Developing a Community Strategic Plan:

A Guidance Document for SPF SIG Grantees

Part A

Minnesota Department of Human Services

Alcohol and Drug Abuse Division

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Introduction

Purpose of Community Strategic Plan

This guidance document is intended to support SPF SIG 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 SIG funding and future prevention work in your community.

The Community Strategic Plan is a required piece of SPF SIG sub-recipients' contract deliverables. Each SPF SIG 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 community
- 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 SIG sub-recipients will engage their community's 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 Community Strategic Plan

Your Community Strategic Plan must include the following components:

1. Assessment Summary
    a. Epidemiological Profile Summary
    b. Capacity, Assets, and Resources Summary
    c. Community Readiness Summary
    d. Description of the Local Conditions Selection, Assessment, and Prioritization Process
2. Target Populations
    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 <u>not</u> described in this guidance document—*Developing a Community Strategic Plan: A Guidance Document for SPF SIG Grantees: Part A*. Part B 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 designated technical assistance provider if you have questions about incorporating information from the following:

- Local Epidemiological Profile Template and Guidance Document – Lead SPF SIG Epidemiologist
- Intervening Variables/Local Conditions Assessment and Prioritization Guidance Materials – Lead SPF SIG Epidemiologist

- Fiscal Host Questionnaire – Wilder Research, SPF SIG Evaluators
- Coalition Functioning Survey – Wilder Research, SPF SIG Evaluators
- One-to-One Community Member Interviews – Wilder Research, SPF SIG Evaluators
- Young Adult Alcohol Survey (YAAS) – Invitation Health Institute, YAAS Contractor and Lead SPF SIG Epidemiologist
- Existing Community Data – Lead SPF SIG Epidemiologist
- Key Informant Interviews with Community Leaders – Wilder Research, SPF SIG Evaluators
- Facilitated Discussions with Coalition – Wilder Research, SPF SIG Evaluators
- Cross-site Evaluation Surveys & Tools – Wilder Research, SPF SIG Evaluators
- Community Workbook on Evidence-based Prevention – ADAD Grant Consultant or Chair of the Evidence-Based Practices Workgroup (EBPW)

Contact the Master Trainers assigned to your community for tips, tools, recommendations, and technical assistance on how to go about:

- 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, Target Populations, the initial components of your Project Plans (Problem Statements, Goals and Objectives), and the initial components of your Capacity and Infrastructure Enhancement Plans (Opportunity Statements and Goals).
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 Lead SPF SIG Epidemiologist, your Wilder Consultant, your ADAD Grant Consultant, and Master Trainers as needed throughout development of your plan.
5. Use the guidance document from Part B (available in the fall of 2012) to continue writing your Project Plans and Capacity and Infrastructure Enhancement Plans
6. Submit your Assessment Summary to DHS ADAD **by November 30, 2012**, along with your Epi Profile.
7. Submit your Target Populations, Problem and Opportunity Statements, and Goals and Objectives to DHS ADAD **by December 21, 2012.**
8. Submit your first complete Strategic Plan draft (including completed Action Plans) to DHS ADAD **by January 31, 2013.**
9. Make revisions as needed to obtain DHS ADAD and EBPW approval **by March 1, 2013**.
10. 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.

11. Develop and submit your Sustainability Plan, corresponding Evaluation Plan, and Approach to Disseminating and Updating the Strategic Plan **by May 15, 2013.**
12. Phase Two begins **July 1, 2013** 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. Epidemiological Profile 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 community is tasked with forming a Local Epidemiological Workgroup or subcommittee to complete the Local Epidemiological Profile; help analyze, interpret, and use data from the Young Adult Alcohol Survey; advise and guide data collection processes and activities involved with assessment; synthesize and summarize findings from the Fiscal Host Questionnaire, Coalition Functioning Survey, One-to-One Community Member Interviews, Key Informant Interviews, Facilitated Discussions with Coalition, the Cross-site Evaluation Surveys and Tools 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

<u>Epidemiological Profile Summary</u>

Step One: summarize key findings from your Local Epidemiological Profile (Epi Profile). Be sure to address all three SPF SIG priorities in your summary: past 30-day alcohol use among sixth through twelfth graders, recent binge drinking among ninth through twelfth graders, and recent binge drinking among 18-25 year olds.

Your community's Epi Profile should contain data on youth and young adult alcohol use, related consequences, and intervening variables. Consider presenting key findings using a combination

of narrative, bullet points, tables, and graphs. Be sure to answer the following questions in this section. Your Epi Profile Summary should not exceed 6 pages.

- What have you learned about the three priorities from your community assessment (think about depth and breadth of these problems)?
- Which consequence data do you think community members care most about?
- Which consequence data do you want your community to be aware of?
- What five or six pieces of key information would you share with the Minnesota's Statewide SPF SIG Advisory Council, or at a local town hall meeting?
- In considering consumption data, consequence data, and intervening variable data together, what surprised you?
- What data collection challenges did you encounter?
- What are some data that would have been helpful that you weren't able to obtain?

