

Session 1 Handouts

Substance Abuse Prevention Skills Training

AGENDA

- **An Introduction to the SAPST**
 - Training Overview and Logistics
- **Setting the Foundation: From Theory to Practice**
 - Behavioral Health
 - Continuum of Care
 - Public Health Approach
 - Risk and Protective Factors
 - Developmental Perspective
 - Introduction to the Strategic Prevention Framework

LEARNING OBJECTIVES

By the end of this session, you will be able to:

- **Define behavioral health**
- **Explain the continuum of care**
- **Identify key characteristics of the public health approach**
- **Describe risk and protective factors in multiple contexts and from the developmental perspective**
- **Summarize the Strategic Prevention Framework**

INDEX OF HANDOUTS

Information Sheet 1.1:	SAPST Overview
Information Sheet 1.2:	Timeline of Alcohol and Drug Abuse Prevention
Information Sheet 1.3:	Behavioral Health
Information Sheet 1.4:	Eight Dimensions of Wellness
Worksheet 1.5:	Activity – Your Eight Dimensions
Information Sheet 1.6:	The Continuum of Care
Worksheet 1.7:	Activity – U, S, or I?
Information Sheet 1.8:	Risk and Protective Factors
Information Sheet 1.9:	Shared Risk and Protective Factors
Information Sheet 1.10:	Developmental Perspective
Information Sheet 1.11:	A Public Health Approach

INFORMATION SHEET 1.1 – SAPST OVERVIEW

Session 1

- **An Introduction to the SAPST**
 - Training Overview and Logistics
- **Setting the Foundation: From Theory to Practice**
 - Behavioral Health
 - Continuum of Care
 - Public Health Approach
 - Risk and Protective Factors
 - Developmental Perspective
 - Introduction to the Strategic Prevention Framework

Session 2

- **Strategic Prevention Framework**
 - Step 1: Assessment
 - Step 2: Capacity

Session 3

- **Strategic Prevention Framework**
 - Step 2: Capacity (cont.)
 - Cultural Competence
 - Step 3: Planning

Session 4

- **Strategic Prevention Framework**
 - Sustainability
 - Step 4: Implementation
 - Step 5: Evaluation
 - Bringing It All Together

INFORMATION SHEET 1.2 – TIMELINE OF ALCOHOL & DRUG ABUSE PREVENTION

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

INFORMATION SHEET 1.3 – BEHAVIORAL HEALTH

Behavioral health refers to “a state of emotional/mental being and/or choices and actions that affect health and wellness.”¹

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, but are not limited to:

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

The scope and impact of behavioral health problems is significant:

- One in five young people experience one or more mental, emotional or behavioral disorders at any given time.²
- An estimated 21 million Americans aged 12 or older needed treatment for an illicit drug or alcohol use problem in 2016—that is about 1 out of every 13 people. In the same year, 1 in 7 young adults aged 18 to 25 needed treatment.³
- The total societal cost of substance abuse in the United States is estimated to be about \$511 billion annually.⁴

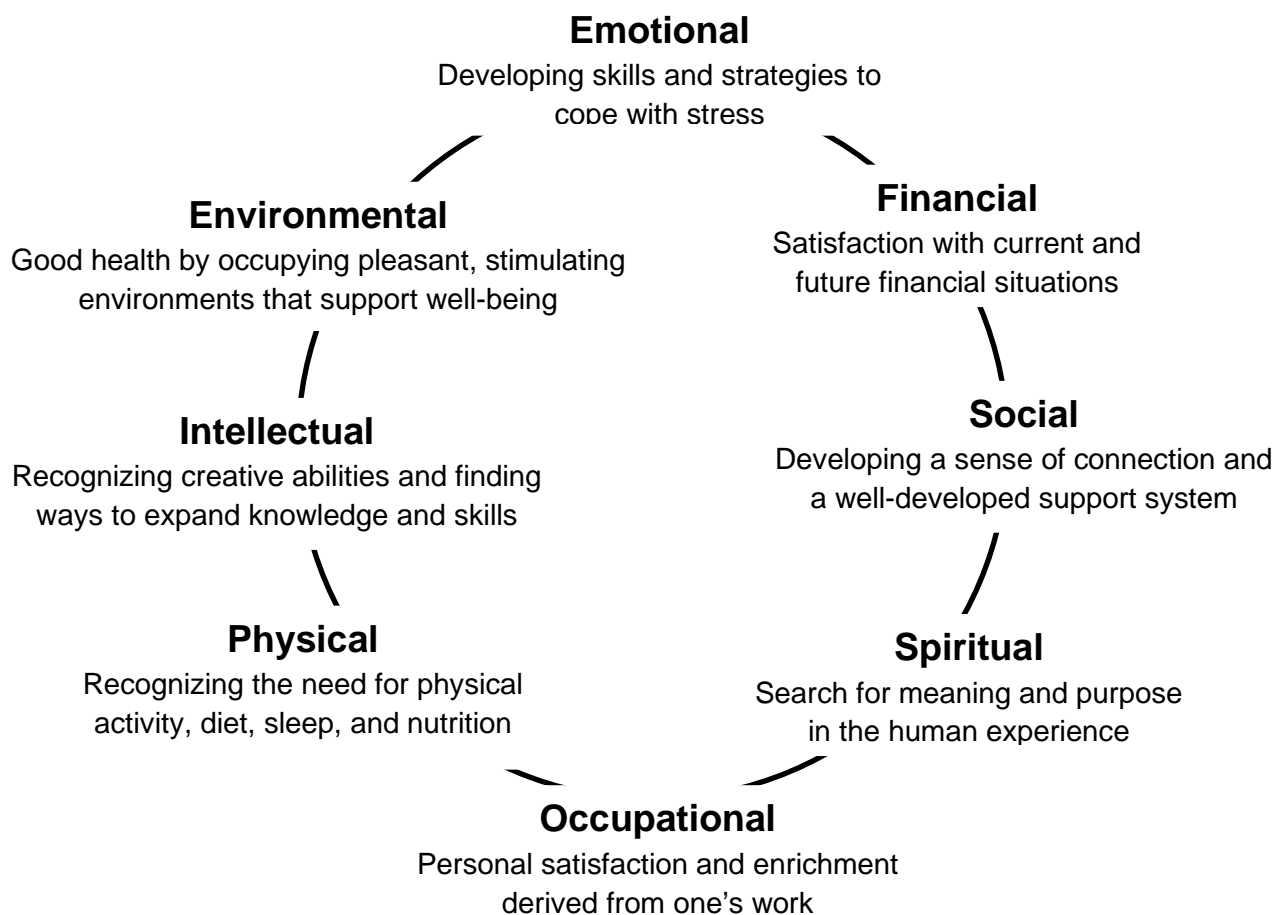
The term *behavioral health* can also be used to describe the service systems surrounding the promotion of mental health, the prevention and treatment of mental and substance use disorders, and recovery support.¹

