

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH
ALCOHOL AND DRUG PROGRAM ADMINISTRATION

STRATEGIC PREVENTION PLAN
ALCOHOL AND DRUG PREVENTION SERVICES
2005-2009

The Los Angeles County
Alcohol and Drug Program Administration (ADPA)

Prevention Vision

Healthy communities free of alcohol and other drug problems.

Mission

The mission of the Alcohol and Drug Program Administration (ADPA), a division of Public Health Programs of the County of Los Angeles Department of Public Health, is to reduce community and individual problems related to alcohol and drug abuse countywide.

Table of Contents

Title Page..... 2

Table of Contents..... 3

Acknowledgements..... 4

Section 1: Background and Purpose..... 6

Section 2: A Comprehensive Approach to Planning..... 9

Section 3: The Strategic Plan: Priorities and Action Plans..... 12

Section 4: Evaluation Plan.....29

Appendices

Appendix A: Risk and Protective Factors.....32

Appendix B: Review of Research Findings on Effective
Alcohol and Other Drug Prevention Approaches.....34

Appendix C: Contracted Alcohol & Drug Prevention Services by
Service Planning Area.....36

Appendix D: Institute of Medicine Classification and Key Features.....38

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Section 1 Background and Purpose

The County of Los Angeles Department of Public Health, Alcohol and Drug Program Administration (ADPA) operates a countywide system of alcohol and other drug (AOD) prevention services through contracts with community-based prevention programs to prevent and address AOD-associated risk factors and increase protective factors within targeted communities. ADPA is responsible for developing a comprehensive plan that is responsive to the needs of the county and that provides guidance in supporting the prevention and treatment service provider system.

This Strategic Prevention Plan is consistent with the federal Substance Abuse Mental Health Service Administration (SAMHSA) Strategic Prevention Framework (SPF). Specifically, ADPA conducted a review of quantitative and qualitative AOD use and problem indicators and trends. This review supported assessment of needs and guided identification of priority AOD issues on which ADPA should focus over the next three provider contractual years.

This document presents the results of the ADPA strategic planning process for Los Angeles County.

County Profile

Los Angeles County is by any standard, unlike any other county in America. It is the most ethnically diverse county, with whites making up less than one third (32%) of the county's overall population. Fully 45% of Los Angeles County's residents are Hispanic/Latino, 12% are Asian/Pacific Islander, 10% are African American, and 1% is Native American. It is also home to the largest populations of Native Americans (156,000), Asians (1.3 million) and Hispanics/Latinos (4.5 million) of any county in the country. By far the most populous county, Los Angeles County's 2000 Census population of 9,519,339 is larger than that of 42 U.S. states and contains both the largest number of children under age 18 (2.7 million) and the largest number of people aged 65 and older (995,000) of any county.

In addition to its rich racial, ethnic and age diversity, Los Angeles County is characterized by a broad-range of community types and socio-economic circumstance. Geographically, Los Angeles County is the second largest county in the United States encompassing over 4,000 square miles. Its communities encompass urban, suburban, rural and wilderness areas, and they encompass great disparities in income and health status, with neighborhoods of great wealth often located directly adjacent to areas of extreme poverty.

A recent analysis determined that the combined economic cost of AOD problems to the County was an estimated \$14.1 billion in 2003. The growing epidemic of underage drinking and young adult binge drinking combined with both persistent pre-existing and newly emerging patterns of drug abuse have contributed to an enormous social and economic burden for County agencies and residents.

Although AOD problems impact all of Los Angeles County public services, the primary responsibility for developing and implementing strategies, approaches and programs to reduce AOD problems resides in the Department of Public Health – Alcohol and Drug Program Administration (ADPA).

Currently, ADPA funds over 500 contracts with more than 200 organizations that collectively provide prevention, treatment and recovery services for individuals in different life stages-from peri-natal to seniors. Specific to prevention, ADPA funds 30 AOD prevention programs and 59 Community Prevention Recovery Programs situated throughout Los Angeles County. In addition, ADPA also manages subcontracts for two (2) Safe and Drug Free Schools and Communities (SDFSC) grants funded through the California Department of Alcohol and Drug Programs (ADP).

In order to maximize effectiveness of prevention services and to leverage relatively limited resources, the ADPA has developed a three year Strategic Prevention Plan.

The planning process was guided by the following functional principles:

- The plan incorporates current principles of effective prevention programming, and will promote the use of evidence-based practice throughout Los Angeles County.
- The plan will be evidence-based, aligning prevention services with problem areas identified through the Strategic Prevention Framework (SPF) analysis.
- The plan will be community oriented, It will build capacity in the community to support and leverage effective prevention, and will facilitate, support and encourage collaborative use of Los Angeles County's diverse community resources to strengthen prevention.
- The plan will be comprehensive, coordinating diverse environmental and direct services strategies to meet the identified needs of the community.

The Plan addresses each of these principles. This document represents an initial platform that will be amended each prevention contract term to reflect new data, information on effective prevention programming and evaluative results within the prevention service provider community.

In summary, the purpose of this document is ...

- to present a rational, practical and data-based plan for using the limited resources of the ADPA allocated for AOD prevention effectively and efficiently;
- to maximize the relevance of services to diverse community needs, and to use Los Angeles County's rich diversity to better meet those needs;
- to identify clear goals, objectives, and activities for ADPA's prevention system that apply new federal and State requirements for prevention services to Los Angeles County; and
- to align prevention funded programs to meet federal and State requirements.

Section 2 A Comprehensive Approach to Planning

One of the emerging lessons in the prevention field is that effective services must be comprehensive, coordinated and data-based. Research and experience over the last two decades have made it clear that AOD related problems take diverse forms; progress differently across population groups of different age, gender, culture and risk; and have diverse causes and harm implications. It follows that a variety of coordinated intervention strategies and activities are necessary to meet the full set of community needs. In short, the development of a comprehensive Strategic Plan must be based in a strong understanding of the social, theoretical and regulatory issues appropriate to the communities being served.

Because AOD problems permeate the entire community environment, solutions to abate these issues must be addressed within the broader social context. Health, education, family and other social services, law enforcement and community groups must be involved in determining and implementing potential solutions. Broad-based, multi-tiered responses and approaches need to be considered in the development and refinement of the Plan. As the next section demonstrates, ADPA has taken this need for a comprehensive perspective into consideration in the development of its objectives for the plan.

Goals and objectives are clearly founded in community needs and contributions rather than reflecting a narrow, pre-determined perspective on problems and solutions. This responsive approach is the core of data-based decision systems. Objectives are clearly related to evidence-based understanding of how to make progress toward the relevant goals, and the objectives clearly recognize the importance of documenting and providing feedback on the results of community actions to reduce underage drinking and other drug use.

Recommended strategies include a mix of environmental and individual interventions consistent with research findings concerning their effectiveness in reducing specific AOD problems within specified at-risk populations. Various segments of the alcohol industry would prefer that the prevention of alcohol problems focus on individual behaviors, not on the environment where production, sales, marketing and large-scale consumption take place. But scientists cannot ignore the environment in which a problem occurs just because it might be controversial. Nor can lawmakers, law enforcement and advocates ignore promising, research-based solutions that could help solve pernicious problems in their communities.¹

To support this comprehensive perspective, ADPA staff has cast a broad net for identifying the best possible interventions to meet County needs. They have examined the prevention literature for effective programs and strategies to guide future decisions in the planning process. (See appendix B).

¹ <http://www.jointogether.org/news/yourturn/commentary.../fight-teen-drinking-from-the.htm>

Furthermore, the agency has adopted the Guiding Principles for Prevention as developed by the California State Department of Alcohol and Drug Programs (SDADP) to frame future decisions (see Exhibit 1).

The plan is consistent with guidelines and reporting requirements for the federal Substance Abuse Prevention and Treatment (SAPT) block grant funds, and for requirements to report prevention activities to the SDADP. Pursuant to federal guidelines, ADPA will be required to provide data that complies with the California Outcomes Measurement Services for Prevention (CalOMS PV) developed by the SDADP for monitoring outcome status.

The CalOMS PV requires prevention funded programs to report prevention services/activities using the Institute of Medicine (IOM) classification and the Six Center for Substance Abuse Prevention (CSAP) strategy areas. The CSAP categorizes primary prevention activities into the following six strategies:

1. Information Dissemination;
2. Education;
3. Alternative Activities
4. Problem Identification and Referral Services;
5. Community Based Process; and
6. Environmental

Federal reporting requirements mandates the use of the IOM classification for describing prevention strategies and interventions. The IOM framework (1) directs prevention at individuals, (2) specifies (or targets) specific types of individuals and risk characteristics for prevention services and (3) defines the types of activities to be provided. Specifically, for prevention, IOM defines three categories of services for the following populations:

- *Universal* prevention activities target the general public or a whole target group that is not identified by individual risk factors.
- *Selective* prevention activities target a specific component of the population whose risk of developing a substance abuse problem are higher than that of the general population and can be specified by particular risk indicators.
- *Indicated* preventive activities target specific individuals who are identified as having minimal but detected signs of symptoms of substance abuse, but do not meet diagnostic levels for treatment at this time (Reducing Risk for Mental Disorders, Institute of Medicine, 1994)²

² See Appendix D for the Institute of Medicine Classification and Key Features for this section.

The comprehensive planning approach used by Los Angeles County ADPA is necessary to effectively target the differential community needs that are recognized in federal and state guidelines and requirements. In order to accommodate this diversity, ADPA must develop a Strategic Plan that:

1. Uses data to distinguish between the needs of various sub-populations in Los Angeles County;
2. Uses this data to guide the choice of activities based on the IOM continuum and other relevant differences in population needs;
3. Recommends strategies that are culturally competent, evidence-based, comprehensive and delivered in multiple setting across diverse population sub-groups;
4. Incorporates technical assistance and training to ensure providers be given the most current information on evidence-based programs and strategies; and
5. Implements standards of reporting and documentation to meet increasingly stringent federal and state reporting requirements.

