Los Angeles County
Department of Public Health

Substance Use Prevention Services

PREVENTION STANDARDS AND PRACTICES MANUAL

August 2025 | Version 5.0

SAPC | Substance Abuse Prevention and Control

County of Los Angeles Public Health

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Prevention Standards and Practices Manual

The Prevention Standards and Practices Manual (cited as the Prevention Standards and Practices in the Substance Use Prevention Services [SUPS] Statement of Work [SOW] and hereafter as the Prevention Manual) provides contractual requirements as outlined in the SUPS SOW and includes policies and procedures associated with these requirements.

This manual is consistent with the following federal Substance and Mental Health Services Administration (SAMHSA) Substance Use Prevention and Treatment Block Grant, also known as SUBG, Prevention Set-Aside requirements:

- SAMHSA Strategic Prevention Framework (SPF) planning process
- California Department of Health Care Services (DHCS) ECCO data reporting system
- SAMHSA's Center for Substance Abuse Prevention (CSAP) prevention strategies
- Institute of Medicine (IOM) classification

The intent of this manual is to clarify expectations of the SUPS contract and the overall ability of SAPC Prevention to effectively implement services that achieve the stated goals, objectives, and outcomes, as outlined in the Strategic Prevention Plan. Although differences may exist among individual programs, the Prevention Manual intends to ensure that all SUPS contracted programs share a common understanding of the SUPS contract requirements and program principles and practices.

The Prevention Manual will be updated and modified as needed over the course of the contract term to refine contract expectations and adjust to advances in the prevention field, including any changes to the SUBG funding requirements. Any updates to this manual will be provided to SUPS Providers in writing and will be referenced in the SOW.

Introduction

Vision

Healthy communities that are safe and free from substance use problems.

Mission

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

SAPC's Commitment to Prevention

When addressing public health challenges, including substance use, the Los Angeles County (LAC) Department of Public Health (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). The Substance Abuse Prevention and Control (SAPC) will work collaboratively with prevention providers on an on-going basis to assess community needs and resources to develop effective, culturally responsive prevention strategies. Particular emphasis will be placed on promoting the inclusion of all provider/community members and their diverse perspectives, ideas, and strategies. This will build rapport and credibility at the local level and improve the efficiency of prevention services within LAC.

Substance Use Prevention and Treatment Block Grant (SUBG) Prevention Set Aside Funding Requirements

SUPS providers are funded with federal SAMHSA SUBG Prevention Set-aside Funds. Title 42, U.S.C. Section 300x-22(a) requires the Department of Health Care Services (DHCS) to spend a minimum of twenty-five (25) percent of the total SUBG Award on primary prevention services. Primary prevention is defined as strategies, programs, and services directed at individuals who have not been determined to require treatment for a substance use disorder. A county's spending of the primary prevention funds that DHCS allocates is integral to meeting federal SUBG spending requirements. For the SUBG Primary Prevention Set-Aside, counties must have an active Prevention Strategic Plan that adheres to SAMHSA's Strategic Prevention Framework (SPF). Priority areas are identified in the plan and strategies are selected based on evidence, where applicable, that will best address the priority areas and populations being served. Strategies may consist of both individual- and population-based services, using the six prevention strategies identified by SAMHSA's Center for Substance Abuse Prevention (CSAP)[1]. The 6 CSAP strategies are:

a. Information Dissemination
b. Education
c. Alternative
d. Problem Identification and Referral
e. Community-Based Process
f. Environmental

Prevention Services Frameworks

There are four distinct frameworks that when combined guide the development of comprehensive, culturally competent, and effective prevention services that aim to strengthen individuals, families and communities. Prevention services will utilize the following four frameworks collectively:

1. The Spectrum of Prevention
2. The Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Prevention Framework (SPF)
3. SAMHSA Center for Substance Abuse Prevention (CSAP) Strategies
4. Institute of Medicine (IOM) Classifications for Prevention

[1] https://www.samhsa.gov/grants/block-grants/sabg

The use of the SPF, CSAP strategies, and the IOM classifications are required by the California Department of Health Care Services (DHCS) and included as part of the mandatory reporting requirements for the web-based ECCO data reporting system. Additionally, use of the Spectrum of Prevention is required by DPH to ensure a comprehensive strategy for prevention services.

THE SPECTRUM OF PREVENTION

The Spectrum of Prevention is a systematic tool that promotes a range of activities for effective prevention. The Spectrum of Prevention has been effectively used nationally in prevention initiatives for traffic safety, violence prevention, injury prevention, nutrition, and fitness.

The Spectrum framework identifies six levels of intervention (see chart below) and helps people move beyond the perception that prevention is merely education. At each level, the most important activities related to prevention objectives are defined. As these activities are identified, they lead to interrelated actions at other levels of the Spectrum. All six levels are complementary and synergistic: when used together, they have a greater effect than would be possible from a single activity or initiative.[2]

Spectrum of Prevention Levels	Definition
Supporting self-efficacy, knowledge and skill acquisition for individuals	Enhancing an individual's capability of preventing injury or crime and promoting well-being
Promoting Healthy Communities	Supporting groups of people with information and resources to promote health and safety and mobilize their communities and neighborhoods.
Educating Providers	Informing providers who will transmit skills and knowledge to others
Fostering Coalitions and Networks	Bringing together groups and individuals for broader goals and greater impact
Changing Organizational Practices and Community Norms	Adopting regulations and norms to improve health and safety and creating new models
Influencing Policy Legislation	Developing strategies to change laws and policies to influence outcomes

[2] https://www.preventioninstitute.org/tools/spectrum-prevention-0

SAMHSA'S STRATEGIC PREVENTION FRAMEWORK (SPF) [3]

The SPF is a five-step planning process that systematically guides the development of prevention services. Central to all steps is ensuring that efforts are culturally and linguistically competent, and sustainable. By addressing each of these steps, prevention services should address the needs of the specific 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 program achieves the intended outcomes.

The following is a brief description of each SPF step and must address cultural competence and sustainability as a fundamental element within each step.

- Step 1: Assessment: What is the problem, and how can I learn more?
- Step 2: Build Capacity: What do I have to work with?
- Step 3: Plan: What should I do and how should I do it?
- Step 4: Implement: How can I put my plan into action?
- Step 5: Evaluate: Is my plan succeeding?

Practicing Effective Prevention

According to SAMHSA's Center for the Application of Prevention Technologies, practicing effective prevention means:

a. Gathering and using data to guide all prevention decisions-from identifying which substance use problems to address in a community, to choosing the most appropriate ways to address these problems, to determining whether selected interventions and strategies are making progress in meeting prevention needs.
b. Working with diverse community partners to plan and deliver culturally appropriate, effective, and sustainable prevention practices that are a good fit for the populations being served.
c. Understanding and applying prevention research so that prevention efforts are informed by best

[3] Strategic Prevention Framework. (n.d.). Retrieved from: https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

practice and shown to influence risk and protective factors associated with prioritized substance misuse and related health problems at the community, State, territory, and tribal levels.

To practice effective prevention, providers must understand substance misuse prevention within the larger context of behavioral health, apply SAMHSA's Strategic Prevention Framework (SPF), incorporate epidemiology into prevention planning to help focus and refine prevention activities based on patterns of substance misuse, and related consequences; and apply prevention approaches that address those factors that contribute to or protect against identified problems, and that are a good match for the community.

SAPC will ensure compliance with these guidelines through contract development and processing, contract compliance and monitoring (Attachment A). Providers must obtain the required training specific to the practice of effective prevention. Utilizing SAMHSA's Strategic Prevention Framework as a part of their contractual requirement, SUPS contracted providers must ensure that their staff receive 24 hours of prevention training per fiscal year.

Cultural Competency and Sustainability

SUPS providers must provide programs that are culturally competent and sustainable. *Cultural Competency* is as a set of 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.

Social Determinants of Health

Social determinants of health explore diverse societal factors that influence health, including substance use risk and protective factors. In participating in substance use-related outreach and education, Provider is required to address the social determinants of health to fully address the community and systems-level factors that directly and indirectly impact substance use and misuse within communities.

CENTER FOR SUBSTANCE ABUSE PREVENTION (CSAP) STRATEGIES AND ACTIVITIES[4]

The SAMHSA 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 target communities through evidence-based interventions and services with the proven ability to achieve the desired results.

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 treatment 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.

[4] Substance Use Block Grant Primary Prevention Data Quality Standards and Definitions Prevention Outcomes and Reporting Unit (Updated February 2025). Retrieved from https://www.dhcs.ca.gov/Documents/Primary-Prevention-Data-Quality-Standards.pdf

THE INSTITUTE OF MEDICINE CLASSIFICATION SYSTEM[5]

The IOM model divides the continuum of services into three parts: prevention, treatment, and maintenance. The prevention classifications are further subdivided into universal, selective, and indicated. The IOM category is assigned by looking at the risk level of the individual or group receiving the service.

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."

- **Universal Direct**: "Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk, (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)."
- **Universal Indirect**: "Interventions support population-based programs and environmental strategies, (e.g., establishing substance use policies, modifying substance use advertising practices). This also could include interventions involving programs and policies implemented by coalitions."

Selective Prevention: "Targets subsets of the total population at risk for substance misuse 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 selective prevention program is presented to the entire subgroup because the subgroup is at higher risk for substance misuse 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 the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) 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 use, and to target them with special programs."

In all cases, these prevention services shall be directed at individuals who never received nor require treatment services, and do not/would not meet criteria for a substance use disorder according to the Fifth Edition of the DSM-5. A screening and/or assessment shall not be conducted for the sole purpose of making this determination.

[5] https://dpbh.nv.gov/uploadedFiles/mhnvgov/content/Meetings/Bidders_Conference/Institute%20of%20Medicine%20Prevention%20Classifications-rev10.20.14.pdf

Los Angeles County Substance Abuse Strategic Prevention Plan

SAPC developed a five-year substance abuse Strategic Prevention Plan (SPP). The purpose of the SPP is to define the steps necessary to achieve SAPC's vision, mission, and goals. The Fiscal Year 2020-2025 SPP is consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) process.

PRIORITY AREAS

The first phase of the FY2020-2025 SPP process was to conduct a comprehensive community assessment collecting needs and resource data describing the AOD issues across the eight SPAs within the county. Through the assessment process, the following four priority areas were defined.

Priority 1: Alcohol Use
Problem Statement: Alcohol consumption rates among youth are high due to low perception of harm, availability of alcohol to teens by retailers, lack of life skills to develop resiliency around their own health and wellness, and the use of alcohol prior to sexual intercourse.

Priority 2: Cannabis Use
Problem Statement: Cannabis use is a priority in LAC following legalization. The low perception of harm by youth, increased availability of cannabis by retailers, lack of resiliency skills, and use of cannabis prior to sexual intercourse among youth contribute to increased cannabis use among youth.

Priority 3: Methamphetamine Use
Problem Statement: Methamphetamine use is a priority in LAC. Use of methamphetamines prior to sexual intercourse among youth, a lack of community awareness of methamphetamine use, and the lack the life skills to develop resiliency around health and wellness among youth contribute to increased methamphetamine use among youth and adults.

Priority 4: Prescription Drug Misuse
Problem Statement: Excessive prescribing among adults, lack of community awareness of proper disposal methods, lack of resiliency skills around prescription drug use among youth, and the use of prescription drugs prior to sexual intercourse among youth contribute to an increase of the misuse and abuse of prescriptions drugs.

COUNTY GOALS AND OBJECTIVES

Goal 1: Decrease Alcohol Use Among Youth
Objective 1.1: Increase perception of underage alcohol use as harmful.
Objective 1.2: Reduce retail availability of alcohol to underage youth.
*Objective 1.3: Increase youth resiliency for underage drinking.
*Objective 1.4: Decrease in high school students who report having consumed alcohol prior to sexual intercourse.
Goal 2: Decrease Cannabis Use Among Youth
Objective 2.1: Increase youth perception of underage cannabis use as harmful.
Objective 2.2: Reduce retail availability of cannabis to underage youth.
*Objective 2.3: Increase youth resiliency for cannabis use.
*Objective 2.4: Decrease in high school students who report having used cannabis prior to sexual intercourse.
Goal 3: Decrease Methamphetamine Use Among Youth and Adults
Objective 3.1: Increase community awareness of the harms of methamphetamine.
*Objective 3.2: Increase youth resiliency for methamphetamine use.
*Objective 3.3: Decrease in high school students who report having used methamphetamine prior to sexual intercourse.
Goal 4: Decrease Prescription Drug Misuse or Abuse Among Youth and Adults
Objective 4.1: Decrease in prescribing of opioid drugs for adults.
Objective 4.2: Reduce youth access of prescription drugs.
*Objective 4.3: Increase youth resiliency for prescription drug use.
*Objective 4.4: Decrease in high school students who report having consumed prescription drugs prior to sexual intercourse.

***** These objectives only apply to the Student Well-Being Centers and do not need to be incorporated into CCP, PEP, and FNL contracts.

COUNTY LOGIC MODEL

The following logic models should be used in conjunction with the County Goals and Objectives. It should also be used to guide the development of Provider's work plans to ensure that the County Goals and Objectives are achieved.

Priority Area 1: Alcohol Use

Problem Statement: Alcohol consumption rates among youth are high due to low perception of harm, availability of alcohol to teens by retailers, lack of life skills to develop resiliency around their own health and wellness, and the use of alcohol prior to sexual intercourse.

Goal (Behavioral Change): Decrease Alcohol Use Among Youth

Objective What do we want to accomplish?	**Strategies** What CSAP strategies will the county implement to accomplish the objective?	**What is going to happen as a result of implemented strategies?**			**Indicators** How will the County measure what happened?
		Short Term Outcomes Immediate implementation: measures process change.	**Intermediate Outcomes** Measures change in contributing factors and/or change in knowledge or skills.	**Long Term Outcomes** Match the objective as if it was accomplished.	
Objective 1.1: By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS[6] or other survey.	Information Dissemination Education	By 2022, the number of youth who perceive underage alcohol use as harmful will increase by 1% as measured by CHKS compared to baseline.	By 2024, the number of youth who perceive underage alcohol use as harmful will increase by 2% as measured by CHKS compared to baseline.	By 2025, the number of youth who perceive underage alcohol use as harmful will increase by 3% as measured by CHKS compared to baseline.	CHKS or other survey
Objective 1.2: By 2025, reduce retail availability of alcohol to teens by 3% as measured by Alcohol Beverage Control infractions.	Environmental Community-Based	By 2022, reduce retail availability of alcohol to teens by 1% as measured by Alcohol Beverage Control infractions.	By 2024, reduce retail availability of alcohol to teens by 2% as measured by Alcohol Beverage Control infractions.	By 2025, retail availability of alcohol to minors will have decreased by 3% as measured by Alcohol Beverage Control infractions.	Alcohol Beverage Control data
Objective 1.3: By 2025, youth resiliency for underage drinking will increase by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, youth resiliency will increase by 1% as measured by pre/post surveys.	By 2024, youth resiliency will increase by 2% as measured by pre/post surveys.	By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Pre/Post Surveys
Objective 1.4: By 2025, there will be a 3% decrease in high school students who report having consumed alcohol before last intercourse as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, there will be a 30% increase in knowledge about the impact of alcohol use on one's ability to practice safer sex as measured by pre/post surveys.	By 2024, youth's perception that substance use may enhance their sexual experiences will decrease by 2% as measured by pre/post surveys.	By 2025, there will be a 3% decrease in students who report having consumed alcohol before last intercourse as measured by pre/post surveys.	Pre/Post Surveys

[6] https://data.calschls.org/resources/Los_Angeles_County_1517_Sec_CHKS.pdf

Priority Area 2: Cannabis Use

Problem Statement: Cannabis use is a priority in LAC, particularly following legalization and continued reductions in perceptions of risk associated with cannabis. The low perception of harm by youth, increased availability of cannabis by retailers, lack of resiliency skills, and use of cannabis prior to sexual intercourse among youth contribute to increased cannabis use among youth.

