degrees. The following is a table showing examples of different degrees, or levels, of involvement.

| **Level** | **Expression**  | **Examples** |
| --- | --- | --- |
| No Involvement | “You do your thing; we’ll do ours.” | Stakeholders engage in separate activities, strategies, and policies. |
| Networking | “Let’s talk and share information.” | Stakeholders share what they are doing during an interagency networking meeting; talk about community issues in which they all have a stake; or communicate with other organizations about existing programs, activities, or services. |
| Cooperation | “I’ll support your program, and you’ll support mine, or we can even co-sponsor one.”  | Partners publicize each other’s programs in organization newsletters, write letters in support of each other’s grant applications, co-sponsor trainings or professional development activities, and/or exchange resources such as printing or meeting space.  |
| Coordination | “Let’s partner on an event.” | Stakeholders serve together on event planning committees or community boards, or implement programs or services together. |
| Collaboration | “Let’s work together on a comprehensive plan to address the issue; after all, our missions overlap.” | Participating organizations create formal agreements including memoranda of understanding or formal contracts, developing common data-collection systems across organizations and community sectors, partnering on joint fundraising efforts, pooling fiscal or human resources, or creating common workforce training systems. |

**Sitting at Others’ Tables.** Opportunities to collaborate not only depend on getting stakeholders to your table, but also whose tables *you’re* sitting at, especially since not all of your needed stakeholders or allies will want to be a part of your work. So you need to go to them and to be a part of their meetings and decisions. If you *don’t* do this . . .

* You may get left out of important conversations.
* Your agenda may get overlooked.
* You could miss potential funding opportunities.

How to get a seat at other tables:

* Ask to join.
* Describe what you can bring to the group (e.g., skills, resources, constituencies).
* Use data to identify overlapping interests, goals, and agendas.

**Strengthen Collaborative Groups**

Many informal partnerships exist in a community. Most communities have some kind of collaborative group, such as a task force, coalition, or interagency group. Some communities have quite a few of them.

A collaborative group can be strengthened in different ways, particularly by:

* **Recruiting new members** so that a broad spectrum of sectors are represented. To do this:
	+ Determine who else needs to be recruited and how to initiate a conversation.
	+ Identify effective techniques for engaging with these agencies, organizations, or population groups
* **Increasing the knowledge of members** through training and technical assistance
* **Improving the structure** and functioning of the collaborative group, through2:
	+ Clear and formalized roles and procedures
	+ Adequately addressing task and maintenance functions
	+ Developing and maintaining quality management strategies, such as effective communication, conflict resolution, and shared decision-making.
	+ Effective leadership (i.e., leaders who are open, task-oriented, and supportive)

**Increase Community Awareness**

When thinking about increasing community awareness, consider both stakeholders and community members. Important champions for prevention may be found in unexpected places, such as the local media, the legislature, and faith or business communities.

Building awareness and educating stakeholders and community members is important for the following reasons:

* Increase awareness of the issues and the need for prevention and health promotion
* Engage potential partners
* Increase readiness of partners and the community to address the issues
* Ensure culture is considered in assessment and planning
* Ensure prevention is sustained over time

Here is some information you might want to share when educating stakeholders and others (keeping in mind that not everyone will need or want the same information):

* Knowledge about the issues
* Knowledge about prevention
* Understanding of data and what it shows
* Knowledge of resources
* Opportunities to contribute to the interventions

Information Sheet 3.2 – strategies to improve community readiness

The following strategies are based on the Tri-Ethnic Center’s Community Readiness Model.3

**STAGE 1 – Community Tolerance/No Knowledge**

* Small-group and one-on-one discussions with community leaders to identify perceived benefits of substance abuse and how norms reinforce use
* Small-group and one-on-one discussions with community leaders on the health, psychological, and social costs of substance abuse to change perceptions among those most likely to be part of the group that begins development of programs

**STAGE 2 – Denial**

* Educational outreach programs to community leaders and community groups interested in sponsoring local programs focusing on the health, psychological, and social costs of substance abuse
* Use of local incidents in one-on-one discussions and educational outreach programs that illustrate harmful consequences of substance abuse

