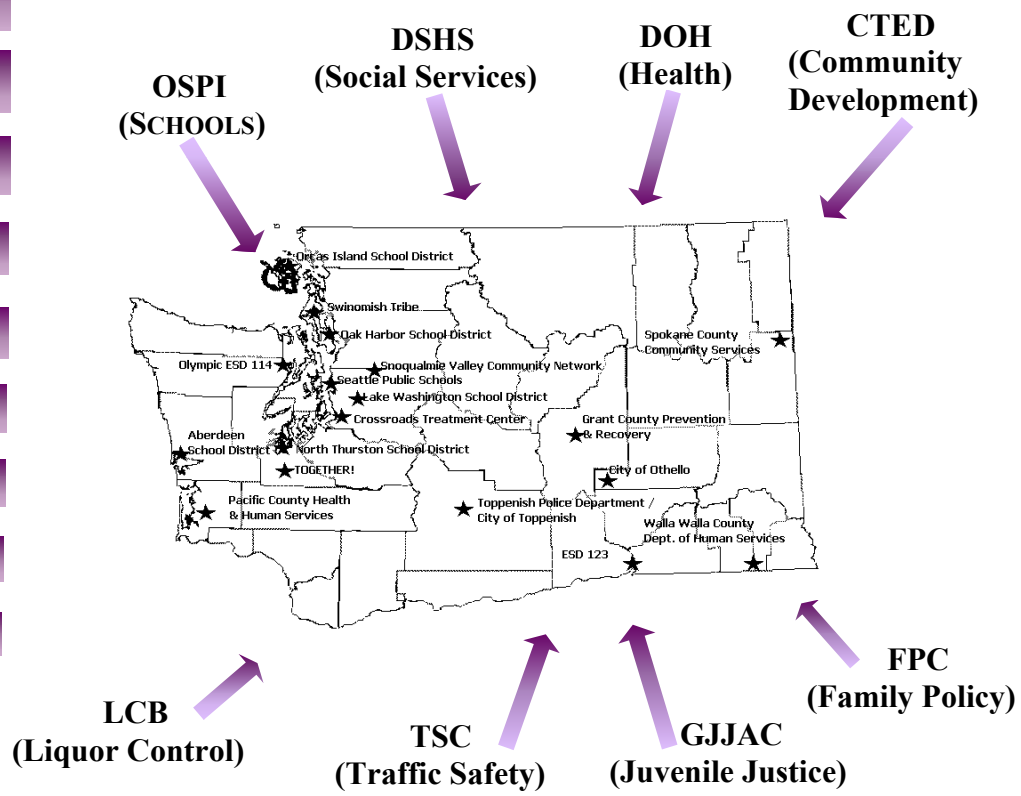
Implementing Science Based Prevention:

The Experiences of Eighteen Communities and Progress Towards Inter-Agency Coordination to Reduce Alcohol and Substance Abuse Among Adolescents



Evaluation Report Appendices for the State Incentive Grant (July 1998 - July 2002)

March 2003

Washington State Department of Social and Health Services
Management Services Administration
Research and Data Analysis Division

CONTENTS

APPENDIX A
EVALUATION METHODS

This appendix describes the research methods used for the evaluation of Washington State Incentive Grant prevention system changes. The appendix begins with an introduction about who conducted the evaluation, why it was done, the relationship of this report to other evaluation reports, and the general evaluation approach. Following the introduction are descriptions of data collection and analysis methods for state and community levels in separate sections.

INTRODUCTION

What agency or organization conducted the evaluation and when was it held? The Division of Alcohol and Substance Abuse (DASA), part of Washington State's Department of Social and Health Services, contracted with the department's Research and Data Analysis Division (RDA) to conduct the evaluation. RDA subsequently contracted with the Western Branch of the Washington Institute for Mental Illness Research and Training, part of the University of Washington's Department of Psychiatry and Behavioral Sciences. The evaluation manager is part of the fulltime, permanent staff of RDA. The staff consisted of an evaluation director and three fulltime and one quarter-time community level evaluators. The evaluation began in February 1999, seven months after the grant was awarded, and ended in June 2002. Data collection ended in March 2002.

Why conduct an evaluation of SIG's prevention system change efforts? The evaluation is intended to provide periodic feedback during the grant's duration to state and community level participants. Reports were provided to the Governor's Substance Abuse Prevention Advisory Committee, the Collaborative Needs Assessment Workgroup, and the community grantees. This type of evaluation is known as a formative evaluation, designed to provide feedback along the way about progress toward objectives and goals and about responses to changes made in the state's system of substance abuse prevention. This is opposed to a purely summative evaluation, in which evaluators provide only a final report, after all grant activities have ended.

How does this report fit in to the overall SIG evaluation? There have been three previous state level evaluation reports:

1. State-Level Agencies Involved in Substance Abuse Prevention: Washington State Status as of September, 1999
2. Washington State Incentive Grant State and Community-Level Evaluation Report Autumn 2000
3. Evaluation Report on the Spring 2001 Collaborative Assessment Process

In addition, two written reports were provided to each community grantee. Reports are available on the Research and Data Analysis website by topic (State Incentive Grant): http://www1.dshs.wa.gov/rda/

This report's primary audience is the federal funding agency for the State Incentive Grant, the Center for Substance Abuse Prevention (CSAP). It is also intended for the federal evaluators, Westat, state project administration staff, participating state agencies and community grantees, and others interested in Washington's prevention system. The topics

addressed in this report were established by the former federal evaluators, COSMOS Corporation.

STATE LEVEL DATA SOURCES

How was data collected? This evaluation uses a qualitative research approach, which means that words are the primary data units, rather than exclusively numbers. Data collection methods reflect the type of data collected. Evaluators asked questions of participants during semi-structured interviews, observed interactions and decisions during advisory committee and workgroup meetings, and read documents and websites. Initial surveys designed by CSAP were administered. For the collaborative needs assessment evaluation, focus groups and surveys were conducted. Details of these information sources are below.

All agencies and offices represented on the Governor's Substance Abuse Prevention Advisory Committee were contacted for interviews following a letter of introduction about the evaluation process from Mary Ann LaFazia, SIG Project Director. The Washington State Liquor Control Board, the Family Policy Council, and the Association of County Human Services were included in the interviews even though they are not members of the Advisory Council. The decision to include agencies not represented on the Advisory Committee followed from their mention by initial interviewees as essential to a complete picture of substance abuse prevention activities in Washington State.

Semi-Structured Interviews: Audio taped interviews were conducted with agency representatives from a total of eleven state agencies, offices, or organizations involved in substance abuse prevention:

1. Alcohol Awareness Program and Reducing UnderAge Drinking Program, Liquor Control Board
2. Community Mobilization Against Substance Abuse Program, Office of Community Development, Department of Community, Trade and Economic Development
3. Division of Alcohol and Substance Abuse, Department of Social and Health Services
4. Family Policy Council
5. Governor Gary Locke's Office
6. Governor's Juvenile Justice Advisory Committee, Department of Social and Health Services
7. Juvenile Rehabilitation Administration, Department of Social and Health Services
8. Lt. Governor Brad Owen's Office
9. Office of the Superintendent of Public Instruction
10. Tobacco Control Program, Department of Health
11. Washington State Traffic Safety Commission

Interviews were also conducted with representatives of the Western Center for the Application of Prevention Technology (WestCAPT) who worked closely with SIG state and community level workgroups, in addition to providing key assistance to grantees during program selection.

Interviewees were informed at the beginning of each interview that the audiotapes were confidential, were for ensuring accuracy, and would be erased as soon as notes were taken from them. They could refuse to be taped and could ask to have the tape recorder shut off at any point during the interview. Questions were based on an interview guide, as well as topics that arose during the interviews. The interview guide used in interviews during January 2002 is included here. Earlier interview guides can be found in previous reports. Data collected from the interviews included the audiotaped interview, agency documents provided by respondents, and handwritten notes taken during and after the interview. Following the interviews, audiotapes were reviewed and notes taken on selected topics discussed therein. Interview summaries were then created, one per agency, which included responses from all interviews at that agency.

Interview Guide
State Level 2002
By Christine Roberts, Ph.D., SIG Evaluation Director
360 902-0249 or 360 561-1479 (cell)

1. *Resource management*
    a. *Describe your agency's coordination of prevention funding or resources with another agency, including the amount. Has SIG had an influence on the amount or type of coordination? What else has influenced this?*
    b. *Describe how your agency has leveraged prevention funds or other resources to gain further funding (include the amount) or to increase non-monetary resources. These can be instances of your agency working alone or with another agency. Has SIG influenced the amount or type of leveraging? Have there been other influences? If so, tell me about them.*
    c. *List how your agency has redirected substance abuse prevention funds to work toward selected benchmarks or toward SIG goals, such as promoting science-based programs or developing a prevention database. Include the amounts of funds that have been redirected. Has SIG influenced this redirecting of funds? What else has done so?*
2. *Planning (Benchmarks)*
    a. *Which benchmarks did your agency support?*
    b. *Have the benchmarks been used for state level planning within your agency? If so, how and by whom? If not, are there plans to do so?*
    c. *How will your agency collect and analyze data to measure progress toward the benchmarks?*
3. *Science-based programs*

a. *What are the requirements of your state agency around funding science-based prevention programs?*

   i. *Do you have a minimum percentage of programs that must be science-based?*

   ii. *Is this minimum percentage statewide or is it per county or contractor/provider?*

   iii. *May I have a copy of the policy or contract that addresses the minimum percentage of programs that must be science-based?*

   iv. *Is the minimum percentage requirement a result of SIG or some other influence?*

b. *What was the number of science-based programs funded by your agency at the outset of SIG in July 1998? What is the number now? Is this change a result of SIG?*

c. *What was the amount of funds that your agency allocated to science-based programs versus the total amount available for prevention in 1998? In 2001? Is this change a result of SIG?*

d. *How does your agency allocate substance abuse prevention funds for science-based programs and what are the sources of those funds? Is this allocation policy and practice a result of SIG?*

4. *Constituent level impacts of the above changes*

   a. *Provide examples, if any, of coordination, leveraging, or redirecting of funds or other resources among state agencies at the local constituent level that have resulted from SIG. Are there any examples that have not resulted from SIG? If so, what was the motivation for them?*

   b. *What is the connection between the benchmarks your agency selected and local level planning for your agency?*

   c. *How have your agency's local constituents responded to the notion of using science-based programs?*

Document review: Interviewees provided written and, on occasion, videotaped documentary material describing his or her agency's prevention activities. Information regarding agency prevention mission, function, strategies, and accomplishments was gleaned from some agencies' websites. Accuracy was checked by inclusion of this information in the summary reviewed by each interview respondent.

Meeting Observations: During meetings of committees and workgroups, evaluation staff took notes on group interactions and decisions for later analysis. Evaluation staff attended the following SIG committee and workgroup meetings: Governor's Substance Abuse Prevention Advisory Committee; State Level System Changes Workgroup; Leveraging Workgroup; Benchmarks Workgroup; Collaborative Needs Assessment Workgroup; Data Collection and Management Workgroup, and the Community Level System Changes

Workgroup. Joint meetings of the Governor's Substance Abuse Prevention Advisory Committee, the Governor's Council on Substance Abuse, and the Citizen's Action Council (an advisory body to the Division of Alcohol and Substance Abuse) were attended. Information on statewide evaluation trends was gathered by joining meetings of the Association for County Human Services (ACHS) Evaluation Workgroup. Several meetings of the Joint School Survey Committee were observed when survey administration schedule changes were under consideration.

STATE LEVEL DATA ANALYSIS

The first step in the analysis was that, during and after interviews, document review, and meeting observations, data collected were weighed in light of previous information. Questions and topics were modified as indicated by the new information. Data verification occurred through cross checking information with that from other sources. For example, a mission statement in a report was reviewed with an interviewee, who responded that the mission statement had since been revised and supplied an updated version.

CSAP and COSMOS Corporation created broad data categories of strategic planning, resource management, and science-based program management around which initial interview questions and inquiry topics were framed. Specific data categories within those broader categories were created, including state level objectives, depending on the frequency of topic occurrence, the unique nature of a topic, or the evaluator's sense that a topic might be relevant to the study. Data were gathered during this evaluation with the intent of answering specific questions.

1. At the state level, the focus was system changes for state-level agencies in resource management, strategic planning, and science-based program management.
2. At the community level, the focus was system changes in resource management and science-based program selection, implementation, and monitoring.

Here is a description of the general steps involved in the data analysis:

1. Enter notes or survey responses in an Excel spreadsheet, creating a separate spreadsheet for each general source of information, e.g., collaborative assessment reports review, focus groups, survey responses.
2. Code each paragraph or sentence with one or more key words. In this case, a general list of key words was already available from the topics of interest to CSAP. Additional key words are generated by the evaluator's assessment of topic importance, whether due to frequency or content.
3. Sort alphabetically by key word.
4. Review alphabetical key word list for unanticipated topics and to reduce duplication or create additional key words for those that are too global.
5. Revise coding as necessary and re-sort.
6. Review revised alphabetical key word list.
7. Group key words into main report outline categories.

8. Within each report outline category, re-arrange key words, sorted alphabetically, into sub-categories in the order they will be addressed in the report.
9. Re-sort the material, originally sorted alphabetically by key word, into main report categories, using guide created in step 7. Create separate Excel spreadsheets for each main report category.
10. Within report category spreadsheets, re-sort the material, using the guide of main report outline categories created in step 8.
11. Review the material, now separated by report outline category, for content.
12. Write initial impressions for each report outline category of what was learned.
13. Seek further information from additional sources, as needed.
14. Re-write, incorporating additional material.
15. Combine sub-categories into main report. Review and revise as necessary.

COMMUNITY LEVEL DATA SOURCES

The primary data sources for the community level findings were the community level evaluation reports by the evaluation staff, including the evaluation director. One report per year for the first two years of grantee funding was written for each of the eighteen community grantees. Years covered July to June of 1999-2000 and 2000-2001.

Data collection methods for community level reports included semi-structured interviews, document review, and meeting and program observations. Descriptive quantitative information was included to describe community contexts. Documents reviewed included SIG administrative reports, community based prevention action plan implementation matrices, program brochures, memos, letters, newspaper articles, and organization reports.

Evaluators visited community grantees on site at least once yearly during the two years. While on location, various people were contacted for interviews, including lead agency staff, program providers, city and school officials, community coalition members, social service providers, law enforcement offices and school resource officers, Tribal police and elders, staff from other grants and from non-SIG funded prevention programs. Follow up phone calls and e-mails allowed contact to be maintained between visits. Some of the evaluators attended community coalition meetings or observed prevention programs in progress. Evaluators also attended the annual and semi-annual meetings of SIG community grantees in Yakima, SeaTac, and Olympia, during which grantees presented information about their projects to the Governor's Substance Abuse Prevention Advisory Committee.

Data sources for program level outcomes included Everest pre-test and post-test scores and program implementation fidelity surveys. These sources are explained in the report text. Program implementation fidelity surveys, the data dictionary for the survey, survey purposes, and decision making rules are provided in Appendix C.

The evaluators and their assigned communities are listed in the table below. Evaluation director, Christine Roberts, Ph.D., researched and wrote reports on three community grantees: Snoqualmie Valley Community Network in King County, Toppenish Police

Department in Yakima County, and TOGETHER!/ROOF in Thurston County. Local evaluator, Linda Weaver, M.A., assisted with some of the data collection for TOGETHER!/ROOF.