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 youth and young adults who reported alcohol use, experienced an alcohol-related consequence, or were exposed to a particular alcohol-related risk or protective factor? For example: "Forty-eight percent of 9th grade females in our community reported past month alcohol use."
- Time trends—which indicators are getting worse over time? Which are improving over time? For example: "The percent of male students reporting binge drinking in the past two weeks increased from 23% in 2007 to 33% in 2010."
- Comparisons—which indicators show that a particular problem is greater in your community that the state average? For example: "9th through 12th graders in our community are twice as likely as the state average to report binge drinking."
- Severity—which indicators are associated with the greatest health impact? For example: "In 2010, eight 12- to 25-year-olds were killed in alcohol-related motor vehicle crashes in our county."
- Economic impact—which indicators are associated with the greatest economic cost? For example: "Emergency department visits for alcohol-related injuries cost are community approximately $42,000 each year."

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

- Age—look for differences between grades when presenting youth data, as rates of use are often higher among 12th graders than among 6th graders. When possible, present young adult data for 18- to 20-year-olds (under the legal drinking age) separate from 21- to 25-year-olds
- 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 the Fiscal Host Questionnaire, Coalition Functioning Survey, One-to-One Community Member Interviews, Key Informant Interviews, Facilitated Discussions with Coalition, the Cross-site Evaluation Surveys and Tools, and applicable data from other sources or additional analysis. Report the key themes from each assessment activity, and answer the following key questions from each. Your Capacity, Assets, and Resources Summary should not exceed 8 pages.

Based on the perceptions of the community members participating in the ***One-on-One Interviews***:

- What efforts are currently taking place in the community to address the priority areas?
- What policies are currently in place to address the priority areas?
- What assets and resources exist in the community that can help address the priority areas?
- What barriers exist in the 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 additional efforts, policies, and resources could be used to address the priority areas?
- How knowledgeable are community members about the coalition and its activities?

From the perspective of the community leaders who participated in the ***Key Informant Interviews***:

- How informed are community members about the priority areas?
- What efforts are currently taking place in the community to address the priority areas?
- What policies are currently in place to address the priority areas?
- What assets and resources exist in the community that can help address the priority areas?
- What barriers exist in the 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 additional efforts, policies, and resources could be used to address the priority areas?

From the perspective of the coalition members who participated in the ***Facilitated Discussion***:

- What efforts are currently taking place in the community to address the priority areas?
- What experience does the coalition have with partnerships or collaborations to their efforts?
- How effective have the current efforts and collaborations been in addressing the priority areas to-date?
- What additional efforts or partnerships could be used to address the priority areas?

From responses to the ***Fiscal Host Questionnaire***:

- What is the fiscal host's organizational experience with prevention?
- What is the staff's experience and training in prevention?
- What resources does the fiscal host currently have in place to support prevention efforts?
- What efforts are currently taking place in the community to address the priority areas?
- What experience does the coalition have with partnerships or collaborations to their efforts?

From the perspective of the coalition members who participated in the ***Coalition Survey***:

- What assets and resources does the coalition have available?
- What are the areas for improvement in how the coalition functions?
- How effectively does the coalition use the skills and resources available?
- How knowledgeable are the coalition members about the SPF and the priority areas?

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

- How knowledgeable are community members about the coalition?
- How knowledgeable are community members about the priority areas?
- What efforts are currently taking place in the community to address the priority areas?
- What policies are currently in place to address the priority areas?
- What assets and resources exist in the community that can help address the priority areas?
- What barriers exist in the 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 additional efforts, policies, and resources could be used to address the priority areas?

- What experience do the coalition and the fiscal host have with prevention efforts?
- What assets and resources do the coalition and the fiscal host have that can help address the priority areas?
- What are the areas for improvement in how the coalition and fiscal host use the assets and resources available?
- How knowledgeable are the coalition members about the SPF and the priority areas?

Community Readiness Summary

Step Three: summarize your community's readiness using data from the Coalition Functioning Survey, One-to-One Community Member Interviews, Key Informant Interviews, the Facilitated Discussions with Coalition, and applicable data from other sources or additional analysis. Report the key readiness themes from each assessment activity and answer the following key questions from each. Your Community Readiness Summary should not exceed 4 pages.

From the perspective of the community members who participated in the ***One-on-One Interviews***:

- 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 think the community can make in addressing these priority areas?
- How aware are community members of the strengths, assets, and barriers in addressing the priority areas?

From the perspective of the community leaders who participated in the ***Key Informant Interviews***:

- 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 or easily motivated are community members in addressing the priority areas?
- How aware are community members of the strengths, assets, and barriers in addressing the priority areas?
- How much progress do community members think the community can make in addressing these priority areas?