Exhibit 1

Guiding Principles for Prevention

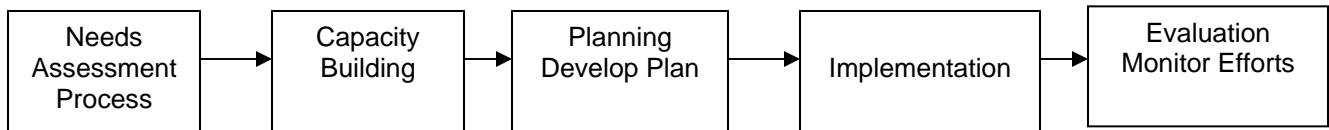
Prevention policies and services adhere to the following basic principles³:

1. Prevention fosters safe and healthy environments for individuals, families and communities.
2. To create safe and healthy environments, prevention must reduce adverse personal, social, health and economic consequences by addressing problematic alcohol, and other drug (AOD) availability manufacture, distribution, promotion, sales and use.
3. By prevention providers leveraging resources, prevention programs will achieve the greatest impact.
4. The entire community shares responsibility for prevention.
5. All sectors, including youth, must challenge their AOD standards, norms, and values to continually improve the quality of life within the community.
6. "Community" includes a) organizations; b) institutions; c) ethnic and racial communities; d) tribal communities and governments; and e) faith communities.
7. Community also includes associations/affinity groups based on age. Social status and occupation, professional affiliations determined by geographic boundaries.
8. Prevention engages individuals, organizations, and groups at all levels of the prevention system.
9. This includes those who work directly, as well as indirectly, in the prevention system who share a common goal of AOD prevention (i.e., medical professionals, hospitals, teachers, employers, religious organizations, etc.).
10. Prevention utilized the full range of cultural and ethnic wealth within communities.
11. By employing ethnic and cultural experience and leadership within a community, prevention can reduce problematic availability, manufacturing, distribution, promotion, sales and use of AOD.
12. Effective prevention programs are thoughtfully planned and delivered.
13. To create successful prevention programs, one must use data to assess the needs; prioritize and commit to the purpose; establish actions and measurements; use problem prevention actions; evaluate measured results to improve prevention outcomes; and use a competent proficient and properly trained workforce.

³ California Department of Alcohol and Drug Programs, Prevention Strategic Plan, October 2002.

Section 3 The Strategic Plan: Priorities and Action Plans

In identifying goals and objectives for the strategic plan, ADPA engaged in a strategic planning process consistent with SAMHSA's current Strategic Prevention Framework five-step planning processes. Specifically, staff followed the five steps outlined in the following exhibit:



1. *Step One* involves the collection and analysis of relevant AOD data. Specific to this task, ADPA reviewed AOD data collected and organized by organizations and agencies relevant to AOD use and the social issues related to this use (e.g. law enforcement, substance use treatment, health and education). Data sources included service records, social indicators, and surveys of different populations (e.g., the California Healthy Kids Survey that is administered in schools). Examples of these data sets are included in Exhibit 2.
2. In *Step Two*, ADPA workgroups reviewed these data to identify problem indicators generally and for specific populations that indicated high need, or trends that indicated increasing need for prevention services. This step includes a plan for facilitating involvement and collaboration with community-based organizations and groups that represent a significant prevention resource. ADPA assessed the identification and allocation of new resources or the alignment of current services to more closely match the needs of the priority areas.
3. In *Step Three* ADPA developed action plans for identifying and implementing specific strategies and interventions to meet plan objectives. On the basis of this review, ADPA identified three priority areas of need on which the plan is focused.
4. *Step Four* involves taking actions guided by the strategic plan to implement strategies for aligning programs to meet federal and State funding requirements and for addressing ADPA's focus areas.
5. *Step Five* continues the data-based planning process by producing a "living" plan that will be up-dated based on evaluative feedback and renewed needs reviews annually. The process leads to the creation of a Final Plan for the first year, with subsequent annual updates. Plans to evaluate the result of implementation are built into the process and are discussed separately.

Identification and Prioritization of Focus Areas (Steps 1 and 2):

The result of Step 1 and Step 2 were the identification of high priority focus areas based on the analysis of the data. Specifically the team identified three focus areas; two involved underage drinking and the third targeted drug use. The three focus areas are:

1. Reduce risk factors associated with underage drinking.
2. Reduce excessive alcohol consumption (binge drinking) by young adults, ages 18 to 25 by lowering associated risk factors and strengthening associated protective factors.
3. Reduce marijuana, methamphetamine and other drug use, especially among adolescents and transition age youth between the ages of 12 and 25 by reducing associated risk factors and strengthening associated protective factors.

The rationale for the choice of these focus areas follows after, which the specific Goals and Action Plans (Step 3) are presented.

Focus Area 1: Reduce risk factors associated with underage drinking.^{4, 5}

Focus Area 2: Reduce excessive alcohol consumption by young adults (18-25).

Focus Areas 1 and 2 are presented together as both involve underage drinking, and for Focus Area 2, binge drinking.

The expanding epidemic of underage and binge drinking and related problems has become a crisis that is increasingly impacting both Los Angeles County and the United States as a whole (Youth Risk Behavior Surveillance: United States 2002. *MMWR: Morbidity and Mortality Report*). Underage alcohol use is more likely to kill young people than all illegal drugs combined (Substance Use, Abuse and Dependence in Adolescence: *Prevalence, symptom profiles and correlates 2002*).

The data, highlighted in a new report, "Alcohol Use and Delinquent Behaviors among Youths", extracted from the National Survey on Drug Use and Health, 2003, show that youth who reported heavy alcohol use in the past month were the most likely to have participated in delinquent behavior. More recently, a report prepared for the California Governor's Prevention Advisory Council. Exhibit 2 presents alcohol data from the California Healthy Kids Survey (CHKS) involving Los Angeles 7th, 9th and 11th grades from 1997-2002.

⁴ Wechsler, J., Kuo, M., Lee, H., & Dowdal, G. (2001). Environmental correlates of underage alcohol use and related problems of college students College Alcohol Study. Harvard School of Public Health.

⁵ National Highway Traffic Safety Administration, Traffic Safety Facts 2002, Early ed. (Washington, DC: National Center for Statistics and Analysis, US Department of Transportation (2003), 114.

**Exhibit 2
Los Angeles Student Use of Alcohol and Binge Consumptions
1997-2002 (CKHS Data)**

| Respondents Reporting Past 30 Day Use of... | School Year | | | | |
|--|-------------|---------|---------|---------|---------|
| | 1997-98 | 1998-99 | 1999-00 | 2000-01 | 2001-02 |
| Any Alcohol (%) | | | | | |
| 7 th Grade | 31.8 | 24.5 | 15.6 | 17.8 | 12.6 |
| 9 th Grade | 40.8 | 39.5 | 30.3 | 30.7 | 25.7 |
| 11 th Grade | 48.4 | 46.6 | 39.7 | 41.1 | 37.9 |
| All Respondents ⁶ | 49.8 | 35.1 | 29.2 | 28.4 | 25.4 |
| 5+ Alcoholic Drinks/Occasion (a.k.a. Binge Drinking (%)) | | | | | |
| 7 th Grade | 10.3 | 8.2 | 5.0 | 5.7 | 4.1 |
| 9 th Grade | 20.7 | 18.8 | 13.3 | 14.2 | 11.2 |
| 11 th Grade | 27.8 | 26.6 | 21.8 | 22.9 | 20.8 |
| All Respondents | 19.3 | 16.7 | 14.4 | 13.4 | 12.4 |

SOURCE: California Healthy Kids Survey.

Approximately one fifth of 11th graders reported binge drinking the prior month; nearly 40% of the 11th graders reported consuming alcohol in the 30 days prior to the survey. Overall, one quarter of all survey respondents, which included 7th grade, reported drinking in the prior 30-day period.

Focus Area 3: Reduce Substance Abuse (marijuana and methamphetamines) Problems Among Young Adults (ages 12-25)

ADPA selected the age group of 12-25. It's consistent with that of the Department of Public Health, High Risk Youth Reduction Work Group. Marijuana, the most widely used illicit drug in Los Angeles County, was the primary drug for which youth (under the age of 18) entered treatment in 2002. Exhibit 3 presents a summary of total admissions for treatment in Los Angeles County over a six-year period.

⁶ All respondents include: responding 7th graders (when applicable), 9th graders, 11th graders, and a small sample of non-traditional students (enrolled in continuation or alternative schooling programs). Therefore, the percentage of "all respondents" may not be equivalent to the average across grade levels.