INFORMATION SHEET 1.4 – EIGHT DIMENSIONS OF WELLNESS

Wellness is a conscious, deliberate process that requires awareness of—and making choices for—a more satisfying lifestyle.⁵ Wellness is not merely the absence of disease, illness, and stress, but the presence of:⁶

- Purpose in life
- Active involvement in satisfying work and play
- Joyful relationships
- A healthy body and living environment
- Happiness

SAMHSA promotes Eight Dimensions of Wellness:⁷



For more information, visit samhsa.gov/wellness-initiative/eight-dimensions-wellness.

WORKSHEET 1.5 – ACTIVITY: YOUR EIGHT DIMENSIONS

Instructions –

Draw your own wellness wheel, indicating how much time you spend on average in a month on the eight dimensions of wellness.

Emotional

Environmental

Financial

Intellectual

Social

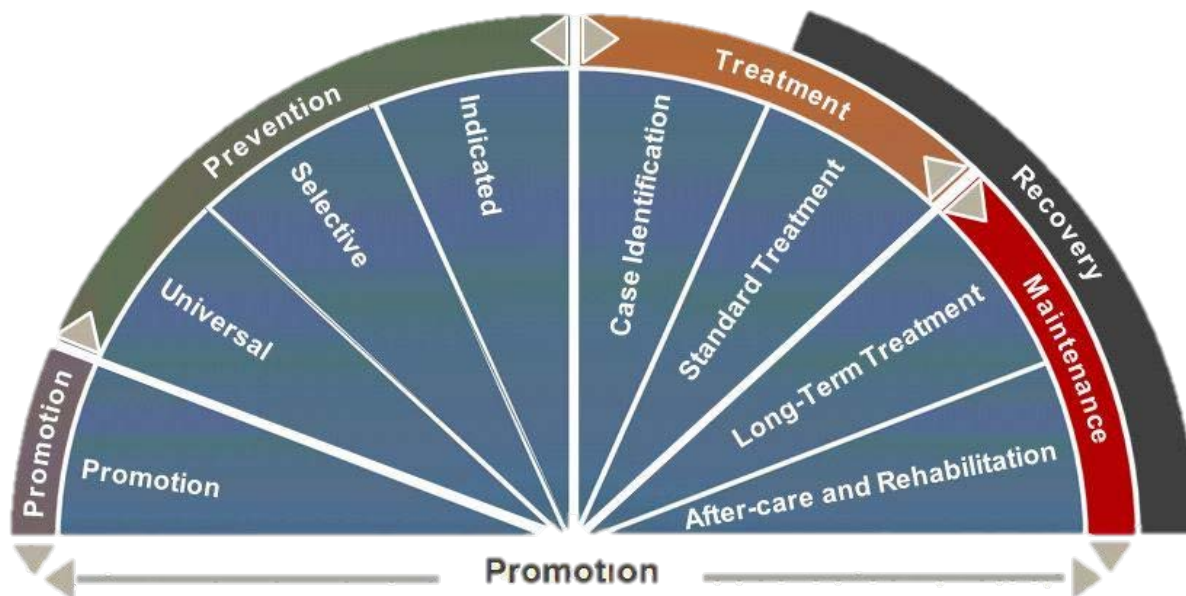
Physical

Spiritual

Occupational

INFORMATION SHEET 1.6 – THE CONTINUUM OF CARE

The Institute of Medicine's *continuum of care* (also known as the *mental health intervention spectrum*) is a classification system that presents the scope of behavioral health services: promotion of health, prevention of illness/disorder, treatment, and maintenance/recovery.²



Promotion involves interventions (e.g., programs, practices, or environmental strategies) that enable people “to increase control over, and to improve, their health.”⁸ As such, interventions that promote health occur independently as well as throughout the continuum of care as part of prevention, treatment, and maintenance/recovery.²

The focus of promotion is on well-being, according to the National Research Council and Institute of Medicine, with the goal of enhancing people’s ability to:²

- “Achieve developmentally appropriate tasks”
- “Acquire “a positive sense of self-esteem, mastery, well-being and social inclusion”
- “Strengthen their ability to cope with adversity”

The National Prevention Strategy concurs. Emotional well-being “allows people to realize their full potential, cope with the stresses of life, and make meaningful contributions to their community.” Further, since childhood experiences can have a lasting impact on a person’s life, promoting wellness in the early years can help “build a foundation for overall health.”⁹

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.² Prevention is also about striving to optimize well-being.

