Rhode Island Prevention Specialist Certification:

STUDY GUIDE FOR THE CERTIFICATION EXAM

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Prepared for: BHDDH

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The Rhode Island Prevention Certification Guide: A Study Guide for the Certification Exam is a resource sponsored by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) to serve as a study aid to assist prevention professionals to prepare for and pass the Rhode Island Prevention Specialist Certification Exam. The Guide was developed by the RI Prevention Resource Center (RIPRC). The RIPRC is implemented by JSI Research & Training Institute, Inc. under contract with the BHDDH. All or part of the funding for the contract is provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). The content of this Guide does not necessarily represent the views or policies of either SAMHSA or the BHDDH.

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INTRODUCTION AND PURPOSE

Introduction

A prevention specialist is a behavioral health professional who has demonstrated competency related to alcohol, tobacco and drug use prevention, and who provides services that help individuals, families and communities to develop the capacities needed to achieve behavioral health and wellness. Prevention specialists deliver evidence-based prevention programming in a wide range of settings including schools, workplaces, health care centers, behavioral health programs, community based organizations, and prevention coalitions.

The RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is committed to building and strengthening the prevention workforce in Rhode Island, by supporting training and professional development opportunities, and facilitating the certification process for both beginning and experienced prevention professionals. Toward that end, BHDDH commissioned the development of this Study Guide for individuals seeking to take the Prevention Specialist Certification Exam offered by the Rhode Island Certification Board.

Purpose of the Guide:

This Guide was designed as a study aid to help prevention professionals prepare for and pass the Rhode Island Prevention Specialist Certification Exam. The content of the Guide is based on the knowledge, skills and job tasks derived from the 2013 Prevention Specialist Job Analysis conducted by the International Certification and Reciprocity Consortium (IC&RC) which sets standards and develops examinations for the credentialing of prevention, substance use treatment, and recovery professionals.

The Guide was developed by the Rhode Island Prevention Resource Center (RIPRC), in consultation with subject matter experts in the prevention field, with input from prevention specialist candidates who have taken or are preparing to take the certification exam.

Overview of the Guide:

The first half of the Study guide summarizes key concepts and strategies so that users can review content areas essential to prevention practice, including:

- public health approaches to prevention in behavioral health
- prevention theories and strategies
- strategic planning for prevention
- cultural competence in prevention
- coalition development
- communication strategies
- ATOD-Effects of drugs on the brain
- ethical issues in prevention

The remainder of the Guide is comprised of practice activities including over 50 sample questions similar in format and level of difficulty to those on the exam, along with an answer key and explanations of the correct responses. Two worksheets and a set of flashcards for study-on-the-go are also included, along with an extensive glossary, a list of acronyms, and references to consult for more in-depth review of important topics. Study tips and test-taking strategies are also provided.

For More Information:

For information on Prevention Specialist Certification in Rhode Island, please contact the Rhode Island Certification Board (RICB): 715-540-4456, info@ricertboard.org, www.ricertboard.org

For information on scheduled workshops on preparing for the certification exam, please contact the Rhode Island Prevention Resource Center: www.riprc.org

For information about the exam itself, please consult the Candidate Guide for the IC&RC Prevention Specialist Examination: http://internationalcredentialing.org/Resources/Candidate%20Guides/PS%20candidate%20guide%204-15.pdf

For information about the behavioral healthcare system in Rhode Island, please contact the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH): 401-462-0644, www.bhddh.ri.gov

PUBLIC HEALTH APPROACHES TO PREVENTION IN BEHAVIORAL HEALTH

What is Behavioral Health?

Behavioral Health refers to "a state of emotional/mental well-being and/or choices and actions that affect health and wellness".

Individuals engage in behavior and make choices that affect their wellness, including whether or not to use alcohol, tobacco or other drugs. Communities can also impact choices and actions that affect wellness, such as imposing and enforcing laws that restrict youth access to alcohol and assuring that all pregnant women have access to prenatal care.

Behavioral health problems include:

- Substance abuse or misuse
- Alcohol and drug addiction
- Mental and substance use disorders
- Serious psychological distress
- Suicide

The term *behavioral health* can also be used to describe the service systems surrounding the promotion of mental health, the prevention and treatment of mental and substance use disorders, and recovery support.

The public health approach and the Institute of Medicine (IOM) Continuum of Care co-exist and both influence the field of prevention in behavioral health.

Public Health Approach

A commonly used definition of ***public health*** from the IOM: "It is what we, as a society, do collectively to assure the conditions for people to be healthy."

Public Health Approach: Key Characteristics

- ✓ **Promotion and prevention** – The focus is on promoting wellness and preventing problems.
- ✓ **Population based** –The focus is not on one individual but on the population that is affected and that is at risk.
- ✓ **Risk and protective factors** – These are the factors that influence the problem.
- ✓ **Multiple contexts** – Contexts relate to the ecological model in which the individual is influenced by different environments, such as the family, neighborhood, school, community, and culture.

- ✓ **Developmental perspective** – Consider the developmental stage of life of the populations at risk (e.g. adolescence, older adults)
- ✓ **Planning process** – Public health utilizes a deliberate, active, and ongoing planning process.

The Public Health approach to developing prevention intervention and strategies asks the following questions…

What? – What substance use and other behavioral problems need to be addressed?

Who? – Who will the interventions focus on—the entire population or a specific population group?

When? – When in the lifespan—at what specific developmental stage—is the population group that the interventions focus on? (e.g., adolescence, young adulthood)

Where? – Where should the interventions take place? Prevention needs to take place in multiple contexts that influence health and where risk and protective factors can be found—in individuals, families, communities, and society.

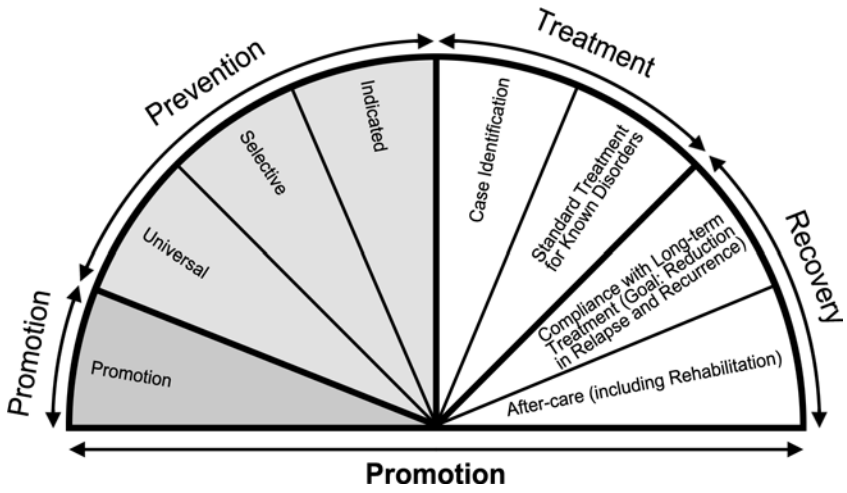
Why? – Why are these problems occurring? This refers to the risk and protective factors that contribute to the problems.

How? – How do we do effective prevention? This refers to a planning process—the Strategic Prevention Framework—that will be used to determine what interventions will be most effective for a specific population group.

Source SAPST, Version 8, November 2012 – SAMHSA Reference #277-08-0218

The IOM Continuum of Care

The Institute of Medicine's continuum of care is a classification system that presents the scope of behavioral health interventions and services, including: promotion of health, prevention of illness/ disorder, treatment, and maintenance/recovery.



Promotion involves interventions (e.g., programs, practices, or environmental strategies) that enable people "to increase control over, and to improve, their health."

Prevention focuses on interventions that occur prior to the onset of a disorder and which are intended to prevent the occurrence of the disorder or reduce risk for the disorder. There are 3 main types of prevention interventions including:

> **Universal** preventive interventions focus on the "general public or a population subgroup that have *not been identified on the basis of risk*."
>
> > *Examples:* community policies that promote access to early childhood education, implementation or enforcement of anti-bullying policies in schools, education for physicians on prescription drug misuse, and social skills education for youth in schools
>
> **Selective** preventive interventions focus on individuals or subgroups of the population "whose risk of developing behavioral health disorders is significantly higher than average."
>
> > *Examples:* prevention education for new immigrant families living in poverty with young children, and peer support groups for adults with a history of family mental illness and/or substance abuse
>
> **Indicated** preventive interventions focus on "high-risk individuals who are identified as having minimal but detectable signs or symptoms" that foreshadow behavioral health disorders, "but who do not meet diagnostic levels at the current time."
>
> > *Examples*: information and referral for young adults who violate campus or community policies on alcohol and drugs; and screening, consultation, and referral for families of older adults admitted to emergency rooms with potential alcohol-related injuries

Treatment interventions include case identification and standard forms of treatment (e.g., detoxification, outpatient treatment, in-patient treatment, medication-assisted treatment).

Maintenance includes interventions that focus on compliance with long-term treatment to reduce relapse and recurrence, and aftercare including rehabilitation and recovery support.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Source: SAPST, Version 8, November 2012 – SAMHSA Reference #277-08-0218

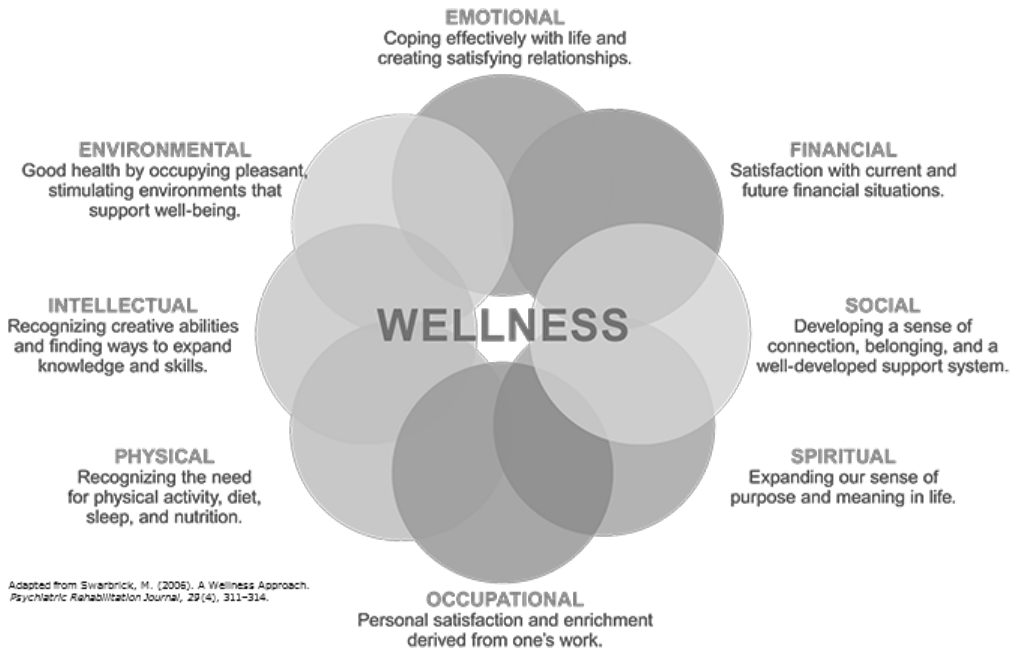
The Ultimate Goal of Prevention Activities is Wellness

Wellness is a conscious, deliberate process that requires awareness of—and making choices for—a more satisfying lifestyle.

Wellness is not merely the absence of disease, illness, and stress, but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness.

Eight Dimensions of Wellness

SAMHSA (the Substance Abuse and Mental Health Services Administration) describes wellness as having eight dimensions:



History

DATE	NATIONAL SITUATION	PREVENTION STRATEGY
1950s	Drug use intensified. Heroin addiction alone hit an all-time high, particularly in urban areas.	Scare tactics through films and speakers
1960s	People began using drugs to have psychedelic experiences. Drug use was associated with the counter culture or racial/ethnic minorities. By the end of the decade drug use was considered a national epidemic.	Scare tactics through films and speakers; information about substance abuse through films and speakers
1970s	Alcohol and drug abuse were recognized as major public health problems. War on Drugs campaign was developed to reduce illegal drug trade. Throughout the decade, society grew more tolerant of drug use.	Drug education using curricula based on factual information; affective education using curricula based on communication, decision- making, values clarification, and self-esteem
1980s	"Just Say No" campaign, part of the War on Drug effort, encouraged youth to resist peer pressure by saying "no." Partnerships developed as the public became increasingly involved in addressing the problems of substance abuse.	Parent-formed organizations to combat drug abuse, social skills curricula, refusal skill training and parenting education
1990s	Research examined the factors that protect people or put them at risk for a variety of problems, including alcohol and drug abuse. The value of professionalism and training in this area grew. Community collaborations received funding to address alcohol and drug problems.	Community-based approaches to prevention; environmental approaches; media campaigns; culturally sensitive programs; evaluation of prevention programs; professional training programs
2000–2010	Understanding of the connections between substance abuse and mental illness/health evolved. "Behavioral health" encompassed both substance use and mental health problems.	Application of evidence-based models; comprehensive programs targeting many contexts (family, school, community); data-driven decision-making through a strategic planning process
2010–present	Greater emphasis is placed on prevention and treatment for everyone. Behavioral health was integrated with primary care under the Affordable Care Act of 2010.	Use of evidence-based practices; strategic planning process; improved access to health insurance with better benefits for mental health and substance abuse services and support

PREVENTION THEORIES AND STRATEGIES

Risk and Protective Factor Theory

Many factors influence the likelihood that an individual will develop a substance abuse or related behavioral health problem. Effective prevention focuses on reducing the factors that put people at risk of behavioral health disorders and strengthening those factors that protect people from these disorders.

Risk factors are certain biological, psychological, family, community, or cultural characteristics that precede and are associated with a higher likelihood of behavioral health problems.

Protective factors are characteristics at the individual, family, or community level that are associated with a lower likelihood of problem outcomes.

Risk and protective factors exist in multiple domains, including:

- *Individual level:* Examples of Individual level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors include positive self-image, self-control, or social competence.
- *Family level:* Examples of Family level risk factors include child abuse and maltreatment, inadequate supervision, and parents who use drugs and alcohol or who suffer from mental illness; a protective factor would be parental involvement.
- *Community level:* Examples of Community level risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and afterschool activities.
- *Society level:* Examples of Society level risk factors include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include policies limiting availability of substances or laws protecting marginalized populations, such as lesbian, gay, bisexual, or transgender youth.

In prevention, it is important to address the constellation of factors across these domains that influence both individuals and populations.

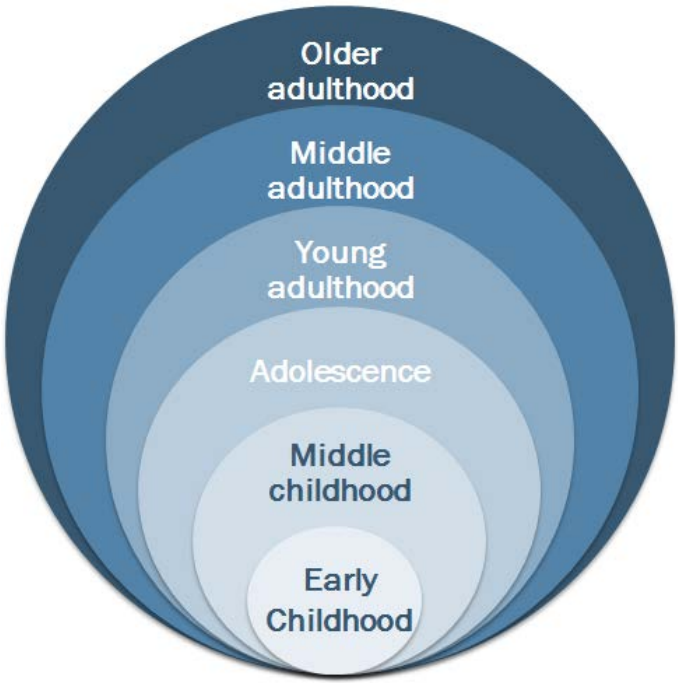
Source: SAPST Info Sheet 1.8, SAPST Version 8, November 2012 – SAMHSA Reference #277-08-0218

Developmental Perspective

As children grow, they progress through a series of developmental periods. Each period is associated with a specific set of developmental competencies: cognitive, emotional, and behavioral abilities. Adults have developmental phases as well. A "developmental perspective" considers the developmental stage of life of the individuals that are the focus of interventions to improve health and prevent disease.

