



**LOS ANGELES COUNTY  
DEPARTMENT OF PUBLIC HEALTH  
SUBSTANCE ABUSE PREVENTION AND CONTROL**

**STRATEGIC PREVENTION PLAN  
JULY 2016 - JUNE 2019**

**ALCOHOL AND OTHER DRUG PREVENTION SERVICES**



Preventing Substance  
Use, Misuse, & Abuse  
Among Children,  
Youth & Young Adults  
(0-24 Years Old)



# 2016-2019 STRATEGIC PREVENTION PLAN

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# I. INTRODUCTION

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## a. Vision

Healthy communities that are safe and free from Alcohol and Other Drug (AOD) problems.

## b. Mission

To implement effective prevention initiatives, guided by best practices and data, to systematically reduce community AOD problems.

## c. Guiding Principles for Prevention

Prevention policies and services adhere to the following basic principles<sup>1</sup>:

### 1. Prevention fosters safe and healthy environments for individuals, families, and communities.

To create safe and healthy environments, prevention must reduce adverse personal, social, health, and economic consequences by addressing problematic AOD availability, manufacture, distribution, promotion, sales, and use.

By prevention providers leveraging resources, prevention programs will achieve the greatest impact.

### 2. The entire community shares responsibility for prevention.

All sectors, including youth, must challenge their AOD standards, norms, and values to continually improve the quality of life within the community.

“Community” includes a) organizations; b) institutions; c) ethnic and racial communities; d) tribal communities and governments; and e) faith communities.

Community also includes associations/affinity groups based on age, social status and occupation, and professional affiliations determined by geographic boundaries.

### 3. Prevention engages individuals, organizations, and groups at all levels of the prevention system.

This includes those who work directly, as well as indirectly, in the prevention system who share a common goal of AOD prevention (i.e., medical professionals, hospitals, teachers, employers, religious organizations, etc.).

### 4. Prevention utilizes the full range of cultural and ethnic wealth within communities.

By employing ethnic and cultural experience and leadership within a community, prevention can reduce problematic availability, manufacturing, distribution, promotion, sales, and use of AOD.

### 5. Effective prevention programs are thoughtfully planned and delivered.

To create successful prevention programs, one must use data to assess the needs, prioritize and commit to the purpose, establish actions and measurements, use problem prevention actions, evaluate measured results to improve prevention outcomes, and use a competent proficient and properly trained workforce.

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<sup>1</sup> California Department of Alcohol and Drug Programs, Prevention Strategic Plan, October 2002

## d. County Profile

Los Angeles County (LAC) has the largest population (10,418,695) of any county in the nation and is larger than 43 States, ranking eighth behind California, Texas, New York, Florida, Illinois, Pennsylvania, and Ohio. Geographically, LAC poses unique challenges to providing services to the all of its residents, encompassing approximately 4,000 square miles of beaches, mountains, forest, and deserts.

LAC is divided into eight service planning areas (SPAs) as shown in Table 1. Each region varies in size, population density, socio-economic status, health status, and other demographic characteristics.

**Table 1. Differentiating characteristics of LAC service planning areas**

SPA	Location	Population*	Examples of differentiating characteristics
SPA 1:	Antelope Valley	390,938	Highest rate of adults with a disability: 29.7% (Table 2)
SPA 2:	San Fernando Valley	2,173,732	Highest percent of young adult treatment admissions for heroin use: 458 admissions (39.3%; Table 8)
SPA 3:	San Gabriel Valley	1,777,760	Highest rate of Asian/Pacific Islanders: 28.2% (LACHS, 2011)
SPA 4:	Metro	1,140,742	Highest incidence of HIV/AIDS: 79 per 100,000 residents (LACHS, 2011)
SPA 5:	West	646,531	Highest divorce rate: 260 per 1000 females (Table 2)
SPA 6:	South	1,027,645	Lowest rate of high school completion: 38.8% of adults have less than a H.S. education (Table 2)
SPA 7:	East	1,311,816	Highest rate of households with children: 49.6% (LACHS, 2011)
SPA 8:	South Bay	1,550,198	High rate of adults who misused prescription drugs in the past year: 6.8% (Table 3)

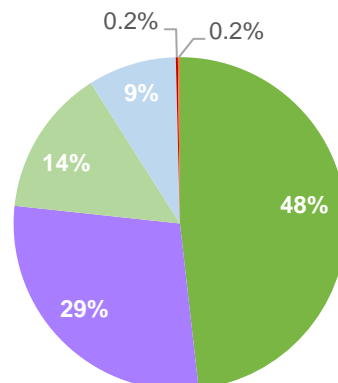
\*2013 estimates (LADPH, 2015)

When addressing public health challenges, including AOD abuse, DPH-SAPC looks not only at implementing effective prevention strategies, but also at the impact of the physical and social environments on health (e.g., land use, safety, poverty, educational attainment). Understanding key factors related to health and the impact of the individual, familial, societal, and environmental factors on AOD use can lead to more effective and comprehensive AOD prevention services.

More than one-fourth (26%) of California’s residents live in Los Angeles County. About half (50.7%) are female; 22.8% are younger than 18, and 12.2% are 65 or older.

More than half (56.8%) of LAC residents speak a language other than English at home (U.S. Census, 2015), and among Medi-Cal eligible individuals, 67.3% speak a language other than English at home. Racial/ethnic composition of county residents is presented in Figure 1, and Table 1 lists the 12 non-English threshold languages spoken in LAC.

**Figure 1 Population by Race/Ethnicity, Los Angeles County 2013**



Note: NHOPI = Native Hawaiian or Other Pacific Islander

**Table 2. Threshold Languages, Los Angeles County 2011**

<b>Spanish</b>	<b>Other Chinese</b>	<b>Armenian</b>
Vietnamese	Russian	Tagalog
<b>Cantonese</b>	<b>Korean</b>	<b>Farsi</b>
Mandarin	Arabic	Khmer (Cambodian)

\*The State of California defines a “Threshold Language” as a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR Section 1810.410(a)(3). Source: State of California – Health and Human Services Agency, Department of Health Care Services. Retrieved February 7, 2014 from [www.dhcs.ca.gov/formsandpubs/Documents/13-09End2.pdf](http://www.dhcs.ca.gov/formsandpubs/Documents/13-09End2.pdf).

## Social Determinants of Health

### Socioeconomic Status (SES) and Built Environment

Socioeconomic and environmental conditions are major influences on health and AOD use.

Specifically, age, where people are born, grow up, live, work, and the systems addressing illness, education, employment, social networks/support and community cohesion have been associated with positive or negative health outcomes.

The built environment, which includes presence of dilapidated/deteriorating buildings, has been associated with negative health outcomes including alcohol problems/heavy drinking (Bernstein, et al., 2007). Similarly, Jitnarin et al. (2015) found that negative perceptions of neighborhood infrastructures were significant predictors of smoking and binge drinking. Table 2 shows various aspects of SES by SPA, LAC, and State.

**Table 3. Socioeconomic indicators for state, county and service planning areas (SPAs)**

Key Indicators	State*	LAC	Service Planning Area (SPA)
<=100% federal poverty level (LACHS, 2011)	16.4%	18.0%	SPA 6: 31.1%, SPA 4: 25.0%, SPA 1: 21.1%, SPA 8: 17.2%, SPA 7: 15.5%, SPA 2: 15.0%, SPA 3: 13.4%, SPA 5: 12.9%
<=138% federal poverty level (U.S. Census, 2013)	N/A	28.0%	SPA 6: 45.8%, SPA 4: 37.5%, SPA 1: 30.5%, SPA 8: 26.1%, SPA 7: 25.7%, SPA 2: 23.5%, SPA 3: 21.8%, SPA 5: 17.1%
Unemployed and looking for work (LACHS, 2011)	6.1%	13.5%	SPA 1: 16.9%, SPA 6: 16.5%, SPA 4: 15.0%, SPA 3: 14.1%, SPA 7: 13.5%, SPA 2: 13.3%, SPA 8: 12.8%, SPA 5: 7.8%
Adults less than high school education (LACHS, 2011)	14.5%	23.2%	SPA 6: 38.8%, SPA 4: 27.6%, SPA 27.5%, SPA 1: 25.0%, SPA 3: 24.1%, SPA 2: 19.1%, SPA 8: 18.9%, SPA 5: 6.7%
Divorce (U.S. Census, 2014)	15.7%	15.2%	SPA 5: 25.4%, SPA 8: 21.5%, SPA 4: 19.2%, SPA 2: 18.5%, SPA 1: 18.1%, SPA 6: 17.2%, SPA 3: 15.7%, SPA 7: 15.5%
Adults who believed their neighborhood was safe from crime (LACHS, 2011)	62.7%	84.3%	SPA: 5: 98.0%, SPA 1: 87.1%, SPA 8: 86.3%, SPA 3: 85.3%, SPA 2: 85.1%, SPA 4: 84.8%, SPA 7: 84.2%, SPA 6: 64.4%
Percent of adults with a disability (LACHS, 2011)	29.7%	19.4%	SPA 1: 29.7%, SPA 4: 20.7%, SPAs 2 & 8: 20.0%, SPA 7: 19.7%, SPA 5: 18.8%, SPA 3: 16.9%, SPA 6: 16.7%

\*State percents obtained from ASKCHIS. Red and green font indicate highest and lowest percentage, respectively among SPAs.

### Undocumented Immigrant Residents

Immigrants traditionally have been identified as a population at risk for poor health outcomes. Moreover, there are many facets to the degree of which they are considered vulnerable, such as: inadequate health care, socioeconomic background, immigration status, limited English proficiency, and federal, state, and local policies affecting access to healthcare. Although difficult to quantify, the best estimates suggest that in 2013, about 2.67 million undocumented immigrants resided in California, and 9.4% of the state’s workforce consisted of undocumented immigrants. More undocumented residents (nearly 815,000) live in LAC than in any other area of the state (Public Policy Institute of California [PPIC], 2015). This population is most concentrated in southeast LAC (SPA 6 & 7), the eastern San Fernando Valley (SPA 2) and the San Gabriel Valley (SPA 3; PPIC, 2015).

Undocumented LAC residents have been in the U.S. for a median of 10 years. Most reside with family who are citizens or legal residents, and are the parents of children who are American citizens (Pastor & Marcelli, 2013). Limited access to health care and utilization among undocumented immigrants is likely to aggravate undiagnosed health problems compared to documented immigrants (Bustamante, Fang, Garza, et al. 2012). Community clinics and hospital outpatient departments are the most common source of ambulatory care for immigrants (Ku & Matani, 2001).

DPH-SAPC system of services is designed to provide services to all residents of LAC. No one regardless of their race or economic status is refused services. Community-based prevention program services and strategies are designed to engage all community residents, public service organizations, and other concerned citizens.

### SAPC’s Commitment to Prevention

When addressing public health challenges, including AOD abuse, DPH looks not only at implementing effective prevention strategies (e.g., policy development, advocacy, media efforts, education, and services) but also at the impact of the physical and social environments on health (e.g., land use, safety, poverty, educational attainment).<sup>2</sup>

Understanding key factors related to health and the impact of AOD use on the individual, family, society, and environment can lead to more effective and comprehensive AOD prevention services. Select indicators from the *Los Angeles County Department of Public Health June 2013 Key Indicators of Health by SPA* are referenced in Table 2.

With the passage of the Affordable Care Act (ACA) a comprehensive approach to behavioral health also means seeing prevention as part of an overall continuum of care.

Elements of the *Behavioral Health Continuum of Care Model (BHCCM)* will be incorporated in SAPC’s prevention plans. The BHCCM recognizes there are multiple opportunities for preventing and addressing behavioral health problems and disorders.

### Strategic Prevention Framework (SPF)

The SPF five step planning process guides the development of prevention services. Central to all steps is ensuring that efforts are culturally competent and sustainable. By addressing each of these steps, the prevention services should address the actual needs of the target community(ies) and population(s), enhance protective factors and reduce risk factors, build community capacity and collaboration, develop goals and measurable objectives, and emphasize evaluation to ensure the county achieves the intended outcomes.



<sup>2</sup> County of Los Angeles, Department of Public Health, *Strategic Plan 2008 – 2011*. Available at: <http://publichealth.lacounty.gov/docs/StrategicPlan.pdf>.

## The Public Health Model

The DPH-SAPC promotes the use of the Public Health Model (PHM), which traditionally focus on approaches designed to affect the individual, peers, or families. The PHM demonstrates that problems arise through relationships and interactions among an agent (e.g., the substance, like alcohol or drugs), a host (the individual drinker or drug user), and the environment (the social and physical context of substance use). These more complex relationships compel coalitions to think in a more comprehensive way. Over time, the PHM has proven to be the most effective approach to creating and sustaining change at a community level.<sup>3</sup>

Today, many coalitions work to reduce substance abuse in the larger community by implementing comprehensive, multi-strategy approaches. Community-based programs that provide direct services to individuals are important partners in a comprehensive coalition-led community-level response. Strategies that focus on the substance and the environment, although more difficult to implement, are likely to impact many more people.

## Overview of Strategic Prevention Planning Process

DPH-SAPC Research and Evaluation team (R&E) conducted a comprehensive assessment. They analyzed data pertaining to community needs and resources and presented AOD-related data for LAC and by SPA when available. The R&E examined the overall context within which AOD problems commonly occur and the prevalence and consequences of AOD use.

LAC DPH-SAPC initiated the development of a new AOD prevention strategic plan. The Fiscal Year 2016-2019 Strategic Prevention Plan is consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) SPF five step processes. The first phase of work was to conduct a comprehensive community assessment collecting needs and resource data describing the AOD issues across the eight SPAs within the county. In addition, a survey was administered to Alcohol and Other Drug Prevention Services contractors in an effort to collect information and recommendations for enhancing the system of services and training needs.

## Prevention Survey Monkey

As part of the DPH-SAPC assessment process a Prevention Survey was administered to Alcohol and Other Drug Prevention Service (AODPS) contractors. The objective of the survey was to:

- Further understand resources, opportunities, and challenges AOD prevention providers experience
- Explore innovative and collaborative approaches that can be implemented in the prevention system
- Inform the planning and structure of a one-day countywide Prevention Summit

## Methods - Questionnaire

Q1. How do we develop good, strategic partnerships?

Q2. How do you make the most of coalitions?

Q3. What other new alliances can strengthen your argument and broaden your base?

Q4. What would you like to learn from your colleagues in the field of prevention?

Q5. What tools do you need to carry out your prevention work?

Q6. What are the most pressing issues that could be addressed with prevention strategies?

Q7. What can SAPC do to support your work?

Q8. What types of training sessions can you benefit from?

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<sup>3</sup> [www.cadca.org/www.coalitioninstitute.org](http://www.cadca.org/www.coalitioninstitute.org)

Q9. What are the most emerging AOD contributing risk factors in your community?

Q10. How can you be more productive with preventing AOD use among youth in your community?

The following four overarching themes were identified:

1. Essential components of strategic partnerships; cultivating meaningful alliances
2. Culture, social norms and perceptions of AOD; culturally relevant prevention strategies
3. Prevention practices re-envisioned; impact of environmental strategies
4. Data collection/analyses; assess community needs and evaluate prevention strategies

The Prevention Summit consisted of a panel discussion and four work group sessions based on the above themes.

### **Prevention Summit**

The Prevention Summit was coordinated by SAPC's Prevention staff and facilitated by Community Prevention Initiative (CPI) consultants. The all-day event was held on September 29, 2015. One hundred and thirteen AODPS participated. Participants were exposed to a "big-picture" understanding of prevention and opportunities to explore ways to establish an ongoing system of support to enhance the implementation of prevention initiatives and practices.

The Prevention Summit stimulated discussion, identified existing service assets as well as deficits, and most importantly, mapped out options for building upon prevention services.

Summit recommendations and survey findings will be used to guide SAPC with strengthening preventions services and systems:

1. Approaches that could significantly enhance the prevention system of services;
2. Support Prevention providers' efforts to engage a broad base of partners on common issues contributing to AOD: violence, crime, equity, and other health related factors;
3. Flexibility to address emerging community issues in need of immediate attention;
4. Establish Learning Communities designed to provide a forum for providers to exchange effective approaches and projects and learn from each other;
5. Hold regular data evaluation meetings to learn about available data and reports and how to use and access data to guide efforts;
6. Involve providers, evaluators, and SAPC;
7. Focus on specific topics, e.g. purpose of data collection; methods; CHIS;
8. Engage in problem solving and peer technical assistance;
9. Culture shift on how the public views AOD use: mobilize new messengers with new messages;
10. Effective prevention work carried out with passion, skill and urgency;
11. Expansion, collaboration broadening the prevention base using a comprehensive, holistic approach;
12. Coordination and integration to address the full continuum of prevention, treatment (Tx) and recovery services;
13. Training opportunities, developing new knowledge and skills, allowing the field to capitalize on, and expand promising practices.



## II. Step 1: Assessment

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In this comprehensive assessment, we analyzed data pertaining to community needs and resources, and present AOD-related data for LAC, and by local SPA, when available. We examined the overall context within which AOD problems commonly occur and the prevalence and consequences of AOD use. This comprehensive assessment will provide guidance to prevention professionals in their assessments of local community needs.

### a. Methodology to Assess the Data

#### *Available Data Sources*

Data were gathered and analyzed from a variety of sources to help target prevention efforts to the appropriate needs of LAC. These data inform the identification and prioritization of AOD problems, clarify the impact of AOD problems on communities and vulnerable populations, and assess readiness and resources needed to protect residents from identified AOD problems.