Table 1A. Local Evaluators and Assigned Grantees

Local Evaluator	Assigned Grantees	County or Tribe
Raymond Mitchell, MA, Ed.	Swinomish Tribal Community	Swinomish Tribal Community
Kojay D. Pan, MPA	ESD 114	Jefferson County
	Seattle Public Schools	King County
	Lake Washington School District	King County
	Orcas Island	San Juan County
	Oak Harbor	Island County
Anne D. Strode, MSW	Spokane	Spokane County
	Walla Walla	Walla Walla County
	ESD 123	Benton County
	Othello	Adams County
	Grant County	Grant County
Linda Weaver, MA	Pacific County	Pacific County
	Aberdeen School District	Grays Harbor County
	Crossroads Treatment Center	Pierce County
	North Thurston School District	Thurston County

COMMUNITY LEVEL DATA ANALYSIS

Data from the community grantee reports were organized into broad categories of resource management and science-based program selection, implementation, and monitoring. As in the state level data analysis, additional topics were noted depending on evaluator judgment regarding frequency and content. Within the broader category of "resource management," data were categorized by the five community level objectives created by the Governor's Substance Abuse Prevention Advisory Committee. Steps in data analysis followed those listed above in the state level description.

Social Development Research Group at the University of Washington, Seattle, was contracted to conduct the statistical analysis of Everest pre-test and post-test scores for a sub-set of programs. One program was selected from each of the eighteen SIG sites, ones

with higher rigor, for which fidelity of implementation information was available (based on the fidelity survey), and for which pre-test and post-test data had been entered into Everest.

Raw data, actual scored responses for each question in each scale, were imported from the SQL database in Everest. Data were 'cleaned,' with particular attention to checking whether respondents had answered a sufficient number of questions for each scale, both in the pre-test and in the post-test so as not to invalidate the summary scale scores. Each prevention program was often offered many times a year, to different persons, youth and/or their parents. Data from different occurrences of the same program in given sites were merged in order to achieve a large enough sample of respondents for statistical analysis. Respondents, identified only by their encrypted IDs, had to have both pre-test and post-test information.

Statistical tests of reliability were conducted to test the internal consistency of each scale used. In other words, scales used for pre-/post-tests were examined to determine if responses to each question within the scale were consistent with responses to other questions in the scale. Reliability coefficients, Cronbach's alpha, were calculated. If responses were consistent, coefficients would be high and scales were deemed reliable

Mean differences in pre-/post-test scores were calculated and statistical tests of significance were conducted for the merged data sets, for each program in each site where data from reliable scales were available for at least 15 respondents. In other words, changes from pre to post were examined for the likelihood of their occurring by chance alone instead of accurately reflecting changes among respondents characteristics. Tests of statistical significance (t tests) were run using SPSS, the Statistical Package for Social Science.

Decision making rules used for interpreting program implementation fidelity survey results are attached as part of the appendix on the fidelity survey, in Appendix C.

APPENDIX B

EXAMPLES OF SIG COMMUNITY GRANTEE EFFORTS AT RESOURCE COORDINATION, LEVERAGING AND REDIRECTING

The table below provides summaries of resource management examples from the eighteen community grantee process evaluation reports. Examples in the "Coordination examples" column often included redirecting resources, but they were not repeated in the "Redirecting examples" column.

SIG community grantee county or tribal affiliations	**Coordination examples**	**Leveraging examples**	**Redirecting examples**
Adams Co.	Enhanced coordination between 2 prevention organizations: Parents Against Illegal Drugs and Community Mobilization.	The Boys & Girls Club, opened with SIG assistance, developed partnerships with the local school district and community businesses and secured grants based on their program successes. Community Network helped raise funds for the Boys and Girls Club.	
Benton-Franklin Co.	SIG built on the roles of Finley school as a community center and Education Service District 111 as a resource infrastructure to provide prevention services.	SIG staff and Finley community members are working to gain support and funds to transform the former elementary school building into a community center. Hired a prevention specialist who began community outreach to parents and businesses.	Expanded provision of prevention services to include previously un-served area.

SIG community grantee county or tribal affiliations	Coordination examples	Leveraging examples	Redirecting examples
Grant Co.	In Soap Lake, one of four Grant County towns funded through SIG, police and local businesspeople began to work with schools to provide alternative activities and prevention information to students. Led county's pilot test of collaborative needs assessment. Involved skilled local volunteers. Law enforcement and local businesses became involved in prevention.	SIG and other funding sources were combined to open a youth outreach center in Soap Lake. Alternative high school graduations attributed to SIG-funded programs. SIG funding provided a motivation for schools to participate.	Quincy School District set aside time and resources to expand the after school program to three days and to use class time for Life Skills Trainings and Smart Moves. Expanded provision of prevention services to include previously un-served areas.
Grays Harbor Co.	Young law offenders who are detained by police are referred to the FAST program. If they do not choose to participate, their alternative is to be arrested. Previously uninvolved parents began attending school meetings.	Counselors and other school staff members who participate in the FAST program have the opportunity to see students interacting with their families. Parents from the science-based prevention program formed an independent parent support group.	

SIG community grantee county or tribal affiliations	Coordination examples	Leveraging examples	Redirecting examples
Island Co.	Located the prevention coordinator in the school building to act as a contact for prevention services; integrated schools with social service organizations. Decreased competition among programs for youth and funding through coordinated planning. Participated in pilot test of collaborative needs assessment with island-wide group of prevention partners.	Increased training and expertise in the risk & protective factor model through SIG helped spread the model to communities outside the SIG target area, contributing to the award of a federal grant to South Whidbey Island. Created prevention service providers support group. Developed alternative solution to high program staffing costs.	Hired an outside service provider to run the after school program when teachers proved to be too expensive. Added school district to prevention service umbrella.
Jefferson Co.	SIG helped fill gaps in prevention services in larger towns and introduce prevention service to smaller towns, creating a more complete and connected prevention system. Mapped school-based prevention resources. SIG emphasis on partnerships reinforced previously established coalition.		Expanded provision of prevention services to include previously un-served small towns.

SIG community grantee county or tribal affiliations	Coordination examples	Leveraging examples	Redirecting examples
King Co. – Lake Washington School District	Formed executive and working coalitions to handle different functions. Increased community and parental support for substance abuse prevention programs in the schools.	Institutionalized SIG prevention programs into the school district.	
King Co. – Seattle Public Schools	Introduced social service organization into schools. Formalized coalition with substance abuse prevention focus.	Used prevention infrastructure; avoided duplication of services and called on expertise of local prevention services organization, enabling access to schools. Performed community and school staff outreach to teach parents and school staff about the effectiveness of substance abuse prevention.	Institutionalized prevention programs into schools.
Pacific Co.	Led county's pilot test of collaborative needs assessment. Involved community members in needs and resource assessments. Countywide, coordinated prevention planning occurred. Increased parent involvement in schools.		Expanded prevention programs to previously un-served areas.

SIG community grantee county or tribal affiliations	Coordination examples	Leveraging examples	Redirecting examples
Pierce Co.	Strengthened existing and created new prevention partnerships, including public health and schools. First joint venture for prevention partners.	Situated program coordinators in the schools, which led other schools in the district to buy-in to the substance abuse prevention package developed under SIG. Success of SIG programs in target schools led to demands for expansion into other schools with alternative funding.	Alternative funding was used to expand SIG programs to additional schools.
San Juan Co.	Built on extant prevention partnerships to introduce science-based programming and promote risk and protective factor model. Opened the Funhouse, a youth center, funded by private donations and volunteer labor. Provided SIG funded programs to youth, as well as programs funded through alternative sources.	Applied for and received a federal OJJDP grant on the basis of the strength of prevention partnerships formed under SIG. The grant will be used to build existing coalitions and create non-traditional high school psychology class and an after school teen program.	

SIG community grantee county or tribal affiliations	Coordination examples	Leveraging examples	Redirecting examples
Swinomish Tribe	Enhanced relationship with schools; introduced risk and protective factor framework. Community wide cultural renewal. Elder and other adult volunteers helped youth identify with Tribal and inter-Tribal communities through Canoe Club activities, including canoe carving, paddling, lifestyle changes, and canoe song and dance revival.	Developed Native American Day, an annual Tribal and majority community celebration of Native culture.	Institutionalized the Canoe Journey by incorporating it into the previously established recreation and cultural renewal infrastructure.
Thurston Co. – North Thurston School District	Used creative involvement of partners in problem solving, planning, and leadership. Attracted new prevention partners, both organizations and individuals.	Research based substance abuse prevention services, included in student support services program were adopted by schools as essential funding priorities. Developed a menu of locally implemented and tested research-based programs, with a system for funding and information on costs and benefits of implementation. Expanded concept of supporting students at critical transitions to non-SIG-funded schools.	Prevention planning was linked to prioritized risk and protective factors for the first time.

SIG community grantee county or tribal affiliations	Coordination examples	Leveraging examples	Redirecting examples
Walla Walla Co.	Led county's pilot test of collaborative needs assessment. Reduced duplication of services by combining a new mentoring program with one previously established. Partnered with Community Network and Parks & Recreation to open successful teen center.	School counselor served as liaison between SIG and the school district. Mental Health Services provided funds to expand a locally developed program. Built on decade long history of partnerships among children's services providers.	Used feedback from prevention providers to modify prevention plan and services offered. Expanded provision of prevention services to include previously un-served area.
Yakima Co.	Located multiple social service organizations under one roof. Created win-win situation for prevention partners. Coalition served multiple purposes through sub-committees.	Created an alternative, alternative school. Opened social service and youth center. Enhanced city/school relations. Used the receipt of SIG funding as a prerequisite for a Weed and Seed Grant from the US Dept. of Justice.	

APPENDIX C

SURVEY PURPOSES, PROGRAM IMPLEMENTATION FIDELITY SURVEY, DATA DICTIONARY, AND FIDELITY RATING DECISION MAKING

PROGRAM IMPLEMENTATION SURVEY PURPOSES

SIG evaluators used the program implementation survey for the following reasons:

- The survey told SIG evaluators and the local SIG providers and staff what they tested with Everest: the program named in their matrix or some variation of that program.
- It gave local SIG providers and staff a comprehensive record of what was changed. When combined with Everest results, the survey can help determine two things:
    1. If Everest results were positive, should this program be used again as it was administered this time?
    2. If Everest results were mediocre or negative, should this program be modified, further modified, or abandoned for a different program?

Date _____ Site _____ Program Service _____

Rigor Level _____ Beginning Date of Program Service _____ Ending Date of Program Service _____

Name of person supplying information _____

Program Implementation Survey

The purpose of this survey is to determine what was measured by the pre-test/post-test associated with your program: was it the program as originally designed and tested, or was it some variation on that program? If program modifications were made, test results may differ from those that would be expected if the program were implemented as originally designed, with the intended target population, taught by a trained instructor. Records of program implementation practices, reviewed in conjunction with program effectiveness measures, can inform future prevention planning. If possible, this form should be completed by the person providing prevention program services.

1. Did this prevention program differ from the original design?

Program Characteristic	**Yes**	**No**	**Description of change**	**General reason for change (check one)**		**Notes on specific reason(s) for change**
				Necessity	**Program improvement**	
1) Number of sessions						
2) Length of sessions						
3) Content of sessions						
4) Order of sessions						
5) Use of materials or handouts						

Program Characteristic	Yes	No	Description of change	General reason for change		Notes on specific reason for change
				Necessity	Program improvement	
6) General location (e.g., at community center instead of school)						
7) Intended population (age, language, level of risk, maturity)						
8) Number of participants						
9) Instructor training						
10) Instructor/ student ratio						
11) Anything else?						

2. If this is a Best Practices or science-based program (rigor 5), did you receive guidance from either the program's designer or from WestCAPT in making changes? _____ Yes _____ No _____ Not applicable

   Is this still considered a best practice (in the opinion of the designer/WestCAPT) after you made these changes? _____ Yes _____ No

3. Instructor training and experience
   a. Did you receive training for this program? _____ Yes _____ No
   b. How many years of experience do you have providing substance abuse prevention services?
      ___<1 ___ 1-3 ___ 4 or more
   c. How many years of experience providing social services or teaching, outside of prevention services?
      ___<1 ___ 1-3 ___ 4 or more

4. What was your observation of participants' engagement with the program?
   Mostly engaged Neutral Less than fascinated

5. What was your response to the program?
   Enjoyable Neutral Tedious

6. Would you use this program again, given the opportunity?
   Probably Maybe Unlikely

7. What shaped your opinion about whether or not you would use this program again, given the opportunity? Please select all that apply.

	Pre-test/post-test results
	Participants' or your own reactions to the program
	Other measures (school grades, behavioral responses)
	Response from parents, school staff, other community members
	Discussion with other prevention professionals
	Anything else? Please list:

Please note: Development of this form grew out of the book, *How to Assess Program Implementation*, by Jean A. King, Lynn Lyons Morris, and Carol Taylor Fitz-Gibbon, published in 1978 by Sage, Newbury Park, California.

Created by the Washington State Incentive Grant Evaluation Team, September 2000: Christine Roberts, Ray Mitchell, Kojay Pan, Anne Strode, and Linda Weaver, University of Washington, Washington Institute of Mental Illness Research and Training/Western Branch. Developed under the guidance of the Department of Social and Health Services, Research and Data Analysis Division for the Department of Social and Health Services, Division of Alcohol and Substance Abuse.

Date _____ Site _____ Program Service _____

Rigor Level _____ Beginning Date of Program Service _____ Ending Date of Program Service _____

Name of person supplying information _____

Program Implementation Survey Data Dictionary

1. Did this prevention program differ from the original design?

Program Characteristic: *Prevention service aspects that affect fidelity, or the adherence of program presentation to the original program design.*	Yes: *a change was made to this program characteristic from the original design*	No: *no change was made to this program characteristic*	Description of change: *If a change was made, the specific change made is described here.*	General reason for change (check one)		Notes on specific reason(s) for change: *Whichever general reason motivated the change (necessity or program improvement) is described in detail.*
				Necessity: *This box is checked if the change was made because of external constraints.*	Program improvement: *This box is checked if the change was made because local providers felt that the original design could be improved by the changes made.*	
1) Number of sessions: *The sum of discrete meetings attended by program participants*						

2) Length of sessions: *Hours spent by program participants in each discrete meeting.*						
3) Content of sessions: *Topics presented to program participants.*						
4) Order of sessions: *Topical presentation sequence.*						
5) Use of materials or handouts: *Visual and physical teaching tools*						
6) General location (e.g., at community center instead of school): *Site of program meetings*						
7) Intended population (age, language, level of risk, maturity): *participant characteristics for which the program has been tested.*						

8) Number of participants: *size of participant audience per discrete meeting*						
9) Instructor training: *participation in formal instruction in this specific prevention program.*						
10) Instructor/ student ratio: *Number of prescribed participants per program provider*						
11) Anything else?: *Any other changes made to the original program design that may have affected program effectiveness.*						

2. If this is a Best Practices or science-based program (rigor 5), did you receive guidance from either the program's designer or from WestCAPT in making changes? _____ Yes _____ No _____ Not applicable
Is this still considered a best practice (in the opinion of the designer/WestCAPT) after you made these changes? _____ Yes _____ No

Science-based programs, also referred to as best practices, have been designated as such by the SIG funding agency, the Center for Substance Abuse Prevention (CSAP). They have been shown effective and replicable across venues and populations in published, refereed research journals or in a meta-analysis. Best practices are categorized by rigor, which is the extent to which the program has been shown, through scientifically defensible research methods, to be effective in different locales and with multiple populations. A rating of rigor 5 is the highest and the lowest rigor is 1.

Instructor training and experience

a. Did you receive training for this program? _____ Yes _____ No

This issue is of concern because people who are trained in specific programs are more likely to understand the rationale behind the program design and are better able to present the program as intended and to make informed choices when faced with situations that require change in the program.

b. How many years of experience do you have providing substance abuse prevention services?___<1 ___ 1-3 ___ 4 or more

People with experience providing prevention services may be more likely to modify prevention programs based on their experience. We don't know the effects of these modifications, when made by experienced versus inexperienced teachers, on program effectiveness. Experience teaching may provide an additional benefit in terms of teaching effectiveness.

c. How many years of experience providing social services or teaching, outside of prevention services? ___<1 ___ 1-3 ___ 4 or more

4. What was your observation of participants' engagement with the program?
   Mostly engaged Neutral Less than fascinated

5. What was your response to the program?
   Enjoyable Neutral Tedious

6. Would you use this program again, given the opportunity?
   Probably Maybe Unlikely

7. What shaped your opinion about whether or not you would use this program again, given the opportunity? Please select all that apply.