The developmental perspective looks at risk and protective factors and their potential consequences and benefits according to defined developmental periods.

- Different age groups have different risk and protective factors. Some risk and protective factors overlap age groups, although the risk and protective factors for adulthood vary from those for childhood.
- People must learn to adapt to new challenges and experiences in each developmental period. Certain risk and protective factors affect healthy development at different periods.
- Trauma and stressful life events can occur during any period of development; however, trauma in youth can impact adult development.



- Transitioning from one stage to another brings new stresses.
- Development might look different in different cultures and with people who have disabilities.

Understanding the developmental perspective is important to substance use prevention because:

- Interventions should be appropriate for the specific developmental stage of the population they target.

- Prevention efforts that are aligned with key periods in young peoples' development are most likely to produce the desired, long-term positive effects.
- People are more vulnerable to substance abuse and other behavioral health problems when they have experienced untreated, unresolved trauma

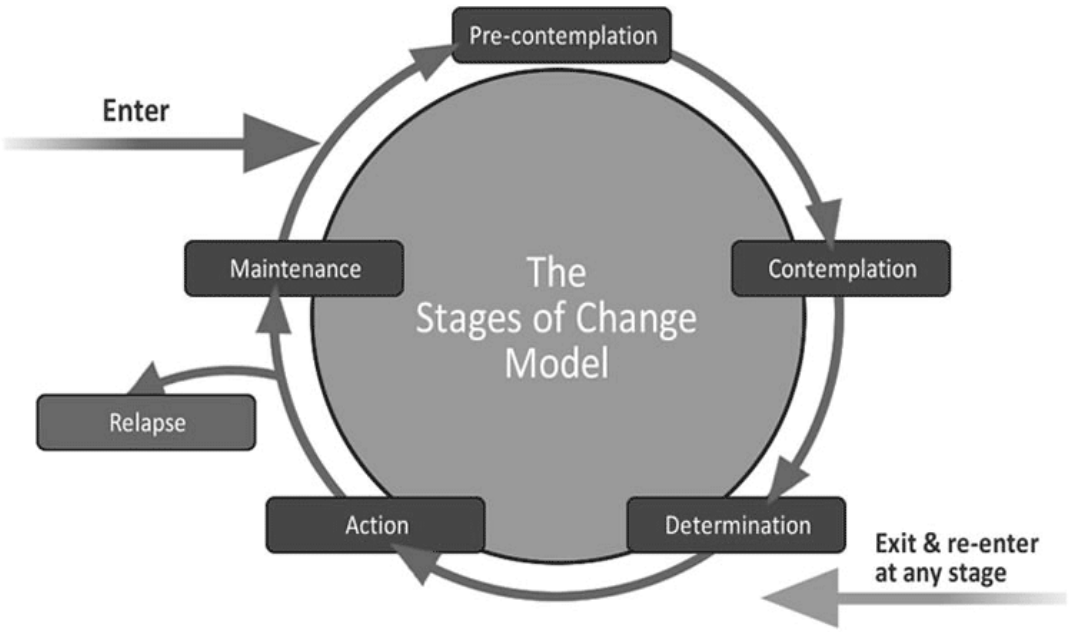
Source: SAPST Version 8, November 2012 – SAMHSA Reference #277-08-0218

Stages of Change

The Stages of Change Model developed by Prochaska and DiClemente (1982) describes the process people go through in modifying a problem behavior.

The model was developed with and for people with substance use disorders, but is applicable to all kinds of behavior change, especially health behavior change.

Stages of Change Model



Source: Johnny Holland. (2011). Stages of Change Model by Prochaska & DiClemente.

The five stages of change are:

- Pre-contemplation
- Contemplation
- Preparation/Determination
- Action
- Maintenance

Relapse (going back to a former behavior or earlier stage) is always possible.

In the process of changing behavior, people move through the stages NOT in a linear way, but cycling between stages. People can learn from relapse/reoccurrence about what to do to sustain a change.

Pre-contemplation: The person does not see the behavior as a problem/does not see a need for change/has no intention to change.

Contemplation: The person has some awareness of the need/desire to change behavior and is actively weighing the pros and cons of the behavior.

Preparation: The person believes that the behavior can be changed and that he/she can manage the change and is taking steps to get ready to make the change.

Action: The person has begun to make the behavior change and has developed plans to maintain the change.

Maintenance: The person has maintained the new behavior consistently for over 6 months and has made the new behavior habitual.

Relapse: The person has a "slip"- reverts back to a previous pattern of behavior. The person may become discouraged but should recognize that most people making a behavior change have some degree of reoccurrence

Source: Rhode Island Behavioral Health Peer Recovery Specialist curriculum, (2015) Day 5

Broad Types of Prevention Strategies

Some types of prevention strategies focus on changing individuals, while others focus on changing the environment in some way.

Individual behavior change strategies

Strategies focused on changing individual's behavior include:

- **Education-based programs** that focus on helping people develop the knowledge, attitudes, and skills they need to change their behavior. Education-based programs may be targeted at young people, parent, merchants, and servers among others.
- **School and community bonding activities** address the risk factor of low attachment to school and community. Specific interventions can include mentoring and alternative activities, such as opportunities for positive social interaction.
- **Communication and public education** involves the media because of the significant role it plays in shaping how people think and behave. Many of the messages on television, billboards, the Internet, as well as in music and magazines, glamorize

drug, alcohol, and tobacco use. Yet, the media can be used to encourage positive behaviors, as well. *See the Communication Strategies section.*

Source: Info Sheet 3.11 SAPST Version 8, November 2012 – SAMHSA Reference #277-08-0218

Environmental Strategies

Environmental strategies are prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies. Environmental strategies enhance public health by altering the physical, social, legal, and economic conditions that influence behavior.

Strategies focused on changing the community environmental context that influence individual behavior include those that:

- **Enhance access/reduce barriers** —Improving systems and processes to increase the ease, ability and opportunity to utilize systems and services (e.g. access to treatment, childcare, transportation, housing, education, cultural and language sensitivity).This strategy can be utilized when it is turned around to reducing access/enhancing barriers.
- **Change consequences (incentives/disincentives)**—Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for deserved behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges).
- **Change physical design**—Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density).
- **Modify/change policies**—Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).
- See also **Communication Strategies**, which can be considered as a type of environmental strategy (pg. 38).

Source: The Coalition Impact: Environmental Prevention Strategies, CADCA 2010

STRATEGIC PLANNING FOR PREVENTION

Strategic Prevention Framework Basics

A strategic planning process is needed in order to systematically define the behavioral health problems in a given community and to determine what interventions will be most effective for addressing the specific problems in a particular community.

In the United States, prevention professionals use SAMHSA's **Strategic Prevention Framework (SPF)** to plan prevention initiatives. The SPF is a 5-step planning process that guides the selection, implementation, and evaluation of evidence-based, culturally appropriate, sustainable prevention activities. The SPF begins with a clear understanding of community needs and depends on the involvement of community members in all stages of the planning process.

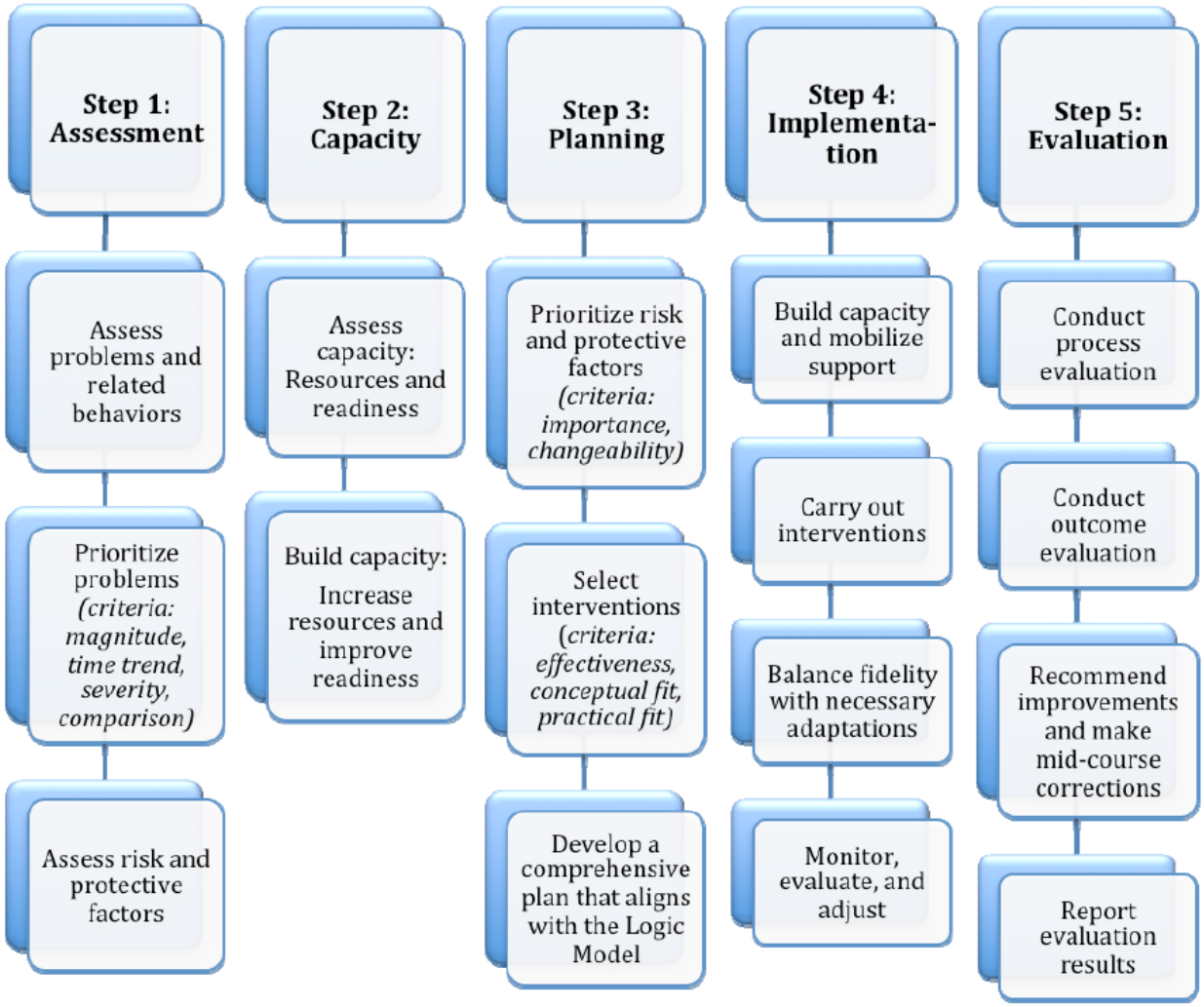
Source: SAMHSA website

The five steps of the SPF include:

1. **Assessment**: Collect data to define behavioral health problems and needs within a geographic area.
2. **Capacity**: Mobilize and/or build capacity within a geographic area to address identified needs.
3. **Planning**: Develop a comprehensive, data-driven plan to address problems and needs identified in assessment phase.
4. **Implementation**: Implement evidence-based prevention programs, policies, and practices.
5. **Evaluation**: Measure the impact of implemented programs, policies and practices.

Sustainability and cultural competence should be integrated into all steps of the SPF.

Strategic Prevention Framework at-a-glance



Assessment

Assessment helps communities better understand the behavioral health problem they seek to prevent. The assessment step is sometimes referred to as "needs assessment".

In the assessment step, data are gathered to help answer the following questions:

- What are the problems and related behaviors that are occurring in the community?
- How often are the problems and related behaviors occurring?
- Where are the problems and related behaviors occurring?
- Which populations are experiencing more of the problems and related behaviors?

In the assessment step, data may also be collected on the risk and protective factors that influence the target problem(s).

Types of Data

- **Quantitative data** indicates how often a behavior/event occurs or to what degree it exists.
    - It can provide the answers to "How many?" and "How often?"
    - It is typically described in "numbers."
    - It can be used to draw general conclusions about a population, such as the level of youth alcohol use in a community.

  Examples of methods for obtaining quantitative data include random sample surveys and archival sources.

- **Qualitative data** explains why people behave or feel the way they do.
    - It can help provide the answer to "Why/Why not?" or "What does it mean?"
    - It is usually described in "words."
    - It can be used to examine an issue or population in more depth to understand underlying issues, such as the way in which community norms contribute to the level of youth alcohol use.

  Examples of methods for obtaining qualitative data include key informant interviews and focus groups.

A "mixed methods" assessment approach that collects both quantitative and qualitative data provides more in-depth understanding of the behavioral health problems being assessed.

Data Collection Methods

Surveys: Standardized paper and pencil, online or phone questionnaires that ask pre-determined questions

Archival data: Data that have already been collected by an agency or organization and which are in their records or archives

Key Informant Interviews: Structured or unstructured, one-on-one directed conversations with key individuals or leaders in a community

Focus Groups: Structured interviews with small groups of like individuals using standardized questions, follow-up questions, and exploration of other topics that arise to better understand participants.

Capacity

Capacity refers to resources and readiness:

- The **resources** (programs, organizations, people, money, expertise, etc.) a community has to address its substance abuse problems
- How **ready** the community is to take action and commit its resources to addressing these problems

This step in the SPF involves both assessing capacity and improving capacity.

Assessing Capacity

A community needs to assess both the types and levels of resources that it has available to address identified behavioral health problems AND how ready the community is to take action to address the targeted behavioral health problem.

Types of resources to assess include:

- **Fiscal resources** – such as grants/donations, computer hardware/software, meeting space/food/printing, promotion/advertising
- **Human resources –** such as trained staff, consultants, volunteers, stakeholders, partners, local champions
- **Organizational resources** – such as vision and mission statements aligned with the prevention effort, and organizational policies, fiscal resources and technology
- **Community resources** – such as previous efforts to address the problem, local policies and regulations

Community Readiness Model

The Tri-Ethnic Center Community Readiness model identifies nine stage of readiness:

STAGE 1 – **Community Tolerance/No Knowledge**: The community or leaders do not generally recognize that there is a problem. Community norms may encourage or tolerate the behavior in social contexts.

STAGE 2 – **Denial:** There is some recognition by some members of the community that the behavior is a problem, but little or no recognition that it is a local problem.

STAGE 3 – **Vague Awareness:** There is a general feeling among some in the community that there is a local problem and that something ought to be done, but there is little motivation to act.

STAGE 4 – **Preplanning:** There is clear recognition by many that there is a local problem and something needs to be done. There may be a committee to address the problem, but no clear idea of how to progress.

STAGE 5 – **Preparation:** The community has begun planning and is focused on practical details. Leadership is active and energetic. Decisions are being made and resources are sought and allocated.

STAGE 6 – **Initiation:** Data are collected that justify a prevention program. Action has begun. Staffs are being trained.

STAGE 7 – **Institutionalization/Stabilization:** Several planned efforts are underway and supported by community decision makers. Staff are trained and experienced.

STAGE 8 – **Confirmation/Expansion:** Programs have been evaluated and modified. Leaders support expanding funding and scope. Data are regularly collected and used to drive planning.

STAGE 9 – **Professionalism/High Level of Community Ownership:** Universal, selective, and indicated efforts are in place for a variety of focus populations. Staff is well trained and experienced. Effective evaluation is routine and used to modify activities. Community involvement is high.

Building Capacity

Three ways to increase resources and improve readiness:

1. Engage stakeholders all steps of the planning process
2. Strengthen collaborative groups/partnerships
3. Raise awareness of the problem to be addressed

1. **Engaging Stakeholders:**

Stakeholders are the people and organizations in the community who have something to gain or lose by your prevention efforts.

Community prevention efforts should include a broad range of stakeholders including:

- Population groups that the intervention serves
- Mental health
- Primary care
- Suicide prevention
- Behavioral health treatment and recovery
- Tobacco control
- School safety and health
- Highway safety
- Injury prevention
- Violence prevention
- Recovery community
- Reproductive, maternal and child health
- HIV/AIDS prevention
- Substance abuse treatment
- Education
- Corrections

2. **Strengthening Collaborative Groups**

   Most communities have some kind of collaborative group, such as a task force, coalition, or interagency group. A collaborative group can be strengthened by:

   - Recruiting new members so that a broad spectrum of sectors are represented
   - Increasing the knowledge of members through training and technical assistance
   - Improving the structure and functioning of the collaborative group

   See also the Coalition Development section for more strengthening collaborative groups (page 32).