Goal (Behavioral Change): Decrease Cannabis Use Among Youth

Objective	Strategies	What is going to happen as a result of implemented strategies?			Indicators
		Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes	
Objective 2.1: By 2025, youth will increase their perception of the harms of underage cannabis use by 3% as measured by CHKS data or other survey.	Information Dissemination Education	By 2022, youth will have increased their perception of the harms of underage cannabis use by 1% as measured by CHKS data, compared with baseline	By 2024, youth will have increased their perception of the harms of underage cannabis use by 2% as measured by CHKS data, compared with baseline	By 2025, youth will have increased their perception of the harms of underage cannabis use by 3% as measured by CHKS data, compared with baseline	CHKS or other survey
Objective 2.2: By 2025, reduce retail availability of cannabis to teens by 3% as measured by pre-post surveys.	Environmental Community-Based	By 2022, reduce retail availability of cannabis to teens by 1% as measured by pre-post surveys.	By 2024, reduce retail availability of cannabis to teens by 2% as measured by pre-post surveys.	By 2025, reduce retail availability of cannabis to teens by 3% as measured by pre-post surveys.	Pre/Post Surveys
Objective 2.3: By 2025, youth resiliency for cannabis use will increase by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, youth resiliency will increase by 1% as measured by pre/post surveys.	By 2024, youth resiliency will increase by 2% as measured by pre/post surveys.	By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Pre/Post Surveys
Objective 2.4: By 2025, there will be a 3% decrease in high school students who report having used cannabis before last intercourse as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, there will a 30% increase in knowledge about the impact of substance use on one's ability to practice safer sex as measured by pre/post surveys.	By 2024, there will be a 3% decrease in youth's perception that substance use may enhance their sexual experiences.	By 2025, there will be a 3% decrease in students who report having used cannabis before last intercourse as measured by pre/post surveys.	Pre/Post Surveys

Priority Area 3: Methamphetamine Use
Problem Statement: Methamphetamine use is a priority in LAC. Use of methamphetamines prior to sexual intercourse among youth, a lack of community awareness of methamphetamine use, and the lack of life skills to develop resiliency around health and wellness among youth contribute to increased methamphetamine use among youth and adults.
Goal (Behavioral Change): Decrease Methamphetamine Use Among Youth and Adults

Objective	Strategies	What is going to happen as a result of implemented strategies?			Indicators
		Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes	
Objective 3.1: By 2025, increase community awareness of methamphetamine by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Environmental	By 2022, increase community awareness of methamphetamine use by 1%, as measured by pre/post surveys.	By 2024, increase community awareness of methamphetamine use by 2%, as measured by pre/post surveys.	By 2025, increase community awareness of methamphetamine use by 3%, as measured by pre/post surveys.	Pre/Post Surveys
Objective 3.2: By 2025, youth resiliency for methamphetamine use will increase by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, youth resiliency will increase by 1% as measured by pre/post surveys.	By 2024, youth resiliency will increase by 2% as measured by pre/post surveys.	By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Pre/Post Surveys
Objective 3.3: By 2025, there will be a 3% decrease in high school students who report having used methamphetamine before last intercourse.	Information Dissemination Education Community-Based Alternative	By 2022, there will a 30% increase in knowledge about the impact of substance use on one's ability to practice safer sex as measured by pre/post surveys.	By 2024, there will be a 3% decrease in youth's perception that substance use may enhance their sexual experience as measured by pre/post test surveys.	By 2025, there will be a 2% decrease in the number of youth who report having used methamphetamine at last intercourse as measured by pre/post test surveys.	Pre/Post Surveys
Objective 3.4: By 2025, decrease adult abuse of methamphetamine by 3% as measured by SUD treatment admission data	Alternative Education Community-Based Environmental	By 2022, decrease adult abuse of methamphetamine by 1% as measured by SUD treatment admission data	By 2023, decrease adult abuse of methamphetamine by 2% as measured by SUD treatment admission data	By 2025, decrease adult abuse of methamphetamine by 3% as measured by SUD treatment admission data	SUD treatment admission data

Priority Area 4: Prescription Drug Misuse
Problem Statement: Excessive prescribing among adults, lack of community awareness of proper disposal methods, lack of resiliency skills around prescription drug use among youth, and the use of prescription drugs prior to sexual intercourse among youth contribute to an increase of the misuse and abuse of prescriptions drugs.
Goal (Behavioral Change): Decrease Prescription Drug Misuse or Abuse Among Youth and Adults

Objective	Strategies	What is going to happen as a result of implemented strategies?			Indicators
		Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes	
Objective 4.1: By 2025, there will be a 5% decrease in prescribing of opioid drugs for adults as measured by PDMP[7].	Information Dissemination Education Environmental Community-Based	By 2022, there will be a 1% decrease in prescribing of opioid drugs as measured by PDMP.	By 2024, there will be a 3% decrease in prescribing of opioid drugs as measured by PDMP.	By 2025, there will be a 5% decrease in prescribing of opioid drugs as measured by PDMP.	PDMP, CHKS or other survey, CNA
Objective 4.2: By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS or other survey.	Information Dissemination Education Environmental Community-Based	Objective 4.2: By 2021, there will be a 1% reduction in youth access to Rx drugs, as measured by CHKS or other survey.	Objective 4.2: By 2023, there will be a 2% reduction in youth access to Rx drugs, as measured by CHKS or other survey.	By 2025, there will be a 3% reduction in youth access to Rx drugs, as measured by CHKS or other survey.	CHKS or other survey
Objective 4.3: By 2025, youth resiliency for prescription drug use will increase by 3% as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, youth resiliency will increase by 1% as measured by pre/post surveys.	By 2024, youth resiliency will increase by 2% as measured by pre/post surveys.	By 2025, youth resiliency will increase by 3% as measured by pre/post surveys.	Pre/Post Surveys
Objective 4.4: By 2025, there will be a 3% decrease in high school students who report having consumed prescription drugs before last intercourse as measured by pre/post surveys.	Information Dissemination Education Community-Based Alternative	By 2022, there will a 30% increase in knowledge about the impact of substance use on one's ability to practice safer sex as measured by pre/post surveys.	By 2024, youth's perception that substance use may enhance their sexual experiences will decrease by 3% as measured by pre/post surveys.	By 2025, there will be a 3% decrease in high school students who report having consumed prescription drugs before last intercourse as measured by pre/post surveys.	Pre/Post Surveys

[7] https://insight.livestories.com/s/v2/prescriptions-opioid-abuse-in-la-county/c153ae4e-020d-4833-ace7-b8ceb7775467

PREVENTION PROVIDER NETWORK**

1. **Community Collaboration Program (CCP)**
   CCP prevention services consist of creating healthy communities safe from AOD problems. Coalition and network development are both key strategies which engage all community groups with respect to effective, culturally relevant, equitable and thoughtful systematic planning to address problematic AOD availability, distribution, promotion, sales, and consumption. The selection of efforts/services are data-driven and designed to specifically address the highest priority problems and contributing factors of the target community(ies). Some activities include modifying alcohol and cannabis advertising, promotion of healthy retail practices, and providing Responsible Beverage Serving trainings.

2. **Prevention Education Program (PEP)**
   PEP prevention services are aimed at general populations in multiple settings, such as schools, clubs, and faith-based organization and match the needs, resources and cultural requirements of community(ies). These programs reinforce and promote bonding to school, community, and positive support systems. This includes changing the local environment and conditions that facilitate AOD use, including the knowledge and behaviors of youth and adults that contribute to community norms about AOD use. Additionally, community health promotion involves addressing priority alcohol and drug related problems by conducting an assessment, prioritization, and problem-solving process.

3. **Friday Night Live (FNL) / Club Live (CL), & FNL Kids**
   FNL builds partnerships for positive, healthy youth development, and engages youth as active leaders, mentors, and advocates to reduce access to and availability of alcohol and other drugs. Services are provided in selected middle and high schools. Youth-adult partnership activities include educating policy-making officials, providing safe social outlets for youth, and hosting trainings and conferences on youth leadership to societal factors that contribute to substance abuse.

4. **LA County Our SPOT Program**
   In collaboration with the LAC Department of Parks and Recreation (DPR), the LAC Our Social Places and Opportunities for Teens (SPOT) program provides substance use prevention education and positive youth development opportunities to at-risk teens in nine parks through LAC, utilizing evidence-based curriculum designed for teens growing up in urban communities that is both developmentally and culturally relevant. Our SPOT helps to empower middle-school and/or high-school teens residing in these vulnerable communities through life skills training, mentorship, youth development, and peer support. Within this tailored and safe space, youth receive mentorship from DPR staff including opportunities to build leadership skills through various drug-free activities and community-based projects.

5. Student Well-Being Centers

DPH, in partnership with Planned Parenthood of Greater Los Angeles and the Department of Mental Health, is establishing Student Well-Being Centers in 50 high schools throughout the County. These Centers provide easy, safe access to confidential substance use prevention, mental health, and sexual health education and services. The Centers utilize a positive youth development framework, which offers young people the opportunity to gain both health content and leadership skills. The Centers provide opportunities for students to serve as health advocates in their school communities and their neighborhoods. A comprehensive curriculum is delivered in health classrooms and through one-on-one and group education in the centers. After hours support and referrals is available to students through a dedicated, centralized call line. Parent educators offer parent and family education and engagement opportunities at each school, facilitating enhanced family communication around adolescent health and wellness.

6. Prevention Media Campaigns (PMC)

SAPC Prevention media campaigns provide countywide awareness and education regarding priority substances that most affect Los Angeles County communities. These data driven media campaigns utilize a multipronged approach to provide messaging that involve the most relevant forms of media, include both general and targeted messaging, and include a significant call to action. Culturally competent campaigns focus on highlighting emerging public health concerns including increased availability within communities and the potential health impacts such as risk of overdose or negatively altering adolescent and young adult brain development. These efforts align with the County goals and objectives, and significantly increases capacity of existing prevention media efforts from individual County providers and community coalitions.

7. My Brother's Keeper Program (MBK)

In partnership with Los Angeles County Libraries, MBK focuses on young boys of color through messaging and mentorship from young men and women peer advocate LA library staff of similar life backgrounds. Through life skills programs that support and offer training in behaviors such as communication, social competence, and peer resistance strategies, youth are offered effective methods for reducing the risk of substance misuse and abuse. All components of this program focus on prevention and diversion by building protective factors such as social and emotional competence, social connections, and meaningful use of time.

8. DPH Positive Youth Development Initiative

The DPH Positive Youth Development Initiative's mission is to raise awareness of substance use issues affecting communities, while working in collaboration with DPH leadership to advise on substance use and public health-related solutions to improve the health and well-being of youth in Los Angeles County. The Youth Advisory Council engages high school students in youth leadership

opportunities using the Positive Youth Development framework, elevating youth voices to improve awareness, outreach, and education of substance use prevention issues affecting adolescents and communities-at-large.

9. Connecting Opportunities for Recovery and Engagement (CORE) Centers

CORE Centers are eight prevention-forward community resource centers that is opened across the County to increase opportunities for youth, adults, and family/friends of individuals to better understand and prevent SUDs and connect them to needed prevention services. The CORE Center serves as a welcoming environment to get information and resources on how to prevent alcohol and drug use. The CORE Center services including prevention workshops (e.g. understanding substance use disorders, substance use and vaping, and recognizing signs of relapse), and community-based outreach.

10. Pathways to Health Program

Pathways to Health is a comprehensive year-round college preparatory, mentoring and internship program for 40 students of color, grades 9-12, with potential interest in mental health and public health careers, or having a relatable lived experience. The program applies alternative activities to support leadership development among young people. In partnership with the Charles R. Drew University of Medicine and Science (CDU) in South Los Angeles and the Los Angeles County Department for Mental Health, Pathways to Health (PHA) prepares high school students to train as peer health educators and lead positive change to promote healthy communities.

** For a list of Prevention Providers, please see Attachment B

Prevention Program Services and Requirements

AGENCY-LED COMMUNITY ASSESSMENT

The purpose of the community assessment is to collect and analyze data from a variety of data sources in order to identify and understand how community risks for substance use affects all four (4) priority substance use problems, (e.g., cannabis, alcohol, methamphetamine, and prescription drugs). The agency-led community assessment also establishes a baseline to benchmark agency outcome measures within the Logic Model and Work Plan(s).

Providers are responsible for the continuous assessment of their respective communities for the prevalence of emerging substances as well as the four (4) priority substances, as referenced in the County Goals and Objectives. The Community Assessment results must be reflected in the Logic Model and Work Plan's programmatic objectives. Data integrity must be maintained to assure that the facts stored in Provider's database are accurate, consistent, and reliable and any inconsistencies can be reconciled. Additionally, the agency-led community assessment must be facilitated by the agency's Program Evaluator. Please refer to your assigned Prevention Program Specialist for more information.

Additionally, providers can elect to conduct an independent agency-led community assessment that may include newly collected data (i.e., archival data, surveys, focus groups, key informant interviews, environmental scans). If interested, provider must confer with their assigned Prevention Program Specialist for programmatic review and approval, and Health Outcomes Data and Analytics (HODA) analyst to review Institutional Review Board (IRB) requirements respectively. The IRB approval process may take up to 6 weeks. Results from this agency-led community assessment should be used to inform Provider logic model and work plan.

Providers may use the results from the SAPC's **2022 CNA Study** to submit an updated Logic Model and Work Plan for FY 24-25. Other sources of data, such as **SAPC Data Reports and Briefs** or other validated, updated local data sources, such as the **California Healthy Kids Survey (CHKS)**, **Youth Risk Behavior Survey (YRBS)**, or the **Los Angeles County Health Survey (LACHS)** may be used to conduct this assessment.