	Pre-test/post-test results
	Participants' or your own reactions to the program
	Other measures (school grades, behavioral responses)
	Response from parents, school staff, other community members
	Discussion with other prevention professionals
	Anything else? Please list:

Please note: Development of this form grew out of the book, *How to Assess Program Implementation*, by Jean A. King, Lynn Lyons Morris, and Carol Taylor Fitz-Gibbon, published in 1978 by Sage, Newbury Park, California.

Created by the Washington State Incentive Grant Evaluation Team, September 2000: Christine Roberts, Ray Mitchell, Kojay Pan, Anne Strode, and Linda Weaver, University of Washington, Washington Institute of Mental Illness Research and Training/Western Branch. Developed under the guidance of the Department of Social and Health Services, Research and Data Analysis Division for the Department of Social and Health Services, Division of Alcohol and Substance Abuse.

DECISION MAKING RULES FOR SIG FIDELITY SURVEY RESULTS

Question 1 on the program implementation fidelity survey contains a chart of eleven program design elements. The first five items refer to the program itself: the number, length, content, and order of sessions and the materials used within the sessions. The next five items are about the program setting, participants, and the instructor. The remaining item is an opportunity to list additional items that were a part of the program's original design that might've been changed.

In thinking about which program design elements and their likely impacts on Everest outcomes, it seemed that the first five elements were the most likely to have an impact.

Decisions about the fidelity of each program's implementation were reported using "High," "Some Changes," or "Low" as the program fidelity status.

"High" indicated that the program was implemented with no program design changes or only one minor change. In one case, there was a program with two design changes that was rated as high fidelity because the second item that was changed was listed in the "anything else" row and was not a central element of the program design.

"Some Changes" indicated that the program had one to three design changes – if only one change was made and the fidelity was rated "Some Changes", the change was major, such as session content. If three design changes were made and fidelity was rated as "Some Changes", they were minor changes to program design elements that did not seem as likely to affect program outcomes as others.

For example, the length of the sessions, the materials used, and the intended population were changed in Spokane's Nurturing Program. Having spoken with the program providers in person, the evaluators knew that the sessions were shortened only slightly; the material deleted was a video that the providers found contained inappropriate language, and the intended population was broadened to include slightly younger age children, as well as the intended age group. The program was not implemented exactly as designed, so it did not merit a high fidelity rating, but the program outcomes, as measured in Everest, were probably not likely to be greatly affected by these changes.

"Low" indicated that the program was implemented with three or more changes to program design elements that were likely to have an effect on program outcomes.

APPENDIX D
RELIABILITY OF SCALES

RELIABILITY OF SCALES[1]

SIG prevention providers used many different scales to measure program outcomes using pre-post test results entered into Everest. The choice of scales depended on the particular goals of the program. The sources of scales differed as well, even though an effort was made to choose ones found to be reliable in previous research efforts. The following is a list of instruments from which scales were taken and their acronyms.

Acronym	Name
CBQ	Child Behavior Questionnaire
COM	Communities that Care Survey (scales that measure community domain factors)
DAS	Drug Attitude Survey
FAM	Communities that Care Survey (scales that measure family domain factors)
FRS	Family Relations Survey
IND/PEER	Communities that Care Survey (scales that measure individual/peer domain factors)
IND	Communities that Care Survey (scales that measure individual domain factors)
LST	Life Skills Training Instrument
RHC	Raising Healthy Children, a Social Development Research Group program
SCH	Communities that Care Survey (scales that measure school domain factors)
SSDP	Seattle Social Development Project

Before program outcomes can be assessed using pre-post test results what needs to be answered is the question of whether the scales themselves are reliable. Statistical tests of reliability were conducted to test the internal consistency of scales: to test whether each item within the scale measured the concept in ways consistent with the other items in the scale.

Table D-1 lists the scales used by a subset of programs for which there were enough participants taking the pre-test or the post-test. The first column lists the various scales and their sources. The second column indicates how many items are included in the scale. The third and fourth columns indicate the number of people who answered questions on these scales either in the pre-test or the post-test. Finally, the last two columns indicate reliability coefficients for each scale either in the pre-test or post-test. Coefficients closer to 1.00 indicate higher reliability.

[1] Michael Arthur and Caryn Blitz of the Social Development Research Group conducted the tests of scale reliability and the subsequent statistical tests on program outcomes.

Table D-1: Pre-Test and Post-Test Scale Reliabilities

SCALE	# of Items	Valid N		Scale Reliabilities (Cronbach's alpha)	
		Pre-Test	Post-Test	Pre-test	Post-test
All Stars Attitude Survey	31	39	15	.73	.83
CBQ: Adolescent Appraisal of Dyad	16	18	19	.86	.83
CBQ: Parent Appraisal of Dyad	14	19	19	.88	.85
COM: Low Neighborhood Attachment	3	32	32	.77	.82
COM: Opportunities for Prosocial Involvement	6	111	111	.62	.71
COM: Perceived Availability of Drugs & Handguns	5	43	43	.78	.83
COM: Rewards for Prosocial Involvement	3	34	9	.63	.76
Comm. Norms: Permissive Attitudes Toward ATOD Use	8	16	12	.89	.86
Commitment to School	3	148	108	.86	.71
DAS: Perceived Costs of Marijuana Use	5	127	105	.81	.75
FAM-III: General Scale	29/50	20	16	.98	.93
FAM: Parental Attitudes Favorable Toward Drug Use	3	24	17	.49	.76
Family Connections: Family Relations II	11	16	12	.82	.72
Family Connections: Family Relations	9	12	9	.82	.84
FRS: Family Cohesion Questions	6	40	34	.82	.71
ICMS (Parent): Monitoring	6	9	5	.71	.31
ICMS (Youth): Monitoring	6	9	4	.62	.82
IND/PEER: Perceived Risks of Drug Use	4	151	113	.74	.79
IND: Belief in the Moral Order	4	701	585	.72	.71
IND: Early Initiation of Drug Use	4	153	114	.69	.75
IND: Favorable Attitudes Toward Drug Use	4	873	693	.87	.91
IND: Friends' Use of Drugs	4	767	631	.82	.84
IND: Perceived Risks of Drug Use	4	721	587	.56	.72
IND: Social Skills	4	703	581	.55	.60
LIFTS PP: Clear Expectations Scale	3	9	5	.78	.44
LST: Assertiveness/General Assertiveness Scale	9	964	845	.65	.77
LST: Questions from Drug Attitudes/Expectancies Section	2	101	96	.33	.71
LST: Questions from Drug Knowledge Section	3	103	100	-.38	.26
LST: Questions from Life Skills Assessment Section	7	103	95	.77	.73
LST: Questions from Normative Expectations Section	2	102	99	.85	.73
LST: Questions from Refusal Skills/Assertiveness Section	1	101	100	n/a	n/a
LST: Expectancies about Drug Use/Drug Attitudes	20	238	255	.95	.97
Nurturing Program: AAPI-2 Form A	40	82	70	.81	.83
Outcome Questionnaire	45	20	10	n/a	n/a

SCALE	# of Items	Valid N		Scale Reliabilities (Cronbach's alpha)	
		Pre-Test	Post-Test	Pre-test	Post-test
Positive School Behaviors Index	5	5	2	-.55	.56
Project Northland Survey	113	107	75	n/a	n/a
RHC Child Survey: Academic Self-Efficacy	3	5	2	.21	1.0
RHC Child Survey: Commitment to School	3	19	19	.78	.85
RHC Child Survey: Decision Making	3	120	70	.87	.83
SAI: Family Cohesiveness	9	9	5	.84	.69
SCH: Academic Failure	2	185	125	.55	.54
SCH: Low Commitment to School	9	173	151	.75	.71
SCH: School Opportunities for Prosocial Involvement	5	300	231	.68	.64
School Activities (Adapted): School Engagement	9	143	107	.54	.59
School Problem Behaviors: Part I	5	5	2	.85	---
School Problem Behaviors: Part II	5/4	5	2	.42	---
Sense of School as a Community	14	148	108	.81	.84
SSC (Elementary): Liking for School	7	23	20	.59	.77
SSDP: Acceptability of Substance Use	4	215	182	.91	.89
SSDP: General Peer Resistance Skills	8	126	71	.81	.82
SSDP: Opportunities for Conventional Classroom Involvement	5	89	74	.87	.90
SSDP: Perceived Risk Involved in Substance Use	6	130	107	.79	.78
Youth Outcome Questionnaire	62	14	9	n/a	n/a

Results suggest that the most of the scales administered in the SIG project reliably measured the selected risk and protective factors.

Almost all of the selected scales showed internal consistency reliability coefficients of .72 or higher, with a little less than half of the scales in the range of .80 or higher.

The few exceptions to this general finding are:

- LST: Questions from Drug Knowledge Section, $\alpha_{pre} = -.38$, $\alpha_{post} = .26$;
- FAM: Parental Attitudes Favorable Toward Drug Use, $\alpha_{pre} = .49$;
- LST: Questions from Drug Attitudes/Expectancies Section, $\alpha_{pre} = .33$.

APPENDIX E
PROGRAM OUTCOMES: STATISTICAL TESTS

Program Outcomes Statistical Tests

SIG Site	Program	Rigor	Provider	Scales	CSAP CMI	Domain	N	Mean Diff.	t	Sig.	Cronbach's Alpha	Fidelity 1999-2001	Fidelity 2001-2002
				IND: Belief in the Moral Order>PF	Yes		540	.06	3.08	.002	.71		
				IND: Favorable Attitudes Toward Drug Use>RF	Yes		557	- .02	- 1.54	.12	.91		
				IND: Friends Use of Drugs>RF	No		565	- .07	- 4.17	.000	.84		
King County-3			Snoqualmie	IND/PEER: Perceived Risks of Drug Use (Wrong)>USR	No		563	- .0007	- .04	.97	.79		
Friends of			Valley School	IND: Social Skills>PF	No		419	.06	2.38	.02	.61		
Youth	Life Skills	5	District	LST: General Assertiveness Scale>PRM>PF	Yes	I/P	565	- .20	- 11.20	.000	.77	High	High
				LST: Drug Att./Expect. Secn.>PRM>RF									
				LST: Selected Qs from Drug Knowledge Secn.>PRM>RF	No		94	- .07	- .72	.47	.71	Some	
Walla Walla-				LST: Selected Qs from Life Skills Assess. Secn.>PRM>RF	No		100	.09	2.45	.02	.26	Changes	
WW Cty. Dept.				LST: Selected Quest. from Norm Expect. Secn.>RF	No		95	.19	1.66	.10	.73		Not
of Human			College Place	LST: Selected Qs from Refusal Skills/Assert.	No		98	- .39	- 3.31	.001	.73	(1999-	Applica
Services	Life Skills	5	School District	Secn.>PRM>RF	No	I/P	98	- .18	- .92	.36	n/a	2000)	ble
Walla Walla-													
WW Cty. Dept.	Life Skills			LST: Instr. #28: Assert. Or LST: Gen. Assert. Scale>PF								High	Not
of Human	2000-		College Place	LST: Expect. about Drug Use or LST: Pt. IV Drug	Yes		74	- .11	- 1.65	.10	.77	(2000-	Applica
Services	2001	5	School District	Att.>PRM>RF	No	I/P	73	- .009	- .14	.89	.97	2001)	ble
Walla Walla-													
WW Cty. Dept.	Life Skills			LST: Instr. #28: Assert. Or LST: Gen. Assert. Scale>PF								Not	
of Human	2001-		College Place	LST: Expect. about Drug Use or LST: Pt. IV Drug	Yes		82	- .04	- .66	.51	.77	Applica	
Services	2002	5	School District	Att.>PRM>RF	No	I/P	82	- .09	- 2.13	.04	.97	ble	High
	Bridge												
	Project/			COM: Perceived Availability of Drugs and Handguns>RF	Yes		43	.06	1.34	.19	.83		Not
Thurston	Transition		North Thurston	IND: Friends' Use of Drugs>RF	No		43	.03	.43	.67	.84		Availabl
County-1	Program	5	School District	SSDP: Acceptability of Substance Use>PRM>RF	No	S,I/P	43	- .02	- .33	.74	.89	Low	e
	Smart		Othello/Boys &			C,							Some
Adams County	Kids	5	Girls Club	SSDP: Acceptability of Substance Use>PRM>RF	No	I/P	32	- .05	- 1.44	.16	.89	High	Changes
	Second												
	Step			Commitment to School>RF	No		24	- .49	- 3.54	.002	.71		Some
San Juan	4th		Orcas Island	SCH: Opportunities for Prosocial Involvement>PF	No		24	.34	2.09	.05	.64		Change
County	graders	3	School District	Sense of School as a Community>PF	No	S	24	.39	3.67	.001	.84	Low	s
	Second												
	Step			Commitment to School>RF	No		29	- .44	- 3.80	.001	.71		Some
San Juan	5th		Orcas Island	SCH: Opportunities for Prosocial Involvement>PF	No		29	.19	1.76	.09	.64		Change
County	graders	3	School District	Sense of School as a Community>PF	No	S	29	.28	3.64	.001	.84	Low	s

San Juan County	Second Step 6th graders	3	Orcas Island School District	Commitment to School>RF SCH: Opportunities for Prosocial Involvement>PF Sense of School as a Community>PF	No No No	S	35 35 35	- .45 .29 .37	- 4.65 2.07 3.96	.000 .05 .000	.71 .64 .84	Low	Some Changes
Island County	Project Alert	5	Oak Harbor School District	COM: Community Opportunities for Prosocial Involvement>PF IND: Early Initiation of Drug Use>RF IND: Favorable Attitudes Toward Drug Use>RF IND: Social Skills>PF School Activities (Adapted): School Engagement>PF SCH: Academic Failure>RF SCH: Opportunities for Prosocial Involvement>PF SCH: Low Commitment to School>RF(Old)	Yes No Yes No No Yes No Yes	I/P	68 112 106 115 100 111 120 120	- .11 - .09 - .10 .000 .02 - .001 .04 - .03	- 1.44 - 1.49 - 2.18 .02 1.46 - .03 .84 - .78	.15 .14 .03 .99 .15 .98 .40 .44	.71 .75 .91 .60 .59 .54 .64 .71	High	High
King County-2WAPIFASA	Project Alert	5	Seattle School District	DAS: Perceived Costs of Marijuana Use>PRM>RFRHC-Child Survey: Decision-Making>PRM>PFSSDP: Acceptability of Substance Use>PRM>RFSSDP: General Peer Resisitance Skills>PRM>PFSSDP: Perceived Risk Involved in Substance Use>PRM>RF	NoNoNo NoNo	S	6968 7170 72	- .06-.13 .04-.18 .11	- 1.12-1.55 .58- 2.13 2.13	.27.13.57.04.04	.75.83.89.82.78	Some Changes	Not Available
Benton County ESD #123	Project Northland	5	Finley School District	Project Northland Survey>PRG>RF SSDP: Opps. for Conventional Classrm. Involvement>PRM>PF	No No	S	59 53	n/a .12	n/a 1.03	n/a .31	n/a .90	Some Changes	High
Grays Harbor County	Aberdeen FAST	5	Aberdeen School District	FRS: Family Cohesion Questions>PRM>PF	Yes	F,S	14	- .11	- 1.03	.32	.71	Some Changes	High
Pierce County	FAST - Adult	5	Crossroads Treatment Center	CBQ: Parent Appraisal of Dyad>PRM>RF	No	F,S	19	.23	4.17	.001	.85	Not Available	High+
Pierce County	FAST - Youth	5	Crossroads Treatment Center	CBQ: Adolescent Appraisal of Dyad>PRM>RF FRS: Family Cohesion Questions>PRM>PF RHC-Child Survey: Commitment to School>PRM>RF SCH: Low Commitment to School>RF>OLD	No Yes No Yes	F,S	18 19 19 19	.17 - .46 .30 .28	2.52 - 3.69 2.39 2.05	.02 .002 .03 .08	.83 .71 .85 .71	Not Available	High+
Spokane/ Spokane Cty Community Services	Nurturing Program - Adult	5	WSU Spokane Co. Extension	AAPI2 Form: Nurturing Program A>PRM>RF	No	F	25	.16	3.05	.006	.83	Some Changes	High+
Spokane/ Spokane Cty Community Services	Nurturing Program - Child	5	WSU Spokane Co. Extension	AAPI2 Form: Nurturing Program A>PRM>RF	No	F	33	.17	3.00	.005	.83	Some Changes	High+

KEY

Rigor: This designation is based upon the rank prepared by the West CAPT. The higher the rigor, the more science-based (i.e., multi-site studies and replications) a program is. Rigor 5 indicates Best Practices programs, with rigor 4 and 3 indicating Promising Approaches. Rigors 1-3 indicate unproven programs.