From the perspective of the coalition members who participated in the ***Coalition Survey***:

- How much of a problem are the priority areas are in the community?
- How much progress can the coalition make in addressing these priority areas?
- How aware and invested are community members in the coalition and its activities?

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 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 six to eight 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. 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/local conditions (these terms are often used interchangeably). 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? Local conditions 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 data for the "required" and "optional" indicators collected and analyzed? (answer the questions for both required and optional indicators)
    - How did you collect your data)?
    - What tools did you use, and where did they come from?
    - How did you analyze your data?
    - Who performed the analysis?

3) Which criteria were used to prioritize the indicators?
    - Which criteria were considered? Magnitude? Time trends? Readiness? Political will? Capacity/resources? Changeability? Others?
    - What definitions did you use for each?
    - How did you determine which criteria to use?
    - Who was involved in the process of selecting criteria?

4) How were the criteria applied?
- What process or methods were used to score, rank, or vote?
- Did you prioritize in phases?
- What tools were used?
- Who participated?

5) Which indicators or local conditions were ultimately selected to address with prevention strategies?
- 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?
- Which intervening variable category do each of your priority local conditions fall within?
- Which prioritized local conditions address each of the three priority areas?

Identifying Target Populations

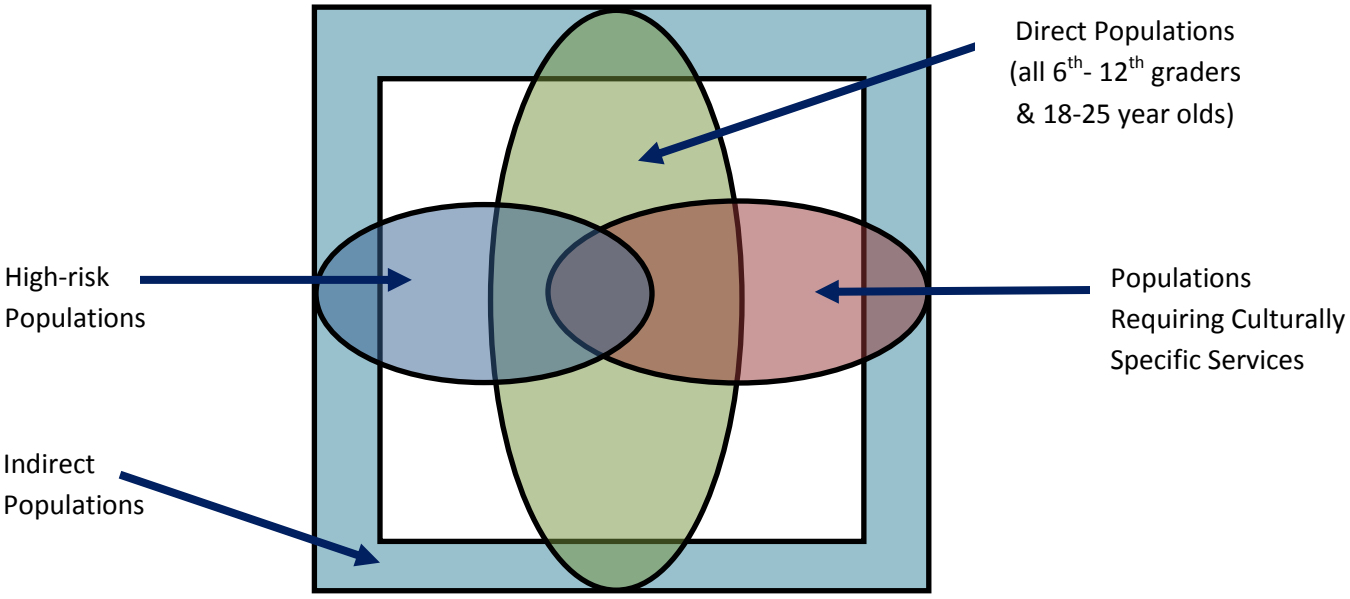
Prior to planning for action, it is important to identify the populations upon which your SPF SIG efforts will need to focus.

Target populations 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 target populations should be identified and addressed throughout your Community Strategic Plan:

- Direct Populations
- High-risk Populations
- Populations Requiring Culturally Specific Services
- Indirect Populations

A comprehensive prevention plan reaches all of these target populations. 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 target population, as outlined in the following graphic.



Instructions

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

Direct Populations

Direct target populations are those who are directly affected by or involved in a problem. For SPF SIG, the direct target populations are 6th through 12th graders and 18 to 25 year-olds. In your Community Strategic Plan, simply specify the geographic area your grant is serving.