**STAGE 3 – Vague Awareness**

* Educational outreach programs on national and state prevalence rates of substance abuse, and prevalence rates in communities with similar characteristics, including use of local incidents that illustrate harmful consequences of substance abuse
* Local media campaigns that emphasize consequences of substance abuse

**STAGE 4 – Preplanning**

* Educational outreach programs to community leaders and sponsorship groups that communicate the prevalence rates and correlations or causes of substance abuse
* Educational outreach programs that introduce the concept of prevention and illustrate specific prevention programs adopted by communities with similar profiles
* Local media campaigns emphasizing the consequences of substance abuse and ways of reducing demand for illicit substances through prevention programming

**STAGE 5 – Preparation**

* Educational outreach programs open to the general public on specific types of prevention programs, their goals, and how they can be implemented
* Educational outreach programs for community leaders and local sponsorship groups on prevention programs, goals, staff requirements, and other startup aspects of programming
* A local media campaign describing the benefits of prevention programs for reducing consequences of substance abuse

**STAGE 6 – Initiation**

* In-service educational training for program staff (paid and volunteer) on the consequences, correlations, and causes of substance abuse and the nature of the problem in the local community
* Publicity efforts associated with the kickoff of the program
* A special meeting with community leaders and local sponsorship groups to provide an update and a review of initial program activities

**STAGE 7 – Institutionalization/Stabilization**

* In-service educational programs on the evaluation process, new trends in substance abuse, and new initiatives in prevention programming, with trainers either brought in from the outside or with staff members sent to programs sponsored by professional societies
* Periodic review meetings and special recognition events for local supporters of the prevention program
* Local publicity efforts associated with review meetings and recognition events

**STAGE 8 – Confirmation/Expansion**

* In-service educational programs on the evaluation process, new trends in substance abuse, and new initiatives in prevention programming, with trainers either brought in from the outside or with staff members sent to programs sponsored by professional societies
* Periodic review meetings and special recognition events for local supporters of the prevention program
* Presentation of results of research and evaluation activities of the prevention program to the public through local media and public meetings

**STAGE 9 – Professionalism/High Level of Community Ownership**

* Continued in-service training of staff
* Continued assessment of new drug-related problems and reassessment of targeted groups within the community
* Continued evaluation of program effort
* Continued update on program activities and results provided to community leaders and local sponsorship groups, and periodic stories through local media and public meetings

**Information sheet 3.3 – CULTURAL COMPETENCE**

**Cultural competence** implies having the capacity to function effectively as an individual, an organization, or a system within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Cultural competence, at the individual, organizational, and systems levels, involves4:

* Being **respectful** of the health beliefs, practices, and cultural and linguistic needs of diverse people and groups. This includes:
	+ Valuing cultural differences
	+ Having an open mind
* Being **responsive** to the health beliefs, practices and cultural and linguistic needs of diverse people and groups. This includes:
	+ Knowing something about the culture of the group that the interventions focus on
	+ Customizing prevention and promotion in a way that respects and fits with the culture of the group that selected interventions target
	+ Involving people from the targeted cultural group in assessing needs, developing resources, planning and implementing interventions, and evaluating their effectiveness— “Nothing about us without us”

**Culture**

Culture must be considered at every step of the Strategic Prevention Framework in order for diverse populations to benefit from selected interventions. It is especially important that the interventions chosen are a good match for the culture of the population group for which they are meant—attuned to their values, customs, beliefs, roles, manners of interacting, and communication styles. For example, an evidence-based program for a Native American community should involve Tribal elders in its development and dissemination.

**“Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.”5**

People typically think of culture in terms of race or ethnicity, but culture also refers to other social groups defined by characteristics such as age, gender, religion, income level, education, geographical location, sexual orientation, disability, or profession.

Culture includes the following elements:

* **Norms** (how people behave)
* **Values** (what is important to people)
* **Beliefs** (what people think about something)
* **Symbols** (how people express themselves through art, stories, music, language, etc.)
* **Practices** (customs or patterns of behavior that may not be connected to beliefs and values)

Some elements of culture are easy to see, but most elements of culture are hidden. For example, in some cultures it is frowned upon for people to get help from professionals for emotional problems. This norm may prevent people from seeking the help they need. So when doing prevention for a particular population group, it is important to be aware of cultural norms and practices that may compromise the effectiveness of an intervention.