CSAP CMI: Scales that are included in the CSAP Core Measures Initiative.

Program Domain: C=Community; F=Family; S=School; I//P=Individual/Peer

N: Number of matched pre-test and post-test subjects

Mean Difference: A value that indicates the average difference score (post-test minus pre-test) across subjects.

t-test: The value of the test used to determine the difference between matched-pairs of pre-test and post-test scores.

Significance: A value that indicates the "strength" of the t-test. P-values are usually reported as follows: p<.05, p<.01, and p<.001. The lower the p-value, the more significant the t-test; in this case, the difference between the pre-test and post-test.

Cronbach's Alpha: A value that indicates how well the scale in question measures what it is supposed to measure for a particular group of subjects. The value range is 0 to 1; the higher the alpha, the better the reliability of the scale. Values of .70 or higher are considered to be good.

Fidelity: A measure that indicates how well a site adhered to the original parameters of the program it implemented. The higher the fidelity score, the closer the site followed the original program, and the more likely it was to reach the same outcomes as the original program.

+ Fidelity surveys for the Pierce County FAST program and the Spokane Nurturing program did not distinguish between child and adult components of the programs.

APPENDIX F
SUMMARIES OF STATE AGENCY PREVENTION PROGRAMS

SUMMARIES OF STATE LEVEL PREVENTION ACTIVITIES

Contained in this appendix are descriptions of prevention activities for state agencies and offices participating in SIG. There are two descriptions for most, one for 1999 and one for 2002. Following is a table of prevention activity descriptions contained in this appendix.

State level entity	1999 Description	2002 Description
Prevention Division, DASA	X	X
Tobacco Prevention and Control Program, DOH		X
FPC	X	X
GJJAC	X	
LCB	X	X
Lt. Governor's Office	X	
Community Mobilization Program, OCD	X	X
OSPI	X	
TSC	X	X

PREVENTION SECTION, DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA), DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)

SUMMARY OF PREVENTION ACTIVITIES, AUGUST, 1999

Interviewees: Fred Garcia, Michael Langer, Louie Thadei, Scott Waller, Pam Darby

Prevention Mission of DASA/Prevention Section: Support individuals, families, and communities in their efforts to raise alcohol, tobacco, and drug-free children and maintain healthy lifestyles.

Theory/framework: Risk and protective factors, using the risk and protective factor framework as a planning guide, balancing environmental and individually-based prevention strategies.

Prevention Focus: Prevention of substance abuse by youth.

Strategy: DASA follows CSAP's six prevention strategies as guidelines for conducting substance abuse prevention:

1. Information dissemination: Provide information about ATOD use, abuse, and addiction prevalence and risks, its effects on individuals, families, and communities, and provide information about prevention policies, programs, and services.
2. Prevention education: Skill-building programs including decision-making, refusal skills, critical analysis, and systematic and judgment abilities. Designed to improve critical life and social skills.
3. Alternatives: Provides ATOD-free activities for targeted populations, offering healthy choices, mentoring, and role modeling activities.
4. Problem identification and referral: Screening for substance abuse risk factors and referral for preemptive treatment to curb further ATOD use or abuse by early initiators.
5. Community-based process: Community mobilization to build prevention commitment. Includes organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.
6. Environmental approach: Setting up or changing written and unwritten community standards, codes, and attitudes that influence ATOD problem incidence in the general population.

Three specific substance abuse prevention strategies that have grown out of these general strategies are as follows:

1. Support programs designed to increase protective and reduce risk factors by contracting through county and tribal governments, state agencies, and statewide non-profit organizations.
2. Fund training of local providers.
3. Provide technical assistance to local providers.

Target populations or behaviors: Increase the percentage of 6th, 8th, and 10th graders who have not used ATOD in the last thirty days.

Funding Sources: Estimated $26million for this biennium. Sources include federal SAMHSA block grant money, Violence Reduction and Drug Education state funds, and grants from various federal sources, such as the Office of Juvenile Justice and Delinquency Prevention, the National Institute on Drug Abuse, and the Center for Substance Abuse Prevention's State Incentive Grant.

Needs/Resource Assessment Process/Form: Program services funded through the county and tribal governments are required to do a needs assessment. Funding for substance abuse prevention programs requires the completion of the Risk Factor Indicator form. This form is very similar to CTED's form by the same name. It is intended to assist in compiling and analyzing indicator data. Information may be submitted in narrative or in whatever format suits contractor needs. Risk factors to target are chosen depending on indicator data and resources available in the community. Respondents identify types, sources, and results of indicator data used to assess each risk factor. Program services funded through the county and tribal governments are required to do a needs assessment.

Outcome Measures:

- Long-term, statewide level: The percentage of 6th, 8th, and 10th graders who have not used ATOD in the last thirty days. The Children's Transition Initiative will be the pilot program for this.
- Program level: Program-specific pre-test and post-test scores, including or consisting of CSAP's core measures, are voluntary for now. CSAP will require the use of core measures by 2003.
- Individual level: The Children's Transition Initiative will be relying on changes in attitudes and behaviors as reflected in CSAP's core measure scores (30 day past use; age of first use; perceived risk/harm; attitudes about substance use; and intention/expectation to use substances). These scores will be tracked at the individual level. Participants will be engaged in several different programs, so changes will not reflect selected program outcomes as much as they will reflect cumulative program outcomes.

Collaboration Examples:

- With DOH and the Liquor Control Board on SYNAR compliance.
- With OSPI and DOH on the Adolescent Health Behavior Survey.
- Participation in the Washington Interagency Network with 14 other agencies on ATOD issues.
- With OSPI, DOH, the Traffic Safety Commission, the Family Policy Council, and CTED on the State Prevention Conference.
- Involvement in interagency committees, including SIG.
- Provision of data and technical assistance to numerous other state agencies involved in prevention.
- Co-funding a position with the Washington Traffic Safety Commission for the Reducing Underage Drinking (RUaD) Program.
- Collaboration with CTED collaborated in the design and updating of the Program Activity Form.
- With OSPI to design and implement school interventions.

PREVENTION SECTION, DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA), DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)

SUMMARY OF PREVENTION ACTIVITIES: JANUARY 2002

Interviewee: Michael Langer, Prevention Section Supervisor

Mission of DSHS/DASA: The mission of the Department of Social and Health Services is to improve the quality of life for individuals and families in need. The Division of Alcohol and Substance Abuse (DASA) promotes strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency.

Theory/framework: Risk and protective factors, using the risk and protective factor framework as a planning guide, balancing environmental and individually based prevention strategies.

Prevention Focus: Prevention or delaying the use of substances by young people and pregnant women by investing in strategies that support communities, families, schools, and individuals.

Strategy: DASA follows CSAP's six prevention strategies as guidelines for conducting substance abuse prevention:

1. Information dissemination: Provide information about ATOD use, abuse, and addiction prevalence and risks, its effects on individuals, families, and communities, and provide information about prevention policies, programs, and services.
2. Prevention education: Skill-building programs including decision-making, refusal skills, critical analysis, and systematic and judgment abilities. Designed to improve critical life and social skills.
3. Alternatives: Provides ATOD-free activities for targeted populations, offering healthy choices, mentoring, and role modeling activities.
4. Problem identification and referral: Screening for substance abuse risk factors and referral for preemptive treatment to curb further ATOD use or abuse by early initiators.
5. Community-based process: Community mobilization to build prevention commitment. Includes organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.
6. Environmental approach: Setting up or changing written and unwritten community standards, codes, and attitudes that influence ATOD problem incidence in the general population.

Three specific substance abuse prevention strategies that have grown out of these general strategies are as follows:

1. Support programs designed to increase protective and reduce risk factors by contracting through county and tribal governments, state agencies, and statewide non-profit organizations.
2. Fund training of local providers.
3. Provide technical assistance to local providers.

Target populations or behaviors: Increase the percentage of 6th, 8th, and 10th graders who have not used ATOD in the last thirty days.

Funding Sources: Estimated $22.6 million for this biennium.

° Federal Substance Abuse Mental Health Service Administration through the Center for Substance Abuse Prevention and the Center for Substance Abuse Treatment.

° Federal Justice Department – Office of Juvenile Justice and Delinquency Prevention.

° State – General Fund.

Needs/Resource Assessment Process/Form: DASA facilitated the development and implementation of the combined needs assessment. The development occurred in conjunction with the Office of Community Development, the Office of the Superintendent of Public Instruction, the Department of Health, the Family Policy Council, the Washington Traffic Safety Commission, and the Governor's Juvenile Justice Advisory Committee.

Outcome Measures:

° Long-term, statewide level: The percentage of 6th, 8th, and 10th graders who have not used ATOD in the last thirty days. DASA is planning to target state benchmarks and federally identified performance measures. The Children's Transition Initiative continues to be piloted. DASA will be collecting data at the individual level.

° Program level: Program-specific pre-test and post-test scores, including or consisting of CSAP's core measures, are voluntary for now. DASA is using core measures through SIG. CSAP is working with the state to develop a set of core measures, including capacity and process, for the block grant.

° Individual level: The Children's Transition Initiative will be relying on changes in attitudes and behaviors as reflected in CSAP's core measure scores (30 day past use; age of first use; perceived risk/harm; attitudes about substance use; and intention/expectation to use substances). These scores will be tracked at the individual level. Participants will be engaged in several different programs, so changes will not reflect selected program outcomes as much as they will reflect cumulative program outcomes.

Collaboration Examples:

° Mentoring Initiative: DASA established the Washington State Mentoring Partnership comprised of mentoring program administrators, service providers, and advocates.

DASA collaborates with the Governor's and Lt. Governor's offices, as well as OSPI, to provide technical assistance to prevention planners and providers interested in developing local mentoring programs.

° Recognition: DASA collaborates with the Governor's Council on Substance Abuse and DASA's Citizen's Advisory Council to award the state's outstanding prevention programs, providers, and media entities.

° Workforce Development: Collaborating with OCD and OSPI, DASA has developed a three-year Workforce Development Plan.

° School-Based Prevention/Early Intervention Program: OSPI administers a school-based program targeting students at-risk for developing alcohol, tobacco, and other drug related problems.

° Reducing Underage Drinking Initiative: LCB and WTSC implement an underage drinking prevention initiative.

° Reducing Access to Tobacco Products: DOH and LCB educate tobacco retailers and enforce laws relating to the sales of tobacco products to our state's children.

° Drug Free Workplace: The Washington State Labor Council assists labor unions in the development of drug-free workplace policies in businesses throughout our state.

° College Campuses: The University of Washington facilitates the College Coalition. The Coalition members administer campus-based prevention services targeting students and university communities.

° Clearinghouse: Washington State Alcohol and Drug Information Clearinghouse and Children's Services provide a statewide toll-free hotline and web page with access to printed material, video lending library, research reports, posters, and other educational material.

° Summit: OSPI, DOH, OCD, Lt. Governor's Office, LCB, WTSC, and the College Coalition contribute to an annual Prevention Summit. The Summit brings together over 1,000 participants representing community teams comprised of educators, parents, youth, law enforcement, prevention specialists, and faith community leaders.

° Survey: OSPI administers biennially and adolescent health behavior survey in schools in conjunction with DOH, OCD, and DASA. The alcohol, tobacco, and other drug prevalence and risk/protective factor data are generated from this survey and used by prevention planners and service providers throughout our state.

° Media: Television, radio, and newspaper entities, regionally and locally, promote alcohol, tobacco, and other drug related prevention messages. Some of the messages are developed by DASA and others are provided by the Federal Office of National Drug Control Policy. DOH serves this project in an advisory capacity.

TOBACCO PREVENTION AND CONTROL PROGRAM, DEPARTMENT OF HEALTH (DOH)

SUMMARY OF PREVENTION ACTIVITIES AS OF JANUARY 2002

Interviewee: Julia Dilley, Evaluation Coordinator, DOH Tobacco Prevention and Control Program.

Mission of DOH: The Department of Health works to protect and improve the health of people in Washington State.

Theory/framework: Public health model. Prevention and control activities will be based on science.

Prevention Focus of the Tobacco Prevention and Control Program: Cessation of tobacco product use among adults and pregnant women and reduction of tobacco product use or initiation among young people. Reduce exposure to secondhand smoke.

Strategy: Tobacco Prevention and Control Program strategies include the major components of successful tobacco prevention efforts identified by the federal Centers for Disease Control and Prevention.

1. Community-based programs
2. School-based programs
3. Cessation
4. Public awareness and education
5. Reduction of youth access to tobacco
6. Assessment and evaluation

Target populations or behaviors: Adults who want to quit tobacco and all youth and pregnant women.

Funding Sources: Funding sources for 1 July 2001-30 June 2002: Tobacco Master Settlement Agreement $17.2 million, Centers for Disease Control and Prevention $1.4 million, American Legacy Foundation $.9 million, Tobacco licensing fees $.9 million. Total: $20.4 million.

Needs/Resource Assessment Process/Form: DOH coordinated with other SIG agencies on the creation of the collaborative assessment process and form, but did not find them useful at the state level for purposes of the Tobacco Prevention and Control Program because DOH and constituents already had access to state and local data related to tobacco use. Some community and school-based constituents found the process valuable for linking to other prevention program staff at the local level.

Outcome Measures:

Statewide Level			
Long-term	A reduction in incidence and mortality rates due to smoking-related heart disease, cancer, and pulmonary diseases (asthma, emphysema).		
Mid-term	A reduction in the proportion of current adult smokers by 3 percent per year from 22.4 percent in 1999 to 16.5 percent or less in 2010.	A reduction in the proportion of youth smokers in 10th and 12th grades by 2 percent per year from 25 percent for 10th graders and 35.2 percent for 12th graders in 1999 to 16.2 percent and 22.6 percent or less, respectively, in 2010.	A reduction in the proportion of women who smoke during pregnancy by 4 percent per year from 13 percent in 1998 to 8 percent or less in 2010.
Short-term	Changes in social attitudes toward tobacco use.		

Program Level			
Community-based programs	Changes in community acceptance of tobacco use.	Better enforcement of existing tobacco-free policies.	Increased awareness of local resources to help people quit.
School-based programs	Increases in the proportion of youth who practice ways to say "no" to tobacco in schools.	Fewer youth report using tobacco on school property.	Increases in the proportion of youth who know about resources to help them quit.
Cessation	More tobacco users are ready to quit.	More tobacco users have made quit attempts and more have succeeded.	
Public awareness and education	Increases in the proportion of youth who have seen ads and report that the ads have given them good reasons not to use tobacco.	Increases in public awareness of harm caused by tobacco use.	Increases in awareness of Quit Line services among adult and youth tobacco users.
Reduction of youth access to tobacco	Increases in the proportion of youth who believe that tobacco is hard to get.	Decreases in the proportion of retailers who sell tobacco to minors during compliance checks.	

