



pennsylvania
DEPARTMENT OF HEALTH

Bureau of Drug and Alcohol Programs
PREVENTION MANUAL

June 20, 2011 – June 30, 2015

Effective 6-20-2011

PREVENTION MANUAL

TABLE OF CONTENTS

Overview of Prevention	iii
Part One: Performance Based Prevention The Six Major Federal Strategies and Other Prevention Categories Three (3) Institute of Medicine Prevention Classifications Program Types	1.01.1
Part Two: Strategic Prevention Framework Requirements Needs Assessment Capacity Planning Implementation Evaluation	2.01.1
Part Three: Utilizing the Performance-Based Prevention (PBPS) Data Management System	3.01.1
Part Four: Training Requirements	4.01.1
Part Five: Reporting Requirements	5.01.1
Part Six: Reduction of Youth Access to Tobacco	6.01.1
Part Seven: Fetal Alcohol Spectrum Disorder	7.01.1

OVERVIEW OF PREVENTION

It is the intent of the Bureau of Drug and Alcohol Programs (BDAP) to further the advancement and implementation of substance abuse prevention programs, strategies, policies, practices, and procedures throughout the Commonwealth, based on proven methodologies. These methodologies are based on research, local innovation and other proven strategies within the substance abuse field. This work is carried out in conjunction with Single County Authorities (SCAs) and their contracted providers. As a result, there is flexibility in allowing SCAs to tailor service delivery based on identified needs and risk factors in their communities. Accomplishing strategic goals and the attainment of measurable outcomes is done in collaboration with local and state partners. Partnerships with other community agencies providing prevention services are also key to overseeing a comprehensive prevention plan.

PART I. Performance-Based Prevention

- A. Prevention funds provided to the SCA must be used to develop and manage a comprehensive system of resources directed at individuals not identified to be in need of treatment. Prevention program activities must be provided in a variety of settings to targeted populations who are affected by risk factors associated with substance abuse, determined through a county-wide bi-annual needs assessment.
- B. While services funded through the SCA must be provided by the SCA or a contracted provider, partnerships with other community agencies providing prevention services are also necessary. To the best of the SCA's ability, the SCA should be aware of prevention activities occurring within their geographic region. It is encouraged that the SCA extend the opportunity for non-SCA funded prevention providers to capture their data in PBPS.
- C. The delivery of comprehensive prevention services has been formalized into six (6) major Federal Strategies; three (3) Institute of Medicine (IOM) Prevention Classifications; three (3) Prevention Services Program Categories and two (2) Prevention Service Types . As a management agency for drug and alcohol services, the SCA must allocate and expend Department of Health funds for the implementation of prevention services under each Federal Strategy and IOM Classification. These services must meet the unique needs of its community identified by the needs assessment process.

The six (6) Federal Strategies must be utilized in conjunction with the three (3) IOM Prevention Classifications in the implementation and delivery of single and recurring programs and strategies,.

For a complete description of the six Federal Strategies, IOM Prevention Classifications, and service codes and populations codes, review the BDAP Minimum Data Set (MDS) Admin Guide in the Performance Based Prevention System (PBPS) Knowledge Base Module under the Resource Library.

Six Federal Strategies:

Defined below are the six (6) federal strategies. The six federal strategies comprise the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs.

1. Information Dissemination – provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, abuse and addiction and the effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

2. Education – involves two-way communication, which is distinguished from the Information Dissemination category by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this category are to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.
3. Alternative Activities – operates under the premise that healthy activities will deter participants from the use of alcohol, tobacco and other drugs. The premise is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs (ATOD) and would, therefore, minimize or eliminate use of ATOD. These activities must be directly linked to an educational or skill-building activity.
4. Problem Identification and Referral – targets those persons who have experienced first use of illicit/age-inappropriate use of tobacco and those individuals who have indulged in the first use of illicit drugs and alcohol in order to assess if their behavior can be reversed through education.

Prevention funds must not be used for Student Assistance Programs (SAP), Employee Assistance Programs (EAP), or Driving Under the Influence (DUI) programs beyond the point of the educational component. Funding for level of care assessment or any other activity directly linked to the inauguration of treatment must come from other designated funding sources.

