Developing a Campus Strategic Plan:

A Guidance Document for SPF PFS Grantees

Part A

Minnesota Department of Human Services

Alcohol and Drug Abuse Division

August 2015

Table of Contents

Introduction 3

Developing Your Assessment Summary 6

Identifying Populations of Focus 12

Developing Problem Statements 17

Developing Opportunity Statements 20

Glossary of Terms 26

Introduction

Purpose of Community Strategic Plan

This guidance document is intended to support SPF PFS sub-recipients in the development of a comprehensive prevention plan that is based on local data collected throughout Phase One and designed to guide Phase Two of SPF PFS funding and future prevention work in your community.

The Campus Strategic Plan is a required piece of SPF PFS sub-recipients' contract deliverables. Each SPF PFS sub-recipient community will develop a data-driven plan that articulates not only a vision for prevention activities and capacity building, but also identifies strategies for organizing and implementing prevention efforts.

The Strategic Plan is focused on documented needs, will build on identified resources and strengths, will set measurable goals and objectives, and will include outcome measures and baseline data against which progress will be monitored. Plans will be individualized as the result of ongoing needs assessment (including community readiness and resources findings) and the monitoring of community-level activities.

The issues of sustainability and cultural competency should be constantly addressed throughout each step of planning and implementation and should lead to the creation of a long-term strategy to sustain effective and culturally relevant policies, programs and practices.

Because prevention initiatives that enhance community readiness and capacity are much more likely to achieve their outcomes, DHS ADAD is also requiring all sub-recipients to include a component dedicated to local capacity development. Particularly important areas of development and readiness include whether or not the community:

- has representative and coordinated leadership working across sectors for the common good of the campus
- has adequate capacity, or is building the capacity, to carry out its work and achieve its common mission and vision
- is engaged in the use of effective practices and processes
- is able to generate a variety of resources to sustain outcomes

It is expected that SPF PFS sub-recipients will engage their campus' Epi Workgroup, coalition, cultural liaisons, and community stakeholders throughout the process of developing their Strategic Plans. The process of developing a comprehensive plan for future prevention work should be inclusive and transparent. Gaining input from a broad group of community members will help build buy-in and ownership for the plan.

The Strategic Plan your community develops through this process is intended to serve as a long-term, future-oriented document that is updated and/or modified as needed.

Outline of Campus Strategic Plan

Your Campus Strategic Plan must include the following components:

1. Assessment Summary
    a. Needs Assessment Workbook Summary
    b. Capacity, Assets, and Resources Summary
    c. Community Readiness Summary
    d. Description of the Local Conditions Selection, Assessment, and Prioritization Process
2. Populations of Focus
    a. Direct Populations
    b. High-risk Populations
    c. Populations Requiring Culturally Specific Services
    d. Indirect Populations
3. Project Plans
    a. Problem Statements
    b. Goals & Objectives*
    c. Action Plans*
4. Capacity and Infrastructure Enhancement Plans
    a. Opportunity Statements
    b. Capacity and Infrastructure Enhancement Goals*
    c. Action Plans*
5. Evaluation Plan*
6. Sustainability Plan*
7. Approach to Disseminating and Updating the Strategic Plan*

Components marked with an asterisk are not described in this guidance document—*Developing a Campus Strategic Plan: A Guidance Document for SPF PFS Grantees: Part A*. Parts B and C will be forthcoming, and will cover these components.

Other Guidance Materials, Data Sources and Processes, and Technical Assistance

Information gathered through the following Phase One tools and processes will be used to write your Strategic Plan. Throughout this guidance document, tips will be provided on how and where to use each resource. Contact the SPF Project Director if you have questions about incorporating information from the following:

- Needs Assessment Workbook
- Assessment Plan Worksheet
- Prioritization Process Protocol, Rating Spreadsheet, and Facilitated Discussion Guide
- Coalition Member Conversation Protocol and Guide

- Existing Community Data
- Community Leader Interviews
- Campus Scan Protocol and Tool
- Policy Review Protocol
- Law Enforcement Data Protocol and Collection Form
- Cross-site Evaluation Surveys & Tools
- Community Workbook on Evidence-based Prevention
- Determining the best ways to gain input from all coalition members on the Strategic Plan
- Facilitating discussions with partners, cultural liaisons, and key community leaders about the assessment findings and planning for Phase Two
- Developing strategic planning meeting agendas
- Identifying strategies for building sustainability into the strategic planning process

Summary of the Strategic Planning Process

1. Use this guidance document (Part A) to begin writing your community's Strategic Plan—namely, the Assessment Summary, Identified Populations of Focus, the initial components of your Project Plans (Problem Statements), and the initial components of your Capacity and Infrastructure Enhancement Plans (Opportunity Statements).
2. Identify and implement a system for obtaining stakeholder input into the planning process.
3. Synthesize information from the other Phase One guidance materials, data sources, and processes as it becomes available.
4. Seek input from the SPF Project Director and the SPF PFS Epidemiologist, your Wilder Consultant, as needed throughout development of your plan.
5. Use the guidance document from Part B (available in the fall of 2015) to continue writing your Project Plans and Capacity and Infrastructure Enhancement Plans
6. Submit your Strategic Plan Part A (Assessment Summary, Identified Populations of Focus, Problem Statements, and Opportunity Statements) to DHS ADAD **by November 30, 2015**, along with your Needs Assessment Workbook.
7. Submit your selected strategies for Phase Two to DHS ADAD **by December 31, 2015.**
8. Submit your SPF logic models for each problem statement **by January 31, 2016**
9. Submit your initial draft of your Strategic Plan Part B (detailed action plan for each strategy identified in the logic model, the applicable activities, timelines, and the responsible individual or staff. Additionally, the implementation and/ or action plan should contain specifics around strategies and activities to address health disparities among sub-populations and for reaching capacity and infrastructure development goals) **by February 29, 2016**.
10. Participate in Strategy Selection Interviews with the EBPW **March 2016.**
11. Make revisions as needed to obtain DHS ADAD and EBPW approval **by March 31, 2016**.
12. As soon as your plan is approved, you'll need to draft a Phase Two Budget and work with your Grant Consultant to establish Phase Two deliverables and due dates.
13. Attend Evaluation Plan and Sustainability Training **April 19-20, 2016.**