Collaboration Examples:

- Participation in the Washington Interagency Network with 14 other agencies on ATOD issues.
- OSPI: One funding stream for school-based tobacco prevention programs is through the Educational Service Districts. Distribution is formula based.
- At the local level, a community-funding scheme is to require one agency per county to act as the fiscal agent for all Tobacco Prevention and Control Program funded programs.
- Reducing Underage Drinking (RUAD): DOH sits on the advisory board for RUaD along with multiple other state agencies, including the Liquor Control Board, the Division of Alcohol and Substance Abuse (DASA, DSHS), and the Traffic Safety Commission.
- Collaboration with DASA and LCB to reduce youth access and perceived availability of tobacco through retailer compliance check monitoring and enforcement programs. DOH conducts monitoring requirements on behalf of DASA to meet requirements for DASA's CSAP grants and the federal SYNAR Amendment. DOH provides enforcement funds to LCB.
- In 1999-2001, Maternity Support Services/Maternity Case Management and First Steps within DOH and DSHS collaborated to conduct a pilot programs study with nine local agencies. The purpose was to test a model for training health care providers working with pregnant women to effectively conduct interventions for tobacco use and exposure. Joint planning for statewide implementation in 2002 is underway.
- DOH participates actively in the Joint School Survey Committee. DOH has provided substantial funding to fully subsidize local data collection to describe risk and protective factors and outcomes at school, community, and state levels.

FAMILY POLICY COUNCIL (FPC)

SUMMARY OF PREVENTION ACTIVITIES, AUGUST, 1999

Interviewee (date): Laura Porter, Staff Director (June 15, 1999)

Prevention Mission of the Family Policy Council: Make systemic changes to improve outcomes for children and families.

Theory/framework:

° Public health model: a target population is picked based on prior knowledge, then resources and needs regarding that population are assessed. Only plans that are appear to be achievable should be chosen. In the community model, an assessment of community needs and resources determines the target population.

° Networks' Recommended Decision Making Process, based on the public health model:

- List possible target problem behaviors.
- List possible target populations (be specific).
- List interim results for each population that, if achieved, would likely lead to reduction in one or more problem behaviors.
- Gather data to inform decision-making and prioritizing process.
- Prioritize the interim results (outcomes) and note their relationship to the possible target populations.
- Choose the priority results for certain populations for Network projects for the coming biennium and choose strategies to achieve these results.

Prevention Focus: For the 1999-2001 biennium, the Family Policy Council's focus will be on increasing support for socially or economically isolated families with children ages prenatal to eight. Research shows social and/or economic isolation to place children at higher risk for youth violence, and problem behaviors believed to contribute to violence: teen substance abuse, teen pregnancy and male parentage, teen suicide attempts, dropping out of school, child abuse or neglect, and domestic violence. Reduction of out-of-home placements is also a Family Policy Council focus.

Strategy:

1. Strategy: A general description of an approach to improving outcomes (i.e., mobilizing families to support children and other families, skills training, service collaboration, outcomes training for service providers, etc.)
2. Fifty-three Community Public Health and Safety Networks, ten of which are Tribal, address problem behaviors by identifying existing services and support, creating strategies to fill gaps in support systems, and monitoring and evaluating progress.

The Networks update and modify their ten-year plan every two years to reflect community and social change.

They provide opportunities for grassroots participation in preventing violence and associated problem behaviors and for direct communication with the heads of five state agencies and organizations: Dept of Social and Health Services, Office of the Superintendent of Public Instruction, Dept of Health, Employment Security Department, Dept of Community, Trade and Economic Development. The varying size and nature of networks result from the recognition of differing social and geographic situations between rural and urban, Tribal and other ethnic or racial minority and mainstream cultures.

3. Family Policy Council provides a means for collaboration between the legislature, with representatives from both House and Senate and from both parties, and state agencies and organizations that are concerned with family policy issues.
4. Reviews and approves Readiness to Learn grants, a collaborative effort between schools and human service organizations.

Target populations or behaviors: At-risk youth and the families and communities in which they live.

Funding Sources: Washington state legislature.

Needs Assessment Process/Form: The form consists of two sections, "Needs" and "Strengths." The Needs section includes checklists on data and opinion topics and indicator data considered in the needs assessment process. Variation in priority problem behaviors from the Network's long-range (10 year) plan is allowed if reasons are supported by data. The Strengths section contains checklists of available formal prevention services; data sources for prevention services, and groups participating in Network plan review. This section also contains an update form for RE-Direct Resource Directory prevention services listings, a table format to enable interim results (outcomes) for the coming biennium, and a list of interim results (outcomes) related to each target population.

Resource Assessment Process/Form: See description above in "Needs Assessment Process/Form" category.

Outcome Measures:

Determined by individual Networks and monitored by the Washington State Institute for Public Policy (WSIPP).

° Results (outcome) indicators: A precise statement of what will be observed or asked that would give data for reporting results (outcomes). (e.g., what is the number of parents who use appropriate disciplinary techniques?; what is the number of families who have at least one person to assist in respite care for child?).

° Long-term result (outcome): A measurable, long-term result, relating to changes in the lives of children and families, that can be expected to change within two (2) to ten (10) years.

° Interim community result (outcome): see community result (outcome).

° Community result (outcome): A change in the skills, practice, awareness and/or response to human needs, on the part of service providers, policy and other decision makers, systems, organizations, communities, that are expected to lead to long term outcomes and/or short term outcomes.

° Short-term result (outcome): A measurable, short-term result, reflecting changes in the lives of children and families, that can be expected to change within one (1) to two (2) years and with sufficient scale and duration is logically related to long term outcome(s).

° Child and/or family result (outcome): A change in the knowledge, skills, attitude, behavior or status of a child or family. This may be a short-term outcome (result), or a long-term outcome (result).

Collaboration Examples:

° With the Office of the Superintendent of Public Instruction, the Family Policy Council reviews and approves Readiness to Learn grants for community agencies working together to help children succeed in schools.

° The Family Policy Council sends lists of family and children support services from the Community Health and Safety Networks to the Employment Security Department's RE-Direct Resource Directory, improving the comprehensive nature of their statewide list of support services.

FAMILY POLICY COUNCIL (FPC)

SUMMARY OF PREVENTION ACTIVITIES: JANUARY 2002

Interviewee: Laura Porter, Staff Director

Prevention Mission of the Family Policy Council: Make systemic changes to improve outcomes for children and families.

Theory/framework:

1. Dual mission: Family Policy Council Networks have a dual mission to both improve outcomes and to engage the community to increase capacity.

2. Public health model: a target population is picked based on prior knowledge, then resources and needs regarding that population are assessed. Only plans that are appear to be achievable should be chosen. In the community model, an assessment of community needs and resources determines the target population.

Networks' Recommended Decision Making Process, based on the public health model:

1. List possible target problem behaviors.
2. List possible target populations (be specific).
3. List interim results for each population that, if achieved, would likely lead to reduction in one or more problem behaviors.
4. Gather data to inform decision-making and prioritizing process.
5. Prioritize the interim results (outcomes) and note their relationship to the possible target populations.
6. Choose the priority results for certain populations for Network projects for the coming biennium and choose strategies to achieve these results.

Prevention Focus: For the 2001-2003 biennium, the Family Policy Council's focus will be on increasing support for socially or economically isolated families with children ages prenatal to eight. Research shows social and/or economic isolation to place children at higher risk for youth violence, and problem behaviors believed to contribute to violence: teen substance abuse, teen pregnancy and male parentage, teen suicide attempts, dropping out of school, child abuse or neglect, and domestic violence. Reduction of out-of-home placements is also a Family Policy Council focus.

Strategy:

1. Strategy: A general description of an approach to improving outcomes (i.e., mobilizing families to support children and other families, skills training, service collaboration, outcomes training for service providers, etc.).

2. Thirty-nine Community Public Health and Safety Networks, ten of which are Tribal, address problem behaviors by identifying existing services and support, creating strategies to fill gaps in support systems, and monitoring and evaluating progress.

The Networks update and modify their ten-year plan every two years to reflect community and social change. They provide opportunities for grassroots participation in preventing violence and associated problem behaviors and for direct communication with the heads of five state agencies and organizations: Dept of Social and Health Services, Office of the Superintendent of Public Instruction, Dept of Health, Employment Security Department, Dept of Community, Trade and Economic Development. The varying size and nature of the Networks result from the recognition of differing social and geographic situations between rural and urban, Tribal and other ethnic or racial minority and mainstream cultures.

3. Family Policy Council provides a means for collaboration between the legislature, with representatives from both House and Senate and from both parties, and state agencies and organizations that are concerned with family policy issues.
4. Review and approve Readiness to Learn grants, a collaborative effort between schools and human service organizations.

Target populations or behaviors: At-risk youth and the families and communities in which they live.

Funding Sources: Washington state legislature.

Needs Assessment Process/Form: Family Policy Council staff were involved in designing the pilot collaborative needs assessment in conjunction with DASA, OCD, OSPI, DOH, GJJAC, and WTSC. Assessment results were used to guide the approval process for those Networks' work plans that are addressing substance abuse prevention.

Resource Assessment Process/Form: Networks are required to complete a checklist of available formal prevention services; data sources for prevention services, and groups participating in Network plan review. This section also contains an update form for RE-Direct Resource Directory prevention services listings, a table format to enable interim results (outcomes) for the coming biennium, and a list of interim results (outcomes) related to each target population.

Outcome Measures: Determined by individual Networks and monitored by the Washington State Institute for Public Policy (WSIPP).

1. Results (outcome) indicators: A precise statement of what will be observed or asked that would give data for reporting results (outcomes). (e.g., what is the number of parents who use appropriate disciplinary techniques?; what is the number of families who have at least one person to assist in respite care for child?).
2. Long-term result (outcome): A measurable, long-term result, relating to changes in the lives of children and families that can be expected to change within two (2) to ten (10) years.

3. Interim community result (outcome): see community result (outcome).
4. Community result (outcome): A change in the skills, practice, awareness and/or response to human needs, on the part of service providers, policy and other decision makers, systems, organizations, communities, that are expected to lead to long term outcomes and/or short term outcomes.
5. Short-term result (outcome): A measurable, short-term result, reflecting changes in the lives of children and families, that can be expected to change within one (1) to two (2) years and with sufficient scale and duration is logically related to long term outcome(s).
6. Child and/or family result (outcome): A change in the knowledge, skills, attitude, behavior or status of a child or family. This may be a short-term outcome (result), or a long-term outcome (result).

Collaboration Examples:

1. The Family Policy Council and the Networks are collaborative by definition. The Council consists of the heads of five state agencies and organizations: Dept of Social and Health Services, Office of the Superintendent of Public Instruction, Dept of Health, Employment Security Department, Dept of Community, Trade and Economic Development. The Council is required to solicit recommendations from the Networks based on community work, not ideas without evidence to back them. These recommendations are all collaborative and some are cross-disciplinary.
2. With the Office of the Superintendent of Public Instruction, the Family Policy Council reviews and approves Readiness to Learn grants for community agencies working together to help children succeed in schools.
3. The Family Policy Council sends lists of family and children support services from the Community Health and Safety Networks to the Employment Security Department's RE-Direct Resource Directory, improving the comprehensive nature of their statewide list of support services.

GOVERNOR'S JUVENILE JUSTICE ADVISORY COMMITTEE (GJJAC), DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)

SUMMARY OF PREVENTION ACTIVITIES, AUGUST, 1999

Interviewee (date): Rosalie McHale, Office Chief (July 13, 1999)

Prevention Mission of the Governor's Juvenile Justice Advisory Committee: In sum, to promote delinquency prevention and improve the juvenile justice system through community-based programs designed by and operated by local communities, thus promoting the development of local solutions to local problems.

Theory/framework: The GJJAC is required to implement the federal Juvenile Justice and Delinquency Prevention Act (JJDPA). Research-based best practices are utilized; various program bases are allowed, including those addressing risk and protection factors, resiliency, and asset building. In addition to the JJDPA, the GJJAC is responsible for administering the federal Byrne Youth Violence Prevention and Intervention Grant Program (YVPIP), and the State Juvenile Violence Grant program. The Byrne Grant Program provides federal funds for community-based youth violence prevention and intervention projects based on a public health model of reducing risks, while enhancing protective or resiliency factors.

Prevention Focus: The focus of the State Juvenile Violence Grant program as well as the Byrne grant program is to assist communities in developing prevention and intervention strategies in order to impact juvenile violence and delinquency. The Federal Juvenile Justice and Delinquency Prevention Act, enacted in 1974, requires states to establish state advisory groups on juvenile justice to carry out the standards created in the Act:

1. Children who have not committed crimes should not be treated like criminals.
2. Children who have committed crimes should never have contact with adult criminals.
3. The juvenile justice system should be free of conscious or unconscious bias.

Strategy:

1. The GJJAC funds local juvenile justice advisory committees, known as Regional Program Development Units, which are community-based programs that are assigned to improve coordination of local juvenile justice services for delinquency prevention and systems improvement efforts.
2. Technical assistance, training, and research projects intended to improve Washington's juvenile justice system receive funds.
3. The GJJAC funds projects to address the needs of runaways and status offenders ($340,000 in 1997-98).

4. The GJJAC provides policy recommendations and information to the Governor, the Legislature, DSHS, other organizations, and the public.
5. Target sites are funded to determine whether a coordinated and complete system of prevention, intervention, and rehabilitation services for youth and their families would result in a significant reduction in delinquent behavior. Evaluations are also funded and have found these efforts effective in reversing upward trends in juvenile arrest rates.
6. Through the *Title V Community Prevention Grants Program,* the GJJAC funds local delinquency prevention programs, including nighttime and after school recreation activities, interventions with youths convicted of domestic violence and parents, conflict resolution and anger management education, mentoring and tutoring programs, life skills training, parent training, and drug and alcohol prevention curricula.
7. *State Challenge Activities* is a federally funded program created in 1992 as an amendment to the Juvenile Justice and Delinquency Prevention Act. This program provides funds for one-year seed grants to enhance juvenile justice and delinquency prevention programs and systems. In 1999, the GJJAC chose to fund programs to improve access to counsel for juveniles accused of crimes before they waive the right to counsel.

Target populations or behaviors: The majority of the projects funded address substance abuse prevention activities in their programs. In general, targeted populations are juvenile offenders who have entered the juvenile court and rehabilitation system, and communities in which juvenile offenses have occurred. Communities in "under funded areas," defined by the GJJAC policy, are favored in the funding process. The GJJAC has provided Target Site/Delinquency Prevention funding to three target sites, to date, to provide a community-wide program to prevent and reduce delinquency with concentrated funding of $250,000 for each grant year. Positive evaluations were completed in both of the first two sites selected. The third site will also be evaluated in time. Byrne Youth Violence Prevention and Intervention Grant Program Projects are targeted towards at-risk youth in accordance with communities' prioritized risk factors that are predictive of violent behavior.

Funding Sources: The federal Office of Juvenile Justice and Delinquency Prevention (OJJDP), US Department of Justice, Title II Formula grants program and Title V Delinquency Prevention grant program. A 50% match requirement (cash or in-kind) exists for Title V funds. Federal block grants stem from the Juvenile Justice and Delinquency Prevention Act, adopted by Congress in 1974 and amended periodically, most recently in 1992. An approximate total of $200,000 was spent in 1998 on substance abuse prevention. Delinquency prevention projects awarded funds by the GJJAC must follow the goals and objectives, tasks and timeline as set forth in the grant contract. GJJAC also administers the State Juvenile Violence Prevention Grant fund and the Byrne Grant Youth Violence Prevention and Intervention Grant Program. The GJJAC was legislatively appointed as the entity to administer the State program (July 1999), and the Byrne program was transferred to the GJJAC by the legislature effective July 1999. Byrne Youth Violence Prevention and Intervention Grant Program Projects are funded for up to four years. Approximately $903,000 has been allocated for fiscal year 2000 to fund sixteen projects across the state. 25

percent of the cost of the project must come from non-federal funds. Approximately $1.8 million was allocated for the biennium by the legislature for state supported juvenile violence and delinquency prevention projects.

Needs Assessment Process/Form: GJJAC requests a narrative statement addressing the following topics: the need intended to be alleviated by the grant; supporting statistical information; other possible community resources and why those resources are inadequate; manner in which grant will address the need. Current funding or other resources available in the applicant's area, minority cultural issues, and the history of prior awards and contract outcomes may influence grant selection.