5. Community-Based Process – aims directly at building community capacity to enhance the ability of communities to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration, coalition building and networking.
6. Environmental – establishes or changes written and unwritten community standards, codes, ordinances and attitudes thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the population. This category is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to action-oriented initiatives.

Institute of Medicine (IOM) Prevention Classifications:

Defined below are the three (3) IOM Prevention Classifications that can contain the six major federal strategies. Included are examples of activities that comprise the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs.

Universal Preventive Interventions - are activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

Selective Preventive Interventions – are activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Indicated Preventive Interventions - are activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing a disorder or having biological markers indicating predisposition for a disorder but not yet meeting diagnostic levels.

Program Categories:

1. Evidence-Based:

Evidenced-based prevention includes strategies, activities, approaches, and programs:

- Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse
- Grounded in a clear theoretical foundation and carefully implemented
- Evaluation findings have been subjected to critical review by other researchers
- Replicated and produced desired results in a variety of settings

Only programs recognized as evidence-based by the following agencies are considered evidence-based in the Performance-Based Prevention System (PBPS):

- The Substance Abuse and Mental Health Services Administration (SAMHSA)/National Registry of Evidence-based Programs and Practices (NREPP)
- U.S Office of Juvenile Justice And Delinquency Prevention
- U.S. Department of Education
- Center for the Study and Prevention of Violence

2. State Approved Programs:

- Program/principle has been identified or recognized publicly, and has received awards, honors, or mentions
- Program/principle may have appeared in a non-referenced professional publication or journal (it is important to distinguish between citations found in professional publications and those found in journals)
- Programs/principle must have an evaluation that includes, but is not limited to, a pre/post test and/or survey

3. State Approved Strategies:

- Capture activities that utilize methods of best practice
- Provide basic alcohol, tobacco and other drug awareness/education, as well as everyday alternative prevention activities
- Captures strategies that address population-level change
- Captures activities necessary to implement or enhance evidence-based and state approved programs

Prevention Service Types:

Each program category must include one of the following:

1. Single Service Type – Single prevention services are one-time activities intended to inform general and specific populations about substance use or abuse. (Examples: Health Fairs, Speaking Engagements.)
 - Individuals who are present at a single prevention service or event are called attendees.
2. Recurring Service Type – Recurring prevention services are a pre-planned series of structured program lessons and/or activities. These types of services are intended to inform, educate, develop skills, and identify/refer individuals who may be at risk for substance use or abuse. A recurring prevention activity needs to have an anticipated measurable outcome, to include but not limited to Pre/Post Tests and/or surveys. (Examples: Classroom Education, Peer Leadership Programs, Peer Mentoring, ATOD Free Activities Recurring). Recurring services also cover certain, limited, types of meetings and activities that are not structured lessons and may not have measurable outcomes. (Examples include coalition meetings, technical assistance meetings, Core Team meetings recurring)
 - Individuals enrolled or registered in a recurring prevention service are called participants. Participants are entered under a group name in the PBPS prior to the start of the recurring service program. Attendance of these participants is then tracked during each session until the program is completed.
 - A group is defined as having a facilitator with at least two or more participants that are able to communicate with each other. An exception to this rule is programs/strategies in which you use PAA06 – Individual Case Monitoring (recurring) such as Nurse Family Partnership.

PART II. Performance-Based Prevention: Strategic Prevention Framework

The SCA must ensure that the following criteria are adhered to in the implementation of performance-based prevention:

A. Needs Assessment

The needs assessment is designed to profile population needs, resources and readiness to address needs and gaps. The process involves the collection and analysis of data to define problems within a geographic area. Assessing resources includes identifying service gaps, assessing cultural competence, and identifying the existing prevention infrastructure in the county and/or community. It also involves assessing readiness and leadership to implement programs, strategies, policies, and practices.

The SCAs must use a data driven decision-making process to determine which risk and protective factors will be utilized to create a Comprehensive Strategic Plan. Structured and relevant programs, strategies, policies, practices, and procedures are essential to successfully reduce risk and enhance protective factors in specific targeted populations and geographic areas. The Needs Assessment must be completed at least once every two years per the BDAP Report Schedule and in accordance with the directions provided in the needs assessment document and any accompanying documents including, but not limited to the BDAP Convenience and Key Representative Surveys.