14. Develop and submit your Sustainability Plan, corresponding Evaluation Plan, and Approach to Disseminating and Updating the Strategic Plan **by June 15, 2016.**
15. Submit your finalized Strategic Plan Part including Parts A, B, and C **by June 30, 2016.**
16. Phase Two begins **July 1, 2016** upon approval of the Community Strategic Plan and will come with a new set of deliverables and dollars in the form of a Contract Amendment.

Developing Your Assessment Summary

In the Assessment Summary, you will summarize key themes and findings from all Phase One assessment activities. All other Community Strategic Plan components will build upon information presented in the Assessment Summary, which contains four sections:

a. Needs Assessment Workbook Summary
b. Capacity, Assets, and Resources Summary
c. Community Readiness Summary
d. Description of the Local Conditions Selection, Assessment, and Prioritization Process

For each section, specific data sources and related questions are provided to guide the development of your summaries.

Role of the Local Epidemiological Workgroup

Your campus is tasked with forming a Local Epidemiological Workgroup or subcommittee to complete the Needs Assessment Workbook; help analyze, interpret, and use data from the College Student Health Survey or the National College Health Assessment; advise and guide data collection processes and activities involved with assessment; and any additional data collection; advise and guide use of data for prioritization and planning; and help use data to monitor progress and outcomes. Collaborate with the workgroup in pulling information from Phase One deliverables, tools, and processes to complete the Assessment Summary section of your Strategic Plan.

Instructions

Needs Assessment Workbook Summary

Step One: summarize key findings from your needs assessment workbook on consumption, consequences, and local conditions related to both underage drinking and young adult marijuana use. Use notes included in your workbook's section summary pages. Answer the following discussion questions in your summary. In addition to a narrative summary, feel free to highlight key findings using tables, graphs, and/or charts.

- What do overall consumption patterns look like (i.e., amount used, frequency of use, use prior to attending college)?
- How do consumption patterns on your campus compare to the average (i.e., all PFS schools combined, all schools participating in the CSHS/ NCHA)?
- Which student populations report the highest rates of underage drinking? Which report the highest rates of marijuana use?
- Which negative consequences due to use are reported by the greatest percentage of students? How do negative consequences from drinking compare to those due to marijuana use?
- What key findings emerged regarding campus and community citations, and school disciplinary incidents?
- What key findings emerged from the sections on intervening variables? This can be a broad-brush summary of the intervening variable categories. For example, what stood out to you in relation to access and availability and community norms? You'll be doing a deeper dive into the specific intervening variables during the prioritization process and the documentation of that process in your strategic plan.

Determining what is "key" can be challenging, especially considering all of the rich information you've obtained throughout Phase One. Consider things like:

- Magnitude—which indicators show the highest number, percent, or rate of alcohol or marijuana use, related consequences, or risk or protective factors? For example: "Forty-eight percent of female College Student Health Survey respondents under the age of 21 reported past month alcohol use."
- Comparisons—which indicators show that a particular problem is greater in your community than the state or national comparison group? For example: "18- 25 year olds on our campus are twice as likely as the six- school PFS average to report marijuana use."

In addition to the above dimensions, you may wish to highlight variations among demographic groups. This will help you identify Populations of Focus later in the strategic planning process. Consider things like:

- Age
- Race/ethnicity
- Gender
- Sexual orientation
- Student or employment status
- Military status

For tools and tips, see the "Analyze and Interpret Data: What do the Data Say?" chapter of the *SUMN Toolkit* (http://sumn.org/tools/Toolbox.aspx#SUMN_toolkit).

Also note which data sources in your community do not have data available by various demographic groups. You may want to address these gaps in your Capacity and Infrastructure Enhancement Plans.

Capacity, Assets, and Resources Summary

Step Two: summarize your community's capacity, assets, and resources using data from Coalition Member Conversations, Key Informant Interviews, Coalition Survey, and applicable data from other sources or additional analysis. Using the key themes from each assessment activity, answer the following key questions. Include references to the data source(s) you used to form your responses. The Capacity, Assets, and Resources Summary should not exceed 8 pages.

Based on combined information from all of the above sources and any additional information collected from your community:

- How knowledgeable are community/campus leaders about the priority areas?
- What efforts are currently taking place in the community or on the campus to address the priority areas?
- What assets and resources exist in the campus community that can help address the priority areas?
- What barriers exist in the campus community that could affect efforts to address the priority areas?
- How effective have the current efforts, policies, and resources been in addressing the priority areas to-date?
- How could the current efforts, policies, and resources be more effective?
- What experience does the coalition have with prevention efforts?
- How knowledgeable are the coalition members about the SPF and the priority areas?
- What assets and resources does the coalition have that can help address the priority areas?
- What are the areas for improvement in how the coalition uses the assets and resources available?

Community Readiness Summary

Step Three: summarize your community's readiness using data from the Coalition Survey, Key Informant Interviews, Coalition Member Conversations, and applicable data from other sources or additional analysis. Using the key themes from each assessment activity, answer the following key questions. Include references to the data source(s) you used to form your responses. Your Community Readiness Summary should not exceed 4 pages.

Based on combined information from all of the above sources and any additional information collected from your community:

- How much of a problem do community members feel that the priority areas are in the community?
    - Are there priority areas they feel are more of a problem or less of a problem than others?
- How interested are community members in addressing the priority areas?
- How much progress do community members and coalition members think the community can make in addressing these priority areas?