Data sources include:

- LAC Health Survey (LACHS), 2011, 2015
- National Survey of Drug Use and Health (NSDUH), 2010, 2011, and 2012
- California Healthy Kids Survey (CHKS), 1999 – 2013
- California Health Interview Survey (CHIS) 2014
- U.S. Census, American Health Survey, 2009 – 2014
- LAC Participant Reporting System (LACPRS) 2014-15
- Coroner’s Toxicology data
- Healthy People 2020 (2008)
- Patient discharge and emergency department visit data
- Statewide Integrated Traffic Records System (SWITRS)
- LAPD crime data
- Alcohol outlet density (on and off site)

#### *Limitations of Data Sources and Findings*

While methamphetamine use is more prevalent in LAC compared to other geographic regions, there is a gap in methamphetamine-related research and prevalence information and a significant need for local data.

Although NSDUH provides local and community level estimates of AOD prevalence (e.g., alcohol, marijuana, prescription drugs), separate rates for SPAs 1 and 5 are not available due to small sample size and some SPA-level estimates are statistically unstable (e.g., for illicit drug use in the past month).

## b. Substance Use Prevalence and Consequences

This section presents rates of substance use prevalence and related consequences from data sources noted in the methodology section for four identified priority areas as well as other important areas of concern. Although it is important to address all addictive substances in a comprehensive manner (Center on Addiction and Substance Abuse, 2015), preliminary assessment indicates prescription and over-the-counter drugs, marijuana, alcohol, and methamphetamine are key priority areas among youth and young adult populations in LAC. Table 4 shows how rates of substance use among adults differ by SPA. Table 5 shows that for the past three years, marijuana, methamphetamine, alcohol, and heroin were the most common substances for which youth and young adults were admitted to Tx.

**Table 4. Indicators of substance use among adults**

Key Indicators	State	LAC	HP 2020	Service Planning Areas
Unintentional drug/alcohol related deaths (LACHS, 2011)	N/A	6.5%	N/A	SPA6: 8.0%, SPA 1: 7.9%, SPA 4: 6.8%, SPA 8: 6.5%, SPA 2: 6.3%, SPA 5: 5.7%, SPA 7: 5.3%, SPA 3: 4.8%
Binge Alcohol use, past 30 days (LACHS, 2011) <sup>^</sup>	15.1%*	15.4%	N/A	SPA 4: 19.2%, SPA 6: 16.9%, SPA 5: 16.5%, SPA 8: 16.3%, SPA 7: 15.7%, SPA 1: 15.1%, SPA 2: 14.9%, SPA 3: 11.7%
Misuse of prescription medications, past year (LACHS, 2011)	N/A	5.2%	N/A	SPA 4: 7.4%, SPA 6: 6.9%, SPA 8: 6.8%, SPA 3: 4.6%, SPA 2: 4.4%, SPA 7: 4.3%, SPA 5: 3.5%, SPA 1: 2.5%
Smoke cigarettes (LACHS, 2011)	11.7%*	13.1%	12.0%	SPA 1: 15.6%, SPA 4: 14.9%, SPA 7: 14.4%, SPA 2: 13.8%, SPA 6: 13.3%, SPA 6: 13.3%, SPA 8: 13.0%, SPA 3: 10.9%

<sup>^</sup>5 drinks for men; 4 drinks for women. \*ASKCHIS. Red and green font indicate highest and lowest percentage, respectively among SPAs.

**Table 5. Primary drug problem among youth and young adults (LACPRS)**

	2012-2013		2013-2014		2014-2015	
	Age 12-17	Age 18-25	Age 12-17	Age 18-25	Age 12-17	Age 18-25
Marijuana	73.8%	40.0%	73.2%	35.6%	77.3%	29.3%
Methamphetamine	13.4%	19.6%	14.8%	23.4%	12.6%	26.2%
Alcohol	8.3%	14.5%	7.9%	12.8%	6.1%	11.0%
Heroin	1.7%	19.3%	2.0%	22.1%	1.3%	27.4%
Prescription drug	0.4%	3.1%	0.3%	3.0%	0.8%	3.1%
Cocaine	0.2%	2.4%	0.3%	2.0%	0.5%	1.9%
Other drug	2.2%	1.1%	1.6%	1.1%	1.4%	1.1%

## c. Priority Areas Identified

- Prescription Drugs, and Over-the-Counter (OTC) Medication Abuse
- Marijuana Availability and Accessibility Among Youth
- Alcohol – Underage Drinking and Binge Drinking
- Methamphetamine and other illicit drug use among youth

## d. Problem Statements

### Priority 1: Prescription Drugs and OTC Medication Abuse

**Problem Statement:** The number of deaths each year from prescription opioids is now greater than the deaths from heroin, cocaine, and benzodiazepine drugs combined. In LAC from 2000 to 2009, there were 8,265 drug-related deaths; 61 percent of those deaths involved a commonly abused prescription or over-the-counter drug. Nearly 75 percent of residents who misuse prescription drugs obtain them from relatives or friends (Gunzenhauser, 2015).

### Priority 2: Marijuana Availability and Accessibility among Youth

**Problem Statement:** Youth are using at higher rates because marijuana is easily available. Currently, marijuana is the most commonly used “illicit” drug in LAC with 8.2% of youth (age 12-17) and 19.2% of young adults (age 18-25) reporting current use (NSDUH, 2010-2012).

### Priority 3: Alcohol – Underage Drinking and Binge Drinking

**Problem Statement:** Alcohol availability and accessibility are associated with increased alcohol consumption. Alcohol outlet density and the proximity of outlets to one’s residence have been associated with negative consequences such as violence, crime, injury, and high-risk sex (Rowland et al., 2015). For example, in LAC SPA 4 had the highest rate of off-premise alcohol outlet density (7.2 in SPA 4 vs 6.2 for LAC overall per 10,000 population) and the highest rate of alcohol-involved traffic collision (6.0 for SPA 4 vs 3.8 for LAC overall per 10,000; see Table 7).

### Priority 4: Methamphetamine and other illicit drugs among youth

**Problem Statement:** Methamphetamine Tx admissions are once again on the rise in Los Angeles County. Methamphetamine is heavily associated with increased risk for psychotic behavior, poor cardiovascular and dental health, transmission of infectious disease (HIV, hepatitis), crime, unemployment, and child abuse (NIDA, 2012). The picture of meth use in LAC is different compared to other geographic regions. According to LACPRS (2015), Tx admissions have been increasing since 2012. In 2014, meth became the second most commonly reported drug problem among clients admitted to LAC public Tx programs.

### Target Priority Area 1: Prescription Drugs and OTC Medication Abuse

Prescription Medications: When used as directed, and by the intended recipient, prescription medications can effectively manage short-term and chronic health conditions. However, opioids (Vicodin, OxyContin, codeine, morphine etc.), central nervous system depressants (Valium, Xanax, other tranquilizers and sedatives etc.) and stimulants (Adderall, Ritalin etc.) can also be used to get high and can become addictive. Due to the potential for use in manufacturing methamphetamine, restrictions on sales of OTCs containing pseudoephedrine already exist in California. However, other OTCs, especially cough medicines containing dextromethorphan (DXM) also have the potential for more immediate misuse. Commonly known as *robo-tripping* or *skittling*, consumption of excessive amounts of DXM create mind-altering effects and consequences can be similar to ketamine and PCP since DXM targets the same part of the brain.<sup>4</sup>

- There has been a dramatic increase in prescriptions of analgesic opioids in the United States (Jurcik et al., 2015).
- Nationally, deaths involving opioids have more than quadrupled since 1999 (CDC, 2010).
- More persons died from drug overdoses in the United States in 2014 than during any previous year on record; 61% of these deaths involved opioids (MMWR, Dec 2015).

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<sup>4</sup>NIDA Info Facts: Prescription and Over-the-Counter Medications. National Institute on Drug Abuse. June 2009. Available at: <http://www.nida.nih.gov/Infofacts/InfofaxIndex.html>.

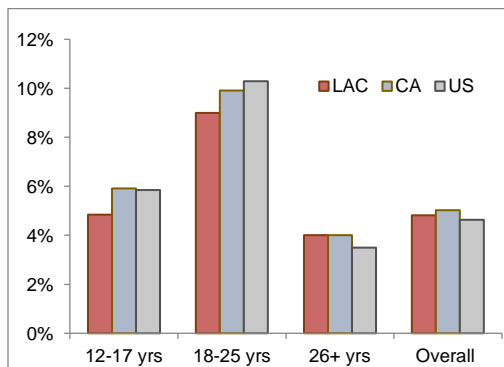
**Table 6. Key indicators of prescription medication misuse and consequences**

Key Indicators	LAC	SPA
Non-medical use of pain relievers, past year, Age 12-17 NSDUH 2010-12	4.8%	SPA 2: 5.3%, SPA 8: 5.2%, SPAs 6 & 7: 4.6%, SPA 4: 4.4%, SPA 3: 4.3%
Non-medical use of pain relievers, past year, Age 18-25 NSDUH 2010-12	9.0%	SPA 2: 10.0%, SPA 8: 9.6%, SPA 6: 8.6%, SPA 7: 8.5%, SPA 4: 8.2%, SPA 3: 7.7%
Adults who misused Rx drugs in the past year (LACHS, 2015)	5.5%	SPA 4: 7.0%, SPA 6: 6.8%, SPA 8: 6.3%, SPA 7: 5.9%, SPA 1: 5.8%, SPA 5: 5.2%, SPA 3: 4.7%, SPA 2: 3.9%
Deaths (tested positive for Rx opioids) Age 12-17, per raw numbers (LAC ISD, 2014)	8 Total count	SPA 4: 4, SPA 6: 3, SPA 3: 1, SPA 5: 0, SPA 7: 0, SPA 8: 0, SPA 1: 0, SPA 2: 0
Deaths (tested positive for Rx opioids) Age 18-25, per 100,000 (LAC ISD, 2014)	1.8	SPA 1: 3.2, SPA 4: 3.1, SPA 2: 1.9, SPA 8: 1.9, SPA 5: 1.5, SPA 6: 1.4, SPA 7: 1.2, SPA 3: 1.1
Tx Admissions Age 12-17 (LACPRS, 2014-15)	0.5%	SPA 5: 4.8%, SPAs 1 & 2: 1.3%, SPA 4: 0.7%, SPA 8: 0.2%, SPAs 3,6,7: 0.0%
Tx Admissions Age 18-25 (LACPRS, 2014-15)	3.0%	SPA 5: 6.3%, SPA 2: 4.4%, SPA 3: 3.9%, SPA 1: 2.9, SPA 4: 2.6%, SPA 8: 2.0%, SPA 6: 1.1%, SPA 7: 0.7%
Rx opioid hospitalizations Age 12-17, per 100,000 (OSHPD 2014)	1.1	SPA 1: 3.8, SPA 5: 1.6, SPA 3: 1.5, SPA 8: 1.1, SPA 2: 1.0, SPA 6: 0.8, SPA 7: 0.7, SPA 4: 0.4
Rx opioid hospitalizations Age 18-25 per 100,000 (OSHPD, 2014)	17.3	SPA 2: 28.7, SPA 5: 23.6, SPA 1: 21.0, SPA 8: 17.8, SPA 3: 14.4, SPA 4: 11.7, SPA 6: 10.4, SPA 7: 8.0
Rx opioid-related ED visits Age 12-17, per 100,000 (OSHPD, 2014)	1.3	SPA 1: 2.7, SPA 2: 1.7, SPA 8: 1.5, SPA 5: 1.4, SPA 3: 1.2, SPA 4: 1.1, SPA 6: 0.7, SPA 7: 0.5
Rx opioid-related ED visits Age 18-25, per 100,000 (OSHPD, 2014)	15.6	SPA 1: 26.1, SPA 2: 26.1, SPA 8: 15.9, SPA 4: 14.4, SPA 5: 13.4, SPA 3: 12.1, SPA 6: 8.0, SPA 7: 7.3

Red and green font indicate highest and lowest percentage/rate, respectively among SPAs; NSDUH data not available for SPAs 1 and 5.

Figure 2 indicates all age groups are affected by misuse of prescription pain medication, and particularly adolescents and young adults. Therefore, a comprehensive approach is needed to address this problem, including training and education, tracking and monitoring, and disposal (LADPH, 2013).

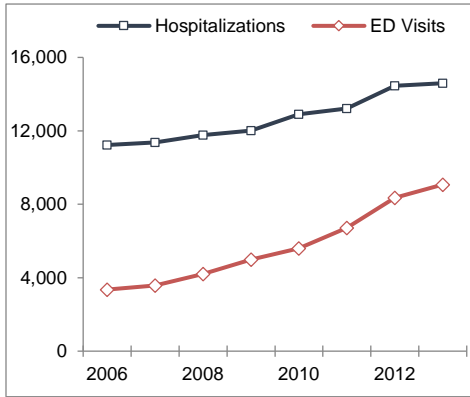
**Figure 2. Misuse of Rx Opioid Pain Medication in the Past Year by Age**



The prevalence rate of misuse of prescription (Rx) opioid pain medication in the past year in 2010-2012 in LAC is 4.8% (NSDUH), which is higher than the national average (4.5%) and lower than the state average (4.9%). Misuse is most common among individuals aged 18-25 years.

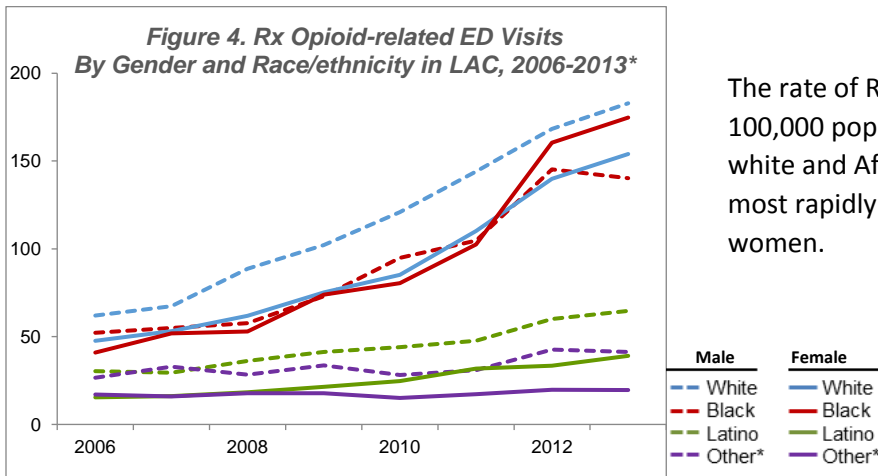
Figures 3 and 4 show healthcare service utilization (i.e., ED visits and hospitalizations) among Rx opioid misusers/abusers has greatly increased in recent years, indicating the economic burden of Rx misuse is substantial and rising.

**Figure 3. Rx Opioid-related ED Visits and Hospitalizations in LAC, 2006-2013**



In LAC, the number of hospitalizations with any Rx opioid-related diagnosis or external cause of injury increased by 30% from 11,230 in 2006 to 14,594 in 2013. ED visits increased by 171% from 3,354 in 2006 from to 9,075 in 2013.

**Figure 4. Rx Opioid-related ED Visits By Gender and Race/ethnicity in LAC, 2006-2013\***

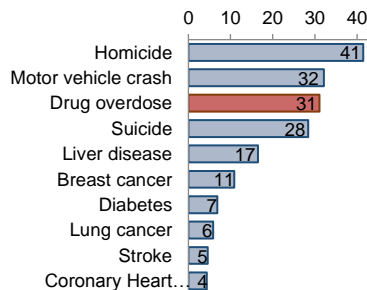


The rate of Rx opioid-related ED visits per 100,000 population increased sharply for white and African Americans, and increased most rapidly among African American women.

\*Rate per 100,000 population

Figure 5 shows average years of potential life lost by underlying cause of death in LAC, 2011.

**Figure 5. Potential Years of Life Lost**



Individuals who died from drug overdose died an average of 31 years prematurely.

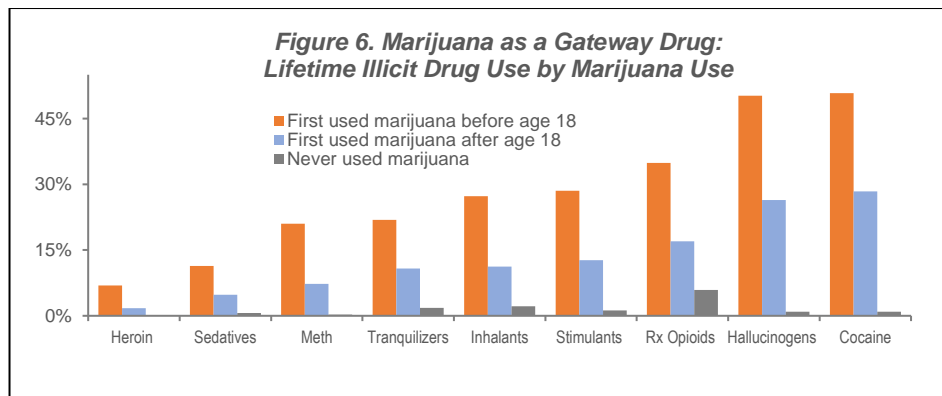
**Target Priority Area 2: Marijuana Availability and Accessibility among Youth**

The following adverse long-term effects of marijuana use were reported in Volkow, et al. (2014):

- Addiction (in about 9% of users overall, 17% of those who begin use in adolescence, and 25 to 50% of those who are daily users)\*
- Altered brain development\*
- Poor educational outcome with increased likelihood of dropping out of school\*
- Cognitive impairment with lower IQ among those who were frequent users during adolescence\*
- Diminished life achievement and satisfaction \*
- Increased risk of chronic psychotic disorders (including schizophrenia) in persons with a predisposition to such disorders

\* The effect is strongly associated with initial marijuana use early in adolescence.