3. **Increasing Community Awareness**

   Raising community awareness of a behavioral health problem can increase readiness of partners and the community to address the problem/take preventive action.

   See the Communication Strategies section for more on methods to increase community awareness (page 38).

Planning

Good planning requires collaboration and must reflect ideas and input from various sectors within the community, particularly the population group that the intervention will focus on.

Planning encompasses the following tasks:

Task 1 - Prioritize risk and protective factors associated with the identified priority

Task 2 - Select prevention interventions that are evidence based, most likely to influence the identified risk factors (conceptual fit), and feasible and relevant to focus population (practical fit).

Task 3 - Develop a comprehensive, data driven prevention plan

Task 1 - Prioritizing risk and protective factors

Two criteria—importance and changeability—can be used to help decide which risk or protective factors to address with prevention interventions.

Importance refers to how much/how strongly a risk or protective factor impacts the targeted behavioral health problem in a community.

Changeability can refer to three issues:

- Whether the community has the capacity to change a particular risk or protective factor
- Whether a suitable evidence-based intervention exists to address a particular problem
- Whether change can be brought about in a reasonable time frame

Task 2 - Selecting effective interventions with good "fit"

There are three criteria for selecting prevention interventions:

- **Effectiveness:** Is the intervention effective?
- **Conceptual Fit**: Will the intervention(s) impact the selected risk or protective factor?
- **Practical Fit**: Is the intervention appropriate to the community?

Effectiveness - Refers to whether an intervention was evaluated and found to be effective under a particular set of circumstances. Priority should be given to interventions with strong evidence of effectiveness. For some problems and populations, there may be fewer interventions that are evidence-based.

Conceptual Fit - To assess the conceptual fit of an intervention, ask the following questions:

- Does it address the targeted problem?
- Does it address the risk/protective factors and conditions associated with the problem?
- Does it target a relevant population and/or context?

Practical Fit - To assess the practical fit of an intervention ask the following questions:

- Is it *feasible*? Does the community have the resources needed for the intervention?
- Is there *synergism*? Does the intervention add to or reinforce other prevention interventions?
- Is the community *ready*? Will stakeholders and the community support the intervention?

- Is the intervention *culturally relevant*? Will the cultural groups that are the focus of the intervention be receptive to it? Are they involved in the planning and implementation?

Task 3 - **Developing a comprehensive, data-driven prevention plan**

A comprehensive plan involves multiple interventions in multiple settings targeting the risk/protective factors identified and adds to what is already happening in the community to address the problem.

A comprehensive prevention plan includes:

- A description of the priority problem and why it was selected
- A list of the prioritized risk factors and how they were prioritized
- A description of community resources, resource gaps, readiness, cultural issues, and how challenges will be addressed
- A description of the interventions chosen to address the selected risk factors
- A logic model with short- and long-term outcomes
- An action plan with timetables, roles, and responsibilities for implementing interventions.

Implementation

Implementation encompasses three main tasks:

Task 1 - Mobilize support for your efforts and build capacity around implementation.

Task 2 - Implement evidence-based programs, policies, and practices, paying specific attention to adaptation and fidelity issues.

Task 3 - Monitor implementation, collect evaluation data, and make mid-course corrections based on what the results show.

Task 1 - Mobilizing support and building capacity involves:

- Increasing community awareness of the problem and of the intervention(s) selected to address it.
- Introducing the intervention to stakeholders to obtain their buy-in and expand partnerships.

- Training for the people implementing the intervention if they do not have the necessary skills.

Task 2 - Implementing interventions involves:

- Balancing the need for maintaining fidelity of the intervention with the need to adapt it. *(See Fidelity and Adaptation of Interventions below).*
- Developing and carrying out an action plan that details what is to occur, who is responsible, and a timeline.

Task 3 - Monitoring and making mid-course corrections involves:

Evaluating implementation to determine whether the intervention is being delivered as intended *(See Step 5: Evaluation).* If monitoring shows a difference between actual and intended implementation of the intervention, make adjustments to get back on track.

Fidelity and Adaptation of Interventions

Fidelity is the degree to which an evidence-based prevention program is implemented as its developer intended.

Adaptation is how an intervention is changed to meet local needs and circumstances.

It is important to balance adaptation with fidelity, because changes to an intervention can compromise its effectiveness.

Guidelines for adaptation:

- Select programs with the best practical fit to local needs and conditions.
- Consult with the program developer.
- Retain core components of the original intervention.
- Add, rather than subtract.

Evaluation

Evaluation is the systematic collection and analysis of information about an intervention to improve its effectiveness and make program decisions.

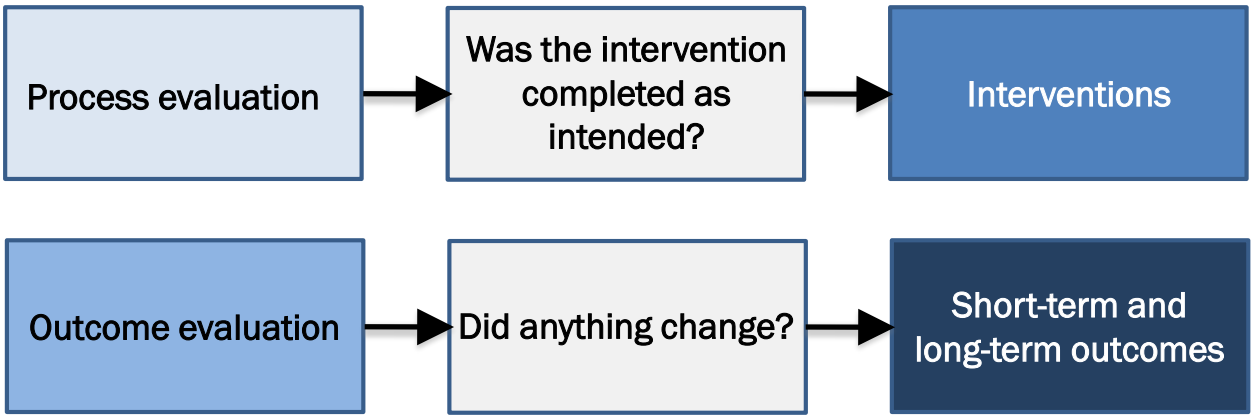
Evaluation:

- Helps to assess the progress of an intervention

- Identifies what does and does not work in a particular setting
- Is used to improve implementation and performance
- Helps determine which interventions and outcomes should be sustained

Types of Evaluation

Evaluation of prevention programs should collect both process and outcome evaluation data. Process evaluation occurs *during* the implementation of an intervention; outcome evaluation occurs *after* the intervention has been implemented.



Process evaluation answers the question: "Did we do what we said we would do?" It describes how the intervention was implemented.

Process evaluation data helps to determine the following:

- Were interventions implemented as planned?
- Who participated and for how long?
- What adaptations were made?
- Were the resources sufficient?
- What obstacles were encountered?

Outcome evaluation answers the question: "Did our intervention make a difference—did it impact the risk factors and problem we wanted to address?" It documents effects achieved *after* the intervention is implemented, such as short- and long-term changes in a population group's knowledge, attitudes, skills, or behavior.

Outcome evaluation data helps to determine the following:

- What changes actually occurred
- How these changes compare to what the intervention was expected to achieve
- How these changes compare with those not exposed to the intervention

Reporting Evaluation Results

Evaluation results are used to improve programs, sustain positive outcomes, and improve a community's overall plan for addressing behavioral health problems and promoting wellness. They can also be used to help obtain funding or to build community awareness and support for prevention.

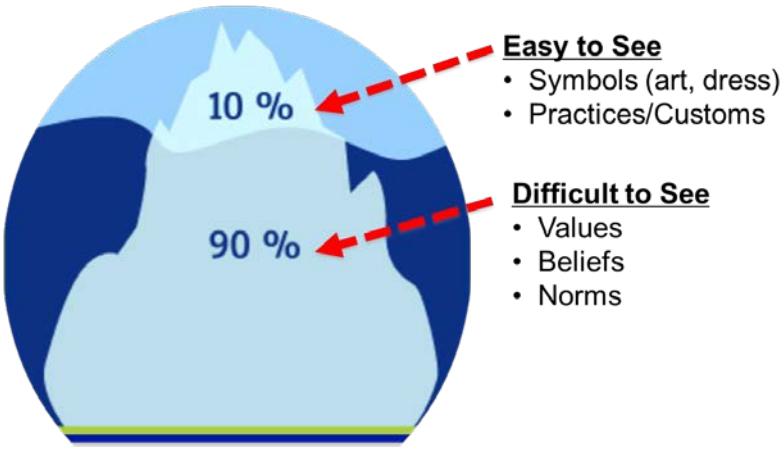
Tips for reporting evaluation results:

- *Brief stakeholders regularly*, throughout the process, not just at the end.
- *Create a dissemination plan*, tailored to the various audiences that need to see the results, including the focus population
- *Select appropriate reporting formats*. Think carefully about the best venues or vehicles for delivering results.
- *Help stakeholders understand the data.* Remember that each stakeholder has his or her own interests, and will be most interested in findings that relate to these interests.

Source for all above: SAPST Version 8, November 2012 – SAMHSA Reference #277-08-0218

CULTURAL COMPETENCE IN PREVENTION

In order for people to benefit from prevention and wellness programs and strategies, it is essential that these interventions fit with their culture—with their values, customs, beliefs, roles, manners of interacting, communication styles, etc. People typically think of culture in terms of race or ethnicity, but culture also refers to other social groups that are defined by age, gender, religion, income level, education, geographical location, sexual orientation, and disability, etc.



Source: Griswold, W. (2008). Cultures and societies in a changing world (3rd ed.). Thousand Oaks, CA: Pine Forge Press.

What is culture?

Culture refers to "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups." (OMH, US DHHS)

The elements of culture:

- **Norms** – how people behave
- **Values** – what is important to people
- **Beliefs** – what people think about something
- **Symbols** – how people express themselves through art, stories, music, language, etc.
- **Practices** – customs or patterns of behavior that may not be connected to beliefs and values

History and personal experience also shape these elements.

Source: SAPST curriculum

Cultural Competence (as defined by SAMHSA/CAPT)

Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures. To produce positive change, prevention practitioners must understand the cultural context of their target community, and have the willingness and skills to work within this context. This means drawing on community-based values, traditions, and customs, and working with knowledgeable persons of and from the community to plan, implement, and evaluate prevention activities.

SAMHSA's Center for Substance Abuse Prevention (CSAP) has identified these principles of cultural competence:

- Ensure community involvement in all areas
- Use a population-based definition of community (that is, let the community define itself)
- Stress the importance of relevant, culturally-appropriate prevention approaches
- Employ culturally-competent evaluators
- Promote cultural competence among program staff and hire staff that reflect the community they serve
- Include the target population in all aspects of prevention planning

Source: SAMHSA CAPT webpages https://captus.samhsa.gov/access-resources/about-strategic-prevention-framework-spf#cultural

Cultural Competence Continuum

Developing cultural competence is an evolving, dynamic process that takes time and occurs along a continuum. The National Center for Cultural Competence at Georgetown University describes the six stages of this continuum:

Cultural destructiveness – Attitudes and practices (as well as policies and structures in organizations) are destructive to a cultural group.

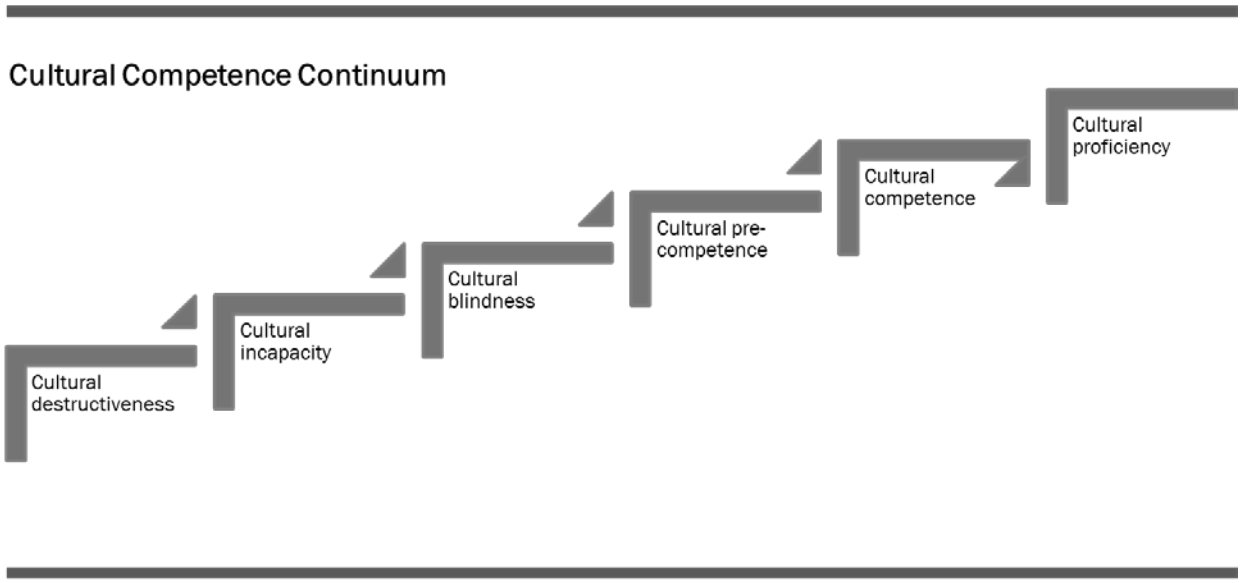
Culture incapacity – The capacity to respond effectively to the needs, interests, and preferences of culturally and linguistically diverse groups is lacking.

Cultural blindness – The predominant philosophy is one that views and treats all people as the same.

Cultural pre-competence – There is awareness of strengths and areas for growth to respond effectively to culturally and linguistically diverse populations.

Cultural competence – Acceptance and respect for culture is consistently demonstrated in policies, structures, practices, and attitudes.

Cultural proficiency – Culture is held in high esteem and used as a foundation to guide all endeavors.



Source: SAMHSA/CAPT web pages URL: https://captus.samhsa.gov/prevention-practice/strategic-prevention-framework/cultural-competence/cultural-competence-continuum

Cultural Considerations in Prevention Planning (using SPF Framework)

Step 1: Assessment

- Work with the community
- Use a culturally competent evaluator for assessment
- Ensure a mechanism for collecting cultural competence-related information/data
- Gain approval of the community for data collection and analysis
- Ensure that data is culturally responsive and appropriate
- Create a process for identifying culturally relevant risk and protective factors and other underlying conditions
- Formulate culturally-based assumptions of change
    - Identify change from the community's perspective

Step 2: Capacity

- Examine community resources and readiness
- Provide a safe and supportive environment for all participants
- Examine the breadth and depth of cultural competence
- Check cultural representation (language, gender, age)
- Develop policies (e.g., recruitment and retention, training, communication and community input) to improve cultural competence
- Ensure that tools and technology are culturally competent

Step 3: Planning

- Ensure the community is represented in the planning process
- Identify mutually acceptable goals and objectives
- When selecting programs and strategies, consider their fit with:
    - Community culture
    - Existing prevention efforts
    - Past history

Step 4: Implementation

- Involve the community in the implementation of the strategic plan
- Create a feedback loop for communicating efforts and successes to the community

Step 5: Evaluation

- Ensure the community is represented in the evaluation process
- Ensure that data collection tools reflect community culture
- Use a culturally competent evaluator for evaluation
- Obtain permission to disseminate the evaluation findings from the organization or entity implementing the intervention

Source: SAPST INFORMATION SHEET 3.6 Version 8, November 2012 – SAMHSA Reference #277-08-0218

Culturally Competent Organizations

Cultural competence applies to organizations and health systems, just as it does to professionals.

A culturally competent organization:

- Continually Assesses Organizational Diversity
- Invests in Building Capacity for Cultural Competency and Inclusion
- Practices Strategic Planning that Incorporates Community Culture and Diversity
- Implements Prevention Strategies Using Culture and Diversity as a Resource
- Evaluates the Incorporation of Cultural Competence

Source: SAPST Information Sheet 3.5 Version 8, November 2012 – SAMHSA Reference #277-08-0218

COALITION DEVELOPMENT

What is a coalition?

A coalition is a formal arrangement for collaboration among groups or sectors of a community, in which each group retains its identity but all agree to work together toward the common goal of a safe, healthy and drug-free community. Coalitions should have deep connections to the local community and serve as catalysts for reducing substance use and other behavioral health disorders.