Description of the Local Conditions Selection, Assessment, and Prioritization Process

It is recommended that your community select 5 to 7 local conditions to address with programs, policies, and practices. The process of selecting priorities to address should be *data driven*—not based on a required number. However, keep in mind that too few indicators will not provide your community with a comprehensive prevention approach while too many indicators may not be feasible given the budget and timeline. It is also important that your coalition prioritizes both alcohol and marijuana local conditions in order to maximize the chances you will have an impact on both substances on your campus. Comprehensive guidance on strategy selection will be provided at a later date.

Step Four: summarize the process your community used to select, analyze, and prioritize intervening variable indicators.
Describe each of the following:

1) How did you select "optional" indicators to collect data on?
    - Did you have any thoughts going into the selection process? Variables that you had already wanted to include? If so, why?
    - What process did you use to narrow down your choices?
    - Who was involved in selecting optional indicators?

2) How were intervening variables selected to address with prevention strategies?
    - Who was involved in the decision making process?
    - How were the final decisions reached?
    - Was there a natural break that helped you determine your final number of priority local conditions? If there was a natural break, what was it?

3) Fill in the following grid with a row for each intervening variable selected.
    - Column A: Enter the Intervening Variable selected.
    - Column B: List the category associated with the intervening variable, such as Access and Availability or Perceived Enforcement.
    - Column C: Identify whether the intervening variable pertains to underage alcohol use, marijuana use, or both. This information can be found in the grid at the beginning of

each section of your Needs Assessment Workbook or in the Local Condition Indicator list.

- Columns D-G: List the rating for each prioritization criteria your coalition assigned to the intervening variable. Then comment on the key rationale for why that rating was assigned.
- Please see the gray row as an example of how to complete this grid.

A. Intervening Variable	B. Category	C. Substance (alcohol or marijuana)	D. Magnitude rating and key rationale	E. Political will rating and key rationale	F. Capacity rating and key rationale	G. Changeability rating and key rationale
Students reporting they got marijuana from a friend	Access and availability	Marijuana	5 – This is the most common source reported for marijuana	4 – Many adults believe this is how students access marijuana and have a desire to reduce use	4 – We have easy access to students to try to limit sharing	3 – There is a lot of room for change, but it could be hard to change how students interact with each other

Identifying Populations of Focus

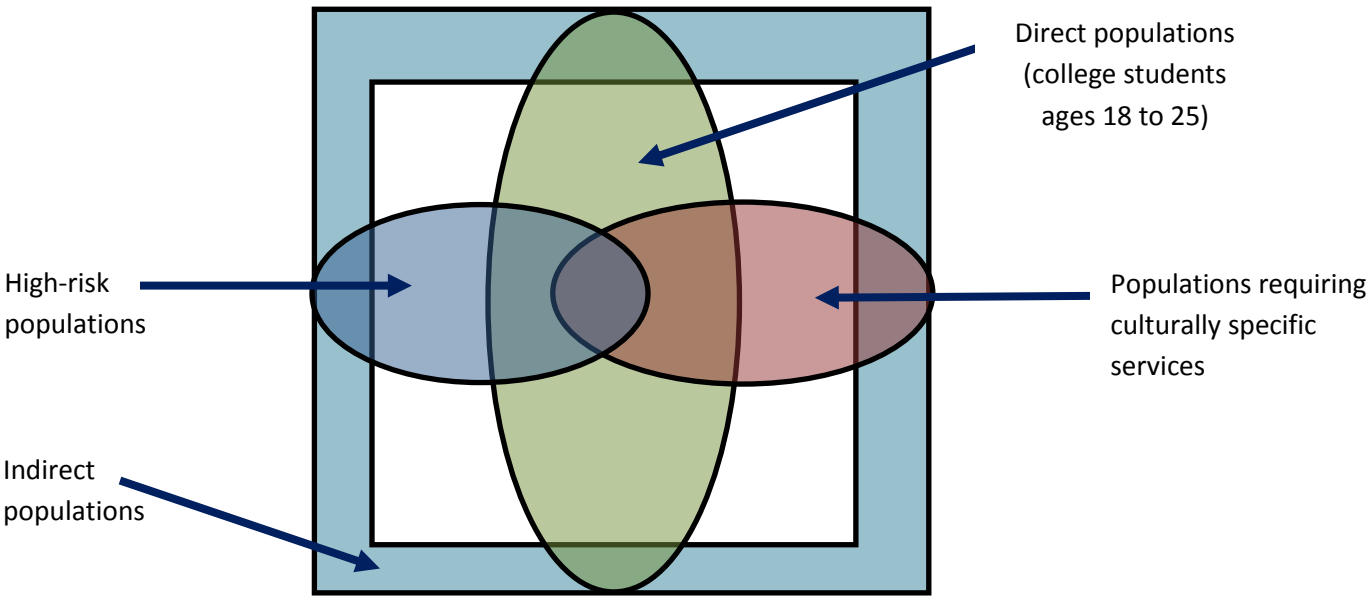
Prior to planning for action, it is important to identify the populations upon which your SPF PFS efforts will need to focus.
Populations of Focus are those individuals and groups who either are directly affected by, involved in, or contribute to the issues identified in your Problem Statements.

Four types of populations should be identified and addressed throughout your Campus Strategic Plan:

- Direct populations
- High-risk populations
- Populations requiring culturally specific services
- Indirect populations

A comprehensive prevention plan reaches all of these Populations of Focus. It is important to note that there is some overlap in these populations, meaning there are people in your

community who fall within more than one type of Populations of Focus, as outlined in the following graphic.



Instructions

Reflect on the questions below each of the population types and address them in the Populations of Focus section of your Strategic Plan. Address each population type in the order presented.