In addition, marijuana use, particularly when initiated during adolescence, is highly correlated with use of other illicit substances, as shown in Figure 6.



NSDUH 2012-2013 data for California

Marijuana prevalence in LAC from CHKS, 2013:

- One in four 9th graders and 37% of 11th graders reported lifetime marijuana use.
- 13% of 9th graders and 18% of 11th graders currently used marijuana (i.e., past 30 days).
- Marijuana use among 7th graders has remained fairly consistent since 1999, ranging between 7% and 10% for lifetime use (CHKS, 1999-2013).

**Table 7. Key indicators of marijuana consumption and consequences**

Key Indicators	LAC	HP 2020	SPA
Marijuana: perception of great risk age 12-17 (NSDUH 2010-12)	23.9%	36.7%	SPA 2: 21.7%, SPA 4: 22.2%, SPA 7: 22.7%, SPA 8: 23.8%, SPA 6: 27.0%, SPA 3: 27.6%
Marijuana: perception of great risk age 18-25 (NSDUH 2010-12)	20.0%	N/A	SPA 2: 17.2%, SPA 8: 18.3%, SPA 4: 18.4%, SPA 7: 22.1%, SPA 3: 22.2%, SPA 6: 27.4%
Current marijuana use, Age 12-17 (NSDUH 2010-12)	8.2%	6.0%	SPA 8: 9.5%, SPA 6: 9.3%, SPA 4: 8.9%, SPA 7: 7.6%, SPA 2: 7.5%, SPA 3: 7.3%
Current marijuana use, Age 18-25 (NSDUH 2010-12)	19.2%	N/A	SPA 8: 24.3%, SPA 4: 22.6%, SPA 6: 18.8%, SPA 2: 17.6%, SPA 3: 15.9%, SPA 7: 14.8%
Any marijuana use in the past year among adults	11.6%	N/A	SPA 5: 15.2%, SPA 4: 15.1%, SPA 1: 14.2%, SPA 8: 13.0%, SPA 6: 11.9%, SPA 2: 11.1%, SPA 7: 9.8%, SPA 3: 7.7%

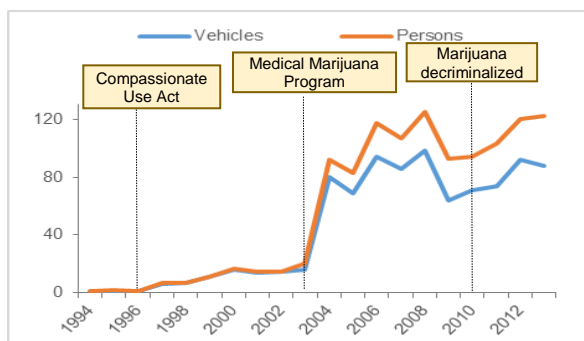
Key Indicators	LAC	HP 2020	SPA
(LAC Health Survey, 2015)			
Deaths (tested positive for marijuana) Age 12-17, per raw numbers (LAC ISD, 2014)*	17 Total count	N/A	SPA 6: 5, SPA 4: 5, SPA 8: 3, SPA 5: 2, SPA 3: 1, SPA 1: 1, SPA 7: 0, SPA 2: 0
Deaths (tested positive for marijuana) Age 18-25, per 100,000 (LAC ISD, 2014)*	1.91	N/A	SPA 4: 3.9, SPA 1: 1.9 SPA 8: 2.1 SPA 2: 1.4, SPA 6: 3.2, SPA 7: 1.4 SPA 3: 1.2, SPA 5: 0.6
Tx Admissions Age 12-17 (LACPRS, 2014-15)	78.5%	N/A	SPA 3: 87.6%, SPA 5: 85.7%, SPA 6: 84.4%, SPA 7: 82.4%, SPA 1: 78.3%, SPA 2: 75.9%, SPA 4: 75.7%, SPA 8: 72.0%
Tx Admissions Age 18-25 (LACPRS, 2014-15)	28.3%	N/A	SPA 8: 37.9%, SPA 7: 37.5%, SPA 4: 35.2%, SPA 6: 31.7%, SPA 1: 29.3%, SPA 3: 28.0%, SPA 2: 17.4%, SPA 5: 5.1%
Hospitalizations Age 12-17 per 100,000 (OSHDP, 2014)	17.8	N/A	SPA 1: 23.8, SPA 3: 20.3, SPA 6: 20.1, SPA 8: 19.4, SPA 2: 18.1, SPA 7: 15.2, SPA 5: 13.1, SPA 4: 12.5
Hospitalizations Age 18-25 per 100,000 (OSHDP, 2014)	53.6	N/A	SPA 6: 79.9, SPA 8: 60.3, SPA 1: 60.0, SPA 4: 52.8, SPA 2: 51.0, SPA 3: 47.5, SPA 7: 43.3, SPA 5: 39.6
ED visits Age 12-17 per 100,000 (OSHDP, 2014)	17.9	N/A	SPA 6: 29.8, SPA 8: 20.6, SPA 7: 18.5, SPA 2: 17.0, SPA 4: 15.7, SPA 1: 15.5, SPA 3: 14.4, SPA 5: 9.6
ED visits Age 18-25 per 100,000 (OSHDP, 2014)	65.2	N/A	SPA 6: 138.2, SPA 4: 83.8, SPA 8: 79.0, SPA 7: 53.0, SPA 5: 52.5, SPA 1: 50.3, SPA 2: 48.8, SPA 3: 36.5

Young adults in SPA 8 had the highest rate of marijuana use and among the lowest rates of perception of risk. Red and green font indicate highest and lowest percentage/rate, respectively among SPAs. NSDUH data not available for SPAs 1 and 5.

In California, voters decided to approve recreational marijuana in 2016. The experience of other states may inform prevention efforts in California.

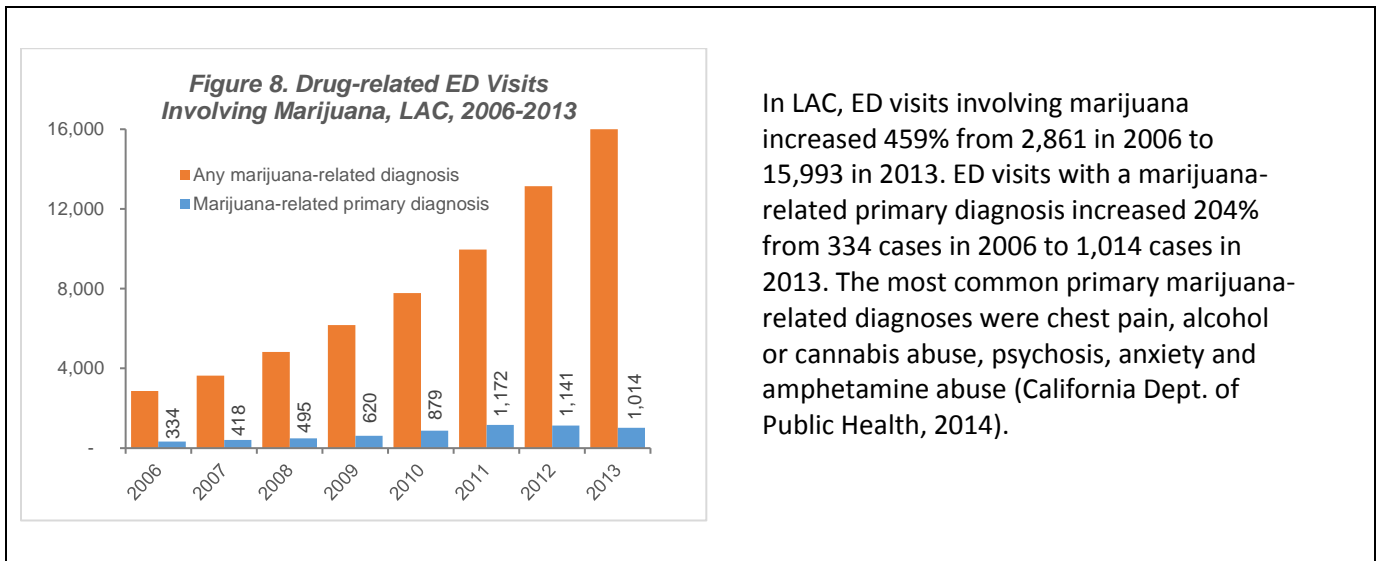
- A report from Colorado showed that hospitalization visits with possible marijuana exposure grew from 810 in 2006 to more than 2,000 from January to June 2014, many of those directly related to edibles (vs. smoked marijuana; Wardarski, 2015).
- Moreover, major policy shifts in marijuana regulations may be related to trends in health-related consequences of AOD use, as shown in Figure 7.

**Figure 7. Traffic Crash Fatalities Involving Marijuana, LAC, 1994-2013**



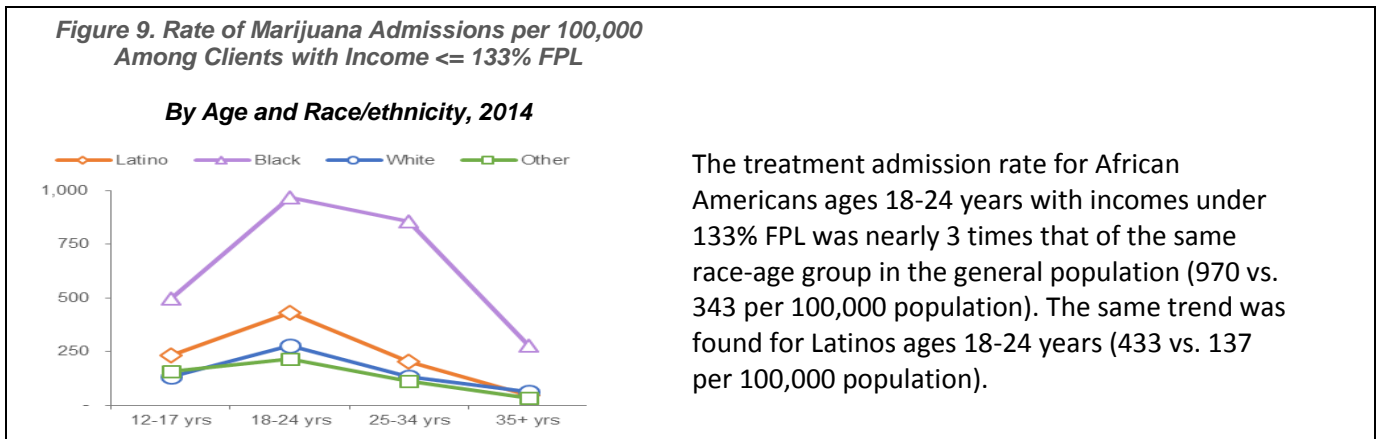
In LAC, according to the Fatality Analysis Reporting System (2014), traffic crash fatalities involving marijuana increased by 510% from 2003-2013. These increases co-occurred with the passage of the Compassionate Use Act, the initiation of the Medical Marijuana Program, and the decriminalization of marijuana (possession of <1oz reduced from misdemeanor to infraction).

Further analyses of trends over time in LAC show a 459% increase in emergency department (ED) visits involving marijuana from 2006 to 2013 (Figure 8). Marijuana was involved in 37% of all drug-related ED visits in LAC.



In LAC, ED visits involving marijuana increased 459% from 2,861 in 2006 to 15,993 in 2013. ED visits with a marijuana-related primary diagnosis increased 204% from 334 cases in 2006 to 1,014 cases in 2013. The most common primary marijuana-related diagnoses were chest pain, alcohol or cannabis abuse, psychosis, anxiety and amphetamine abuse (California Dept. of Public Health, 2014).

Understanding populations at risk for marijuana-related harms can inform prevention strategies by targeting the appropriate developmental life stage among individuals with the greatest need. Figure 9 shows African Americans and young adults are more likely than other ethnicities and age groups to receive SUD Tx for marijuana use (LACPRS, 2014). Most clients admitted to publicly funded SUD Tx programs in LAC are under 133% FPL, which tends to have much higher SUD rates than the general population.



The treatment admission rate for African Americans ages 18-24 years with incomes under 133% FPL was nearly 3 times that of the same race-age group in the general population (970 vs. 343 per 100,000 population). The same trend was found for Latinos ages 18-24 years (433 vs. 137 per 100,000 population).

### Target Priority Area 3: Alcohol - Underage and Binge Drinking

Excessive alcohol use contributes to a host of health problems/alcohol-related illnesses, high risk behaviors, traffic accidents/DUI, falls, suicides, poisoning, and occupational injuries. Risk taking behavior, especially among adolescents and young adults, is compounded when combined with alcohol use. Research (NIAAA, 2006) shows that the younger the age of alcohol initiation, the greater the likelihood of experiencing legal, social, mental health, and other problems including risky sexual activity, poor school performance, use of other substances and development of substance use disorders (SUD). Thus, investing in prevention efforts to delay initiation and reduce consumption may be the best way to avoid the costly consequences of risky use and addiction.



**Table 8. Key indicators of alcohol consumption and consequences**

Key Indicators	LAC	SPA
Alcohol use, past month age 12-17 (NSDUH 2010-12)	12.6%	SPAs 2 & 8: 13.5%, SPA 4: 12.8%, SPA 7: 12.4%, SPA 6: 11.6%, SPA 3: 11.0%
Alcohol use, past month age 18-25 (NSDUH 2010-12)	54.4%	SPA 4: 59.2%, SPA 8: 57.0%, SPA 2: 55.9%, SPA 7: 53.1%, SPAs 3 & 6: 47.8%
Current binge alcohol use <sup>a</sup> age 12-17 (NSDUH 2010-12)	7.1%	SPA 8: 7.7%, SPA 7: 7.5%, SPA 2: 7.3%, SPA 4: 7.2%, SPAs 3 & 6: 6.4%
Current binge alcohol use <sup>a</sup> age 18-25 (NSDUH 2010-12)	34.4%	SPA 4: 37.7%, SPA 7: 37.2%, SPA 8: 36.4%, SPAs 2 & 3: 31.2%, SPA 6: 30.7%
Current binge alcohol use among adults (LAC Health Survey, 2015)	15.9%	SPA 5, 18.2%, SPA 7, 17.6%, SPA 4, 17.6%, SPA 8, 16.4% SPA 3, 15.5%, SPA 2, 14.3%, SPA 6, 13.8%, SPA 1, 13.6%
Alcohol Outlets – offsite, per 10,000 (CA ABC Agency)	6.2	SPA 4 & 7: 7.2, SPA 8: 6.9, SPA 5: 6.2, SPA 2: 5.8, SPA 3: 5.5, SPA 6: 5.4, SPA 1: 4.5
Alcohol Outlets – onsite per 10,000 (CA ABC Agency)	11.0	SPA 5: 23.7, SPA 4: 20.9, SPA 8: 12.3, SPA 3: 9.7, SPA 2: 9.1, SPA 7: 7.4, SPA 1: 6.2, SPA 6: 2.3
Alcohol-involved Traffic Collision*, per 10,000 (SWITRS, 2014)	3.8	SPA 4: 6.0, SPA 6: 4.8, SPA 2: 4.4, SPA 7: 3.6, SPA 1: 3.6, SPA 8: 3.0, SPA 5: 3.0, SPA 3: 2.7
Deaths (tested positive for alcohol) Age 12-17, per raw numbers (LAC ISD, 2014)	5 Total count	SPA 6: 2, SPA 2: 1, SPA 3: 1, SPA 8: 1, SPA 7: 0, SPA 1: 0, SPA 4: 0, SPA 5: 0
Deaths (tested positive for alcohol) Age 18-25, per 100,000 (LAC ISD, 2014)	1.6	SPA 4: 2.8, SPA 1: 2.3, SPA 6: 2.0, SPA 2: 1.67, SPAs 3 & 8: 1.3, SPA 7: 1.1, SPA 5: 0.9
Violent crime per 10,000 (LASD, LAPD, State DOJ, 2013)	32.8	SPA 6: 85.7, SPA 4: 58.3, SPA 8: 32.8, SPA 1 & 7: 28.2, SPA 3: 19.9, SPA 2: 19.5, SPA 5: 18.0
Tx Admissions Age 12-17 (LACPRS, 2014-15)	10.9%	SPA 8: 22.3%, SPA 6: 9.8%, SPA 7: 9.7%, SPA 4: 9.6%, SPA 5: 9.5%, SPA 2: 8.5%, SPA 3: 5.1%, SPA 1: 3.0%
Tx Admissions Age 18-25 (LACPRS, 2014-15)	10.8%	SPA 8: 13.4%, SPA 5: 12.0%, SPA 1: 11.9%, SPA 2: 11.4%, SPA 4: 11.1%, SPA 6: 9.6%, SPA 7: 9.1%, SPA 3: 7.8%
Hospitalizations Age 12-17 per 100,000 (OSHPD, 2014)	8.5	SPA 3: 11.3, SPA 8: 9.6, SPA 1: 9.6, SPA 2: 8.5, SPA 6: 8.3, SPA 7: 6.7, SPA 4: 6.1, SPA 5: 6.0
Hospitalizations Age 18-25 per 100,000 (OSHPD, 2014)	37.8	SPA 3: 44.1, SPA 8: 41.5, SPA 6: 40.8, SPA 4: 36.8, SPA 1: 35.0, SPA 2: 34.2, SPA 7: 33.8, SPA 5: 30.6
ED visits Age 12-17 per 100,000 (OSHPD 2014)	18.2	SPA 2: 22.6, SPA 8: 18.9, SPA 4: 18.4, SPA 1: 18.2, SPA 6: 17.0, SPA 7: 16.4, SPA 5: 15.4, SPA 3: 15.2
ED visits Age 18-25 per 100,000 (OSHPD, 2014)	95.7	SPA 6: 129.7, SPA 4: 110.8, SPA 8: 102.7, SPA 1: 101.7 SPA 2: 90.9, SPA 5: 89.8, SPA 7: 89.5, SPA 3: 71.5