Coalitions work to promote wellness and reduce behavioral health disorders in the larger community by implementing comprehensive, multi-strategy plans, which incorporate evidence-based approaches. Effective coalitions focus on improving systems and environments that make it easier to adopt and sustain healthy behaviors, and that discourage unhealthy behaviors. Collectively, a coalition's interventions or strategies must be geared toward population-level changes.

Goals of coalitions

1. Reduce behavioral health disorders by addressing the factors in a community that increase the risk of substance use and other behavioral health disorders and promoting the factors that minimize these risks.

2. Establish and strengthen collaboration among communities, private nonprofit agencies and federal, state, local and tribal governments to support the efforts of community coalitions to prevent and reduce behavioral health disorders among youth.

Coalition membership

Key sectors to be represented in a coalition include:

- Youth (18 or younger)
- Parents
- Young adults
- Adults
- Older adults
- Concerned citizens
- Business
- Media
- School/colleges/universities
- Community- and youth-serving organizations
- Law enforcement
- Religious/Fraternal organizations
- Health care providers

- Social service providers
- Civic/Volunteer groups (i.e., local organizations committed to volunteering, not a coalition member designated as a "volunteer")
- Recovery community
- State, local, or tribal governmental agencies with expertise in the field of behavioral health (including, if applicable, the state/county agency with primary authority for behavioral health)
- Other organizations involved in reducing behavioral health problems

Strategies to affect community change

1. **Provide information**—Educational presentations, workshops or seminars and data or media presentations (e.g., public service announcements, brochures, billboard campaigns, community meetings, town halls, forums, Web-based communication).

2. **Enhance skills**—Workshops, seminars or activities designed to increase the skills of participants, members and staff (e.g., training, technical assistance, distance learning, strategic planning retreats, parenting classes, evidence-based programs in schools).

3. **Provide support**—Creating opportunities to support people to participate in activities that reduce risk or enhance protection (e.g., providing evidence-based alternative activities, mentoring, referrals for services, support groups, parenting groups).

4. **Enhance access/reduce barriers****—Improving systems and processes to increase the ease, ability and opportunity to utilize systems and services (e.g., access to treatment and recovery support for individuals and families, childcare, transportation, housing, education, special needs, cultural and language sensitivity).

5. **Change consequences** (incentives/disincentives)—Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for desired, pro-social behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges).

6. **Change physical design**—Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, recreational space, landscapes, signage, lighting, outlet density).

7. **Modify/change policies**—Formal change in written procedures, by-laws, policies, proclamations, ordinances, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).

**This strategy can be utilized when it is turned around to reducing access/enhancing barriers, for example establishing barriers to youth smoking by enforcing youth access laws.

The list of strategies was distilled by the University of Kansas Work Group on Health Promotion and Community Development—a World Health Organization Collaborating Centre. Research cited in selection of the strategies is documented on CADCA's website, www.cadca.org.
Source for all above: Handbook for Community Anti-Drug Coalitions. CADCA, National Community Anti-Drug Coalition Institute. 2012

Levels of Involvement

Different sectors and stakeholders may want or need to be involved in your prevention activities to different degrees. Here is a table showing examples of different levels of involvement.

LEVEL	EXPRESSION	EXAMPLES
No Involvement	"You do your thing; we'll do ours."	Stakeholders engage in separate activities, strategies, and policies.
Networking	"Let's talk and share information."	Stakeholders share what they are doing during an interagency networking meeting; talk about community issues in which they all have a stake; or communicate with other organizations about existing programs, activities, or services.
Cooperation	"I'll support your program, and you'll support mine, or we can even co-sponsor one."	Partners publicize each other's programs in organization newsletters, write letters in support of each other's grant applications, co-sponsor trainings or professional development activities, and/or exchange resources such as printing or meeting space.
Coordination	"Let's partner on an event."	Stakeholders serve together on event planning committees or community

LEVEL	EXPRESSION	EXAMPLES
		boards, or implement programs or services together.
Collaboration	"Let's work together on a comprehensive plan to address the issue; after all, our missions overlap."	Participating organizations create formal agreements including memoranda of understanding or formal contracts, developing common data-collection systems across organizations and community sectors, partnering on joint fundraising efforts, pooling fiscal human resources, or creating common workforce training systems.

Source: SAPST, Version 8, November 2012 –SAMSHA Reference #277-08-0218

Advantages of coalitions:

Coalitions offer numerous potential advantages over working independently.

- Coalitions can conserve resources.
- Coalitions can achieve more widespread reach within a community and accomplish objectives beyond the scope any single organization could attain.
- Coalitions have greater credibility than individual organizations.
- Coalitions provide a forum for sharing information and for great networking opportunities.
- Coalitions provide a range of advice and perspectives.
- Each coalition member or member organization can contribute their particular expertise or resources to facilitate activities by other members or by the coalition as a whole.
- Coalitions can foster cooperation between grassroots organizations, community members, and/or diverse sectors of a large organization.
- Effective network for information dissemination regarding coalition activities.

Stakeholders are individuals, groups or organizations who are:

- involved with the operation or outcomes of a program,
- affected directly or indirectly by its activities,
- able to influence the program, who can assist with funding, or who can benefit from its results or anyone who has a specific interest in the success or failure of a project

Steps to forming an effective coalition

1. **Starting a Coalition**

    - Identify the problems (e.g., underage drinking) and related behaviors (deaths and injuries related to underage drinking).
    - Identify risk and protective factors related to the identified problems and related behaviors.
    - Determine community readiness.
    - Determine a need for a new coalition or revising an existing coalition.
    - Determine the potential goals and objectives.
    - Identify membership – i.e. key stakeholders by their skills, expertise, participation, diverse population represented.
    - Set final goals and objectives by consensus.
    - Assess and build capacity.

2. **Building a Coalition**

    - Determine Coalition structure: (1) ad hoc or ongoing; (2) informal or formal; (3) open or closed membership.
    - Develop a mission or purpose statement for the coalition.
    - Recruit members to include all major stakeholders, represent multiple sectors.
    - Determine a decision-making process – consensus or group vote.
    - Facilitate prevention planning and implementation strategies.

3. Needs Assessment
    - Identify behavioral health problems based on quantitative and qualitative data.
    - Determine community resources.
    - Conduct an analysis of resource gaps.
4. Developing a Plan
    - Identify evidence-based policies, programs, and strategies for the focus populations.
    - Develop an action plan, timeline, and measures.
5. Evaluation
    - Develop a logic model.
    - Develop a data collection plan and identify a data collection tool.
6. Sustainability
7. Develop and implement sustainability planning in all strategies.
8. Cultural Competence
    - Ensure culturally competence throughout the coalition development process.

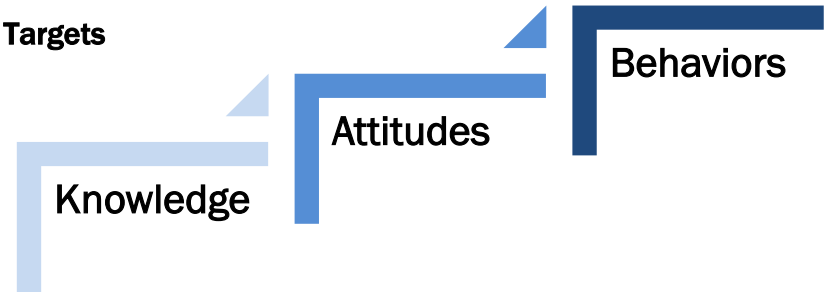
Source for all above: Handbook for Community Anti-Drug Coalitions. CADCA, National Community Anti-Drug Coalition Institute. 2012 and SAPST, version 8, November 2012 – SAMHSA Reference #277-08-0218

COMMUNICATION STRATEGIES

Prevention specialists use a variety of communication strategies to provide information and to change community **norms** around substance use and behavioral health issues.

Norms are patterns of belief or behavior in a particular group, community or culture, accepted as normal and to which an individual is expected to conform.

Health Communication Targets



Communication strategies that may be used in community prevention efforts include:

Public Awareness Campaigns: A comprehensive effort that includes multiple components (messaging, grassroots outreach, media relations, government affairs, budget, etc.) to help reach a specific goal.

Social Marketing: The application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviors of target audiences in order to improve their personal welfare and that of their society.

Advocacy: Taking action to support an idea or a cause. Advocates educate community members, the media, and elected officials in order to raise awareness, increase understanding of key issues, and mobilize support with the goal of creating positive change.

Media Advocacy: The strategic use of media to advance a social and/or public policy initiative. Media advocacy seeks to change the social and political environment in which decisions that affect health and health resources are made by influencing the mass media's selection of topics and by shaping the debate about those topics.

Media Literacy: Media literacy is the ability to access, analyze and produce information for specific outcomes. Media Literacy teaches intended audiences (often youth) to deconstruct media messages so they can identify the sponsor's motives. It also teaches communicators how to compose messages attuned to the intended audience's point of view.

Source: Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies. (January 2013). Social Marketing: A Six Phase Approach to Creating Change [webinar series]. Rockville, MD: author.

Social Marketing

Use social marketing to:

- Create awareness of problem
- Identify needed change (what should be done)
- Resources to make changes (how to do it)
- Change levels of readiness & resources

Social marketing related to substance use prevention targets the following risk or protective factors:

- Perception of risk or harm of substance use
- Access or availability of alcohol, tobacco, and other drugs
- Norms Supporting Use
    - Parental monitoring
    - Perception of peer approval or peer use
    - Low enforcement of policies/ordinances/youth access laws

When developing key messages to send to target audiences in a social marketing campaign, consider "The Four P's" (taken from commercial marketing):

- **Product**
    - What is the target audience being asked to know, believe or do?
- **Price**
    - What is the cost/benefit to the target audience of doing it?
- **Promotion**
    - Who is the messenger/delivers the message?
- **Placement**
    - What channels are used to disseminate the message?

Source: Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies. (January 2013). Social Marketing: A Six Phase Approach to Creating Change [webinar series]. Rockville, MD: author.

Facilitation Tips

What is facilitation?

Facilitation involves guiding meetings and groups while using a specific set of skills and tools. Facilitators create an environment in which group members share ideas, opinions, experiences, and expertise in order to achieve a common goal. A skilled facilitator smooths the way for group members to brainstorm options, identify viable solutions, and develop and implement action plans.

Facilitation skills

- Make everyone feel comfortable and valued
- Encourage participation
- Prevent and manage conflict
- Listen and observe
- Guide the group
- Ensure quality decisions
- Ensure outcome-based meetings
- Assess the group's concentration and engagement
- Clarify confusing discussions
- Provide feedback when necessary
- Enforce group guidelines

Running an effective meeting

- Welcome participants
- Introduce participants and yourself
- Set the tone and pace
- Establish/Review group guidelines in positive terms
- Go over and approve meeting objectives and agenda
- Review minutes
- Keep the group on task in timely manner
- Keep group moving through agenda
- Summarize meeting outcomes
- Identify next steps
- Evaluate the meeting
- Adjourn on a positive note

Techniques for handling challenging situations

- Make sure that all sides have an opportunity to be heard
- Help to clearly define the issues, perhaps by having each side of the debate restate the position of the other side to its satisfaction
- Keep discussion focused on the substance of the conversation rather than the individuals
- Encourage the various sides to meet separately and come back to the full group for further discussion
- Help individuals to save face and be able to change their position
- Bring in outside assistance—individuals not directly involved in the situation—to help provide an outside perspective

- Try to get to options of mutual gain – those that will satisfy the interests and goals of the various parties
- Use brainstorming to identify all alternatives that may satisfy mutual interests

Source: Adapted from Training Guide: A Resource for Orienting and Training Planning Council and Consortium Members. U.S. Department of Health and Human Services, Health Resources and Services Administration, Rockville, MD, 1997. From AED Facilitation Document

Effective Listening

Some tips for being a good listener:

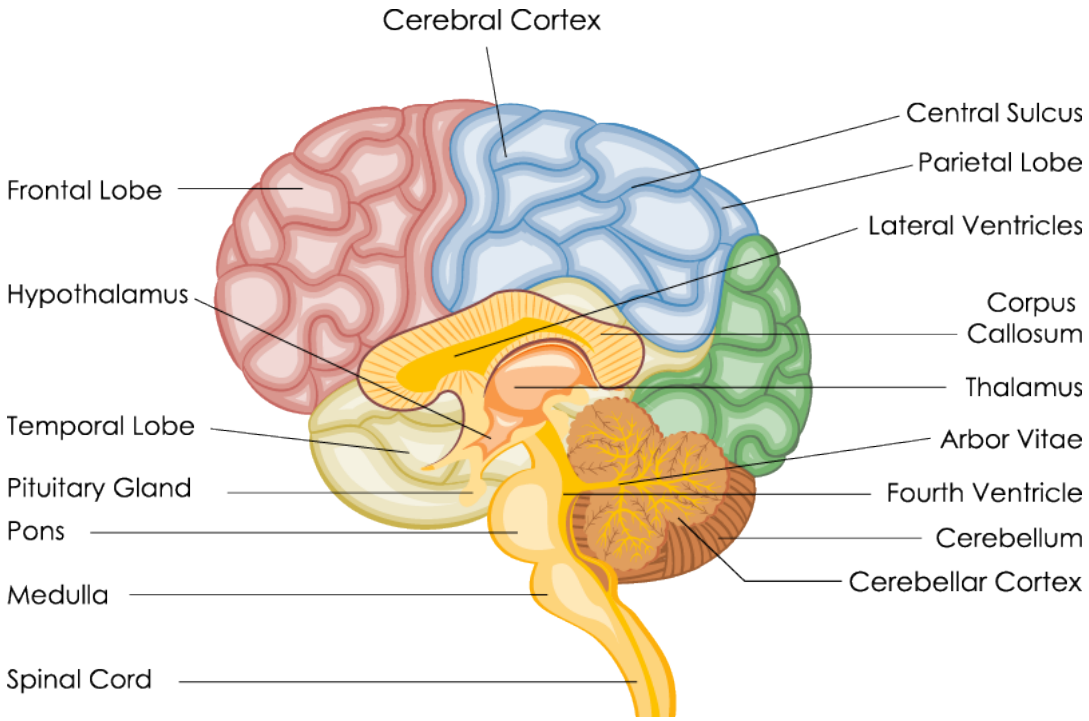
- Focus your attention on the speaker
- Avoid distractions
- Seat yourself appropriately close to the speaker
- Acknowledge any emotional state
- Set aside your prejudices and opinions
- Be other directed—focus on the person communicating
- Follow and understand the speaker as if you were walking in their shoes
- Be aware. Listen with your ears, but also with your eyes and other senses.
- Let the argument or presentation take its course. Don't interrupt.
- Be involved: actively respond to questions or directions. Use your body position (lean forward) and attention to encourage the speaker and signal your interest.

Be aware of and avoid these barriers to effective listening:

- Assuming you know what the other person is thinking
- Listening selectively
- Jumping to conclusions
- Letting your mind wander
- Working on a response or solution while the other person is still talking
- Shifting the topic before the person is done
- Automatically agreeing before understanding completely

Source: Recovery Support Specialist Training, Community Care Alliance

ALCOHOL, TOBACCO & OTHER DRUGS – EFFECTS ON THE BRAIN



The brain is made up of many parts that all work together as a team. Different parts of the brain are responsible for coordinating and performing specific functions. Drugs can alter important brain areas that are necessary for life sustaining functions and can drive the compulsive drug abuse that marks addiction. Brain areas affected by drug abuse include:

- The **brain stem**, which controls basic functions critical to life, such as heart rate, breathing, and sleeping.
- The **cerebral cortex**, which is divided into areas that control specific functions. Different areas process information from our senses, enabling us to see, feel, hear, and taste. The front part of the cortex, the frontal cortex or forebrain, is the thinking center of the brain; it powers our ability to think, plan, solve problems, and make decisions.
- The **limbic system**, which contains the brain's reward circuit. It links together a number of brain structures that control and regulate our ability to feel pleasure. Feeling pleasure motivates us to repeat behaviors that are critical to our existence. The limbic system is activated by healthy, life sustaining activities such as eating and socializing—but it is also activated by drugs of abuse. In addition, the limbic system is responsible for our perception of other emotions, both positive and negative, which explains the mood-altering properties of many drugs.

Source: National Institute of Drug Abuse. (2008).Drugs, Brains, and Behavior: The Science of Addiction.