Exhibit 3

**Participants Under 21 Years of Age By Age Category
And Key Demographics**

| Characteristics | Under 18 Years | | 18 – 20 Years | | Total | |
|---|----------------|---------|---------------|---------|--------|---------|
| | Number | Percent | Number | Percent | Number | Percent |
| Admissions | 7,434 | 100.0 | 3,999 | 100.0 | 11,433 | 100.0 |
| Participants | 6,736 | 100.0 | 3,468 | 100.0 | 10,204 | 100.0 |
| <u>Gender</u> | | | | | | |
| Male | 4,407 | 65.4 | 2,421 | 69.8 | 6,828 | 66.9 |
| Female | 2,329 | 34.6 | 1,047 | 30.2 | 3,376 | 33.1 |
| <u>Race/Ethnicity</u> | | | | | | |
| White | 787 | 11.7 | 802 | 23.1 | 1,589 | 15.6 |
| Black/African American | 1,125 | 16.7 | 534 | 15.4 | 1,659 | 16.3 |
| Latino | 4,388 | 65.1 | 1,868 | 53.9 | 6,256 | 61.3 |
| Native American | 25 | 0.4 | 20 | 0.6 | 45 | 0.4 |
| Asian/Pacific Islander | 163 | 2.4 | 116 | 3.3 | 279 | 2.7 |
| Other | 248 | 3.7 | 128 | 3.7 | 376 | 3.7 |
| <u>Education</u> | | | | | | |
| None | 18 | 0.3 | 12 | 0.3 | 30 | 0.3 |
| 1 – 8 years | 1,750 | 26.0 | 130 | 3.7 | 1,880 | 18.4 |
| 9 – 12 years | 4,960 | 73.6 | 3,252 | 93.8 | 8,212 | 80.5 |
| 13 or more years | 8 | 0.1 | 74 | 2.1 | 82 | 0.8 |
| <u>Employment Status</u> | | | | | | |
| Employed | 345 | 5.1 | 552 | 15.9 | 897 | 8.8 |
| Unemployed | 6,391 | 94.9 | 2,916 | 84.1 | 9,307 | 91.2 |
| <u>Homeless</u> | | | | | | |
| Yes | 30 | 0.4 | 288 | 8.3 | 318 | 3.1 |
| No | 6,706 | 99.6 | 3,180 | 91.7 | 9,886 | 96.9 |
| <u>Primary Drug Problem</u> | | | | | | |
| Alcohol | 1,699 | 25.2 | 665 | 19.2 | 2,364 | 23.2 |
| Cocaine/Crack | 146 | 2.2 | 232 | 6.7 | 378 | 3.7 |
| Heroin | 14 | 0.2 | 109 | 3.1 | 123 | 1.2 |
| Marijuana/Hashish | 3,947 | 58.6 | 1,411 | 40.7 | 5,358 | 52.5 |
| Methamphetamine | 757 | 11.2 | 918 | 26.5 | 1,675 | 16.4 |
| Other | 173 | 2.6 | 133 | 3.8 | 306 | 3.0 |
| <u>Admissions by Type of Service</u> | | | | | | |
| Non-Residential Day Program Intensive | 1,071 | 14.4 | 368 | 9.2 | 1,439 | 12.6 |
| Non-Residential Detoxification | 1 | 0.0 | 25 | 0.6 | 26 | 0.2 |
| Non-Residential Treatment/Recovery | 5,588 | 75.2 | 2,746 | 68.7 | 8,334 | 72.9 |
| Residential Detoxification – Non-Hospital | 7 | 0.1 | 107 | 2.7 | 114 | 1.0 |
| Residential Treatment/Recovery >30 days | 750 | 10.1 | 710 | 17.8 | 1,460 | 12.8 |
| Residential Treatment/Recovery <31 days | 17 | 0.2 | 43 | 1.1 | 60 | 0.5 |

Source: ADPA Contracted Treatment/Recovery Programs – Los Angeles County Participant, 2003-04 Fiscal Year

Youth Under 21 Years of Age

- During the 2003-04 Fiscal Year, a total of 10,204 participants under 21 years of age were admitted to AOD treatment/recovery programs. There were 6,736 under 18 years of age (younger youth) and 3,468 were between 18 and 20 years of age (older youth).
- Youth participants were more likely to be male (66.9%), Latino (61.3%), and completed between 9 to 12 years of education (80.5%).
- Three out of 100 (3.1%) reported they were homeless.
- The majority (52.5%) of youth reported marijuana/hashish as their primary drug problem.
- Older youth (26.5%) were more likely than younger youth (11.2%) to report methamphetamine as their primary drug problem.
- The majority (85.7%) of the admissions for youth participants were to programs that provided non-residential services.
- Older youth (21.6%) were twice as likely to be admitted to residential programs as younger youth (10.4%).

Data from the California Healthy Kids Survey (CHKS) indicate that the largest percentage of survey respondents reporting past 30-day use of AOD reported using marijuana (12%), followed by inhalants (5%), methamphetamine (4.1%), cocaine (3.9%) and LSD other psychedelics (3.3%). (These are reports for all respondents.)

As Exhibit 4 indicates reported use increased significantly in the higher grades. For instance while 4.4% of 7th graders reported using marijuana, slightly more than 18% of the 11th graders reported use of this substance in the prior 30 days.

**Exhibit 4
Los Angeles Student Use of Drugs
1997-2002 (CHKS Data)**

| Respondents Reporting Past 30 Day Use of... | School Year | | | | |
|---|------------------|---------|---------|---------|---------|
| | 1997-89 | 1998-99 | 1999-00 | 2000-01 | 2001-02 |
| Cocaine (any form) (%) | | | | | |
| 7 th Grade | N/A ⁶ | N/A | N/A | N/A | N/A |
| 9 th Grade | 3.9 | 3.7 | 3.1 | 3.1 | 3.0 |
| 11 th Grade | 4.0 | 4.1 | 4.0 | 3.8 | 3.3 |
| All Respondents ⁵ | 3.6 | 4.7 | 4.9 | 4.3 | 3.9 |
| Inhalants (%) | | | | | |
| 7 th Grade | 7.3 | 10.8 | 4.6 | 4.8 | 4.5 |
| 9 th Grade | 7.4 | 8.3 | 5.6 | 4.9 | 4.8 |
| 11 th Grade | 4.9 | 5.1 | 4.8 | 4.2 | 4.1 |
| All Respondents | 7.1 | 9.2 | 5.7 | 5.1 | 5.0 |
| LSD/Other Psychedelics (%) | | | | | |
| 7 th Grade | | | | | |
| 9 th Grade | N/A | N/A | N/A | N/A | N/A |
| 11 th Grade | 3.5 | 4.5 | 3.2 | 3.2 | 2/5 |
| All Respondents | 3.6 | 4.9 | 4.7 | 4.6 | 3/1 |
| | 3.7 | 6.0 | 5.0 | 4.4 | 3/3 |
| Marijuana (%) | | | | | |
| 7 th Grade | 7.3 | 7.2 | 4.4 | 5.7 | 4.4 |
| 9 th Grade | 19.9 | 17.7 | 12.5 | 14.8 | 12.1 |
| 11 th Grade | 22.8 | 24.4 | 18.2 | 19.3 | 18.1 |
| All Respondents | 16.7 | 15.6 | 13.2 | 13.0 | 12.0 |
| Methamphetamine (%) | | | | | |
| 7 th Grade | N/A | N/A | N/A | N/A | N/A |
| 9 th Grade | 5.0 | 4.7 | 2.8 | 2.9 | 2.9 |
| 11 th Grade | 4.9 | 5.4 | 3.9 | 4.7 | 3.7 |
| All Respondents | 5.2 | 6.2 | 4.6 | 4.3 | 4.1 |

Source: California Healthy Kids Survey

⁵ All respondents include: responding 7th graders (when applicable), 9th graders, 11th graders, and a small sample of non-traditional students (enrolled in continuation or alternative schooling programs). Therefore, the percentage of “all respondents” may not be equivalent to the average across grade levels.

⁶ N/A = not applicable (the question was either not asked or the response rate is too low).

The following presents the Goals and Objectives to guide ADPA in aligning prevention funded programs with meeting SDADP funding requirements.

| |
|--|
| <p>Focus Area One: Reduce Risk Factors Associated with Underage Drinking</p> |
| <p>Goal 1: Reduce underage alcohol consumption by lowering associated risk factors and strengthening associated protective factors.</p> |
| <p>Objective 1.1: By September 1, 2006 Conduct training of key ADPA staff and prevention providers on the key principles, techniques, and skills needed to implement evidence-based prevention programming to reduce underage alcohol consumption in local communities.</p> <p>Task 1: Contract/or contact Technical Assistance/Training provider Task 2: Determine content areas Task 3: Schedule training event Task 4: Assess results of the training (90-120 days post event)</p> |
| <p>Objective 1.2: By October 1, 2006 Complete development of ADPA's internal administrative operations needed to implement evidence-based programming to reduce underage alcohol consumption in local communities, including program standards and practices, contract requirements, exhibits, provider work plan formats, performance monitoring instruments, and data reporting systems.</p> <p>Task 1: Develop program standards and practices Task 2: Revise prevention contract exhibit Task 3: Develop program provider work plan Task 4: Revise monitoring instrument Task 5: Develop data reporting system Task 6: Finalize documents</p> |
| <p>Objective 1.3: By November 1, 2006 Assess risk and protective factors associated with underage alcohol consumption in each community served by ADPA contracted prevention service providers.</p> <p>Task 1: Assess provider alcohol risk and protective factors. Task 2: Assess community risk and protective factors associated with underage alcohol consumption Task 3: Conduct analysis of risk and protective factors</p> |

| |
|--|
| <p>Objective 1.4: By April 1, 2006 Prepare a baseline report in the target communities of specific alcohol problems associated with underage drinking.</p> <p>Task 1: Identify current data source (e.g. focus group data, local program data, and needs assessment data from the Strategic Plan)</p> <p>Task 2: Collect available data and compile it into a data report</p> <p>Task 3: Disseminate the baseline data report to key stakeholders and via Presentation and County website.</p> |
| <p>Objective 1.5: By July 1, 2006 Complete implementation of administrative operations described in Objective 2 with at least 50% of contractors; by October 1, 2006, complete implementation of administrative operations with all contractors.</p> <p>Task 1: Revise and finalize prevention standards</p> <p>Task 2: Finalize work plans</p> <p>Task 3: Finalize prevention contract exhibit</p> <p>Task 4: Develop a tool to measure program implementation progress</p> |
| <p>Objective 1.6: By October 1, 2006 Complete implementation of programming developed to reduce underage drinking in local communities by at least 50% of contracted providers; by March 1, 2007 complete implementation by all contracted providers.</p> <p>Task 1: Provide on going technical assistance</p> <p>Task 2: Meet with programs to identify barriers</p> <p>Task 3: Provide training sessions on the implementation process</p> <p>Task 4: Develop tool for monitoring progress</p> |
| <p>Objective 1.7: By June 30, 2008 Reduce underage alcohol consumption in the targeted communities at a rate that exceeds county and state averages. (A related goal (goal 2) developed by ADPA staff, specifically focuses on excessive alcohol consumption (binge drinking) by young adults. It acknowledges the need to intervene, with different approaches and strategies given that a large number of these young people are of legal drinking age. Many of the objectives parallel the proposed work plan identified in Goal 1.)</p> <p>Task 1: Contract/or contact TA/Training provider</p> <p>Task 2: Determine content areas</p> <p>Task 3: Schedule training event</p> <p>Task 4: Assess results of the training (90-120 days post event)</p> |