LOGIC MODEL

The Logic Model outlines the four (4) priority substances as referenced in the County Goals and Objectives, with substance-related problems and programmatic solutions. Data from the factors identified during the agency-led community assessment and Logic Model translate these priorities into program goals and objectives. These planning tools will be the foundation for determining what substance use prevention efforts are implemented by Provider during the contract term.

Integral to the success of these efforts is the active and sustained involvement of local community residents, (youth and adults), leaders, businesses, substance use service providers, and others who are knowledgeable of the local substance use related issues and are committed to engaging in evidence-based solutions. Providers will engage community members and leaders throughout the process to best identify, implement, and sustain efforts to address substance use prevention issues within the community.

Providers can elect to use the results from the SAPC's 2022 CNA Study or any other updated local data source to submit an updated Logic Model and Work Plan for FY 25-26.

WORK PLANS

The Work Plan(s) outlines the specific major activities and associated tasks needed to achieve the County Goals and Objectives, and additional goals as outlined in the Provider's Logic Model. Only the most relevant efforts that directly contribute to achieving the identified County Goals and Objectives may be included in the Work Plan(s) and claimed for reimbursement.

The Work Plan(s) will capture all services provided and may be revised with SAPC approval, where revisions may be used to approve additional work. Additionally, any use of screening tools under prevention contracts must be included on the Work Plan(s) and approved by SAPC in advance.

Each contract will have a separate Work Plan based on the local data priorities and community needs. The Work Plan(s) will be an attachment to the contract and must be completed using the required SAPC-provided template and instructions, which include/s the following criteria:

1. The Work Plan(s) will capture all services provided and may be revised with SAPC approval, where revisions may be used to approve additional work.
2. Any use of screening tools under prevention contracts must be included on the Work Plan(s) and approved by SAPC, at least sixty (60) calendar days prior to the start of each fiscal year.
3. The goals and objectives need to be **S**pecific, **M**easurable, **A**ttainable, **R**elevant, and **T**ime-

based (SMART).

4. All providers must address County goals #1-4: 1) Alcohol Use; 2) Cannabis Use; 3) Methamphetamine Use; 4) Prescription Drug Misuse.
5. Overall, the Work Plan(s) must include a progression in services and activities needed to favorably impact the selected County Goals and Objectives.
6. The identified process and outcome measures should collectively determine if the combination of services and activities have the expected impact or if modifications are needed.
7. Providers can elect to use the results from the SAPC's 2022 CNA Study to submit an updated Logic Model and Work Plan for FY 25-26.
8. The documents must be submitted in the required format and include an adequate scope of services corresponding to the funding amount.

Adding New Prevention Programs to Work Plans

This section outlines how to request the addition of a new prevention program (e.g., Responsible Beverage Service Trainings; Parents Who Host Lose the Most) after the Work Plan has already been approved by the assigned SAPC Prevention Program Specialist.

Prevention agency staff should first contact their SAPC assigned Prevention Program Specialist to inform him or her of the proposed new program they would like to incorporate into their existing Work Plan.

The following information is required to ensure that SAPC Prevention Program Specialist receives sufficient information to approve the new program:

- Program name
- Program description
- Program start date
- Program type (evidence-based practice; research-based; local/innovative)
- Background evidence for effectiveness of the proposed program (e.g., publications from SAMHSA, scholarly research articles; evidence of local success)
- Service population (e.g., youth, parents/adults)
- CSAP strategy(ies) to be implemented
- IOM service category
- How often will program services be implemented per week, per month, etc.?
- Location of program services (e.g., school, community center, etc.)
- City/ies or community/ies, in which program services will be implemented

The SAPC Prevention Program Specialist will have up to two weeks to review and approve the proposed new program/s. If approved, an updated Work Plan must be submitted to the assigned SAPC Prevention Program Specialist who will then refer the contracted prevention provider to the Health Outcomes and Data Analytics (HODA) Unit for the completion of the New Program Request form. This form will enable HODA to create the new prevention program in the ECCO system. Once this is completed, the prevention provider may begin reporting their service activities directly into ECCO, for the new program.

If the Program Specialist does not approve the addition of the proposed program within the two-week period, SAPC will inform the prevention provider with a justification.

EVIDENCE-BASED AND INNOVATIVE PROGRAMS

Evidence-based, substance use prevention services, activities, and/or programs are encouraged and strongly considered. Additionally, local innovation programs that, although not widely researched, demonstrate promise in achieving positive substance use prevention and related outcomes, are encouraged. As such, all Work Plan major activities and associated tasks must be directly related to the successful implementation of the allowable evidenced-based programs (EBP) or local innovative programs.

For FY 25-26, SAPC is mandating that all Prevention Education Program (PEP) providers offer at least one (1) Botvin's LifeSkills Training (LST) middle school (15 sessions) or high school curriculum (10 sessions) as one of their evidence-based programs. For more information, please refer to the LifeSkills Training Factsheet located on the SAPC Prevention Provider webpage.

Providers may elect to provide additional EBPs, which can be selected from the attached list of SAPC recommended evidence-based programs (Attachment C) or from the following allowable options:

1. EBP or curricula categorized under substance misuse prevention on *SAMHSA's Evidence-Based Practices Resource Center*[8] or *Communities That Care Prevention Strategies Guide*[9].
2. Substantiated prevention strategies such as those described in the *RAND Preventing Underage Drinking Technical Report*[10].
3. *Blueprints for Healthy Development* from the Institute of Behavioral Science at the University of Colorado Boulder[11].

[8] SAMHSA: Evidence-Based Practices Resource Center, available at https://www.samhsa.gov/ebp-resource-center
[9] The Center for Communities That Care, available at https://www.communitiesthatcare.net/
[10] RAND: Preventing Underage Drinking, available at https://www.rand.org/pubs/technical_reports/TR403.html
[11] Blueprints for Healthy Development, available at https://www.blueprintsprograms.org/

4. *College Alcohol Intervention Matrix (CollegeAIM)* from the National Institutes on Alcohol Abuse & Alcoholism[12].
5. *OJJDP's Model Program Guide* from the Office of Juvenile Justice and Delinquency Prevention[13].
6. *WYSAC Environmental Strategies Tool* from the Wyoming Survey and Analysis Center, University of Wyoming[14].
7. Promising practices 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 conducted by an evaluator independent of the proposer that documents the ability of the program/curricula to achieve the intended outcomes. For a list of recommended evidence-based programs, pre-approved by SAPC, please see Attachment C for additional information.
8. California Department of Health Care Services (DHCS) Substance Use Prevention Evidence-Based Resource (SUPER).

If using option seven (7), the provider must ensure that evidence of program effectiveness and any collected data or validated research reports are sent to SAPC Prevention Program for review and approval, at least 30 days prior to the program implementation.

All new programs within the Work Plan must be approved by SAPC prior to program implementation. All evidence-based practices shall be evaluated and reported in the Year-End Report and Annual Evaluation Report, in collaboration with the provider's Program Evaluator. For a list of recommended evidence-based programs, pre-approved by SAPC, please see Attachment C for additional information.

The primary and secondary/satellite sites (e.g., schools) where services are provided and/or administered must be identified and specified. An agreement letter/memorandum of understanding (MOU) is required for all regular services provided at all locations where the contractor does not own or lease the property. This agreement must comply with all host site requirements including services to be provided, (e.g., frequency, days/times, group topics). *The agreement letter/MOU will need to be assigned to whomever is responsible for the property to which services will be provided*. A signed copy must be provided to SAPC prior to the delivery of services, within 60 days of Contract Execution. The provider is required to provide prevention services during the hours that are most effective and convenient for persons served.

[12] College Alcohol Intervention Matrix (CollegeAIM), available at https://www.collegedrinkingprevention.gov/CollegeAIM/

[13] OJJDP's Model Program Guide, available at www.ojjdp.gov/mpg

[14] WYSAC Environmental Strategies Tool, available at https://www.wyomingpreventiondepot.org/strategies/

Failure to document implementation and evaluation of the evidence-based practices listed above with fidelity, including modifications approved by the County for each fiscal year of the SOW term, shall be determined a breach of contract, and may result in a funding reduction up to, and including, SOW termination.

COUNTY COALITIONS/GROUPS

SAPC's prevention providers are required to develop a process to consistently engage community members and key stakeholders in the identification of local substance use problems and contributing risk factors to guide the development and implementation of prevention activities and services.

The overall mission of SAPC's SPA-based coalitions is to actively engage communities in addressing the four priority areas listed on page 10 of this manual. These SPA-based coalitions are led by the assigned CCP providers who have the capacity to mobilize and organize community residents including youth, parents and other SPA-based coalition partners that include a minimum of twelve (12) community sectors, as recommended by the Community Anti-Drug Coalitions of America (CADCA)[15].

1) Businesses
2) Civic/Volunteer Groups
3) Elementary and Secondary Education
4) Government
5) Healthcare Professionals
6) Law Enforcement
7) Media
8) Parents
9) Religious and Fraternal Organizations
10) Youth
11) Youth-Serving Organizations
12) Others involved in prevention, treatment, or recovery

Additionally, CCP providers are required to recruit and retain at least two (2) youth and/or young adults throughout the contract term to sustain youth partnership efforts needed to collaborate successfully across all sectors of a community to address local and county substance use problems.

SPA-Based Coalition Guidelines

[15] CADCA: https://www.cadca.org/wp-content/uploads/2019/02/handbookcompressed.pdf

To ensure the coalition establishes a coherent purpose and committed membership, the following activities must be included in the Work Plan and formalized through a charter, including documentation establishing the coalition's structure and expectations of members:

1. *Vision, Mission, and Objective(s):* Each of the SPA-Based Coalitions creates a vision and mission, including coalition objectives designed to drive and address substance use prevention and coalition work.
2. *Data Handouts:* How will findings from the community needs 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, staff)?
    b. Who will complete administrative duties such as drafting agendas, meeting notifications, inter-meeting communication, and meeting minutes (e.g., elected position, 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 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?
    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 provider specific meeting?
6. *Deliverables:* What materials will be provided at each meeting and in what format (meeting announcement, agenda, and meeting minutes)?

Provider Requirements

CCP Providers must establish and coordinate a coalition comprised of local community residents (youth

and adults), leaders, non-AOD focused businesses, AOD services providers (including PEP Providers in the specified SPA), and others from the target city(ies)/community(ies) to better understand local AOD related issues and participate in implementation of the environmental AOD-related prevention efforts and identified policy effort. CCP Providers will further work with their target population(s) and communities to build capacity and strategically address substance use associated risk factors. PEP Providers are required to actively and consistently participate with the SPA-based coalition and events led by the CCP Provider in the SPA(s) where services are provided. The collaboration among CCP and PEP Providers is required to effectively inform and engage local community members and agencies to address the County's identified Goals and Objectives.

The coalition shall have an established charter with stated mission/vision, objectives, structure, and membership roles/responsibilities. It shall convene at least monthly for the purpose of advancing the substance use availability and accessibility objectives. An agenda, sign-in sheet, and meeting minutes must be maintained for each session where the minutes include statements of proceedings, listings of attendees, absentees, topics discussed, resolutions, and motions proposed with actions taken.

It is SAPC's expectation that CCP agencies will independently conduct the research necessary to develop and implement the required action steps to maintain successful and effective coalitions. Providers are expected to update items numbers 1 through 6 above as needed and maintain the same standard of service as described throughout the contract term. If additional guidance is needed, please contact your Prevention Program Specialist.

CCP PROVIDERS - PROGRAM DELIVERABLES

Within the Work Plan, the CCP Provider will be required to deliver the following:

a. Three (3) SAPC mandated innovative programs to be implemented within their SPA:

- Let's Make a Difference
- Responsible Alcohol Delivery Project
- Smoke Shop Project

b. Deliver at least (1) one annual SPA-Summit/Conference/Townhall Meeting during each fiscal year. This large-scale event shall address substance use prevention policy issues and community advocacy needs for that SPA and promote awareness of local substance-use related issues, including participation in implementation of the environmental substance use prevention efforts.

c. Develop, coordinate, and maintain one (1) SPA-based Coalition comprised of local community

residents (youth, young adults, and adults), leaders, non-substance use focused businesses, substance use prevention providers (including SAPC Prevention Education Program (PEP) Providers in the specified SPA), and others from the target city(ies)/community(ies).

d. Facilitate consistent participation of all SPA-based SAPC providers through the Coalition. The collaboration among CCP and PEP Providers is required to effectively inform and engage local community members and agencies to address the County Goals and Objectives.

e. Provide consistent technical assistance and/or in-service trainings to the PEP providers within your SPA. The CCP provider shall utilize the SPA-based Coalition, as well as other forums to supplement County efforts with additional technical assistance and support on community engagement, partnership development, and general provision of environmental substance use prevention community resources.

f. Recruit youth, parents and other SPA-based coalition partners that include a minimum of twelve (12) community sectors, as recommended by the Community Anti-Drug Coalitions of America (CADCA) as stated on page 25.

g. Coalition members are required to meet at a minimum of once per month, the outcome(s) of which should be reflected on meeting agenda, minutes, and sign-in sheets. The process shall be inclusive, innovative, and holistic in approach. The coalition shall have an established mission/vision, objectives, structure, and membership roles/responsibilities.

h. Participate monthly in a SAPC-led Prevention Advisory Committee to guide Countywide prevention efforts and propose innovative ways to implement new and improved programming that connect youth, young adults, and communities to LAC substance use prevention services.

i. Provider shall collaborate with SAPC to design a SPA-specific community assessment to determine local comparative substance use, scope of problems, and prevention program effectiveness. SAPC Program evaluator will collaborate with Provider to incorporate program goals into the evaluation design to ensure the evaluation addresses the survey results, meets program objectives, evaluation expectations, and program priorities. CCP Providers shall execute these assessments as the primary lead and are encouraged to collaborate with PEP providers within their SPAs.

j. Support County environmental substance use prevention activities such as coalitions, public health awareness campaigns, social media and marketing efforts, and policy advocacy strategies.

k. Social Determinants of Health: Social determinants of health explore diverse societal factors that influence health, including substance use risk and protective factors. In participating in substance use-related environmental efforts, Provider is required to address the social determinants of health to fully address the community and systems-level factors that directly and indirectly impact substance use and misuse within communities.

l. Additional Requirements: The SAPC Prevention Manual and/or associated SAPC Bulletins provide additional details on programmatic requirements of the Contract, including but not limited to those listed above.