High-Risk Populations

High-risk populations include sub-sets of the population who are at higher risk for underage and binge drinking because of certain characteristics or inclusion in higher risk categories. High–risk groups may be identified on the basis of individual, relational, community, societal risk factors known to be associated with alcohol use/abuse. Remember—while age is an important factor in determining an individual's level of risk, youth and young adults are not considered a "high-risk sub-population" for the Minnesota SPF SIG because all youth and young adults are priorities.

Several high-risk populations have been identified through national literature and resources. The Risk and Protective Factor Theory out of the University of Washington is well-known and can be very helpful in identifying high-risk groups, but there is research that identifies other groups that Hawkins and Catalano et al did not specifically study. For example, national research shows that LGBT young adults report higher rates of drinking.

There are some important things to note when considering high-risk populations. An individual may be a member of more than one group of high-risk people; there's a lot of overlap and many risk factors impact one another.

There are multiple ways in which we categorize groups of people who are considered high-risk. Some of the below examples are reflective of people experiencing specific risk factors and some are *populations* that have been identified as high-risk due to members experiencing a similar *clustering* of multiple risk factors.

Below are lists of some examples of nationally-identified high-risk groups and populations. These are not comprehensive lists, but are intended to assist you in beginning to identify potential sub-sets of the population who are at higher risk for underage and binge drinking.

Step One: review the lists below

Groups of people experiencing specific risk factors:

- People who have experienced trauma (such as childhood physical or sexual abuse)
- People living in poverty
- People experiencing unemployment
- People experiencing social rejection/isolation
- People involved in the criminal justice system
- People involved in gangs
- People with mental health problems
- People with an alcohol and/or drug abuser in the household

High-risk populations:

- People identifying as LGBT
- Veterans and military families
- American Indians and Alaskan Natives
- Immigrants and Refugees

Step Two: review local data and answer the related questions

Additionally, you can identify high-risk populations in your community by taking a closer look at differences in local use rates between different sub-groups of 6th through 12th graders and 18 to 25 year-olds. For example, your Minnesota Student Survey (MSS) data may show that 9th grade girls attending alternative schools and area learning centers have much higher binge drinking rates compared to other youth in the community.

Ask the Lead SPF SIG Epidemiologist or your local Epi Workgroups for guidance on running cross-tabs on different demographics and characteristics of MSS and the Young Adult Alcohol Survey (YAAS) responders to identify which groups are using at higher rates. Consider things like grade, age, race/ethnicity, gender, sexual orientation, mental health indicators, parental use,

student or employment status, etc. Additionally, ask the Lead SPF SIG Epidemiologist for help determining whether or not these differences are meaningful or statistically significant. Just because there is a difference between groups, doesn't mean that it is a meaningful one.

In this section, be sure to describe how you decided on which groups to look closer at. After taking a closer look at your local-level MSS and YAAS data, answer the following questions:

- Which sub-groups of 6th through 12th graders report the highest rates of past 30-day alcohol use (think beyond grades)?
- Which sub-groups of 9th through 12th graders report the highest rates of binge drinking (think beyond grades)?
- Which sub-groups of 18 to 25 year-olds report the highest rates of binge drinking?
- Where there any vast difference among groups that surprised you?

In addition to the MSS, the YAAS, and other local use and consequence data, reflect on the findings from the Community Leader Key Informant Interviews. Key questions relevant to high-risk sub-populations that your community leaders were asked include**:**

- Are there any sub-populations in your community that are at especially high risk for either underage drinking or binge drinking among young adults?
- Do you think that people in your community are interested in addressing the underage or binge drinking issues in these high-risk sub-populations?
- What barriers, if any, do you see to incorporating these high-risk sub-populations into your 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 that you would like to learn more about. 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 one priority group or population

Based on your worksheet findings, select 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 data from this group. If you would like to work with more than one group, please contact your Wilder Evaluation Consultant.

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

Be sure to also identify these efforts in your Capacity and Infrastructure Enhancement Plans.

Populations Requiring Culturally Specific Services

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 efforts? See the IOM categories in the Glossary for information about universal 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 target populations are those who play an important role in the conditions that promote or prevent the problem (i.e., parents, police officers, alcohol retail employees, coaches and athletic directors, etc.). Indirect populations may have a positive or a negative impact on the target population. 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 middle school youth?
- Who are the people who are most influential in the lives of high school youth?
- Who are the people who are most influential in the lives of 18 to 20 year-olds?
- Who are the people who are most influential in the lives of 21 to 25 year-olds?
- Who, beyond the target populations themselves, is often blamed for the community's alcohol problems?
- Who contributes to or has control over your priority local conditions?
- Are there any individuals who serve as highly visible role models for youth and young adults in your community (positive or negative)?

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?
- Are there different community leaders or role models for these groups?

Note which of the above target population questions you cannot answer and where data gaps exist in your community. You may want to address these gaps in your Capacity and Infrastructure Enhancement Plans.