Projects funded through the $1.8 million (biennial amount) Juvenile Violence Prevention Projects must be based on research that supports the effectiveness of the project in reducing delinquency; be for the prevention of juvenile crime, not as a disposition or confinement option for adjudicated or diverted juvenile offenders; have community support; and be a new program or a replication of an existing program in another area. 25 percent of the cost of the project must come from non-state funds.

Resource Assessment Process/Form: See description above in "Needs Assessment Process/Form" category.

Outcome Measures: All recipients of grant awards are required to use 7% of their funds to hire outside qualified evaluators. The written evaluation must be submitted within 30 days of the contract's end date. Projects must submit quarterly progress and financial reports to the Office of Juvenile Justice. Awards recipients must provide a list of matching funds. Projects are monitored onsite by Office of Juvenile Justice staff for fiscal and program compliance.

Collaboration Examples:

- Some aspects of target site projects are funded in collaboration with the Office of the Superintendent of Public Instruction, improving school achievement, reducing class disruptions, and reducing violent and assaultive behavior.
- Other projects collaborate with DASA, JRA and Children's Administration, DCFS.

LIQUOR CONTROL BOARD (LCB), ALCOHOL AWARENESS PROGRAM

SUMMARY OF PREVENTION ACTIVITIES, AUGUST, 1999

Interviewees: Manuel Romero, Alcohol Awareness Program Manager, and Jennifer McDougal, past Alcohol Awareness Program Manager

Interview Date: June 17, 1999

Situation within the larger Agency/Organization: The Alcohol Awareness Program, created in 1992, is one part of the Enforcement Division of the Liquor Control Board. Liquor and Tobacco Enforcement is the other part of the Enforcement Division. There are five other divisions besides Enforcement.

Prevention Mission of the Liquor Control Board and Alcohol Awareness Program: "Through education and enforcement, ensure liquor and tobacco products are available only to legally eligible persons and that liquor is sold and served in a safe environment and used in a responsible manner."

Alcohol Awareness Program goals include the development of programs to reduce underage drinking and foster responsible behavior in adults who choose to drink.

Theory/framework: The primary framework for Liquor Control Board and the Alcohol Awareness Program's activities is provided by liquor and tobacco-related legislation. Hawkins and Catalano's community norms theory is used at the Liquor Control Board, as are Healthy People 2010 benchmarks.

Prevention Focus: Prevention of substance abuse. The Alcohol Awareness Program provides technical assistance, training, and education regarding liquor and tobacco laws and appropriate use on group and personal levels.

Strategy: The LCB takes a preventive approach to enforcement, educating licensees, servers, and the public. Liquor control agents are fully empowered to enforce tobacco laws, tobacco tax, and sales to underage youth and all alcohol laws. Licensee orientation with each retailer is one-on-one, explaining expectations and laws. Alcohol servers receive training and are certified through private trainers who are required to use Liquor Control Board approved programs. The Board monitors training presentations. Grocery store licensees are trained directly by liquor control agents.

Target populations or behaviors:

° Populations – youths and pregnant women, people who drink and drive.

° Behaviors – purchases by or for underage youth, possession by underage youth, and licensees and/or servers providing additional alcohol to obviously inebriated customers.

Funding Sources:

° Operating funds: The Liquor Control Board receives all operating funds from liquor and tobacco tax revenues. Discretionary funds are available for special projects, such as the public service announcements described below in "Collaboration Examples."

° Educational materials and programs: The liquor industry occasionally provides advertisement-free educational material for schools.

° The National Alcohol Beverage Control Association and the Washington Traffic Safety Commission provide funding for the creation and maintenance of the Hospital Resource Panel, described below under "Collaboration Examples."

Needs Assessment Process/Form: None.

Resource Assessment Process/Form: None.

Outcome Measures:

° Immediate or Program specific: education r/t fatal vision goggles, alcohol-related crime, particularly in target populations; reduced rates of fetal alcohol syndrome births.

° Intermediate: None.

° Long-term: Statistics on alcohol-related crime rates, particularly in target populations and reduced rates of fetal alcohol syndrome births.

Collaboration Examples:

° Funding: The Liquor Control Board funded "Ready or Not" parent education programs for school parent networks. The Washington Traffic Safety Commission funds some programs for the Liquor Control Board, e.g., "Cops in Shops," funded for two years, provided undercover law enforcement officers to assist grocery stores in preventing alcohol or tobacco purchases by or for underage youth. The Liquor Control Board initiated the program through discretionary funds, and then the Traffic Safety Commission picked it up.

° Program oversight: Community Mobilization is providing oversight for a $26,000 grant to create and maintain a Hospitality Resource Panel, a coalition between Western Washington University, Tacoma-Pierce County DUI Task Force, and Washington State University and liquor licensees who serve alcohol on the premises as equal members. The Alcohol Awareness Program provides technical assistance for the Panel. Healthy People 2010 led to the formation of this panel.

° In the office: Review of other agencies' grant applications is common, as is reciprocal sharing of technical assistance and research. Participation in groups and efforts to prevent alcohol misuse, such as the Governor's Council on Substance Abuse,

Community DUI Task Forces, Traffic Safety Advisory Group, Washington Substance Abuse College Task Force, and other state and national organizations.

Poster Contest: OSPI and the Alcohol Awareness Program conduct an annual poster contest, with winning designs distributed to all public and private schools in the state. Winners receive a certificate and are recognized at the annual prevention conference.

° In the field:

Technical assistance is provided to school districts in writing needs assessments and/or classroom activities addressing substance abuse prevention.

Liquor control agents work with fully commissioned law enforcement in communities. Agents also provide education to law enforcement officers regarding liquor and tobacco laws.

° Across cultures: A Yakima public radio station was awarded discretionary funds to produce a series of public service announcements to educate licensees about the consequences of selling to minors, targeted toward Hispanic licensees, and to educate Spanish-speaking parents. These will run for twelve months and include interviews with a Spanish-speaking member of the Liquor Control Board and a liquor control agent. Depending on outcomes, this may spread to Spokane.

° State and national trade organization funding: The National Alcohol Beverage Control Association and the Washington Traffic Safety Commission jointly fund the Hospitality Resource Panel. The purpose of the Panel is to form partnerships between hospitality industry members who serve alcohol and the Tacoma-Pierce Co. DUI Task Force, Western Washington State University, and Washington State University. Goals include liquor law education, responsible serving, and the creation of environments where getting drunk is not the ultimate goal, thus reducing driving under the influence violations and alcohol-related accidents and deaths.

LIEUTENANT GOVERNOR BRAD OWEN'S OFFICE

SUMMARY OF PREVENTION ACTIVITIES, AUGUST, 1999

Interviewee: Sydnie Baron, Substance Abuse Prevention Coordinator for the Lt. Governor's Office (June 15, 1999)

Prevention Mission of the Lt. Governor's Office: Substance abuse prevention was the Lt. Governor's campaign theme, and he has made promotion of substance abuse prevention a priority of his time in office.

Theory/framework: Risk and protective factors, resiliency, asset building, early brain development.

Prevention Focus: Prevention of substance abuse and associated problem behaviors and attitudes, public involvement/community service.

Strategy:

1. *Take a Page from Our Book* was designed by the Lt. Governor and his staff to provide information and ideas for community members of all ages to become involved in prevention work. It includes stories and profiles of youth and adults who have made a difference in their communities. The need for this book was evident from audience members' responses to Lt. Governor Owen's presentations: people were inspired to help their communities, but they weren't clear what they could do as individuals and groups. *Take a Page from Our Book* was designed to help answer that question. It is available in color hardcopy and on the Lt. Governor's website (www.ltgov.wa.gov).
2. Website creation through High Intensity Drug Trafficking Area (HIDTA) funds: the M-files. Information about marijuana prevention, use and abuse (www.mfiles.org).
3. Lt. Governor Owen presents educational or keynote speeches about substance abuse prevention at conferences and schools and participates in community forums. He also holds fact-finding meetings with constituents.
   - Lt. Governor Owen created and supports Strategies for Youth, a multi-media presentation that is given in middle schools and high schools throughout the state. The presentation is a tribute to youth who have made, and continue to make, contributions in today's society.
   - Networks with Traffic Safety, Community Mobilization, OPSI/ESD Coordinators, and Health and Safety Networks.
4. Participating in meetings, for example, the Governor's Substance Abuse Advisory Committee, the High Intensity Drug Trafficking Area Prevention Advisory Board, the RUaD Committee, the Washington State Mentoring Partnership, the Community Mobilization Advisory Board, and workgroups, such as SIG; and conferences, including the state's annual drug prevention conference and the national prevention conference.

5. Marijuana/Methamphetamine Education Specialist: Position funded through HIDTA. Gives presentations to students, law enforcement, community block leaders, health care professionals, community mobilizers, prosecutors, and others. Produced meth awareness poster for retailers. Organized a statewide meth conference in September at Wenatchee. Developing Marijuana/Methamphetamine education CD.

Target populations or behaviors: Youth and communities.

Funding Sources: The Lt. Governor's office budget provided the funds for the idea-generating book, *Take a Page from Our Book,* for the Lt. Governor's presentations, and for committee, workgroup, and conference participation. The Office of National Drug Control Policy (ONDCP) HIDTA (High Intensity Drug Traffic Area) program has funded website development, and materials such as a video and fact sheet/brochure done in English and Spanish. HIDTA also funds the marijuana/methamphetamine education outreach position.

Assessment Process/Form: None.

Outcome Measures: Program specific and long-term. Programs are assessed through phone survey pre- and post-tests with program participants of a "train the trainers" session regarding attitudes toward marijuana. Also, in the process of tying in Strategies for Youth presentations with OSPI's Essential Learning format.

Collaboration Examples:

° Traffic Safety Commission

° CTED

° Law Enforcement

COMMUNITY MOBILIZATION AGAINST SUBSTANCE ABUSE AND VIOLENCE (CMASA), SAFE AND DRUG-FREE COMMUNITIES UNIT, DEPT OF COMMUNITY, TRADE AND ECONOMIC DEVELOPMENT (CTED), DEPT OF SOCIAL AND HEALTH SERVICES (DSHS)

SUMMARY OF PREVENTION ACTIVITIES, AUGUST, 1999

Interviewees:

° Susie Roberts, Program Supervisor for Community Mobilization (June 2, 1999)

° Paul Perz, Managing Director for the Safe and Drug-free Communities Unit (June 10, 1999)

Prevention Mission: To effectively address the problems of substance abuse and violence by promoting collaboration, cooperation, communication, commitment, and cultural competency.

Theory/framework: CMASA uses the risk and protective factor framework in its prevention work. Communities that choose to focus on asset building or resiliency skills are included as emphasizing protective factors, thus promoting community participation and implementation of prevention programs.

Prevention Focus: "…Provide incentive and support for communities to develop targeted and coordinated strategies to reduce the impact and incidence of the abuse of alcohol and other drugs and violence." (Community Mobilization Application for Funding, 1999-2001 Biennium, p 3).

Strategy:

1. Assist communities in implementing an integrated, logic model prevention approach. CTED has contracted with DRP to do logic model and self-evaluation training for Community Mobilization contractors. Principles of Effectiveness provide guidance for choosing prevention programs (in brief):
   - Assess objective drug and violence data for schools and communities
   - Design program related to measurable goals and objectives
   - Use science-based programs
   - Evaluate progress and use the results

2. "Services include job training and placement, parent education and support, anger management and conflict resolution skill building, alcohol and other drug abuse prevention, education and treatment, peer support groups, tutoring and mentoring programs, and alternative educational programs. The program also works to bring community norms and rules into closer alignment with no-drugs, no-violence philosophy.

3. Educate legislators about the changes effected by Community Mobilization sponsored prevention programs.
4. Train Community Mobilization contractors regarding logic model consistency and self-evaluation techniques.
5. Directly provide or subcontract prevention programs at the local level. Community Mobilization contractors have the authority to provide mini-grants to prevention related projects.
6. Contract for outside evaluation of CMASA to provide perspective and guidance.

Target populations or behaviors: Substance abuse and violence among youth and families.

Funding Sources: Community Mobilization receives half of its funds from state money (Washington State Omnibus Controlled Substances and Alcohol Abuse Act) and half from federal money (US Dept of Education, through the Governor's portion of the Department of Education's Safe and Drug-free Schools Act).

County boards are not required to choose the county as fiscal agents, although they can if desired. They are also free to choose a city government, a school, a non-profit (as long as they have a 501C3), or a college. Community Mobilization's contractor, then, is this fiscal agent. A memorandum of understanding (MOU) is required between the board and the fiscal agent, specifying authority and responsibility for different tasks.

Safe and Drug Free Communities Unit contractors administer several categories of funding: local health jurisdictions, drug courts, and undercover narcotics task forces.

Community Mobilization contractors know how much money they're applying for ahead of time because they know allocation formula results. The RCW requires that half of the state funds be awarded on a competitive basis. There are requirements for matching funds on the state portion of the funding. The amounts per biennium for Community Mobilization funds are $3.4million from the state and $1.4 million annually from the federal government.

The Byrne Grant funded the Governor's Council on Substance Abuse (GCSA) at $91,000 this past biennium.

Needs/Resource Assessment Process/Form: The Risk Factor Indicator form is intended to assist in compiling and analyzing indicator data. Information may also be submitted in narrative or in whatever format suits contractor needs. Nineteen risk factors are listed. Respondents identify types, sources, and results of indicator data used to assess each risk factor. This form is very similar to DASA's form. The differences are that it lists two additional risk factors, over DASA's seventeen, to choose from and it allows for the consideration of risk factors not listed, but which meet the criteria of a minimum of two longitudinal studies showing ATOD use predictability or alternate standards of evidence for certain populations. In addition, CM contractors are required to focus on at least one risk or protective factor from the community domain.

Outcome Measures:

- Immediate program evaluation includes the use of surveys or pre-tests and post-tests, depending on the county.
- Intermediate outcome measures include surveys and qualitative data.
- Long-term measures include time-series analyses, surveys, qualitative data analyses, and archival indicators.
- In 1999, seven of thirty-eight Community Mobilization contractors began to create their own outcome tools; all contractors will implement outcome tools designed around risk and protective factors in 2000.

Collaboration Examples:

- To reduce duplication, CTED and DASA agreed to make the PAR form [Program Activity Reporting form] a common reporting instrument, saving time and effort for Community Mobilization contractors and county chemical dependency coordinators.
- In Pacific County, CTED arranges for volunteers in schools to teach refusal skills, personal health and safety issues, and conflict resolution.
- In Pierce County, CTED helped coordinate efforts between local government, law enforcement, the local health department, schools, block groups, and neighborhood coalitions to reduce illegal drug availability. Fifty-three drug houses were closed through their combined efforts.

COMMUNITY MOBILIZATION AGAINST SUBSTANCE ABUSE AND VIOLENCE (CMASA), SAFE AND DRUG-FREE COMMUNITIES UNIT, OFFICE OF COMMUNITY DEVELOPMENT (OCD)

SUMMARY OF PREVENTION ACTIVITIES JANUARY 2002

Interviewee: Susie Roberts, Program Supervisor for Community Mobilization

Prevention Mission: To effectively address the problems of substance abuse and violence by promoting collaboration, cooperation, communication, commitment, and cultural competency.

Theory/framework: CMASA uses the risk and protective factor framework in its prevention work. Communities that choose to focus on asset building or resiliency skills are included as emphasizing protective factors, thus promoting community participation and implementation of prevention programs.

Prevention Focus: "…Provide incentive and support for communities to develop targeted and coordinated strategies to reduce the impact and incidence of ATOD abuse and violence" (Community Mobilization Application for Funding, 2001-2003 Biennium, p 2).

Strategy:

1. Directly organize (mobilize communities to reduce substance abuse and violence).
2. Assist communities in implementing an integrated, logic model prevention approach. OCD has completed its contract with DRP to do logic model and self-evaluation training for Community Mobilization contractors. Beginning in July 2001, OCD hired a CM Program Evaluator on staff who has initiated various levels of program evaluation within each county using an in-depth interview process. Principles of Effectiveness provide guidance for choosing prevention programs (in brief):
    - Assess objective drug and violence data for schools and communities
    - Design program related to measurable goals and objectives
    - Use science-based programs
    - Evaluate progress and use the results
    - Include input from parents
3. Services include job training and placement, parent education and support, anger management and conflict resolution skill building, alcohol and other drug abuse prevention, education and treatment, peer support groups, tutoring and mentoring programs, and alternative educational programs. The program also works to bring community norms and rules into closer alignment with no-drugs, no-violence philosophy.