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| <p>Focus Area Two: Reduce excessive alcohol consumption (binge drinking) by young adults, ages 18 to 25 by lowering associated risk factors and strengthening associated protective factors.</p> |
| <p>Goal 2: Reduce excessive alcohol consumption (binge drinking) by young adult's ages 18 to 25 by lowering associated risk factors and strengthening associated protective factors.</p> |
| <p>Objective 2.1: By September 1, 2006 Conduct a training of key ADPA staff and its contracted prevention providers on principles, techniques, and skills needed to implement evidence-based prevention programming to excessive alcohol consumption by young adults ages 18-25 in local communities.</p> <p>Task 1: Contract/or contact TA/Training provider Task 2: Determine content areas Task 3: Schedule training event Task 4: Assess results of the training (90-120 days post event)</p> |
| <p>Objective 2.2: By July 1, 2006 Complete development of ADPA's internal administrative operations needed to implement evidence-based programming to reduce excessive alcohol consumption by young adults in local communities, including program standards and practices, contract requirements, exhibits, provider work plan formats, performance monitoring instruments, and data reporting systems.</p> <p>Task 1: Develop program standards and practices Task 2: Revise prevention contract exhibit Task 3: Develop program provider work plan Task 4: Revise monitoring instrument Task 5: Develop data reporting system</p> |
| <p>Objective 2.3: By March 1, 2006 Complete an assessment of risk and protective factors associated with excessive alcohol consumption by young adults in each community served by ADPA contracted prevention service providers.</p> <p>Task 1: Develop tool to assess provider alcohol risk and protective factors Task 2: Assess risk and protective factors associated with underage alcohol consumption Task 3: Conduct analysis of risk and protective factors</p> |
| <p>Objective 2.4: By September 6, 2006 Complete implementation of administrative operations described in Objective 2.2 with at least 50% of contractors; by May 1, 2006, complete implementation of administrative operations with all contractors.</p> <p>Task 1: Revise and finalize prevention standards Task 2: Finalize work plans Task 3: Finalize prevention contract exhibit Task 3: Develop a tool to measure program implementation progress</p> |

Objective 2.5: By October 1, 2006

Monitor on going progress of provider efforts to address focus area 2.

Task 1: Provide on going technical assistance

Task 2: Meet with programs to identify barriers

Task 3: Provide training sessions on the implementation process

Task 4: Develop tool for monitoring progress

Focus Area Three: Reduce marijuana, methamphetamine and other drug use, especially among adolescents and transition age youth between the ages of 12 and 25 by reducing associated risk factors and strengthening associated protective factors.

Goal 3: Reduce marijuana, methamphetamine and other drug use, especially among adolescents and transition age youth between the ages of 12 and 25 lowering associated risk factors and strengthening associated protective factors.

Objective 3.1: By September 1, 2006

Conduct training of key staff of ADPA and its contracted prevention providers on the key principles, techniques, and skills needed to implement evidence-based prevention programming to reduce marijuana, methamphetamine and other drug consumption by adolescents and young adults in local communities.

- Task 1:** Contract/or contact TA/Training provider
- Task 2:** Determine content areas
- Task 3:** Schedule training event
- Task 4:** Assess results of the training (90-120 days post event)

Objective 3.2: By July 1, 2006

Complete development of ADPA's internal administrative operations needed to implement evidence-based programming to reduce marijuana, methamphetamine and other drug consumption in local communities, including program standards and practices, contract requirements, exhibits, provider work plan formats, performance monitoring instruments, and data reporting systems.

- Task 1:** Develop program standards and practices
- Task 2:** Revise prevention contract exhibit
- Task 3:** Develop program provider work plan
- Task 4:** Revise monitoring instrument
- Task 5:** Develop data reporting system
- Task 6:** Finalize documents

Objective 3.3: By March 1, 2006

Complete an assessment of risk and protective factors associated with marijuana, methamphetamine and other drug consumption in each community served by ADPA contracted prevention service providers.

- Task 1:** Develop tool to assess provider alcohol risk and protective factors
- Task 2:** Assess community risk and protective factors associated with substance abuse.
- Task 3:** Conduct analysis of risk and protective factors

Objective 3.4: By July 1, 2006

Complete implementation of administrative operations described in Objective 2 with at least 50% of contractors; by October 1, 2006, complete implementation of administrative operations with all contractors.

- Task 1:** Provide on going technical assistance
- Task 2:** Meet with programs to identify barriers
- Task 3:** Provide training sessions on the implementation process
- Task 4:** Develop tool for monitoring progress

Objective 3.5: By October 1, 2006

Complete implementation of programming developed to reduce marijuana, methamphetamine and other drug consumption in local communities by at least 50% of contracted providers; by March 1, 2007, complete implementation by all contracted providers.

- Task 1:** Provide on going technical assistance
- Task 2:** Meet with programs to identify barriers
- Task 3:** Provide training sessions on the implementation process
- Task 4:** Develop tool for monitoring progress

The following describe additional tasks that were necessary to establish for meeting reporting requirements and for gathering county data on prevention services:

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| <p>Goal 4: One hundred percent of prevention programs will have reported services/activities using the California Outcomes Measurement Service for Prevention (CalOMS PV).</p> |
| <p>Objective 4.1. By July 1, 2009 ADPA prevention funded programs will have reported prevention services/activities on CalOMS PV.</p> |
| <p>Task 1: Establish goals and objectives for ADPA's Strategic Prevention Plan Task 2: Prepare notice for providers regarding CalOMS PV Objectives for focus areas Task 3: Assign objectives to providers Task 4: Inform Contract Program Auditors (CPA) about CalOMS PV Objectives. Task 5: Prevention staff reviews and releases CalOMS PV data on a weekly basis. Task 6: Coordinate at least 2 training sessions for providers on CalOMS PV data entry requirements, focus areas, problem statements, goals, and program objectives Task 7: Use CalOMS PV system for outcome data</p> |
| <p>Goal 5: Accomplish goals and objectives outlined on ADPA's Strategic Prevention Plan.</p> |
| <p>Objective 5.1 By July 2009 increase provider capacity to address AOD focus areas and meet goals and objectives.</p> |
| <p>Task1: Oversee responsibilities for ongoing implementation of the strategic prevention plan Task2: Review provider plans and identify areas for technical assistance Task 2: Inform providers about the option to up load plans Task 3: Share provider plans with the CPA's Task 4: Provide on-going training and technical assistance around evidenced-based strategies to address focus areas</p> |
| <p>Goal 6: Adopt the use of the Institute of Medicine for addressing prevention risk factors</p> |
| <p>Objective 6.1. Increase prevention provider knowledge for understanding the IOM classification and reporting CalOMS PV data.</p> |
| <p>Task 1: On going monitoring of provider IOM data entries Task 2: Provide training and technical assistance to providers as needed. Task 3: Coordinate at least 2 IOM training sessions on the IOM</p> |
| <p>Goal 7: Develop and sustain an effective AOD prevention system that meets the identified needs of Los Angeles County.</p> |
| <p>Objective 7.1. Increase provider awareness of evidence-based approaches for addressing ADPA focus areas.</p> |
| <p>Task 1: Coordinate at least 2 training session per fiscal year for key ADPA staff and providers on evidence-based prevention strategies for addressing focus areas. Task 2: Coordinate focus groups to assess AOD associated risk factors and identify priority areas Fiscal Year 2009-10.</p> |

The next sub-section presents ADPA's Strategic Prevention Plan problem statements, goals and objectives.

Focus Area 1

Problem Statement: The expanding epidemic of underage and binge drinking and related problems has become a crisis that is increasingly impacting both Los Angeles County and the United States.

Source: Youth Risk Behavior Surveillance: United States 2002. MMWR: Morbidity and Mortality Report). Underage alcohol use is more likely to kill young people than all illegal drugs combined (Substance Use, Abuse and Dependence in Adolescence: Prevalence, symptom profiles and correlates 2002).

Goal: Reduce excessive alcohol consumption (binge drinking) by young adult's ages 18-25 by lowering associated risk factor and strengthening associated protective factors.

- Objective 1.a.** Increase reporting of no alcohol use in the past 30 days among adolescents 7th through 11th grade.
- Objective 1.b.** Increase knowledge/skills concerning strategies for reduction of alcohol availability for youth.
- Objective 1.c.** Promote and strengthen enforcement of existing policies and regulations which prevent alcohol problems among youth.
- Objective 1.d.** Increase AOD awareness, prevention knowledge/skills, and alternative activities among youth, adults, and older adults.