B. Capacity

The SCA must increase efforts to mobilize and/or build capacity to address needs. Building capacity involves the mobilization of resources within a community. A key aspect of capacity building is convening key stakeholders, coalitions and service providers to plan and implement sustainable prevention efforts during the planning and implementation phase. The mobilization of resources includes financial and organizational resources as well as the creation of partnerships. Readiness, cultural competence and leadership capacity are addressed and strengthened through education and systems thinking. Additionally, capacity building should include a focus on sustainability as well as an evaluation of capacity and:

- (1) The SCA must address capacity building in their Comprehensive Strategic Plan.
- (2) The SCA must conduct quarterly prevention meetings either internally if the SCA directly provides prevention services and does not contract with providers or with all contracted providers to discuss prevention service delivery as it relates to planning, implementation, barriers, evaluation, and technical assistance. The SCA must maintain the minutes of each quarterly meeting on file at the SCA office.
- (3) The SCA must build capacity by training staff. Training requirements for staff are listed in Part Four: Training Requirements of the Prevention Manual.

C. Planning

The SCA must develop a Comprehensive Strategic Plan. Planning involves the development of a plan that includes implementing programs and strategies that create a logical, data-driven plan that reduces the risk factors and enhances the protective factors identified in a specific county/community that contribute to substance abuse. The planning process produces strategic county-wide and community targeted goals and involves the identification and selection of programs and strategies that will reduce substance abuse. Even though one community may show similar alcohol-related issues, the underlying factors that contribute most to them will vary between each community. If the programs and strategies, do not address the underlying risk and protective factors that contribute to the problem, then the intervention is unlikely to be effective in changing the substance abuse problem or behavior.

The SCA must complete a Comprehensive Strategic Plan per the instructions provided in the Comprehensive Strategic Plan document and submit it to BDAP according to the BDAP Report Schedule.

The SCA's Comprehensive Strategic Plan must include a combination of programs and strategies which address county-wide and community targeted goals as identified by the SCA. In some instances, it may also be necessary for the SCA to use non-targeted activities related to general events and to provide services related to FASD and SAP as they are mandated by BDAP regardless of available data.

County-wide and Community Targeted Goals and Plans

1. Developing County-wide and Community Targeted Goals

Targeted Goals identify the specific, planned level of change/result to be achieved (e.g. defines who or what and where you expect to change as a result of your efforts).

- a. The **County-wide Targeted Goal** process utilizes data from PBPS and other sources that will be used to establish a measurement of outcome.

County-wide Implementation Plan – Based on the influencing risk and protective factors, magnitude, changeability and capacity determined by the Needs Assessment, choose the issues that will be addressed county-wide

- b. The **Community Targeted Goal** process utilizes local data sources which includes, but is not limited to, social indicator data, pre/post tests, and/or surveys that will be used to establish a measurement for the reduction of risk and/or enhancement of protective factors.

Community Implementation Plan – Based on the influencing risk and protective factors, magnitude, changeability and capacity determined in the Needs Assessment, choose the issues that will be addressed in your Community.

2. Non-targeted Activities (No goal)

- Not based on data, but provided as a result of State mandates or a request from a school, community organization, etc.
- Non-SCA funded activities in which the provider requests to enter data into PBPS
- Occurs out of County/State

The SCA's Comprehensive Strategic Plan must also include a detailed plan for implementation of services to include the following:

1. All SCA funded prevention services must be outlined in the Comprehensive Strategic Plan
2. All funding source(s) used to support the program services must be identified
3. All six federal strategies
4. All three Institute of Medicine (IOM) Classifications
 - (a) All program categories (Evidence-based, State Approved Programs and State Approved Strategies) All Evidence-based and State Approved Programs must demonstrate positive outcome measures and ongoing effectiveness over the course of service delivery
 - (b) 25% of program services must be delivered through a combination of Evidence-based and State Approved Programs.
6. All prevention service types (single and recurring) - The SCA is required to provide 20% of services through recurring events.
7. Programs/Strategies to be administered must be connected to the following components:
 - a. State Fiscal Year
 - b. Type of Implementation Plan
 - c. Targeted Community Name or Non-targeted Community Name
 - d. Program/Strategy
 - e. Funding Source(s)
 - f. IOM (Universal, Selective, Indicated)
 - g. Service Type (Single and/or Recurring)
 - h. Service Code(s)
 - i. Population Code(s)
 - j. Pre/Post/Follow-up Test Instrument (for all evidence-based and state approved programs)
 - k. Fidelity/Adaptation

FRAMEWORK

This format must be followed when entering plans into PBPS.