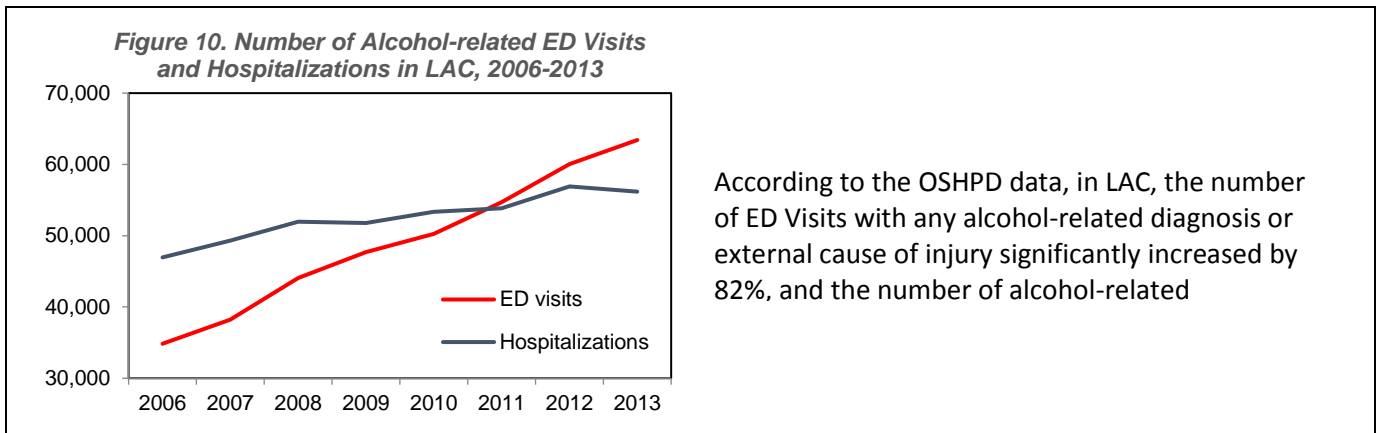
\* Includes the number of both injuries and fatalities; <sup>a</sup>Over 1 in 3 young adults binge drink; defined as 5 drinks for men, 4 drinks for women. Red & green font indicate highest & lowest percentage/rate, respectively among SPAs. NSDUH data not available for SPAs 1 and 5.

Understanding AOD-related trends and emerging issues in LAC can assist with identifying specific targets for prevention strategies. Identifying specific issues such as “alcopops,” emerging trends in alcohol-related health consequences and specific populations at elevated risk can inform effective prevention strategies.

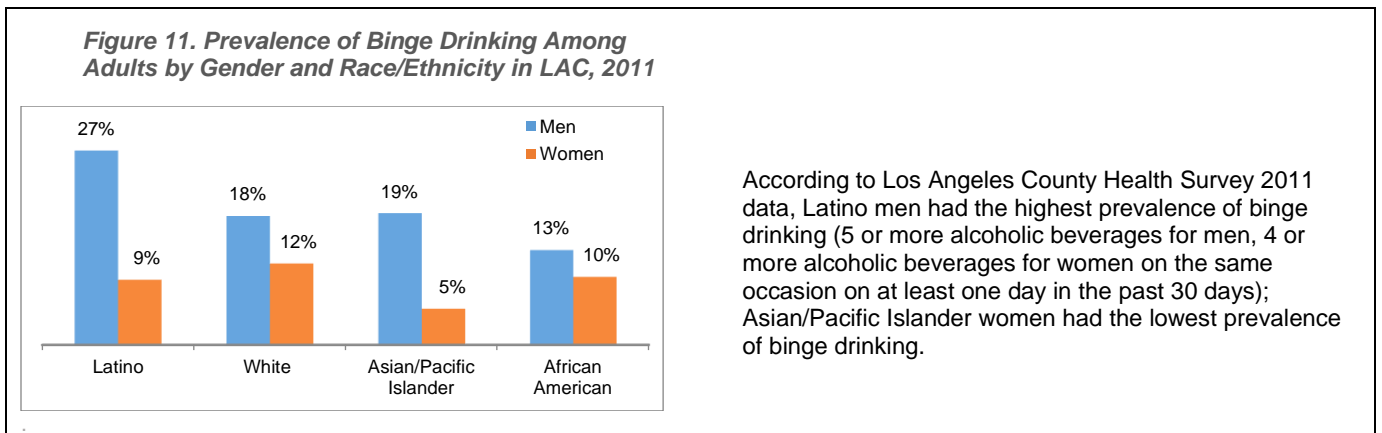
#### Alcopops and youth

- Alcopops are popular among youth due to their sweet taste, variety of flavors, low price, and high alcohol content.
- A major study found 50% of underage drinker’s ages 13-20 report drinking alcopops; youth drinkers who consumed alcopops were four times more likely to engage in binge drinking (Albers et al., 2015).

Time trends of health outcomes over the past seven years show a significant increase in alcohol-related emergency department visits and hospitalizations (see Figure 10).



In addition, gender and race/ethnicity place vulnerable populations at greater risk for developing AOD-related problems (see Figure 11).



Alcohol-related costs translate into billions of U.S. dollars spent on premature death, disability, medical care, and law enforcement, and other costs. Table 9 shows how these costs are distributed in LAC.

**Table 9. Alcohol-related Tangible Costs in LAC, 2014**

Cost Category	Annual Cost
Healthcare	\$976.7 million
Lost Productivity <sup>a</sup>	\$7.7 billion
Other <sup>b</sup>	\$1.6 billion
<b>Total</b>	<b>\$10.3 billion</b>

According to Sacks et al (2006; data extrapolated for LAC and adjusted for inflation to 2014 US dollars), the total tangible direct and indirect costs of excess alcohol consumption in LAC in 2014 was over \$10.3 billion.

<sup>a</sup> Reduced productivity at work, work absenteeism, lost productivity due to death  
<sup>b</sup> Criminal justice system costs, motor vehicle crashes, property damage

**Target Priority Area Four: Methamphetamine and other illicit drug use among youth**

The picture of meth use in LAC is different compared to other geographic regions. According to LACPRS (2015), Tx admissions have been increasing since 2012. In 2014, meth became the second most commonly reported drug problem among clients admitted to LAC public Tx programs. Although meth use is a significant problem in LAC overall, it is especially problematic among women and the impact has increased; the number of women admitted to SUD Tx who were primary meth users increased nearly six-fold from 1996 to 2011 (TEDS, 2014).

In addition, the cost of meth has decreased by half since the late 1990s (Mozingo, 2015) and the potency and accessibility of meth have increased (Ferranti, 2015).

**Table 10. Key indicators of methamphetamine consumption and consequences**

Key Indicators	LAC	SPA
Deaths (tested positive for meth) Age 12-17, per raw numbers (LAC ISD, 2014)	7 Total count	SPA 6: 3, SPA 4: 3, SPA 3: 1, SPA 5: 0, SPA 7: 0, SPA 2: 0, SPA 8: 0, SPA 1: 0
Deaths (tested positive for meth) Age 18-25, per 100,000 (LAC ISD, 2014)	1.1	SPA 4: 2.2, SPA 1: 1.3, SPA 8: 1.2, SPA 2: 1.1, SPA 6: 0.9, SPA 7: 0.7, SPA 3: 0.7, SPA 5: 0.6
Tx Admissions Age 12-17 (LACPRS, 2014-15)	7.6%	SPA 1: 13.5%, SPA 4: 11.6, SPA 2: 9.8%, SPA 7: 6.1%, SPA: 5.4%, SPA 8: 4.2%, SPAs 5 & 6: 0.0%
Tx Admissions Age 18-25 (LACPRS, 2014-15)	30.2%	SPA 7: 37.7%, SPA 6: 37.2%, SPA 1: 34.6%, SPA 4: 33.6%, SPA 3: 32.4%, SPA 8: 27.8%, SPA 2: 23.0%, SPA 5: 22.9%

Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

## RISK AND PROTECTIVE FACTORS FOR PRIORITY AREAS

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (U.S. Department of HHS, 2015). Specific to LAC AOD priority areas, important contributing risk and protective factors are enumerated in the table below.

Priority Areas	Risk Factor	Protective Factor
Prescription Drugs and OTC Medications	<ol style="list-style-type: none"> <li>1. Prescription Drugs and OTC Medication are legal and readily available</li> <li>2. Majority of residents who misuse prescription drugs obtain them from relatives or friends</li> <li>3. Excessive prescribing and incorrect disposal</li> </ol>	<ol style="list-style-type: none"> <li>1. Knowledge of dangers of prescription drugs and their availability</li> <li>2a. Parents educate kids about the negative impacts and consequences of prescription drug abuse.</li> <li>2b. Adults reduce their availability and properly dispose of surplus.</li> <li>3a. Education on best practices for pharmacists and those with prescribing privileges (doctors, physician assistants, nurses, etc.)</li> <li>3b. Prescribers consult a prescription drug monitoring program for patients' drug history before prescribing</li> </ol>
Marijuana Availability and Accessibility	<ol style="list-style-type: none"> <li>1. Marijuana is readily available to all ages</li> <li>2. Use is acceptable (community)</li> <li>3. Production is integrated into the economy (community)</li> <li>4. Youth perception of harm for marijuana use is low (individual)</li> </ol>	<ol style="list-style-type: none"> <li>1. Awareness about the harmful effects of marijuana</li> <li>2. Positive community norms</li> <li>3. Laws exist to protect communities and the environment that are negatively affected by marijuana manufacturing</li> <li>4. Teens possess positive decision-making skills</li> </ol>
Alcohol – Underage Drinking and Binge Drinking	<ol style="list-style-type: none"> <li>1. Availability and access of alcohol to teens by adults (community)</li> <li>2. Parents do not believe drinking is that bad (family)</li> <li>3. Parents have a substance abuse history (family)</li> <li>4. Teens have favorable attitude towards drinking (individual)</li> </ol>	<ol style="list-style-type: none"> <li>1a. Adults understand how alcohol is detrimental to the developing brain.</li> <li>1b. Effective law enforcing policies to restrict availability and access to teens</li> <li>2. Parents teach their kids about the negative impacts and consequences of underage drinking.</li> <li>3. Positive social norms reinforced by family</li> <li>4a. Integration of family, school, and community efforts</li> <li>4b. Sense of well-being/self confidence</li> </ol>
Methamphetamine and other illicit drug use among youth	<ol style="list-style-type: none"> <li>1. Production is elementary and integrated into the economy (community)</li> <li>2. Precursor ingredients used to make methamphetamine are inexpensive and readily obtainable.</li> </ol>	<ol style="list-style-type: none"> <li>1. Laws exist to protect communities and the environment that are negatively affected by methamphetamine manufacturing and other illicit drug use.</li> <li>2. Positive attitudes towards school. For example, transitional age youth are deterred from using/manufacturing illicit drugs if they are employed or are enrolled in higher education.</li> </ol>

## ***Summary of Risk and Protective Factors***

### *Availability and Access to AOD - Alcohol Outlet Density*

AOD availability and accessibility are associated with increased AOD consumption. Alcohol outlet density and the proximity of outlets to one's residence have been associated with negative consequences such as violence, crime, injury, and high risk sex (Rowland et al., 2015). A study in California found that adolescent binge drinking and driving was associated with alcohol retailers within 0.5 miles of home, and through simulation showed that decreased sales to minors could lead to reductions in driving after binge drinking (Chen et al., 2010). Access within the home, at school, and from peers also contributes to adolescent AOD use (Hingson & White, 2014). Therefore, it is important to develop prevention interventions/efforts that not only focus on the individual, but also the community and environment.

### *Legalization of Marijuana for Recreational Use*

With the legalization of recreational marijuana in California, the use of marijuana will be even more normalized. In spite of common public perception, research strongly suggests that marijuana use during adolescence and early childhood results in impaired brain development; affecting learning and memory (Ventura County, 2014). Driving under the influence of marijuana has twice the risk of a crash than driving sober (Asbridge et al., 2012).

### *Social Norms and Exposure to AOD Mass Media Messages*

Families, peers, media website advertisements, music, movies, advertising, laws, and regulations all play a role in influencing social norms and individual beliefs and attitudes about AOD use. How families model values, attitudes, and beliefs about AOD use shapes their children's values, attitudes, and beliefs about AOD use. Exposure to music promoting marijuana use has also been associated with early marijuana use by urban American adolescents (Primack et al., 2010).

### *Adverse Childhood Experiences - Trauma, Abuse, Neglect*

A NIDA (2015) study suggests that childhood maltreatment is a severe stressor that alters trajectories of brain development; regions involved in monitoring internal awareness of emotions may more strongly influence a person's behavior. At the same time, regions that control impulses become less connected and are reduced to a less central role in the network. These changes may set the stage for *an increased risk for substance use and other mental health disorders throughout life*. In addition, Parental alcohol problems also influence whether the child would later use (Alcohol Marketing and Youth, 2009).

### *Family Management Practices and Disapproval of AOD use*

Family management practices including parental monitoring and family cohesion have been found to be associated with reduced AOD use (Murphy et al., 2009). Parental disapproval of drinking amplified the link between peer disapproval and lower alcohol use; accordingly, interventions should target both parental and peer disapproval throughout adolescence (Mrug & McCay, 2013). Consistent disapproval throughout adolescence plays a stronger role than maintained moderate disapproval or declining disapproval with age (Martino, 2009). Providing adolescents with credible, accurate, and age-appropriate information about the harm associated with substance use is a key component in prevention programming (SAMHSA, 2013).

### *Resiliency*

Protective factors such as school connectedness/academic competence, family cohesion, self-control, anti-drug use policies, and strong neighborhood attachment contribute to resiliency in youth (NIDA, 2015). Resiliency involves a child's ability to grow up to be a healthy and well-functioning adult despite having to overcome various forms of adversity in their lives, and the capacity to move back into growth-promoting connections after an acute disconnection or times of stress.

Other Important Concerns

Other areas important to target for prevention include heroin, ecstasy, E-cigarettes/vaping, inhalants, and synthetic marijuana. Although the LAC Prevention Plan does not currently address these issues, we will continue to track these trends, and will be prepared to address them should the data warrant.

- Some experts consider alternative, non-combustible products that contain nicotine but no tobacco such as electronic cigarettes to be less harmful than tobacco products. However, their proliferation among middle and high school students, and emerging evidence that these products are not harmless are cause for concern (CASA, Oct. 2015).
- Street forms of synthetic cannabinoids - so-called “synthetic marijuana” - were linked to 11,406 of the 4.9 million drug-related emergency department (ED) visits in 2010, according to a report by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012)
- Heroin is currently the highest reported primary drug by clients admitted to publicly funded SUD Tx programs in LAC (LACPRS, 2014).

Table 11 shows important indicators for SUDs overall and for substances other than those noted in priority areas 1-4.

**Table 11. Substance use disorders among youth and young adults, other drug use**

Key Indicators	National	State	LAC	SPA
SUD, past year age 12-17 NSDUH 2010-12	6.8%	7.9%	8.1%	SPA 4: 8.2%, SPAs 2,6,7: 8.1%, SPA 8: 8.0%, SPA 3: 7.8%
SUD, past year age 18-25 NSDUH 2010-12	19.1%	21.0%	20.2%	SPA 7: 21.3%, SPA 2: 20.4%, SPA 4: 19.8%, SPA 3: 19.7%, SPA 8: 19.5%, SPA 6: 18.9%
Needed but did not receive Tx past year age 12-17 NSDUH 2010-12	4.1%	5.0%	5.0%	SPA 3: 5.2%, SPAs 7 & 8, 5.1%, SPA 4: 5.0%, SPA 2: 4.8%, SPA 6: 4.7%
Needed but did not receive Tx past year age 18-25 NSDUH 2010-12	7.1%	9.1%	8.4%	SPA 2: 8.5%, SPA 8:8.4%, SPA 3: 8.3%, SPA 6: 8.1%, SPA 7: 8.0%, SPA 4: 7.9%
Heroin Tx Admissions for young adults (Age 18-25; LACPRS, 2014-15)	N/A	N/A	22.0%	SPA 2: 39.3%, SPA 3: 14.7%, SPA 8: 10.8%, SPA 4: 8.2%, SPA 5: 7.6%, SPA 1: 6.4%, SPA 7: 4.9%, SPA 6: 4.3%

Red and green font indicate highest and lowest percentage/rate, respectively among SPAs.

**Sustainability and Cultural Competence**

SAPC will work collaboratively with prevention providers on an on-going basis to assess community needs and resources and identify the most pressing AOD problems and contributing factors in their communities to develop and improve effective, culturally responsive prevention strategies. Well-coordinated, multi-component prevention models that impact key risk and protective factors across multiple life domains may reduce negative long-term outcomes for adolescents at risk for AOD problems.