COMMONLY ABUSED DRUGS

Visit NIDA at www.drugabuse.gov

NIDA NATIONAL INSTITUTE ON DRUG ABUSE

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Intoxication Effects*/Potential Health Consequences
Cannabinoids			*euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination/cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety, panic attacks; tolerance, addiction*
hashish	boom, chronic, gangster, hash, hash oil, hemp	I/swallowed, smoked	
marijuana	blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I/swallowed, smoked	
Depressants			*reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration/fatigue; confusion; impaired coordination, memory, judgment; addiction; respiratory depression and arrest; death*
barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital:* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V/injected, swallowed	*Also, for barbiturates—sedation, drowsiness/depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal*
benzodiazepines (other than flunitrazepam)	*Ativan, Halcion, Librium, Valium, Xanax:* candy, downers, sleeping pills, tranks	IV/swallowed, injected	*for benzodiazepines—sedation, drowsiness/dizziness*
flunitrazepam***	*Rohypnol:* forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	*for flunitrazepam—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects*
GHB***	*gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy	I/swallowed	*for GHB—drowsiness, nausea/vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death*
methaqualone	*Quaalude, Sopor, Parest:* ludes, mandrex, quad, quay	I/injected, swallowed	*for methaqualone—euphoria/depression, poor reflexes, slurred speech, coma*
Dissociative Anesthetics			*increased heart rate and blood pressure, impaired motor function/memory loss; numbness; nausea/vomiting*
ketamine	*Ketalar SV:* cat Valiums, K, Special K, vitamin K	III/injected, snorted, smoked	*Also, for ketamine—at high doses, delirium, depression, respiratory depression and arrest*
PCP and analogs	*phencyclidine:* angel dust, boat, hog, love boat, peace pill	I, II/injected, swallowed, smoked	*for PCP and analogs—possible decrease in blood pressure and heart rate, panic, aggression, violence/loss of appetite, depression*
Hallucinogens			*altered states of perception and feeling; nausea; persisting perception disorder (flashbacks)*
LSD	*lysergic acid diethylamide:* acid, blotter, boomers, cubes, microdot, yellow sunshines	I/swallowed, absorbed through mouth tissues	*Also, for LSD and mescaline—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors*
mescaline	buttons, cactus, mesc, peyote	I/swallowed, smoked	*for LSD—persistent mental disorders*
psilocybin	magic mushroom, purple passion, shrooms	I/swallowed	*for psilocybin—nervousness, paranoia*
Opioids and Morphine Derivatives			*pain relief, euphoria, drowsiness/nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death*
codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine:* Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV, V/injected, swallowed	*Also, for codeine—less analgesia, sedation, and respiratory depression than morphine*
fentanyl and fentanyl analogs	*Actiq, Duragesic, Sublimaze:* Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	I, II/injected, smoked, snorted	*for heroin—staggering gait*
heroin	*diacetylmorphine:* brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I/injected, smoked, snorted	
morphine	*Roxanol, Duramorph:* M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
opium	*laudanum, paregoric:* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	
oxycodone HCL	*OxyContin:* Oxy, O.C., killer	II/swallowed, snorted, injected	
hydrocodone bitartrate, acetaminophen	*Vicodin:* vike, Watson-387	II/swallowed	
Stimulants			*increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness/rapid or irregular heart beat; reduced appetite, weight loss, heart failure, nervousness, insomnia*
amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	*Also, for amphetamine—rapid breathing/tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction, psychosis*
cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/injected, smoked, snorted	*for cocaine—increased temperature/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks*

*Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Some Schedule V drugs are available over the counter.

**Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.

***Associated with sexual assaults.

2/07

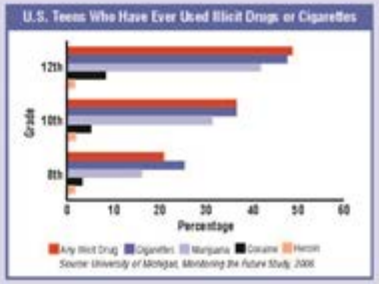
Source: National Institute on Drug Abuse. (2015).Commonly Abused Drug Charts.

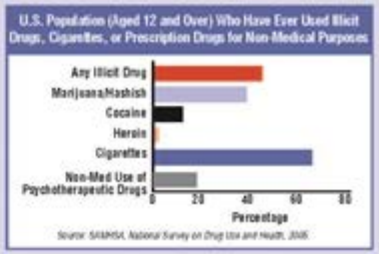
Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Intoxication Effects*/Potential Health Consequences
Stimulants (continued)			
MDMA (methyl-enedioxymeth-amphetamine)	Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I/swallowed	*for MDMA—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings*/impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity
methamphetamine	*Desoxyn*: chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II/injected, swallowed, smoked, snorted	*for methamphetamine—aggression, violence, psychotic behavior*/memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction
methylphenidate (safe and effective for treatment of ADHD)	*Ritalin*: JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	*for nicotine—additional effects attributable to tobacco exposure*: adverse pregnancy outcomes; chronic lung disease, cardiovascular disease, stroke, cancer; tolerance, addiction
nicotine	cigarettes, cigars, smokeless tobacco, snuff, spit tobacco, bidis, chew	not scheduled/smoked, snorted, taken in snuff and spit tobacco	
Other Compounds			
anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise*: roids, juice	III/injected, swallowed, applied to skin	*no intoxication effects*/hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
Dextromethorphan (DXM)	Found in some cough and cold medications; Robotripping, Robo, Triple C	not scheduled/swallowed	*Dissociative effects, distorted visual perceptions to complete dissociative effects*/for effects at higher doses see 'dissociative anesthetics'
inhalants	*Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl)*: laughing gas, poppers, snappers, whippets	not scheduled/inhaled through nose or mouth	*stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing*/unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

Principles of Drug Addiction Treatment

More than three decades of scientific research have yielded 13 fundamental principles that characterize effective drug abuse treatment. These principles are detailed in NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide*.

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each patient's problems and needs is critical.
2. **Treatment needs to be readily available.** Treatment applicants can be lost if treatment is not immediately available or readily accessible.
3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
4. **At different times during treatment, a patient may develop a need for medical services, family therapy, vocational rehabilitation, and social and legal services.**
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Buprenorphine, methadone, and levo-alpha-acetylmethodol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol dependence. Nicotine patches or gum, or an oral medication, such as bupropion, can help persons addicted to nicotine.
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.
10. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
11. **Possible drug use during treatment must be monitored continuously.** Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection.** Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.





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ETHICAL ISSUES IN PREVENTION

Six principles of ethics for prevention specialists

The six principles of the Prevention Think Tank Code of Ethics guide prevention professionals in the performance of their professional responsibilities and express the basic tenets of ethical and professional conduct. The six principles are:

1. Nondiscrimination
2. Competence
3. Integrity
4. Nature of services
5. Confidentiality
6. Ethical obligations for community and society

These principles help prevention professionals to respond appropriately to ethical dilemmas, make sound and respectful choices each day, create a climate of respect and protect those involved in and served by prevention activities.

Description and Key Concepts for Each of the Six Principles

1. Non-discrimination

   Prevention professionals shall not discriminate against service recipients or colleagues based on race, ethnicity, religion, national origin, sex, age, sexual orientation, education level, economic or medical condition, or physical or mental ability.

   Key concepts:

   - Avoiding/preventing discrimination
   - Complying with anti-discrimination laws and regulations
   - Promoting cultural competence

2. Competence

   Prevention professionals shall master their prevention specialty's body of knowledge and skill competencies, strive continually to improve personal proficiency and quality of service delivery, and delegate professional responsibility to the best of their ability.

Key concepts:

- Assessing your qualifications, working within your existing skill set and only within the prevention domain
- Building your knowledge and skills
- Using best prevention practices
- Addressing personal impairment
- Addressing the unethical conduct of colleagues

3. Integrity

To maintain and broaden public confidence, prevention professionals should perform all responsibilities with the highest sense of integrity.

Key Concepts:

- Providing accurate information
- Giving credit for ideas, information and materials
- Avoiding deception
- Supporting impaired colleagues and service recipients

4. Nature of Services

Practices shall do no harm to service recipients. Services provided by prevention professionals shall be respectful and non-exploitive.

Key concepts:

- Involving the focus population in all aspects of planning
- Protecting participants from harm
- Maintaining appropriate boundaries

Informed consent: The process of obtaining consent from participants that includes a full description and explanation of the activity presented in a way participants can understand and ensures that participants provide their consent willingly free from coercion or undue influence. *Active consent* requires a signature from all participants in a research project and/or their legal representatives. *Passive consent* requires a signature from only those

individuals who do not agree to participate in the research activity and/or their legal representative.

Active consent: Active consent requires a signature from all participants in a research project and/or their legal representatives.

Passive consent: Passive consent requires a signature from only those individuals who do not agree to participate in the research activity and/or their legal representative.

5. **Confidentiality**

Confidential information acquired during service delivery shall be safeguarded from disclosure, including—but not limited to—verbal disclosure, unsecured maintenance of records or recording of an activity or presentation without appropriate releases.

Key concepts:

- Knowing and complying with confidentiality laws and regulations
- Protecting confidential information from disclosure
- Releasing confidential information (when a participant provides written consent OR under specific extenuating circumstances)

6. **Ethical obligations for community and society**

According to their consciences, prevention professionals should be proactive on public policy and legislative issues. The public welfare and the individual's right to services and personal wellness should guide the efforts of prevention professionals to educate the general public and policy makers.

Key Concepts:

- Advocating for prevention
- Protecting the health of others
- Promoting your own wellness

Advocacy vs. Lobbying: Advocacy is taking action to support a broad idea or cause, while lobbying attempts to influence specific legislation.

PREPARING FOR THE EXAM

About the Prevention Specialist Exam

The IC&RC Prevention Specialists Exam is 150 multiple choice questions, but only 125 count toward your score. To pass the test, you need to successfully answer 78 of the 125 questions. You will have three hours to complete the computer-based exam, or 3 ½ hours for the pencil and paper version. Listen to instructions from the exam Proctor, and read test instructions carefully. You will not be able to ask questions after the exam has started.

Even if you have been in the prevention field for years, it is important to prepare for this exam. Start studying early, become very familiar with the contents of this Study Guide, and plan your test taking strategy. Below, find test taking techniques, study strategies, and advice for the day before and day of the exam.

Test Taking Tips

Going into a test with a good knowledge of basic test-taking techniques will help you do your best. Here is a sampling of common test-taking advice:

- **Listen carefully to directions.**
  Listen carefully to the test directions: How much time is available? How will the test be scored? What advice, if any, is given about when to randomly guess on multiple-choice test questions? Does the test administrator have any special instructions?

- **Scan the test before starting to answer questions.**
  Scan the test first to get an idea of length and difficulty. The test is made up of multiple-choice questions, so work on the questions in order and don't spend too much time on any one question. It is OK to skip and come back, but you must remember the number you want to come back to.

- **Understand a question before answering it.**
  Read questions carefully prior to answering. When in doubt, eliminate choices that know to be wrong, and then choose an answer from the remaining choices. The correct answer is always listed in multiple-choice exams.

- **Review the choices.**
  Read the question, try to think of an answer, and then look for it among the available answer choices. If that doesn't work, at least eliminate the choices that appear to be wrong prior to guessing an answer. Do not over-analyze; if you think a question is a "trick," you may be over-thinking the question.

- **Review your work.**
  Review your answers. The test is not over until the time is up, or at least until every answer has been checked.

- **Stay as calm as you can.**
  Stay calm and simply do the best job you can with the time available. Staying calm will make you more efficient while you are answering. A sample strategy for calming oneself is stretching and/or breathing deeply.

Study Strategies

You can prepare for the exam in multiple ways. This study guide is one way, but there are many additional ways to reinforce your mastery of the Prevention Specialist exam topics. Several suggestions are provided below.

Mark your calendar. As soon as you choose an exam date, mark it on your calendar. Plan a study schedule based on the number of days until the exam.

Test yourself. Take a practice test to find out what you know and what you need to study. Find a practice test that's similar to the one you'll be taking.

Work on weak areas. Review subjects that you are weakest on. If certain types of questions give you problems, focus on understanding them better.

Make a daily study commitment. Block off some time each day to study. Creating a specific time to study helps with time management and establishes predictable study habits.

Create Study Checklists. Use your study guide to outline key points for each of the domain areas. Pay attention to lists, steps, or categories.

Focus on the Key Terms. Understanding key terms throughout this study guide is important to mastering the exam; however don't limit yourself to just the key terms.

Create flashcards. Use the flashcards in this Guide or create your own, and quiz yourself or have others quiz you.

Study with others. Group studying can be helpful for practicing questions or for reviewing information that might be unclear.

Understand your learning style. Some people learn best by reading, some learn by hearing, and others learn best by doing. You may learn best through a combination of these styles.

If a study strategy is not working for you, do not be afraid to try a different strategy. Find a system that works for you and stick with it.

The Day Before and the Day of the Exam

Before the Test

- *Eat well.* Good nutrition to concentrate and perform your best.
- *Sleep well.* While it may be helpful to review your study materials the day before the exam, do not pull an all-nighter. Get plenty of rest, and set your alarm!
- *Bring the right supplies.* Gather all materials you may need to bring with you the night before the exam. This may include pencils, erasers, pens, registration paperwork, photo identification, a watch to time your progress, or whatever else you need on test day. Note: You will not be allowed to bring study materials into the testing room.
- *Arrive early.* Give yourself plenty of time for traffic, parking, or other transportation concerns that may arise.
- *Follow your normal routine.* Testing day is not the time to try something different.

During the Test

- *Read the directions.* It's important that you follow the instructions exactly. For example, some questions may have more than one correct answer.
- *Review the whole test before you start.* See how many sections and what types of questions are on the test. Determine how much time to allow for completing each section.
- *Answer easy questions first.* Doing this can jog your memory about useful facts. You may also come across information that can help you with other questions.
- *Answer every question.* Try to answer every question; do not change an answer unless you are certain your first response is wrong.
- *Identify key words*. This helps you focus on the main idea of challenging questions.
- *Rephrase difficult questions.* To understand questions better, you may want to rewrite them in your own words. Be careful not to change the meaning.
- *Use the extra time to proofread and review your answers.*

The above test-taking tips and strategies were adapted from the following sources:

College Board. (2015). Big Future: How to Prepare for Admissions Tests
EMT Associate. (2012). Studying for Success: Preparing for and Passing the IC&RC Prevention Specialist Exam
eHow Vickie Christensen: What makes a Test Standardized?
SABES Adventure in Assessment Volume 16. (2004). Learning Centered Approaches to Assessment and Evaluation in Adult Literacy

SAMPLE EXAM PRACTICE MATERIALS

Sample Exam Questions

Practice Activity: Process or Outcome Evaluation?

Practice Activity: U, S, or I?

Flashcards

SAMPLE EXAM QUESTIONS

Use the sample questions below to study for the exam.
An answer key is provided on page 62.

1. Qualitative data is often collected through key informant interviews, focus groups, listening sessions, and:
   A) Community meetings
   B) Newspaper articles
   C) Arrest reports
   D) Hospital records

2. A program that has been researched and found to be effective is known as:
   A) Universal.
   B) Evidence-based
   C) Promising
   D) Excellent.

3. An example of an indicated prevention strategy is:
   A) Student Assistance Program (SAP)
   B) Media Campaign
   C) Schools Assemblies
   D) Social Norm Program

4. Mobilizing community members to participate in a community prevention effort is an example of:
   A) Community readiness
   B) Problem prioritization
   C) Coalition building
   D) Community needs assessment

5. You are planning to use a proven, evidence-based program but realize it is not feasible to implement all of the program components. You should:
   A) Not proceed at all with your choice
   B) Consult with the program's developers to determine potential impact
   C) Go ahead, as most programs can be modified to meet local circumstances
   D) Add additional alternatives to fill out the missing components

6. A prevention program that has been designated as a best practice means:
   A) It has been adapted by many prevention programs throughout the country
   B) It reflects the specific cultural needs of the community
   C) It needs to involve a skilled, experienced program director
   D) It has been shown through research and evaluation to be effective

7. Which of the following is an example of quantitative data?
   A) Interviews with service providers
   B) A review of archival data
   C) A survey of prevention program directors/staff
   D) A review of program documents

8. A prevention strategy aimed at informing broad segments of society is called a:
   A) Universal intervention
   B) Selective intervention
   C) Indicated intervention
   D) Risk and protective approach

9. Information collected from interviews, focus groups, and/or observations involving document reviews to produce a descriptive report is called:
   A) Indicator data
   B) Qualitative data
   C) Outcome data
   D) Quantitative data

10. An objective statement:
    A) Is time-bound, specific and measurable
    B) Identifies specific individuals and their responsibilities
    C) Is general and inclusive
    D) Compares planned to achieved tasks

11. Key informants are people who:
    A) Represent official positions of power in a community
    B) Are engaged by program evaluators to monitor program implementation
    C) Go undercover to provide school officials with tips on drug traffic
    D) Are essential information sources in needs assessments

12. What question should be asked at the HIGHEST level of prevention evaluation?
    A) Did community-wide behaviors change?
    B) Did intended participants attend regularly?
    C) Did program participants' behavior change?
    D) Did participants' attitudes change or did self-esteem improve?