GOAL FRAMEWORK:

Targeted County:

Countywide or Community Targeted Name:

Note: The countywide targeted name is what connects your data back to your targeted goal.

Targeted Goal:

Data to be Measured:

TARGETED IMPLEMENTATION PLAN FRAMEWORK:

State Fiscal Year:

Type of Implementation Plan:

Targeted Community Name or Countywide Targeted Name:

Program/Strategy:

Funding Source(s):

IOM (Universal, Selective, Indicated):

Service Type (Single and/or Recurring):

Service Code(s):

(Single Service Codes must include the following information):

of Times the Services is Delivered:

of people or things projected:

(Recurring Service Codes must include the following information):

of Groups:

of Service/Activities Projected:

of people projected:

Population Code(s):

Pre/Post/Follow-up Test Instrument (Recurring Service Type Only):

Fidelity and Adaptation:

NON-TARGETED IMPLEMENTATION PLAN FRAMEWORK:

State Fiscal Year:

Type of Implementation Plan:

Program/Strategy:

Funding Source(s):

IOM (Universal, Selective, Indicated):

Service Type (Single and/or Recurring):

Service Code(s):

(Single Service Codes must include the following information):

of Times the Services is Delivered:

of people or things projected:

(Recurring Service Codes must include the following information):

of Groups:

of Service/Activities Projected:

of people projected:

Population Code(s):

Pre/Post/Follow-up Test Instrument (Recurring Service Type Only):

Fidelity and Adaptation:

D. Implementation

The SCAs and their contracted providers must implement the components of their Comprehensive Strategic Plan in order to meet all prevention programming requirements (e.g., 20% of services must be recurring, pre/post test instruments must be administered for evidence-based and state approved programs, etc).

SCAs are required to provide ongoing monitoring of their Comprehensive Strategic Plan.

This includes, but is not limited to: the collection of process measure data, performance targets, and the fidelity of implementation. Any modifications and changes that are made to the original programs must be documented throughout the implementation of the program utilizing the fidelity/adaptation functionality in PBPS. The purpose is to understand if expected outcomes may or may not have been attained due to adaptations made to programs.

E. Evaluation

The SCAs must evaluate their Comprehensive Strategic Plan.

This evaluation process involves:

- Measuring the impact of the implemented programs and strategies
- Identifying areas for improvement and necessary corrective action
- Emphasizing sustainability since it involves measuring the impact of the implemented programs and strategies
- Reviewing the effectiveness, efficiency and fidelity of implementation in relation to the Comprehensive Strategic Plan and desired outcome measures

The evaluation requirements are as follows:

- (1) The SCA must analyze and evaluate their PBPS data monthly. This evaluation is to determine compliance with BDAP's reporting requirements and to develop methods for improving program services. This is to be completed, at a minimum, utilizing the Monthly Fund Management module of PBPS.
- (2) The SCA must ensure an Evaluation is completed as per instructions in the Comprehensive Strategic Plan and submitted in accordance with the BDAP Report Schedule.
- (3) The SCA must collect the data specified as outlined in the Prevention Manual, Part Three: Utilizing the PBPS Data Management System

F. Sustainability & Cultural Competence

The SCA must incorporate sustainability and cultural competency into their Comprehensive Strategic Plan.

Sustainability refers to the process through which a prevention system becomes a norm and is integrated into ongoing operations. Sustainability is vital to ensuring that prevention values and processes are firmly established, that partnerships are strengthened, and that financial and other resources are secured over the long term.