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 three SPF SIG 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 SIG Priority Problem Statements—describe the problems of past 30-day alcohol use among 6^{th}-12^{th} graders, binge drinking among 9^{th}-12^{th} graders, and binge drinking among 18-25 year olds

- Local Condition Problem Statements—describe the prioritized local conditions that contribute to the SPF SIG Priorities

Local conditions describe why something is, or is not, a problem in your community—how intervening variables manifest themselves at the local level (e.g., bartenders serving intoxicated patrons at specific establishments, youth reporting getting alcohol from their friends' parents).

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 SIG Project has adopted the following six categories of intervening variables: retail access/availability, social access/availability, enforcement, pricing and promotion, community norms, and individual factors.

A Local Condition Problem Statement should reflect a measure of an intervening variable (e.g., within the community norms intervening variables category, the number and percent of YAAS responders reporting that it is acceptable or somewhat acceptable for 18-20 year olds to get drunk).

Instructions

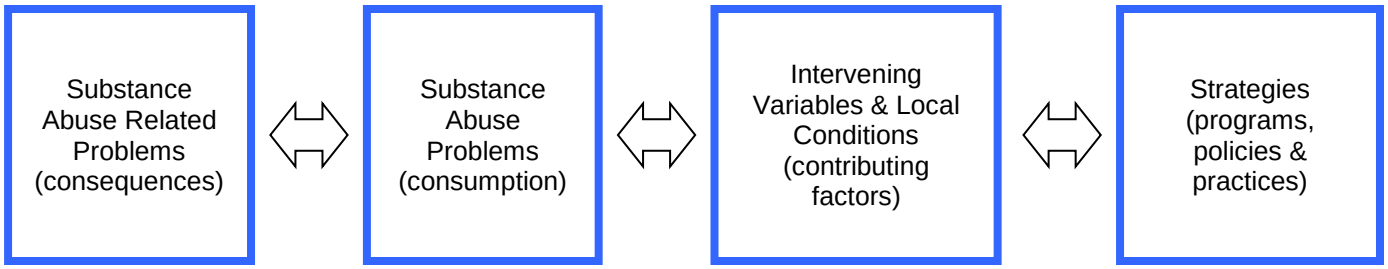
Step One: using your community's Minnesota Student Survey (MSS) data, Young Adult Alcohol Survey (YAAS) data, and/or other local data draft a unique problem statement for *each* SPF SIG Priority. Be a specific as possible, and cite the data source used.

Examples:

- **SPF SIG Priority Problem Statement 1**: In 2010, 20% of Minnesota 6th, 9th, and 12th graders reported past 30-day alcohol use (Source: MSS).
- **SPF SIG Priority Problem Statement 2**: In 2010, 16% of Minnesota 9th and 12th graders reported past two week binge drinking (Source: MSS).
- **SPF SIG Priority Problem Statement 3**: In 2012, 36% of Minnesota 18 to 25 year-olds surveyed reported past 30-day binge drinking (Source: YAAS).

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 type of intervening variable 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 SIG Priority Problems and your community's local conditions.



Using the template below, list the Local Condition Problem Statements with the SPF SIG Priority Problem Statements they relate to. Some local conditions may be relevant for more than one the SPF SIG Priorities.

Examples

SPF SIG Priority Problem Statement 1: In 2010, 20% of Minnesota 6th, 9th, and 12th graders reported past 30-day alcohol use (Source: MSS).
Local Condition Problem Statement 1: In 2010, Minnesota had one liquor license for every 335 people (IV Type: Retail Access/Availability; Source: MN AGED Liquor License Database).
Local Condition Problem Statement 2: In 2010, there were only 4,305 juveniles arrested for liquor laws in Minnesota while 23,599 6th, 9th, and 12th graders reported using alcohol in the past 30 days in 2010 (IV Type: Enforcement; Source: MN DPS Crime Information Report, MSS).
Local Condition Problem Statement 3: In 2010, 74% of Minnesota 9th and 12th graders reported being home alone or in an unsupervised place after school (IV Type: Social Access/Availability or Individual Factors; Source: MSS).
Local Condition Problem Statement 4: As of July 2012, only one community in the county being served by our SPF SIG had a Social Host Ordinance in place (IV Type: Enforcement or Community Norms; Source: personal correspondence with local law enforcement agencies).

SPF SIG Priority Problem Statement 2: In 2010, 16% of Minnesota 9th and 12th graders reported past two week binge drinking (Source: MSS).
Local Condition Problem Statement 1: In 2010, Minnesota had one liquor license for every 335 people (IV Type: Retail Access/Availability; Source: MN AGED Liquor License Database).
Local Condition Problem Statement 2: In 2010, there were only 4,305 juveniles arrested for liquor laws in Minnesota while 23,599 6th, 9th, and 12th graders reported using alcohol in the past 30 days in 2010 (IV Type: Enforcement; Source: MN DPS Crime Information Report, MSS).
Local Condition Problem Statement 3: In 2010, 74% of Minnesota 9th and 12th graders reported being home alone or in an unsupervised place after school (IV Type: Social Access/Availability or Individual Factors; Source: MSS).
Local Condition Problem Statement 4: As of July 2012, only one community in the county being served by our SPF SIG had a Social Host Ordinance in place (IV Type: Enforcement or Community Norms; Source: personal correspondence with local law enforcement agencies).