PEP PROVIDERS - PROGRAM DELIVERABLES

a. Deliver at least four (4) educational outreach events during each fiscal year. These events shall provide education and outreach with respect to substance use prevention issues for that SPA. The event(s) shall promote awareness of local substance-use related issues, including participation in implementation of the PEP-contracted prevention efforts and identified public health issues. Providers shall ensure that the events organized advance agency's assessments, reports, and evaluations to promote prioritization of specific substance use-related problems, encouraging a community-based problem-solving process as aligned with the County's identified goals and objectives.

b. Utilize at minimum one (1) County mandated evidence-based program (EBP) during each fiscal year, along with additional recommended EBPs as listed in the SAPC Prevention Manual Attachment C. Evidenced-based prevention services are a key component of delivering data-driven and community-informed educational and outreach services, focusing on substance use prevention-related efforts. Provider is required to report pre- and post-survey results as indicated in the required EBP by the end of every fiscal year through the Work Plan, Year-End Report, and Annual Evaluation Report in collaboration with the provider's Program Evaluator.

c. Provide consistent direct substance use education services to at least one (1) school, community college, university, educational setting, and/or community center during each fiscal year. This service should involve youth within their communities, schools, organizations, peer groups, and families. This substance use prevention service activity shall utilize and enhance young people's

strengths and promote positive outcomes for youth; they serve as protective factors for youth and young adult populations. This outreach and educational intervention should also provide opportunities that foster positive community relationships, provide skill building opportunities, and support their leadership strengths.

d. For schools or community settings where you are expected to provide substance use prevention services for more than one (1) time per FY, a Memorandum of Understanding (MOU) is required. This document should include terms of agreement, roles, responsibilities, and scope of services. Provider is required to send the signed MOU to SAPC for approval, within six months of the execution of the Contract. Failure to obtain the required MOU may be considered a violation in the terms of the Contract. This agreement must comply with all host site requirements, (e.g., school, district), including services to be provided, (e.g., frequency, days/times, group topics). The Provider shall be required to provide prevention services during the hours that are most effective and convenient for the targeted population. Hours may be the standard Monday through Friday between 8:00 a.m. – 5:00 p.m. but may also include alternative hours such as evenings and weekends. For additional MOU information, please refer to page 24 of this program manual.

e. Participate consistently in the SPA-based Coalition and other existing coalition-related programs and events, which are led and facilitated by the Community Collaboration Program (CCP) Provider within your designated SPA. The Coalition is comprised of local community residents, (youth and adults), leaders, non-substance use focused businesses, substance use prevention providers, and others from the target city(ies)/community(ies). The collaboration among PEP and CCP Providers is required to effectively inform and engage local community members as well as agencies in order to address the County's identified goals and objectives. As a coalition member, PEP Provider shall meet at minimum quarterly, the outcome of which should be reflected on meeting agenda, minutes, and sign-in sheets.

f. Participate ***as requested*** in a monthly SAPC-led Prevention Advisory Committee to guide Countywide prevention efforts. As requested by SAPC, propose innovative ways to implement new and improved programming that connect youth, young adults, and communities to LAC substance use prevention services.

Support County environmental prevention activities such as coalitions, public health awareness campaigns and social media and marketing efforts.
Additional Requirements: The SAPC Prevention Manual and/or associated SAPC Bulletins provide additional details on programmatic requirements of the Contract, including but not limited to those listed above.

DATA REPORTING AND EVALUATION

Data management: Provider is required to devise a data management plan that outlines how data are to be handled for the duration of the contract term. The data management plan should identify what data elements would be collected and how this data would be stored and maintained. Data variables collected may include gender, race/ethnicity, age, education, sexual orientation, health history, knowledge level and evidence of learning or level of satisfaction, indicated as a scale. Data management can be implemented through Microsoft excel, (or other software) once the data has been collected. Hard copies must be maintained in a locked cabinet, and electronic data must be password protected.

ECCO System:
All substance use prevention services indicated in the Work Plan must be entered in the ECCO web-based data collection system as required by the California Department of Health Care Services (DHCS). Provider shall enter data on an ongoing basis, comply with meeting monthly reporting timelines, participate in webinar training sessions, and follow guidelines for reporting prevention service activities. Payments may be delayed and/or disallowed if ECCO data entry is consistently delinquent, inaccurate, does not fully represent completion of services in the County approved Work Plan, and/or otherwise does not comply with County and DHCS data reporting requirements. Prevention services are only available to Universal, Selective, and Indicated populations, and individuals who do not require or receive treatment or harm reduction services. Prevention service recipients do not/would not meet criteria for a substance use disorder according to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Providers may utilize all six Center for Substance Abuse Prevention (CSAP) strategies: Information Dissemination, Problem Identification and Referral, Education, Alternative, Community-Based Process, and Environmental Strategies, to create new programs in ECCO.

Please note: Since ECCO collects reportable hours and billing invoices includes both reportable and non-reportable hours, it is strongly recommended that each agency maintains a spreadsheet that reconciles monthly staff-hours between ECCO and billing invoices.

a) Reportable hours are related to direct services, i.e. teaching LST to students.
b) Non-reportable hours include material preparation, copying/faxing, preliminary phone-calls, and follow-up calls, travel time, etc.

Annual Evaluation Report: Provider shall coordinate with their prevention program evaluator to conduct a process and outcome evaluation to determine whether the Provider's services, objectives, and outcomes outlined in the County approved Work Plan were achieved. The Annual Evaluation Report shall be

submitted with the Year-End Report. Provider shall verify that a minimum of five (5) percent, not to exceed maximum of ten (10) percent of the budget, is allocated for program evaluation each fiscal year, how fidelity to the evidence-based model(s) or practice(s) is maintained and measured, and the qualifications of the evaluator/s.

County Conducted Assessment and Evaluation: Provider agrees to participate in any County conducted assessment or evaluation plan to determine comparative substance use, scope of problems, and prevention program effectiveness. Examples of County conducted assessments include Community Needs Assessment (CNA) surveys that aim to quantify the scope of community conditions as they relate to substance use.

Evaluation Trainings: Provider participation shall include, but is not limited to, training on program evaluation procedures, data collection and reporting, administration of standardized evaluation and outcome reporting instruments, completing on-line surveys and interviews as requested, and other requirements as detailed by the County. Failure of Provider to participate in the evaluation activities as described shall constitute a breach of contract may be terminated by County.

REQUIRED REPORTS

The following reports are required annually and must comply with all requirements outlined in the instructions/templates:

A. Annual Work Plan(s) outlining major activities and associated tasks, goals and objectives, as outlined in the Logic Model.
B. Work Plan Amendments (as required) emphasizing new programs or service locations
C. Year-End Report highlighting all prevention activities performed throughout the fiscal year (including quarterly updates as required). The Year End Report is to be completed by the Prevention Coordinator in collaboration with program evaluators.
D. Annual Work Plan Evaluation Report to present program effectiveness and fidelity.
E. Quarterly Coalition Progress Report (CCP Providers only) to present program development and validity to work plan.

Additional Requirements: The annual prevention budget shall fund evaluation efforts at a minimum of five (5) percent, and not to exceed ten (10) percent of the total contract budget. Additional reports may be required as necessary to ensure contract compliance and quality assurance. Report formats will be provided and claims reimbursement may be delayed if reports are not submitted on-time and as required. Please refer to the SAPC Strategic Prevention Plan.

Policy and Procedures

QUALITY ASSURANCE PLAN

The County may evaluate the Provider's performance under this contract using performance benchmarks and/or dashboards, and the following additional requirements:

County Audits

County audits would occur at least once each fiscal year to verify all administrative and personnel requirements, contract program activities and deliverables, measurable outcomes, monthly ECCO data submission, material submission and approval forms, and County objectives as outlined in the Work Plan and the SOW. Unsubstantiated and/or incomplete deliverables would be discussed and cited as a deficiency in the Program Monitoring Summary Report. Deficiency(ies) would require a Corrective Action Plan (CAP) that identifies how the agency would prevent reoccurrence(s).

County Observations:

In addition to departmental contract staff, other County personnel may observe performance, activities, and review documents relevant to the current prevention contract at any time during normal business hours without interfering with the provider's performance.

QUALITY CONTROL

The provider must establish and utilize a comprehensive Quality Control Plan to assure a consistently high level of service throughout the term of the contract. The Plan should be submitted to the designated County contract program auditor for review and must include but not limited to the following:

1. Methods of monitoring to ensure that contract requirements are being met.
2. A record of all inspections conducted by the provider, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, must be provided to the County upon request.
3. Data Management: Provider is required to devise a data management plan that outlines how data are to be handled for the duration of the contract term. The data management plan should identify what data elements would be collected and how this data would be stored and maintained. Data variables collected may include gender, race/ethnicity, age, education, health history, knowledge level and evidence of learning or level of satisfaction, indicated as a scale. Data management can be implemented through Microsoft Excel (or other software), once the data has been collected. Hard copies must be maintained in a locked cabinet, and electronic data must be password protected.

STAFFING REQUIREMENTS

Program Director

A Program Director is expected to administer the prevention services provided according to the signed contract. In addition to the Minimum Qualifications described below, such person shall have a minimum of two (2) years of professional experience in the areas of: budgeting, facility operation, fiscal management, personnel, evidence-based prevention program planning, report writing, documentation of specific activities, program evaluation and knowledge of State and County funding and substance use prevention services. Provider shall provide a phone number and email address where the Program Director may be reached on an eight (8) hour per day basis during those hours.

Prevention Coordinator

One 100% full-time position must be assigned to the contract to serve as the Prevention Coordinator. Unless otherwise designated by the Provider, this individual will be the primary contact for the contract and responsible for oversight of daily operations. This includes implementation of the County approved Work Plan; ensuring compliance with County, State and federal funding contract requirements; and, maintaining compliance with data entry into ECCO. The Prevention Coordinator is under the direct supervision of the Program Director.

It is highly recommended that the Prevention Coordinator receive certification as a Certified Prevention Specialist under the California Consortium of Addiction Programs and Professionals. Credentialed prevention staff ensure that funded programs are delivered utilizing the latest evidence-based practices and a thorough understanding of substance use prevention.

Program Evaluator

All Providers shall have a Program Evaluator with the following minimum qualifications:

a. Formal education and training in research methods.
b. Experience in evaluation methods, research skills, as well as specific experience with the populations and health issues being addressed.
c. Skilled at clearly presenting findings and conclusions to a variety of audiences, including, but not limited to project staff, program participants, funding agency representatives, and legislators.

Minimum Qualifications

All staff employed (full-time and part-time) under the contract to provide direct services must meet the following minimum qualifications:

a. One (1) year of experience providing substance use prevention services prior to employment. Education may be substituted for experience where coursework is directly related to substance use prevention, or the public health field.

b. Experience developing, providing, and/or evaluating environmental prevention programs/services.
c. Experience conducting activities that align with the Spectrum of Prevention (Attachment D) and Strategic Prevention Framework (SPF) (Attachment E).
d. Experience in leading, facilitating, engaging and/or organizing community members, schools, businesses, and other stakeholders in the implementation/adoption of a community and/or population-based effort.
e. Ability to implement evidence-based strategies and prevention concepts to address substance use related community problems and contributing factors.
f. Competency to work with the various ethnic/cultural groups in the target area/community(ies).
g. If applicants for positions other than the Program Director and Prevention Coordinator do not meet the above requirements, other relevant experience (e.g., community organizing, other prevention experience) may be substituted if trainings are provided by an external training organization within three (3) months of employment.

Employee Compensation: Providers shall conduct environmental studies to ensure employees under this contract are given a competitive and fair salary, including employee benefits, to the best ability of the organization. Paying staff competitive wages and benefits to support a positive work environment is a key component of a productive workforce and positive work environment. Additionally, establishing a robust and rewarding Employee Benefits Package is essential to worker recruitment and retention, while adding to a positive employee/employer relationship and work environment.

Fingerprint Clearance Requirements: Provider shall comply with all fingerprint clearance requirements as outlined in the Master Agreement, under the Background and Security Investigations paragraph. All costs associated with the background and fingerprint investigation shall be paid by the Provider. Provider shall provide evidence of clearance upon request.

Agency Training Requirements: Provider shall institute and maintain close supervision of all persons providing services pursuant to this SOW. Provider shall be responsible for training employees (In-Service Training), as appropriate, concerning applicable federal, State and County laws, regulations, guidelines, directives, and administrative procedures. Provider shall provide each administrative (i.e., management) and service employees (i.e., prevention and support personnel) with a minimum of twenty-four (24) hours of training per contract year. Provider shall institute a training program in which all personnel employed in-full, or in-part, by this SOW shall participate. This includes requirements as outlined in the Master Agreement under the Staff and Training/Staff Development paragraph.

Professional and Career Development: Providers shall offer professional, career development, and advancement opportunities, as well as competitive salary schedules and benefits to their prevention staff to ensure best human resource practices and standards in pay equity, hiring, and promotion. Providers shall

promote cultural and linguistic competency and sensitivity through additional trainings and certifications to increase meaningful engagement with diverse demographic subpopulations of LAC.

County Meetings and Training Requirements: The Program Director and/or Prevention Coordinator shall attend all County and State mandated meetings and trainings, and the representative(s) in attendance must have the ability to participate and make decisions in reference to their SOW on behalf of the Provider.

Staff Positions and Vacancies

Provider shall assign a reasonable number of employees to perform the required work. At least one (1) 100% full-time employee on site shall be authorized to act for Provider in assuring compliance with contractual obligations at all times.

All positions outlined in the Budget to provide substance use prevention services must be filled at the approved designated level and pay scale proportionate with workload and responsibilities throughout the SOW term. Providers are expected to ensure pay equity and a just and professional work culture.

If any position becomes vacant during the term of this SOW, the SAPC Director or designee must be notified within ten (10) calendar days. All vacancies must be filled within ninety (90) calendar days after the vacancy occurs.

Staffing Changes Guidelines

Prevention contracted providers must report staffing changes in writing to their assigned prevention specialist within *10 calendar days* to ensure accurate reimbursement of contracted services. Monthly invoices must reflect the staffing changes in contrast to the original budget allocation for the assigned personnel. This will support the ability of SAPC prevention program staff to ensure contract compliance with established programmatic and fiscal standards prior to payment, and/or submission to the Department of Health Care Services (DHCS).

Staff change notices, invoice statements, and timecards must reflect all relevant modifications to be verified by your assigned Prevention Program Specialist and Finance staff prior to payment.
Claims must first be paid or denied based on accurate invoice statements and in accordance with any other federal/state/local/SAPC restrictions and written contracts. Provider shall assign a reasonable number of employees to perform the required work. At least one (1) full-time employee on site shall be authorized to act for Provider in assuring compliance with contractual obligations at all times.

All positions outlined in the Budget to provide substance use prevention services must be filled at the

approved designated level and pay scale proportionate with workload and responsibilities throughout the SOW term. Providers are expected to ensure pay equity and a just and professional work culture.

All vacancies must be filled within ninety (90) calendar days after the vacancy occurs.