**Cultural Competence Continuum**

Developing cultural competence is an evolving, dynamic process that takes time and occurs along a continuum.6 The National Center for Cultural Competence at Georgetown University’s Center for Child and Human Development describes the six stages of this continuum:7

1. **Cultural destructiveness** – Attitudes and practices (as well as policies and structures in organizations) are destructive to a cultural group.
2. **Culture incapacity** – The capacity to respond effectively to the needs, interests, and preferences of culturally and linguistically diverse groups is lacking.
3. **Cultural blindness** – The predominant philosophy is one that views and treats all people as the same.
4. **Cultural pre-competence** – There is awareness of strengths and areas for growth to respond effectively to culturally and linguistically diverse populations. For instance, an agency recognizes that there are language needs in the community, but feels it doesn’t have the budget to meet those needs. They may ask someone to translate a few materials, but their attempts to address the needs of the population are not enough.
5. **Cultural competence** – Acceptance and respect for culture is consistently demonstrated in policies, structures, practices, and attitudes. These agencies and individuals are characterized by respect for difference among cultural groups, continuous self-assessment, expansion of cultural knowledge and attention to the dynamics of difference.
6. **Cultural proficiency** - All of the concepts of cultural competence are incorporated into an agency’s policy, practice and attitude. This agency or individual has the ability to add to the body on knowledge and to teach those concepts to others.Cultural proficiency is a goal that few organizations reach. Depending upon the cultural context we are working within, we can move back and forth along the continuum (especially between pre-competence and competence). Ongoing assessment, performance monitoring, and evaluation are essential to ensure that we are on the right track.

**information sheet 3.4 – SKILLS FOR CULTURAL COMPETENCE**

Professionals who are moving towards cultural competence are able to do the following when applying the steps of the Strategic Prevention Framework:

**Assessment**

* Accurately assess the influence of their own values, perceptions, opinions, knowledge, and social position on their interactions with others.
* Provide and promote an atmosphere in which similarities and differences can be explored, and understand that this process is not only cognitive but attitudinal and affective, as well.

**Capacity**

* Learn to be an ally to groups that experience prejudice and discrimination in the community. Help others learn to be an ally to their own cultural groups.
* Help expand other people’s knowledge of their culture, and affirm and legitimize other people’s cultural perspectives.

**Planning**

* Learn to embrace new, ambiguous, and unpredictable situations, and be persistent in keeping communication lines open when misunderstandings arise.
* Encourage community members to see themselves in a multicultural perspective, and encourage skills-building in cross-cultural interactions and communication.

**Implementation**

* Encourage and accommodate a variety of learning and participation styles, building on community members’ strengths.
* Draw upon the experiences of participants or collaborators to include diverse perspectives in any given intervention.

**Evaluation**

* Be skeptical about the validity of diagnostic tools applied to people who are culturally different from those upon whom the norms were based.
* Understand, believe, and convey that there are no culturally deprived or culturally neutral individuals or groups, and that all cultures have their own integrity, validity, and coherence, and deserve respect.

**iNFORMATION sHEET 3.5 – BARRIERS TO CULTURAL cOMPETENCE**

**Purpose**

As part of your journey to acquiring cultural competence, please consider the following scenarios which describe a variety of potential barriers to cultural competence. The purpose of this activity is to provide you with the opportunity to practice what you have learned with examples from the field.

**Instructions –**

* You will be asked to work in a small group on one assigned scenario
* Read the scenario individually
* As a group determine the barriers presented in the scenario and discuss strategies for overcoming the identified obstacle
* Select a group member to report the results of your discussion

**Scenario A**

You are a community coalition that has been in existence for many years. Although the Latino community and Asian community have a strong presence in your area, your coalition has never had representation from either community. You have invited representatives from both communities, but still struggle to engage them.

**Scenario B**

You are writing a grant proposal that requires cultural diversity. You are thinking about engaging key contacts from other organizations but you fear that the relationship building will take too long and there may be needs brought up that can’t be met with this proposal.

**Scenario C**

You have engaged the Cambodian community in your coalition and several representatives have been attending the meetings. They are interested in doing activities that are not evidence-based and not allowed in your grant.

**Scenario D**

Your coalition has been in existence for many years and recently received a federal grant that requires evidence-based strategies. Many members of the coalition feel uncomfortable with the language and jargon and feel the coalition is losing community solutions.