Focus Area 2

Problem Statement: Excessive drinking contributes to interpersonal and sexual violence. It is estimated that each year, 600,000 college students aged 18-24 are assaulted by another student who has been drinking and 70,000 college students aged 18-24 are victims of alcohol-related sexual assault or date rape.

Source: Hingson, et al., 2002 as cited in California Department of Alcohol and Drug Programs. (2002, April). High-risk drinking in college: what we need to learn: final report of the panel on contexts and consequences. ADP Publication No. (ADP) 02-4758

Goal: Reduce excessive alcohol consumption (binge drinking) by young adult's ages 18-25 by lowering associated risk factor and strengthening associated protective factors.

- Objective 2.a.** Promote binge drinking prevention education/awareness skills in communities/targeted settings.
- Objective 2.b.** Increase awareness and knowledge of consequences of underage binge drinking/alcohol use.
- Objective 2.c.** Target high-risk adolescent and young adults for intensive awareness/education interventions.
- Objective 2.d.** Increase AOD awareness, prevention knowledge/skills, and alternative activities among youth, adults, and older adults.

Focus Area 3

Problem Statement: In 2004, 1.4 million persons aged 12 or older had used meth in the past year, and 600,000 had used it in the past month (National Survey on Drug Use and Health).

Source: Data from the CHKS indicated that the largest percentage of survey respondents reporting past 30-day use of AOD reported using marijuana followed by inhalants, meth, cocaine, and LSD.

Goal: Reduce marijuana and methamphetamine and other drug use, especially among adolescent and transition age youth between the ages of 12-25 by lowering associated risk factors and strengthening associated protective factors.

- Objective 3.a.** Increase knowledge/skills concerning strategies for reduction of marijuana, meth, and other drug associated problems.
- Objective 3.b.** Increase awareness among students, parents, and other community members about the risks associated with methamphetamine use.
- Objective 3.c.** Increase reporting of no marijuana use in the past 30 days among adolescents 7th through 11th grade.
- Objective 3.d.** Increase AOD awareness, prevention knowledge/skills, and alternative activities among youth, adults, and older adults.

Section 4 Evaluation Plan

Program Outcome and Performance Measures

ADPA must comply with State and Federal requirements for compiling and reporting information on program outcome and performance measures for its prevention services. The SDADP established the California Outcomes Measurement Services for Prevention (CalOMS Prevention) Program as its data system for counties and their contracted service providers to report specific measurable outcomes of prevention and treatment services. The federal SAMHSA also requires the State to report on specific measurable outcomes for prevention and treatment services funded through the SAPT Block Grant Program. While final measures are still in development at the State and Federal levels, ADPA uses the following set of interim measures.

Performance measures include the following:

- Increased use of evidence-based practices and the SAMHSA SPF.
- Increased access to services (service capacity).
- Increased number of programs reporting on the CalOMS Prevention data-base.
- Increased number of programs tracking and reporting process and outcome measures.

Federal outcome measures include the following:

- Increased abstinence from alcohol abuse/drug use (30-day past use of alcohol and illicit drugs).
- Increased perception of drug use as harmful (ages 12-17).
- Increased/retained employment or return/stay in school attendance.
- Decreased criminal justice/juvenile justice involvement.
- Increased stability in family and living conditions.
- Increased social supports/social connectedness.
- Increased provision of services within acceptable cost bands (cost effectiveness).

Program Evaluation Plan

Program evaluation serves multiple critical functions for publicly funded agencies such as ADPA. First, program evaluation enables ADPA to demonstrate accountability for demonstrating the responsible use of public monies for the purposes intended. Secondly, program evaluation enables ADPA, its contracted service providers, and its other partners to assess progress in accomplishing stated goals and objectives and to make program adjustments in a continuing process to improve their effectiveness and efficiency.

ADPA's program evaluation plan for prevention services consists of the following:

- Monitoring Annual Program Work Plans
- Using CalOMS Prevention data collection system
- Analysis of Year-End Program Reports

Continuous quality improvement process:

In addition to assessing progress in accomplishing specific program outcome and performance measures, ADPA also uses program evaluation as a key component in a continuous quality improvement process. This process enables ADPA to improve the effectiveness and efficiency of prevention services implemented through its internal operations and its contracted service providers and through collaborative efforts with other partners.

The continuous quality improvement process consists of the following activities:

ADPA:

Annual compliance review of State/Federal program requirements (SPF)
Quarterly service data performance reports to State (CalOMS Prevention)
Quarterly interactive feedback meetings with providers (Prevention Roundtable meetings)

Contracted service providers:

Annual contract compliance review (conducted by ADPA contract program auditors)
Annual submission of program work plans
Quarterly program performance reports (CalOMS Prevention)

Partners:

Monthly reports at meetings of ADPA advisory commissions and their prevention committees (Commission on Alcoholism, and the Narcotics and Dangerous Drugs Commission)
Participation in various interagency advisory and coordination bodies for prevention programming

Appendices

- Appendix A: Risk and Protective Factors
- Appendix B: Review of Research Findings on Effective Alcohol and Other Drug Prevention Approaches
- Appendix C: Contracted Alcohol & Drug Prevention Services by Service Planning Area
- Appendix D: Institute of Medicine Classification and Key Features

Appendix A: Risk and Protective Factors

The goals, objectives, and activities described in the Action Plan use strategies intended to increase and strengthen protective factors and decrease risk factors in each of the six domains of influence. The following describes various activities implemented to address protective and risk factors associated with alcohol and other drug problems.

| Domain | Activities | Risk Factors Addressed | Protective Factors Addressed |
|--|--|--|---|
| Individual <i>Values, Skills, Knowledge, Behaviors</i> | Media literacy skills training. Alternative drug-free recreational activities. Culturally appropriate services. Social/life skill building. After school sports. Problem identification and referral. | Early and persistent antisocial behavior. Early initiation of the problem behavior. Rebelliousness. Favorable attitudes toward alcohol and other drug use. Sensation seeking behavior. | Knowledge of alcohol and other drug resistance skills. Attitudes against alcohol and other drug use. Availability of parental supervision. Critical thinking skills. |
| Peer <i>Norms, Activities, Bonding</i> | Alternative drug-free recreational activities. Peer education. Peer-led Summits. | Peers engage in the problem behavior. Peers providing opportunities to use. Peers providing and using alcohol and other drugs. | Perceived peer use of alcohol and other drugs. Peer norms against use of alcohol and other drugs. |
| School <i>Bonding, Climate, Policy, Performance</i> | Health education curricula. Life/social skills training. Peer counseling. Peer leadership. Parent-peer groups. After school programs. | Academic failure. Lack of commitment to school. | Connectedness to school. School safety. Commitment to education. Commitment to substance abuse prevention in school policies. Good academic grades. Positive school climate. |
| Family <i>Function, Management, Bonding</i> | Parent education. Parent involvement programs. Parenting skills training. Family skills training. Parent support groups. | Favorable parental attitudes toward alcohol and other drug use. Parental or sibling drug use. Family management problems. Family conflict. | Perceived parental attitudes against alcohol and other drug use. Family bonding. Parent communication skills. Good family management. Economic stability. |

| Domain | Activities | Risk Factors Addressed | Protective Factors Addressed |
|--|--|---|--|
| <p>Community</p> <p><i>Bonding, Norms, Resources, Mobilization, Awareness</i></p> | <p>Public awareness campaigns. Community coalitions/task forces. Tutoring. Alternative programs for youth. Job skills training. Establishing Drug Free zones.</p> | <p>Availability of alcohol and other drugs. Community laws and norms favorable toward alcohol and other drug use. Transition and mobility. Low neighborhood attachment and community disorganization. Extreme economic deprivation.</p> | <p>Norms against alcohol and other drug use/abuse. Community actions against illegal sale and provision of alcohol to underage youth. Attachment to social and community institutions. Ability to address alcohol and other drug related community problems.</p> |
| <p>Environmental</p> <p><i>Norms, Policies</i></p> | <p>Drug/alcohol policy changes. Merchant outreach/education. Social marketing programs. Reducing negative community conditions. Media campaign (press conference). Youth-led counter-advertising. Responsible beverage training.</p> | <p>Community conditions conducive to illegal and harmful alcohol and other drug use. Inappropriate negative sanctions for use and abuse.</p> | <p>Community awareness and media efforts. Public policies to discourage illegal and harmful consumption of alcohol and other drugs.</p> |

SAMHSA. *Science-Based Prevention Programs and Principles* (2002).
 CSAP's Western Center for the Application of Prevention Technologies Substance Abuse Prevention Specialist Training Manual (2004).

Appendix B: Review of Research Findings on Effective Alcohol and Other Drug Prevention Approaches

Focus Area One: Underage alcohol consumption.

Yvonne A. Bonomo, Glenn Bowes, Carolyn Coffey, John B. Carlin, and George C. Patton. Teenage Drinking and the Onset of Alcohol Dependence: A Cohort Study Over Seven Years. *Addiction*: Volume 99, 1520-1528 (2004).

A community sample of almost 2,000 individuals was followed from ages 14-15 to 20-21 years to determine whether adolescent alcohol use and/or other adolescent health risk behavior predisposes to alcohol dependence in young adulthood. The study found that teenage drinking patterns and other health risk behaviors in adolescence predicted alcohol dependence in adulthood. Prevention and early intervention initiatives to reduce longer-term alcohol-related harm therefore need to address the factors, including alcohol supply, that influence teenage consumption and in particular high-risk drinking patterns.

Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report*: Volume 53, number 21, p. 452-454 (June 4, 2004).

To reduce alcohol sales to persons under 21 years in Concord, New Hampshire, the Concord Police Department and New Hampshire Liquor Commission conducted a pilot program of enhanced law enforcement with quarterly compliance checks of alcohol licensees during March 2002 through February 2004. The study found that enhanced enforcement resulted in a 64% reduction in retail alcohol sales to underage youths and was temporarily associated with declines in alcohol use and binge drinking among Concord high school students.

Phyllis L. Ellickson, Rebecca L. Collins, Katrin Hambarsoomians, and Daniel F. McCaffrey. Does Alcohol Advertising Promote Adolescent Drinking? Results From a Longitudinal Assessment. *Addiction*, 100, 235-246. 2005.

Several forms of alcohol advertising predict adolescent drinking; which sources dominate depends on the child's prior experience with alcohol. Alcohol prevention programs and policies should help children counter alcohol advertising from multiple sources and limit exposure to these sources.

Eileen M. Harwood, Darin J. Erickson, Lindsey E.A. Fabian, Rhonda Jones-Webb, Sandy Slater, and Frank J. Chaloupka. Effects of Communities, Neighborhoods, and Stores on Retail Pricing and Promotion of Beer. *Journal of Studies on Alcohol*: September 2003, p.720-726.

This study examines how communities, neighborhoods and stores influence retail pricing and promotion of beer. Overall, the pricing and promotion of beer vary systematically by some characteristics of communities, neighborhoods and stores, but not significantly by the number of young people populating a neighborhood.

In addition, pricing and promotion of Budweiser and Miller beers, in particular, do not appear to target racial minority populations. Because of the significant effect of store characteristics, public health agencies and advocates might focus prevention efforts on collaborations with liquor control agencies to reduce variations in pricing and promotion of beer, which ultimately encourage risky drinking behaviors. Further studies are needed to examine the effects of pricing and promotion on alcohol-related social problems.

David H. Jernigan, Joshua Ostroff, Craig Ross, James A. O'Hara III. Sex Differences in Adolescent Exposure to Alcohol Advertising in Magazines. *Archives of Pediatric and Adolescent Medicine*: Volume 158, July 2004, p. 629-634.

Exposure of underage girls to alcohol advertising is substantial and increasing, pointing to the failure of industry self-regulation and the need for further action.

William C. Kerr, Thomas K. Greenfield, Jason Bond, Yu Te, and Jurgen Rehm. Age, Period, and Cohort Influences on Beer, Wine, and Spirits Consumption Trends in the US National Alcohol Surveys. *Addiction*, 99, 1111-1120. 2004.

Changing cohort demographics are found to have significant effects on beverage specific consumption, indicating the importance of controlling for these effects in the evaluation of alcohol policy effectiveness and the potential for substantial improvement in the forecasting of future beverage specific consumption trends, alcohol dependence treatment demand, and morbidity and mortality outcomes.

Office of Alcohol and Other Drug Abuse, American Medical Association. *Policy Briefing Paper: Partner of Foe? The Alcohol Industry, Youth Alcohol Problems, and Alcohol Policy Strategies*. (2002)

This briefing paper includes an introduction to the environmental approach to prevention and its role in addressing industry-marketing strategies.

Ann Stueve and Lydia N. O'Donnell. Early Alcohol Initiation and Subsequent Sexual and Alcohol Risk Behaviors Among Urban Youths. *American Journal of Public Health*: Volume 95, Number 5, p. 887-893 (May 2005).

This study examined the relationship between early alcohol use and subsequent alcohol and sexual risk behaviors among 1034 African American and Hispanic youths between the 7th and 10th grades. Early drinking was found to be associated with alcohol and sexual risks through mid-adolescence. Early drinkers were more likely to report subsequent alcohol problems, unprotected sexual intercourse, multiple partners, being drunk or high during sexual intercourse, and pregnancy. Among females, early drinking was also related to sexual initiation and recent sexual intercourse. The researchers concluded that prevention programs should address combined risks of early alcohol use and sexual intercourse, especially where levels of HIV and other sexually transmitted infections are elevated.

Geoffrey R. Twitchell. *Concentrated Alcohol Consumption by Heavy Drinkers: Associated Risks and Costs*. Report developed for the California Department of Alcohol and Drug Programs. November 2003.

This briefing paper includes a summary of studies on alcohol consumption patterns in the United States, the economic costs of heavy drinking, and recommendations for interventions and policies. Recommendations include: prevention and intervention strategies should focus on concentrated alcohol users and industry marketing practices supporting excessive, heavy use; social norms marketing may have benefits for the young male concentrated alcohol user; the preference for beer exhibited by the heavier drinking young male coupled with increased incidence of hazardous use of beer suggests that strategies should focus on the consumption, marketing and pricing of beer; policy efforts to control underage drinking may be effective and feasible; and policymakers should consider using taxation as an intervention to decrease alcohol consumption and traffic fatalities.

Alexander C. Wagenaar and Cheryl L. Perry. Community Strategies for the Reduction of Youth Drinking: Theory and Application. *Journal of Research on Adolescence*: Volume 4, Number 2, 319-345 (1994).

This is a review of the core concepts and key proposition from several theories concerning youth alcohol use integrated into a single theory of drinking behavior. The resulting model illustrates the centrality of social interaction in influencing drinking and the critical importance of changing broader socio environmental conditions to achieve long-term reductions in youth drinking and associated problems. Two large-scale randomized community trials in progress (Communities Mobilizing for change on Alcohol and Project Northland: Partnerships for Youth Health) are testing key components of the model of youth drinking. Conclusions are that effective long-term alcohol prevention programs require strategies for community and societal change.

Alexander C. Wagenaar, Traci L. Toomey, and Darin J. Erickson. Preventing Youth Access to Alcohol: Outcomes From a Multi-Community Time-Series Trial. *Addiction*: Volume 100, p. 335-345 (2005).

The study evaluated the Complying with the Minimum Drinking Age project, a community trial designed to test effects of two interventions designed to reduce alcohol sales to minors by providing training for management of retail alcohol establishments and conducting enforcement checks of alcohol establishments in 20 cities in 4 geographic areas in the United States Midwest. The results of the training intervention were mixed. Specific deterrent effects were observed for enforcement checks, with an immediate 17% reduction in likelihood of sales to minors. These effects decayed entirely within 3 months in off-premise establishments and to an 8.2% reduction in on-premise establishments. Researchers concluded that enforcement checks prevent alcohol sales to minors. At the intensity levels tested, enforcement primarily affected specific establishments checked, with limited diffusion to the whole community. Most of

the enforcement effect decayed within 3 months, suggesting that a regular schedule of enforcement is necessary to maintain deterrence.

Focus Area Two: Excessive alcohol consumption (binge drinking) by young adults ages 18 to 25.

Ricky N. Blumenthal, Didra Brown-Taylor, Norma Guzman-Becerra, and Paul L. Robinson. Characteristics of Malt Liquor Beer Drinkers in a Low-Income, Racial Minority Community Sample. *Alcohol Clinical Experimental Research*, Volume 29, Number 3, 2005: pages 402-409.

The authors observed substantial differences in sociodemographic characteristics, drinking patterns, and ethanol consumption by beverage type in this community sample. Malt liquor beer drinkers seem to have distinctive drinking patterns that require additional study to determine whether this pattern is associated with increased individual or community risk.

R.W. Hingson, R.C. Zakocs, T. Heeren, M.R. Winter, D. Rosenbloom, and W. DeJong. Effects on Alcohol Related Fatal Crashes of a Community Based Initiative to Increase Substance Abuse Treatment and Reduce Alcohol Availability. *Injury Prevention*, Volume 11, p. 84-90 (2005).

This study tested whether comprehensive community interventions that focus on reducing alcohol availability and increasing substance abuse treatment can reduce alcohol related fatal traffic crashes. Five of 14 communities awarded Fighting Back grants by The Robert Wood Johnson Foundation to reduce substance abuse and related problems attempted to reduce availability of alcohol and expand substance abuse treatment programs. The 5 communities experienced significant declines of 22% in alcohol related fatal crashes at 0.01% blood alcohol concentration or higher, 20% at 0.08% or higher, and 17% at 1.5% or higher relative to fatal crashes not involving alcohol.

Mothers Against Drunk Driving (MADD). *Protect, Serve and Prevent: Successful Law Enforcement Strategies to Stop Drunk Driving. MADD 2004 Law Enforcement Leadership Summit Report.*

This report summarized research findings on effective law enforcement strategies for preventing and reducing drunk driving and related problems. These findings included: sobriety checkpoints reduce alcohol-related crashes, strong state legislative, enforcement and education activities to prevent drunk driving reduces the rate of drinking and driving, and highly publicized, frequent and visible law enforcement efforts such as sobriety checkpoints reduce alcohol-related fatal traffic crashes.

Ingeborg Rossow and Ragnar Hauge. Who Pays for the Drinking? Characteristics of the Extent and Distribution of Social Harms From Others Drinking. *Addiction*: Volume 99, p. 1094-1102 (2004).

Relatively minor harms from others' drinking are experienced quite frequently. Multivariate analyses showed that social harms from others' drinking were most often reported by younger persons, women, those with high education level, those who reported a higher annual alcohol intake, more frequent episodes of intoxication frequency and more frequent visits to public drinking places. The impact of intoxication frequency on victimization from alcohol-related social harms was stronger for women than for men. Similar individual characteristics were also associated with victimization from physical harm and victimization in the public sphere.

Wendy S. Sluske. Alcohol Use Disorders Among U.S. College Students and Their Non-College-Attending Peers. *Archives of General Psychiatry*. volume 62, p. 321-327, March 2005.