- Address all addictive substances that impact local communities in a comprehensive manner
- Address the full range of risk factors, e.g., coping skills, trauma, mental health issues, family history of AOD use, peer AOD use
- Address full range of protective factors, e.g., academic performance/achievement, family, school, peer groups, community support, environment

## e. Sustainability

- Identify champions and leaders
- Conduct interviews with community leaders involved in implementing the Strategic Prevention Plan
- Recruit community members with skills in needs assessment
- Continuously identify funding streams to ensure that effective programs can continue beyond the length of the original contract
- Invest in the communities being served. Establish partnerships within the community, demonstrate consistency and reliability, earn credibility, especially with youth

## f. Cultural Competence

It is clear that LAC is comprised of many cultures and differing perspectives. However, a unifying principle is Angelinos' remarkable capacity to plan ahead, shape the future, and adapt to new circumstances. Moving forward, how we further shape and build our AOD prevention efforts will potentially have a profound impact on the overall health of LAC residents and our communities. The SAPC Prevention team will continuously strive to implement the following activities:

### Use data to target disparities

Equity concerns will be addressed in our assessment and evaluation activities. We will use data to explore providers' efforts to take culture into account when delivering prevention services. For example, to be relevant in the community and obtain buy-in from stakeholders, providers' ability to address a range of issues, many of which stem from equity concerns, will be explored.

### Work with the community

Including a diverse range of partners will expand the base of prevention stakeholders. Thus, engaging increasing numbers of interested community members in assessment activities and effectively disseminating evaluation findings throughout local communities in LAC will further facilitate sustainability.

### Collect and use cultural competence-related information/data

It is important to utilize cultural competency data to improve prevention services, increase mutual respect and understanding between providers and SAPC. This will promote the inclusion of all provider/community members. The goal is to incorporate different perspectives, ideas, and strategies that will eventually improve prevention services and the efficiency of care.

### Build cultural competence skills to identify culturally-relevant risk and protective factors and other underlying conditions

The SAPC Prevention team will establish learning communities designed to provide a forum for providers/communities to exchange effective approaches and projects to learn from each other in order to identify culturally relevant risk and protective factors, and other underlying conditions. These learning communities will help prevention providers develop new knowledge and skills, allowing the field to capitalize on new strategies to address risks that are targeted to specific communities.

### Hire culturally competent staff and evaluators

Culturally competent staff and evaluators who are familiar with the diversity of Angelinos in terms of religion, traditions, language, race/ethnicity, sexual orientation, and other factors will be hired and ongoing training will be provided in order to build rapport and credibility at the local level.

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### III. Step 2: Capacity

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Ensuring appropriate capacity involves mobilizing target communities to identify and address local AOD problems and strengthen programs ability to respond effectively to the identified needs. Cultural competency and community readiness are central to capacity building.

During the Capacity Building assessment phase, SAPC hosted a Prevention Summit open to SAPC’s network of contracted SUD prevention program providers. The event provided a “big-picture” understanding of prevention and innovative collaborative efforts to prevent AOD and improve community health. Participants identified existing service assets as well as deficits, and most importantly, mapped out options for building capacity within their targeted communities. In addition to the summit, SAPC administered an AOD prevention survey in order to better understand the needs and service capacity of its provider network.



#### a. County Contracted Prevention Programs

DPH-SAPC’s network consists of 37 agencies, 57 contracts and 7 different contract types: 12 Adolescent Prevention Services contracts, 8 Environmental Prevention Services contracts, 33 Comprehensive Prevention Services contracts, 1 Friday Night Live contract, 1 Memorandum of Understanding with the Los Angeles County Sheriff’s Department to provide school-based services, 1 Community Centered Emergency Room Project contract, and 1 Prevention Media Campaign contract.

##### 1. Adolescent Prevention Services (APS)

A. Prevention Services and target populations shall be consistent with the Institute of Medicine prevention classification of populations that includes universal, selective, and indicated prevention, and the Center for Substance Abuse Prevention (CSAP) six (6) strategies: Information Dissemination, Education, Alternative Activities, Problem Identification and Referral, Community-Based Process, and Environmental and the associated activities. These services, such as outreach, brief screening, educational sessions, alternative activities and other activities shall be tracked and reported through the Primary Prevention Substance Use Disorder Data System (PPSDS).

##### 2. Environmental Prevention Services (EPS) SPA Based Coalitions

AODPS-EPS contracts aim to decrease underage drinking and binge drinking, especially among youth and young adults by reducing alcohol and other drug availability and accessibility in Los Angeles County through culturally competent evidence-based prevention environmental efforts that change the policies, ordinances, and practices that facilitate alcohol use and develop methods to ensure efforts are enforced and sustained once implemented. The selection of environmental efforts/services is data-driven and designed to specifically address the highest priority alcohol related problems and contributing factors of the target community(ies). The environmental efforts/services must also clearly align with the County’s Strategic Prevention Framework (SPF). This includes addressing where and how alcohol is sold and marketed, alcohol serving and sales practices, alcohol sales to minors, passage of alcohol related ordinances/policies, and compliance with local alcohol related regulations.

Integral to the success of these environmental efforts is active and sustained involvement of local community residents (youth and adults), leaders, non-alcohol and other drug (AOD) focused businesses, AOD services providers, and others who are knowledgeable of the local alcohol related issues and who are committed to engaging in evidence-based solutions. AODPS-EPS contractors will appropriately

engage community members and leaders throughout the process to best identify, implement and sustain efforts.

### **3. Comprehensive Prevention Services (CPS)**

The purpose is to 1) change the local conditions that facilitate alcohol and drug use, 2) identify individuals who could benefit from prevention services or contribute to prevention efforts, and 3) change the knowledge and behaviors of youth and adults that contribute to community norms about alcohol and drug use. Depending on the program, services may focus on individual level activities such as school-based prevention classes, or on community-level services such as making changes to the local environment or changing policies/practices that contribute to substance use and/or norms favorable to substance use.

### **4. Friday Night Live (FNL)/Club Live (CL), & FNL Kids**

The FNL aims to decrease 1) underage drinking and binge drinking; 2) illicit drug use that is marijuana, methamphetamine, and ecstasy; and/or 3) misuse of legal products that is inhalants, over-the-counter medications, and prescription (Rx) drugs, among youth and young adults. This is achieved by ensuring opportunities for positive youth development and the ability to identify and direct implementation of school and community-based efforts to reduce alcohol availability and accessibility and decrease the social norms and community conditions that contribute to AOD use.

### **5. Los Angeles County Sheriff's Department –Success through Awareness and Resistance (STAR)**

The STAR program aims to prevent or decrease alcohol, tobacco, and other drugs, and violence in SPA 3 by targeting youth who live in poverty-stricken areas that have higher rates of crime, substance abuse, and gang involvement. This is achieved by implementing the three-pronged program that includes a school curriculum, after-school activities, and a summer program. This three-pronged approach allows for deputies to establish positive relationships with school administrators, teachers, parents, and students.

### **6. Community Centered Emergency Room Project (CCERP)**

The program aims to bridge the gap among health services, public health services, mental health services, and community prevention services. The CCERP is part of the Needs Special Assistance (NSA) care coordination efforts to reduce the large number of NSA individuals who frequently use the LAC+USC Medical Center Emergency Department (MC ED). CCERP was funded to provide a comprehensive, community-based approach with specific strategies aimed at engaging homeless individuals, creating cooperative relationships with organizations, coordinating care, while building leadership, improving community conditions and reducing the overuse of LAC+USC MC ED.

### **7. Prevention Media Campaigns (PMC)**

Media services are needed to launch up to three media campaigns to educate youth, young adults, and/or parents/guardians on the harms of substance use. The three target substances/substance categories are marijuana, prescription opioids and heroin, and synthetic drugs (e.g., methylenedioxymethamphetamine (MDMA), Lysergic acid diethylamide (LSD), γ-Hydroxybutyric acid (GHB), ketamine, and methamphetamine). DPH, in partnership with the contracted media firm, will ensure that appropriate efforts are conducted in each Supervisorial District, and are in English and Spanish and, where feasible, other appropriate targeted community threshold languages.

**PREVENTION PROVIDER NETWORK  
ALCOHOL AND OTHER DRUG PREVENTION SERVICES CONTRACTED PROVIDERS**

<b>No.</b>	<b>Contracted Alcohol and Other Drug Prevention Services (AODPS)</b>	<b>EPS - SPA Based Coalitions</b>	<b>CPS</b>	<b>Special Project</b>	<b>APS</b>
1	Asian American Drug Abuse Program	SPA 8	X		X
2	Avalon Carver Community Center		X		
3	Behavioral Health Services, Inc.		X		X
4	California Hispanic Commission on Alcohol & Drug Abuse	SPA 7	X		X
5	Cambodian Association of America		X		
6	Child and Family Center – Santa Clarita				X
7	Children's Hospital of Los Angeles		X		X
8	City of Pasadena Recovery Center		X		
9	Clare Foundation Inc.		X		
10	Community Coalition for Substance Abuse Prevention & Treatment	SPA 6	X		
11	Day One, Inc.	SPA 3	X		
12	Didi Hirsch Psychiatric Services				X
13	Frasier Communications			PMC	
14	Helpline Youth Counseling, Inc.		X		X
15	Institute for Public Strategies	SPA 5	X		
16	Jewish Family Services of Los Angeles		X		
17	Koreatown Youth & Community Center	SPA 4	X		
18	Los Angeles County Office of Education		X	FNL	
19	Los Angeles County Sheriff's Department (STAR Unit)			MOU	
20	MJB Transitional Recovery, Inc.		X		
21	NCADD of East San Gabriel and Pomona Valley, Inc.		X		

No.	Contracted Alcohol and Other Drug Prevention Services (AODPS)	EPS - SPA Based Coalitions	CPS	Special Project	APS
22	NCADD of San Fernando, Inc.		X		
23	Pacific Clinics		X		X
24	People Coordinated Services of Southern California		X		
25	Phoenix House of Los Angeles		X		
26	Prototypes a Center for Innovation		X		
27	Pueblo Y Salud, Inc.		X		
28	San Fernando Valley Partnership, Inc.	SPA 2			
29	Shields for Families, Inc.				X
30	Social Model Recovery Systems, Inc.		X	CCERP	
31	South Central Prevention Coalition		X		
32	Special Services for Groups				X
33	SPIRITT Family Services, Inc.		X		X
34	Tarzana Treatment Center	SPA 1	X		X
35	The Wall Memorias Project		X		
36	Volunteers of America		X		
37	Watts Health Foundation, Inc.		X		
	<b>TOTAL</b>	<b>8</b>	<b>33</b>	<b>4</b>	<b>12</b>

EPS - Environmental Prevention Services  
 CPS - Comprehensive Prevention Services  
 APS - Adolescent Prevention Services  
 FNL - Friday Night Live  
 MOU - Memorandum of Understanding  
 CCERP - Community Centered Emergency Project  
 PMC - Prevention Media Campaign

## Provider contact information :

Please visit the link below for provider contact information by SPA.

<http://publichealth.lacounty.gov/sapc/prevention/PP/SAPCPreventionContractorList.pdf>

For APS providers, please visit link below.

<http://publichealth.lacounty.gov/sapc/prevention/PP/APSProviderContractList.pdf>

## b. County Coalition Groups

AODPS contracted programs are required to develop a process (e.g., coalition, community forums, Town Hall meetings) to consistently engage community members and key stakeholders in the identification of local AOD problems and contributing risk factors and guide the development and implementation of prevention activities and services.

The overall mission of SAPC's 8 EPS SPA-Based Coalition is to actively engage communities in addressing the four priority areas describe in the assessment process. EPS and CPS providers have the capacity to mobilize and organize community residents including youth, business, and representatives of other community-based organizations, (education, law enforcement, and public social services) as appropriate, to address local and county AOD problems.

### ***EPS Coalition Guidelines***

To ensure that the coalition establishes a coherent purpose and committed membership, the following activities must be included on the Prevention Work Plan and formalized through documents establishing the coalition's structure and expectations of members:

1. Vision and Mission: Each of the EPS SPA-Based Coalitions creates a vision and mission designed to drive and address AOD prevention and coalition work.
2. Data Handouts: How will findings from the county assessment be presented to community stakeholders?
3. Structure: How will the coalition be structured to ensure an action oriented and community responsive process? This includes:
  - a. Who will develop the agenda and facilitate meetings (e.g., elected position, EPS staff)?
  - b. Who will complete administrative duties such as drafting agendas, meeting notifications, inter-meeting communication, and meeting minutes (e.g., elected position, EPS staff)?
  - c. If there are elected positions, what are the respective roles and responsibilities?
  - d. What is the process for determining actionable items/efforts of the coalition?
  - e. What is the process for establishing a Steering Committee and/or Subcommittee(s)?
4. Membership: How will recruitment and membership be addressed including defining roles and responsibilities?
  - a. What key community sectors<sup>5</sup> will be recruited for membership?
  - b. How will active and continued membership of the identified sectors be maintained?
  - c. How is membership established and the membership list developed/maintained?

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<sup>5</sup> The Community Anti-Drug Coalitions of America (CADCA) recommends the following community sectors be included: youth, parents, business, media, schools, youth-serving organizations, law enforcement agencies, religious or fraternal organizations, civic and volunteer groups, healthcare professionals, state/local/tribal government agencies with expertise in the substance abuse field, and other organizations involved in reducing substance abuse. For more information visit: [www.cadca.org](http://www.cadca.org).

- d. What is the orientation process for new members?
  - e. What are the responsibilities of members? How does this vary, for Steering Committee and/or Subcommittee members (if applicable)?
5. Frequency: What is the frequency of meetings (minimum quarterly)? If applicable, are there any subcommittee, steering committee, or CPS contractor specific meeting?
  6. Deliverables: What materials will be provided at each meeting and in what format (meeting announcement, agenda, and meeting minutes)?

In addition, AODPS CPS contractors are required to actively participate with the SPA-based coalition led by the AODPS Environmental Prevention Services (EPS) contractor in the SPA(s) where it provides services. This coalition focuses on addressing local AOD related problems, contributing factors, and reducing availability and accessibility to underage youth. CPS contractors will further work with their target population(s) and communities to build capacity and strategically address AOD associated risk factors that contribute to problems.

## **CPS Led Prevention Community Council (PCC)**

The overall mission of the CPS is to establish a formal mechanism to obtain community feedback to guide the development of its prevention services and effectively and efficiently adjust to changing community needs. The size and structure of the PCC may vary depending on the scope of services provided. For example, a school-based program may involve primarily students, parents, and teachers; whereas a policy-focused program may involve a wide array of individuals and more closely resemble a coalition structure. In addition, the CPS agencies also participate on the SPA Coalition meetings in the SPA(s) to effectively inform, engage, and mobilize community support; particularly in its target area(s), around the PCC's prevention efforts.

### ***Guidelines for Establishing Membership and Participation Expectations***

To ensure that the PCC establishes a coherent purpose and committed membership, the following activities must be included on the Prevention Work Plan and formalized through documents establishing the PCC's structure and expectations of members:

1. Purpose: What is the purpose and goals of the PCC and its membership in guiding development and implementation of CPS services and how will efforts of the SPA-Based Coalition be incorporated to promote local support?
2. Membership: How will recruitment and membership be addressed including defining roles and responsibilities?
  - a. What sectors/type of representatives will be recruited to best support implementation of the CPS services and why? A minimum of five non-agency participants are required.
  - b. How will active and continued membership of the identified sectors/representative types be maintained?
  - c. What is the orientation process for new members and what are member roles/responsibilities?
3. Frequency: What is the frequency of meetings (minimum quarterly)?
4. Deliverables: What materials will be provided at each meeting and in what format (meeting announcement, agenda, and meeting minutes)

### **SAPC's SafeMed Los Angeles Coalition**

SafeMed LA is a broad, cross-sector coalition that will take a coordinated and multipronged approach to comprehensively address the prescription drug abuse epidemic in LAC, guided by its five-year strategic plan. SAPC developed a five-year strategic plan that will be carried out through the broad, cross-sector SafeMed LA coalition. The strategic plan utilizes a "9-6-10" approach, with 9 Action Teams focusing on 6 priority areas with 10 key objectives; each tackling a specific component of the prescription drug abuse problem. AODPS contracted programs are members of the SafeMeds LA Community Education Action Team.



## Healthy Retail Stores

The LAC Tobacco Control and Prevention Program (TCPP) is participating in a 10-year campaign led by the California Tobacco Control Program to explore ways in which the retail environment can be utilized as a force to build healthier communities/neighborhoods. The Health Stores for a Healthy Community campaign will involve TCPP, SAPC Prevention Programs, and other CTCP-funded programs throughout the state in a new and integrated effort. SAPC AODPS contracted providers focus on increasing merchant knowledge of best practices and responsibility related to the advertisement and sales of AOD products.

## Rethinking Access to Marijuana (RAM)

RAM is a collaboration of public health professionals seeking to prevent marijuana-related harms by limiting youth access to marijuana. This group was established with the vision of educating communities about the potential harms of marijuana use; implementing and evaluating environmental strategies formulated to limit youth accessibility and availability of marijuana; and influencing policy actions that support flourishing youth and communities free from marijuana-related harms. RAM neither supports nor opposes any specific legislation. Rather, we take a prevention-oriented public health approach by educating policy-makers and communities about ways to protect youth from the potential harms of marijuana use and abuse.

## c. Workforce Development

SAPC coordinated a lecture on Marijuana on Friday, April 29, 2016- 10:00am-1:15pm. This lecture on thinking about marijuana from a public health perspective was designed for participants to understand current perceptions about marijuana and what recent field research is showing. The presenters discussed issues around commercialization and youth exposure. The lecture featured a panel discussion on the national and local perspectives on current policies, as well as a discussion around the consequences of recreational marijuana legalization in Colorado from a public health perspective.