**Scenario E**

Your coalition has a diverse membership with key stakeholders and representatives from key constituency groups from the community. A new member has been very vocal about the lack of participation of youth on the coalition. Members of the coalition are concerned about tokenism and retaining youth. Two youth participated in the coalition in the past but they did not stay long.

**Scenario F**

Your coalition has a diverse membership with key stakeholders and representatives from key constituency groups from the community. A new member has been very vocal about the lack of participation of people in recovery on the coalition. Members of the coalition are concerned about the coalition’s work shifting away from prevention and towards treatment and recovery.

**iNFORMATION sHEET 3.5a – culturally competent organizations**

Cultural competence applies to organizations and health systems, just as it does to professionals. A culturally competent organization:

**Continually Assesses Organizational Diversity**

* The organization conducts a regular assessment of members’ experiences working with diverse communities and/or focus populations.
* The organization regularly assesses the range of values, beliefs, knowledge, and experiences within the organization that would facilitate working with focus communities.

**Invests in Building Capacity for Cultural Competency and Inclusion**

* The organization has policies, procedures, and resources that facilitate the ongoing development of cultural competence and inclusion.
* The organization is willing to commit the resources necessary to build or strengthen relationships with groups and communities.
* Members are representative of the focus population.

**Practices Strategic Planning that Incorporates Community Culture and Diversity**

* The organization collaborates with other community organizations, and organization members are involved in supportive relationships with other community groups.
* The organization is seen as a partner by other community organizations and members.

**Implements Prevention Strategies Using Culture and Diversity as a Resource**

* Community members and organizations have had an opportunity to create and/or review audiovisual materials, public service announcements, training guides, printed resources, and other materials to ensure they are accessible to, and attuned to their community or focus population.

**Evaluates the Incorporation of Cultural Competence**

* There is a regular forum for a wide variety of community members to provide both formal and informal feedback on the impact of interventions in their community.

**information sheet 3.6 – CULTURAL CONSIDERATOINS IN THE SPF9**

**Step 1: Assessment**

* Work with the community
* Use a culturally competent evaluator for assessment
* Ensure a mechanism for collecting cultural competence-related information/data
* Gain approval of the community for data collection and analysis
* Ensure that data is culturally responsive and appropriate
* Create a process for identifying culturally relevant risk and protective factors and other underlying conditions
* Formulate culturally-based assumptions of change
* Identify change from the community’s perspective

**Step 2: Capacity**

* Examine community resources and readiness
* Provide a safe and supportive environment for all participants
* Examine the breadth and depth of cultural competence
* Check cultural representation (language, gender, age)
* Develop policies (e.g., recruitment and retention, training, communication and community input) to improve cultural competence
* Ensure that tools and technology are culturally competent

**Step 3: Planning**

* Make sure the community is represented in the planning process
* Identify mutually acceptable goals and objectives
* When selecting programs and strategies, consider their fit with:
* Community culture
* Existing prevention efforts
* Past history

**Step 4: Implementation**

* Involve the community in the implementation of the strategic plan
* Create a feedback loop for communicating efforts and successes to the community

**Step 5: Evaluation**

* Make sure the community is represented in the evaluation process
* Ensure that data collection tools reflect community culture
* Use a culturally competent evaluator for evaluation
* Obtain permission to disseminate the evaluation findings from the organization or entity implementing the intervention

information sheet 3.7 – key tasks of planning

Planning is pivotal to prevention success—it helps to focus the energy of staff and other stakeholders, ensures that they are working toward the same goals, and provides the means for assessing, evaluating, and adjusting programmatic direction.

Good planning is also crucial to sustainability. It ensures the involvement and commitment of stakeholders beyond the initial funding period, establishes the organizational structure necessary to maintain program activities over time, and greatly increases the likelihood that expected outcomes will be achieved.

Planning typically involves the following tasks:

* **Establish criteria for prioritizing risk and protective factors** associated with the identified priority problems (e.g., changeability, importance).
* **Select prevention interventions** that are evidence-based, most likely to influence the identified risk factors (conceptual fit), and feasible and relevant to the population the intervention will serve (practical fit).
* **Develop a comprehensive, logical, and data-driven plan** that includes a logic model, strategies for addressing resource and readiness gaps, anticipated evaluation activities, and how issues of cultural competence have and will be addressed.