Direct Populations

Direct populations are those who are directly affected by or involved in a problem. For SPF PFS, the direct Populations of Focus are college students ages 18 to 25, with a particular focus on preventing alcohol use among those under age 21 and preventing marijuana use among all students in that age rage. In your Community Strategic Plan, simply specify which college is being served and include the approximate number of enrolled students ages 18 to 25.

High-Risk Populations

High-risk populations include sub-sets of the population who are at higher risk for underage drinking and/or marijuana use because of certain characteristics or inclusion in higher risk categories. High–risk groups may be identified on the basis of individual, relational, community, and/or societal risk factors known to be associated with alcohol and/or marijuana use.

It's important to note that individuals may be higher risk for multiple reasons (i.e., depression + peer use + Greek involvement). Further, there are multiple ways in which we can categorize groups of people who are considered high-risk. Some examples are reflective of people experiencing specific risk factors (i.e., trauma) and some are *populations* that have been

identified as high-risk due to members experiencing a similar *clustering* of multiple risk factors (i.e., GLBTQ, veterans).

As part of the prioritization process, you will be selecting key intervening variables that contribute to use (i.e., easy access, low perceived risk of harm). These intervening variables will then be addressed with prevention strategies. In addition, you will also be prioritizing at least one high-risk population. Meeting the prevention needs of your high-risk populations may involve selecting an intervention geared towards their specific needs, and/or tailoring or adapting other strategies being implemented to ensure they specifically address the needs of these students.

Step One: identify potential high-risk populations using national-, state-, and community-level data and research

One way to identify populations at higher risk is through a review of the national research literature. Many college libraries provide access to research articles through databases like PubMed. Another resource is SAMHSA's Center for the Application of Prevention Technologies website: https://captus.samhsa.gov/access-resources. In addition, the Minnesota Prevention Resource Center's librarian can help identify research on high-risk populations. In addition to state-level college health survey data, high-risk college populations can be identified by reviewing findings from the National College Health Assessment (http://www.achancha.org/) and/or the CORE survey (http://core.siu.edu/results/index.html). Lastly, the tip sheets on high-risk Populations of Focus for marijuana prevention (shared during the June assessment training) are now available in the SUMN.org ToolBox:
http://www.sumn.org/tools/Toolbox.aspx#MJPreventionToolkit

Existing state-level data can also be used to identify higher-risk populations, in the absence of local data. Aggregate data from the 2015 College Student Health Survey can be used to show disparities in underage drinking and young adult marijuana use among college students. Minnesota Student Survey data can also be used to help identify high-risk groups of youth who may eventually feed into Minnesota colleges and universities. These data can be found at www.sumn.org.

Step Two: review local data and answer the guiding questions below

Ideally, you'll be able to use your own local data to identify high-risk populations. In addition to your local college health survey data (which may or may not have an adequate sample size), you may also have data that show a disproportionate level of negative consequences due to use for some student populations (i.e., disciplinary data, arrest data, injury data). Further, you will likely have information about Populations of Focus from your Community Leader Key Informant Interviews and from your Coalition Member Conversations.

Guiding questions to answer using local- and/or state-level college health survey data:

- Which populations of students under age 21 are reporting the highest rates of alcohol use?

- Which populations of students age 18 to 25 are reporting the highest rates of marijuana use?
- Which populations of students are not currently being reached by existing prevention efforts?

Step Three: identify three groups to explore further and complete the *Prioritizing High-Risk Groups/Populations Worksheet* for each

After answering all of the above questions, collaborate with coalition and/or Epidemiological Workgroup members to identify three different high-risk groups or populations. Note these groups in this section of your Strategic Plan, and explain how you selected them. Then complete the *Prioritizing High-Risk Groups/Populations Worksheet* for each of the three groups, which asks you to consider the following:

- What do you already know about this population based on national and state-level research?
- What local data are available for this population? Do not include anecdotal information.
- Do you have an estimate for how many people within this group exist in your community? If yes, how many? If not, why?
- To what extent does your community have the capacity (e.g. cultural liaisons, trust, interpreters, existing organizations or community groups, etc.) to serve this population? Rate your community's capacity on a scale of 1-5, 1 being no capacity, 5 being lots of capacity.
- What ethical considerations may arise in working with this population?

Step Four: select *at least* one priority group or population

Based on your worksheet findings, select at least one priority group/population you will work with (engage, collect data on, target prevention efforts towards). Wilder will assist you in determining how to move forward in collecting any additional needed data.

In your Strategic Plan: 1) describe the priority high-risk group/population(s) selected, 2) explain the process your coalition or Epidemiological Workgroup underwent to select that group/population, and 3) provide justification for your selection.

<u>Populations Requiring Culturally Specific Services</u>

Populations requiring culturally specific services include sub-sets of the overall population who may require tailored assessment tools, programs, and/or outreach and dissemination strategies. Culture may be defined by race, ethnicity, religion, socio-economic status, sexual orientation or gender identity, language, employment sector, rural/urban residence, and other characteristics. These populations may or may not be high-risk. High-risk groups will likely require some tailored services, but there are some populations that may not be considered high risk that also require tailored services. Here are some questions that should be considered

by your coalition and addressed in this section to help identify sub-populations that may need culturally-specific outreach or programming.

- Are there people who are being missed by our universal prevention efforts?
- Who has been left out in the past?
- Who could be better reached if we tailored our approach with them?
- Are there people who, if we change our message, or change how our message is being communicated, we might be more effective in reaching?
- Are there populations that prevention efforts have not reached because of a lack of trust in the coalition, the fiscal host, or mainstream efforts?
- Are there people experiencing specific barriers to receiving prevention services?

Though these groups should be identified now, much of the work around tailoring services and making cultural adaptations will happen in Phase Two. Per the SPF model, this is something that needs to be continuously revisited throughout all five steps.