13. After you've collected all data for your needs assessment, the best next step would be to:
    A) Analyze the data
    B) Prepare a report
    C) Determine stakeholders' needs
    D) Draft recommendations

14. Archival data is:
    A) Information from a large number of individuals
    B) Information contained in public records
    C) Hard to find
    D) Collected from surveys

15. A process evaluation:
    A) Is done at the completion of the program
    B) Is done throughout the delivery of program services
    C) Involves random assignment of participants
    D) Involves the collection of participant information after they leave the program

16. Key Informant Interviews as a method of data collection:
    A) Eliminate the possibility of bias in collection information
    B) Can be done by anyone
    C) Provide in-depth information about community needs
    D) Do not take much time

17. The best reason to use a pre-post survey method is that it:
    A) Tells you whether the individual has changed their behavior, attitude, knowledge, or belief
    B) Provides an opportunity for the program participant to criticize the program
    C) Is less expensive and more effective than any other evaluation method
    D) Can give you information about the program that other data collection methods can't provide

18. An example of a selective intervention is:
    A) A classroom-based prevention program for all seventh graders in a school district in a high risk community
    B) A skills-based program for youth from military families who have experienced many transitions
    C) A parenting program which is open to all residents in a rural town hosted by a local church.
    D) A media campaign targeting Latino youth in a big city

19. Which of the following is an example of a risk factor for behavioral health problems in youth?
    A) Ability to obtain positive attention
    B) Desire to achieve
    C) Inadequate supervision
    D) Adequate income

20. An example of an information dissemination approach would be:
    A) Talking to a student about the dangers of illegal drugs
    B) Mass media campaign on methamphetamine addiction
    C) Server intervention training workshops
    D) Student Assistance Programs

21. The conditions that build resilience to buffer negative effects such as substance abuse among parents, low-commitment to school, or drug-abusing environment, are called:
    A) Support factors
    B) Universal factors
    C) Resilient factors
    D) Protective factors

22. An example of an evidence-based environmental approach to substance abuse prevention is:
    A) School-based curriculum highlighting community risks
    B) Server intervention training
    C) Program serving student drop-outs
    D) Community health fairs

23. A way the media can be used to educate and inform is through:
    A) Parenting skills classes
    B) After school programming
    C) PTA meetings
    D) Opinion editorials

24. The attitude and habit that MOST increases cultural sensitivity is:
    A) Leading
    B) Demonstrating sympathy
    C) Displaying concern
    D) Working alongside

25. As a facilitator in a community planning process, how would you get community buy-in?
    A) Ensure food is provided at the planning meeting
    B) Get an announcement placed in the local newspaper
    C) Involve community members in the planning process
    D) Present the completed program plan to community leaders

26. In order to increase diverse community involvement in a coalition, you should:
    A) Present at events throughout the community
    B) Distribute flyers in the languages of community residents
    C) Use public events (e.g., fairs) to publicize your needs
    D) Go directly to the focus community and recruit potential members

27. Prevention specialists who are facilitating community prevention coalitions must tailor their facilitation style to the group's blend of bylaws, ground rules, people and:
    A) Consultants
    B) Funding
    C) History
    D) Strategies

28. When facilitating a community coalition or planning group, a prevention specialist should avoid:
    A) Listening and observing
    B) Managing conflict
    C) Encouraging participation
    D) Inserting personal opinions

29. Which of the following is categorized as a depressant drug?
    A) Alcohol
    B) Oxycodone
    C) Marijuana
    D) Methamphetamine

30. Materials that are not copyrighted are considered to be:
    A) Tangible
    B) Minimally creative
    C) Original
    D) Public domain

31. What is a social marketing campaign?
    A) An environmental prevention technique that directs behavior through word of mouth.
    B) A type of prevention strategy that allows for the selection of the best way to reduce use in a community by popular vote
    C) The application of commercial marketing technologies to prevention programs in order to improve personal welfare and that of society
    D) An environmental prevention program that targets events and gatherings as the places to deliver its message

32. Prevention professionals must determine what factors helped explain why people begin to engage in problem behaviors. At the most basic level these factors are:
    A) Schools and communities
    B) Family and peers
    C) Individuals and family
    D) Risk and protective

33. Media campaigns in prevention are most typically intended to:
    A) Educate the public
    B) Encourage legislation supporting prevention
    C) Recruit volunteers
    D) Change people's behavior

34. The Institute of Medicine (IOM) continuum of care defines three types of prevention approaches. One IOM approach is:
    A) Indicated
    B) Children of Substance Abusing Parents
    C) High-Risk Behaviors
    D) Substance Use Disorders

35. The primary purpose of creating a logic model is to:
    A) Identify evaluation tools
    B) Enhance community involvement
    C) Determine appropriate staffing patterns
    D) Connect goals, strategies and outcomes

36. If your community coalition lacks participation from a specific focus community, you should:
    A) Go to those groups that have volunteered to serve in your coalition
    B) Attend an event sponsored by the focus community
    C) Wait until the coalition has completed its work
    D) Have coalition members go to that community and ask them to participate

37. A goal statement:
    A) Provides general purpose, direction, and desired outcomes
    B) Specifies what and when something is to be accomplished
    C) Identifies who will do what tasks
    D) Is the same as a mission statement

38. There was an underage drinking problem in the community. Enforcement of minimum-purchase-age laws against selling alcohol and tobacco to minors through the use of undercover buying operations was utilized to address the underage drinking problem. What type of prevention strategy was used?
    A) Alternatives to drug use
    B) Dissemination of information
    C) Prevention education
    D) Environmental approach

39. Focus groups are used to bring together people:
    A) With common characteristics for implementing programs
    B) From diverse backgrounds to discuss a wide variety of topics
    C) To evaluate types of proposed program materials
    D) With common perspectives that relate to a specific topic

40. A person who has been designated by group members to be caretaker of the meeting process is known as the:
    A) president
    B) board leader
    C) facilitator
    D) advocate

41. The first step in developing a comprehensive community prevention plan is:
    A) Assessment of readiness
    B) Capacity building
    C) Planning
    D) Implementation

42. Before working in a community to implement prevention programming, what is an important first step?
    A) Learning as much information about the community as possible
    B) Evaluating the community's current programming efforts
    C) Informing community members of the best strategies to help them
    D) Selecting the type of program you want to implement

43. When is it appropriate to engage community members in the program evaluation process?
    A) During the evaluation design portion, but not the data collection portion
    B) For data collection purposes only, because they can use their connections in the community
    C) All the way through
    D) Not at all, since their presence may bias evaluation results

44. Information overload is a barrier to effective listening because:
    A) The receiver gets too much content at one time
    B) The audience member does not have a chance to respond
    C) The receiver is forced to hear the speaker talk for too long
    D) The audience member is unable to talk to their peers about what they are learning

45. What best defines a facilitator's role?
    A) Someone who sets up a meeting site, including deciding the place and time
    B) Someone who oversees the meeting process
    C) Someone who writes minutes from a meeting and distributes them to all members
    D) Someone who ensures that a follow-up meeting date is set by the end of the meeting

46. What would best describe a community in denial about a substance abuse problem?
    A) The community might recognize substance abuse as a problem in general, but does not acknowledge that it is a problem for them specifically.
    B) The community has no awareness that substance abuse is a problem.
    C) The community has no leadership to do anything about the problem.
    D) The community might acknowledge substance abuse exists in their community but does not see it as a problem.

47. A community coalition is advocating for an ordinance to ban the sale of alcohol at the annual fall family festival. This is an example of:
    A) An alternative activity strategy
    B) A family intervention strategy
    C) An environmental strategy
    D) An enforcement strategy

48. Data collection efforts to determine a community's norms can be conducted using which of the following?
    A) Informal discussions after meeting
    B) Journals from health classes
    C) Focus groups
    D) Attendance at an event

49. What is social norms marketing?
    A) The theory that marketing is a normal way of conveying information.
    B) How people look to the media for understanding about their peers
    C) Conveying the idea that most people practice healthy behaviors
    D) Showing how abnormal sobriety is on college campuses

50. A prevention specialist provides life skills classes at a local school. They are asked by the principal to lead group therapy sessions for children of alcoholics while the guidance counselor is on leave. The prevention specialist should:
    A) Respectfully refuse
    B) Accept the challenge
    C) Volunteer to co-facilitate
    D) Accept but provide life skills classes instead of therapy

51. Strategies that aim to enhance individuals' ability to develop competence, a positive sense of self-esteem, mastery, well-being, social inclusion, and strengthen their ability to cope with adversity are:
    A) Mental health promotion interventions
    B) Universal preventive interventions
    C) Selective preventive interventions
    D) Indicated preventive interventions

52. What is the most basic guiding ethical principle in prevention work?
    A) Never encourage substance use
    B) Take every opportunity to spread the prevention message
    C) Do no harm
    D) Lead by example

53. In prevention work, when a prevention specialist's personal opinions differ from a coalition member's on a relevant issue, what is the best way to approach the topic?
    A) Use the position of authority to attempt to influence the member
    B) Acknowledge internally the difference between personal viewpoints and professional and uphold professionalism at all times
    C) Tell the member you can no longer work with him/her
    D) Find a compromise between the two positions

54. Treating every community in which you provide services the same, regardless of their culture, is an example of:
    A) Cultural competence
    B) Cultural humility
    C) Cultural blindness
    D) Cultural sensitivity

Answers can be found on next page.

Answers to sample exam questions:

1. A
2. B
3. A
4. C
5. B
6. D
7. C
8. A
9. B
10. A
11. D
12. A
13. A
14. B
15. B
16. C
17. A
18. B
19. C
20. B
21. D
22. B
23. D
24. D
25. C
26. D
27. C
28. D
29. A
30. D
31. C
32. D
33. A
34. A
35. D
36. D
37. A
38. D
39. D
40. C
41. A
42. A
43. C
44. A
45. B
46. A
47. C
48. C
49. C
50. D
51. A
52. C
53. B
54. C

Answers to sample exam questions explained:

1. *A*: Qualitative data is subjective information about a topic or issue that can't actually be measured. Qualitative data are usually reported in words. Sources of qualitative data include stories, key informant interviews, testimonials, and focus groups. Qualitative data is gathered from individuals and/or communities usually in person and/or the phone. The data is then compiled, reported and utilized to illustrate community and/or population specific perspectives, e.g. the how and the why.

2. *B:* Evidence-based programs have been researched and analyzed in a methodical way and found to be effective.

3. *A*: The Institute of Medicine (IOM) describes an indicated prevention strategy as a strategy that focuses on a person and/or group who have participated in an identified risk behavior. The key is the risk level of the person and/or group. Student assistance programs often focus on youth who have exhibited risk behaviors.

4. *C*: Community mobilization engages all sectors of the population in a community-wide effort to address a health, social, or environmental issue. It brings together policy makers, opinion leaders, local, state, federal governments, professional groups, religious groups, businesses, and individual community members. Community mobilization empowers individuals and groups to take some kind of action to facilitate change. A common community mobilization strategy is coalition building and development.

5. *B*: Adaptation of an evidence-based program requires consultation and approval from the developer to ensure programmatic fidelity and determine if adaptations will impact program effectiveness.

6. *D*: Best practices in prevention refer to a set of prevention activities that evaluation research has shown to be effective.

7. *C*: Quantitative data provide information about quantities; that is, information that can be measured and written down with numbers. Sources of quantitative data include counting, checklists, surveys, and analysis of statistics.

8. *A:* The Institute or Medicine (IOM) defines a universal prevention strategy/approach as focused on a broad group regardless of participation in an identified risk factor, environment, biological or other external factors.

9. *B*: Qualitative data provide information about qualities; information that can't actually be measured. Qualitative data are usually reported in words. Sources of qualitative data include key informant interviews, case studies, testimonials, and focus groups.

10. *A*: Objective statements provide a description of the specific ends you wish to achieve through the implementation of a model, plan, or program. Objective statements should be specific, measurable, achievable, relevant/realistic, and time-bound (SMART).

11. *D*: Key Informants are people who have specialized knowledge about a topic that you wish to understand and can convey that knowledge to you. Key informants are a necessary component of a needs assessment process.

12. *A*: Evaluating success at the participants-only level is not the highest level at which we can evaluate a program. The ultimate goal, or highest level, is to impact the entire community, beyond the people reached directly by a specific intervention.

13. *A*: The needs assessment process helps to define community needs, motivations, and behaviors — what they do, how they do it, and why. The steps in a needs assessment include: formulating needs assessment questions, reviewing existing data sources, collecting new data, analyzing data, reporting findings and using the findings.

14. *B*: Archival Data are any data that are collected and stored prior to the beginning of a research study and made available to the public by government agencies and academic institutions.

15. *B*: Process evaluation looks at how program activities are delivered. It helps practitioners determine the degree to which an intervention was implemented as planned and the extent to which it reached the targeted participants. Process

evaluation has to do with the intervention itself and answers the question: Did we do what we said we would do? It is collected throughout the delivery of the program.

16. *C:* Key informant interviews are structured conversations with people (stakeholders) who have specialized knowledge and/or interest in the population and/or content area and provide in-depth information about a focus population or a community.

17. *A*: *Pre-Post survey* methods are a survey style in which respondents answer a series of survey questions both before and after completing a program or task. The answers to these two identical sets of questions are compared in order to measure growth in understanding and effectiveness of the program and to measure if individuals have changed their behavior, attitude, belief and/or knowledge.

18. *B*: Selective interventions focus on people or a population sub-group whose risk of developing mental disorders and/or substance abuse disorders is higher than average, prior to the diagnosis of a disorder but who have not yet engages in the risky behavior themselves. Selective interventions target biological, psychological, or social risk factors that are more prominent among high-risk groups than among the wider population. Some examples are: prevention education for new immigrant families living in poverty with young children, peer support groups for individuals with a family history of mental illness and/or substance abuse.

19. *C:* Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of problem outcomes. Parental neglect and/or lack of adequate supervision are examples of risk factors for individuals.

20. *B:* An information dissemination approach is a method by which specific groups of people are made aware of important data, policies, decisions, and ideas that are of particular relevance to them e.g. mass media campaigns, community health fairs.

21. *D*: Protective factors within the family and community help promote resiliency, combatting problem behaviors.

22. *B*: An environmental approach/strategy is a prevention strategy aimed at altering the immediate cultural, social, physical and economic environments in which people make their choices about drug use or other risky behavior. Some examples are policy changes, social media campaigns.

23. *D:* Media is designed to reach the largest population possible. Opinion editorials are one media strategy to reach a broad audience.

24. D: In order to engage diverse communities and demonstrate cultural sensitivity, prevention providers should work directly, collaboratively and alongside the community of focus. Collaboration reduces exclusion and ensures prevention initiatives are appropriate for a diverse population.

25. *C*: Engaging and involving the community in the planning process versus informing them after the fact establishes the foundation for ownership and buy-in from the

community, and helps ensure that the selected interventions are culturally appropriate.

26. *D*: Strategies to increase the participation of diverse communities on coalitions require outreach to the focus community. Proactively going to the community, or going the their "table" to engage and recruit increases the likelihood of identifying what the coalition can provide and what the focus community can contribute to the coalition. The other options listed are passive, not active, approaches that are less likely to meet this goal.

27. *C*: When facilitating a coalition, the prevention specialist, must consider the group's history in addition to existing bylaws, ground rules and coalition membership. It is essential that, as a facilitator, the prevention specialist understands the culture of a group and how it has operated in the past.

28. *D*: The definition of facilitate is "to make easy" or "ease a process." A facilitator plans, guides and manages a group to ensure that the group's objectives are met effectively, with clear thinking, good participation and full buy-in from everyone who is involved. The facilitator's focus is on guiding the group process, not controlling it. Therefore, he/she should not insert personal opinions and bias.