The study compared the prevalence of alcohol use disorders and alcohol use disorder symptoms in college-attending young adults with their non-college-attending peers within in a large (n=6352) and representative US national sample (young adults ages 19-21 years from the 2001 National Household Survey on Drug Abuse). The researcher found that college students suffer from some clinically significant consequences of their heavy/binge drinking, but they do not appear to be at greater risk than their non-college-attending peers for the more pervasive syndrome of problems that is characteristic of alcohol dependence.

Traci I. Toomey and Alexander C. Wagenaar. Environmental Policies to Reduce College Drinking: Options and Research Findings. *Journal of Studies on Alcohol*: Supplement Number 14, p.193-205 (2002).

The goal of this article is to provide an overview of environmental strategies that may reduce college drinking. The identified environmental strategies fall into four categories: increasing compliance with minimum legal drinking laws, reducing consumption and risky alcohol use, decreasing specific types of alcohol-related problems, and de-emphasizing the role of alcohol on campus and promoting academics and citizenship. Although the extant research indicates that many environmental strategies are promising for reducing alcohol-related problems among the general population, few of these strategies have been evaluated for effects on the college population. Further research is needed to evaluate effects of alcohol control policies on alcohol consumption and its related problems among college students.

Andrew J. Treno and Juliet P. Lee. Approaching Alcohol Problems Through Local Environmental Interventions. *Alcohol Research and Health*, Volume 26, Number 1, 2002.

One approach for reducing alcohol and other drug problems is community-based prevention programs. These programs focus on changing the environment in which a person consumes alcohol rather than the behavior of the individual drinker. Several international and U.S. programs have assessed the effectiveness of such approaches in reducing alcohol-related problems.

Some of those analyses have had inconclusive results. Others, however, found reductions in alcohol-related problems such as drunk driving, alcohol-related care crashes and their consequences, the sale of alcohol to underage drinkers, and assault injuries. Nevertheless, several aspects of community-based prevention programs require further study.

Elissa R. Weitzman, Toben F. Nelson, Hang Lee, and Henry Wechsler. Reducing Drinking and Related Harms in College: Evaluation of the “A Matter of Degree” Program. *American Journal of Preventive Medicine*: Volume 27, Number 3, p.187-196 (2004).

While there was no change in the ten “A Matter of Degree” (AMOD) schools in study measures, significant although small improvements in alcohol consumption and related harms at colleges were observed among students at the five AMOD sites that most closely implemented the environmental model. Fidelity to a program model conceptualized around changing alcohol-related policies, marketing, and promotions may reduce college student alcohol consumption and related harms. Further research is needed over the full course of the AMOD program to identify critical intervention components and elucidate pathways by which effects are realized.

J. Elizabeth Wells, L. John Horwood, and David M. Fergusson. Drinking Patterns in Mid-Adolescence and Psychosocial Outcomes in Late Adolescence and Early Adulthood. *Addiction*: Volume 99, p.1529-1541 (2004).

The study describes the pattern of drinking at age 16 and to relate this to outcomes are 16-21 years and 21-25 years across a number of psychosocial domains for 1265 subjects with contacts at 18, 21, and 25 years. The researchers found that drinking at age 16 is a clear indicator of future life-course over most domains in late adolescence and early adulthood. Many of these associations are due to other covariates. Outcomes specific to drinking at age 16 are alcohol outcomes, number of sexual partners, and violence.

Andris Ziemelis, Ronald B. Buckman, and Abdulaziz M. Elfessi. Prevention Efforts Underlying Decreases in Binge Drinking at Institutions of Higher Education. *Journal of American College Health*: Volume 50, Number 5. (March 2002).

An analysis of 94 drug prevention programs at post-secondary education institutions in the United States. Researchers found 8 prevention factors that improved base-rate prediction of institutional decrease in binge drinking by 28.1%. Factor synthesis yielded a 3-construct binge-drinking prevention model based on student participation and involvement strategies, educational and informational processes, and campus regulatory and physical change efforts. The model improved base-rate prediction of decreased binge drinking by 33.2%.

Focus Area Three: Marijuana and methamphetamine use, especially among adolescents and transition age youth (ages 12 to 25).

Phyllis L. Ellickson, Steven C. Martino, and Rebecca L. Collins. Marijuana Use From Adolescence to Young Adulthood: Multiple Developmental Trajectories and Their Associated Outcomes. *Health Psychology*. Volume 23, Number 3, p.299-307 (May 2004).

This study used latent growth mixture modeling to identify discrete developmental patterns of marijuana use from early adolescence (age 13) to young adulthood (age 23) among a sample of 5,833 individuals. The researchers found in comparing the trajectory groups (early high users, stable light users, steady increasers, and occasional light users) on behavioral, socioeconomic, and health outcomes at age 29 revealed that abstainers consistently had the most favorable outcomes.

D.M. Fergusson, L.J. Horwood, M.T. Lynskey, and P.A. Madden. Early Reactions to Cannabis Predict Later Dependence. *Archives of General Psychiatry*. Volume 60, Number 10, p.1033-9 (October 2003).

This study examined the extent to which subjective responses to early (prior to age 16 years) cannabis use were associated with subsequent cannabis dependence in a birth cohort (n = 198) studied to the age of 21 years in New Zealand. The researchers found early subjective responses to cannabis are prognostic of later cannabis dependence.

F. Poulin, T.J. Dishion, and B. Burraston. Three-Year Iatrogenic Effects Associated With Aggregating High-Risk Adolescents in Cognitive-Behavioral Preventive Interventions. *Applied Development Science*. Volume 5, Number 4, p.214-224 (2001).

The study found that 11- to 14-year-olds at high risk for drug abuse and increasingly serious delinquency who were grouped together for a 12-week program designed to reduce problem behavior actually increased their levels of self-reported smoking and teacher-reported delinquency over 3 years. These youths exhibited significantly worse behaviors than similarly at-risk youths who were given prevention materials to study by themselves individually or received no intervention at all.

Marianne B.M. Van Den Bree and Wallace B. Pickworth. Risk Factors Predicting changes in Marijuana Involvement in Teenagers. *Archives of General Psychiatry*. Volume 62, p. 311-319, March 2005.

The study examined which risk factors best explain different stages of marijuana involvement among 13,718 middle schools and high school students aged 11-21 years participating in the National Longitudinal Study of Adolescent Health. The researchers found 3 risk factors (own and peer involvement with substances, delinquency, and school problems) were the strongest predictors of all 5 stages of marijuana involvement. They concluded that assessment of substance use, school, and delinquency factors is

important in identifying individuals at high risk for continued involvement with marijuana and that prevention and/or intervention efforts should focus on these areas of risk.

Executive Office of the President of the United States, Office of National Drug Control Policy. *Predicting Heavy Drug Use*. February 2004.

The results of a study using the Department of Labor’s National Longitudinal Survey of Youth – 1979 cohort, representing 33.6 million youth. For the last 23 years, the survey followed a representative sample of about 10,000 youth (aged 14-21 as of December 31, 1978) through their late thirties and early forties by 2000. The study used the battery of questions on drug use that were administered every 4 years from 1984 through 1998 to describe drug use and to predict who becomes a heavy drug user. The researchers found that:

- Youth who wait longer before their first use of alcohol, cigarettes, marijuana, cocaine or crack are less likely to become heavy cocaine users.
- Youth who first used cigarettes, alcohol and marijuana late more closely resemble non-users with regard to their heavy cocaine use.
- However, those youth who started smoking cigarettes daily, using cocaine, or using crack late have heavy cocaine use percentages more like early users than non-users.
- Those who smoked marijuana more than 50 times as adolescents are more than six times as likely to become heavy cocaine users as those who did not smoke marijuana as adolescents. The odds ratio decreases as marijuana use in adolescence decreases.
- Young male drug users are almost twice as likely as female drug users to become heavy cocaine users.
- Those who were suspended from school are one and one-half times more likely to become heavy cocaine users as those who were not suspended from school.
- Individuals reporting a significant amount of illegal income as adolescents are more than two times more likely to become heavy cocaine users than those who had no illegal income as adolescents.
- Those who attended religious services at least twice a month are one third less likely to become heavy cocaine users as those who did not attend religious services. Attending infrequently is associated with a one-quarter lower likelihood of becoming a heavy cocaine user.
- Those selling hard drugs during adolescence are twice as likely to become heavy cocaine users as those who did not sell drugs as adolescents.