Indirect Populations

Indirect Populations of Focus are those who play an important role in the conditions that promote or prevent the problem (i.e., professors, counselors, coaches, parents, and landlords). Indirect populations may have a positive or a negative impact on the direct population of focus. Consider the following questions to identify indirect populations:

- Who are the largest suppliers of alcohol to underage youth in your community?
- Who are the people who are most influential in the lives of college students?
- Who, beyond the direct population themselves, is often blamed for the community's alcohol and/or marijuana problems?
- Who is concerned about alcohol and/or marijuana use in your community?
- Who contributes to or has control over your priority local conditions?

Indirect populations may vary for different high-risk or cultural sub-groups. Considering those groups within your community:

- Who are the most influential people in the lives of your specific high-risk populations?
- Who are the most influential people in the lives of your specific cultural groups?
- Are there differences in how these groups access alcohol and/or marijuana?
- Are there different community leaders or role models for these groups?

Note which of the above questions you cannot answer and where data gaps exist in your community. You may want to address these gaps in your Opportunity Statements.

Developing Problem Statements

In order to create positive change in your community, it's important to define what needs to look different in the future. The first components of your Project Plans, which map out how your coalition will create change in the two SPF PFS priority areas, are Problem Statements.

A Problem Statement is a brief description of what currently *exists* that needs to change. These statements should be clear and concise, and developed using your local data. A problem statement should name only one problem at a time. Statements should not frame the problem as the absence of the solution, but the existence of an issue or specific condition to be changed. Specifically, identify who (i.e., which age group), what (i.e., name the behavior, condition, perception), when (i.e., provide the year or range of years the data are from), where (i.e., the geographic area where the problem occurs), and how much (i.e., what number or percent of the population is affected).

You will be developing two different types of Problem Statements:

- SPF PFS Priority Problem Statements— describe the problems of past 30-day alcohol use among college students under age 21, and marijuana use among 18-25 year-old college students
- Local Condition Problem Statements—describe the prioritized local conditions that contribute to the SPF PFS Priorities

Local conditions describe why something is, or is not, a problem in your community—how intervening variables manifest themselves at the local level (i.e., underage college students drinking to celebrate milestones, young adults reporting getting marijuana at parties).

Intervening variables are factors that have been identified as being strongly related to, and influential in, the occurrence and magnitude of alcohol use problems. The Minnesota SPF PFS Project has adopted the following five categories of intervening variables: access and availability; perceived enforcement; pricing and promotion; community norms; and individual/family factors.

Instructions

Step One: using your community's College Student Health Survey or National College Health Assessment data, draft a unique problem statement for *each* SPF PFS Priority. Be a specific as possible, and cite the data source used.

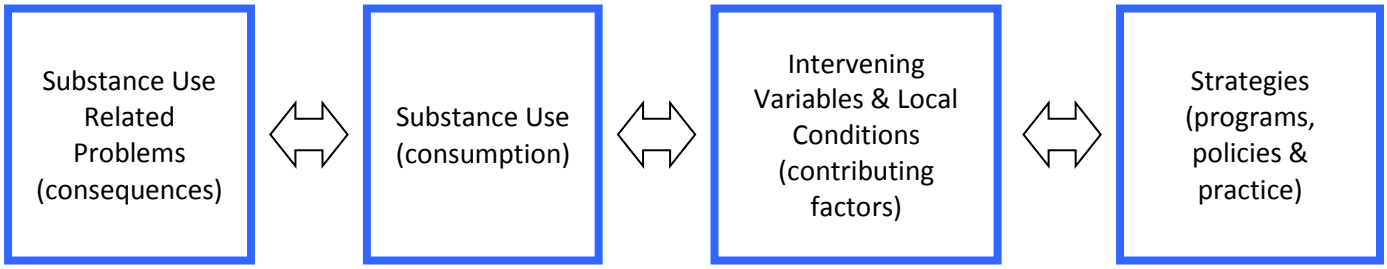
Examples

SPF PFS Priority Problem Statement 1: In 2015, 63% of [campus] 18 to 20 year-olds reported past 30-day alcohol use (Source: CSHS)

SPF PFS Priority Problem Statement 2: In 2015, 19% of [campus] 18 to 25 year-olds reported past 30-day marijuana use (Source: CSHS)

Step Two: once you have selected which local conditions will be addressed with prevention strategies through a local prioritization process, draft a problem statement for *each* of the priority local conditions. Again, use local data in the problem statement and cite the data source(s). Also make note of the intervening variable category for each. If your data are from focus groups, key informant interviews, or facilitated discussions be sure to note how many people participated.

Recall that the SPF Outcome-Based Prevention Model requires us to think about the relationships between our SPF PFS Priority Problems and your community's local conditions.



Using the template below, list the Local Condition Problem Statements with the SPF PFS Priority Problem Statements they relate to. Some local conditions may be relevant for more than one the SPF SIG Priorities. Summarize why each priority was selected in the rationale section, using your assessment data and any other information used during the prioritization process.

Examples

SPF PFS Priority Problem Statement 1: In 2015, 63% of [campus] 18 to 20 year-olds reported past 30-day alcohol use (Source: CSHS)

> **Local Condition Problem Statement 1a.** In 2015, 47% of [campus] 18 to 20 year-olds reported they drink to celebrate holidays, victories, and milestones (Source: CSHS)
>
> **Rationale for Local Condition Problem Statement 1a.** The magnitude for this local conditions is very high. While the most commonly reported reason for drinking was "because it's fun", coalition members didn't feel that the campus community has the

capacity to address the fun factor. "To celebrate" was the second most commonly reported factor; coalition members felt that action could be taken to prevent underage drinking following milestones like athletic victories and completion of final exams.