29. *A*: Alcohol is a depressant (drug). Depressants have a suppressive effect on the nervous system, resulting in slow brain function, slowed pulse and breathing, lowered blood pressure, poor concentration, confusion, fatigue, dizziness, slurred speech, sluggishness, disorientation, lack of coordination, and other effects. They are also known commonly as "downers." Oxycodone is a narcotic. Marijuana is typically not categorized. Methamphetamine is a stimulant. (See the National Institute of Drug Abuse (NIDA) chart).

30. *D:* A copyright is the exclusive legal right given to an originator or an assignee to print, publish, perform, film, or record literary, artistic, or musical material, and to authorize others to do the same. The public domain is the state of belonging or being available to the public as a whole, and therefore not subject to copyright.

31. *C*: Social marketing campaigns are marketing campaigns that seek to contribute to the overall societal good by employing commercial marketing techniques for non-commercial goals, for example, prevention messaging to improve personal and community wellness.

32. *D*: The most basic factors prevention specialists should identify are risk and protective factors. Both risk and protective factors may occur at the biological, psychological, family, community, or cultural level. Risk factors are associated with a higher likelihood of problem outcomes, and protective factors are associated with a lower likelihood of problem outcomes.

33. *A*: Media campaigns are a planned series of newspaper articles, television interviews, etc. that are intended to achieve a particular aim, such as education, persuasion, or marketing to the public or broad audience.

34. *A*: The Institute of Medicine (IOM) continuum of care conceptualizes prevention in three main ways: Universal prevention includes strategies that are delivered to broad populations without consideration of individual differences in risk for substance abuse. Selective prevention includes programs and practices that are delivered to sub-groups of individuals identified on the basis of their membership in a group that has an elevated risk for developing substance abuse problems. Finally, indicated prevention further focuses the ability to design interventions to address specific risk behaviors in individuals already engaged in them but not clinically diagnosed.

35. *D:* A logic model is a visual tool intended to communicate the logic, or rationale, behind a program or process. Like a roadmap, it is meant to show, as clearly and in as few words as possible, where you are, where you are going, and how you will get there. Specifically, logic models offer a way to describe the relationships between goals, strategies and expected outcomes.

36. *D:* Engaging a focus community is most successful when the prevention providers are able to demonstrate how they can benefit from participating in prevention efforts and how they can contribute. Going to the focus community, illustrates the willingness to meet the community where they are and shows an investment in their work.

37. *A:* A goal statement is a description of the purpose, direction and outcome intended to be achieved through the implementation of a model, plan, or program.

38. *C:* Environmental prevention strategies include policies/ordinances, enforcement programs, and practices that promote the well-being of people and reduce the consumption of and the problems associated with the use, misuse or abuse of alcohol, tobacco and other drugs.

39. *D:* A focus groups is a group of people that participates in a guided discussion about a particular topic prior to program implementation, or that provides insight into a particular topic of interest in order to get a broad perspective on that topic.

40. *C:* A facilitator plans, guides and manages a group and its process to ensure that the group's objectives are met effectively, with clear thinking, good participation and full buy-in from everyone who is involved.

41. *A*: The first step in developing a prevention strategy is assessing community readiness. A readiness assessment allows prevention specialists to tailor programs to address the needs identified by the community, and to assess the community's ability and willingness to participate.

42. *A*: In order to work effectively with a community, prevention providers need to know and understand the community and its needs. An important and initial step is learn as much as possible about the community, including but not limited to: its history, decision making process, key stakeholders, community norms and attitudes about problem behaviors.

43. *C*: Community members should be involved in evaluation throughout implementation of a program to ensure cultural appropriateness and relevance. Programs should be

collecting both process and outcome data for the focus population and/or community.

44. *A:* An effective communication technique is to avoid information overload. If individuals or communities receive too much information, they may tend to put up a barrier because the amount of information is coming so fast that they may have difficulty comfortably interpreting that information.

45. *B:* A facilitator is someone who assists and oversees a group of people, understands their common objectives, and assists them in planning how to achieve these objectives. In doing so, the facilitator remains neutral, meaning that he/she does not take a particular position in the discussion.

46. *A:* The Community Readiness Model defines nine stages of readiness. Stage 2 is denial/resistance, where the community has some recognition of the problem but denies it is a local issue or believes it cannot be addressed. Communities in Stage 1, (tolerance/no knowledge), do not generally recognize substance abuse as a problem at all or might acknowledge substance abuse exists in their community but do not see it as a problem. Communities in Stage 3 have a vague awareness of the problem but no leadership to address it.

47. *C*: An environmental approach/strategy is a prevention strategy aimed at altering the immediate cultural, social, physical and economic environments in which people make their choices about drug use or other risky behavior. Examples are policy changes, social media campaigns, and enforcement.

48. *C*: One technique for assessing community norms is qualitative data collection strategies like focus groups in order to gain an understanding of what specific communities' value and how they respond to situations.

49. *C*: Social norms marketing is designed to influence social norms which are rules of behavior that are considered acceptable in a group or society. Social norms marketing strategies involve the shaping of what is considered to be "normal" to produce a change in the opinions or practices of a population. "Most teens use a designated driver when they consume alcohol" is an example of a social norms marketing message.

50. *D:* Providing therapy of any kind is out of the scope of work of a prevention professional whether or not he/she has the training or credentials to do so. When functioning as a prevention specialist, one must provide only prevention services. Therapy is a treatment strategy.

51. *A:* Mental health promotion intervention is the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Strategies include: promoting person competence, positive self-esteem and self-worth, increased social inclusion and the ability to manage stressors and other adversities.

52. *A*: The most basic guiding principle in all ethical codes related to human services, including prevention, is to do no harm to those we serve. The other options listed, while important, are actually derived from this primary principle.

53. *B*: When prevention specialists' personal opinions differ from those of coalition members on a relevant issue, they should acknowledge internally the difference between personal viewpoints and their professional role and uphold professionalism at all times. The prevention specialist's role is to facilitate discussion, provide current information on the topic, and ensure there are meeting outcomes. It is not to take a position or stance on an issue or to convince the group of a point of view. The facilitator is not responsible for identifying a solution or compromise, which should come from the group membership.

54. *C:* Cultural blindness is an expressed philosophy of viewing and treating all people as the same and disregarding approaches in the delivery of prevention services that support and acknowledge cultural differences and strengths.

PRACTICE ACTIVITY: PROCESS OR OUTCOME EVALUATION?

Instructions: Review each of the evaluation questions below and decide whether it is a process or outcome evaluation question. Check the appropriate box.

EVALUATION QUESTIONS	PROCESS	OUTCOME
1. How many individuals/groups did the intervention serve?		
2. To what extent did the intervention lead to improved coping skills among participants?		
3. To what extent was the intervention implemented completely, as intended?		
4. How many participant youth used alcohol one year after the end of the intervention?		
5. To what extent did the intervention lead to a change in participants' attitudes toward the harmful effects of using tobacco?		
6. How many students who were referred to the intervention actually participated?		
7. What cultural adaptations were made to the intervention?		
8. Were the people exposed to the intervention representative of the population the intervention was intended for?		
9. How are preliminary evaluation findings being used to improve the intervention?		
10. After the intervention, did people exposed to it have more positive normative beliefs compared to those not exposed?		

Source: SAPST Worksheet 4.8, Version 8, November 2012 – SAMHSA Reference #277-08-0218

Answer key:

1. Process	*2. Outcome*	*3. Process*	*4. Outcome*	*5. Outcome*
6. Process	*7. Process*	*8. Process*	*9. Process*	*10. Outcome*

PRACTICE ACTIVITY: U, S, OR I?

Instructions: Assign the appropriate classification—**universal**, **selective** or **indicated**—to each of these examples.

	UNIVERSAL	SELECTIVE	INDICATED
1. Support groups for adults with a family history of mental illness			
2. Laws that increase penalties for providing alcohol to minors			
3. Programs for families experiencing transitions			
4. Social norming campaign to decrease norms favorable to marijuana use			
5. School-based alcohol prevention programs for youth involved in the juvenile court system			
6. Mentoring programs for children of incarcerated parents			
7. An education program for senior citizens who have experienced problems related to alcohol and prescription drug interactions			
8. A prevention program for all middle school students in a community			
9. College campus policies on alcohol			
10. Programs for people arrested for drunk driving			

Source: SAPST Information Sheet 1.7, Version 8, November 2012 – SAMHSA Reference #277-08-0218

Answer key:

1. Selective	*2. Universal*	*3. Selective*	*4. Universal*	*5. Indicated*
6. Selective	*7. Indicated*	*8. Universal*	*9. Universal*	*10. Indicated*

FLASHCARDS

Utilize the following as flashcards. Cover answers with a sheet of paper and use as a study tool.

What is behavioral health?	A state of mental/emotional being and/or choices and actions that affect wellness.

What is a risk factor?	A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

What is a protective factor?	A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a lower likelihood of problem outcomes.

What is qualitative data?	Qualitative data is information about qualities; information that can't actually be measured. Qualitative data are usually reported in words. Sources of qualitative data include stories, case studies, testimonials, and focus groups.

What is quantitative data?	Quantitative data is information about quantities; that is, information that can be measured and written down with numbers. Sources of quantitative data include counting, checklists, surveys, and analysis of statistics.

What are five elements of culture?	Elements of culture: norms, values, beliefs, symbols, and practices

What is epidemiology?	Epidemiology is the study of the distribution and determinants of the health and wellness of populations. In the behavioral health prevention field, epidemiologists study the patterns of use and abuse and the factors associated with an increased or decreased risk of developing substance abuse problems.

What is sustainability?	The ability or likelihood of a coalition, program or activity to continue over a period of time.

What is program fidelity?	Fidelity occurs when a program is implemented with the same specifications as the original program.

What is confidentiality in the context of prevention?	Keeping information given by or about an individual in the course of a professional relationship secure and secret from others.

What is pharmacology?	The science or study of drugs, including their composition, uses and effects upon living organisms.

What are the three key areas in which to build capacity?	1. Engage and build relationships with stakeholders, 2. Strengthen collaborative groups, 3. Increase community awareness

What are five levels of involvement for stakeholder engagement?	1. No involvement, 2. Networking, 3. Cooperation, 4. Coordination, 5. Collaboration

What should a prevention specialist consider when selecting interventions?	1. Effectiveness, 2. Conceptual fit, 3. Practical fit

What are the components of the Institute of Medicine's Continuum of Care?	Promotion; Prevention: Universal, Selective, Indicated; Treatment: Case Identification, Standard Treatment; and Maintenance: Long-term treatment, After-care and Rehabilitation

What are Universal prevention interventions?	Universal prevention interventions are interventions that take the broadest approach and focus on the general public or any population that is not identified based on risk.

What are Selective prevention interventions?	Selective prevention interventions are those that focus on individuals or sub-groups whose risk of developing mental health disorders and/or substance use disorders are significantly higher due to biological, psychological, and/or social risk factors.

What are Indicated prevention interventions?	Indicated prevention interventions focus on higher risk individuals who are identified as having signs and/or symptoms or behaviors foreshadowing a mental, emotional and/or substance use disorder.

What is an assessment?	The systematic gathering and examination of data related to substance abuse and associated problems, as well as related conditions and consequences in the community. It identifies the problems; the populations that are most affected; and the conditions that put the community at risk, and those that can protect against the problems identified.

What are evaluation methods?	The manner in which evaluation information or data is collected.

What is media advocacy?	The strategic utilization of the media to advance a social and/or public policy initiative.

Use these blank cards to make your own flashcards.	

Use these blank cards to make your own flashcards.	

Use these blank cards to make your own flashcards.	

REFERENCE MATERIALS

1. Common Acronyms
2. Glossary
3. NIDA Drug Table
4. Reference List

ACRONYMS

AMA	American Medical Association
AOD	Alcohol and other drugs
APA	American Psychological Association
APHA	American Public Health Association
ATF	Bureau of Alcohol, Tobacco, Firearms and Explosives
ATOF	Alcohol, tobacco and other drugs
BAC	Blood alcohol content
CADCA	Community Anti-Drug Coalitions of America
CAPT	Center for the Application of Prevention Technologies
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CMHS	Center for Mental Health Services
CPS	Certified Prevention Specialist
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DEA	U.S. Drug Enforcement Administration
DFC	Drug Free Communities [Grantee or Mentee]
DFSCA	Drug Free Schools and Communities Act
DUI	Driving under the influence
DWI	Driving While Intoxicated
EAP	Employee Assistance Programs
ED	U.S. Department of Education
FASD	Fetal Alcohol Spectrum Disorders
FBI	Federal Bureau of Investigations
FDA	Food and Drug Administration
HHS	U.S. Department of Health and Human Services
IC&RC	International Certification and Reciprocity Consortium
IOM	Institute of Medicine
IRB	Institutional Review Board
MADD	Mothers Against Drunk Driving
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NIAA	National Institute on Drug Abuse
NOMS	National Outcome Measures
NPN	National Prevention Network
NREPP	SAMHSA's National Registry of Evidence-Based Programs and Practices
NSDUH	National Survey on Drug use and Health
N-SSATS	National Survey on Substance Abuse Treatment Services
OJJDP	Office of Juvenile Justice and Delinquency Prevention
ONDCP	Office of National Drug Control Policy
RADAR	Regional Alcohol and Drug Awareness Resource Network
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDFSCA	Safe and Drug Free Schools and Communities Act
SIG	State Incentive Grant[ee]
SPF	Strategic Prevention Framework
SSA	Single State Agency
TEDS	Treatment Episode Data Set
TIG	Tribal Incentive Grant[ee]
YRBSS	Youth Risk Behavior Surveillance System

ACRONYMS (Rhode Island-specific)

BHDDH	Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
CPRC	Cancer Prevention Research Center at University of RI
CRST	Community Research and Services Team at University of RI
DATA	Drug and Alcohol Treatment Association
DCYF	RI Department of Children, Youth and Families
GCBH	RI Governor's Council on Behavioral Health
HEALTH	RI Department of Health
PAC	Prevention Advisory Committee
PFS	Partnerships for Success
RICARES	RI Community of Addictions Recovery Efforts
RICCMHO	RI Council of Community Mental Health Organizations
RIDE	Rhode Island Department of Education
RISAPA	RI Substance Abuse Prevention Act
RISS	RI Student Survey
RISAS	RI Student Assistance Services
SEOW	State Epi Outcomes Workgroup

GLOSSARY

Please note: The terms found below are not a complete list of those that may be found on the exam.

A

Adaptation: Modifications made to a chosen intervention; changes in audience, setting, and/or intensity of program delivery. Research indicates that adaptations are more effective when underlying program theory is understood; core program components have been identified; and both the community and needs of a population of interest have been carefully defined.

Addiction/stages of addiction: Compulsive physiological need for and use of a habit-forming substance (as marijuana, nicotine or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal.

Advocacy: Taking action to support an idea or a cause. Advocates educate community members, the media, and elected officials in order to raise awareness, increase understanding of key issues, and mobilize support with the goal of creating positive change.

Archival data: Data that have already been collected by an agency or organization which are in are their records or archives.

Assessment: A process of gathering, analyzing and reporting information, usually data, about your community. A community assessment should include geographic and demographic information, as well as a collective review of needs and resources within a community that indicates what the current problems or issues are that could be addressed by a coalition.

B

Behavioral health: A state of mental/emotional being and/or choices and actions that affect wellness. The term *behavioral health* can also be used to describe the service systems surrounding the promotion of mental health, the prevention and treatment of mental and substance use disorders, and recovery support.

Brainstem: The lower portion of the brain. Major functions located in the brainstem include those necessary for survival, e.g., breathing, heart rate, blood pressure, and arousal.

C

Capacity: The various types and levels of resources that an organization or collaborative has at its disposal to meet the implementation demands of specific interventions. Capacity includes both the resources a community has to address its problems (e.g., programs, organizations, people, money, expertise) and how ready the community is to take action to address its problems.

Capacity building: Increasing the ability and skills of individuals, groups and organizations to plan, undertake and manage initiatives. The approach also enhances the capacity of the individuals,

groups and organizations to deal with future issues or problems. Building capacity involves increasing the resources and improving the community's readiness to do prevention.

Cerebellum: A portion of the brain that helps regulate posture, balance, and coordination.