SPF SIG Priority Problem Statement 3: In 2012, 36% of Minnesota 18- to 25-year-olds surveyed reported past 30-day binge drinking (Source: YAAS).
Local Condition Problem Statement 1: In 2010, Minnesota had one liquor license for every 335 people (IV Type: Retail Access/Availability; Source: MN AGED Liquor License Database).
Local Condition Problem Statement 2: In 2012, 48% of Minnesota 18-20 year olds surveyed who reported past month alcohol use said they were given alcohol by a friend, acquaintance, or sibling who was 21 or older (IV Type: Social Access/Availability; Source: YAAS).
Local Condition Problem Statement 3: As of July 2012, only one community in the county being served by our SPF SIG had a Social Host Ordinance in place (IV Type: Enforcement or Community Norms; Source: personal correspondence with local law enforcement agencies).
Local Condition Problem Statement 4: Forty-one of the 48 focus group participants aged 18-25 reported seeing alcohol advertisements at local events in the past year (IV Type: Pricing/Promotion; Source: September 2012 County Public Health Focus Groups).

Developing Opportunity Statements

In addition to preventing and reducing underage drinking and binge drinking among youth and young adults, goals of Minnesota's SPF SIG 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

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 target populations.

Examples

Opportunity Statement 1: While community leaders and coalition members are aware of the SPF SIG priority problems, awareness among the broader community could be increased (Sources: One-on-One Interviews, Community Leader Key Informant Interviews, Facilitated Discussion with Coalition).

Opportunity Statement 2: The SPF SIG Community Coalition is active and engaged, but could be expanded to be more representative of the broader community (Sources: One-on-One Interviews, Coalition Functioning Survey, Facilitated Discussion with Coalition).

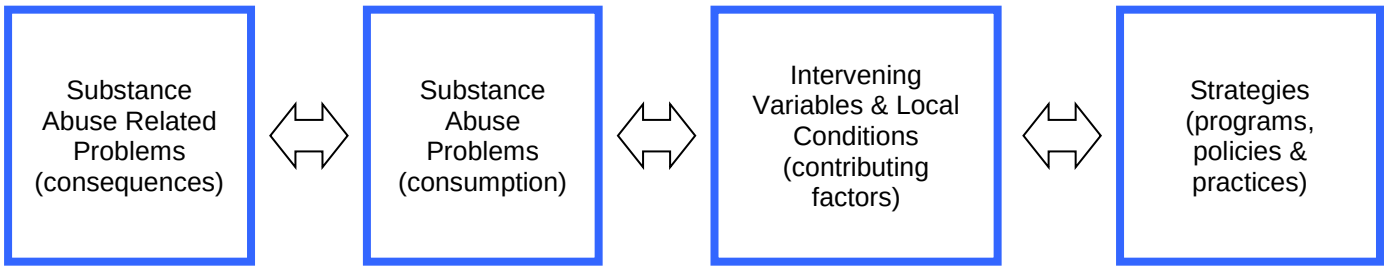
Opportunity Statement 3: Though a number of individual prevention strategies are currently being implemented at the community college, prevention efforts should be enhanced to impact all young adults in the community (Sources: One-on-One Interviews, Community Leader Key Informant Interviews, Facilitated Discussion with Coalition, Fiscal Host Questionnaire).

Opportunity Statement 4: Though the coalition is aware that national literature indicates that the LGBT population is a higher risk for substance abuse problems, coalition members are not aware of any local data on this population (Sources: Facilitated Discussion with the Coalition).

Writing Goals and Objectives

Outcome-Based Prevention Model

Once again, we refer back to the Outcome-Based Prevention Model. Utilizing this model, our ultimate task is to change the local conditions and intervening variables and reduce consumption behavior (and, in turn, reduce the associated negative consequences).



Communities can implement programs, policies, and practices that change their local conditions by reducing factors related alcohol use problems and at increasing factors related to prevention of substance use problems, but before selecting strategies for Phase Two, it is important to identify what you want your community to look like in the future.

Definitions

Goals describe general desired changes in behavior. Substance abuse prevention goals describe the changes in *human* behaviors that are needed to prevent the problems. Goals should be related to the drinking behavior of the direct target populations identified in your SPF SIG Priority Problem Statements. Goals of creating statistically significant change in the three SPF SIG priorities have already been identified for you.

Objectives describe specific changes in the local conditions that must occur in order to achieve your goals.

Capacity and Infrastructure Expansion Goals will address how Grantees will to utilize their assets to build capacity, lay the ground work for future efforts, and make prevention "everyone's business."