Cultural competence is the process of communicating with audiences from diverse geographic, ethnic, racial, cultural, economic, social, and linguistic backgrounds. Becoming culturally competent is a dynamic process that requires cultural knowledge and skill development at all service levels, including policymaking, administration, and practice.

PART III. Utilizing the Performance-Based Prevention Data Management System

- A. The SCA must plan, monitor, evaluate and analyze prevention service delivery using PBPS.
- B. The SCA must ensure that data associated with all prevention and early intervention services, including but not limited to SAP Services, funded by the SCA are included in the SCA's Comprehensive Strategic Plan and entered into PBPS according to BDAP data entry requirements and timelines in an accurate manner to ensure data integrity. Services are entered into PBPS utilizing service and population codes outlined in the MDS Admin Guide. The MDS Admin Guide is located under the Knowledge Base module of PBPS.
- C. The SCA must ensure that pre and post test results as well as surveys are recorded in the PBPS within 4 weeks of the pre and post test and survey completion dates.
- D. SCA/providers are required to use the developer's pre/post tests and/or surveys for all evidence-based and State Approved Programs for the purposes of capturing outcomes. The use of an alternate instrument requires prior approval from BDAP and justification for the request to use an alternate instrument must be provided by the requestor. Regardless of the instrument used, the results from each pre/post test and/or survey administered with these evidence-based and State Approved Programs must be entered into PBPS.
- E. SCAs and their providers are required to administer the Adult and Youth NOM survey to single service attendees and recurring service participants from October 1st through November 30th of each year. The survey is administered once per attendee/participant (it is not a pre/post test). All surveys must be connected to either a single or recurring service in order to assist in the evaluation of the effectiveness of the services. The NOMS should be administered to as many attendees and participants as possible. Survey results must be entered into PBPS no later than January 31st of each year.
- F. The SCA must enter each prevention provider's organization information in PBPS, and assign each prevention provider all programs and strategies that the provider is expected to deliver during a fiscal year.

The SCA must enter prevention service data into the PBPS when the SCA delivers their own prevention services. If an SCA provides direct prevention services, the SCA must establish a PBPS-generated provider Organization ID, and enter the prevention services under their provider Organization ID (6-digit number).

All contracted providers that deliver prevention services must enter their own prevention service data into PBPS. If any contracted provider cannot enter their own data into PBPS, the SCA may enter the provider's prevention service data into PBPS on their behalf with prior approval from BDAP via the approval of the provider in PBPS with the SCA having data entry rights.

The SCA must maintain a policy and procedure for entering prevention service data into PBPS on behalf of a prevention provider(s), and make it available upon request.

The SCA must enter the provider's service data into PBPS under the provider's PBPS-generated Organization ID (6 digit number), not under the SCA's Organizational ID. (Note: SCA data entry staff must be added to the provider's organization as staff member[s] to access the organization's information and make entries. The actual staff at the provider organization who deliver prevention services must also be added to the provider organization in PBPS so they can be attached to services.) Should circumstances change and the SCA would begin to have the provider enter their own data, the SCA must request the change via PBPS and the request is subject to approval by BDAP. This change can only be made at the beginning of a fiscal year. Methodologies for data entry cannot be changed in mid-fiscal year.

- G. At least 70% of prevention service data must be entered into the PBPS within two (2) weeks of the date the service was delivered. The expectation is to maintain a 70% monthly average. The data entered monthly must be monitored for accuracy and analyzed for progression toward outcomes by the 30th of the following month.
- H. The SCA and contracted prevention providers must enter into PBPS the service location of programs delivered in any school, government building, church, college, etc., unless the address is confidential. Confidential addresses are to be used only for particular types of locations
 - a. Examples:
 - i. Services which occur in private homes through programs such as Nurse Family Partnership, etc.
 - ii. Abuse Shelters
 - b. Note: Prior approval must be obtained from BDAP for any other location to be classified as confidential.
- I. All previous fiscal year service data must be entered into the PBPS by July 21st.

PART IV. Training Requirements

Specified staff with responsibilities in Sections A, B and C have (12) months from the time of hire or twelve (12) months from the time of acquiring the responsibilities outlined within each training to complete the appropriate course(s) and obtain certificates of completion.

Copies of SCA and contracted provider staff certificates must be made available upon request.