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The National Prevention Strategy states that “preventing drug abuse and excessive alcohol use improves quality of life, academic performance, workplace productivity, and military preparedness; reduces crime and criminal justice expenses, and motor vehicle crashes and fatalities; and lowers health care costs for acute and chronic conditions. Excessive alcohol use includes binge drinking, underage drinking, drinking while pregnant, and alcohol impaired driving. Drug abuse includes inappropriate use of pharmaceuticals and any use of illicit drugs.”⁹

Preventive interventions, according to the Institute of Medicine, can be designed to address three levels of risk: universal, selective, and indicated.²

- **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).²

Maintenance includes interventions that focus on compliance with long-term treatment to reduce relapse and recurrence and aftercare, including rehabilitation and recovery support.²

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.¹⁰

“Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities” by Institute of Medicine and National Research Council is online at http://www.nap.edu/catalog.php?record_id=12480. Purchase the book or download the free PDF.

WORKSHEET 1.7 – 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 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 the community			
9. College campus policies on alcohol			
10. Programs for people arrested for drunk driving			

INFORMATION SHEET 1.8 – RISK AND PROTECTIVE FACTORS

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 substance abuse and strengthening those factors that protect people from the problem.

According to the National Research Council and Institute of Medicine's 2009 report, *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities*, **risk factors** are certain biological, psychological, family, community, or cultural characteristics that *precede* and are associated with a *higher* likelihood of behavioral health problems. Whereas **protective factors** are characteristics at the individual, family, or community level that are associated with a *lower* likelihood of problem outcomes.²

The study of risk and protective factors is evolving. We know more about risk and protective factors that occur in childhood and early adulthood than for middle age and older adulthood. What we do know to-date is important for prevention:

- Different age groups have different risk and protective factors.
- Some risk and protective factors overlap between age groups.
- Risk and protective factors tend to be correlated and have cumulative effects and are predictive of multiple issues.

One person or agency cannot adequately impact a problem alone, so it makes sense to look for opportunities to work with other disciplines to address shared risk and protective factors.

Multiple Contexts²

Individuals have certain biological and psychological characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health problems. Risk factors at the individual level include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors might include positive self-image, self-control, or social competence.

But individuals don't exist in isolation. They are part of families, communities (youth are a part of schools), and society. A variety of risk and protective factors exist within each of these contexts or domains. For example:

- In **families**, 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.
- In **communities**, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and afterschool activities.
- In **society**, risk factors can 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 youth who identify as lesbian, gay, bisexual, transgender or queer/questioning (LGBTQ).

In prevention, we need to address the constellation of factors across these contexts that influence both individuals and populations—targeting just one context is unlikely to do the trick.

For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults. A more effective—and comprehensive—approach might include school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training.

Examples of Research-Based Risk Factors for Substance Abuse

The following table, compiled by the National Research Council and Institute of Medicine, shows research-based risk factors for several behavioral health disorders at the individual, family, and school/community level during specific stages of development from early childhood through young adulthood.² There is other research on risk factors throughout the lifespan.

RISK FACTORS: Early Childhood			
Individual		Family	Community (school)
Substance Abuse	<ul style="list-style-type: none"> • Difficult temperament 	<ul style="list-style-type: none"> • Cold and unresponsive mother behavior • Parental drug/alcohol use 	
Depression	<ul style="list-style-type: none"> • Temperament: inhibited, socially reticent and easily upset • Dysthymia (chronically low mood) • Insecure attachment • Hostile to peers, socially inhibited 		<ul style="list-style-type: none"> • Poor academic performance in early grades
Anxiety	<ul style="list-style-type: none"> • Behavioral inhibition 	<ul style="list-style-type: none"> • Marital conflict • Negative events 	<ul style="list-style-type: none"> • Specific traumatic experiences • Negative events • Lack of control or mastery experiences