SMART Goals and Objectives

Your community's goals and objectives should be SMART—Specific, Measurable, Attainable, Relevant, and Time-specific. In Part A of your Strategic Planning Process, you will outline goals and objectives, but you will be adding more specificity after you select strategies in Part B.

Specific: Explicitly state what you want to happen, where, and to whom after Phase Two.

- Specific objective: Increase the number of county schools who have established and instituted written, campus-wide alcohol policies by June 30, 2014.
- Non-specific objective: Schools will have alcohol policies in place.

  Explanation: The specific objective above includes more detail about who, where, and what you are expecting to happen, as shown in the underlined text.

Measurable: This means you select a change that can be measured. That is, your goal or objective is one for which it can be determined whether and to what extent change has occurred. Measurable objectives will guide evaluation design, allowing you to track progress, document success or know where interventions aren't progressing as planned.

- Measurable objective: Decrease alcohol-related emergency department visits among young adults age 18 to 25 by June 30, 2015.
- Non-measurable objective: Prevent alcohol-related injuries.
  Explanation: It is difficult to measure something that hasn't happened (prevented) and there is not a reliable way to capture all injuries, so this example is not reasonably measurable.

Achievable (and Realistic): Especially when you aim to prevent behaviors, like drinking, you may have to settle for small steps in a long process. If you overreach, your target audience may turn away completely. Besides, your realism reflects on your credibility. You cannot save the world with any intervention. But you can make the world a better place in a very concrete, albeit incremental, way.

- Achievable goal: Create a statistically significant reduction in reported binge drinking in the past 30 days among Minnesota young adults age 18 to 25 by June 30, 2015.
- Non-achievable goal: Stop young adults from binge drinking.

  Explanation: The achievable goal above focuses on changing a behavior rather than completely eliminating it. Absolute statements are rarely achievable.

Relevant: Objectives must be logically related to your overall goals regarding the three priority areas. Check with your target population and use the Outcome-Based Prevention Model to ensure that what you hope to achieve in the short run will get you where you want to be in the long run. Objectives must also be relevant to the themes and findings presented in your assessment summary.

Priority area: Past 30-day alcohol use among Minnesota 6th through 12th graders

- Relevant objective: Decrease the percent of Minnesota 6th through 12th graders reporting they took alcohol from their home by June 30, 2016.
- Irrelevant objective: Reduce the percent of parents in the community who drink alcohol at a local establishment.

Explanation: The relevant objective is focused on youth access to alcohol, which is directly related to underage alcohol use. However, the irrelevant objective is focused on parents' behaviors outside of the home. While there may be some connections you can make between parental behaviors at a local establishment and youth alcohol use, these connections are not as direct as they would be for other more relevant objectives.

Time-specific: Identify a timeframe (specific dates) that you hope to see the changes in your local conditions and priority problems.

- Time-specific objective: Increase the number liquor retail outlets at which compliance checks are conducted at least semi-annually in our county by December 2013.
- Non-time-specific objective: Compliance checks will be conducted semi-annually at liquor retail outlets in our county.

Explanation: The time-specific goal provides a date by which the desired change is expected to occur.

Instructions for Developing Project Plans

Step One: Following the sample template below, insert the SPF SIG and Local Condition Problem Statements you've already identified for each SPF SIG Priority. In the example provided below, these statements are italicized.

Step Two: The SPF SIG Advisory Council, through the process of prioritizing our three SPF SIG problems, has identified goals for creating statistically significant change in these three specific areas for funded communities. Add your community's name to the goals for SPF SIG Priority Problem Areas 1 and 2. You will need to work with the Lead SPF SIG Epidemiologist to develop the goal for Priority Problem Area 3 based on your local YAAS data.

The goals for SPF SIG Priority Problem Areas 1 and 2:

- **Priority Problem Area 1:** Achieve a decrease in past 30-day alcohol use among 6th through 12th graders surveyed by the MSS in (add your SPF SIG geographic area) between 2013 and 2016 that is statistically significantly greater than the decrease achieved by all other Minnesota Communities that participated in both the 2013 and 2016 MSS.
- **Priority Problem Area 2:** Achieve a decrease in binge drinking among 9th and 12th graders surveyed by the MSS in (add your SPF SIG geographic area) between 2013 and 2016 that is statistically significantly greater than the decrease achieved by all other Minnesota Communities that participated in both the 2013 and 2016 MSS.

Step Three: Within each SPF SIG Priority Statement, develop one objective for each Local Condition Problem Statement.