* * * * *

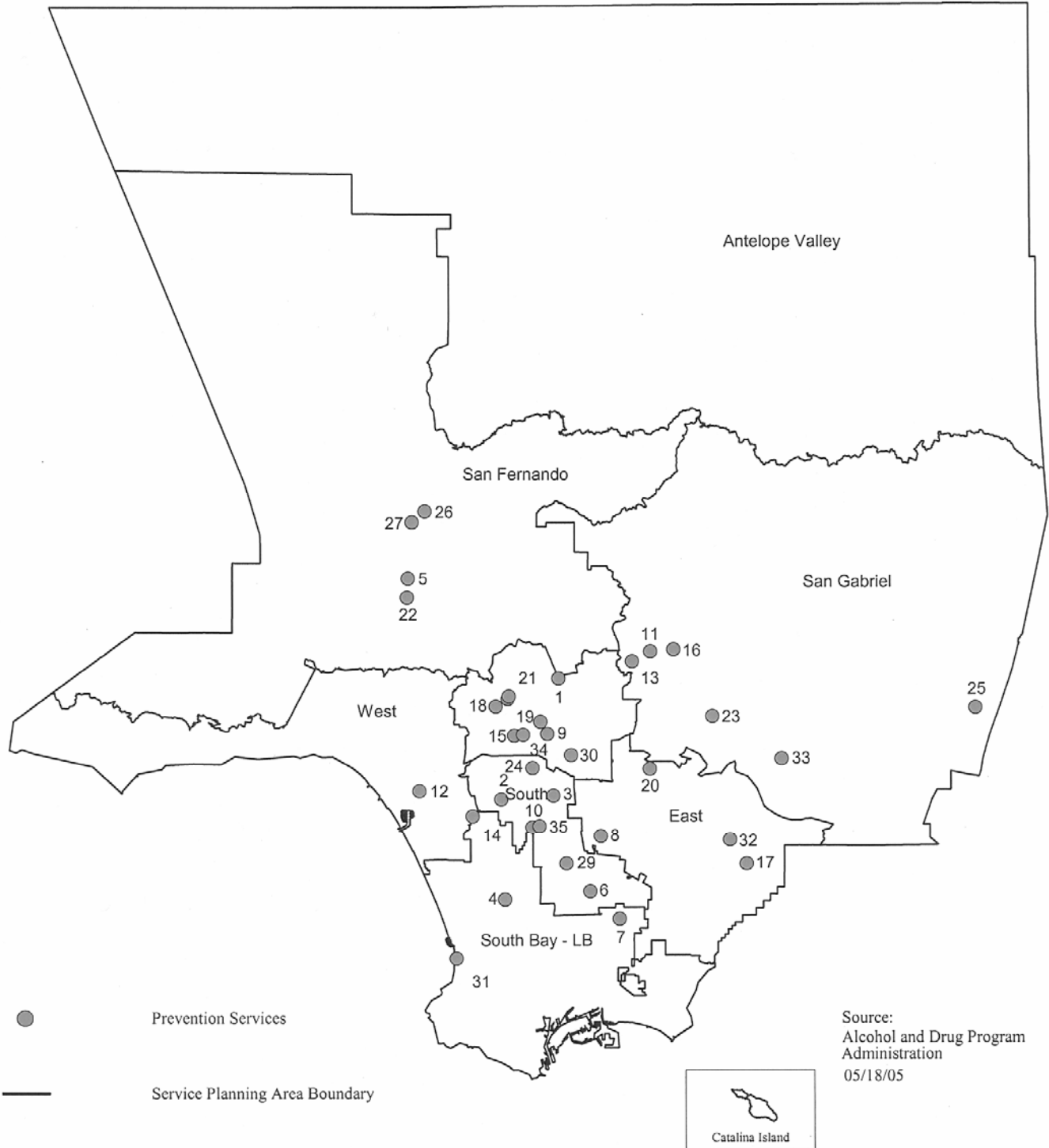
Appendix C: Contracted Alcohol & Drug Prevention Services by Service Planning Area

| LABEL SITE | SITE ADDRESS | CITY | ZIP CODE |
|--|--------------------------------|---------------|-----------------|
| 1 Alcoholism Center for Women, Inc. | 3429 Glendale Boulevard | Los Angeles | 90039 |
| 2 Asian American Drug Abuse Program | 5318 South Crenshaw Boulevard | Los Angeles | 90043 |
| 3 Avalon Carver Community Center | 4920 South Avalon Boulevard | Los Angeles | 90011 |
| 4 Behavioral Health Services | 15519 Crenshaw Boulevard | Gardena | 90249 |
| 5 Bridge Focus, Inc./b/a Positive Alternative for Youth | 14418 Chase Street | Panorama City | 91402 |
| 6 California Women's Commission on Addictions | 409 E. Palmer Street | Compton | 90221 |
| 7 City of Long Beach Students Talking About Resisting Substances | 6335 Myrtle Avenue | Long Beach | 90804 |
| 8 City of South Gate/Project JADE | 8650 California Avenue | South Gate | 90280 |
| 9 Clinica Msr. Oscar Romero | 318 South Alvarado Street | Los Angeles | 90057 |
| 10 Community Coalition for Substance Abuse Prevention and Treatment | 8101 South Vermont Avenue | Los Angeles | 90044 |
| 11 Day One, Inc. | 175 North Euclid Avenue | Pasadena | 91101 |
| 12 Didi Hirsch Psychiatric Services | 12420 Venice Boulevard | Los Angeles | 90066 |
| 13 Haven House | P.O. Box 50007 | Pasadena | 91105 |
| 14 Korea town Youth and Community Center, Inc. | 680 South Wilton Place | Los Angeles | 90005 |
| 15 Los Angeles County Office of Education/Friday Night Live/Club Live | 1785 E. Locust Street, Suite 4 | Pasadena | 91106 |
| 16 Los Angeles County Sheriff's Department | 11515 South Colima Road | Whittier | 90604 |
| 17 Los Angeles Gay & Lesbian Center | 1125 North McCaden Place | Los Angeles | 90038 |
| 18 Los Angeles Youth Network | 1550 N. Gower Street | Los Angeles | 90028 |
| 19 California Hispanic Commission on Alcohol and Drug Abuse/Latino Family Center | 5801 East Beverly Boulevard | Los Angeles | 90022 |
| 20 Los Angeles Free Clinic | 6043 Hollywood Boulevard | Los Angeles | 90028 |
| 21 New Directions for Youth | 7400 Van Nuys Boulevard | Van Nuys | 91405 |
| 22 Pacific Clinics-Asian Pacific Family Center | 9353 East Valley Boulevard | Rosemead | 91770 |
| 23 People Coordinated Services of So. California | 3021 South Vermont Avenue | Los Angeles | 90007 |
| 24 Prototypes Women's Center | 831 East Arrow Highway | Pomona | 91767 |
| 25 Pueblo Y Salud, Inc. | 1024 North Maclay Avenue | San Fernando | 91340 |
| 26 San Fernando Valley Partnership | 1131 Celis Street | San Fernando | 91340 |
| 27 Search to Involve Pilipino Americans | 3200 West Temple Street | Los Angeles | 90026 |
| 28 Shields for Families | P.O. Box 59129 | Los Angeles | 90059 |
| 29 Social Model Recovery Systems/United Coalition East Prevention Program | 804 East 6th Street | Los Angeles | 90021 |
| 30 South Bay Youth Project | 320 Knob Hill | Redondo Beach | 90277 |
| 31 SPIRITT Family Services | 9401 Painter Avenue | Whittier | 90605 |
| 32 SPIRITT Family Services - AASUL | 147 South 6th Avenue | La Puente | 91746 |
| 33 Volunteers of America | 3600 Wilshire Boulevard | Los Angeles | 90010 |
| 34 Watts Healthcare Corporation | 8005 S. Figueroa Street | Los Angeles | 90003 |

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

Alcohol and Drug Program Administration

FY 2005-06 Contracted Alcohol and Drug Prevention Services by Service Planning Area



Appendix D: Institute of Medicine Classification for Prevention Intervention Strategies

Universal preventive interventions are activities targeting the general public or a whole population group that has not been identified on the basis of individual risk.

Key Features of Universal Prevention Programs

- The programs designed to reach the entire population;
- They are designed to delay or prevent substance abuse;
- Participants are not recruited to participate in the programs;
- The degree of individual substance abuse risk of the program participants is not assessed the program is communicated to everyone in the population regardless of whether they are at risk for substance abuse;
- The program usually have lower staff-to-audience member ratio than selective or indicated programs and may require less time and effort from the audience;
- Staff members can be professionals from other fields, such as teachers or school counselors, who have been trained to deliver the program; and
- Cost are spread over a large group and tend to be lower on a per-person basis than selective and indicated programs

Selective preventive interventions are activities targeting individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Key Features of Selective Prevention Programs

- Programs target subgroups of the general population that are determined to be at risk for substance abuse;
- They are designed to delay or prevent substance abuse;
- Recipients of selective prevention are known to have specific risk for substance abuse and are recruited to participate in the prevention effort because of that group's risk profile.
- The degree of individual vulnerability or personal risk of members of the targeted subgroup generally is not assessed, but vulnerability is presumed on the basis of their membership in the at-risk group;

- Knowledge of specific risk factors within the target group allows program designers to address specific risk reduction objectives;
- Selective prevention programs generally run for a longer period of time and require more time and effort from participants than universal programs;
- Selective programs require skilled staff because they target multi-problem youth, families, and communities that are at risk for substance abuse;
- The programs may be more expensive per person than universal programs because they require more time and effort; and
- The program activities generally are more involved in the daily lives of the participants and attempt to change the participants in specific ways, for example, by increasing participants' communication skills.

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

Key Features of Indicated Prevention Programs

- Programs target individuals who are experiencing early signs of substance abuse and other related problem behaviors;
- Programs are designed to stem the progression of substance abuse and related disorders;
- Programs can target multiple behaviors simultaneously;
- Individuals are specifically recruited for the prevention intervention;
- The individual's risk factors and problem behaviors are specifically addressed;
- Programs require a precise assessment of an individual's personal risk and level of related problem behaviors, rather than relying on the person's membership in an at-risk subgroup;
- Programs are frequently extensive and highly intensive; they typically operate for longer periods of time (months), at greater frequency (one hour per day, five days a week), and require greater effort on the part of the participants, than do selective or universal programs;
- Programs attempt to change the participants' behaviors;

- Programs require highly skilled staff that have clinical training and counseling training and counseling or other clinical intervention skills; and
- Programs may be more expensive per person to operate than either universal or selective programs because they require more intensive work with individuals and small groups and more highly skilled staff.

Institute of Medicine. New directions in definitions. In: Mrazek, P.J., and Haggerty, R.J., eds. *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington, DC: National Academy Press, 1994.

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