RISK FACTORS: Middle Childhood			
Individual		Family	Community (school)
Substance Abuse	<ul style="list-style-type: none"> • Poor impulse control • Low harm avoidance • Sensation seeking • Lack of behavioral self-control • Aggressiveness • Anxiety • Depression • Attention deficit/hyperactivity disorder • Antisocial behavior • Early persistent behavior problems • Early substance use 	<ul style="list-style-type: none"> • Permissive parenting • Parent-child conflict • Low parental warmth • Parental hostility • Harsh discipline • Child abuse/maltreatment • Parents/siblings model drug use • Parents have favorable attitude towards alcohol and/or drugs • Inadequate supervision • Low parental aspirations for child • Lack of or inconsistent discipline 	<ul style="list-style-type: none"> • School failure • Low commitment to school • Peer rejection • Deviant peer group • Peer attitudes toward drugs • Alienation from peers • Laws and norms favorable toward alcohol and drug use • Availability of and access to alcohol • Extreme poverty for antisocial children
Depression	<ul style="list-style-type: none"> • Temperament: apathy • Negative cognition about self and negative explanatory and inferential style • Anxiety • Dysthymia (chronically low mood) • Insecure attachment • Disengagement, involuntary and emotion-focused coping • Poor social skills: impulsive, aggressive, passive, and withdrawn 	<ul style="list-style-type: none"> • Parental depression • Poor parenting: rejection, lack of parental warmth, high hostility, harsh discipline, high maternal negative affect • Child abuse/maltreatment • Loss • Marital conflict or divorce • Aversive family environment 	<ul style="list-style-type: none"> • Peer rejection and poor quality peer relationships • Stressful life events • Poor grades/achievements • Poverty • Stressful community events, such as interpersonal conflict, separation, and loss (violence)
Anxiety	<ul style="list-style-type: none"> • Behavioral inhibition • Disgust sensitivity • Cognitive development allows cognitive errors 	<ul style="list-style-type: none"> • Parental anxiety • Parental over-control • Rejection • Anxious child-rearing • Parents model, prompt, and reinforce threat appraisals and avoidant behavior • Marital conflict; poor marital adjustment • Negative life events 	<ul style="list-style-type: none"> • Specific traumatic experiences • Negative events • Lack of control or mastery experiences

RISK FACTORS: Adolescence			
Individual		Family	Community (school)
Substance Abuse	<ul style="list-style-type: none"> • Negative emotionality (propensity towards negative emotions) • Behavioral disengagement coping (giving up) • Conduct disorder • Favorable attitudes toward drugs • Rebelliousness • Early substance use • Antisocial behavior 	<ul style="list-style-type: none"> • Substance abuse among parents • Lack of adult supervision • Poor attachment with parents 	<ul style="list-style-type: none"> • School failure • Low commitment to school • Not college bound • Aggression toward peers • Associating with drug-using peers • Societal/community permissive norms about alcohol and drug use
Depression	<ul style="list-style-type: none"> • Female gender • Early puberty • Difficult temperament: inflexibility, low positive mood, withdrawal, poor concentration • Negative cognitions such as low global self-worth, perceived incompetence, negative explanatory and inferential style • Anxiety • Dysthymia (chronically low mood) • Insecure attachment • Disengagement, involuntary and emotion-focused coping • Poor social skills: communication and problem-solving skills • Extreme need for approval/social support 	<ul style="list-style-type: none"> • Parental depression • Parent-child conflict • Poor parenting: rejection, lack of parental warmth, high hostility, harsh discipline, high maternal negative effect • Child abuse/maltreatment • Single-parent family (girls) • Divorce • Marital conflict • Family conflict • Aversive family environment 	<ul style="list-style-type: none"> • Peer rejection and poor quality peer relationships • Stressful events • Self-generated stressors • Poor grades/achievement • Poverty and low SES • Community-level stressful or traumatic events • Stressful community events, such as interpersonal conflict, separation, and loss (violence)
Anxiety	<ul style="list-style-type: none"> • Behavioral inhibition • Disgust sensitivity • Cognitive development allows cognitive errors 	<ul style="list-style-type: none"> • Marital conflict • Family conflict 	

RISK FACTORS: Young Adulthood			
Individual		Family	Community (school/work)
Substance Abuse	<ul style="list-style-type: none"> • Lack of commitment to conventional adult roles • Antisocial behavior 	<ul style="list-style-type: none"> • Leaving home 	<ul style="list-style-type: none"> • Attending college • Substance-using peers
Depression	<ul style="list-style-type: none"> • Early-onset depression and anxiety • Negative cognitions • Need for extensive social support 	<ul style="list-style-type: none"> • Parental depression 	<ul style="list-style-type: none"> • Decrease in social support accompanying entry into a new social context
Anxiety	<ul style="list-style-type: none"> • Childhood history of untreated anxiety • Childhood history of poor physical health • Childhood history of sleep and eating problems • Poor physical health 	<ul style="list-style-type: none"> • Spousal conflict • Single parenthood 	<ul style="list-style-type: none"> • Negative life events

Examples of Research-Based Protective Factors

Protective factors can reduce the negative impact of risk factors. Prevention is not just about eliminating a risky or harmful behavior; it is also about supporting protective factors—like resilience and development assets—and striving to optimize well-being.

The following table, compiled by the National Research Council and Institute of Medicine, shows the factors that affect healthy development at the individual, family, and school/community levels during specific stages of development from early childhood through young adulthood.² There is other research on protective factors throughout the lifespan.

PROTECTIVE FACTORS: Early Childhood		
Individual	Family	Community (school)
<ul style="list-style-type: none"> • Attention regulation • Appropriate emotional inhibitions and expression • Early mastery and intrinsic motivation • Executive functioning, planning, and problem solving • Secure attachment • Functional language • School attendance and appropriate conduct • Initiating interactions and appropriate conduct • Understanding of self and others' emotions 	<ul style="list-style-type: none"> • Reliable support and discipline from caregivers • Responsiveness • Protection from harm and fears • Affection • Opportunities to resolve conflict • Support for development of new skills • Reciprocal interactions • Experience of being respected • Stability and consistency in caregiver relationship • Adequate income • Ability to provide adequate nutrition, childcare, safe housing, health care • Higher parental education • Cognitive stimulation in the home • Parental low economic stress 	<ul style="list-style-type: none"> • Support for early learning • Access to supplemental services, such as feeding, and screening for vision and hearing • Stable, secure attachment to child-care provider • Low ratio of caregivers to children • Regulatory systems that support high quality of care