BDAP Mandatory Training Courses

A. Performance-Based Prevention System (PBPS) Training

Any individual entering or monitoring data into PBPS or who is directly responsible for supervising others with these responsibilities must view the training videos related to their role in prevention and data entry on the KIT PBPS Support Site and pass a certification test with a score of at least 80%. Upon the creation of a user account, the user has 90 days to view the videos and pass the certification test. If the user fails the test, they will be able to take it again every 7 days until they are able to pass the test. After 90 days if the user has not passed the test, they will not be able to utilize PBPS other than to log in and retake the test until they pass.

- *PBPS training certificates dated prior to June 1, 2010 are no longer valid.*

B. Making the Connection: Prevention Program Services, Fidelity Adaptations and Minimum Data Sets (MDS) Service Codes

This course offers participants an opportunity to advance their knowledge and skills in the planning, development, delivery and reporting of Prevention Program Services. It provides an in-depth understanding in:

- Using Evidenced-based, State Approved Programs and State Approved Strategies,
- Maintaining Program Fidelity and utilizing Program Adaptations when needed,
- Selecting and using appropriate MDS Service Codes in the documentation and reporting of Program Services.

The following individuals must be trained in Making the Connection: Prevention Program Services, Fidelity Adaptations and MDS Service Codes:

SCA Requirement

Any individual who is directly involved with prevention assessment, planning, supervising and monitoring, direct service delivery, and data entry.

Provider Requirement

Any individual responsible for direct service, supervising and monitoring, and/or data entry.

Exemptions to the Making the Connection: Prevention Program Services, Fidelity Adaptations and MDS Service Codes Training requirements include:

- Part-time SCA and provider staff that provide prevention services in the evening or on weekends, and have full-time day employment elsewhere.
- Volunteers who deliver and/or support prevention programs.
- Individuals such as nurses, police officers and school teachers who provide direct prevention services as a component of their jobs.
- If you already hold a certificate for the MDS Service Codes Training, but not the Fidelity Training, BDAP encourages, but does not require, taking the new course.

If further clarification of these exemptions are needed, please contact your assigned Program Analyst.

C. Needs Assessment Training Course

(This training will only be offered prior to each Needs Assessment.)

All SCA and contracted provider staff who will be involved in the facilitation of the Needs Assessment process are required to attend the Needs Assessment Training Course when offered by BDAP.

- *Mandatory attendance, regardless of previous training documentation, may be required by BDAP if modifications have been made to the Needs Assessment Process. A new certificate of completion will be issued.*

D. Annual Outcome Evaluation Training Course

All SCA and/or contracted provider staff who will be responsible for the completion of the Annual Outcome Evaluation Report are required to attend an Annual Outcome Evaluation Training Course when offered by BDAP.

- *Mandatory attendance, regardless of previous training documentation, may be required by BDAP if modifications have been made to the Annual Outcome Evaluation Process. A new certificate of completion will be issued.*

E. Fetal Alcohol Spectrum Disorder (FASD)

The SCA liaison and any prevention provider staff member delivering FASD services must be trained prior to implementing services. The liaison must complete at least six hours of FASD training within six months of acquiring the responsibility of a liaison. Training can be acquired through the following resources:

- SAMHSA online at www.fasdcenter.samhsa.gov
Multiple courses are offered free of charge through this website under the **Education – Training** link.
- FASD trainings offered by BDAP. For a schedule and information on available courses visit the BDAP Training Management System:
<https://bdap.health.state.pa.us/btms/Logon.aspx>

These six (6) hours of training can be considered as part of the 12 hours of training required per year as outlined below.

F. Twelve (12) Hours Per Year Training Requirement

All full-time prevention staff (SCA or contracted provider) who deliver or supervise prevention services must complete 12-hours of prevention training courses each year. Courses may be completed either in a classroom setting or online and must be offered by a recognized drug and alcohol prevention organization including, but not limited to:

- Pennsylvania Dept. of Health, Bureau of Drug and Alcohol Programs (BDAP)
- Commonwealth Prevention Alliance (CPA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Center for Substance Abuse Prevention (CSAP)
- Northeast Center for the Application of Prevention Technologies (NE CAPT)
- FRIENDS National Resource Center for Community-Based Child Abuse Prevention (CBCAP)

Sample online training sites include, but are not limited to, the following:

- <http://pathwayscourses.samhsa.gov/index.htm>
- <http://www.attcnetwork.org/learn/education/index.asp>
- <http://www.cequick.com/myeln/FRIENDS/default.asp>

Certificates of completion for the twelve (12) hours of training need to contain, at a minimum:

- the course name
- number of hours
- date
- name of the organization providing the course

Certificates must be filed and made available upon request.