Local Condition Problem Statement 1b. Campus stadiums are sponsored by the alcohol industry, and include visible alcohol branding on both permanent and temporary fixtures (Source: 2015 PFS Campus Scan)

Rationale for Local Condition Problem Statement 1b. Development of stadiums on campus was partially supported by two alcohol producers; their branding is on both temporary banners and permanent stadium VIP suites.

SPF PFS Priority Problem Statement 2: In 2015, 19% of [campus] 18 to 25 year-olds reported past 30-day marijuana use (Source: CSHS)

Local Condition Problem Statement 2a. In 2015, 29% of [campus] 18 to 25 year-olds reported no perceived risk of harm from use marijuana once or twice per week.

Rationale for Local Condition Problem Statement 2a. National research literature clearly shows that low or no perceived risk of harm is associated with use. Further, the Monitoring the Future study found that each year perceived risk of marijuana use went down, the following year use went up. Our campus' rate of no perceived harm is higher than the state average, and Coalition Member Conversations revealed concerns that marijuana is viewed by many as safer than alcohol.

Local Condition Problem Statement 2b. [Campus] has no policy specifically addressing vaping (Source: 2015 Policy Review)

Rationale for Local Condition Problem Statement 2b. Review of campus policies revealed that no specific mention of vaping is made in campus tobacco and drug policies. National research shows that many people using vaping paraphernalia to consume marijuana as well as tobacco. Without an explicit vaping policy, the campus has no guidelines as to how a violation is defined or what the consequences should be.

Developing Opportunity Statements

In addition to preventing and reducing underage drinking and marijuana use among students, goals of Minnesota's PFS initiative include state and community-level capacity building and enhancement of prevention infrastructures. Similar to the Problem Statements, your community will develop Opportunity Statements describing what currently exists within your prevention infrastructure that could be enhanced.

Instructions

1) Using information from your Capacity, Assets, and Resources Summary and your Community Readiness Summary, develop at least three Opportunity Statements. Be a specific as possible, and cite the data source(s) used. Statements should name only one opportunity at a time. Building on existing strengths and assets, use local data to identify areas for enhancement.

   Remember to address things such as data gaps and relationships you need to develop in order to reach all members of your Populations of Focus.

2) Provide a brief statement about why you selected each Opportunity Statement. Draw from your assessment data and any other information used during your decision making process.

Examples

Opportunity Statement 1: Increase awareness of the Partnerships for Success priority problems among community members (Sources: Community Leader Key Informant Interviews and Coalition Member Conversations).

Rationale forOpportunity Statement 1: Based on the Community Leader Key Informant Interviews and Coalition Member Conversations, community leaders and coalition members are aware of the PFS priority problems, but they do not believe that the broader community is aware of these issues.

Opportunity Statement 2: The PFS coalition is active and engaged, but could be expanded to be more representative of the broader community (Sources: Coalition Survey, Coalition Member Conversations, and Coalition Member Roster).

Rationale forOpportunity Statement 2: We have a core group of eight coalition members who attend meetings regularly and report being strongly committed to the coalition in the Coalition Survey, but our member roster shows that we could use more members, particularly members that represent the community around our campus.

Opportunity Statement 3: Though there appears to be higher rates of marijuana use among students who identify as LGBTQ, the coalition does not have information about how to best reach this population (Sources: College Student Health Survey and Coalition Member Conversations).

Rationale for Opportunity Statement 3: In our College Student Health Survey, students who identify as LGBTQ are more likely to report using marijuana. In addition, our coalition members identified that LGBTQ students are not usually effectively reached with prevention efforts and they are unsure how to best reach this group with inclusive strategies.

Glossary of Terms

Below are definitions of some of the terms commonly used in the SPF PFS Program.

ADAD: Acronym referring to the Minnesota Department of Human Services Alcohol and Drug Abuse Division. ADAD administers the Minnesota SPF PFS funding, houses the project staff, and oversees all activities of the SPF PFS.

Adaptation: Modification made to a chosen intervention; changes in audience, setting, and/or intensity of program delivery. Research indicates that adaptations are more effective when (a) underlying program theory is understood; (b) core program components have been identified; and (c) both the community and needs of a population of interest have been carefully defined. Research also indicates that success improves when adaptations are handled as additions to, rather than deletions of, program components.

Age of Onset: In substance abuse prevention, the age of first use of alcohol, drugs or tobacco.

Anecdotal Evidence: Information derived from a subjective report, observation, or example that may or may not be reliable but cannot be considered scientifically valid or representative of a larger group or of conditions in another location.

Assessment: Assessment involves the collection of data to profile population needs, resources, and readiness to address needs and gaps within a geographic area. The assessment identifies, analyzes, and depicts the nature and extent of a problem in the community. Based on these data, a subset of modifiable factors or conditions are selected as the focus of the coalition's prevention strategies.

Asset Mapping: The process of cataloging the resources of a community.

ATOD: Acronym for alcohol, tobacco, and other drugs.

Baseline Data: The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention.

Capacity: Generally refers to the skills, infrastructure, and resources of organizations and communities that are necessary to effect and maintain behavior change.

Capacity Building: Increasing the ability and skills of individuals, groups, and organizations to plan, undertake, and manage initiatives. It involves the attainment of necessary relationships and knowledge and the mobilization of resources within a community. It also enhances the capacity of the individuals, groups, and organizations to deal with future issues or problems.

Coalition: A union of people and organizations working for a common cause.

Collaboration: The act of working jointly or in partnership with groups or organizations, often ones with whom no previous connections had existed, toward a common goal. Collaboration is an important concept in prevention, community development, technology transfer, and all social change activities.

Community: The intended area of focus for a coalition's work. For the Minnesota SPF PFS Project, community is defined by the campus and the community the campus is a part of that the coalition intends to impact.

Community-level Change: Change that occurs across the population of focus in your community.