PROTECTIVE FACTORS: Middle Childhood		
Individual	Family	Community (school)
<ul style="list-style-type: none"> • Learning to read and write a language • Learning basic mathematics • Attending and behaving appropriately at school • Following rules for behavior at home, at school, and in public • Getting along with peers in school • Making friends with peers • Empathy and acceptance of other children's emotional expressiveness • Preference for pro-social solutions to interpersonal problems • Realistic control attributions • Self-efficacy 	<ul style="list-style-type: none"> • Time in emotionally responsive interactions with children • Consistent discipline • Language-based, rather than physically based, discipline • Extended family support • Parental resources, including positive personal efficacy, adaptive coping, self-views high on potency and life satisfaction 	<ul style="list-style-type: none"> • Positive teacher expectancies • Perceived teacher support • Effective classroom management • Positive partnering between school and family • Culturally relevant pedagogy • High academic standards, strong leadership, concrete strategies to promote achievement

PROTECTIVE FACTORS: Adolescence		
Individual	Family	Community (school)
<ul style="list-style-type: none"> • Positive physical development (good health habits, good health risk management skills) • Positive intellectual development (life, school, vocational skills; critical and rational thinking; cultural knowledge and competence) • Positive psychological and emotional development (self-esteem and self-regulation; coping, responsibility, problem-solving; motivation and achievement; morality and values) • Positive social development (connectedness to peers, family, community; attachment to institutions) 	<ul style="list-style-type: none"> • Physical and psychological safety • Appropriate structure (limits, rules, monitoring, predictability) • Supportive relationships with family members • Opportunities to belong (sociocultural identity formation, inclusion) • Positive social norms (expectations, values) • Support for efficacy and mattering • Opportunities for skill building • Integration of family, school, and community efforts 	<ul style="list-style-type: none"> • Physical and psychological safety • Appropriate structure (limits, rules, monitoring, predictability) • Supportive relationships • Opportunities to belong (sociocultural identity formation, inclusion) • Positive social norms (expectations, values) • Support for efficacy and mattering • Opportunities for skill building • Integration of family, school, and community efforts

PROTECTIVE FACTORS: Young Adulthood		
Individual	Family	Community (school/work)
<ul style="list-style-type: none"> • Identity exploration in love, work, and world view • Subjective sense of adult status in self-sufficiency, making independent decisions, and becoming financially independent • Future orientation • Achievement motivation 	<ul style="list-style-type: none"> • Balance of autonomy and relatedness to family • Behavioral and emotional autonomy 	<ul style="list-style-type: none"> • Opportunities for exploration in work and school • Connectedness to adults outside of family

INFORMATION SHEET 1.9 – SHARED RISK AND PROTECTIVE FACTORS

In 2012, SAMHSA's Center for the Application of Prevention Technologies (CAPT) reviewed literature concerning risk and protective factors for substance abuse and mental health disorders. Existing research and data suggest that there are a number of common or *shared* risk and protective factors throughout life that impact both substance abuse and mental health outcomes.

The four examples provided in this section illustrate only some of the shared risk and protective factors for childhood through young adulthood. There are other shared risk and protective factors for those age groups and for adulthood and older adulthood.

The tables below highlight two examples of **shared risk factors**. Note that each table has its own list of references separate from this overall document.

SHARED RISK FACTOR: Poor Grades/Achievement	
Definition	This indicator includes poor grades, poor/low academic performance or achievement, and school failure.
Risk Factor for	Poor grades/achievement is a risk factor for: depression ¹ ; substance abuse ^{2,3,4} ; binge drinking in adulthood ⁵ ; drug use among boys (related to IQ decline from age 11 to 18) ³ ; adolescent drug use/abuse ³ ; and increased alcohol and drug use between 7 th and 9 th grades. ⁶
Age Group(s)	Early childhood through adolescence
References	<ol style="list-style-type: none"> 1. National Research Council and Institute of Medicine. (2009). <i>Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities</i> (O'Connell, M. E., Boat, T., & Warner, K. E., Eds.) Washington, DC: National Academies Press. 2. Wright, D., & Pemberton, M. (2004). <i>Risk and protective factors for adolescent drug use: Findings from the 1999 National Household Survey on Drug Abuse</i> (DHHS Publication No. SMA 04-3874, Analytic Series A-19). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. 3. Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. <i>Psychological Bulletin</i>, 112(1), 64-105. 4. National Institute on Drug Abuse. (2003). <i>Preventing drug use among children and adolescents: A research-based guide for parents, educators, and community leaders</i> (2nd ed). Bethesda, MD: National Institutes of Health. 5. Courtney, K. E., & Polich, J. (2009). Binge drinking in young adults: Data, definitions, and determinants. <i>Psychological Bulletin</i>, 135(1), 142-156. 6. Chassin, L., Pitts, S. C., & Prost, J. (2002). Binge drinking trajectories from adolescence to emerging adulthood in a high-risk sample: Predictors and substance abuse outcomes. <i>Journal of Consulting and Clinical Psychology</i>, 70(1), 67-78.