Staffing Qualifications

Required Qualifications of Staff Providing Prevention Services are as follows:

- A.** Staff delivering prevention services employed in a Planning Council or Public Executive SCA model must meet all State Civil Service Commission classification requirements of the Drug and Alcohol Prevention Program Specialist Trainee, Drug and Alcohol Prevention Program Specialist or Drug and Alcohol Prevention Specialist. Those persons responsible for supervision of prevention staff must meet, at a minimum, all State Civil Service Commission classification requirements of the Drug and Alcohol Prevention Program Supervisor.

- B.** Staff delivering prevention services employed in a Private Executive or Independent SCA model must meet the MET requirements of the State Civil Service Commission classification for Drug and Alcohol Prevention Program Specialist Trainee, Drug and Alcohol Prevention Program Specialist or Drug and Alcohol Prevention Specialist. Those persons responsible for supervision of prevention staff must meet, at a minimum, all State Civil Service Commission classification requirements of the Drug and Alcohol Prevention Program Supervisor.

PART V. Reporting Requirements

The SCA must submit reports to the Department in accordance with the BDAP Report Schedule.

All SCA funded prevention services must be reported in PBPS regardless of the funding source.

PART VI. Reduction Of Youth Access To Tobacco

In identifying alcohol and other drug related issues inherent to the geographic area of the Single County Authority (SCA), the SCA must include tobacco use among youth as a consideration in the needs assessment process and incorporate the reduction of tobacco use among youth as a part of its Comprehensive Strategic Plan, when applicable. In addressing risk and protective factors associated with tobacco use among youth, consideration must be given to current activities promulgated by the Primary Contractor for the Department of Health, Division of Tobacco Prevention and Control, as not to duplicate services being provided through those arrangements. In some cases, the SCA serves as a subcontract to the Primary Contractor and should incorporate those activities into its overall Comprehensive Strategic Plan.

In addition to activities incorporated in the Comprehensive Strategic Plan or done in concert with the Primary Contractor for a particular geographic area, SCAs may be called upon to assist the Department of Health in administrative activities associated with the Annual Synar Survey and Report or the recurring Coverage Study required by the Center for Substance Abuse Prevention to validate the comprehensiveness of the lists used in the Annual Synar Survey. Such activities shall be considered inclusive to the functions to be performed under the Grant Agreement between the SCAs and the Department of Health, Bureau of Drug and Alcohol Programs.

PART VII. Fetal Alcohol Spectrum Disorders (FASD)

In addition to addressing other alcohol and drug related issues, the SCA must address the prevention of FASD as a part of its Comprehensive Strategic Plan. BDAP, through its FASD State Task Force has established an Action Plan to address the prevention and treatment of FASD. (View the Pennsylvania FASD Action Plan at www.health.state.pa.us/bdap). FASD is an umbrella term used to describe the nation's leading category of preventable birth defects, developmental disabilities and behavioral health problems associated with alcohol consumption during pregnancy. As target populations are identified and needs assessments are conducted regarding prevention activities, the implications of this issue must be considered, as the impact is far reaching and is intertwined with various existing priorities.

In response to this, FASD prevention services that are directed toward reducing risk factors must be identified within the SCA's Comprehensive Strategic Plan in the following manner:

1. The SCA must identify a staff member to serve as a liaison who is responsible to ensure FASD awareness and/or education is included within their Comprehensive Strategic Plan to include at minimum:
 - Two community activities
2. The SCA liaison and any prevention provider staff member delivering FASD services must complete required training as defined in Section IV, Training.

FASD programs, strategies and information are available on BDAP web link resources www.health.state.pa.us/bdap .