Keep in mind that good planning requires collaboration. Whether planning happens within a formal coalition or among a more informal group of partners, it cannot represent the thoughts and ideas of just one person. Decisions must reflect the ideas and input of individuals from various sectors within the community and, particularly, of the population that the intervention will focus on.

Information Sheet 3.8 – prioritizing risk and protective factors

Prioritizing risk and protective factors is a crucial part of the SPF planning process. Different criteria can be used to prioritize risk and protective factors. Communities often use two of these—**importance**and **changeability**—to decide which risk or protective factors to address. You will want to select risk or protective factors that are high in both importance and changeability.

**Importance**

Importance refers to how much a risk or protective factor impacts the substance abuse problem in a community.

When examining assessment data, ask yourself how important a particular risk or protective factor is in reducing a specific problem in a community. If the answer is “very important,” then this risk or protective factor would have high importance. If your answer is “not very important,” then the factor would have low importance.

For example, consider the problem of underage drinking. Assessment data from the community show that many more youth obtain alcohol from stores (referred to as *retail access*) than from their homes or peers (referred to as *social access*). In this case, retail access would be considered high importance, whereas social access would be considered low.

When weighing the importance of risk and protective factors, be sure to consider the following information as well:

* **Will the risk or protective factor impact other behavioral health issues?** For example, having a parent with a substance abuse problem increases the risk that the child of this parent will engage in underage drinking. It also increases the risk that she or he will experience other behavioral health issues. This risk factor is therefore important because focusing on it can reduce both youth substance abuse and mental health problems.
* **Does the risk or protective factor directly impact the specific developmental stage of the population group that is experiencing the problem?** For example, parental monitoring is a protective factor for underage drinking. This factor would have high importance for addressing underage drinking among 14 to 17 year olds—a developmental stage when parental monitoring is critical. It would have low importance for addressing underage drinking among 18 to 20 year-olds, when parental monitoring plays less of a role.

**Changeability**

Changeability can refer to three issues:

* Whether the community has the capacity—readiness and resources—to change a particular risk or protective factor
* Whether a suitable evidence-based intervention exists to address a particular problem
* Whether change can be brought about in a reasonable time frame, recognizing that changing some risk or protective factors may take too long to be a practical solution

If a community has ample resources and sufficient readiness to address a particular risk or protective factor, if a suitable evidence-based intervention exists, and if change can occur within a reasonable time frame, then the risk or protective factor would have high changeability. If a community does not have adequate resources, is not ready to address the risk or protective factor, or if changing the factor takes too long to be practical, then the factor would have low changeability.

**Worksheet 3.9 – case study- assessment information**

**I. Background Information**

|  |
| --- |
| **Community Overview**Community XYZ is located in an urban setting with a population that is 76% white, 15% Latino, 6% African American, and 3% Asian/Pacific Islander. Twenty years ago the community was thriving and considered to be the center for manufacturing for the state. Over the last five years, manufacturing businesses have either closed down or moved out of the area and the state. This has left the community economically depressed with a high unemployment rate. Many of the young people growing up in the community leave to go to college and/or find work. **Task Force Overview**The Substance Abuse Prevention Task Force was started by a group of concerned parents seven years ago. There were several incidents that caused concern, including the death of a teen due to alcohol poisoning. The task force consists of 25 parents, a representative from the mayor’s office, a pediatrician, several representatives from the Women’s Guild (an organization for women over age 65), representatives from a Health Task Force serving the Latino community, local artists, a newspaper reporter, and youth from the local church youth group. |

**II. Results of Assessment**

**Priority Problem Selected**

Based on reviewing a lot of different sources of data on the substance use behaviors and related problems in their community, the task force decided to focus its attention on **underage drinking.**

**Risk and Protective Factors**

The three research-based risk factors, and one protective factor, for underage drinking selected by the community were:

1. Parental monitoring
2. Social access
3. Perception of harm
4. Positive opportunities to belong

**1. Parental Monitoring**

Survey (parents who have youth aged 14–18)

* + 30% of parents do not call ahead to parties their children attend.
	+ 15% of parents would rather their children drink at home where the parents can supervise.
	+ 55% of parents have left their teen alone when they have gone away for the weekend.
	+ 85% of parents surveyed have spoken to their children regarding drugs and alcohol.
	+ 25% of parents surveyed thought their youth might have experimented with alcohol.
	+ 75% of parents did not think their youth were experimenting with alcohol.