SHARED RISK FACTOR: Family History of Substance Use Disorders	
Definition	Family history of substance use disorders can include, but is not limited to, exposure during childhood to: parental substance abuse; parental alcoholism; growing up in a household in which there is substance abuse; family drug behavior; parental and/or sibling modeling of drug/alcohol use
Risk Factor for	Co-occurring disorders; ^{1,2} non-comorbid major depressive episode; ³ non-comorbid substance use disorder; ³ comorbid PTSD and substance use disorder; ³ comorbid PTSD and major depressive episode; ³ alcohol, cocaine, or opioid dependence; ³ mood and anxiety disorders; ⁴ family history of substance abuse is a risk factor for lifetime alcohol use; ⁵ current alcohol use; ⁵ current binge drinking; ^{5,6} lifetime marijuana use; ⁵ current marijuana use; ⁵ increased alcohol and drug use between 7 th and 9 th grades; ⁶ early onset of drinking and persistence of alcohol use disorders; ⁷ substance abuse. ^{1,8,9} * <i>comorbid = a disease that occurs simultaneously with another; co-occurring</i>
Age of Exposure	Youth (Infancy through Adolescence) and Young Adulthood
References	<ol style="list-style-type: none"> 1. National Research Council and Institute of Medicine. (2009). <i>Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities</i> (O'Connell, M. E., Boat, T., & Warner, K. E., Eds.) Washington, DC: National Academies Press. 2. Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services. (n.d.). <i>CPS facts: Co-occurring disorders in adults</i> [PDF]. Retrieved from https://dmh.mo.gov/docs/mentalillness/cooccurringadults.pdf 3. Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. <i>Journal of Consulting and Clinical Psychology, 71</i>(4), 692-700. 4. Douglas, K. R., Chan, G., Gelernter, J., Arias, A. J., Anton, R. F., Weiss, R. D., Brady, K., Poling, J., Farrer, L., & Kranzler, H. R. (2010). Adverse childhood events as risk factors for substance dependence: Partial mediation by mood and anxiety disorders. <i>Addictive Behaviors, 35</i>(1), 7-13. 5. Harris Abadi, M., Shamblen, S. R., Thompson, K., Collins, D. A., & Johnson, K. (2011). Influence of risk and protective factors on substance use outcomes across developmental periods: A comparison of youth and young adults. <i>Substance Use & Misuse, 46</i>(13), 1604-1612. 6. Chassin, L., Pitts, S. C., & Prost, J. (2002). Binge drinking trajectories from adolescence to emerging adulthood in a high-risk sample: Predictors and substance abuse outcomes. <i>Journal of Consulting and Clinical Psychology, 70</i>(1), 67-78. 7. Chassin, L., Flora, D. B., & King, K. M. (2004). Trajectories of alcohol and drug use and dependence from adolescence to adulthood: The effects of parent alcoholism and personality. <i>Journal of Abnormal Psychology, 113</i>(4), 483-498. 8. Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. <i>Psychological Bulletin, 112</i>(1), 64-105. 9. Weitzman, M., Rosenthal, D. G., & Liu, Y. H. (2011). Paternal depressive symptoms and child behavioral or emotional problems in the United States. <i>Pediatrics, 128</i>(6), 1126-34.

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The following tables highlight two examples of **shared protective factors**. Note that each table has its own list of references separate from this overall document.

SHARED PROTECTIVE FACTOR: Parental Support and Bonding	
Definition	This indicator includes, but is not limited to: parents as a source of social support, parent and family bonding, relationship with the main caregiver, bonding to a family with healthy beliefs and clear standards, meaningful opportunities to contribute to the family, family connectedness, child attachment to parent, and recognition/ acknowledgement of efforts to bond with or contribute to the family. See also the protective factors of parental encouragement, and of positive parental involvement and reinforcement.
Protective Factor for	Substance use/abuse ^{1,4} ; problem alcohol use in adulthood ² ; lifetime mood and anxiety disorders ² ; drug use and initiation of drug use ³ ; suicidal thoughts ⁴ ; smoking initiation ⁵
Age Group(s)	Youth and young adults
References	<ol style="list-style-type: none"> 1. Wright, D., & Pemberton, M. (2004). <i>Risk and protective factors for adolescent drug use: Findings from the 1999 National Household Survey on Drug Abuse</i> (DHHS Publication No. SMA 04-3874, Analytic Series A-19). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. 2. Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., ... Udry, J. R. (1997). Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health. <i>JAMA</i>, 278(10), 823-832. 3. Douglas, K. R., Chan, G., Gelernter, J., Arias, A. J., Anton, R. F., Weiss, R. D., Brady, K., Poling, J., Farrer, L., & Kranzler, H. R. (2010). Adverse childhood events as risk factors for substance dependence: Partial mediation by mood and anxiety disorders. <i>Addictive Behaviors</i>, 35(1), 7-13. 4. Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. <i>Psychological Bulletin</i>, 112(1), 64-105. 5. Fleming, C. B., Kim, H., Harachi, T. W., & Catalano, R. F. (2001). Family processes for children in early elementary school as predictors of smoking initiation. <i>Journal of Adolescent Health</i>, 30(3), 184-189.