On April 22, 2016, SAPC coordinated a Safe Med LA Coalition training session for contracted providers on prescription drugs and OTC medication misuse and abuse. Providers will participate in the Coalition Community Action Team, which focuses on public awareness of risk of prescription drug abuse, safe use/storage/disposal, and available resources for help.

Additional training and technical assistance will be provided throughout the year by Dr. Cheryl Grills, a CPI and SAPC prevention consultant. Dr. Grills will lead quarterly Learning Communities with the 8 EPS SPA Coalitions and CPS providers. This concept was designed to assist providers with meeting county goals and objectives that aim to strengthen their overall community engagement efforts.

SAPC is also hosting a CPI Module 2: Prevention Theories and Frameworks training late June or early September 2016. The date, time, and location has not been confirmed but SAPC is committed to hosting this training for its providers.

Beginning July 1, 2016, SAPC will coordinate quarterly CPI training sessions for AODPS contractors. Training sessions will be designed to assist contractors implement LAC's SPP. Additionally, a Module 1 training on Prevention Theories and Frameworks is scheduled for July 28, 2016 for new AODPS contractors and SAPC staff. SAPC requires prevention contracted providers to participate in CPI webinars and to utilize CPI technical assistance resources and materials.

### Survey Monkey Question 8 (training topics)

AODPS providers recommended training sessions that can develop new knowledge and skills, allowing the field to capitalize on, and expand promising practices. The top 5 topics included:

- 1) Environmental Prevention,
- 2) Community Mobilization and Engagement,
- 3) Cultural Competence,
- 4) Policy Development, and

## 5) Evidence-Based Practices.

All training and technical assistance will be tailored to assist providers with strengthening their program efforts to meet County goals and objectives.

### **Prevention Website:**

In an effort to prevent substance use among the youth and young adult population, SAPC intends to launch three (3) separate media campaigns to inform and educate the target population of youth, young adults, and parents/guardians on marijuana and other substance use. More information on the media campaigns can be found on the SAPC prevention website: <http://publichealth.lacounty.gov/sapc/prevention/PreventionLinks.htm>. The three (3) separate campaign topics are described below:

### **Marijuana Education Campaign:**

Marijuana is the most commonly used illicit drug in the United States, with 19.8 million current users aged 12 or older. Additionally, 1.7 million youth (aged 12 to 17) reported having used marijuana in the past month. This campaign will aim to highlight emerging public health concerns of smoking and/or ingesting marijuana particularly among adolescents and its impacts on brain development, and potential individual and community impact from increased use and/or availability (e.g., driving under the influence). The campaign would align with the Cross-County Marijuana Collaborative's efforts and content would be determined based on current research and community conditions.

### **Opioid Misuse and Heroin Use Prevention Campaign:**

Misuse/abuse of prescription opioids in LAC (9.0%), California (9.9%), and the United States (10.3%) is most common among individuals ages 18 through 25. According to the Los Angeles County Participant Reporting System (LACPRS) data, the number of individuals admitted to publicly funded Tx programs for prescription opioids as their primary drug of choice in LAC significantly ( $p < 0.01$ ) increased by 86 percent from 1,490 in 2006 to 2,766 in 2013. Because it is cheaper and can be easier to access than prescription opioids, heroin is increasingly being used as a substitute for prescription opioids. In LAC, from 2005 to 2013, the number of heroin-related emergency room visits among individuals aged 18 through 34 increased by 227 percent. The numbers increased more rapidly since 2009, and surpassed those of individuals aged 35 through 54 in 2010.

### **Synthetic Drug Use Prevention Campaign:**

Due to the unpredictable nature and variety of chemicals used to create synthetic drugs, individuals who use them experience highly adverse health effects, which are increasingly leading to emergency room visits, and occasionally death. A lack of quality controls, regulatory oversight, and consumer awareness are contributing to these health harms. Further compounding this problem is the episodic, binge-like manner in which many of these drugs are used. These harms have been extensively documented for synthetic drugs such as MDMA, LSD, GHB, methamphetamine, and ketamine. However, less is known about the dosing levels and effects of newer synthetic drugs such as synthetic cannabinoids (Spice), Synthetic cathinones/Alpha-pdp (Flakka), Alpha-methyltryptamine (AMT), and 251NBOMe (N-Bomb).

### **Prevention Service Gaps**

In an effort to expand capacity and address service gaps, this new Fiscal Year 2016-19 AODPS-contracted providers received a funding augmentation to address goal 1: Prescription Drugs and OTC Medication Abuse. AODPS were required to join SAPC's Safe Meds Los Angeles Coalition, Community Education Action Team. This opportunity expands prevention capacity across the communities in LAC.

## **d. Cultural Competence**

SAPC's prevention principles are consistent with the following CADCA principles:

1. Each group has unique cultural needs. Coalitions acknowledge that several paths lead to the same goal.
2. Coalitions must recognize that what works well for one cultural group may not work for members of another cultural group.

3. Culture is ever-present, dynamic, and complex. Acknowledge culture as a predominant force in shaping behaviors, values, and institutions.
4. Cultural competence is not limited to ethnicity, but includes age, gender, disability, sexual identity and other variables. SAPC is in the process of finalizing the Culturally and Linguistically Appropriate Services (CLAS) Cultural Competence Strategic Plan. It will be used to ensure cultural competence across all systems of services.

The above CADCA guiding principles enable programs and coalitions to have positive interactions in culturally diverse environments.

### **e. Sustaining Resources**

DPH-SAPC has the resources and readiness to support priority areas identified during the assessment process. SPA-Based Coalitions engage community residents, law enforcement, educational representatives, elected officials, faith-based and other community organizations to learn about common community concerns. Collectively, they learn how to change community conditions and advocate for community improvement projects. Teaching the community how to organize and mobilize is key for sustaining resources after a contract ends.

### **f. Prevention Training Plan, Fiscal Year 2016-2019**

The Community Prevention Initiative (CPI) provides no-cost training and technical assistance to LAC AODPS and its contracted providers. Since 2003, the Center for Applied Research and Solutions has been honored to serve California's substance abuse prevention community through the CPI. CPI is a long-term statewide training and technical assistance project funded through the California Department of Health Care Services, Substance Use Disorder Prevention, Treatment & Recovery Services Division (DHCS). This project is designed to help California communities address substance abuse through data-driven processes, evidence-based implementation, and outcome-based decision making.

Unlimited Capacity - Webinar: July 11, 2016, Time: 10:00 - 11:30 a.m. Facilitator: Paul Nolfo

#### **Adverse Childhood Experiences (ACES) and Substance Use Disorder (SUD) Prevention**

This webinar will discuss the role of ACEs as a contributor to developing problem behaviors during adolescence and adulthood. ACEs occur as a result of trauma i.e. violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences. More and more communities are adopting a trauma-informed approach to prevent and treat the impacts of ACEs and the consequential problem behaviors, including substance use/misuse.

SUD prevention interventions are more effective when implementation occurs before risk factors negatively impact behavior which is why many prevention interventions are targeted at middle school and high school students. ACEs are a widespread, harmful, and costly public health problem and have no boundaries with regards to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. Participants will learn the following:

1. Defining ACEs and their relationship with the social determinants of health, trauma, and health inequities;
2. Understanding the impact of ACEs on SUD;
3. Selecting data sources that identify vulnerable populations at higher risk for ACEs; and
4. Utilizing prevention strategies to address ACEs

Capacity: 40-50 Participants - Training: July 27, 2016, Time: 8:30 a.m. 4:30 p.m.

Facilitator: Angela Da Re, Western Center for the Application of Prevention Certified Trainer

**Foundational Competencies, Module 1: Introduction to substance abuse prevention**

This training will explore the foundational concepts and define the content and scope of substance abuse prevention. A historical overview will be provided to understand how past strategies have progressed and continue to inform current prevention practices. The importance of substance abuse prevention and its impact on individuals and communities will be highlighted. The session will conclude with a discussion about the future of substance abuse prevention. The session will: define substance abuse prevention; examine drug classifications; discuss the importance of substance abuse prevention and its health and legal implications; and provide a historical prevention overview to understand how prevention has evolved into its current state and continues to progress for the future.

Capacity: 40-50 Participants - Training: July 28, 2016. Time: 8:30 a.m. - 4:30 p.m.

Facilitator: Angela Da Re, Western Center for the Application of Prevention Certified Trainer

**Substance Use Disorder Prevention Theories and Frameworks**

Substance Abuse Prevention is founded on proven theories and frameworks to inform its methodologies, strategies, and innovations. This training discusses behavioral change theories, explains how behavioral change theories inform SUD prevention, and reviews those foundational SUD prevention theories and frameworks that promote effective prevention

Capacity: 40-50 Participants - Training: September 29, 2016, Time: 8:30 a.m. - 4:30 p.m.

Facilitator: Angela Da Re, Western Center for the Application of Prevention Certified Trainer

**Professional Competency Series: Module 1 – Needs Assessment**

This training explores the first module of the five-step process of the SPF, Assessment. This step is described by the SAMHSA as the point at which "communities are expected to assess population needs, including levels of substance abuse and related problems; available resources to support prevention efforts, and community readiness to address identified prevention problems or needs." Module 1 covers: the role of a community needs assessment in prevention planning; Identifying relevant data sources; Analyzing various types of data sources; Determining when and how to collect data locally; Defining methods for analyzing and interpreting AOD data; Identifying service gaps, and prioritizing needs based on assessment of community conditions; and Learning how to articulate your findings in the form of a problem statement.

Capacity: 40-50 Participants - Training: September 29, 2016, Time: 8:30 a.m. - 4:30 p.m.

Facilitator: Angela Da Re, Western Center for the Application of Prevention Certified Trainer

**Professional Competency Series: Module 2 – Community Organizing and Capacity Building**

This training explores the second module of the five-step process of the SPF, Community Organizing and Capacity Building. SAMHSA notes that for successful implementation of the SPF, "States and communities must have the capacity--that is, the resources and readiness--to support the prevention programs and practices they choose to address. This training will help participants learn to identify community assets and challenges, assess the demographics in your community, and understand the community values that will drive prevention.

Capacity: 40-50 Participants - Training: January 12, 2017, Time: 8:30 a.m. - 4:30 p.m.

Facilitator: Angela Da Re, Western Center for the Application of Prevention Certified Trainer

**Professional Competency Series: Module 3 – Planning**

This training explores planning, the third module of the five-step process of the SPF. Planning is an integral step in ensuring the implementation of a successful prevention strategy. SAMHSA notes, "Planning will increase the effectiveness of prevention efforts-by focusing energy, ensuring that staff and other stakeholders are working toward the same goals, and providing the means for assessing and adjusting programmatic direction, as needed." This training will provide participants with an overview of: The role of logic models in program planning; Strategic planning to address community needs and desired outcomes; identifying resources to sustain prevention efforts.

Capacity: 40-50 Participants - Training: January 12, 2017, Time: 8:30 a.m. - 4:30 p.m.

Facilitator: Angela Da Re, Western Center for the Application of Prevention Certified Trainer

**Professional Competency Series: Module 4 – Implementation**

This training explores the fourth module of the five-step process of the SPF, Implementation. Careful thought and consideration is paramount in considering which prevention strategies will match community needs. According to SAMHSA, implementation is "where the rubber hits the road," and where all of the previous data assessment and planning efforts transform into action. Building on the first three modules, this training will provide participants with an overview of: Ideas for selecting an appropriate prevention strategy; Understanding the difference between evidence, science-based; and research-based strategies; Ensuring fidelity and adaptation are considered for implementation.

Capacity: 40-50 Participants - Training: April 20, 2017, Time: 8:30 a.m. – 4:30 p.m.

Facilitator: Angela Da Re, Western Center for the Application of Prevention Certified Trainer

**Professional Competency Series: Module 5 – Evaluation**

This training explores evaluation- a vital component of the five-step SPF. Evaluation is essential to ensure prevention efforts meet goals and objectives. It allows you to plan your program, monitor prevention efforts, and make adjustments and improvements that will enhance your services. Evaluation results not only keep your prevention efforts on track, they can also be used to further your sustainability efforts. This training will provide participants with an overview of: The role and purpose of evaluation; Types of evaluation designs and strategies; Components of a useful evaluation plan; Strategies to disseminate your evaluation findings.

Capacity: 40-50 Participants - August 8-9, 2016 – Orange County

**"All About Data" Regional Prevention Forum**

Presenters will discuss data concepts, introduce the new CPI County Indicator Toolkit, and provide guidance on selecting appropriate data sources and analyzing data effectively to tell your prevention story. Participants will learn to work with data in a more meaningful way through guided, hands-on activities and group discussions.

Capacity: 300 participants- January 11, 2018- The California Endowment

**"Cannabis Summit Conference"**

The purpose of this summit is to provide strategic direction and identify effective evidence-based strategies that mitigate potential harms and promote health equity & social justice. The Summit will bring together researcher, prevention experts, you, partners from public health, community-based organizations, and speakers with practical experience from other states.

Capacity: 300 participants- January 12, 2018- The California Endowment

**"Youth Summit Conference: Thriving and Striving in Changing Times"**

PURPOSE: As communities throughout Los Angeles County begin implementing recreational marijuana legalization, there is opportunity to be proactive toward preventing adverse consequences to our youth. The Summit will bring together researchers, prevention experts, you, partners from government partners, community-based organizations, and speakers with practical experience from other states.

**AODPS invited to attend - UCLA/ISAP Lecture**

Capacity: 31 AODPS Directors - July 29, 2016

**Time: 10:00 a.m. – 1:15 p.m. Location: DPH-SAPC Auditorium**

**Adolescent Substance Use: Current Advances in Science & Effective Interventions**

**Presenters: Rachel Gonzales-Castaneda, PhD, MPH**, Associate Professor, Department of Psychology, Azusa Pacific University

**Elizabeth J. D'Amico, PhD**, Senior Behavioral Scientist, RAND Drug Policy Research Center

This lecture will review the epidemiology of substance use trends among adolescents, along with current advances in science on the short and long-term effects of use on the developing adolescent. This lecture will discuss the current personal, social, and environmental barriers and challenges that prevent adolescents who

are at risk for developing SUDs from getting the care they need. The lecture will also highlight developmentally appropriate interventions that have been shown to be effective for identifying and addressing AOD problems among adolescents. The lecture will end with featuring a panel to discuss national and local perspectives on current drug policies and Tx implications for adolescents.

### Department of Health Care Services - Conferences 2016

#### Statewide Conference – Orange County

##### Halfway There: Local Control as a Prevention Resource

This workshop is offered to support County AOD prevention programs dedicated to helping cities take full advantage of the great potential available through local planning and zoning ordinances to reduce and prevent harm associated with retail alcohol outlets.

Two County AOD prevention programs actively working with cities to strengthen their alcohol outlet CUPs will report on current projects and advances to date. Kern County will report on its Small Communities Prevention Program. LAC will report on its Retail Framework Project in San Fernando Valley communities. Presentations are based on the SPF planning process.

Friedner Wittman , President, CLEW Associates

Albert Melena, Executive Director, San Fernando Valley Partnership

Adrienne Buckle, Prevention Services Supervisor, Kern County Mental Health

Yolanda Cordero, Prevention Services, Los Angeles County DPH

### AODPS Providers – DPH-SAPC Finance Division: Prevention Budget Training

Capacity: 40 – 50 AODPS Finance and Prevention Directors

July 14, 2016 – 10:00 a.m. – 12:00 p.m.

Facilitator: Robert Lucero

Location: Auditorium

### Prevention Directors Meetings - 10:00 a.m.-12:00 p.m.

Capacity: 40-50 AODPS Providers

Thursday, September 22, 2016 – DPH-SAPC Room 8050 by the Auditorium

Strategic Prevention Plan

SafeMeds LA – Action Team Updates

Addiction and the Adolescent Brain – Anne Ortega, San Fernando Valley Partnership

Thursday, December 15, 2016 – DPH-SAPC Room 8050 by the Auditorium

DMC-ODS 101 Presentation

SafeMeds LA – Action Team Updates

SPA Based Provider Reports

Thursday, January 26, 2017 – Ground Floor Conference Room 2

DPH-SAPC and Prevention Updates

SafeMeds LA – Action Team Updates

SPA Based Provider Reports

Thursday, April 27, 2017 – DPH-SAPC Ground Floor Conference Room 2

DPH-SAPC and Prevention Updates

SafeMeds LA – Action Team Updates

SPA Based Provider Reports

Thursday, July 27, 2017 – DPH-SAPC Ground Floor Conference Room 2  
DPH-SAPC and Prevention Updates  
SafeMeds LA – Action Team Updates  
SPA Based Provider Report

Thursday, September 21, 2017-Department of Public Works Conference Room  
DPH-SAPC and Prevention Updates  
Director of Public Health  
SPA-Based Provider Updates

Thursday, November 16, 2017-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA – Action Team Updates  
SPA Based Provider Reports

Thursday, February 1, 2018-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA-Action Team Updates  
SPA Based Provider Reports

Thursday, April 12, 2018-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA-Action Team Updates  
SPA Based Provider Reports

Thursday, June 14, 2018-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA-Action Team Updates  
SPA Based Provider Reports

Thursday, July 12, 2018-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA-Action Team Updates  
SPA Based Provider Reports

Thursday, August 6, 2018-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA-Action Team Updates  
SPA Based Provider Reports

Thursday, September 6, 2018-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA-Action Team Updates  
SPA Based Provider Reports

Thursday, October 11, 2018-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA-Action Team Updates  
SPA Based Provider Reports

Thursday, November 8, 2018-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA-Action Team Updates  
SPA Based Provider Reports

Thursday, December 13, 2018-DPH-SAPC Auditorium  
DPH-SAPC and Prevention Updates  
SafeMeds LA-Action Team Updates  
SPA Based Provider Reports



## IV. Step 3: Planning

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Planning involves applying assessment results to develop a strategic plan that includes policies, programs, and practices based on evidence-based theories. The planning process produces strategic goals, objectives, measurements, performance targets, and logic models.