Examples

SPF SIG Priority Problem Statement 1: In 2010, 20% of Minnesota 6th, 9th, and 12th graders reported past 30-day alcohol use (Source: MSS).
Goal 1: Achieve a decrease in past 30-day alcohol use among 6th through 12th graders surveyed by the MSS in (add your SPF SIG geographic area) between 2013 and 2016 that is statistically significantly greater than the decrease achieved by all other Minnesota Communities that participated in both the 2013 and 2016 MSS.
Local Condition Problem Statement 1: *In 2010, Minnesota had one liquor license for every 335 people (IV Type: Retail Access/Availability; Source: MN AGED Liquor License Database).*
Objective 1: By June 30, 2015, the state's liquor licenses per capita will decrease across the state, including in low-income areas.
Local Condition Problem Statement 2: *In 2010, there were only 4,305 juveniles arrested for liquor laws in Minnesota while 23,599 6th, 9th, and 12th graders reported using alcohol in the past 30 days in 2010 (IV Type: Enforcement; Source: MN DPS Crime Information Report, MSS).*
Objective 2: Increase the number of juveniles arrested for liquor laws in Minnesota by 2015 (IV Type: Enforcement; Source: MN DPS Crime Information Report).
Local Condition Problem Statement 3: *In 2010, 74% of Minnesota 9th and 12th graders reported being home alone or in an unsupervised place after school (IV Type: Social Access/Availability or Individual Factors; Source: MSS).*
Objective 3: By June 30, 2016, the percent of Minnesota 9th and 12th graders who report being home alone or in an unsupervised place after school will decrease.
Local Condition Problem Statement 4: *As of July 2012, only one community in the county being served by our SPF SIG had a Social Host Ordinance in place (IV Type: Enforcement or Community Norms; Source: personal correspondence with local law enforcement agencies).*
Objective 4: By June 30, 2014, increase the number of communities in the county being served by our SPF SIG that have a Social Host Ordinance in place.

Instructions for Developing Capacity and Infrastructure Enhancement Plans

Step One: Following the sample template below, insert the Opportunity Statements you've already identified.

Step Two: For each Opportunity Statement, develop corresponding Capacity and Infrastructure Expansion Goals.

Examples

Opportunity Statement: The SPF SIG Community Coalition is active and engaged, but could be expanded to be more representative of the broader community (Sources: One-on-One interviews, Coalition Functioning Survey, Facilitated Discussion with Coalition).
Capacity and Infrastructure Expansion Goal 1: Recruit at least two young adults to be active members of the SPF SIG Community Coalition by September 1, 2013.
Capacity and Infrastructure Expansion Goal 2: Recruit at least one member of the Hispanic/Latino community to be an active member the SPF SIG Community Coalition by September 1, 2013.
Capacity and Infrastructure Expansion Goal 3: Recruit at least one representative from the active military or veteran community to be an active member of the SPF SIG Community Coalition by September 1, 2013.

Opportunity Statement: Though the coalition is aware that national literature indicates that the LGBT population is a higher risk for substance abuse problems, coalition members are not aware of any local data on this population (Sources: Facilitated Discussion with the Coalition).
Capacity and Infrastructure Expansion Goal 1: Identify a cultural liaison to facilitate confidential dialog between people identifying as LGBT and a small group of coalition members by June 30, 2013.
Capacity and Infrastructure Expansion Goal 2: Develop a data collection plan in collaboration with Wilder Research and members of the target population by January 31, 2014.
Capacity and Infrastructure Expansion Goal 3: Begin collecting local data from the LGBT population by July 1, 2015.

You will revisit your goals and objectives throughout the strategic planning process and Phase Two. Your community-specific local conditions and objectives should guide strategy selection, but you will add more specificity to your objectives after identifying strategies.

Glossary of Terms

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

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

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 SIG Project, community is defined by the geographical area 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 SIG 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.

DFC: Acronym referring to SAMHSA's Drug Free Communities Program. There are multiple DFC grantees throughout Minnesota, and SPF SIG 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 SIG 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 SIG, goals are related to the changes sub-recipients hope to make in the three SPF SIG 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 Sub-populations: For SPF SIG, sub-groups of the target populations (6th through 12th graders and 18-25 year-olds) who are at higher risk for underage and binge drinking.

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.

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 SIG Project has adopted the following six categories of intervening variables: retail access/availability, social access/availability, enforcement, pricing and promotion, community norms, and individual 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 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 SIG, 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.

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 SIG 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 SIG project and collaborates with the SPF SIG Advisory Council and staff on data-related activities, including the identification of SPF SIG priorities, the development of the 18-25 year old survey (Young Adult Alcohol Survey), the development of the Local Epidemiologic Profile Template, and the evaluation of community data sources.

SPF SIG: Acronym for the Strategic Prevention Framework State Incentive 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 SIG 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.

Target Population: The target population 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 target populations. Target populations also include high-risk sub-populations and populations requiring culturally specific efforts.

Youth: For the purposes of the SPF SIG, youth refers to either 6th -12th graders (when discussing youth past 30-day alcohol use) or 9th-12th graders (when discussing youth binge drinking).

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