SHARED PROTECTIVE FACTOR: Participation in Social Activities	
Definition	Participation in social activities includes, but is not limited to, regular participation in organized school, neighborhood, or community sports, arts, or clubs outside of regular school and/or work hours. See also the protective factors of volunteering and participation in religious/spiritual activities.
Protective Factor for	Substance abuse; ^{1,2} lifetime mood and anxiety disorders; ³ stress and depression; ⁴ alcohol and marijuana use; ² depression & anxiety ²
Age Group(s)	Youth through adulthood
References	<ol style="list-style-type: none"> 1. Wright, D., & Pemberton, M. (2004). <i>Risk and protective factors for adolescent drug use: Findings from the 1999 National Household Survey on Drug Abuse</i> (DHHS Publication No. SMA 04-3874, Analytic Series A-19). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. 2. Benson, P. L., Scales, P. C., Hamilton, S. F., & Sesma, A., Jr. (with Hong, K. L., & Roehlkepartain, E. C.). (2006). Positive youth development so far: Core hypotheses and their implications for policy and practice. <i>Search Institute Insights & Evidence</i>, 3(1), 1-13. 3. Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. <i>Psychological Bulletin</i>, 112(1), 64-105. 4. Douglas, K. R., Chan, G., Gelernter, J., Arias, A. J., Anton, R. F., Weiss, R. D., Brady, K., Poling, J., Farrer, L., & Kranzler, H. R. (2010). Adverse childhood events as risk factors for substance dependence: Partial mediation by mood and anxiety disorders. <i>Addictive Behaviors</i>. 35(1), 7-13.

INFORMATION SHEET 1.10 – DEVELOPMENTAL PERSPECTIVE

A developmental approach to prevention helps to ensure that interventions have the broadest and most significant impact. Risk and protective factors and their potential consequences and benefits are organized according to defined developmental periods. This enables practitioners to match their prevention and promotion 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.

Stages of Development

Preventing behavioral problems begins with an understanding of how young people develop and how the challenges they face and overcome interact to produce changes in their mental and physical health over their lifetimes. As children grow, they progress through a series of developmental periods. Each of these periods is associated with a set of developmental competencies: cognitive, emotional, and behavioral abilities children need to adapt to new challenges and experiences.

Developmental competencies are critical, particularly as young people mature and begin to take on adult roles and responsibilities. The likelihood individuals will gain these competencies depends on the other competencies they have already mastered, and the risk and protective factors they encounter at each developmental stage.

Windows of Opportunity

When addressing risk and protective factors, timing is critical. Half of all behavioral disorders appear during adolescence. The first symptoms of most behavioral health disorders typical occur two to four years before diagnosis. In the case of substance abuse disorders, for example, initial symptoms appear around age fourteen—about four years before these symptoms progress to the point of a diagnosable disorder.

If we can intervene during these windows of opportunity— during the period between the time when symptoms can be first detected and disorders can be diagnosed—we are more likely to prevent the onset of the disorder and produce lasting and long-term impacts. And if we can intervene even sooner, to promote healthy lifestyles, our potential for reducing the toll of behavioral health problems on individuals, communities, and society is even greater.

Matching Interventions to Developmental Phase

Certain risk and protective factors are more common and influential during particular developmental periods. So it is important to match prevention and promotion efforts to the developmental needs and competencies of the population group the intervention will focus on.

Consider the following scenarios:

Scenario 1: A prevention and wellness committee of an urban elementary school reviews recent efforts to reduce substance abuse and improve behavioral health. The committee decides to address identified gaps in programming for kindergartners by implementing a program that focuses on healthy decision-making and critical-thinking skills.

Scenario 2: A community-wide substance abuse coalition identifies underage drinking as a primary focus for its prevention efforts; coalition members are concerned about alcohol being served at community events and that adults buy alcohol for minors. To address these problems, the coalition decides to implement Across Ages, an evidence-based intervention designed to increase protective factors for high-risk students by matching youth with older adult community mentors.

In both scenarios, the intentions are good but the developmental appropriateness is questionable since neither intervention matches the developmental phase of the population it serves, nor addresses the risk and protective factors most influential during that phase of development.

In the first scenario, the intervention addresses competencies that children develop later in life, during their middle-childhood and adolescence. A more appropriate intervention might be one that targets kindergarten teachers, helping them to provide better support for their students' behavioral health. In the second scenario, the intervention targets individual-level behavior change. A more effective approach might be to reduce social access to alcohol—by enforcing bans on serving and selling alcohol to minors.

Matching Interventions to Setting

It's also important to consider the "where" of an intervention. Children develop competencies in a range of settings. In just one day, a child might move from his home to school, then to afterschool day-care, then on to a neighborhood park to play with friends. Each of these settings plays a role in a child's development. As individuals progress through their youth and into adulthood, the significance of setting in shaping behavioral health evolves. For example, when individuals are very young, immediate family members play a key role in shaping development. But as children mature, their friends and peers become significantly more influential, which introduces new risk and protective factors in and out of school.

INFORMATION SHEET 1.11 – A PUBLIC HEALTH APPROACH

The focus of public health is on the safety and well-being of entire populations by preventing disease, rather than treating it.² The Institute of Medicine defines public health as follows:

“What we, as a society, do collectively to assure the conditions for people to be healthy.”¹¹

Therefore, a public health approach to behavioral health involves working with allied health professionals, families, schools, social services, neighborhoods, and communities to create conditions that will foster well-being.²

These important questions will be answered using the public health approach:

- What?** What substance use problems (or other behavioral problems such as mental health problems, suicide, and serious psychological distress) need to be addressed?
- Who?** Who will the interventions focus on—the entire population or a specific population group?
- When?** When in the lifespan—or at what specific developmental stage—is the population that the interventions will focus on? (e.g., adolescence, young adulthood)
- Where?** Where should the interventions take place? Prevention needs to take place in the 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 or influence 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.