Youth Risk Behavior Survey (youth in grades 9–12 from local high schools)

* + 40% of youth indicated they had alcohol in the last 30 days
	+ 50% of youth, when asked, said they could access alcohol from parents, older siblings, and friends.

Focus Group (teenagers arrested for alcohol or/other non-violent crimes)

* A majority of the youth reported that their parents don’t ask where they are going or what they’re doing when they go out with friends, and their parents have no real idea what they are doing.

**2. Social Access**

Youth Risk Behavior Survey (youth in grades 9–12 from local high schools)

* 50% of youth, when asked, said they could access alcohol from older siblings and friends.
* 66% of students reported that they thought alcohol was easy to obtain in the town.

Focus Groups (200 ethnically diverse teenagers; 6 focus groups)

* A common theme that emerged across all six focus groups was the many ways youth had to obtain alcohol, including in social settings from friends and older siblings.
* Youth mentioned that drinking parties at outdoor locations, such as parks and nearby lakes, were very common.

Additional Information Collected on Social Access

* The police estimated there are about 35 underage drinking parties on the weekends when alcohol is available to young people, particularly through older siblings and friends.

**3. Perception of Harm**

Focus Groups (200 ethnically diverse teenagers; 6 focus groups)

* Of the six focus groups conducted by the task force, one focus group comprised youth who have been arrested for alcohol or non-violent offenses.
* A common theme that emerged across all six focus groups was the number of youth who did not see drinking as harmful, but instead saw it as a rite of passage. Many youth pointed to the need to keep youth safe after their drinking by starting a safe rides program.
* In the focus group of youth arrested for alcohol and or other non-violent offenses, several youth talked about drinking with their parents and the permissive attitude about underage drinking. “How can it be harmful if I am doing it with my mom and dad?”

Youth Risk Behavior Survey (youth in grades 9–12 from local high schools)

* The community conducts this survey of youth’s risky behavior every two years.
* For the past six years there has been a significant decrease in the number of youth who perceive drinking alcohol as harmful. This decrease has occurred for both boys and girls and for each grade level from 9–12.
* In addition, 30% of youth answered “yes” to the question “Have you ever been drinking in school?” This is a significant increase from 24% five years ago.

**4. Positive Opportunities to Belong**

Survey (youth in grades 9-12 from local high schools)

* 40% of youth were identified as participating in after-school activities
	+ 20% youth in sports
	+ 15% youth in community-based activities
	+ 5% youth volunteer

Focus Groups (200 ethnically diverse teenagers; 6 focus groups)

* A major theme across all of the focus groups is that many youth enjoy the options of after-school activities, as it gives them opportunities to have something to do with their friends instead of going home right away while their parents are working

**Resources and Readiness**

**Resources**

Within this urban setting, many of the key stakeholders are involved in the task force.

The churches have been active in youth prevention efforts, including an interfaith prevention education series for parents and weekly prevention education tips posted in church bulletins. Community XYZ is home to one of the oldest African American churches in country. In addition, the local churches and the local community health center have partnered to become a resource and safe haven for new immigrants to the community. This church is a strong leader in the community interfaith group. Over the last several months, the interfaith group has established a practice of not serving alcohol at events sponsored by the faith community. Several other organizations have also agreed not to serve alcohol at their sponsored events when young people are present.

The Latino community includes families, business owners, cultural and educational organizations, and a Health Task Force made up physicians, former physicians and other medical professionals concerned about the health-related issues. Some members from the Health Task Force are also members of the Substance Abuse Prevention Task Force. Information and events are shared across the two groups, and they have worked on some joint projects.

Community XYZ has several community-wide events including a Fall Festival, Summer Arts Festival, and a Chinese New Year’s Celebration. The Fall Festival is sponsored by local and national businesses, including the alcohol industry. This event includes an Oktoberfest Beer Garden where it is easy for underage youth to get to alcohol. The local hospital has reported several hospitalizations due to alcohol poisoning that corresponded to these events.