Monitoring and Mechanism of Accountability: SAPC Contract Program Auditors and prevention program Specialists will facilitate communication between the service providers and SAPC, on an ongoing basis, Program Specialists provide technical assistance and ongoing programmatic support to agencies and monitor Work Plans and monthly invoices to ensure that each agency is meeting contract requirements. All Prevention contracts will have one compliance monitoring site visit per fiscal year.

Additional Staffing Requirements

Prevention Concepts: All prevention staff will receive appropriate training on the Strategic Prevention Framework, environmental prevention strategies, and other evidence-based prevention strategies to enhance the quality of prevention services and fulfill the training requirement for the applicable period.

Language Skills: Provider is encouraged to recruit and hire staff in service positions who are fluent in American Sign Language and the primary language of any special population group being served.

Child Abuse Reporting and Neglect: All staff must be trained in child abuse reporting and neglect issues, and requirements of mandated reporters.

Sexual Harassment and Sexual Contact: Sexual harassment and sexual contact is prohibited between participants, and service employee staff and administrative staff, including members of the Board of Directors. Provider must include a statement in each employee's personnel file noting that each employee has read and understands the sexual harassment and sexual contact prohibition. Provider must include this prohibition policy as part of an overall participant's rights statement given to the participant at the time of admission. Such prohibition policy must remain in effect for no less than six (6) months after a participant exits prevention recovery service program.

All training received during the term of the Contract should be included in the personnel file of all administrative and service staff employed by the provider.

Disability Coordinator: Provider will designate at least one employee as "Disability Access Coordinator" to ensure program access for disabled individuals, and to receive and resolve complaints regarding access for disabled persons at the contracted facility(ies).

Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) Education and Training: Prevention Providers are subject to the following abbreviated HIV/AIDs requirements:

- Ensure that agency's board of Directors reviews and adopts an HIV/AIDS policy (either the SAPC policy or an agency policy which incorporates all elements of the SAPC policy). Ensure all new staff members receive at a minimum a four (4) hour basic HIV/AIDs education, HIV prevention information and resources for prevention, testing, treatment, and supportive services within thirty (30) calendar days of starting employment. Maintain program facility(ies) and services in a manner which will reduce the risk of HIV virus transmission. Ensure availability of up-to-date brochures and other education materials which are reflective of the population served by the agency, in a culturally appropriate format and languages.

- Comply with all applicable federal and State laws relating to confidentiality of the HIV/AIDS status of participants.

Contract Change Requests

The Contract Change Approval Process ensures the eligibility and timely processing of such requests as LOCATION, HOURS, STAFFING, and/or SERVICE POPULATION. For more information, please refer to SAPC INFORMATION NOTICE 22-14: Requesting Amendments to Existing Service Contracts And Agreements.

Criteria for Approval of Amendment

Contract change requests must be submitted via a completed SAPC Contract Amendment Request Form within 10 calendar days of the intended change. SAPC will assess the feasibility and validity of this request based on the review criteria listed below.

Criteria	Review Criteria
Amendments	• *Change in location:* Prevention must assess if the location is in the same Service Planning Area or Supervisorial District, and if it is not within close proximity of another Prevention agency. • *Change in hours:* Prevention must assess whether new hours meet the programmatic necessity of the service population. • *Change in service population:* Prevention must assess whether this request accurately reflects the programmatic goals as identified in the Work Plan.

Performance	• Provider reports Prevention activities on the ECCO (Electronic Records System) as scheduled. • Provider submits all required reports on time. • Provider attends Prevention coalition meetings, training sessions, and workgroup meetings. • Provider is successfully implementing corrective action plans on non-compliance issues on all SAPC and non-SAPC compliance audits/reviews. • Provider has satisfactorily responded to all compliance monitoring requests in a timely manner. • Provider and provider's staff are in good standing in relation to all relevant regulations. • Feedback on provider agency performance received from stakeholders (e.g., clients, other agencies).
Community Needs	• Amendment supports needed community services in under-served areas and/or populations based on current contracted network services. • Overall service utilization service rates and data that show needed services/capacity in targeted areas. • Provider agency justification of services and community need in a specific geographic area or within a particular population.
Utilization	• No outstanding monies owed to the County without a repayment plan. • Availability of County funds to support that service or change. • Contract utilization percentage of at least 60%. • Corporate status is in good standing and funding guidelines support service.

Materials Review Guidelines

To ensure that printed or digital materials are accessible, easy to understand, and consistent with SAPC Prevention missions and goals, all SAPC contracted providers must submit the intended materials to SAPC for review and approval prior to distribution. These materials must be submitted via the **Materials Review Form**, to your assigned Prevention Program Specialist (PPS) at least ten (10) business days prior to the intended use date. Also, a checklist outlining our evaluation criteria is located on the third page of the

Materials Review Form and must be completed as part of the submission process. Additionally, all translated materials must be verified to match the approved English version. If your agency needs support with translations to any threshold language, please send the English version to your assigned PPS for approval and specify which language(s) are needed. Translations may take up to 2 weeks to be processed. Please submit translation requests at least 3 weeks prior to the intended release date.

Requirement: All materials intended for public distribution require materials review and approval by SAPC Prevention. These include press releases, brochures, flyers, social media posting, video/radio public service announcements, infographics, survey tools, and others.

1. When a request for materials review is submitted by a service provider, SAPC staff will review subject materials to make sure content accuracy, timeliness, relevance and effectiveness of all public health messaging is conveyed and to ensure rights of all parties are protected.
2. All materials must include the following statement: “This material was made possible by funds from the County of Los Angeles, Department of Public Health, Substance Abuse Prevention and Control. The messages, views, or opinions made by any of the publications, speakers, or staff do not reflect the official policy or position of any LA County Agency, including SAPC."
3. All approved material is valid for distribution for one year from the date of approval. After the one-year timeframe, they must be reviewed and reauthorized prior for further use.

Disclaimer: Any changes to the approved material – including but not limited to, modifications to the date, time, location, or other key details – will revoke the one-year timeframe. In such cases, the material must be resubmitted for review and approval.

The materials review includes assessing the right fit of material (i.e. press conference vs. community briefing) for the intended audience; the use of cited data and health information; guidance on the use of County/DPH logos; assistance with copyright issues; consultation on protecting patient/minor privacy rights, subject expert review and help with crafting relevant and easy to understand materials and prevention messaging.

Review Checklist
Material presentation fits intended audience needs
Writing style (use active voice /plain language/multi-lingual materials plan). Use simple and familiar terms, not acronyms or technical language (jargon).
Printed/Electronic Material: • Titles must be formatted with a 24-point font • Body text must be formatted in a minimum of 12-point font (14-point recommended for

readability).
PowerPoints Presentations: • Titles must be formatted with a 44-point font • Body text needs to be between 24-32-point font for optimal visibility during presentations
All capital letters are used only for headings and when grammatically correct
There is adequate amount of white space (1" margins around text)
Bullets or numbers are used for lists (ensure consistent formatting and adequate spacing between each bullet for clarity and readability).
Use frequencies (numbers), not percentages (e.g., 3 out of 10 youth use cannabis vs.30% of youth use cannabis)
There is adequate contrast between the print color and the background color
Visuals are simple and uncluttered (no more than 1-2 visuals per page)
Use clear visuals (not distorted, stretched, pixelated, or with watermarks)
Visuals must be relevant to the accompanying text
Avoid splitting words between lines (hyphenation)
Avoid placing text over pictures or other graphic elements
Graphics, photos, logos (copyright issues checked; written consent is on file; credit is provided)
Appropriate use of data to advance story, highlight scope of problem, progress
Cultural and Linguistic Standards (CLAS) are addressed
Subject expert review of technical and clinical content
Case stories protect minor/patient's rights
Americans with Disability (ADA) Compliant
All source material must be properly cited, including references for all information used

Additional Guidelines

- Know or select the audience, consider demographic factors including age, gender, geography, literacy level, socio-economic, cultural and language background.
- When writing for the public, write at 6th grade level or below (check content reading level in Word or other software).
- Consider the diverse communities of the County of Los Angeles and State/County/Federal mandates, such as the Cultural and Linguistic Standards (CLAS) to appropriately serve all residents.
- Prevention education materials' primary audience is youth and young adults and their parents.
- Confidential health information is protected. See link for related patient's rights

  http://publichealth.lacounty.gov/sapc/PatientPublic/Patient-Rights-Responsibilities.pdf

Writing Style is Simple

- Write in plain, active voice, and organized language that your intended audience can understand.
- Use positive voice, avoid negativity, and text should be free of jargon.
- Press releases use an inverted pyramid style-placing the most important information first
- Social media messages should be friendly, easy to share, relevant and engaging.
  Resources for community and youth education multi-lingual materials:
  Department of Public Health's Library of Educational Materials
  Culturally And Linguistically Appropriate Service Requirements

Graphic, Icons, Photos, County/DPH logos address copyright issues, consent

- When using images from other organizations, check for copyright issues and give credit for photos, etc.
- For images with an identifiable person, place, logo, or trademark, including mainstream movies, cartoons, video games, and comic-book characters, ensure proper usage rights are secured (e.g., purchasing style guides or purchasing via a stock image site).
- If using a photo for publication, have subjects sign an informed consent form, and/ or display an onsite media notification.
- Ensure graphics, icons, photos, County/DPH logos are high-resolution and clearly visible, without it being distorted, stretched, pixelated, or with watermarks.

Data and Use of Public Domain Materials

- Use timely and relevant data points from trusted sources to illustrate the scope of a public health/SUD problem and trends over time and to highlight issue/community change.

  a) SAPC's Data Reports and Briefs:
  b) SAMHSA's publications and digital products
  c) CA Dept. of Public Health Let's Talk Cannabis
  d) CA Friday Night Live Organization

MATERIALS, SUPPLIES, AND/OR EQUIPMENT

SUPS providers are responsible for the purchase of all materials, supplies, and/ or equipment to provide the needed services. Provider must use materials, equipment, and/or supplies that are safe for the environment and safe for use by the employee.

The County will not be liable or responsible for payment of materials or equipment purchased prior to the contract approval.

Finance

In accordance with the Department of Health Care Services' Substance Use Prevention and Treatment Block Grant funding requirements, the Los Angeles County Department of Public Health's Substance Abuse Prevention and Control (SAPC) is continuing to enforce timely reporting and invoicing requirements for Prevention cost reimbursement claims.

As a reminder, reimbursement will be disallowed if provider is non-compliant with certain terms of the Statement of Work (SOW), including failure to submit timely cost reimbursement claims on-time and in-full by each Fiscal Year (FY) deadline.

Please note that the deadline to submit all claims for each FY is within the **first week in July unless stated otherwise by SAPC Finance**. Claims that are submitted after the date will not be processed.

REIMBURSEMENT STRUCTURE

Provider will be reimbursed for actual, eligible, reimbursable costs incurred while providing services designated in the contract in accordance with the dollar amounts listed in the provider's approved budget(s). Costs must be reflected in provider's billing statements. The definition of "services" includes time spent performing and preparing any service activities designated in the provider's contract and work plan(s).

Reimbursement may be delayed and/or disallowed if provider is non-compliant with the terms of their contract. This may include failure to complete County approved Work Plan services on-time and in-full, submit required reports on-time and in-full, and submit data/documentation as outlined in the County approved Work Plan. Additionally, all direct and indirect services must be accurately documented into the ECCO database. Providers shall regularly monitor expenditures to ensure full allocation of budgeted amount per contract term. The County is not liable for costs incurred while performing activities outside of approved workplans.

MONTHLY PROVIDER INVOICES

SAPC Prevention contracted service agencies are required by contract to submit monthly invoices through the **SAPC Provider Invoice Automation System (PIAS)**, by the 10th of every month. These monthly invoices need to be processed by SAPC Prevention and Finance by the 15th of every month. Payments are generally processed by the 25th of every month by SAPC Finance.

PIAS users must be registered with the County and establish log in credentials. This includes establishing an account to access the County's Virtual Private Network (VPN). Please follow necessary steps to obtain access to PIAS.

Step 1: Register for your C#.

a. If you are assigned a Sage user to also use PIAS, then this user will already have a C# assigned. In this case, you can skip this step and complete *Step 2: Complete VPN application and PIAS registration process*.
b. Apply for your C# on this website. Please register one primary and one backup contact each for a C#.
c. After you have registered for a C#, please email SageForms@ph.lacounty.gov alerting them that a C# request was submitted.

Step 2: Complete the VPN application and PIAS registration process.

a. Complete **both** the VPN registration form and the application user registration form and email to sapc_app_support@lacounty.gov

For more details, please refer to the instructions from both the training video and manual.

Questions regarding PIAS can be directed to SAPC-Finance@ph.lacounty.gov and cc your respective programmatic contacts. IT questions can be directed to sapc_app_support@lacounty.gov

Requirement: Monthly invoice statements must be verified by your assigned prevention Program Specialist and Finance staff prior to payment. The monthly invoices report monthly expenditures by each agency/contract. Claims must first be paid or denied based on accurate invoice statements and in accordance with any other federal/state/local/SAPC restrictions and written contracts. Contracted agencies will only be reimbursed after their monthly invoices are submitted. DHCS also relies on these monthly provider invoices during auditing.

Supplemental Invoices

A supplemental invoice is an additional invoice entered after an original invoice to account for changes or additions to a service provided. Supplemental invoices are used to reflect increases (or sometimes decreases) in the value of services. For example, if all expenditures for the month are not included on the original invoice, then a supplemental invoice may be entered for the remaining expenditures for that same month.

Supplemental invoices may be entered in the PIAS any time during the fiscal year and can only be entered after the original invoice has been submitted. Supplemental invoices are not a replacement for the original invoices and allow for the Administrative Overhead amount to be entered manually without an ICR rate. Only one supplemental invoice should be entered per month, but under certain circumstances a second supplemental invoice can be entered in the PIAS.

For specific instructions on how to enter a supplemental invoice in PIAS, please review the PIAS training manual or video, in the Finance Documents section, http://publichealth.lacounty.gov/sapc/providers/prevention/prevention-providers.htm?tm.

ANNUAL BUDGET

Please refer to SAPC INFORMATION NOTICE 25-03 Budget Format for Substance Use Services Agreements and Contracts, for updated information describing SAPC's new budget template and system to be used by provider agencies with an agreement or contract to provide SUD prevention services. Please refer to Attachment I: Budget Instructions and Attachment II: Budget Narrative for additional information.

Provider is to ensure that programmatic costs are necessary and reasonable for proper and efficient performance of primary prevention activities as defined within the contracted agency work plan(s). SAPC reviews and verifies that programmatic and organizational expenditures generally meet contractual and programmatic expectations for activities as defined within the contracted agency work plan(s). Please ensure that negotiated overhead rates and changes to any category spending (such as Salary/Wages, Services and Supplies) are justifiable with a detailed, written description. These documents, such as changes to overhead rates and/or category spending greater than 10%, are subject to an objective review and approval process by the Contracts and Compliance, Programs, and Finance teams. If there are concerns with any expenditures, you may be notified by SAPC to request a resubmission with your proposed edits.