Key Characteristics of a Public Health Approach

Promotion and Prevention¹²

A public health approach promotes the conditions that foster health and well-being, and prevents the occurrence of disease.

- **Promotion** seeks to *optimize well-being* by addressing the determinants of health—the biological, physical, geographical, social, and economic factors that impact health.
- **Prevention** aims to *reduce behavioral health problems* by addressing the determinants of health.
- Promoting well-being and preventing behavioral health problems require that interventions include every setting in which the population has meaningful interactions.

Population-based¹²

A public health approach concentrates on the health of entire populations, rather than at the individual level.

- The focus is on changing a population's behaviors to reduce the likelihood of disease, and addressing the factors that contribute to disease.
- Population-based interventions use public policy as a key tool. Some policies are regulatory while others are programmatic or involve resource allocation.
- A public health approach uses multi-level interventions as part of a comprehensive and coordinated effort.

Risk and Protective Factors

A public health approach addresses determinants of health—the biological, physical, geographical, social, and economic factors¹² that contribute to the positive or negative health of a population. Risk factors are associated with a higher likelihood of behavioral health problems. Protective factors are associated with a lower likelihood of behavioral health problems.¹³

- Some risk factors are associated with specific disorders, while others can be linked to multiple behavioral health problems.¹¹
- Risk and protective factors have been shown to influence each other and to have a cumulative effect over time.¹¹
- Promotion and prevention focuses on addressing the factors that are part of the social, economic, physical, or geographical environment that contribute to good and poor health and that can be influenced by programs, policies, and practices.¹²

Multiple Contexts

Individuals are influenced by different contexts such as their own biology and psychology; their family, community, and culture; and society. In a public health approach, it is therefore important to look at the context to understand what might be influencing the problem and to determine how to make changes within that context in order to reduce risk factors and promote protective factors.

- A comprehensive plan to reduce behavioral health problems and promote well-being includes a combination of interventions targeting risk and protective factors in multiple contexts.¹³
- Since multiple contexts influence health and well-being, it's important to collaborate with professionals in different sectors such as education, justice, law enforcement, etc.

Developmental Perspective²

A public health approach considers the developmental stage of life of the individuals or groups that are the focus of interventions to improve health and prevent disease.

- As individuals grow from infancy, they progress through a series of developmental periods. Each of these periods is associated with a set of developmental competencies: cognitive, emotional, and behavioral abilities.
- Human development might look different in different cultures and with people who have disabilities.
- Certain risk and protective factors affect healthy development at different periods.
- Trauma during youth can impact adult development.¹⁴
- People are more vulnerable to substance abuse and other behavioral health problems when they have experienced untreated, unresolved trauma.¹⁵
- Interventions should be appropriate for the specific developmental stage of the population they target.

Planning Process

A public health approach utilizes a planning process that is active, deliberate, and ongoing.

- 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 effectiveness of this prevention planning process begins with a clear understanding of community needs and depends on the involvement of community members in all stages of the process.
- The SPF is dynamic, deliberate, and ongoing. Each of the steps will be explained in greater detail later in the training.

REFERENCES

- ¹ Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's role and actions 2011-2014* (HHS Publication No. (SMA) 11-4629). Rockville, MD: Author.
- ² National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities* (O'Connell, M.E., Boat, T., & Warner, K.E., Eds.) Washington, DC: National Academies Press.
- ³ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>
- ⁴ Miller, T. R., & Hendrie, D. (2009). *Substance abuse prevention dollars and cents: A cost-benefit analysis* (DHHS Publication No. (SMA) 07-4298). Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.
- ⁵ Swarbrick, P. (1997). A wellness model for clients. *Mental Health Special Interest Section Quarterly*, 20, 1–4.
- ⁶ Dunn, H. L. (1959). High-level wellness for man and society. *American Journal of Public Health and the Nation's Health*, 49(6), 786-92.
- ⁷ Substance Abuse and Mental Health Services Administration. (2017, October 24). *The eight dimensions of wellness* [Website]. Retrieved from <https://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness>
- ⁸ World Health Organization. (2018). *Health promotion* [Website]. Retrieved from www.who.int/topics/health_promotion/en
- ⁹ National Prevention Council. (2011). *National prevention strategy: America's plan for better health and wellness*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. Retrieved from <https://www.surgeongeneral.gov/priorities/prevention/strategy/index.html>
- ¹⁰ Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's working definition of recovery*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from <http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF>
- ¹¹ Committee for the Study of the Future of Public Health, Division of Health Care Services. (1988). *The future of public health*. Washington DC: National Academies Press.
- ¹² Miles, J., Espiritu, R. C., Horen, N. M., Sebian, J., & Waetzig, E. (2010). *A public health approach to children's mental health: A conceptual framework*. Washington, DC: Georgetown University Center for child and Human Development, National Technical Assistance Center for Children's Mental Health.
- ¹³ Center for Substance Abuse Prevention. (2011). Identifying and selecting evidence-based interventions: Revised guidance document for the Strategic Prevention Framework State Incentive Grant Program (HHS Publication No. (SMA)09-4205). Rockville, MD: Author.
- ¹⁴ Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards V., ... Marks, J. S. (1998). The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine*, 14, 245–258.
- ¹⁵ Centers for Disease Control and Prevention (2016, April 1) *Adverse childhood experiences (ACEs)* [Website]. Retrieved from <https://www.cdc.gov/violenceprevention/acestudy/index.html>