AODPS providers Logic Models (LM) to plan program goals and objectives that would correspond to and address the problems identified in the DHS-SAPC SPP Goals and Objectives. The LM allows AODPS contractors to create a multi-strategy approach by evaluating combinations of services as well as the likelihood of achieving and sustaining intended results. Contractors were required to examine best practice research and agency capacity in consideration of planned goals and objectives.

Consistent with the SPF approach, DPH-SAPC relies on information gathered through needs analyses and other applied research initiatives (e.g., surveys, focus groups, analyses of existing data, key informant interviews, and evaluations) to establish prevention priorities.

### **Prevention Logic Models for Los Angeles County Priority Areas for Fiscal Years 2006-2019**

SAPC developed the 4 logic models, one for each of the following priority areas:

#### Targeted Priority Areas:

1. Prescription Drugs and OTC Medication Abuse
2. Marijuana Availability and Accessibility Among Youth
3. Alcohol – Underage Drinking and Binge Drinking
4. Methamphetamine and other illicit drug use among youth

#### **a. Sustainability**

In order to meet the needs of diverse local communities, LAC's planning process focuses on selecting sustainable, culturally competent interventions overall, and specifically in the following areas.

- *Engage stakeholders in strategic planning meetings*  
A diverse range of champions and leaders from local communities will be engaged to identify and address the most pressing AOD problems and contributing factors in their communities to develop and improve effective, culturally responsive prevention strategies.
- *Encourage involvement in the selection of policies, programs, and strategies*  
Meetings and interviews with community leaders and residents will be conducted in the selection of policies, programs, and strategies.
- *Consider adaptability of the identified prevention efforts; ensure they reflect the needs of the community*  
Prevention approaches will incorporate local community members' diverse perspectives, ideas, and strategies to improve prevention services. Flexibility and ability to be nimble midcourse will also facilitate sustainability. Prevention efforts will address community members' priorities and adapt services to specific needs as we learn about emerging community issues in need of immediate attention. Work plans will be responsive to changes and priorities in the community.

## b. Cultural Competence

- *Planning groups should mirror community demographics and target populations*  
Culturally competent prevention professionals who are familiar with the diversity of Angelinos in terms of religion, traditions, language, race/ethnicity and other factors will provide prevention services and participate in the SAPC Prevention team. Ongoing related training will be provided in order to build rapport and credibility at the local level.
- *Target disparities when planning strategies*  
To be relevant in the community and obtain buy-in from stakeholders, providers will address a range of issues related to AOD prevention, many of which stem from equity concerns. Prevention interventions will take culture into account when planning services.
- *Make sure community history and existing prevention efforts are considered*  
Prevention intervention plans will incorporate different perspectives, ideas, and strategies to improve prevention services. Including a diverse range of partners in the planning process will expand the base of prevention stakeholders and increase the number of interested community members in prevention activities, further facilitating cultural competence and sustainability.
- *Build cultural competence skills among the people that will participate in prevention activities*  
Our prevention team will participate in trainings and establish learning communities designed to provide a forum for providers/communities to exchange ideas on effective approaches and projects and to identify culturally relevant prevention approaches and risk and protective factors. These learning communities will assist in developing new knowledge and skills for the prevention field to capitalize on new strategies to address risks that are targeted to specific communities.

**COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH  
SUBSTANCE ABUSE PREVENTION AND CONTROL**

**ALCOHOL AND OTHER DRUG PREVENTION SERVICES (AODPS)  
C. LOGIC MODEL**

<b>ORGANIZATIONAL OBJECTIVE</b>					
<b>Objective</b> <i>What do we want to accomplish?</i>	<b>Strategies</b> <i>What method(s) will we use to help us accomplish the objectives? (Identified in Step 4 of this Planning chapter)</i>	<b>Short Term Outcomes</b> <i>What is going to happen as a result of our methods?</i>	<b>Intermediate Outcomes</b> <i>What is going to happen as a result of our methods?</i>	<b>Long Term Outcomes</b> <i>What is going to happen as a result of our methods? (Match the objectives as if it already occurred.)</i>	<b>Indicators</b> <i>How we will know what happened?</i>
By 2019, ensure that 100% of prevention programs utilize SMART objectives in their implementation plans.	Create Prevention Program Evaluation Team including program directors, evaluators, SAPC prevention and evaluation team. Convene prevention program evaluation team meetings, which will provide a forum for evaluating prevention strategies, including developing SMART objectives.	Prevention Program Evaluation Team will meet regularly with at least 50% of prevention program directors/evaluators to address prevention activities and SMART objectives.	By 2018, at least 75% of prevention programs will utilize SMART objectives in their implementation plan.	By 2019, 100% of prevention programs utilized SMART objectives in their implementation plan.	Implementation work plans Meeting attendance sheets

**PRIORITY AREA 1: PRESCRIPTION AND OVER-THE-COUNTER MEDICATION MISUSE AND ABUSE**

**Problem Statement:** Misuse of prescription (Rx) and over the counter (OTC) medications accounts for growing numbers of overdose deaths, ED visits, hospitalizations and SUD treatment admissions. **Contributing Factors:** 1) Rx and OTC medications are legal and readily available. 2) Majority of residents who misuse Rx drugs obtain them from relatives or friends, 3) Excessive prescribing and incorrect disposal are common.

**Goal:** Reduce misuse of Rx and OTC Medications

<b>Objective</b> What do we want to accomplish?	<b>Strategies</b> What method(s) will we use to help us accomplish the objectives? (Identified in Step 4 of this Planning chapter)	<b>Short Term Outcomes</b> What is going to happen as a result of our methods?	<b>Intermediate Outcomes</b> What is going to happen as a result of our methods?	<b>Long Term Outcomes</b> What is going to happen as a result of our methods? (Match the objectives as if it already occurred.)	<b>Indicators</b> How we will know what happened?
<u>Education/Perception Objective</u> By 2019, the number of students and community members will increase their knowledge about the risks of Rx and OTC drug abuse and safe disposal by 50% as measured by percent change in pre-post-tests.	Information dissemination (e.g., brochures, data briefs, newsletters, SNS messages), community education and environmental campaigns supporting public awareness of risks of harms of Rx and OTC misuse and safe disposal. For example, integrate Rx information into existing strategies (e.g., Guiding Good Choices, Life Skill Training, and Reality Party) and identify school personnel to champion efforts to introduce prevention program in schools.	By 2017, the number of students and community members who increase their knowledge about risks of Rx and OTC drug abuse and safe disposal will increase by 20% as measured by percent change in pre-post-tests.	By 2018, the number of students and community members who increase their knowledge about risks of Rx and OTC drug abuse and safe disposal will increase by at least 30% as measured by percent change in pre-post-tests.	By 2019, the number of students and community members who increase their knowledge about risks of Rx and OTC drug abuse and safe disposal increased by at least 50% as measured by percent change in pre-post-tests.	Pre-and post-tests on perception of risk  Memoranda of understanding between schools and prevention programs.  Class attendance records.  Results of in-class activities recorded by health educators.
<u>Behavioral Objective</u> By 2019, the number of students and young adults who misuse Rx and OTC medications during the past 30 days will decrease by 3% compared to baseline as measured by CHKS, and other available data sources.	Information dissemination, community education and environmental campaigns supporting public awareness of risks of harms of Rx and OTC misuse and safe disposal. For example, appeal to students' values of health and community.	By 2017, the number of students and young adults who misuse Rx and OTC medications in the past 30 days will decrease by 1% as measured by CHKS	By 2018, the number of students and young adults who misuse Rx and OTC medications in the past 30 days will decrease by 2% as measured by CHKS.	By 2019, the number of students and young adults who misuse Rx and OTC medications in the past 30 days decrease by 3% as measured by CHKS and other available data sources.	Rx and OTC Medication misuse (CHKS); Non-medical use of pain relievers (NSDUH); Rx and OTC misuse treatment admissions (LACPRS) Pre and post tests
<u>Policy Objective</u> By 2019, 50% of individuals and community groups targeted by Prevention Providers will participate in pharma take-back public education and outreach campaigns as measured by Providers' tracking data.	Support convenient, safe, and environmentally responsible prescription drug disposal programs through environmental campaigns and community education. For example, educate pharmacists regarding universal and timely use of prescription drug monitoring programs (PDMP).	By 2017, 20% of individuals/community groups targeted by Prevention Providers will participate in pharma take-back public education and outreach campaigns.	By 2018, 30% of individuals/community groups targeted by Prevention Providers will participate in pharma take-back public education and outreach campaigns	By 2019, 50% of individuals/community groups targeted by Prevention Providers participated in pharma take-back public education and outreach campaigns as measured by Providers' tracking data.	Prevention Providers' tracking data

**PRIORITY AREA 2: REDUCE UNDERAGE MARIJUANA USE**

**Problem Statement:** Marijuana is the most frequently used illicit drug, and is perceived to be safe, which contributes to its increased use; adolescents who initiate early use are at significant risk.

**Contributing Factors** 1) Marijuana is readily available to all ages 2) Use is acceptable (community); potential legalization for recreational use further normalizes use 3) Production is integrated into the economy (community) 4) Youth perception of harm for marijuana use is low (individual)

**Goal 2:** Reduce underage marijuana use

<b>Objective</b> <i>What do we want to accomplish?</i>	<b>Strategies</b> <i>What method(s) will we use to help us accomplish the objectives? (Identified in Step 4 of this Planning chapter)</i>	<b>Short Term Outcomes</b> <i>What is going to happen as a result of our methods?</i>	<b>Intermediate Outcomes</b> <i>What is going to happen as a result of our methods?</i>	<b>Long Term Outcomes</b> <i>What is going to happen as a result of our methods? (Match the objectives as if it already occurred.)</i>	<b>Indicators</b> <i>How we will know what happened?</i>
<u>Education/Perception Objective</u> By 2019, the number of youth who perceive marijuana use as harmful will increase by 5% as measured by CHKS compared to baseline.	Conduct educational and information dissemination campaigns (e.g., strategies to increase awareness of harmful effects) and environmental campaigns (e.g., to restrict marketing and advertising practices that appeal to youth), to reduce marijuana availability and access by youth.	By 2017, the number of youth who perceive marijuana use as harmful will increase by at least 1% as measured by CHKS compared to baseline.	By 2018, the number of youth who perceive marijuana use as harmful will increase by at least 3% as measured by CHKS compared to baseline.	By 2019, the number of youth who perceive marijuana use as harmful will increase by at least 5% as measured by CHKS compared to baseline.	CHKS; pre and posttest will also be examined by providers who collect these data
<u>Behavior Objective</u> By 2019, there will be a 3% decrease in the number of youth who used marijuana in the past 30 days as measured by CHKS compared to baseline.	(As above) Apply educational, information dissemination and environmental strategies to address community needs to reduce marijuana availability to youth, and educate community/students of marijuana-related harms. Work with community leaders to reshape norms supporting substance use.	By 2017, there was at least a 1% decrease in the number of youth who used marijuana in the past 30 days compared to baseline as measured by CHKS.	By 2018, there was at least a 2% decrease in the number of youth who used marijuana in the past 30 days compared to baseline as measured by CHKS.	By 2019, there was a 3% decrease in the number of youth who reported using marijuana in the past 30 days compared to baseline as measured by CHKS.	CHKS; pre and posttest will also be examined by providers who collect these data

**PRIORITY AREA 3: UNDERAGE ALCOHOL DRINKING AND BINGE DRINKING**

**Problem Statement:** Youth consume excessive amounts of alcohol, too often, and at too young of an age.

**Contributing Factors:** 1) Availability and access to alcohol by youth provided by adults in retail and social settings. 2) Parents do not believe that drinking is bad. 3) Parental history of substance abuse. 4) Teens have a favorable attitude towards drinking.

**Goal:** Decrease underage drinking, and binge drinking among youth and young adults.

<p align="center"><b>Objective</b> What do we want to accomplish?</p>	<p align="center"><b>Strategies</b> What method(s) will we use to help us accomplish the objectives? (Identified in Step 4 of this Planning chapter)</p>	<p align="center"><b>Short Term Outcomes</b> What is going to happen as a result of our methods?</p>	<p align="center"><b>Intermediate Outcomes</b> What is going to happen as a result of our methods?</p>	<p align="center"><b>Long Term Outcomes</b> What is going to happen as a result of our methods? (Match objectives as if it already occurred.)</p>	<p align="center"><b>Indicators</b> How we will know what happened?</p>
<p><u>Education/Perception Objective</u> By 2019, the number of youth who perceive underage and/or binge drinking as harmful will increase by 3% as measured by CHKS compared to baseline.</p>	<p>Information dissemination, community education, environmental campaigns and alternative strategies to address community needs to reduce underage and binge drinking, and educate communities and students of alcohol-related harms. Work with community leaders to address norms supporting substance use.</p>	<p>By 2017, the number of youth who perceive underage and/or binge drinking as harmful will increase by 1% compared to baseline as measured by CHKS.</p>	<p>By 2018, the number of youth who perceive underage and/or binge drinking as harmful will increase by 2% compared to baseline as measured by CHKS.</p>	<p>In 2019, the number of youth who perceive underage and/or binge drinking as harmful increased by at least 3% compared to baseline as measured by CHKS.</p>	<p>CHKS; other available data sources will be examined, e.g., NSDUH alcohol treatment admissions (LACPRS) Pre and post tests</p>
<p><u>Behavior Objective</u> By 2019, there will be a 3% decrease in the number of youth who ever reported using alcohol compared to baseline as measured by CHKS.</p>	<p>Information dissemination, community education, environmental campaigns and alternative strategies to address community needs to reduce underage and binge drinking, and educate communities and students of alcohol-related harms.</p>	<p>By 2017, there will be at least a 1% decrease in the number of youth who ever reported using alcohol compared to baseline as measured by CHKS.</p>	<p>By 2018, there will be at least a 2% decrease in the number of youth who ever reported using alcohol compared to baseline as measured by CHKS.</p>	<p>By 2019, there was a 3% decrease in the number of youth who ever reported using alcohol compared to baseline as measured by CHKS.</p>	<p>CHKS NSDUH alcohol treatment admissions (LACPRS) Pre and post tests</p>
<p><u>Retail Policy Objective</u> By June 2019, there will be a 10% increase in the number of alcohol retailers responsive to environmental prevention strategies (e.g., who decrease window advertising, participate in responsible beverage service), as measured by Prevention Provider data, and ABC and Police reports.</p>	<p>Environmental strategies such as Responsible Alcohol Merchant Award programs to restrict marketing and advertising practices that appeal to youth and limit sales of products that are particularly attractive to young people, such as alcopops. Increase retail outlet managers/employees who are informed of alcohol retail laws through traditional media (e.g., posters) and social media.</p>	<p>By 2017, there will be a 5% increase in the number of merchants who receive Responsible Alcohol Merchant awards compared to baseline.</p>	<p>By 2018, there will be a 5% increase in the number of alcohol retailers responsive to environmental prevention strategies</p>	<p>By 2019, there was a 10% increase in the number of alcohol retailers responsive to environmental prevention strategies, as measured by Prevention Provider data, and ABC and Police reports.</p>	<p>ABC and Police reports, Prevention provider reports</p>

Priority area 3 (alcohol) continued

Objective	Strategies	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes	Indicators
<p><u>Social Policy Objective</u> By 2019, there will be a 15% increase in the number of community members aware of social host ordinances (SHO) and harms of social access, as measured by Prevention Providers' data, e.g., pre-post tests.</p>	<p>Educational campaigns and environmental strategies to raise awareness of SHO and social access to alcohol; information dissemination; alternative strategies; and school-based youth programs such as Teen/Family counseling and mentoring.</p>	<p>By 2017, there will be a 5% increase from 2016 in the number of community members aware of SHO/harms of social access, as measured by Prevention Providers' data.</p>	<p>By 2018, there will be a 10% increase in the number of community members aware of SHO/harms of social access.</p>	<p>By 2019, there was a 15% increase in the number of community members aware of SHO/harms of social access, as measured by Prevention Providers' data e.g., pre-post tests.</p>	<p>Pre-post tests; Prevention Providers data and reports.</p>

**PRIORITY AREA 4: METHAMPHETAMINE AND OTHER ILLICIT DRUG USE**

**Problem Statement:** Social norms such as favorable attitudes promoting drug use, and indifference to illegal drug activity are conducive to methamphetamine use in Los Angeles County. Methamphetamine use appears to be increasing as indicated by SUD treatment admissions, and is especially problematic among women, Hispanic residents and the LGBT community.

**Contributing Factors:** 1. Methamphetamine is available and accessible, and 2. Availability and accessibility of illegal drugs have been shown to impact consumption.