For budget modifications, please submit Attachment III: Budget Revision Worksheet to your assigned Prevention Program Specialist.

Budget Automated System

The system is available at the following link: Budget Automated System

LA County's Virtual Private Network

All county system users must adhere to the County's security protocols and controls. This includes registering all BAS users to allow access to the County's Virtual Private Network (VPN). Please use this link to register: VPN Registration Form

BAS Training Video & User Guide

SAPC has developed a Training Video and User Guide to assist provider's use of the system.

FISCAL REPORT

Provider must submit accurate and complete cost reports for the previous fiscal year by August 30th of the following fiscal year. For more information, please see SAPC's Fiscal Report Forms and Instructions.

For Instructions in completing Cost Reports, please view the Prevention, Harm Reduction and Other Services Fiscal Report PowerPoint Instructions.

Provider must submit the following:

a. Original Fiscal Report - E-mail completed cost report (excel file) to SAPC Finance representative and send original signed documents to:

   County of Los Angeles Department of Public Health
   Substance Abuse Prevention and Control Cost Reporting Unit
   1000 S. Fremont Ave., Bldg A-9 East
   3rd Floor, North Wing, Unit 34
   Alhambra, California 91803

b. "Cost Certification" or "Provider Information and Certification" with original signature.

Over/Under-Utilization

It is the responsibility of the provider to review their agency's budget to ensure billing and expenditures are consistent with their funding amount as to avoid over or under utilization of funds.

BUDGET AUGMENTATION APPROVAL REQUEST PROCESS

Provider augmentation request must be submitted using Attachment III: Budget Revision Worksheet with justification, in writing or via email to the SAPC Contracts and Compliance Division (CCD) at SAPCMonitoring@ph.lacounty.gov and your assigned Prevention Program Specialist.

Budget Augmentation Eligibility Criteria: For more information, please refer to SAPC INFORMATION NOTICE 22-14: Requesting Amendments to Existing Service Contracts And Agreements.

Providers must meet the criteria below to be eligible for proposed budget augmentations.

Criteria	Review Criteria
Standards	Budget augmentation does not exceed the 10% limit. Augmentations require Board of Supervisor and SAPC Bureau Director's approval, as noted in your Substance Use Prevention Services (SUPS) Master Agreement Work Order (MAWO) Statement of Work (SOW).

	Written justifications by the contractor and the PPS are included, describing the programmatic need for a budget augmentation. Provider must submit SAPC Contract Amendment Request Form Provider must have consistently submitted monthly billing claims by the 10th of each new month. The request for the current fiscal year must be submitted no later than 90 days prior to the end of the fiscal year, or April 1st of that fiscal year. Budgets submitted between April 2nd and June 30th of that fiscal year will be automatically denied.
Performance	• Provider reports Prevention activities on ECCO data reporting system as scheduled. • Provider submits all required reports on time. • Provider attends Prevention coalition meetings, training sessions, and workgroup meetings. • Provider is successfully implementing corrective action plans on non-compliance issues on all SAPC and non-SAPC compliance audits/reviews. • Provider has satisfactorily responded to all compliance monitoring requests in a timely manner. • Provider and provider's staff are in good standing in relation to all relevant regulations. • Feedback on provider agency performance received from stakeholders (e.g., clients, other agencies).
Community Needs	• Amendment supports needed community services in under-served areas and/or populations based on current contracted network services. • Overall service utilization service rates and data that show needed services/capacity in targeted areas. • Provider agency justification of services and community need in a specific geographic area or within a particular population.
Utilization	• No outstanding monies owed to the County without a repayment plan. • Availability of County funds to support that service or change. • Contract utilization percentage of at least 60%. • Corporate status is in good standing and funding guidelines support service.

SUBG ALLOWABLE COSTS

Costs for items below should be reasonable, appropriate, and justifiable.

Costs for the following items are allowable under the SUBG:

Staff meetings and conferences:

a. Costs of meetings and conferences, the primary purpose of which is the dissemination of technical information, are allowable. This includes costs of meals, lodging, and transportation.

b. For conferences offered by providers, allowable costs include rental of facilities, speakers' fees, meals and non-cash incentives and other incidental items. The total cost of food and non-cash incentives offered to meeting/conference attendees should not exceed $30 per person per fiscal year.

c. Advertising expenses, Code of Federal Regulations (CFR), 45 CFR 75.421(b)(4) are allowable for "program outreach and other specific purposes necessary to meet the requirements of the Federal award." Usually, advertising is related to the primary prevention strategy, Information Dissemination, but in some cases, may be linked to the Environmental strategy; both of which are population-based strategies.

Costs for the following items are **not** allowable under the SUBG funding:

a. Fund raising and investment management costs. Costs of organized fund raising, including financial campaigns, solicitation of gifts and bequests, and similar expenses incurred to raise capital or obtain contributions are unallowable, regardless of the purpose of which the funds will be used. Agency Marketing or advertising activities are only allowed if it includes specific prevention programs, and it must be approved by your assigned prevention specialist.

b. Lobbying activities. Costs associated with lobbying activities are unallowable. Providers are responsible for maintaining compliance with the Hatch Act and Los Angeles County lobbyist policies. For more information, please refer to § 75.215 Disclosure of lobbying activities and § 75.450 Lobbying of the SUBG Policy Manual.

Incentives

According to SAMHSA, "Incentives" refer to any monetary or service benefit that are provided to program participants to attract and retain them in the service or prevention program. Incentives have a $30 cap per person and must be necessary to meet program goals. The program must have a demonstrable purpose linking incentive costs to program. For example, if an agency can associate outreach i.e., tabling at events (under primary prevention strategy information dissemination), to improved access to prevention services, then those costs are allowable.

The SUBG Policy Manual 3.2, Section 3.8 - Incentives, states the following:
SUBG funds can be used for non-cash incentives to encourage attendance and attainment of treatment or prevention goals. Incentives must be an integral part of a program design. The value of incentives should be the minimum amount necessary to meet the program and evaluation goals of the grant, up to $30. Incentives are an allowable component of SUBG programming if they are intended to:

- Improve an individual's access to and retention in treatment that is deemed essential to meeting program goals as they relate to the target population;
- Improve access to and retention in prevention programs;
- Meet abstinence benchmarks; or
- Increase participation in required data collection follow-up.
- Examples of non-cash incentives:
    i. Gift cards
    ii. Bus passes
    iii. Food
    iv. Educational outreach items containing program identifiers
- Gift cards are not considered cash payments and remain allowable.

Non-cash incentives shall not exceed $30 per participant, per FY. This amount must include all types of non-cash incentives, such as gift cards, program identifiers, food purchases, and bus passes.

- Gift card incentives shall not exceed $15 per participant, per FY to allow for additional non-cash expenditures.

Additionally, SAMHSA provides specific guidance for non-cash incentives. Please refer to the following webpage here.

Non-Cash Incentives for Providers

DHCS guidance on the use of non-cash incentives, including the use of gift cards, can be found in the SUBG Policy Manual. SAMHSA guidance on use of SUBG funds for incentives has changed over the years, so please refer to the most recent version of the SUBG Policy Manual for accurate information.

- Non-cash incentives are an allowable use of SUBG funds. Non-cash incentives may be utilized to encourage attendance, retention, and attainment of SUD prevention programs and activities.
- Examples of non-cash incentives:
  - gift cards
  - bus passes
  - food
  - educational outreach items containing program identifiers
- Gift cards *are not* considered cash payments and remain allowable.

- **Non-cash incentives shall not exceed $30 per participant, per FY year. This amount must include all types of non-cash incentives, including gift cards, program identifiers, food purchases, and bus passes.**
  Gift Card incentives shall not exceed $15 per participant, per FY year to allow for additional non-cash expenditure.

Approval for Use of Incentives

To ensure that non-cash incentives are utilized properly according to State and Federal guidelines, SAPC-contracted SUPS providers shall:

1. Request approval of gift card incentives from SAPC 14 days in advance. Upon receipt, SAPC shall approve/deny the request within 14 business days.
2. Upon approval, Provider shall report non-cash incentives in the monthly billing invoice, under Section II. Services and Supplies. The invoice shall state the type(s) of non-cash incentive and provide a description of the total amount of non-cash incentive(s). Examples include:
   a. Gift cards: 30 participants x $10 gift cards = $300
   b. Bus passes: 10 participants x $25 (7)-day bus pass = $250
   c. Food: 30 participants x $10 healthy snacks = $300
   d. Program Identifiers: 10 participants x $10 backpacks = $100
3. A non-cash incentive journal shall be maintained for recording all disbursements. The journal shall contain, but not limited to the following headings: Date, Invoice Number, Non-Cash Incentive column, Expense Account Name, and Description.
4. Maintain adequate care to safeguard accounting records and supporting documentation.
5. All accounting records (e.g., journals, ledgers, etc.), financial records, and supporting documentation (e.g., invoices, receipts, checks, etc.) must be retained for a minimum of five years

after the termination of the Contractor's Agreement.

6. Invoices, receipts, canceled checks and other documentation, including electronic documentation clearly establishing the nature of the expenditure and its relevance to the County program being contracted for shall be required to support an outlay of funds. Unsupported disbursements will be disallowed upon audit. Provider will be required to repay County for all dollar-for-dollar disallowed costs. Photocopies (including scanned images) of invoices or receipts, any internally generated documents (e.g., vouchers, request for check forms, requisitions, canceled checks, etc.), and account statements do not constitute supporting documentation for purchases. To the extent the source for electronic documentation is an original hardcopy document (e.g., PDF scans of original vendor invoices) Provider shall retain the original source document for inspection by County. County at its sole discretion may accept photocopies of supporting documentation in preference to the original documents. Provider shall ensure that receipts for non-cash incentives are saved and stored for auditing purposes. Please maintain an internal log and receipts.
7. Provider shall be provided with the County of Los Angeles Department of Auditor-Controller Contract Accounting and Administration Handbook. The purpose of the handbook is to establish accounting, internal control, financial reporting, and contract administration standards for organizations (contractors) that contract with the County.
8. Providers are expected and required to report suspected fraud, waste, or misuse of public monies and misconduct to the Los Angeles County Fraud Hotline (Hotline). Providers are also expected and required to report suspected fraud committed by their employees and subcontractors when that fraud affects their contract with the County. Reportable conditions shall be reported to the Hotline upon their discovery by Provider. Failure to report the types of fraud/misconduct discussed above may be grounds for contract termination. The reporting party may remain anonymous. Reports can be made via telephone, mail or by internet to:

Online: www.lacountyfraud.org
Email: hotline@auditor.lacounty.gov
Toll Free Number: 1 (800) 544-6861
U.S. Mail: Los Angeles County Fraud Hotline
Office of County Investigations
500 W. Temple Street, Room 515
Los Angeles, CA 90012

Meals: Meals will be allowed in certain situations.

These include:

- Off-site meetings and conferences, the primary purpose of which is the dissemination of technical information (this would include training)
- Formal meetings where a working lunch is necessary (this does not include standard staff meetings)
- Off-site meetings in areas where eating establishments are too far away and it is not feasible to have participants leave the premises due to time constraints
- Nutritional snacks for youth engaged in before and after school programs.

The following are links to the Code of Federal Regulations cited in this letter:

- Title 2 CFR 225 (http://www.gpo.gov/fdsys/pkg/CFR-2006-title2-vol1/pdf/CFR-2006-title2-vol1-part225.pdf)
- Title 45 CFR 96 (http://www.gpo.gov/fdsys/pkg/CFR-1996-title45-vol1/pdf/CFR-1996-title45-vol1-part96-subpartL.pdf)

Appendices

Attachment A

LOS ANGELES COUNTY - HEALTH AGENCY DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
POLICIES AND PROCEDURES

POLICY AND PROCEDURE NO: 4023

SUBJECT: Policy and Procedure for Primary Prevention Services
PURPOSE: To establish a uniform policy and procedure for ensuring primary prevention programs are directed at individuals who have not been determined to require treatment for a Substance Use Disorder (SUD).

POLICY STATEMENT

It is the policy of the Los Angeles County, Department of Public Health (DPH), Substance Abuse Prevention and Control (SAPC) subject to an agreement with the State of California Department of Health Care Services (DHCS) and in accordance with 45 CFR § 96.125 Primary prevention, shall include a clause for purposes of 45 CFR § 96.124, each State shall develop and implement a comprehensive prevention program which includes a broad array of prevention strategies directed at individuals not identified to be in need of treatment. The comprehensive primary prevention program shall include activities and services provided in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk for substance abuse.

Title 42, U.S.C. Section 300x-22(a) Primary prevention requires the State to spend a minimum of 20 percent of the total Substance Use Prevention and Treatment Block Grant (SUBG) Award to California on primary prevention services and is defined as strategies, programs and services directed at individuals who have not been determined to require treatment for a substance use disorder. In accordance with 45 CFR §96.125, prevention providers must ensure that primary prevention programs and services are aimed at informing and educating individuals on the risk associated with substance use and providing activities to reduce the risk of such use.

Furthermore, for SUBG Primary Prevention Set-Aside, counties must have an active prevention plan that adheres to the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework. Priority areas are identified in the plan and strategies are selected, based on evidence where applicable, that will best address the priority areas and populations being served. Strategies may consist of both individual- and population-based services using one or more of the six prevention strategies identified by the Federal SAMHSA Center for Substance Abuse Prevention (CSAP).

The strategies are Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-Based Process, and Environmental.

To ensure adherence to the provisions of 45 CFR §96.125, following the guidelines found in the Strategic Prevention Framework (SPF), and other regulations as outlined above, providers will develop and implement policies that incorporate the following:

1. **Strategic Prevention Framework**

The SPF, the Institute of Medicine (IOM) population classification system, and SAMHSA's CSAP Strategies are the three (3) distinct frameworks that when combined contribute to the development of comprehensive, culturally competent, and effective prevention services. Use of these frameworks and the ECCO data reporting system are required by DHCS, State-County Contract Exhibit A, Section 1B Attachment 1, Part 3-E, ECCO reporting requirements, and DHCS Substance Use Disorder Information Notices.

The steps of the SPF include:

Step I: Assess Needs: What is the problem, and how can I learn more?
Step 2: Build Capacity: What do I have to work with?
Step 3: Plan: What should I do and how should I do it?
Step 4: Implement: How can I put my plan into action?
Step 5: Evaluate: Is my plan succeeding?

SPF guiding principles:
Cultural competence: The ability to interact effectively with members of diverse populations
Sustainability: The process of achieving and maintaining long-term results

2. **Institute of Medicine Prevention Population Classification**

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 Fifth Edition 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.