Cerebral cortex: Region of the brain responsible for higher cognitive functions, including language, reasoning, decision making, and judgment.

CNS depressants: A class of drugs (also called sedatives and tranquilizers) that slow CNS function; some are used to treat anxiety and sleep disorders (includes barbiturates and benzodiazepines).

Coalition: A formal arrangement for cooperation and collaboration between groups or sectors of a community, in which each group retains its identity but all agree to work together toward a common goal of building a safe, healthy and drug-free community.

Community Readiness: The degree of support for or resistance to identifying substance use and abuse as significant social problems in a community. Stages of community readiness for prevention provide an appropriate framework for understanding prevention readiness at the community and state levels.

Confidentiality: Keeping information given by or about an individual in the course of professional relationship secure and secret from others.

Co-occurring disorder: Having one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

Cultural competence: Cultural competence, at the individual, organizational, and systems levels, involves being respectful and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups.

Cultural diversity: Differences in race, ethnicity, language, nationality or religion among various groups within a community. A community is said to be culturally diverse if its residents include members of different groups.

Culture: The shared values, traditions, norms, customs, arts, history, folklore and institutions of a group of people that are unified by race, ethnicity, language, nationality or religion. C*ulture* refers to "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups."

D

Depressants: Drugs that relieve anxiety and promote sleep. Depressants include barbiturates, benzodiazepines, and alcohol.

Developmental Approach/Perspective: A developmental approach to prevention suggests that risk and protective factors and their potential consequences and benefits are organized according to defined developmental periods. This enables practitioners to match their prevention efforts to the developmental needs and competencies of their audience. It also helps planners align prevention

efforts with key periods in peoples' development, when they are most likely to produce the desired, long-term effects.

Dopamine: A brain chemical, classified as a neurotransmitter, found in regions of the brain that regulate movement, emotion, motivation, and pleasure.

E

Environmental strategies: Prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies.

Epidemiology: The study of factors that influence health and illness in populations. Epidemiologists study the distribution and determinants of the health and wellness of populations.

Ethics: The rules and standards governing professional conduct. Core ethical principles in prevention include: nondiscrimination, competence, integrity, nature of services, confidentiality, and ethical obligations to community and society.

Evaluation: Evaluation is the systematic collection and analysis of information about an intervention to improve its effectiveness and make decisions. A process that helps prevention practitioners to discover the strengths and weaknesses of their activities

Evidence-based prevention interventions: An Evidence-based Intervention is a prevention service (program, policy, or practice) that has been proven to positively change the problem being targeted. In general, there needs to be evidence that the intervention has been effective at achieving outcomes through some form of evaluation.

F

Fidelity: When replicating a program model or strategy, fidelity is to implement the model or strategy with the same specifications as the original program. Fidelity can be balanced with adaptation to meet local needs.

Focus group: Structured interview with small groups of like individuals using standardized questions, follow up questions, and exploration of other topics that arise to better understand participants.

G

Goal statement: A description of the specific ends you wish to achieve through the implementation of a model, plan, or program.

H

Hallucinogens: A diverse group of drugs that alter perceptions, thoughts, and feelings. Hallucinogenic drugs include LSD, mescaline, PCP, and psilocybin (magic mushrooms).

Health disparities: A "health disparity" is a difference in health that is closely linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Hippocampus: An area of the brain crucial for learning and memory.

I

Implementation: Implementation involves mobilizing support for your efforts, selecting and carrying out evidence-based programs, policies, and practices, and monitor implementation to make mid-course corrections as necessary.

Indicated intervention: Indicated prevention interventions focus on higher risk individual identified as having signs and/or symptoms or behavior foreshadowing a mental, emotional, and/or substance use disorder.

Informed consent: The process of obtaining consent from participants that includes a full description and explanation of the activity presented in a way participants can understand and ensures that participants provide their consent willingly free from coercion or undue influence. *Active consent* requires a signature from all participants in a research project and/or their legal representatives. *Passive consent* requires a signature from only those individuals who do not agree to participate in the research activity and/or their legal representative.

> **Active consent**: Active consent requires a signature from all participants in a research project and/or their legal representatives.
>
> **Passive consent**: Passive consent requires a signature only from those individuals who do not agree to participate in the research activity and/or their legal representative.

Inhalant: Any drug administered by breathing in its vapors. Inhalants are commonly organic solvents, such as glue and paint thinner, or anesthetic gases, such as nitrous oxide.

J

K

Key informant: A person who has a specialized knowledge about a topic that you wish to understand and can convey that knowledge to you.

L

Limbic system: Area of the brain that is involved with feelings, emotions, and motivations. It is also important for learning and memory.

Lobbying: A type of advocacy that attempts to influence specific legislation.

Logic Model: The program logic model is defined as a picture of how your organization does its work – the theory and assumptions underlying the program. A program logic model links outcomes (both short- and long-term) with program activities/processes and the theoretical assumptions/principles of the program

M

Media Advocacy: The strategic use of media to advance a social and/or public policy initiative.

Media Literacy: The ability to access, analyze and produce information for specific outcomes and the ability to "read" and produce media messages.

Mental disorder: Mental disorders involve changes in thinking, mood, and/or behavior. These disorders can affect how a person relates to others and make choices.

N

Neuron (nerve cell): A unique type of cell found in the brain and throughout the body that specializes in the transmission and processing of information.

Neurotransmitter: A chemical produced by neurons to carry messages to adjacent neurons.

Norms: Pattern of behavior in a particular group, community or culture, accepted as normal and to which an individual is expected to conform.

O

Objective statement: Statements that describe the specific, measurable products and deliverables that the project will deliver.

Opioids (or opiates): Controlled substances most often prescribed for the management of pain. They are natural or synthetic chemicals similar to morphine that work by mimicking the actions of enkephalin and endorphin (endogenous opioids or pain-relieving chemicals produced in the body).

Outcome evaluation: Evaluation that describes the extent of the immediate effects of project components, including what changes occurred. Outcome evaluation documents whether the intervention made a difference, and if so, what changed.

P

Phases of the IOM continuum

> **Promotion:** Promotion involves interventions (e.g., programs, practices, or environmental strategies) that enable people "to increase control over, and to improve, their health." The focus of promotion is on well-being.
>
> **Prevention:** Prevention focuses on interventions that occur prior to the onset of a disorder and which are intended to prevent the occurrence of the disorder or reduce risk for the disorder. Prevention is also about striving to optimize well-being.
>
> **Treatment**: Interventions targeted to individuals who are identified as currently suffering from a diagnosable disorder that are intended to cure the disorder or reduce the symptoms of the disorder, including the prevention of disability, relapse, and/or comorbidity**.** Treatment interventions for substance use disorders include case identification and standard forms of treatment (e.g., detoxification, outpatient treatment, in-patient treatment, medication-assisted treatment).
>
> **Maintenance:** Maintenance includes interventions that focus on compliance with long-term treatment to reduce relapse and recurrence and aftercare, including rehabilitation and recovery support.

Planning: Planning involves establishing criteria for prioritizing risk and protective factors, selecting prevention interventions, and developing a comprehensive, logical, and data-driven prevention plan.

Pre-frontal cortex: Located in the frontal lobe of the brain, this area is important for decision making, planning, and judgment.

Prevention: Interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder.

Process evaluation: Evaluation that describes and documents what was done, how much, when, for whom and by whom during the course of the project. Process evaluation documents all aspects of the implementation of an intervention. It describes how the intervention was implemented.

Protective Factor: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a lower likelihood of problem outcomes.

Public health: What we, as a society, do collectively to assure the conditions for people to be healthy. The focus of public health is on the safety and well-being of entire populations by preventing disease rather than treating it.

Q

Qualitative data: Primarily exploratory research to gain an understanding of underlying reasons, opinions, and motivations. Some common methods include focus groups (group discussions), individual interviews, and participation/observations.

Quantitative data: Research that generates numerical data or data that can be transformed into useable statistics Quantitative data collection methods include various forms of surveys, longitudinal studies, polls, and systematic observation.

R

Resilience: The ability to recover from or adapt to adverse events, life changes and life stressors.

Resources: The various types and levels of assets that a community has at its disposal to address identified substance abuse problems, including fiscal, human and organizational resources.

Risk factor: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

S

Selective intervention: A selective prevention intervention focus on individuals or sub-groups whose risk of developing mental health disorders and/or substance use disorders are significantly higher due to biological, psychological, and/or social risk factors.

Social Marketing: Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviors of target audiences in order to improve their personal welfare and that of their society.

Stakeholders: Stakeholders are the people and organizations in the community who have: a stake in prevention because they care about promoting health and well-being and have something to gain or lose by prevention or promotion efforts.

Stimulants: A class of drugs that elevates mood, increases feelings of well-being, and increases energy and alertness. Stimulants include cocaine, methamphetamine, and prescription drugs used to treat ADHD.

Strategic Prevention Framework: The Strategic Prevention Framework—or SPF—is a 5-step planning process used by SAMHSA to understand community needs and strengths, and to guide the selection, implementation, and evaluation of effective, developmentally and culturally appropriate, and sustainable prevention activities. The five steps are: Assessment, Capacity, Planning, Implementation, and Evaluation. Sustainability and Cultural Competence are included in all steps of the SPF.

Substance use disorder: Substance Use Disorder refers to the overuse of, or dependence on, a drug (legal or illegal) leading to effects that are detrimental to the person's physical and mental health, and cause problems with the person's relationships, employment and the law.

Sustainability: The likelihood of a program, coalition, or activity to continue over a period of time, especially after grant monies disappear. Sustainability is not about maintaining strategies but about achieving and sustaining positive outcomes.

T

Technical Assistance: Services provided by professional prevention staff intended to provide technical guidance to prevention programs, community organizations and individuals to conduct, strengthen or enhance activities that will promote prevention.

U

Universal intervention: Universal prevention interventions take the broadest approach and focus on the general public or a wide population that was not identified based on risk.

V

W

Wellness: A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.

X

Y

Z

COMMONLY ABUSED DRUGS

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NIDA NATIONAL INSTITUTE ON DRUG ABUSE

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Intoxication Effects*/Potential Health Consequences
Cannabinoids			*euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination*/cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety, panic attacks; tolerance, addiction
hashish	boom, chronic, gangster, hash, hash oil, hemp	I/swallowed, smoked	
marijuana	blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I/swallowed, smoked	
Depressants			*reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration*/fatigue; confusion; impaired coordination, memory, judgment; addiction; respiratory depression and arrest; death
barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital:* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V/injected, swallowed	*Also, for barbiturates—sedation, drowsiness*/depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal
benzodiazepines (other than flunitrazepam)	*Ativan, Halcion, Librium, Valium, Xanax:* candy, downers, sleeping pills, tranks	IV/swallowed, injected	*for benzodiazepines—sedation, drowsiness*/dizziness
flunitrazepam***	*Rohypnol:* forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	*for flunitrazepam*—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects
GHB***	*gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy	I/swallowed	*for GHB—drowsiness, nausea*/vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death
methaqualone	*Quaalude, Sopor, Parest:* ludes, mandrex, quad, quay	I/injected, swallowed	*for methaqualone—euphoria*/depression, poor reflexes, slurred speech, coma
Dissociative Anesthetics			*increased heart rate and blood pressure, impaired motor function*/memory loss; numbness; nausea/vomiting
ketamine	*Ketalar SV:* cat Valiums, K, Special K, vitamin K	III/injected, snorted, smoked	*Also, for ketamine—at high doses, delirium, depression, respiratory depression and arrest*
PCP and analogs	*phencyclidine:* angel dust, boat, hog, love boat, peace pill	I, II/injected, swallowed, smoked	*for PCP and analogs—possible decrease in blood pressure and heart rate, panic, aggression, violence*/loss of appetite, depression
Hallucinogens			*altered states of perception and feeling; nausea;* persisting perception disorder (flashbacks)
LSD	*lysergic acid diethylamide:* acid, blotter, boomers, cubes, microdot, yellow sunshines	I/swallowed, absorbed through mouth tissues	*Also, for LSD and mescaline—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors*
mescaline	buttons, cactus, mesc, peyote	I/swallowed, smoked	*for LSD—persistent mental disorders*
psilocybin	magic mushroom, purple passion, shrooms	I/swallowed	*for psilocybin—nervousness, paranoia*
Opioids and Morphine Derivatives			*pain relief, euphoria, drowsiness*/nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death
codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine:* Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV, V/injected, swallowed	*Also, for codeine—less analgesia, sedation, and respiratory depression than morphine*
fentanyl and fentanyl analogs	*Actiq, Duragesic, Sublimaze:* Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	I, II/injected, smoked, snorted	*for heroin—staggering gait*
heroin	*diacetylmorphine:* brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I/injected, smoked, snorted	
morphine	*Roxanol, Duramorph:* M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
opium	*laudanum, paregoric:* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	
oxycodone HCL	*OxyContin:* Oxy, O.C., killer	II/swallowed, snorted, injected	
hydrocodone bitartrate, acetaminophen	*Vicodin:* vike, Watson-387	II/swallowed	
Stimulants			*increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness*/rapid or irregular heart beat; reduced appetite, weight loss, heart failure, nervousness, insomnia
amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	*Also, for amphetamine—rapid breathing*/tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction, psychosis
cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/injected, smoked, snorted	*for cocaine—increased temperature*/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks

**Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Some Schedule V drugs are available over the counter.*

***Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.*

****Associated with sexual assaults.*

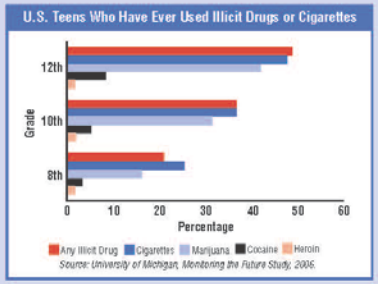
2/07

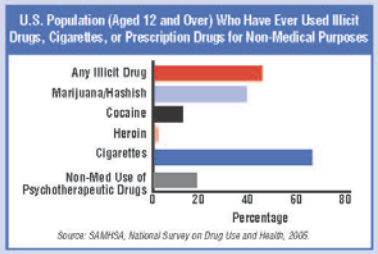
Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Intoxication Effects*/Potential Health Consequences
Stimulants (continued)			
MDMA (methyl-enedioxymeth-amphetamine)	Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I/swallowed	*for MDMA—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings*/impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity
methamphetamine	*Desoxyn:* chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II/injected, swallowed, smoked, snorted	*for methamphetamine—aggression, violence, psychotic behavior*/memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction
methylphenidate (safe and effective for treatment of ADHD)	*Ritalin:* JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	*for nicotine*—additional effects attributable to tobacco exposure: adverse pregnancy outcomes; chronic lung disease, cardiovascular disease, stroke, cancer; tolerance, addiction
nicotine	cigarettes, cigars, smokeless tobacco, snuff, spit tobacco, bidis, chew	not scheduled/smoked, snorted, taken in snuff and spit tobacco	
Other Compounds			
anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise:* roids, juice	III/injected, swallowed, applied to skin	*no intoxication effects*/hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
Dextromethorphan (DXM)	Found in some cough and cold medications; Robotripping, Robo, Triple C	not scheduled/swallowed	*Dissociative effects, distorted visual perceptions to complete dissociative effects*/for effects at higher doses see 'dissociative anesthetics'
inhalants	*Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl):* laughing gas, poppers, snappers, whippets	not scheduled/inhaled through nose or mouth	*stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing*/unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

Principles of Drug Addiction Treatment

More than three decades of scientific research have yielded 13 fundamental principles that characterize effective drug abuse treatment. These principles are detailed in NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide.*

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each patient's problems and needs is critical.
2. **Treatment needs to be readily available.** Treatment applicants can be lost if treatment is not immediately available or readily accessible.
3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
4. **At different times during treatment, a patient may develop a need for medical services, family therapy, vocational rehabilitation, and social and legal services.**
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Buprenorphine, methadone, and levo-alpha-acetylmethodol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol dependence. Nicotine patches or gum, or an oral medication, such as buproprion, can help persons addicted to nicotine.
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.
10. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
11. **Possible drug use during treatment must be monitored continuously.** Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection.** Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.





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EXAMINATION REFERENCE LIST

The following resources were compiled as suggested reading to assist candidates preparing for the IC&RC Prevention Specialist Examination. Consulting these and other references may be beneficial to candidates. Please note that this is not a comprehensive listing of all references and that not all questions on the examination came from these references.

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Source: IC&RC Candidate Guide