**Goal:** Decrease methamphetamine and other illicit drug use

Objective <i>What do we want to accomplish?</i>	Strategies <i>What method(s) will we use to help us accomplish the objectives? (Identified in Step 4 of this Planning chapter)</i>	Short Term Outcomes <i>What is going to happen as a result of our methods?</i>	Intermediate Outcomes <i>What is going to happen as a result of our methods?</i>	Long Term Outcomes <i>What is going to happen as a result of our methods? (Match the objectives as if it already occurred.)</i>	Indicators <i>How we will know what happened?</i>
By 2019, there will be a 2% decrease in the number of youth who use methamphetamine in the past 30 days as measured by CHKS compared to baseline, pre-post tests and other available data sources.	Conduct environmental strategies targeted at reducing availability and access to meth by youth and young adults.	By 2017, increase by 5% the number of youths who perceive meth as harmful as measured by pre and post tests.	By 2018, youth will report a 1% decrease in methamphetamine and other illicit drug use in the past 30 days.	By 2019, youth reported a decrease in past 30 days methamphetamine use by 2% as measured by CHKS and other available data sources.	Pre-post tests CHKS (assesses drug use other than marijuana); NSDUH police reports and prevention providers' reports
By 2019, there will be a 2% decrease in the number of youth who report lifetime use of methamphetamine as measured by CHKS, pre-post tests and other available data sources.	Conduct community/school-based educational strategies that can increase awareness of the harmful effects of methamphetamine and other drug use among youth.	By 2017, increase by 5% the number of youths who perceive meth as harmful as measured by pre and post tests.	By 2018, there will be a 1% decrease in the number of youth who report lifetime use of methamphetamine.	By 2019 there was a 2% decrease in the number of youth who reported lifetime use of methamphetamine as measured by CHKS and other available data sources.	Pre-post tests CHKS (assesses Cocaine, Methamphetamine, or any amphetamines (meth, speed, crystal, crank, ice) NSDUH police reports and prevention providers' reports



## V. STEP 4: IMPLEMENTATION

In Step 4 of the Strategic Prevention Framework (SPF), AODPS-contracted providers develop work plans to implement their chosen prevention interventions.

### a. WORK PLANS

With clear goals and objectives outlined in the work plans, contractors will be ready to delineate specific strategies and activities necessary to achieve them. This was accomplished in the third step of the planning process: developing a Work Plan (WP; see format below). A Work Plan is a cohesive set of evidence-based strategies and activities specifically designed to achieve the goals and objectives. It is an explicit plan to accomplish a projected outcome, with measurable process and outcome indicators aiding in the development of a program evaluation framework.

<b>PREVENTION WORK PLAN FY 2016-2017</b> Substance Abuse Prevention and Control - Alcohol and Other Drug Prevention Services							
<b>CONTRACTOR NAME:</b>						<b>CITY/AREA SERVED:</b>	
<b>CONTRACT TYPE:</b>			<b>Provider ID #</b>				
<b>COUNTY GOAL (UNDERAGE RELATED)</b>				<b>PROVIDER GOAL</b>			
<b>COUNTY LONG-TERM OBJECTIVE</b>				<b>PROVIDER LONG-TERM OBJECTIVE</b>			
<b>COUNTY SHORT-TERM OBJECTIVE</b>				<b>PROVIDER SHORT-TERM OBJECTIVE</b>			
<b>[INSERT SUBSTANCE]</b>							
Major Activity	EBP Code & Title	Task #	Tasks to Accomplish Activity	Proposed		Process Measure	Short - Term Outcome Measure
				Start Date	End Date		

The table below and the subsequent Work Plan must include the same EBPs as those included in your agency's FY 2016-2017 Work Plan. Additions and deletions are acceptable as long as it aligns with the SPP's goals and objectives. All EBPs must be implemented with fidelity.

EBP Code	SAPC EBP #	EBP Status	Brief Title/ Description of EBP Curriculum/Strategy Selected	Brief Description of Research Findings Supporting Selection of the EBP

**SAPC EBP #:** Insert the number that corresponds with the EBP used - 1) evidence-based programs or curricula categorized under substance abuse prevention on the National Registry of Evidence-based Programs and Practices or Communities That Care Prevention Strategies Guide; 2) substantiated AOD environmental strategies such as those described in the RAND Preventing Underage Drinking Technical Report or the Centers for Disease Control and Prevention Community Guide; or 3) where the program or curricula is not a recognized best practice/model program (as described in one and two above), substantiated results of an evaluation/research conducted by an evaluator independent of the proposer that documents the ability of the program/curricula to achieve the intended outcomes. If using option three (3), the County must ensure that a comprehensive service approach can be implemented based on the selection(s), and validate the research and approve the selection(s) prior to implementation. EBPs must be implemented with fidelity and Work Plan Tasks must reflect major steps to fully implement the effort.

Work Plan: The Work Plan shall outline the specific major activities and associated tasks needed to achieve the Short-term outcomes (STOs) that will ultimately impact the long-term outcomes (LTOs) and Goals, as outlined in the Planning Logic Model. Only the most relevant efforts that directly contribute to achieving the identified County Goals, LTOs and STOs may be included in the Work Plan and claimed for reimbursement. The Work Plan must be completed using the required template and by following the provided instructions, which include but are not limited to the following criteria:

- The Work Plan(s) must include all major activities and associated tasks needed to achieve the County STOs and selected evidence-based practices as further outlined;
- The Work Plan(s) must be submitted to the County at least sixty (60) calendar days prior to the start of each fiscal year for approval. The document(s) must fully detail the necessary major activities and associated tasks to achieve the County STOs and include a sufficient volume of services commensurate to the funding amount;
- The Work Plan(s) will be an attachment to the contract and may be revised with SAPC approval; and
- Overall, the Work Plan(s) submitted over the entire statement of work sub-contract term must include a logical and appropriate progression in services and activities needed to favorably impact the selected Goals, LTOs and STOs. Furthermore, the identified strategies and prevention services should collectively impact STOs and LTOs or indicate if program modifications are necessary if STOs are not being met.

All Work Plan Major Activities and associated Tasks must be directly related to successful implementation of allowable environmental related EBP(s). Allowable EBP options include:

1. Evidence-based programs categorized under substance abuse prevention on the National Registry of Evidence-based Programs and Practices or Communities That Care Prevention Strategies Guide;
2. Substantiated AOD environmental strategies such as those described in the RAND Preventing Underage Drinking Technical Report or the Centers for Disease Control and Prevention Community Guide; or
3. Where the program or curricula is not a recognized best practice/model program (as described in one and two above), substantiated results of an evaluation/research conducted by an evaluator independent of the proposer that documents the ability of the program/curricula to achieve the intended outcomes. If using option three (3), the County must ensure that a comprehensive service approach can be implemented based on the selection(s), and validate the research and approve the selection(s) prior to implementation.

The following Institute of Medicine (IOM) prevention classification categories are allowable:

- **Universal Prevention:** Targets the entire population (national, local community, school, and neighborhood) with messages and programs aimed at preventing or delaying the (ab)use of alcohol or other drugs. All members of the population share the same general risk for substance (ab)use, although the risk may vary among individuals.
- **Selective Prevention:** Targets subsets of the total population at risk for substance abuse by virtue of their membership in a particular population segment. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. The selection prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically assessed or identified, and is based solely on a presumption given his or her membership in the at-risk subgroup.
- **Indicated Prevention:** Targets individuals who do not meet Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision (DSM-IV-TR) criteria for abuse or dependence, but who are showing early danger signs, such as failing grades and consumption of alcohol and other gateway drugs. The mission of indicated prevention is to identify individuals who are exhibiting potential early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs.

In all cases, these prevention services shall be directed at individuals who do not require Tx services and do not meet criteria for a SUD according to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Prevention screenings are allowable services.

California Department of Health Care Services (DHCS) Primary Prevention Substance Use Disorder Data Service (PPSDS) System: AODPS contracted providers are required to report prevention services in the PPSDS web-based data collection system as required by DHCS.

The SAMHSA Center for Substance Abuse Prevention (CSAP) has classified common prevention activities into six major categories termed “strategies.” These CSAP strategies, and the associated activities, are basic definitions that broadly describe the most frequent types of efforts for each term. An effective prevention program should be knowledgeable of these strategies and activities but base the program design on how to comprehensively address the actual needs of the target community(ies) through evidence-based interventions and services with the proven ability to achieve the desired results.

Activities selected should be used to assist providers with accomplishing work plan goals and objectives. AODPS contractors may utilize all the following six Center for Substance Abuse Prevention (CSAP) strategies and report selected activities in the PPSDS System:

1. **Environmental Strategy** - focuses on establishing or changing community standards, codes, and attitudes thereby influencing incidence and prevalence of alcohol and other drug use within the community. The strategy depends on engaging a broad base of community partners, focuses on places and specific problems, and emphasizes public policy.
2. **Community-Based Process Strategy** - focuses on enhancing the capacity of the community to address AOD issues through organizing, planning, collaboration, coalition building, and networking.
3. **Information Dissemination Strategy** - focuses on improving awareness and knowledge of the effects of AOD issues on communities and families through “one-way” communication with the audience such as speaking engagements, health fairs, and distribution of print materials.
4. **Problem Identification and Referral Strategy** – focuses on identifying individuals who have infrequently used or experimented with AOD who could change their behavior through education. The intention of the screening must be to determine the need for indicated prevention services and not Tx need.
5. **Education Strategy** – focuses on “two-way” communication between the facilitator and participants and aims to improve life/social skills such as decision making, refusal skills, and critical analysis.
6. **Alternative Strategy** – focuses on redirecting individuals from potentially problematic situations and AOD use by providing constructive and healthy events/activities.

County Monitoring: Monitoring visits will occur at least once each fiscal year to determine completion of activities, outcomes, and STOs outlined in the *Work Plan* and SOW. Unsubstantiated and/or incomplete activities will be discussed and included as an area of deficiency in the monitoring site visit report as applicable. All areas of deficiency and/or technical assistance needs will require a written Corrective Action Plan (CAP) where the Contractor must identify the steps to be taken to ensure the deficiencies do not reoccur. A CAP follow-up visit will occur in the next fiscal year.

## **b. Cultural Competency and Sustainability**

Cultural Competency must be integrated within and throughout the SPF and activities. Cultural competency are behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable effective work in cross-cultural situations. Such programming respects and is responsive to the health beliefs, practices, and cultural and linguistic needs of diverse individuals and is more likely to bring about positive change. *Sustainability* is the multiple factors that contribute to program success over the long-term including continued community support and engagement, stable infrastructure, and available resources and training.

## VI. Step 5: Evaluation

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*Applying data to enhance prevention approaches and sustain desired results*

### a. Evaluation Plan Overview

The LAC Evaluation plan to conduct AOD prevention process and outcome evaluation will begin by engaging stakeholders (e.g., prevention program directors, program contracted evaluators, SAPC prevention program director/coordinator) as members of the prevention evaluation team. SAPC's prevention evaluation team within the Health Outcomes and Data Analytics (HODA) Section will continue working collaboratively with members of prevention evaluation team throughout the evaluation process to develop shared program goals, objectives, and activities. The evaluation plan will include the following steps: evaluation design, gathering and analyzing data/evidence, justifying conclusions, and reporting evaluation results (dissemination plan). Indicators corresponding to each priority area reported in the Assessment chapter (e.g., prevalence, Tx admissions, emergency department visits/hospitalizations, deaths) will be used when appropriate to identify trends to gauge efforts toward reducing AOD use and related harms. The overall purpose of this evaluation is to monitor progress toward the program's goals, to determine whether program strategies are producing the desired progress on outcomes, and to ensure that effective strategies/programs are maintained, and resources are not spent on ineffective strategies and/or programs.

### b. Stakeholder Engagement in Evaluation Activities

SAPC will host on-going prevention program evaluation meetings to provide a forum for reciprocal exchange of ideas about prevention program evaluation activities such as refining logic models and SMART objectives (specific, measurable, attainable, results-focused, and timely), survey development, data collection, identifying data sources, analyzing data, disseminating outcome findings. The HODA prevention evaluation team will convene these meetings and ensure a clear explanation of the goals and objectives of LAC Evaluation Plan. Meetings will discuss prevention program strategies, address concerns and challenges regarding program evaluation activities, and provide technical assistance if necessary. The HODA prevention evaluation team will take minutes, summarize discussion points, and share findings/deliverables with stakeholders when appropriate.

### c. Methodology

This section describes our plan to collect and analyze evaluation data that is responsive to the regional and cultural diversity of LAC.

#### Gather Credible Data/Evidence (Data Collection)

The HODA prevention evaluation team will gather data and evidence either qualitative (e.g., meeting notes) or quantitative data for process and outcome evaluation.

#### *Process Evaluation*

The HODA prevention evaluation team will perform process monitoring and evaluation based on Providers' input and data obtained from regular meetings (e.g., meeting notes), work plans, PPSDS System, Providers' year-end reports, and program specific data collected by providers (e.g., outreach and surveys) when appropriate. In order to support programs in delivering prevention activities as intended, the HODA prevention evaluation team will evaluate whether process strategies are aligned with programs' intended goals and objectives. Data will be used to monitor how prevention strategies are being implemented and where modifications are needed to improve implementation of these strategies.

### Outcome Evaluation

Programs' goals and objectives for their targeted priority areas will be examined with reference to data presented in the Assessment chapter when appropriate. Specific data will be determined by Providers' strategies, and may include pre and post-tests, population, community, public, and SAPC datasets, crime rates, data generated by Prevention Providers, and data specific to adolescent (12-17) and young adults (18-25). Prevention program evaluations will include information about assessing outcomes related to one or more of the four priority areas noted in the Assessment chapter. AOD-related outcomes will be examined periodically as data become available throughout the reporting period (2016-2019). Community coalition activities associated with variations in local and county-level outcomes will be examined. According to timelines described in each program's evaluation plan, providers will periodically report on progress towards short, intermediate, and long-term outcomes.

### Data Analyses

Qualitative (e.g., content analysis) and quantitative data analyses (e.g., descriptive statistics, pre-post-test, logic models) will be conducted to evaluate program activities, implementation of strategies, effectiveness, and outcomes. Data will be used to identify and justify successes and challenges of prevention strategies, activities, and outcomes.

## **d. Roles and Responsibilities**

SAPC's HODA prevention evaluation team will be responsible for conducting county-level process and outcome evaluation and reporting evaluation results. Contracted prevention program directors, program evaluators, and SAPC prevention program team will be involved in the evaluation process from the beginning. The prevention evaluation team will be responsible for convening the prevention program evaluation meetings and will identify and share successes and challenges throughout the process.

## **e. Sustainability**

Sustainability will be facilitated by demonstrating that county and local prevention efforts have made a positive impact on well-being of LAC residents by reducing AOD use and related harms as measured by outcome evaluation data. Effective dissemination of evaluation findings (addressed below) will further facilitate sustainability. Flexibility and ability to be nimble midcourse will also facilitate sustainability. Prevention efforts will address community members' priorities and adapt services to specific needs as we learn about emerging community issues in need of immediate attention. Work plans need to be responsive to changes and priorities in the community.

## **f. Cultural Competence**

Evaluation activities will explore providers' ability to take culture into account when delivering prevention services. For example, to be relevant in the community and obtain buy-in from stakeholders, providers need to address a range of issues, many of which stem from equity concerns. This expands the base by including a wide range of partners. In addition, prevention efforts that are appealing, fun, and engaging to youth and promote healthy environments/messages/activities and oppose norms that encourage or accept AOD use will be explored.

The SAPC prevention evaluation team will work collaboratively with prevention providers on an on-going basis to assess community needs and resources and identify the most pressing AOD problems and contributing factors in their communities to develop and improve effective, culturally responsive prevention strategies. As noted in the Assessment chapter, evaluation activities will continuously involve:

Use data to target disparities: Equity concerns will be addressed in our evaluation activities. We will use data to explore providers' efforts to take culture into account when delivering prevention services.

Work with the community: Including a diverse range of partners will expand the base of prevention stakeholders. Engaging community members in assessment activities and effectively disseminating evaluation findings throughout local communities in LAC will further facilitate sustainability.

Collect and use cultural competence-related information/data: Cultural competent data will be used to improve prevention services and increase mutual respect and understanding between providers and SAPC. This will promote the inclusion of all provider/community members. The goal is to incorporate different perspectives, ideas, and strategies that will eventually improve prevention services.

Development of learning communities to identify culturally-relevant risk and protective factors and other underlying conditions: The SAPC Prevention team will establish learning communities designed to provide a forum for providers/communities to exchange effective approaches and projects to learn from each other in order to identify culturally relevant risk and protective factors, and other underlying conditions. These learning communities will help prevention providers develop new knowledge and skills, allowing the field to capitalize on new strategies to address risks that are targeted to specific communities.

Hiring of culturally competent staff and evaluators: Culturally competent staff and evaluators who are familiar with the diversity of Angelinos in terms of religion, traditions, language, race/ethnicity, sexual orientation, and other factors will be hired, and ongoing related training will be provided in order to build rapport and credibility at the local level.

## **g. Reporting Evaluation Results (Dissemination Plan)**

Evaluation findings will be disseminated to enhance prevention efforts and share lessons learned. This step is needed to turn the data collected into meaningful, useful, and accessible information. Program evaluation meetings will address topics related to dissemination including:

- Sharing of preliminary and final evaluation results
- Eliciting feedback on interpretation of results
- Recommendations on how to modify strategies based on results
- Integrating traditional prevention practices with new/innovative approaches
- Dissemination of evidenced-based and innovative practices and curricula

Program evaluation meetings will be utilized to present preliminary findings on topics such as fidelity of prevention service implementation and progress updates on AOD priority areas. Meetings will also be utilized to clarify and interpret findings, justify conclusions, determine formats and media for distribution of findings, and to determine target audiences (e.g., current and potential funders, administrators, board members, and community-based groups and organizations). Evaluation findings will be disseminated in annual progress reports to state, county, local funders, stakeholders, Coalitions, and LAC residents in oral and written formats as results become available.

# VI. ATTACHMENTS

## Alcohol and Other Drug Prevention Service Providers