Community Readiness: The community's level of awareness of, interest in, and ability and willingness to support substance abuse prevention initiatives. More broadly, connotes readiness for changes in community knowledge, attitudes, motives, policies, and actions.

Consequences: The social, economic and health problems associated with the use of alcohol and illicit drugs e.g., illnesses related to alcohol (cirrhosis, fetal effects), drug overdose deaths, crime, and car crashes or suicides related to alcohol or drugs.

Consumption Patterns: The way in which people drink, smoke and use drugs. Consumption includes overall consumption, acute or heavy consumption, consumption in risky situations (e.g., drinking and driving) and consumption by high-risk groups (e.g., pregnant women).

CSAP: Acronym for the Center for Substance Abuse Prevention, part of the (Federal) Substance Abuse and Mental Health Services Administration (also see SAMHSA). CSAP administers the SPF PFS program and oversees the work of Minnesota's project.

Cultural Competence: (1.) A set of congruent behaviors, attitudes and policies that come together in system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations. (2.) The attainment of knowledge, skills, and attitudes to enable administrators and practitioners to provide for diverse populations. This includes an understanding of that group's or members' language, beliefs, norms, and values, as well as socioeconomic and political factors that may have a significant impact on their well-being, and incorporating those variables into programs.

Cultural Diversity: The existence of multiple cultural groups at all levels of a community or organization; also the deliberate inclusion of diverse cultural groups in community or organizational planning and development.

Culturally Specific Services: Services targeted to comprehensively address the needs of an individual cultural group and foster positive cultural identity development. Services intentionally allow for culture to affect and guide, to ensure that the services are responsive to the unique needs of the populations receiving them.

Data-driven: A process whereby decisions are informed by and tested against systematically gathered and analyzed information.

Demographics: The statistical characteristics of human populations.

Direct Populations: The populations directly affected by or involved in a problem or consequence (ie. college students).

DFC: Acronym referring to SAMHSA's Drug Free Communities Program. There are multiple DFC grantees throughout Minnesota, and SPF PFS sub-recipients are expected to collaborate with these communities.

DHS: Acronym referring to the Minnesota Department of Human Services, the State department that houses the Alcohol and Drug Abuse Division (also see ADAD).

Domain: Sphere of activity or affiliation within which people live, work, and socialize (e.g., self, peer, school, workplace, community).

Environmental Factors: Those factors that are external or perceived to be external to an individual but that may nonetheless affect his or her behavior. At the broader level, these refer to social norms and expectations as well as policies and their implementation.

Environmental Strategies: Prevention efforts that aim to change the context in which substances are used or influence community standards, institutions, structures, and attitudes that shape individuals' behaviors.

EBPW: Acronym for the Minnesota Evidence-Based Practices Workgroup. This workgroup was established under the SPF SIG and is responsible for adopting definitions, tools, and guidance around appropriate strategy selection. The EBPW will also be reviewing the SPF PFS sub-recipient Strategic Plans for approval.

Epidemiology: Epidemiology is the study of the distribution and determinants of disease within a Population, the study of health data.

Evaluation: A systematic, data-driven examination of coalition development, functioning, outcomes, and effectiveness, or the examination of changes occurring as a result of a program, strategy, or intervention.

Evidence-based Program, Practices, and Polices: Prevention strategies that are proven to have produced positive change. SAMHSA/CSAP presents three definitions of "evidence-based," which the EBPW has adopted for use in Minnesota.

Fidelity: Fidelity is the degree to which a specific implementation of a program or practice resembles, adheres to, or is faithful to the model on which it is based.

Goal: A broad statement of what the coalition intends to accomplish. For SPF PFS, goals are related to the changes sub-recipients hope to make in the two SPF PFS Priority Problems.

High-risk (aka "At-risk"): The condition of being more likely than average to develop an illness or condition, such as substance abuse, because of some predisposing factor such as family history or the display of other problem behaviors.

High-risk populations: For SPF PFS, specific groups of students under age 21 who are at higher risk for drinking alcohol, and specific groups of students ages 18-25 who are at higher risk for using marijuana.

Incidence: The number of new cases of a disease or occurrences of an event in a particular time period, usually expressed as a rate, with the number of cases as the numerator and the population at risk as the denominator. Incidence rates are often presented in standard terms, such as the number of new cases per 100,000 population.

Indirect Populations: The populations who play an important role in the conditions that promote or prevent the problem (i.e., college staff, parents).

Implementation: Taking action guided by the Strategic Plan. Progress toward achieving objectives related to the goal of changing behavior is made through the implementation of related activities.

Intervening Variables: Factors that have been identified through research as being strongly related to and influential in the occurrence and magnitude of substance use problems and consequences. The Minnesota SPF PFS Project has adopted the following five categories of intervening variables: access/availability, perceived enforcement, pricing and promotion, community norms, and individual/ family factors. Also see *Local Conditions*.

Intervention: An activity or set of activities to which a group is exposed in order to change the group's behavior. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance abuse or substance abuse-related problems.

IOM Categories: Institute of Medicine's characterization of prevention interventions into three categories: Universal, Selected, and Indicated.

- **Universal** interventions target general populations without regard to individual risk factors.

- **Selective** interventions target subgroups of the general population that are determined to be at higher risk for substance abuse. People are recruited to participate because of the subgroup's profile of high risk, not because of an individual's assessment as being at high risk.
- **Indicated** intervention programs target individuals identified as experiencing early signs of substance abuse and other related problem behaviors, but who do not meet the criteria for addiction. They are designed to address multiple risk factors in individuals/families. People are recruited to participate because of their individual profile of being at high risk and the display of risky behavior.

Local Conditions: Local measures of intervening variables that describe why something is or is not a problem in each unique community—how the intervening variable manifests itself at the local level.