The task force has had an excellent relationship with the editor of the local paper. At the suggestion of the task force chair, the newspaper editor provided the task force with a monthly column to write about kids and prevention issues. This column has become a great vehicle to begin educating the public about substance abuse issues, and readers have been encouraged to send in questions. In addition, using youth volunteers, the task force started an educational website with pages for kids as well as parents.

The task force has a positive relationship with the courts and has assisted in developing programs targeted at youth in the juvenile justice system. The community also has a youth drug court, where youth who are found guilty for alcohol and or other drug offences receive case management and other services, such as brief intervention, screening, and referrals.

Over the last several years, the task force has tried to build positive relationship with the public school system. The focus of the outgoing superintendent of schools has been on scholastics over social and emotional health. In addition, budget cuts in the past few years have significantly reduced the size of the guidance department and the health education program. Despite some of these setbacks, the task force recognizes many of the positive activities coming from the local schools, such as all elementary schools having active Parent and Teach Organizations (PTOs), where they host family focused out-of-school activities at least twice a month. The schools also have a cross-age teaching program in robotics and other sciences where high school students mentor elementary and middle school children.

**Readiness**

The readiness to address the problem of alcohol and other drugs is not consistent across the community. There are key stakeholders such as the faith community, health care providers, youth-serving agencies, newspapers and a growing constituency of parents that see underage drinking as an important issue to be addressed. There have been several incidents of youth injured while drinking alcohol. The most recent involved the drowning of an intoxicated adolescent boy at a party at a nearby lake. This has many parents in the community concerned about the issue. Other sectors, such as the school, do not see underage drinking as a problem and do not believe that the schools should be focused on such efforts.

There are several sectors, such as the police and business community, that are aware of the problems of alcohol and other drugs, but they are not sure of their role in solving the problem.

**workSHEET 3.10 – case study activity – Prioritizing Risk and Protective Factors**

**Purpose of Activity** – To have the chance to practice applying the criteria of changeability and importance to risk and protective factors, using the case study.

**Instructions –**

1. Your case study group will be assigned one of the following risk or protective factors:
* Risk Factors
	+ **Parental monitoring** – The degree to which parents watch over their children, and know what they are doing and who they are doing it with
	+ **Social access** – How easy it is for underage youth to obtain alcohol in their home, from older siblings, from friends, or from other adults
	+ **Perception of harm** – Awareness of the risks involved with alcohol use
* Protective Factor
	+ **Positive opportunities to belong** – The degree to which someone feels included and valued in a group
1. Write your risk factor on a large sticky note (for the debrief at the end).

***Importance* – How much is the risk/protective factor contributing to the problem?**

1. Review the data provided about the case on **Worksheet 3.9: Case Study – Assessment Information**, to determine the *importance* of the risk/protective factor assigned to your group.
2. Be sure to consider the following questions:
* How much is the risk/protective factor influencing the problem?
* Does it influence other behavioral health issues?
* Does it directly impact the developmental stage of the population?
1. Based on your review, determine whether the risk/protective factor is high or low *importance*.
2. Check the appropriate box:

 High importance
 Low importance

***Changeability* – Does the community have the necessary resources and readiness to address the risk/protective factor?**

1. Your group reviewed the resources and readiness of the case in **Session 2,** **Worksheet 2.11: Case Study Activity – Determining Resources and Readiness**. Use this information to help determine the *changeability* of this risk/protective factor. You may also want to refer back to the resources and readiness of this case, which can be found in **Worksheet 3.9: Case Study – Assessment Information**.
2. Be sure to consider the following questions:
* Is there adequate capacity to change the risk/protective factor?
* Does a suitable evidence-based intervention exist?
* Can change occur in a reasonable amount of time?
1. Based on your review of the information on resources and readiness, determine whether the risk/protective factors have a high or low *changeability*.
2. Check the appropriate box:

 High changeability
 Low changeability

***Prioritization* – What is the importance and changeability for the risk/protective factor?**

11. Using the answers you recorded above about the importance and changeability of the risk/protective factor, fill out the box below.

 **CHANGEABILITY**

 High Low

**IMPORTANCE**

|  |  |
| --- | --- |
| High |  |
|  Low |  |

12. What are the issues you discussed when making this decision? (Write them down in the space below.)

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