4. Educate legislators about the changes effected by Community Mobilization sponsored prevention programs.
5. Train Community Mobilization contractors regarding logic model consistency and self-evaluation techniques.
6. Directly provide or subcontract prevention programs at the local level. Community Mobilization contractors have the authority to provide mini-grants to prevention related projects.
7. Contract for outside evaluation of CMASA to provide perspective and guidance.

Target populations or behaviors: Substance abuse and violence among youth and families.

Funding Sources: Community Mobilization receives about half of its funds from state money (Violence Reduction and Drug Enforcement dedicated account) and half from federal money (US Dept of Education, Governor's portion, Safe and Drug-free Schools and Communities Act).

County boards are not required to choose the county as contractual agent, although they can if desired. They are also free to choose a city government, a school, a non-profit (as long as they have a 501C3), or a college. Community Mobilization's contractor, then, is this contractual agent. The local CM Board is a policy board that is tasked with the authority to make local CM program decisions. For this reason, a memorandum of understanding (MOU) is required between the board and the contractual agent, specifying the authorities and responsibilities of each party in fulfilling the contractual requirements of CM with OCD.

Community Mobilization contractors know how much money they're applying for ahead of time because annual funding is based upon an allocation formula per county. The RCW requires a 25% match (cash or in-kind). The funding level for CM for Community Mobilization funds is $3.4 million from the state VRDE account per biennium, and $1.4 million annually from the federal SDFSC grant. (Note: During the 2001 Legislative session SB 5367 passed which removed the requirement that half of the CM state funding be distributed to local contractors based upon a competitive process.)

Needs/Resource Assessment Process/Form: The Collaborative Local Needs Assessment process was used by six different state agencies (OCD, DSHS/DASA, OSPI, DOH, WTSC, and FPC) to instruct their local contractors to work collaboratively together to assess the strengths and needs of their local communities. The Local Needs Assessment was to be conducted prior to developing their local prevention plans. It was intended to assist local contractors in compiling and analyzing risk and protective factor indicator data. Respondents identify types, sources, and results of indicator data used to assess each risk and protective factor. This form is identical to DASA's form.

Outcome Measures:

- Immediate program evaluation includes the use of surveys or pre-tests and post-tests, depending on the county.
- Intermediate outcome measures include surveys and qualitative data.
- Long-term measures include time-series analyses, surveys, qualitative data analyses, and archival indicators.
- In 1999, seven of thirty-eight Community Mobilization contractors began to create their own outcome tools; OCD is currently working with all CM contractors to develop and implement outcome tools designed around risk and protective factors in their local programs.

Collaboration Examples:

- To reduce duplication, OCD and DASA agreed to make the PAR form [Program Activity Reporting form] a common reporting instrument, saving time and effort for Community Mobilization Contractors and County Prevention Coordinators. OCD and DASA are currently working to implement an interactive web-based PAR form. It is planned that the web-PAR will first be used by local DASA and OCD contractors to enter their 2001-2003 second quarter PAR data.
- In Pacific County, OCD arranges for volunteers in schools to teach refusal skills, personal health and safety issues, and conflict resolution.
- In Pierce County, OCD helped coordinate efforts between local government, law enforcement, the local health department, schools, block groups, and neighborhood coalitions to reduce illegal drug availability. Fifty-three drug houses were closed through their combined efforts.
- The Safe and Drug Free Communities Unit administers several different programs besides CM, including funding for local health jurisdictions, drug courts, and several programs funded by the federal drug law enforcement grant, known as the "Byrne" grant, including undercover narcotics task forces. The Unit also staffs the state's Governor's Council on Substance Abuse, which is funded by the Byrne Grant at $91,000 per year.

OFFICE OF THE SUPERINTENDENT OF PUBLIC SCHOOLS (OSPI)

SUMMARY OF PREVENTION ACTIVITIES, AUGUST, 1999

Interviewees (dates): Tom Kelly, Assistant Superintendent, Operations and Support (June 10, 1999), and Martin Mueller, Program Supervisor, Prevention and Intervention Services(June 14, 1999).

Prevention Mission of the Office of the Superintendent of Public Schools (OSPI): Assist school districts and their family and community partners in creating and sustaining quality learning environments that support the success of children and youth.

Theory/framework: Early childhood development, risk and protective factors, asset building, and the resiliency model.

Prevention Focus: Provide early drug and alcohol prevention and intervention services to students and their families; assist in referrals to treatment providers; strengthen the transition back to school for students who have had problems of drug and alcohol abuse.

Strategy:

1. The Prevention and Intervention Services Program places intervention specialists in schools to provide prevention and intervention services for students and their families, referring to treatment providers where necessary, and assisting during the transition period for students returning to school following problems with substance abuse. Prevention activities in the Prevention and Intervention Services Program target classrooms or the entire school.
2. Manage the Adolescent Health Behavior Survey, which occurs every two years.

Target populations or behaviors: The Safe and Drug-free Schools program targets all students. Parents of pre-kindergarten through grade 3 students are targeted by the parental education program, funded through retail license fees collected by the Liquor Control Board. The Prevention and Intervention programs target school age youth, particularly those attending middle and high schools. About half are referred because they are using or experimenting with drugs and nearly two-thirds are in need of improved social skills or attitudes regarding refusal to use. Students can refer themselves for intervention specialist services (one-third), although they are more frequently referred by school staff (one-half).

Funding Sources:

- The Prevention and Intervention Services Program is funded through the state Omnibus Alcohol and Controlled Substances Act. $9million was distributed during the last biennium (1997-98). The Division of Alcohol and Substance Abuse (DASA) contracts with OSPI to provide these services.
- The Readiness to Learn Program distributes $7million per biennium in state funds.

- Safe and Drug-free Schools distributes $10million in grants per biennium, with 70% of the funds distributed to school districts per student FTE, and the remainder distributed to the 10% (approximately 30) school districts in greatest need.
- $300,000 per biennium is distributed to schools for parental education around alcohol and substance abuse issues. The program is funded through the state legislature from retail license fees collected by the Liquor Control Board.
- An additional $20million per biennium is administered by OSPI for violence prevention.

Needs and Resource Assessment Process/Form: For the Safe and Drug-free Schools program, applicants must describe the need for the project in terms of drug, violence, or safety problems that will be served by coordinators funded, problem behavior statistics in their school, and the extent to which service and infrastructure gaps or weaknesses will be addressed by the proposed project.

Outcome Measures:

Students receiving treatment/intervention services are tracked individually in four areas: compliance with service plan, protective factors, substance use, and school success.
For students receiving prevention services only:

- Immediate — None.
- Intermediate or interim outcome measures of risk and protective factor rates are used only with students receiving treatment services.
- Long-term —Rates of substance use and abuse are compared with similar age groups in prior years. Not formally measured on an individual basis, although school records and PISP records would indicate if a child became or continued to be involved in substance use or abuse.

Collaboration Examples:

- OSPI and the Liquor Control Board co-sponsor a poster contest each year for Drug-free Washington month. The Liquor Control Board is the funding source for a parenting education program regarding alcohol-related issues.
- OSPI participates in the state prevention conference.
- OSPI staff are active in the HIDTA program, along with representatives from other state agencies and organizations.
- OSPI is an active participant in the Joint School Survey Committee, the Needs Assessment Workgroup, the System Change Workgroup, and the Governor's Substance Abuse Advisory Committee.

WASHINGTON STATE TRAFFIC SAFETY COMMISSION

SUMMARY OF PREVENTION ACTIVITIES, AUGUST, 1999

Interviewee: Letty Mendez, State Coordinator

Prevention Mission: Reduce the number of deaths and serious injuries that result from traffic crashes.

Theory/framework: Elements of the Protection Program: Use prevention combined with law enforcement. Using research-based design for Reducing Underage Drinking (RUaD) Program.

Prevention focus:

- ° Reduce impaired driving motor vehicle deaths and serious injuries as a percentage of all motor vehicle deaths and serious injuries.
- ° Reduce the rate of drinking-driver related deaths and serious injuries per 10,000 population for younger age groups.
- ° Reduce the percentage of fatally injured drivers found to have drugs in their systems.
- ° Deterrence: To prevent from happening by consideration of significant negative consequences that are perceived to be certain, swift, and continuous.

Strategy:

1. Improve local capacity for coalition building: law enforcement and prevention are promoted via twenty DUI Community task forces.
2. Build on local infrastructure: Access youth through local clubs and organizations, such as Students Against Destructive Decisions (SADD) and Future Farmers of America (FFA), for programs such as:
   - SAFTYE — Stop Auto Fatalities Through Youth Efforts (85% school based, 15% tribal and community based, e.g., the Boys and Girls Clubs.
   - RUaD — Reducing Underage Drinking Project
3. Set and monitor zero tolerance standards in youth participating at the state level in advisory boards and conferences. Monitoring occurs by three adults for each youth.
4. At the Institute of Medicine's universal level, recreate crash scenes to powerfully deter drinking and driving.
5. Involve youth in advisory boards, committees, and focus groups: Responsibility plus accountability guides these groups, which results in improved community attachment, self esteem, and bonding with pro-social peers.
6. Provide technical assistance and training to county.

Target populations or behaviors: Adults who drink and drive, youth who drink at all.
Funding Sources: Federal agencies — the National Highway Traffic Safety Administration (NHTSA) and the Office of Juvenile Justice and Delinquency Prevention.

Needs/Resource Assessment Process/Form: Narrative form, available over the web.

Outcome Measures:

- Detailed activity report forms are required from each school club involved in SAFTYE.
- Project reports are required from each school funded for the purchase of breath testing machines.

Collaboration Examples:

- Sought assistance from DASA for a section of the SAFTYE Handbook on data.
- The mentorship task force at DASA is using the TSC's model for involving youth, developed through the SAFTYE program.
- DASA provided funding, through the federal Office of Juvenile Justice and Delinquency Prevention's RUaD Program, for TSC's .08 law media campaign.
- DASA is co-funding a position to work on the RUaD Program.
- Washington State National Guard has supplied a position to TSC for program development and drug-free education with youth.

WASHINGTON STATE TRAFFIC SAFETY COMMISSION

SUMMARY OF PREVENTION ACTIVITIES, FEBRUARY 2002

Interviewee: Gina Beretta, WTSC Program Manager

Prevention Mission: Reduce the number of deaths and serious injuries that result from traffic crashes.

Theory/framework: Elements of the Protection Program: Use prevention combined with education and law enforcement. Using research-based design where possible for funding community traffic safety programs.

Prevention focus:

- ° Reduce the number of motor vehicle related deaths and disabling injuries to zero by the year 2030.
- ° Reduce impaired driving motor vehicle deaths and serious injuries as a percentage of all motor vehicle deaths and serious injuries.
- ° Reduce the rate of drinking-driver related deaths and serious injuries per 10,000 population for younger age groups.
- ° Reduce the percentage of fatally injured drivers found to have drugs in their systems.
- ° Deterrence: To prevent from happening by consideration of significant negative consequences that are perceived to be certain, swift, and continuous.

Strategy:

1. Focus on impaired driving as one of two main emphases at the Commission (the other being occupant protection).
2. Improve local capacity for coalition building: law enforcement and prevention are promoted via twenty-three Community DUI/Traffic Safety task forces.
3. Build on local infrastructure: Access youth through local clubs and organizations, such as Students Against Destructive Decisions (SADD) and Future Farmers of America (FFA).
4. Involve youth in advisory boards, committees, and focus groups: Responsibility plus accountability guides these groups, which results in improved community attachment, self esteem, and bonding with pro-social peers.
5. Provide technical assistance and training to county.

Target populations or behaviors: Adults and youth who drink and drive, or make other unsafe choices such as not using seatbelts.

Funding Sources: The National Highway Traffic Safety Administration (NHTSA) and some state funds (for the community task forces).

Needs/Resource Assessment Process/Form: Narrative form, available over the web.

Outcome Measures:

- Quarterly reports from the Washington State SADD coordinator.
- Reports from schools and organizations who receive funds to conduct traffic safety activities in their schools and communities.
- Quarterly reports from Community DUI/Traffic Safety Task Force coordinators.

Collaboration Examples:

- WTSC is providing funding to the state Department of Health to support SafeKids activities in the state.
- WTSC and the Department of Transportation worked together to create the Target Zero guidelines and publication.
- WTSC is working with SADD Washington State on issues relating to youth driving while impaired and other traffic safety issues.
- WTSC is co-funding a position at the Liquor Control Board to coordinate the RUaD Program.
- WTSC is providing support to the Washington State Patrol for their Drug Recognition Expert program.
- WTSC is partnering with the Division of Alcohol and Substance Abuse and the Liquor Control Board to oversee the RUaD program.
- WTSC supports local government safety and prevention activities through the Community DUI/Traffic Safety Task Force.
- WTSC has worked with military bases in the state to create brochures aimed at underage military personnel who drink and drive.

APPENDIX G
STATE EFFORTS AT RESOURCE COORDINATION, LEVERAGING, AND REDIRECTING

TABLE 1: COORDINATION EFFORTS

Action/product (related to state level objectives)	**Related state level objective**	**State agency**	**Type of involvement**	**Funding amount**	**Resources**	**Funding source**	**Date**
Selection of benchmarks; discussion of data sources to be used as measures for benchmarks and the role, label, and reporting of benchmarks.	Adopt a set of common outcome measures, which builds on substance abuse prevention science of risk factor reduction and protective factor enhancement approach to prevention.	DASA	Meetings and discussion	Not tracked as a separate item	Staff	Staffing budgets	Began in spring 2001; ongoing
		DOH					
		FPC					
		GJJAC					
		LCB					
		OSPI					
		OCD					
		TSC					

Action/product (related to state level objectives)	Related state level objective	State agency	Type of involvement	Funding amount	Resources	Funding source	Date
Development and pilot testing of collaborative needs assessment	Develop, coordinate, and administer common community needs and resource assessment tools to reduce duplication in community assessment and help communities focus on local planning based on common outcome measures.	DASA	Development and training	Not tracked as a separate item	Staff; meeting rooms; support staff	Staffing and travel budgets for DASA and OCD	Development began in 1998 and is ongoing. Testing occurred Spring 2001.
		DOH	Development				
		FPC	Development				
		OCD	Development and training				
		OSPI	Development				
		TSC	Development				
		GJJAC	Development				

Action/product (related to state level objectives)	Related state level objective	State agency	Type of involvement	Funding amount	Resources	Funding source	Date
Western Center for the Application of Prevention Technologies (WestCAPT) worked with SIG staff to select and define best practices. SIG's requirement that 50% of community grantee prevention programs be science-based helped other agencies introduce the concept to their constituents.	Define criteria for selection of science-based prevention programs and programs with components of promising approaches that reduce risk factors and increase protective factors.	DASA (SIG and WestCAPT staff)	Development	Not tracked as a separate item	Staff	SIG and WestCAPT staffing budgets	Spring 2001

Action/product (related to state level objectives)	**Related state level objective**	**State agency**	**Type of involvement**	**Funding amount**	**Resources**	**Funding source**	**Date**
1. Development and testing of web-based participant level prevention program outcome measurement. 2. Discussion of Washington State Survey of Adolescent Health Behavior and other prevention related measures as data sources for community and state level prevention program outcomes. 3. Discussion of funding centralized prevention database to use for planning & reporting.	Develop uniform reporting mechanisms to capture outcomes of individual community prevention programs. Build upon existing electronic databases to be shared across participating state agencies.	DASA	Development & testing of web-based program measurement; discussion		Staff		Ongoing
		DOH	Development & testing of web-based program measurement; discussion	Not available		Tobacco settlement funds	Ongoing
		FPC	Discussion	Not tracked		Staffing budget	Ongoing
		LCB	Discussion	Not tracked		Staffing budget	Ongoing
		OCD	Development, training, and testing of program measurement	$381,570		Federal Safe & Drug Free Schools & Communities; some state CM funds	Ongoing
		OSPI	Discussion	Not tracked		Staffing budget	Ongoing

Action/product (related to state level objectives)	Related state level objective	State agency	Type of involvement	Funding amount	Resources	Funding source	Date
Selection of benchmarks	Develop guidelines for leveraging and redirecting money and resources, based on the confidence of scientifically established outcome measures, uniform community assessments, and reliable reporting.	DASA DOH FPC GJJAC LCB OCD OSPI TSC	Discussion and selection of benchmarks	None	Staff	Staffing budgets	Ongoing; began in spring 2001
Development and implementation of Substance Abuse Prevention Specialist Training (SAPST); development of curriculum for college training substance abuse prevention professionals.	Create a system for continuous professional development for prevention providers, both paid and volunteers.	DASA OCD	WestCAPT developed the trainings and college curricula in conjunction with DASA. SAPST is being modified to meet the needs of OCD local constituents.	$200,000*	Staff, meeting rooms, travel	SIG	Development began in 2000. Trainings were implemented in early 2001 and are ongoing.