Logic Model: A graphic depiction or map of the relationships between the local substance abuse problem, the risk/protective factors (intervening variables) and local conditions that contribute to it, and the interventions known to be effective in altering those underlying factors and conditions. An evaluation logic model is a tool for describing the relationships between resources, activities, and expected outcomes. An evaluation logic model illustrates the underlying program theory and serves as framework for the evaluation.

Methodology: A procedure for collecting data.

Mobilization: The process of bringing together and putting into action volunteers community stakeholders, staff, and/or other resources in support of one or more prevention initiatives

Morbidity: The presence of a condition, illness, or disease.

Mortality: A fatal outcome, or death.

Norms: A behavior or belief of a community that represents the majority.

Objectives: What is to be accomplished during a specific period of time to move toward achievement of a goal, expressed in specific, measureable terms. For SPF PFS, objectives describe the desired changes in local conditions and intervening variables.

Outcomes: The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be short-term, intermediate, or long-term.

Outcome Measures: Assessments that gauge the effect or results of services provided to a defined population. Outcomes measures include the consumers' level of knowledge or skills

and perception of quality of life, as well as objective measures of mortality, morbidity, and health status.

Population of Focus: the population of focus is the specific population of people whom a particular program or practice is designed to serve or reach. A program, practice, or policy may have direct and indirect Populations of Focus. Populations of Focus also include high-risk populations and populations requiring culturally specific efforts.

Populations Requiring Culturally Specific Programming: Subgroups of the community or groups of individuals who require culturally specific or tailored services in order for prevention messages or programming to be effective. This may involve adaptations such as changing the language of the prevention message, changing the delivery method, or adding cultural information to the content to make it more relevant. These sub-groups may or may not be at higher risk.

Prevalence: The number of all new and old cases of a disease or occurrences of an event during a particular time period, usually expressed as a rate, with the number of cases or events as the numerator and the population at risk as the denominator. Prevalence rates are often presented in standard terms, such as the number of cases per 100,000.

Prevention: Prevention is a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. The goal of substance abuse prevention is the fostering of a climate in which (a) alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal; (b) prescription and over-the-counter drugs are used only for the purposes for which they were intended; (c) other abusable substances (e.g., aerosols) are used only for their intended purposes; and (d) illegal drugs and tobacco are not used at all.

Process Measures/Indicators: Measures of participation, "dosage," staffing, and other factors related to implementation. Process measures are not outcomes, because they describe events that are inputs to the delivery of an intervention

Program: A coordinated set of activities designed to achieve specific objectives over a period of time.

Protective Factors: Factors that increase an individual's ability to resist the use of drugs (e.g., strong family bonds, external support systems, problem solving skills).

Qualitative Data: Qualitative data are records of thoughts, observations, opinions, or words. Qualitative data typically come from asking open-ended questions to which the answers are not limited by a set of choices or a scale. Examples of qualitative data include answers to questions and are used only if the user is not restricted by a pre-selected set of answers. Qualitative data are best used to gain answers to questions that produce too many possible answers to list them all or for answers that you would like in the participant's own words.

Quantitative Data: Quantitative data are numeric information that includes things like personal income, amount of time, or a rating of an opinion on a scale. Even things that you do not think of as quantitative, like feelings, can be collected using numbers if you create scales to measure them. Quantitative data are used with closed-ended questions, where users are given a limited set of possible answers to a question. They are for responses that fall into a relatively narrow range of possible answers.

Resilience: Resilience is either the capacity to recover from traumatically adverse life events and other types of adversity and achieve eventual restoration or improvement of competent functioning or the capability to withstand chronic stress and to sustain competent functioning despite ongoing stressful and adverse life conditions.

Resources: Anything that can be used to improve the quality of community life—the things that can help close the gap between what is and what ought to be. There are many types of resources, including human resources, technical resources, financial resources, etc.

Risk Factors: Individual characteristics and environmental influences associated with an increased vulnerability to the initiation, continuation, or escalation of substance use.

SAMHSA: Acronym for the Substance Abuse and Mental Health Services Administration, the federal agency charged with focusing attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders. SAMHSA houses the Center for Substance Abuse Prevention, the agency responsible for administering the SPF PFS Program (also see CSAP).

SEOW: Acronym for State Epidemiological Outcomes Workgroups. The SEOW is a group that has been compiling and monitoring substance abuse data since 2006. The SEOW has contributed significantly to the SPF PFS project and collaborates with the SPF PFS Advisory Council and staff on data-related activities, including the identification of SPF PFS priorities, the development of the PFS Module for the college student surveys, the development of the Needs Assessment Workbook, and the evaluation of community data sources.

SPF PFS: Acronym for the Strategic Prevention Framework Partnerships for Success Grant.

Stakeholder: An individual, organization, constituent group, or other entity that will be affected by prevention activities or has an interest in the activities or outcomes of a substance abuse intervention.

Strategic Planning: A deliberate set of steps that consider needs and resources; define target audiences and a set of goals and objectives; plan and design coordinated strategies with evidence of success; logically connect these strategies to needs, assets, and desired outcomes; and measure and evaluate the process and outcomes.

Strategy: The overarching approach of a coalition to achieve intended results, including programs, practices, or policies.

Sub-recipient Communities: The entities that receive funds from the State of Minnesota to carry out SPF PFS activities or prevention interventions. The term *sub-recipients* is often used interchangeably with the term *grantee*.

Substance Abuse: Abuse of or dependency on alcohol, tobacco and other drugs. The DSM-IV definition is: The maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period: * recurrent substance use resulting in a failure to fulfill major role obligations; * recurrent substance use in situations in which it is physically hazardous; * recurrent substance-related legal problems; and * continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.

Sustainability: (1.) 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. (2.) The process of ensuring an adaptive and effective substance abuse prevention system that achieves long term results that benefit a focus population.

Young Adults: For the purposes of the SPF PFS, the term *young adults* refers to persons are who between the ages of 18 and 25.