3. **§ 96.125 Primary Prevention**

   a. Each provider shall develop and implement a comprehensive prevention program which includes a broad array of prevention strategies directed at individuals not identified to be in need of treatment. The comprehensive primary prevention providers must include activities, and/or programs that have been adequately substantiated by evidence/research to impact community and/or individual level Alcohol and Other Drug (AOD) use and related outcomes. This is defined as:

      1) SAMHSA's Evidence-Based Practices Resource Center
      2) Communities That Care Prevention Strategies Guide
      3) RAND: Preventing Underage Drinking Technical Report
      4) Centers for Disease Control and Prevention Community Guide
      5) Where the program or curricula is not a recognized best practice/model program.

   b. Provided activities and services in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk for substance abuse.

   c. Prevention provider shall use a variety of strategies in implementing the prevention program, as appropriate for each target group.

4. **Primary prevention activities are classified using the following six (6) SAMHSA CSAP Strategies:**

   a. Information Dissemination Strategy
   This Strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco, drug use, abuse, addiction, and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-on-one communication from the source to the audience, with limited contact between the two. (CFR 96.125, p 514)

   b. Education Strategy
   This Strategy involves two-way communication and is distinguished from the Information Dissemination Strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities.
   Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis, and systemic judgement abilities. (CFR 96.125, p 514)

   c. Alternative Strategy
   This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use. The assumption is that constructive and healthy activities offset the attraction to or otherwise meet the needs usually filled by alcohol,

tobacco, and other drugs and would, therefore, minimize or remove the need to use these substances. (CFR 96.125, p 514 & 515)

d. Problem Identification and Referral Strategy
This strategy aims at identification of those individuals who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs and to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. (CFR 96.125, p 515)

e. Community-Based Process Strategy
This strategy aims to enhance the ability of the community to more effectively provide prevention services for alcohol, tobacco, and drug abuse disorders.
Activities in this strategy include organizing, planning, and enhancing the efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking. (CFR 96.125)

f. Environmental Strategy
This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco, and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to the service and action- oriented initiatives. (CFR 96.125, p 515)

5. **Practicing Effective Prevention**

According to SAMHSA's Center for the Application of Prevention Technologies, practicing effective prevention means:

a. Gathering and using data to guide all prevention decisions-from identifying which substance use problems to address in a community, to choosing the most appropriate ways to address these problems, to determining whether selected interventions and strategies are making progress in meeting prevention needs.

b. Working with diverse community partners to plan and deliver culturally appropriate, effective, and sustainable prevention practices that are a good fit for the populations being served.

c. Understanding and applying prevention research so that prevention efforts are informed by best practice and shown to influence risk and protective factors associated with prioritized substance misuse and related health problems at the community, State, territory, and tribal levels.

6. **To practice effective prevention, providers will:**

   a. Understand substance misuse prevention within the larger context of behavioral health;
   b. Apply SAMHSA's Strategic Prevention Framework (SPF) a five-step planning process framework designed to help states, tribes, jurisdictions, and communities more effectively understand and deliver effective prevention practices;
   c. Incorporate epidemiology into prevention planning to help focus and refine prevention activities based on patterns of substance misuse, and related consequences; and
   d. Apply prevention approaches that address those factors that contribute to or protect against identified problems, and that are a good match for the community.

SAPC shall ensure compliance with this policy by SUD providers through the following procedure.

PROCEDURE

Accountability	Step
Contract Services Division Contract Development and Processing	1. Will include a clause with SUD providers that primary prevention programs and services are aimed at informing and educating individuals on the risk associated with substance use and providing activities to reduce the risk of such use subject to an agreement with the State of California DHCS and in accordance with the 45 CFR §96.12, and all other applicable governmental regulations.
Contract Compliance and Monitoring	2. Will provide applicable training to providers, as needed.
Contract Compliance and Monitoring	3. Will require that prevention providers obtain additional Monitoring training specific to the practice of effective prevention and the utilization of SAMHSA's Strategic Prevention Framework as a part of their contractual requirement to provide 24 hours of staff training per fiscal year.

Contract Compliance and Monitoring	4. Will conduct annual, or whenever necessary, site reviews which include: • Review of work plan that includes: goals, objectives, related tasks and activities; • Review of ECCO Prevention; • Review Year-End Report; • Attendance verification of mandatory coalition and SAPC provider meetings; • Interviews with participants; and • Employees' signed acknowledgement of policy.
Contract Compliance and Monitoring	5. Will cite as a deficiency any provider who is found not to be in compliance with the primary prevention guidelines and standards within its SAPC contract.
Contract Compliance and Monitoring	6. Will submit an audit report to the agency, within 30 days of the exit interview, indicating any deficiencies that need to be corrected, and requesting that a corrective action plan be submitted to SAPC within 30 days of the date of the report.
Contract Compliance and Monitoring	7. Will submit a copy of the audit report to DHCS within two weeks of its completion, in accordance with SAPC Procedure Number 400 I.

NOTED AND APPROVED:

GZ

Gary Tsai, MD Interim Division Director
Substance Abuse Prevention and Control

10/16/20
Date

Approved: {October 2020}

Attachment B

FY2024-2025 PREVENTION PROVIDER NETWORK
SUBSTANCE USE PREVENTION SERVICES (SUPS) PROVIDERS

Agency Name/Program Name	SPA	Contract Type	Address
Asian American Drug Abuse Programs, Inc. (AADAP)	8	CCP	2900 Crenshaw Boulevard Los Angeles, CA 90016
Asian American Drug Abuse Programs, Inc. (AADAP)	8	PEP	1360 E. Anaheim St., Suite 205 Long Beach, CA 90813
Avalon Carver Community Center	6	PEP	4920 South Avalon Boulevard Los Angeles, CA 90011
Behavioral Health Services (BHS)	4	PEP	6838 Sunset Blvd. Hollywood, CA 90028
Behavioral Health Services (BHS)	8	PEP	15519 Crenshaw Blvd. Gardena, CA 90249
Cambodian Association of America (CAA)	8	PEP	2390 Pacific Avenue Long Beach, CA 90806
Change Lanes Youth Support Services	1	PEP	45118 13th West Lancaster, CA 93534
Child and Family Service Center	1	PEP	38345 30th St. East C – 1&2 Palmdale, CA 93550
Child and Family Service Center	2	PEP	21545 Centre Pointe Parkway Santa Clarita, CA 91350
Children's Hospital Los Angeles (CHLA)	4	PEP	5000 Sunset Boulevard, Suite 701 Los Angeles, CA 90027
Community Coalition for Substance Abuse & Treatment (CoCo)	6	CCP	8101 S. Vermont Avenue Los Angeles, CA 90044
Community Coalition for Substance Abuse & Treatment (CoCo)	6	PEP	8101 S. Vermont Avenue Los Angeles, CA 90044
CORE Centers	ALL	Special Project	1000 South Fremont Avenue, Bldg A-9 East, 3rd Fl, Alhambra, CA 91803
Day One	3	CCP	175 North Euclid Avenue Pasadena, CA 9110
Day One	3	PEP	175 North Euclid Avenue Pasadena, CA 91101
DPH Positive Youth Development Initiative	ALL	Special Project	600 S. Commonwealth Avenue, Ste. 800, Los Angeles, CA 90005

HealthRIGHT 360 - Prototypes	3	PEP	1890 N Garey Ave Suite C, Pomona, CA 91767
Helpline Youth Counseling (HYC)	7	CCP	14181 Telegraph Road Whittier, CA 90604
Helpline Youth Counseling (HYC)	7	PEP	12440 E. Firestone Blvd, Suite 316 Norwalk, CA 90650
Institute for Public Strategies (IPS)	4	PEP	5701 W. Slauson Ave., Suite 203 Culver City, CA 90230
Institute for Public Strategies (IPS)	5	PEP	5701 W. Slauson Ave., Suite 203 Culver City, CA 90230
Institute for Public Strategies (IPS)	5	CCP	5701 West Slauson Ave, Suite 204 Culver City, CA 90230
Korean American Family Services, Inc.	4	PEP	3727 W 6th Street, Suite 320 Los Angeles, CA 90020
Koreatown Youth & Community Center (KYCC)	4	CCP	680 South Wilton Place Los Angeles, CA 90005
Koreatown Youth & Community Center (KYCC)	4	PEP	3727 W 6th Street, Suite 300 Los Angeles, CA 90020
LA County Our SPOT Program	ALL	Special Project	1000 S. Fremont Ave. A-9 W, 3rd Fl. Alhambra, CA 91803
Los Angeles County Office of Education (LACOE)	7	PEP	9300 Imperial Hwy Downey, CA 90242
Los Angeles County Office of Education (LACOE) - Friday Night Live	7	Special Project	9300 Imperial Highway, ECW 251 Downey, CA 90242
My Brother's Keeper Program	ALL	Special Project	7400 E. Imperial Hwy. Downey CA 90242
NCADD-East San Gabriel & Pomona Valleys (ESGPV)	3	PEP	4626 North Grand Avenue Covina, CA 91724
NCADD-San Fernando Valley (SFV)	2	PEP	6166 Vesper Avenue Van Nuys, CA 91411
Pacific Clinics	3	PEP	9353 Valley Blvd. Rosemead, CA 91770
Pathways to Health Program	6	Special Project	1731 E. 120th Street Los Angeles, CA 90059
Parents Anonymous, Inc.	1	PEP	38627 32nd Street Palmdale, CA 93550

Parents Anonymous, Inc.	3	PEP	845 E Arrow Hwy Pomona, CA 91767
People Coordinated Services (PCS)	6	PEP	3021 South Vermont Avenue Los Angeles, CA 90007
Phoenix Houses of Los Angeles, Inc.	2	PEP	11600 Eldridge Avenue Lake View Terrace, CA 91342
Phoenix Houses of Los Angeles, Inc.	2	CCP	11600 Eldridge Avenue Lake View Terrace, CA 91342
Pueblo Y Salud	1	PEP	39130 3rd St. East Palmdale, CA 93550
Pueblo Y Salud	2	PEP	1024 North Maclay Avenue M13 San Fernando, CA 91340
Rescue Agency Public Benefit, LLC	3	Media	6430 Sunset Boulevard Suite 504
San Fernando Valley Partnership	ALL	Special Project	1131 Celis Street San Fernando, CA 91340
Social Model Recovery Systems (SMRS)	4	PEP	804 E. 6th Street Los Angeles, CA 90021
South Central Prevention Coalition (SCPC)	6	PEP	3701 Stocker, Suite 401 Los Angeles, CA 90008
Special Services for Groups	6	PEP	5849 Crocker St. Unit L Los Angeles, CA 90003
Student Well-Being Centers	ALL	Special Project	1000 South Fremont Avenue, Bldg A-9 East, 3rd Fl, Alhambra, CA 91803
Tarzana Treatment Centers (TTC)	1	PEP	44421 10th Street West Lancaster, CA 93534
Tarzana Treatment Centers (TTC)	2	PEP	18700 Oxnard Street Tarzana, 91356
Tarzana Treatment Centers (TTC)	1	CCP	44443 10th Street West Lancaster, CA 93534
The Wall Las Memorias Project (TWLMP)	4	PEP	5619 Monte Vista Street Los Angeles, CA 90042
The Wall Las Memorias Project (TWLMP)	7	PEP	800 W. 6th Street, Suite 750 Los Angeles, CA 90017
Watts Healthcare Corporation	6	PEP	1051 Rosecrans Avenue Compton, CA 90222

Attachment C

County of Los Angeles-Department of Public Health
Substance Abuse Prevention and Control
Community and Youth Engagement

* Program has an online version

RECOMMENDED EVIDENCE-BASED INTERVENTIONS FY 2024-2025		
Evidence-Based Intervention	**Description**	**Recommendation Rationale**
Active Parenting of Teens: Families in Action	The program is a universal school- and community-based intervention for middle school-aged youth (ages 12-14) designed to increase protective factors that prevent and reduce the use of alcohol, tobacco, and other drugs, including irresponsible sexual behavior and violence. The program is rated Promising by *Youth.gov*.	• Recruits both middle-school youth and their parents on outcome measures that focus on preventing youth AOD abuse; • The curriculum can be implemented in schools, after-school programs, and community centers. • Participants in the treatment group reported (1) greater family cohesion, (2) school attachment, (3) higher levels of self-esteem, and an (4) older age for alcohol consumption than the control group
Climate Schools: Alcohol and Cannabis Course	The Climate Schools: Alcohol and Cannabis Course is a school-based program for 13- and 14-year-olds that aims to prevent and reduce alcohol and cannabis use as well as related harms. Designed to be implemented within the school health curriculum, Climate Schools is based on a social influence approach to prevention and uses cartoon storylines to engage and maintain student interest and involvement.	• Highly accessible, easy to implement, interactive, fun, with impactful graphics. • Waiting on evaluation study/-ies to assess the program's effectiveness.