* Note: funding amount is approximate and includes development.

TABLE 2: LEVERAGING EFFORTS

Action/product	State agency	Funding amount	Resources	Funding source	Date
Increased contact and awareness about prevention as a result of SIG meetings led to a greater focus on prevention than previously and improved participants' knowledge of other agencies' prevention roles.	Majority of participating agencies	None	Staff	Staffing budget	Ongoing

TABLE 3: RE-DIRECTING EFFORTS

Action/product	State agency	Funding amount	Resources	Funding source	Date
None reported					

APPENDIX H
COLLABORATIVE NEEDS ASSESSMENT EVALUATION REPORT

Fro a complete version of this report, including it's appendices see:
http://www1.dshs.wa.gov/rda/research/4/41/default.htm

The main report text is included here.

Evaluation Report

Reason for the Research

An evaluation was conducted during September and October 2001 on the initial collaborative assessment process, which occurred during spring 2001. The report on the collaborative assessment process is part of a larger evaluation concerning the Washington State Incentive Grant and was prepared upon request for the Washington Interagency Network (WIN) to help them improve the collaborative assessment process.

Evaluation methods used included focus groups, semi-structured face to face and phone interviews, and written surveys distributed and returned by electronic mail and fax, and a review of eleven collaborative assessment reports. Data was collected from five state agencies and twenty-seven counties, six of which functioned or were reported on as two-county combinations. *Appendix A* contains details on evaluation methods and response rates. *Appendices B* and *C* are local and state surveys.

History

In 1997, county-level constituents requested that state agencies involved in prevention reduce duplication in paperwork and reporting requirements. The Washington Interagency Network (WIN), a group of state agency mid-level managers, formed a workgroup to address these requests. Meetings were held, but once the complexity of collecting and delivering the data needed for a collaborative assessment process became apparent, efforts began to falter.

Efforts were renewed with the award of the Washington State Incentive Grant (SIG), which made the development, coordination, and administration of a collaborative needs assessment one of its six state-level objectives for the Washington State Substance Abuse Prevention System. In a workshop in Yakima, Washington, more than 40 prevention providers and agency representatives from across the state identified creation of a single needs assessment process for prevention as their most desired prevention system improvement. This helped provide a context and motivation for further work toward a collaborative needs assessment, as well as visible support from agencies involved with SIG. The work done prior to the SIG grant award was acknowledged and incorporated into SIG as the collaborative assessment.

State agencies involved in prevention began addressing the complex issues associated with a collaborative needs assessment. Complex data gathering and dissemination issues were addressed by the agencies and through the Joint School Survey Committee. One of the biggest obstacles was the date of the Washington State Survey of Adolescent Health Behavior (WSSAHB), a primary source for the risk and protective factor and prevalence data required by the needs assessment. The Joint School Survey Committee changed the survey administration

schedule from spring to fall, ostensibly so community planners would have recent data to use in their prevention planning in Spring 2001. The first administration of the fall survey was in fall 2000. Researchers had anticipated that data from the fall 2000 survey would be available early in spring 2001 to provide sufficient time for collaborative assessment meetings. The inability to meet this timeline was one of the greatest frustrations for persons involved in community-level collaborative assessment processes, although agencies are hopeful that data will be delivered at an earlier date in the future.

Needs assessment workgroup members collected and compared assessment forms currently in use by individual state agencies. A form was created, discussed, and modified to incorporate the core needs assessment requirements of the participating state agencies, with the understanding that additional requests for information could be appended to the form by individual agencies.

In fall 2000, the Division of Alcohol and Substance Abuse (DASA) county alcohol and drug coordinators agreed to convene county-level collaborative assessment meetings. Staff from Research and Data Analysis (RDA), Community Mobilization from the Office of Community Development (OCD), and the Division of Alcohol and Substance Abuse (DASA) provided trainings during fall 2000, with one training held during early 2001. Trainings were hosted by each of the nine Educational Service Districts and were open to all prevention professionals. Training topics were the collaborative assessment process, data collection and analysis, and comprehensive community prevention planning.

The initial collaborative assessment process occurred during spring 2001 in most cases, although some counties began collecting data and meeting as early as fall 2000. All collaborative assessment reports were completed by May 2001. This research was conducted during September and October 2001.

Results

The purpose of the collaborative assessment process is to avoid duplication of work at the county level, allowing one needs assessment to answer a set of basic questions required by all participating agencies. It is understood that individual agencies might require additional information to meet funding requirements. There are several goals, then, contained within the collaborative process:

1. State agencies will inform their local constituents about the collaborative assessment process, including expectations of data sharing, participation in trainings and meetings, and reports.
2. Local constituents of participating state agencies will understand and engage in the collaborative process.
3. Adequate and timely data will be available to conduct the assessments.
4. Collaborative assessment reports will be available to all participating state agencies.
5. The reports will be useful and necessary to local and state level staff for planning and funding requirements.

The first sub-section below is a table of data sources and overall experiences with the collaborative assessment process. Following this table is a description of *what worked,* a general list of positive aspects of initial collaborative assessments. Following the list of *what worked* is the sub-section titled *what needs work,* which corresponds directly with the above list of five goals.

Data sources and overall experiences

Nine of the twenty-four counties or county combinations studied (over one-third) had overall positive experiences conducting the collaborative assessment process. One had a negative experience, while the remaining fourteen (over half) had mixed experiences. Information was examined from approximately two-thirds of Washington's thirty-nine counties. Below is a table of the counties who either responded to inquiries about the collaborative assessment process or whose collaborative assessment report (CAR) was reviewed. The Family Policy Council (FPC) conducted an inquiry among their networks in response to a request for information for this report. Three sets of county responses were combined because their representatives or reports were bi-county: Asotin-Garfield, Benton-Franklin, and Skamania-Klickitat. The rightmost column of the table contains the overall experiences of the county with the collaborative assessment process. A + symbol indicates that the county's experiences were mostly positive; a – indicates a mostly negative experience; the combined plus and minus symbols mean that the county had a mixed experience or that experiences reported by different sources were not in agreement.

County Data Sources and Experiences

Counties	CAR reviewed	Evaluation survey response	Focus group attendance	FPC survey response	Overall experience
Asotin-Garfield*			**X**	**X**	+/–
Benton-Franklin*		**X**		**X**	+
Clallam		**X**			+/–
Clark	**X**	**X**		**X**	+
Columbia		**X**			+
Cowlitz				**X**	+/–
Grant			**X**		+/–
Island	**X**	**X**		**X**	+/–
Jefferson	**X**			**X**	+
King	**X**			**X**	+/–
Kitsap		**X**		**X**	+
Kittitas	**X**				+/–
Mason				**X**	+/–
Pacific	**X**				+/–
Pend Oreille	**X**				+/–
Pierce		**X**			–

San Juan	**X**	**X**		**X**	+/–
Skagit	**X**	**X**			+/–
Skamania-Klickitat*	**X**	**X**		**X**	+
Snohomish				**X**	+
Spokane			**X**		+/–
Stevens	**X**	**X**			+/–
Walla Walla				**X**	+
Whitman		**X**			+

** Note on above table: Benton and Franklin Counties filed a combined Collaborative Assessment Report. The response from the Network was about Franklin County, not Benton. Skamania County's Collaborative Assessment Report was reviewed. The Klickitat County Report was not. The Network representative that responded to the Family Policy Council survey serves both counties.*

What worked

Since this was the initial collaborative assessment process, it was unlikely that the process should run either smoothly or to everyone's satisfaction. Still, there were some remarkable achievements.

100% completion of reports: All counties completed a collaborative assessment report.

First time collaborative efforts: For several counties, the process was the first time local constituents of different agencies had worked together. Some workgroups that formed for the collaborative assessment decided to continue meeting after the assessment was completed.

Trainings well received: Nine trainings on data collection analysis were held around the state. Provided by Linda Becker, Ph.D., Research and Data Analysis Division, Marscha Irving, Office of Community Development, and Scott Waller, DASA, and hosted by Educational Service Districts, the trainings were largely well received and perceived as useful in "real world" situations. Especially appreciated, in light of the multiple prevention models that prevention professionals use, were explanations on how to translate problems and assets to risk and protective factors.

Beyond needs assessment to planning: Some constituents decided to move beyond the collaborative assessment and create comprehensive and complementary prevention plans for their areas in conjunction with local partners.

Public outreach: Education of community members who are not normally involved in the world of prevention occurred during some county's community meetings. Some rural counties conducted traveling data shows in multiple towns within the county, seeking to educate about prevention needs and assess local concerns. One county published their data and results.

Overall: The collaborative assessment was deemed by the majority of respondents to be a beneficial process and the report, a useful product. State agencies were urged to continue their efforts in this direction.

What needs work

As might be expected from an initial attempt at such a complex process, none of the goals listed above were completely met. Here are some specifics about what led to problems completing the collaborative assessment process out in the field.

Joint or simultaneous announcements were needed: Announcements about the collaborative assessment process would have been more productive if participating state agencies had made them jointly or at least simultaneously. Local prevention stakeholders who did know about the collaborative assessment process expected their peers from other agencies and offices to know, which was rarely the case and led to confusion and resentment. The question was asked: If the state agencies and offices cannot collaborate any better than this, how do they expect us to do it? The answer to this question is not an easy one. At the very least, issues of differences in administrative boundaries, fiscal agents, prevention focus, prevention delivery systems, and the usefulness and necessity of the collaborative assessment form must be addressed.

Announcements need to include expectations: Announcements from state agencies about the collaborative process did not always include expectations for local constituents about the following:

- Attendance at trainings
- Data sharing
- Prevention focus of the collaborative assessment (substance abuse alone or in conjunction with other types of prevention)
- Participation in meetings and report writing
- Report distribution, both to state agencies and locally

A lack of common information about the collaborative assessment and about each agency's expectations regarding local involvement led to confusion and resentment for some participants, both those in the know and those without information. People who knew about the assessment often had to educate their peers and attempt to enforce the state's notion of a collaborative assessment single-handedly. They were not always successful.

Data requests: More and better data is a constant refrain from everyone these days, and local constituents did not hesitate to join in on the chorus. Requests included the following:

- Website: A website for access to data that has already been analyzed and is accessible through charts and graphs, as well as numerically.
- Indicators versus outcomes or both: Clarification on using school survey and archival data as indicators of needs to be addressed versus or in addition to using these data as outcomes. People do not understand how the same data, collected at different points in time, can be both indicators of need and measurement of change.
- Timing and level of analysis: WSSAHB data delivered on time and in graphs and charts, as well as numerically. From some, a request for a return to the spring

administration date, so that data would be available the following spring without a doubt.

- Local data: More county- and sub-county-level data, whether generated by the state or locally.
- More training: Education for prevention specialists and others who communicate with their peers and the public about data. Frequent repetitions of the same trainings in data collection, analysis, and presentation are needed in light of high turnover rates among local prevention staff and minimal state-level staff available to perform data analysis and create charts and graphs that reflect local needs.

Report availability: Once an interactive website is established for the collaborative assessment reports, they will be available to all state agencies and, potentially, to the public so that local constituents can read reports from other counties. As it stands now, the reports were sent in hard copy to DASA and the Office of Community Development (OCD), leaving other state agencies in the position of having to request copies. For example, the Family Policy Council is using the prioritized risk and protective factors in the reports as part of the funding requirements for those Networks that are focusing on substance abuse prevention. It was cumbersome and time-consuming to procure this information from the hard copies.

Report usefulness: Not all participating state agencies required or requested copies of the collaborative assessment reports for biennial funding requests. From this, one could conclude that not all of the participating agencies feel the report, as it currently exists, contains useful and necessary information for them. This was true, by extension, for local constituents of these agencies. This may end up being a collaborative assessment for fewer agencies than originally anticipated unless the needs of all agencies are met.

Related concerns raised by constituents

An assumption and hope throughout the creation of the collaborative assessment process has been that people will move beyond a collaborative assessment to collaborative planning. Some local constituents do not perceive this as logical and are downright resistant to it. They think that, in collaborative planning, all prevention partners would have to address all of the risk and protective factors selected. It would be easy to dismiss this perception as a simple misinterpretation of the notion and assume that such ideas will be corrected as time goes by. Training should begin to address this now to avoid the marked resistance to collaborative planning that was observed from this misinterpretation that could easily become part of the local fabric.

Two concerns around decision-making authority were reported: as a logistical barrier to making collaborative decisions at meetings and as a conflict of interest. A logistical barrier within collaborative assessment meetings is that those attending the meetings sometimes felt they were being asked to agree that their local agency or organization supported the selected risk and protective factors, when, in fact, they needed to report to their boards or supervisors before

making such an agreement. Collaborative meetings would probably be more productive if some initial discussion of decision making authority occurred and then procedures were made for follow-up with those present who do not have decision making authority on the meeting topic. This suggestion could be promoted by state agencies in trainings for collaborative assessments.

The second concern raised that is related to decision-making authority is that of a perceived conflict of interest. Prevention stakeholders are usually the sole actors in the prioritization of risk and protective factors, upon which funding decisions are based. One county raised the concern that this is a conflict of interest: the stakeholders earn their living from providing and/or contracting for prevention services. There is the possibility, and reportedly a history, that individual participants will advocate for risk factors that their services address. If "their" risk factor is chosen, they can then tell funding sources that their service should be funded because it is addressing an identified need in the county. There may be a middle ground for a solution to this perceived conflict of interest, such as requiring a system of checks and balances or educating and involving a select group of community members to insure that prevention stakeholders have not acted in a wholly self-interested fashion. The Family Policy Council and Community Mobilization have developed models of community-level decision-making that address this issue.

Conclusion

The collaborative assessment work that has been done is the most visible progress to date toward achieving any of the state-level SIG objectives. Its importance in this role cannot be overstated. It is evidence of the level of commitment and action of participating state agencies toward the creation of a state substance abuse prevention system. The state has invested in meetings over several years to create a report form and expectations around the report. The initial collaborative assessment process yielded both expected and unexpected payoffs, as described above. Significant, but not insurmountable, issues remain to be addressed, the greatest of which involves collaboration at the state level.

Issues to be addressed include the following:

1. Agreement at the highest management levels of SIG state agencies to participate in the collaborative assessment process.
2. Identification of individual state agency needs that are not met by the current collaborative assessment form or process and resolution of those unmet needs.
3. The creation of joint or simultaneous communication methods between participating state agencies and their constituents around collaborative assessment.
4. Creation of an interactive website containing state-provided data (current, analyzed, and with the ability to make charts and graphs).
5. Creation of an electronic collection and distribution method for collaborative assessment reports.
6. Continuing education for prevention professionals on data collection, analysis, and presentation.

APPENDIX I
WASHINGTON STATE SUBSTANCE ABUSE PREVENTION SYSTEM
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