Communities Mobilizing for Change on Alcohol (CMCA)	An environmental, community-organizing program designed to reduce teens' (ages 13 to 20) access to alcohol by changing community policies and practices. CMCA seeks to limit youths' access to alcohol and to communicate a clear message to the community that underage drinking is inappropriate and unacceptable. It employs a range of social-organizing techniques to address legal, institutional, social, and health issues related to underage drinking. The goals of these organizing efforts are to eliminate illegal alcohol sales to minors, obstruct the provision of alcohol to youth, and ultimately reduce alcohol use by teens. The program involves community members in seeking and achieving changes in local public policies and the practices of community institutions that can affect youths' access to alcohol.	• The program helps change social norms and attitudes within communities. • Program reduced underage youths' access to alcohol by organizing community efforts to reduce sale to minors by alcohol retailers and other adults.
Creating Lasting Family Connections (CLFC)/Creating Lasting Connections (CLC)	CLFC is a structured curriculum for youth ages 9-17 and their parents, guardians, and other family members, to improve their ability to provide a nurturing environment for each other.	• The group appreciated the parent and youth component of the prevention program. • Available research on the program's effectiveness merits its recommendation to providers.
Guiding Good Choices (GGC)	Guiding Good Choices (GGC) provides parents of children in grades 4 through 8 (9 to 14 years old) with the knowledge and skills needed to guide their children through early adolescence. 5 session curricula, setting clear family expectations regarding drugs, avoiding trouble and managing conflict. GGC is available in Spanish.	• It is found "promising" in Blueprints; and "Effective" Youth.gov. • It helps parents understand the harms of substance use to communicate prevention messages with their children to prevent substance use initiation.
I Can Problem Solve (ICPS)	I Can Problem Solve (ICPS) is a universal school-based program that focuses on enhancing the interpersonal cognitive	• The school-based program aims to promote protective factors

	processes and problem-solving skills of children ages 4-12. ICPS is based on the idea that there is a set of these skills that shape how children (as well as adults) behave in interpersonal situations, influencing how they conceptualize their conflicts with others, whether they can think of a variety of solutions to these problems, and whether they can predict the consequences of their own actions.	among children/youth, ages 4-12. • Protective factors reported by several studies included the outcome measures: school bonding; self-regulation; reducing aggressive behaviors and promoting prosocial behaviors (e.g., sharing and taking turns). • Evaluation studies showed: program's impact on youth's behavior lasted at least one full year. • ICPS-trained children improved more than controls in self-regulation and school bonding as wells as perceptions of positive school climate and feelings of connectedness to school/teachers/peers.
Keep A Clear Mind (KACM)	Keep a Clear Mind (KACM) is a take-home drug education program for elementary school students in grades 4-6 (ages 9-11) and their parents. KACM is designed to help children develop specific skills to refuse and avoid use of "gateway" drugs.	• The nature of the program and the available evidence in its support are reasons to recommend.
Keepin' it REAL	Keepin' it REAL is a multicultural, school-based substance use prevention program for students 12-14 years old; 10-lesson curriculum taught by trained classroom teachers in 45-minute sessions over 10 weeks, with booster sessions delivered in the following school year. culturally grounded resiliency model to incorporate traditional ethnic values and practices that protect against substance use.	• Uses a 10-lesson curriculum taught by trained classroom teachers in 45-minute sessions over 10 weeks, with booster sessions delivered in the following school year. • Reduces rates of alcohol, tobacco, and cannabis use by up to 45%, leading to discontinuation of use. • Leads to more realistic perceptions

		of peer use, increases anti-substance use attitudes, increases efficacy in resisting offers of substances, improves relationship skills, self-awareness, and responsible decision-making.
LifeSkills Training (LST)*	LifeSkills Training (LST) addresses multiple risk and protective factors and teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist prodrug influences. LST is designed to provide information relevant to the important life transitions that adolescents and young teens face, using culturally sensitive and developmentally and age-appropriate language and content. LST is available in Spanish.	• LifeSkills Training (LST) is a flexible, interactive, and widely utilized program. • Numerous studies, extensive evaluation demonstrating effectiveness at reducing tobacco, alcohol, opioid, and illicit drug use by as much as 80%. • Multi-component program that has been demonstrated to be effective with a wide range of populations.
Media Ready	A media literacy education and substance use prevention program for 6th through 8th grade students. The goal of the program is to prevent or delay the onset of underage alcohol and tobacco use by increasing students' critical thinking skills about media messages, particularly those related to alcohol and tobacco products, and to encourage healthy beliefs and attitudes about abstaining from substance use.	• Workgroup recommended this program for inclusion in the program manual Appendix to help offset the abundance of positive online, media messages on drugs (e.g., cannabis vaping) and alcohol. • The program may be implemented during after-school programs, if not during school/class time.
Nurturing Parenting Programs	The Nurturing Parenting Programs are a family-centered trauma-informed initiative designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices.	• Great intervention potential, applicable to primary prevention; community- and school-based capacities; trauma-informed structure.
Positive Action	The program addresses substance use (i.e., alcohol and other drug prevention and treatment), violence-related behavior, disruptive behavior, and bullying, as well	• The prevention program is comprehensive in nature and is recommended by Blueprints

	as social–emotional learning, positive youth development, character, and academics.	("Model" rating) and youth.gov ("Effective" rating). • Evaluation studies showed it was effective in reducing youth's self-reported rates of lifetime substance use. • The program is valuable and effective tool for preventing lifetime substance use and violent behavior among youth in the intervention group.
Project Alert	Project ALERT is a school-based, substance use prevention program for middle or junior high school students. The program aims to prevent adolescent nonusers from experimenting with alcohol, tobacco, and cannabis and prevent adolescent users of these substances from becoming more regular users. Based on the social influence model of prevention. 11 lessons in the first year and 3 lessons in the second year.	• The team recommended this program for prevention providers given the evidence in support of its effectiveness.
Project Northland	Project Northland is a multilevel intervention involving students, peers, parents, and community in programs designed to delay the age at which adolescents begin drinking, reduce alcohol use among those already drinking, and limit the number of alcohol-related problems among young drinkers.	• It is adaptable to community settings as well as school settings and the group appreciated the nature of the program and its focus on alcohol prevention.
Say It Straight (SIS)	Say It Straight (SIS) is a communication training program designed to help students and adults develop empowering communication skills and behaviors and increase self-awareness, self-efficacy, and personal and social responsibility.	• The effectiveness of SIS has been tested using behavioral and self-reported measures with follow-up periods as long as 19 months after training. • After SIS, youth are 3.7 times less likely to have substance abuse related school suspensions and

		4.5 times less likely to have juvenile criminal police offenses.
Storytelling for Empowerment	School-based, bilingual (English and Spanish) intervention for teenagers at risk for substance abuse, HIV, and other problem behaviors due to living in impoverished communities with high availability of drugs and limited health care services.	• Adapted digitally, on tape, inexpensive, via a storyteller adapted to multiple ethnicities and languages-recommended especially during current crises.
Strengthening Families Program (SPF)*	Strengthening Families Program (SPF) is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3-16 years old. SFP comprises three life-skills courses delivered in 14 weekly, 2-hour sessions. The Parenting Skills sessions are designed to help parents learn to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting. The Children's Life Skills sessions are designed to help children learn effective communication, understand their feelings, improve social and problem-solving skills, resist peer pressure, understand the consequences of substance use, and comply with parental rules. SFP has been adapted for African American, Asian/Pacific Islander, Hispanic, and American Indian families.	• The original NIDA study (1983 to 1987) involved a true pre-test, post-test, and follow-up: SFP was found highly effective in decreasing anti-social behaviors, conduct disorders, and aggression which contribute to substance use, with Effect Sizes (ES) ranging from .85 to 1.11 range depending on outcomes measured.
Strengthening Families Program: For Parents and Youth 10-14	Strengthening Families Program: For Parents and Youth 10-14 is a family skills training intervention designed to enhance school success and reduce youth	• Evaluation demonstrated that both youth and parents who participated in the program

	substance use and aggression among 10- to 14-year-olds. It is theoretically based on several etiological and intervention models including the biopsychosocial vulnerability, resiliency, and family process models. The program includes seven 2-hour sessions and four optional booster sessions in which parents and youth meet separately for instruction during the first hour and together for family activities during the second hour. Supplemental teaching manual has been developed for use with special groups who may not relate to the African American, Hispanic, or White actors; parents who are not able to understand or read English).	showed significant positive changes. • Youth who participated in the study had less substance use, fewer conduct problems, and better resistance to peer pressure. • Results indicated that program parents were better able to show affection and support and set appropriate limits for their children.

RECOMMENDED EVIDENCE-BASED INTERVENTIONS FY 2024-2025 Special Population			
Evidence-Based Intervention	**Special Population**	**Description**	**Recommendation Rationale**
America on Track	Children of Justice-Involved Parent Population	America on Track offers a youth asset building program with conflict resolution training for vulnerable populations. Youth focused components include youth-to-youth mentoring, leadership training and development of youth advocates for drug-free communities, and a youth camp. The program also provides a parent component through parent education seminars. Other components include building and utilizing multi-strategy and multi-component coalition services and a prevention media campaign.	• Youth-to-youth mentoring. The program is for children of prisoners (special population program). • Evaluation studies supported the program's effectiveness in achieving a meaningful outcome. • The program has a well-respected reputation for achieving measurable and meaningful outcomes and involving youth in the process.
ATHENA (Athletes Targeting Healthy Exercise & Nutrition Alternatives)	High School Female Athletes	The ATHENA (Athletes Targeting Healthy Exercise & Nutrition Alternatives) program uses a school-based, team centered format that aims to reduce disordered eating habits and deter use of body-shaping substances	• An innovative and unique approach to reducing substance use.

		among middle and high school female athletes.	
ATLAS (Athletes Training and Learning to Avoid Steroids)	High School Male Athletes	A school-based, universal drug prevention program designed for male, high-school athletes to deter drug use, including anabolic steroids, and to promote healthy nutrition and exercise as alternatives to drug use. Program rated *promising* by *Blueprints.org* and *Youth.gov*.	• Effective in educating high-school male athletes on alcohol and drug refusal skills and the harmful effects of anabolic steroids. • The program is also feasible to implement, assuming buy-in from the school districts and schools.
Building Skills	Justice-Involved Youth	Building Skills Grade 5 is a universal, 12-lesson, classroom-based social development curriculum created for high-risk students in the fifth grade. The goal of the program is to decrease the likelihood of alcohol and other drug use and delinquent behaviors by enhancing social and personal skills. The program is grounded in social theory and uses a competence-enhancement approach, which is a substance-use prevention approach addressing key risk and protective factors. According to this approach, drug use is conceptualized as a socially learned and functional behavior that results from an interplay	• Special populations: justice-involved youth.

		between social and personal factors. A distinctive feature of the competence-enhancement approach is an emphasis on teaching generic self-management and social skills.	
Familias Unidas Preventive Intervention	Latinx Families and Teens	The Familias Unidas Preventive Intervention is a family-based program for Hispanic families with children ages 12-17. It is designed to prevent conduct disorders; use of illicit drugs, alcohol, and cigarettes; and risky sexual behaviors by improving family functioning.	• Several studies reported showed reduction in substance use among prevention service-receiving youth while youth in the control groups showed an increase in substance use.
Prevention through Alternative Learning Styles (PALS)	Middle School Students and Teachers	PALS: Prevention through Alternative Learning Styles is an alcohol, tobacco, and other drugs (ATOD) prevention program primarily for middle school students. Goals of PALS include (1) lowering students' intentions to use ATOD, (2) increasing students' use of refusal skills, and (3) enhancing students' knowledge of the effects of ATOD, peer pressure and healthy decision making, and different learning styles.	• PALS students had statistically significantly lower intentions to use alcohol and tobacco; These lower intentions to use held at one-year and two-year post-intervention follow-ups.

Project MAGIC (Making A Group and Individual Commitment)	Justice-Involved Youth	MAGIC is an innovative, collaborative prevention program designed to help juvenile offenders leave the criminal justice system and become productive members of society.	• MAGIC is designed for, and has proven successful with, teens just entering the juvenile justice system or juveniles with low incident rates.
Project Towards No Drug Abuse	Continuation or Alternative High School Students	Project Towards No Drug Abuse curriculum is designed to help students develop self-control and communication skills, acquire resources that help them resist drug use, improve decision-making strategies, and develop the motivation to not use drugs. It is packaged in 12 40-minute interactive sessions to be taught by teachers or health educators. The TND curriculum was developed for high-risk students in continuation or alternative high schools.	• Favorable program effect on 30-day substance use at the 1-year or longer follow-up. • Favorable effect on hard drug use at 2 year and 5 year follow up. • Sussman and colleagues (1998) Results indicated that, at 1 year after the intervention, participants receiving Project Towards No Drug Abuse (Project TND) reported significant reductions in hard drug use.

SAFEChildren	Inner City Kids	A family-focused preventive intervention designed to increase academic achievement and decrease risk for later drug abuse, aggression, school failure, and low social competence.	• The program promotes protective factors by enhancing parental involvement in their children's lives and improving SU prevention message communication. • The program also reduces harmful factors by reducing students' aggressive and hyperactivity behaviors.
Strong African American Families (SAAF)	African American teens and parents	SAAF is a family-based prevention program designed for low-income, rural African American preadolescents and their primary caregivers.	• Effective program on reducing substance use and improving parent teen relations. • Children in the treatment group had negative images and attitudes of drinkers, drinking, and early sexual activity, as well as more effective resistance skills

			and future-oriented goals when compared to those in the control group. • Children in the treatment group were also less likely to use alcohol. The treatment group did experience a growth in alcohol use, but its increase was 17.4 percent smaller than the increase in the control group.

Attachment D

PREVENTION INSTITUTE: SPECTRUM OF PREVENTION[17]

"The Spectrum of Prevention is a systematic tool that promotes a multifaceted range of activities for effective prevention. Originally developed by Larry Cohen while working as Director of Prevention Programs at the Contra Costa County Health Department, the Spectrum is based on the work of Marshall Swift in treating developmental disabilities. It has been used nationally in prevention initiatives targeting traffic safety, violence prevention, injury prevention, nutrition, and fitness.

The Spectrum identifies multiple levels of intervention and helps people move beyond the perception that prevention is merely education. The Spectrum is a framework for a more comprehensive understanding of prevention that includes six levels for strategy development.

These levels, delineated in the table below, are complementary and when used together produce a synergy that results in greater effectiveness than would be possible by implementing any single activity or linear initiative. At each level, the most important activities related to prevention objectives should be identified. As these activities are identified they will lead to interrelated actions at other levels of the Spectrum."

LEVEL OF SPECTRUM	DEFINITION OF LEVEL
6. Influencing Policy and Legislation	Developing strategies to change laws and policies to influence outcomes
5. Changing Organizational Practices	Adopting regulations and shaping norms to improve health and safety
4. Fostering Coalitions and Networks	Convening groups and individuals for broader goals and greater impact
3. Educating Providers	Informing providers who will transmit skills and knowledge to others
2. Promoting Community Education	Reaching groups of people with information and resources to promote health and safety
1. Strengthening Individual Knowledge and Skills	Enhancing an individual's capability of preventing injury or illness and promoting safety

[17] Prevention Institute: Spectrum of Prevention available at:
https://www.preventioninstitute.org/sites/default/files/uploads/1PGR%20Spectrum%20of%20Prevention.pdf

Attachment E

Strategic Prevention Framework (SPF)

PREVENTION FRAMEWORK

To achieve comprehensive, effective, and culturally competent alcohol and other drug (AOD) prevention services, SAPC combines the following three frameworks:

1) Federal Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Prevention Framework (SPF) planning process.
2) SAMHSA's Center for Substance Abuse Prevention (CSAP) prevention strategies.
3) Institute of Medicine (IOM) classification.

The use of these frameworks is required by the California Department of Health Care Services (DHCS) and is part of the mandatory reporting requirements for the web-based ECCO data reporting system.

SAMHSA'S Strategic Prevention Framework (SPF)[18]

The SPF is a five-step planning process that systematically guides the development of prevention services. Central to all steps is ensuring cultural competency and sustainability. By addressing each of these steps, prevention services should: address the needs of the target communities and populations; enhance protective factors and reduce risk factors in communities; build community capacity and collaboration; develop goals and measurable objectives; and emphasize evaluation to ensure the prevention program achieves the intended outcomes. The following is a brief description of each SPF step:

- Step 1: Assess Needs: What is the problem, and how can I learn more?
- Step 2: Build Capacity: What do I have to work with?
- Step 3: Plan: What should I do and how should I do it?
- Step 4: Implement: How can I put my plan into action?
- Step 5: Evaluate: Is my plan succeeding?

[18] Strategic Prevention Framework. (n.d.). Retrieved from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf