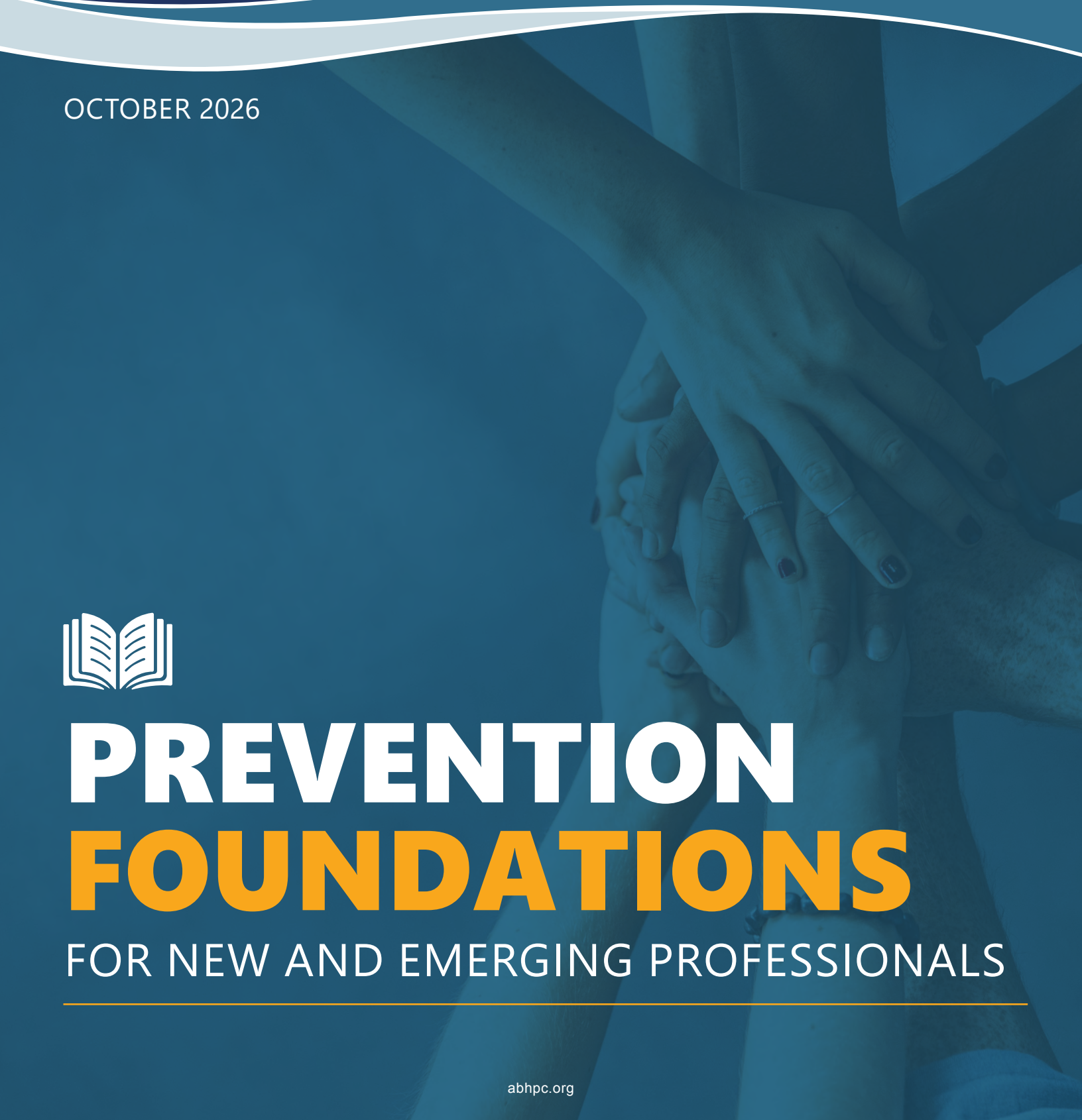
DHCS | Advance Behavioral Health Prevention California

OCTOBER 2026



PREVENTION FOUNDATIONS

FOR NEW AND EMERGING PROFESSIONALS

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PORTFOLIO INTRODUCTION

Welcome! This portfolio has been thoughtfully designed for entry-level and newly established prevention professionals. The topics covered in this portfolio provide a roadmap for early success in your behavioral health prevention career and provide introductory knowledge on content related to state and national behavioral health prevention priorities, the Strategic Prevention Framework (SPF), the Social Drivers of Health (SDOH), best practices in substance use disorder (SUD) primary prevention, and more. Although the content addressed in this portfolio is critical for success in SUD prevention, this is not a comprehensive resource. As the authors of this portfolio continue developing resources, it is suggested to continue to explore these concepts through ongoing training, research, networking, and your prevention practice.



WHAT IS ADVANCE BEHAVIORAL HEALTH PREVENTION CALIFORNIA (ABHPC)?

Advance Behavioral Health Prevention California (ABHPC) is an innovative training and technical assistance (TTA) program for behavioral health services in California. Specialized in substance use disorder (SUD) primary prevention efforts and rooted in a community-centered approach, ABHPC offers training events, consultation, professional development opportunities, workforce sustainability initiatives, and the advancement of culturally appropriate and relevant services in primary prevention. All services are free of charge to primary prevention providers and professionals in California.

ABHPC is funded by the California Department of Health Care Services (DHCS) with TTA administered through the Center for Applied Research Solutions (CARS). The CARS ABHPC TTA team works proactively in coordination with DHCS and a pool of subject matter experts to provide services and meet statewide TTA needs. Through this tailored approach, participants in ABHPC TTA spaces can network, discuss, and directly engage with the ABHPC consultant team when taking part in training events, community of practice spaces, customized training requests, and consultation opportunities.

As a part of the DHCS Big 5 by 2025 initiative, ABHPC focuses on SUD prevention TTA and the advancement of behavioral health in a variety of ways. The program strives to reach prevention providers and professionals throughout California in meaningful, person-centered ways. TTA uplifts evidence-based strategies, empirical research, and is aligned with national prevention standards through the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP). Services also consider the social drivers of health and community needs in the delivery of SUD primary prevention efforts.



"ALPHABET SOUP" – COMMON PREVENTION ACRONYMS AND TERMS

1. Frameworks, Practices, and General Terms

» **AOD:** Alcohol, Tobacco, and Other Drugs

» **CSAP Six Primary Prevention Strategies:**

- ***Definition:*** The six primary prevention strategies to develop and implement a comprehensive prevention system delivery required by the Code of Federal Regulations (see CSAP Six Primary Prevention Strategies section for more details): Information Dissemination; Education; Alternatives; Problem Identification and Referral; Community-Based Process; and Environmental.

  Source: DHCS Primary Prevention Data Quality Standards and Definitions

» **EBP:** Evidence-Based Practices

- ***Definition:*** A program, activity, or strategy with the highest degree of proven effectiveness via research and evaluation. The Evidence-Based Practices Resource Center provides communities, clinicians, policymakers and others with the information and tools to incorporate evidence-based practices into their communities or clinical settings.

  Source: Evidence-Based Practices Resource Center, SAMHSA Resources and Publications

» **HiAP:** Health in All Policies

- ***Definition:*** Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

  Source: Health in All Policies, A Guide for State and Local Governments

» **PP:** Promise Practice

- ***Definition:*** A program, activity, or strategy that has worked within one organization and shows promise for becoming a best practice.
- Programs or practices that have some evidence indicating effectiveness but do not yet have enough research to be classified as evidence-based.

  Source: SAMHSA Resources and Publications

» **SDOH:** Social Drivers (Determinants) of Health

- ***Definition:*** SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

  Source: Healthy People 2030

» **SPF:** Strategic Prevention Framework

- ***Definition:*** A planning process developed by SAMHSA to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. (see SPF section for more details).

  Source: SAMHSA SPF

» **SPF:** Strategic Prevention Framework

- ***Definition:*** A planning process developed by SAMHSA to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. (see SPF section for more details).

  Source: ABHPC

2. Federal/State and Partner Entities; Funding

» **ABHPC:** Advance Behavioral Health Prevention California

- ***Definition:*** ABHPC provides Training and Technical Assistance services to primary prevention providers across California at no cost through DHCS funding for the Center for Applied Research Solutions.

  Source: ABHPC

» **CalPOP:** California Prevention Outcomes Partnership

- ***Definition:*** CalPOP is California's statewide prevention partnership that strengthens county capacity and supports shared outcomes across the continuum of prevention. Its mission is to empower state and local partners to improve substance use prevention by assessing needs, guiding prevention planning, and elevating data-informed outcomes across the behavioral health spectrum.

  Source: CalPOP

» **CARS:** Center for Applied Research Solutions

- ***Definition:*** A California-based nonprofit dedicated to enriching the behavioral and public health field by promoting evidence-based practice and workforce development. CARS provides training, consultation, and coaching to individuals, organizations, and initiatives.

  Source: CARS

» **CHKS:** California Healthy Kids Survey

- ***Definition:*** The California Healthy Kids Survey (CHKS) is an anonymous, confidential survey of school climate and safety, student wellness, and youth resiliency. It is administered to students at grades five, seven, nine, and eleven. It enables schools and communities to collect and analyze data regarding local youth health risks and behaviors, school connectedness, school climate, protective factors, and school violence. CHKS is a collaborative project between the California Department of Education (CDE), WestEd, and the KidsData.org website. Query CHKS allows users to generate tables, maps, graphs, and charts comparing key CHKS data among district, county and with the state.

  Source: California Department of Education

» **CSAP:** Center for Substance Abuse Prevention

- ***Definition:*** A national entity under SAMHSA focusing on promoting effective prevention strategies to reduce substance use and misuse and its related problems. **Mission:** CSAP provides leadership and collaborates across sectors to advance prevention across the lifespan. CSAP works to prevent **initiation** of substance use, prevent **progression** of substance use, and prevent and reduce **harms** associated with substance use.

  Source: SAHMSA, Center for Substance Abuse Prevention

» **DHCS:** Department of Health Care Services

- ***Definition:*** The California Department of Health Care Services (DHCS) is the backbone of California's health care safety net, helping millions of Californians every day. DHCS' purpose is to provide access to quality health care, leading to a healthy California for all.

  Source: DHCS

» **IOM:** Institute of Medicine (now the National Academy of Medicine)

- ***Definition:*** Provides expert advice on biomedical science, medicine, and health. The mission is to advance science, inform policy, and catalyze action to achieve human health and well-being.

  Source: National Academy of Medicine

» **SAMHSA:** Substance Abuse and Mental Health Services Administration

- ***Definition:*** The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA envisions that people with, affected by, or at risk for mental health and substance use conditions receive care, achieve well-being, and thrive.

  Source: SAMHSA

» **SUBG:** Substance Use Prevention, Treatment, and Recovery Services Block Grant

- ***Definition:*** SUBG is a federal grant administered by SAMHSA. The California DHCS distributes SUBG funds to local governments, enabling them to provide SUD services or contract with local providers.



FUNDING ORIGINS AND PREVENTION FRAMEWORKS

Effective prevention programs and interventions are essential to improving public health outcomes. Substance Use Disorder (SUD) primary prevention funding, frameworks and partners aim to reduce the burden of mental health diagnoses, SUDs, chronic diseases, and other public health challenges. SUD prevention incorporates a range of strategies, from policy development to funding mechanisms, and underscores the importance of early intervention and community-based programs.

Origins of Public Health Funding and SUD Prevention

The roots of public health prevention funding trace back to early 20th-century health policies that focused on disease control and prevention. In the United States, the establishment of government agencies such as Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control (CDC), alongside state health departments like Department of Health Care Services (DHCS), laid the groundwork for an organized, sustained effort in public health prevention.

- **SAMHSA's Role:** Founded in 1992, SAMHSA's core mission is to reduce the impact of substance use and misuse and mental health challenges. SAMHSA has evolved to include prevention programs targeting substance use and misuse, mental health challenges, and co-occurring disorders.

- **Healthy People Initiative:** Established in 1979, the Healthy People initiative provides a framework for identifying the nation's health priorities and establishing measurable health objectives. The 2030 iteration continues this tradition by focusing on measurable health objectives and addressing differences in health outcomes through prevention.

- **DHCS and State Health Programs:** The establishment of DHCS was central to California's public health system, particularly in delivering accessible health care programs (like Medi-Cal) and integrating behavioral health into primary care. As a state-level health agency, DHCS plays a critical role in facilitating and managing prevention programs aimed at improving the mental and physical health of residents.

Funding Mechanisms for Prevention Programs

1. **Federal Funding:**
    - **SAMHSA Grants:**[13] SAMHSA is a primary source of funding for substance use and mental health prevention programs. SAMHSA provides competitive grants to local, state, and Tribal governments, as well as nonprofits, to fund a wide array of prevention, treatment, and recovery support services.

- **CDC and Office of Juvenile Justice and Delinquency Prevention (OJJDP) Grants:**[14, 15] These agencies fund prevention programs focused on behavioral health, chronic diseases, and youth risk factors, particularly in high-risk communities. The CDC offers grants for disease prevention and health promotion, while the OJJDP funds youth-focused prevention initiatives.

- **Drug-Free Communities (DFC) Coalition Grant:**[16] Administered by the White House Office of National Drug Control Policy and SAMHSA, the DFC grant supports community coalitions in preventing youth substance use through collaboration and evidence-based strategies.

2. **State Funding:**

   - **DHCS Funding for Prevention:**[17] DHCS provides state-level funding for health care and mental health services, including the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG). DHCS funds public health campaigns, SUD treatment, and mental health services, with an emphasis on addressing identified community needs.

3. **Community-Based and Collaborative Funding:**

   - Partnerships with nonprofit organizations like WestEd[18] and California Department of Public Health (CDPH)[19] help fund local programs that target prevention, particularly in schools and communities with high need. Collaborative funding models also integrate research, evaluation, and program delivery to ensure the effectiveness and sustainability of initiatives.

Focus on SUBG: Substance Use Prevention, Treatment, and Recovery Services Block Grant

1. **SUBG**, formerly known as the Substance Abuse Prevention and Treatment Block Grant (SABG), is a federal grant administered by SAMHSA. The California DHCS distributes SUBG funds to local governments, enabling them to provide SUD services or contract with local providers.[20]

2. **20% Primary Prevention:** A requirement of the SUBG is that 20% of the funds be spent on primary prevention services, which are strategies, programs, and services for people who have not been determined to need treatment for a SUD. California continues to prioritize prevention and as a result DHCS increased the county Primary Prevention Set Aside from 20% to 25% of the total award. The SUBG supports activities that align with the Center for Substance Abuse and Prevention Six Primary Prevention Strategies and use the Institute of Medicine Continuum of Care.

3. **Friday Night Live (FNL) and SUBG;** FNL is an integral part of the SUBG in California, aligning with state prevention goals to reduce youth substance use. FNL focuses on

positive youth development by providing funding and support for county-level programs that empower young people to lead and implement prevention initiatives in their communities.

Prevention Contributors and Partners

1. Centers for Disease Control and Prevention (CDC)

- The CDC works to protect public health through research, monitoring, and prevention programs. The agency addresses critical health issues such as infectious diseases, chronic conditions, and environmental health threats.

  Key Contributions: Leads public health surveillance efforts and provides evidence-based guidelines. Partners with SAMHSA, DHCS, and others to support behavioral health and substance use and misuse prevention. Offers grants and resources to support community-based health initiatives.



2. Office of Juvenile Justice and Delinquency Prevention (OJJDP)

- The OJJDP is part of the U.S. Department of Justice and focuses on improving the juvenile justice system. Their work ensures that at-risk youth have access to services that prevent juvenile delinquency and address mental health and substance use concerns.

  Key Contributions: Provides funding to community organizations focused on youth prevention and intervention programs. Collaborates with SAMHSA to integrate mental health and substance use and misuse services into juvenile justice reform.

3. California Department of Public Health (CDPH)

- CDPH is dedicated to improving the public health and well-being of California's residents. The department focuses on a variety of health issues, including chronic disease prevention, immunizations, and the promotion of mental and behavioral health.

  Key Contributions: Collaborates with DHCS and SAMHSA to enhance statewide public health policies. Addresses social drivers of health through community engagement and local health initiatives.

4. WestEd



- WestEd is a nonprofit agency focused on advancing education and health systems to promote learning and development in various communities. Their work involves research and evaluation, providing insights to improve policy and practice in public health and education.

  Key Contributions: Partners with agencies like DHCS and SAMHSA to deliver evidence-based research for policy reforms. Supports state and local educational systems in addressing mental health and substance use within school environments. West Ed works in partnership with California Schools to support the data collection, analysis, and workshops related to the California Healthy Kids Survey (CHKS)



ROLE OF PREVENTION PROVIDERS

Substance Use Disorder (SUD) prevention providers play a critical role in reducing the prevalence and impact of substance use and misuse within individuals, families, and communities. Prevention professionals and organizations operate to implement prevention services across systems of care in various settings.

Systems of care include governmental agencies that administer health care, social services, public health, justice, academic services, and most important, the communities themselves. SUD prevention providers are essential for creating healthier communities by addressing substance use. Collaboration across all levels is crucial to achieve comprehensive prevention. Continued investment in prevention efforts will allow providers to innovate and expand their reach.

This document outlines some of the roles and responsibilities of SUD prevention providers and emphasizes the importance of collaboration and evidence-based practices.

Shared Responsibilities Across All Levels

Despite their unique roles, all SUD prevention providers share common responsibilities:

- **Civic Engagement to Sustain Prevention Funding:** Ensuring availability of ongoing resources for prevention programs.
- **Capacity Building:** Offering training and technical assistance to staff and partners.
- **Access to Prevention Services:** Identifying barriers to prevention services and supporting access to appropriate prevention services.
- **Assessment:** Ongoing data collection to identify SUD priorities and differences in health outcomes as well as evaluation of current prevention practices and programs to demonstrate impact or need for change.

County-Level Providers

- Responsible for program development and strategic oversight.
- Coordinate and fund local prevention initiatives.
- Collect and analyze data to identify trends and implement evidence-based strategies.
- Champion for policies that prioritize prevention.
- Regularly evaluate program outcomes to ensure effective resource use.

Community-Level Providers

» Raise awareness about substance use risks and promote healthier behaviors.

» Partner with local organizations to deliver targeted interventions.

» Foster environments that support healthy behaviors by organizing events and campaigns.

» Address social drivers of health, such as access to substances and community norms.

School-Based Providers

» Deliver age-appropriate curricula on substance use risks, life skills, resiliency, and peer pressure resistance skills.

» Identify at-risk students and offer support services or connect students to prevention partners.

» Partner with caregivers to create supportive home environments that promote SUD prevention practices that include a no-use message and perception of harm regarding youth use.

Health Care and Social Service Providers

» Integrate substance use prevention into routine care.

» Use preventative, non-diagnostic screening tools to identify individuals at risk for SUDs.

» Educate participants about the dangers of substance use and promote healthy choices.

Law Enforcement and Justice System Providers

» Focus on reducing substance use among individuals involved with law enforcement.

» Provide alternatives to incarceration, such as drug courts and diversion initiatives.

» Collaborate with community prevention providers on outreach and education efforts.

CULTURAL RESPONSIVENESS AND COMMUNITY STRENGTHS IN PREVENTION SERVICES

Why Cultural Responsiveness?

Successful prevention requires understanding the populations and communities being served and incorporating that understanding throughout planning, implementation, and evaluation. Individuals and communities may experience different circumstances that affect health, access to services, and participation in prevention programs. These circumstances can include economic conditions, geographic location, language, transportation, availability of services, family and community supports, and other social drivers of health.

Considering these factors can help practitioners develop prevention strategies that are relevant, accessible, and responsive to community needs.

Understanding Community Context

Health and well-being are influenced by a range of individual, family, community, and societal factors. Community conditions can develop over time and may affect access to health care, education, housing, employment, transportation, and other resources.

Understanding local conditions can help prevention practitioners identify needs, recognize existing strengths and resources, and select strategies that are appropriate for the populations and communities they serve. Prevention efforts can be strengthened when practitioners consider both the challenges communities experience and the resources, relationships, knowledge, and skills they already possess.

Community Cultural Wealth (CCW):

"Community Cultural Wealth," a framework developed by Tara J. Yosso,[5] identifies forms of knowledge, skills, relationships, and resources that communities may draw upon. The framework describes six forms of capital: Linguistic, Aspirational, Familial, Social, Navigational, and Resistant Capital.

Understanding community strengths and resources can help practitioners identify opportunities to make prevention services more relevant and responsive to the populations they serve.

Let's explore how each of these forms of capital can transform health practices...

» **Linguistic Capital (The Power of Communication):** Language and communication are important resources within communities. Practitioners can build on linguistic capital by considering the languages and communication preferences of the populations they serve. For example, partnering with trusted community organizations to provide health education in multiple languages can help make information easier to understand and access.

» **Aspirational Capital (Uplifting Dreams and Goals):** Individuals, families, and communities bring goals, hopes, and aspirations that can support positive health outcomes. Practitioners can build on these strengths by connecting prevention activities with the goals that are important to participants. For example, wellness programs can incorporate goal setting related to long-term health, reducing substance use, or other personally meaningful milestones.

» **Familial Capital (Honoring Relationships and Traditions):** Family relationships, traditions, and shared experiences can be important sources of knowledge and support. Practitioners can consider these strengths when developing prevention programs and activities. For example, health screenings or educational activities may be incorporated into family or community events when appropriate. Aligning services with community practices can help encourage participation and strengthen connections.

» **Social Capital (Strengthening Networks of Support):** Social networks can provide information, resources, encouragement, and practical support. Practitioners can build on these networks by working with trusted community leaders, organizations, and other local partners. These relationships can help practitioners better understand community needs, share prevention information, and connect individuals and families with available resources.

» **Navigational Capital (Guiding Through Complex Systems):** Health care and social service systems can be difficult to navigate. Challenges may include transportation, language, scheduling, insurance requirements, or limited availability of services. Community health workers, peer navigators, and other support professionals can help individuals understand available services, schedule appointments, identify transportation options, and navigate insurance or other administrative processes.

» **Resistant Capital (Empowering Civic Engagement and Resilience):** Communities may draw on shared knowledge, experience, and collective action to address challenges and improve local conditions. Practitioners can support these efforts by listening to community concerns, strengthening partnerships, and working with community members and organizations to identify practical solutions that support health and well-being.

Consider this: Communities already use a variety of strengths and resources that reflect the dimensions of Community Cultural Wealth. For example, social capital can be seen in networks of mutual support, such as faith-based groups, neighborhood associations, and community organizations that share health information and connect people with resources.

Familial capital can be reflected in the role families and other support networks play in encouraging healthy behaviors and helping individuals access services.

Linguistic capital is evident in the way communities share vital information in native languages through trusted local leaders or community-led initiatives.

Navigational capital can be demonstrated when community members help one another understand and access health care, social services, and other resources.

Recognizing these existing strengths can help practitioners build stronger partnerships and develop prevention approaches that respond to local needs.

Community Case Study: Community-based initiatives can demonstrate how local strengths, relationships, and resources support prevention efforts. Examples of community strengths may include partnerships with trusted local organizations, health education and outreach, assistance accessing health care and insurance, and support from community health workers. Examining these types of approaches can help prevention practitioners consider how community knowledge, relationships, and resources can inform prevention efforts in their own communities.

Commitment to Cultural Responsiveness and Safety

Culturally responsive prevention services recognize that individuals and communities bring different experiences, needs, strengths, and perspectives to prevention programs. Practitioners can support effective participation by creating environments that are respectful, welcoming, and responsive to the populations they serve.

Physical safety includes providing environments in which participants feel protected and comfortable. Emotional and psychological safety can be supported by treating participants with respect, listening to their concerns, communicating clearly, and creating opportunities for meaningful participation.

Practitioners can strengthen prevention services by approaching community members with curiosity and respect, recognizing existing strengths, and building relationships that support trust and collaboration. These practices can help create prevention programs that are responsive to community needs and support positive health and well-being.

Land and Labor Acknowledgements[6]

Indigenous land acknowledgments are historically significant and vital practices that go beyond simply recognizing the occupied land, but that honor the history, resilience and ongoing contributions of Indigenous peoples and their stewardship of the land. Meaningful acknowledgments begin with researching the local Tribes and consulting Tribal leaders to understand their preferences and priorities, including opportunities for community accountability, such as participation in events or civic engagement efforts. Both virtual and in-person spaces must include tailored land acknowledgments to ensure accountability

and respect for Indigenous communities in all prevention settings. By embedding these acknowledgments into our practices, we center awareness, honor history and present-day suffering, and commit to supporting Indigenous efforts moving forward.

Acknowledgments and Key Ideas:

- Always reference your local Tribal leaders for guidance and understanding on the way in which they prefer to be acknowledged along with guidance on any opportunities for community accountability (i.e. upcoming events, monthly civic engagement efforts, etc.).
- Research about the local Indigenous land and Tribe is part of the acknowledgment process.
- Concrete action steps are encouraged to help participants continue providing support.
- There is a difference in virtual and in-person land acknowledgments, both should be acknowledged as mandatory in prevention work.

Examples:

1. Beyond Land Acknowledgment Guide - Native Governance Center
2. Indigenous Land Acknowledgment Guide - Native Governance Center
3. Indigenous Land Acknowledgment - Native Governance Center
4. Labor Acknowledgment – Seattle Colleges

Commitment to Responsive Prevention Services

Not only are culturally responsive services vital to prevention, but these concepts are built into the Prevention Specialist Code of Ethics from the International Certification and Reciprocity Consortium.[8] The principles of non-discrimination, competency, and nature of services outline appropriate conduct for prevention specialists around service delivery, knowledge, competency, and a commitment to lifelong learning around health outcomes and cultural responsivity.

Learn more: Read the Prevention Specialist Code of Ethics from the International Certification and Reciprocity Consortium (IC&RC)

STRATEGIC PREVENTION FRAMEWORK (SPF)

Overview



Over the centuries, people have recognized the harms that come from substance use and misuse and have tried many ways to prevent those harms. In the modern era, some promote the idea that simply saying "no" will work. Others try sharing horror stories about the effects of substances on users. Others provide substance-free activities or hand out brochures. These and other strategies work sometimes, but they don't work all the time.

To provide a model that works reliably and predictably, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the Strategic Prevention Framework[9] (SPF), a five-step model to plan and implement effective, evidence-based initiatives to prevent substance use and misuse and related harms.

The basic premise of the SPF is that communities must plan before acting. Actions must be based on a clear understanding of local community needs, actively involve community members, and make use of data to drive planning, implementation and evaluation. The SPF challenges us to collaborate with key partners, to recognize the many influencing factors that lead to substance use and misuse, and to think strategically about intended outcomes and how to best achieve those outcomes—all while centering the voices of the community.

The SPF has two guiding principles integrated into each of its five steps:

» **Cultural Responsiveness** (referred to in the SPF as "cultural competence") helps ensure that prevention programs are developed, delivered, and evaluated in ways that are relevant and effective for the populations they are intended to serve. Strategies to support cultural responsiveness include understanding the unique needs and strengths of a priority population, including the priority population in prevention planning and delivery, training prevention staff, and tailoring evidence-based practices to a priority population.

» **Sustainability** is the capacity to maintain outcomes over time. Prevention staff may come and go. Funding may come and go. New problems may arise. Old problems may resurface. The ability to maintain services over time, despite changes to staffing, funding, and organizations, creates sustainable programs and outcomes.

Using the Strategic Prevention **Framework** results in a locally created Strategic Prevention **Plan**. The plan describes a community's challenges with substance use and misuse and outlines concrete, evidence-based steps to handle those challenges.

The Five Steps

1. **Assessment** involves systematic gathering and examination of data related to substance use and misuse and related problems, as well the conditions that lead to substance use/ misuse, and the consequences substance use and misuse have on people's lives. There are two broad categories of data: quantitative and qualitative. Quantitative data is information that can be counted or measured and given a numerical value. It tells us how many, how much, how severe, or how often things happen. Qualitative data, on the other hand, is narrative rather than numeric. It's based on stories and observation rather than numbers. Qualitative data tells us why and how things happen, why they happen, where they happen, how ready people are to do the necessary work, what resources might be needed, and the impact substance use and misuse has on people's lives.

To understand substance use, misuse, and substance use disorders, you need information about:

» **Consumption** – e.g., what substances are consumed in what quantities, by whom, and how often.

» **The factors that contribute to consumption** – e.g., risk and protective factors, social drivers of health, adverse childhood experiences, traumatic life events.

» **The consequences of consumption** – e.g., accidents, hospitalizations, overdoses, academic failure, incarceration, removal of family members from the home, fatalities

» **Capacity to get the work done** – e.g., the resources you have, and those you need, including how knowledgeable and ready your community is to engage in the work.

To get quantitative data, you can look at the California Healthy Kids Survey, public health departments records, law enforcement records, hospitals and emergency room data, school records, and social services departments.

To get qualitative data, conduct:

» **Interviews with key informants** – e.g., community leaders, elders, law enforcement officials, school personnel, emergency room doctors, people personally impacted by substance use and misuse.

» **Focus groups** – Interviews conducted in groups with people linked by a common theme, e.g., all of similar demographic characteristic, experience, or prevention need; are parents of substance using children; are people with histories of substance use and misuse.

» **Open ended-questionnaires and surveys** – Disseminated through traditional methods such as classrooms, community events, or online using listservs and social media.

After collecting the qualitative and quantitative data about consumption, contributing factors, consequences and capacity, data is analyzed.

2. **Capacity Building.** All communities already have some capacity to prevent substance use and misuse. But sometimes the resources on hand are not up to the challenges, and additional resources are needed, such as more funding, more personnel, more community awareness and involvement, and more organizational support. Additional forms of capacity are discussed in the "Community Cultural Wealth" section of this portfolio. Each Strategic Prevention Plan includes a capacity building element where communities describe their capacity needs and the steps they will take to build that additional capacity. A critical consideration in capacity-building efforts is involving community champions, including local stakeholders as well as the rights holders of the land and local traditions.

3. **Planning.** In an effective planning process, communities engage with various community partners, review data and envision the outcomes they would like to see. Community planners consult with registries of evidence-based programs and practices to see what has worked for others and what might work for them. Communities end up creating a comprehensive, evidence-based prevention action plan and logic model that can address priority substance use and misuse problems and meet their intended outcomes.

4. **Implementation** is putting the Strategic Prevention Plan into action. Since what you implement is based on the data collected during the assessment phase and on both the capacity you have and additional capacity you build, your Plan replaces guesswork, intuitions, and hunches with evidence-based programs and practices. Sometimes evidence-based programs can be implemented with fidelity; sometimes they must be adapted to better reflect the attitudes, beliefs, experiences, culture, and values of your community and focus populations.

5. **Evaluation.** The goal of implementing prevention strategies is to create change. So, it is important to measure change to see if you're getting the outcomes you intended. Effective evaluation helps monitor activities, decide whether they are working, and whether they should continue.

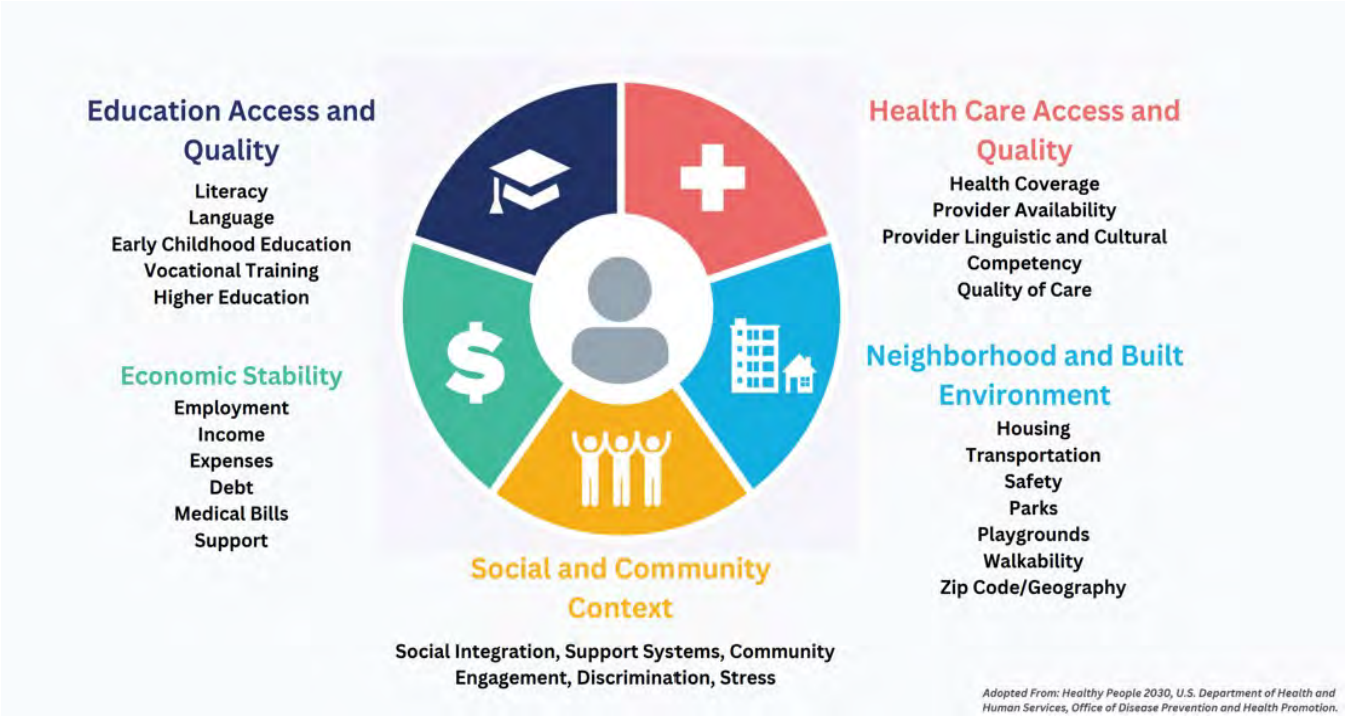
   To ensure cultural responsiveness and sustainability, each step of the SPF—from collecting and analyzing data, to developing a capacity building plan, to formulating an evidence-based prevention plan, to implementing that plan and evaluating its results—all are done with your community, with its stakeholders, rights holders, and with those most personally impacted by substance use.

   To learn more about the Strategic Prevention Framework, check out SAMHSA's Strategic Prevention Framework guide

SOCIAL DRIVERS OF HEALTH (SDOH)

The social drivers of health, also called the social determinants of health (SDOH)[4] are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect health, functioning, and quality-of-life outcomes.

They exist across the domains of risk and protective factors, including individual, relational (family, peer, and school), and community factors. SDOH can also influence health-related risks and behaviors. Although SDOH can affect individuals and families, they are often shaped by broader community and societal conditions.



Being healthy is about much more than having access to medical care. Health is impacted by multiple factors (the “drivers” in the SDOH model), including income and expenses, the availability of adequate transportation, educational quality, neighborhood safety, housing quality, nutritional value of available food, and other social and environmental conditions.

Around the circle in the diagram above are the five commonly recognized social drivers of health. Each of these drivers is a factor that either supports or creates barriers to health and well-being. The stronger these factors are in people’s lives, the more resilient they are. The weaker they are, the more vulnerable people are to poor physical and behavioral health, including being at risk for substance use and misuse.

SDOH may contribute to differences in health outcomes across populations. Addressing these factors can therefore support health outcomes for individuals and communities. In the context of substance use disorder prevention work, it is critical to align SDOH considerations with

prevention risk factors, protective factors, priorities, and outcomes. Please see the “Risk and Protective Factor Theory” section for more information.

Additional Resource: Read 5 Bites: Understanding the Social Drivers of Health in Substance Use Disorder Primary Prevention



THE CENTER FOR SUBSTANCE ABUSE PREVENTION'S SIX PRIMARY PREVENTION STRATEGIES (CSAP-6)

How is substance use disorder (SUD) prevention implemented? Substance Abuse and Mental Health Services Administrations' Centers for Substance Abuse Prevention (CSAP) identified six strategies that reliably promote prevention.[11] They are commonly referred to as the CSAP-6. Some of the six are effective by themselves, while others are only effective if paired with a strategy that is already effective by itself.

1. **Information Dissemination:** This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

    a. **Service Activity Examples Include:** Social media posts, brochures, flyers, billboards, and public service announcements. Information dissemination is necessary, but insufficient, to prevent SUD. Since, for example, you cannot ask a question of a brochure, information dissemination has a limited scope.

2. **Education:** The strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator and/or facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages) and systematic judgement abilities.

    a. **Service Activity Examples Include:** Classroom educational services, youth or adult groups, mentoring, parenting classes, and peer-leader programs.

3. **Alternatives:** This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use. The assumption is that engaging in constructive, healthy activities reduces the appeal of alcohol, tobacco, and other drugs, or fulfills the needs they often meet, thereby minimizing or preventing their use.

    a. **Service Activity Examples Include:** Free social and recreational activities, sober graduations and proms, community drop-in centers, community service activities, and youth/adult leadership activities.

4. **Problem Identification and Referral:** This strategy aims to identify individuals who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those who have engaged

in their first use of illicit drugs, to assess if their behavior can be reversed through education. It should be noted that this strategy does not include any activity designed to determine if a person needs treatment.

a. **Service Activity Examples Include:** Employee assistance programs, student assistance programs, and prevention screening.



5. **Community Based Processes:** This strategy aims to enhance the community's ability to provide effective prevention and treatment services for alcohol, tobacco and other drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.

   a. **Service Activity Examples Include:** Organizing, planning, enhancing the efficiency and effectiveness of prevention service implementation, interagency collaboration, coalition building, networking, and creating strategic prevention plans.

6. **Environmental:** This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to the service and action-oriented initiatives

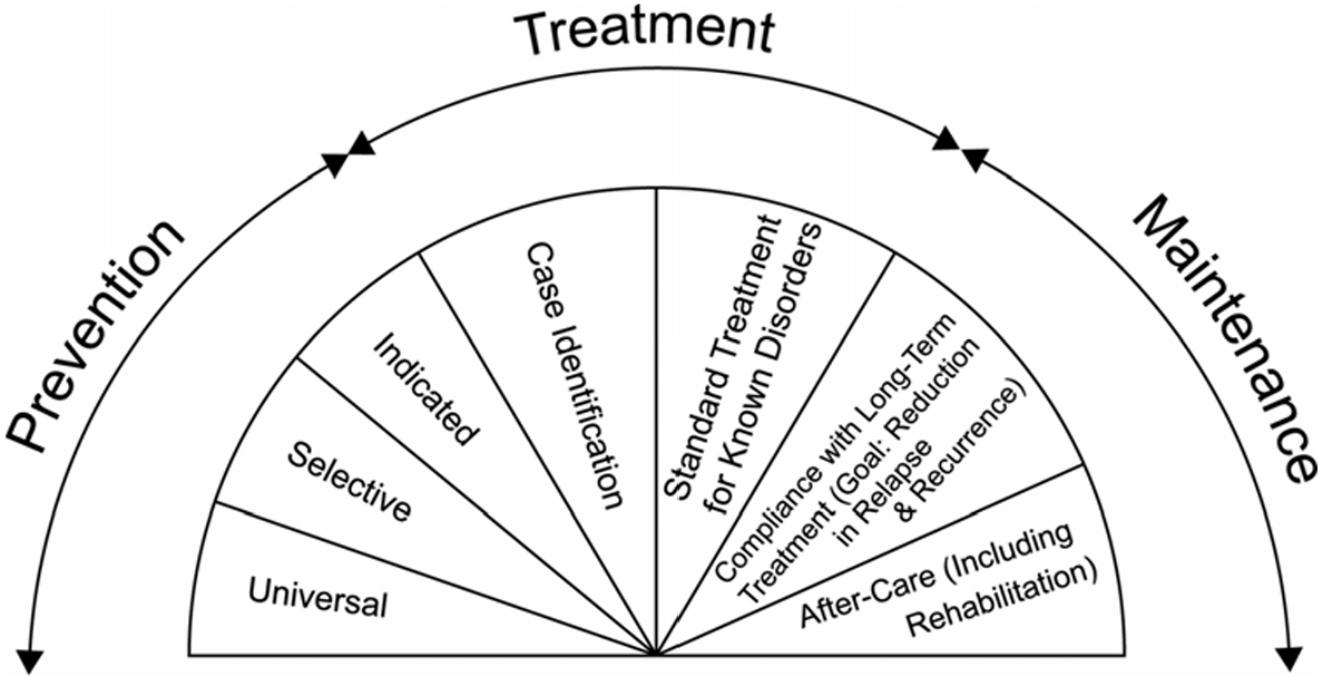
   a. **Service Activity Examples Include:** Promoting the establishment and review of alcohol, tobacco and drug use policies in schools; Technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco and other drug use; Modifying alcohol and tobacco advertising practices; and Product pricing strategies.

NOTE:

Harm reduction strategies are not included in the CSAP-6 as they are not considered primary prevention. The goal of primary prevention is to stop disorders from developing before they start. Harm reduction is a set of strategies and ideas aimed at reducing the negative consequences of substance use for those already using substances. To learn more about DHCS' harm reduction effort visit California Overdose Prevention and Harm Reduction Initiative - DHCS Opioid Response.

CONTINUUM OF CARE

In 1994, the Institute of Medicine (IOM)—now called the National Academy of Medicine—developed a continuum of care model that the behavioral health field adopted to describe prevention, treatment, and recovery services.[12] It's illustrated below, and it's often called the "IOM Protractor."



The model is divided into three sections: prevention, treatment, and maintenance. The prevention arc is further divided into universal, selective and indicated prevention services.

Definitions

Universal prevention strategies address the general public or a segment of the entire population with average probability of developing a substance use disorder (SUD), risk, or condition. A school assembly attended by all students without regard for individual students' potential risk factors is an example of a universal prevention strategy. A public awareness campaign like Alcohol Awareness Month is another example. The campaign addresses everyone, including people who used to drink but now don't, people who never drink, and people who never will.

Selective prevention strategies serve specific sub-populations whose risk of a disorder is significantly higher than average. A support group for youth who come from homes where drugs and alcohol are used daily is an example of a selective intervention. Such youth have a higher-than-average risk of substance use and misuse themselves, even if they haven't started. A selective prevention strategy helps to reduce the risk that they will develop a SUD.

Indicated prevention strategies address individuals who have used substances and who have minimal but detectable signs or symptoms suggesting a disorder. Problem Identification and Referral, or an after-school group for youth found under the influence of a substance while on school grounds, are examples of an indicated prevention strategy. Indicated prevention aims to reverse early use of a substance thereby preventing a SUD from developing.

Note that all three strategies fall under the general category of primary prevention—that is, stopping a disease or disorder before it starts. The treatment arc of the IOM protractor doesn't begin until case identification (diagnosis) is made. If prevention strategies are insufficient to reverse a person's use of substances, a referral to a licensed clinician is in order. The clinician will assess whether the person meets the criteria for a diagnosis of SUD.



DEFINING SUBSTANCE USE DISORDER AND IDENTIFYING COMMONLY USED AND MISUSED SUBSTANCES

Understanding what prevention aims to address can be helpful when discussing prevention efforts. Substance use disorder is a mental health condition involving patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects. This definition is from the 5th edition of the Diagnostic and Statistical Manual (DSM-5),[21] which is considered the "gold standard" reference for the names, symptoms, and diagnostic features of recognized mental health conditions, including addiction.

The DSM-5 identifies 11 symptoms, or criteria, for substance use and misuse. These criteria fall under four basic categories—impaired control, physical dependence, social problems and risky use. The following criteria are published in the DSM-5 as follows:

1. Using more of a substance than intended or using it for longer than you're meant to.
2. Trying to cut down or stop using the substance but being unable to.
3. Experiencing intense cravings or urges to use the substance.
4. Needing more of the substance to get the desired effect—also called tolerance.
5. Developing withdrawal symptoms when not using the substance.
6. Spending more time getting and using drugs and recovering from substance use.
7. Neglecting responsibilities at home, work or school because of substance use.
8. Continuing to use even when it causes relationship problems.
9. Giving up important or desirable social and recreational activities due to substance use.
10. Using substances in risky settings that put you in danger.
11. Continuing to use despite the substance causing problems to your physical and mental health.

Three Levels of Severity

Like other illnesses, substance use and misuse worsens over time. The SUD criteria explained in the DSM-5 allow clinicians to determine how severe a SUD has become depending on how many symptoms are present. For example:

» One symptom could indicate an individual is at risk.

» Two or three criteria point to a mild SUD.

» Four or five symptoms indicate someone has a moderate SUD.

» Six or more criteria indicate a severe SUD, which signals an addiction to that substance.

NOTES:

1. A person must have two or more of these symptoms to get a diagnosis of SUD. Once someone is diagnosed with SUD, they are no longer recruited to participate in prevention services. In a broad sense, what the prevention field works to do is help people have no more than one of these eleven symptoms.
2. A trained clinician makes a diagnosis of SUD. Trained clinicians include psychiatrists, psychologists, licensed clinical social workers, and drug counselors specializing in addiction. Prevention professionals who do not have this training or relevant degrees/ certifications, and/or who are acting in the role of a prevention professional, are not able to make these diagnoses.

Commonly Used and Misused Substances

There are 10 commonly used and misused substances that the prevention field addresses. Eight of the most commonly used and misused substances are:

» **Alcohol:** In small amounts, alcohol is a stimulant. It can promote feelings of euphoria and confidence. But when it's consumed in quantities greater than the body can process at any one time, it becomes a central nervous system depressant, meaning that it slows down brain functioning and neural activity. It also reduces the functioning of various vital functions in the body. According to the 2024 National Survey on Drug Use and Health (NSDUH), 27.9 million people ages 12 and older (9.7% of this age group had alcohol use disorder in the past year.[22]

» **Cannabis:** Cannabis is a mind-altering (psychoactive) drug. Its effects vary from person to person, and even in the same person at different times. It can be a stimulant, a depressant, and a hallucinogen. In California, use of cannabis (also called marijuana, pot, weed, and grass) is legal for those 21 and older, but it is so abundant that it is easy to access by people younger than 21. According to the CDC,[23] Cannabis is the most commonly used federally illegal drug in the United States; 52.5 million people, or about 19% of Americans, used it at least once in 2021. The risk of developing cannabis use disorder is great for people who begin to use it before age 18.

» **Opioids:** Opioids are a class of drugs made directly from the opium poppy (morphine, codeine) or are synthesized (fentanyl, oxycodone [OxyContin®], hydrocodone [Vicodin®]); as well as the illegal drug, heroin. Opioids by themselves, or in combination with other substances, are one of the main drivers of drug overdoses in the country.[24] According to the CDC, estimated overdose

deaths involving opioids declined from 55,296 in 2024 to 44,564 in 2025. Despite this decline, opioid-related overdose remains a significant public health concern.[25]

» **Stimulants:** Stimulants are a class of drugs that increase the speed of the body's systems, including the nervous system. In low doses, they can make a person feel euphoric, increase alertness, and create heightened feelings of well-being. In higher doses, they can lead to anxiety, nausea, tremors, seizures, coma, and death. Common stimulants include legal substances such as caffeine and nicotine; prescription medications such as amphetamines, Adderall, methylphenidate (Ritalin); and illicit substances such as methamphetamines (speed) and cocaine.[26]

» **Hallucinogens:** Hallucinogens are drugs that alter a person's sense of reality and can lead to hearing, seeing, tasting, smelling, or feeling things that are not real. There are three broad categories of hallucinogens: psychedelic drugs, dissociative drugs, and others that have hallucinogenic effects but are neither psychedelic nor dissociative. Psychedelic drugs can affect a person's sense of self and result in visual changes. Drugs in this category include LSD (lysergic acid diethylamide; also commonly referred to as acid), DMT (N,N-Dimethyltryptamine), mescaline, and psilocybin. Dissociative drugs can result in a person feeling disconnected from their body and surroundings. Drugs in this category include ketamine and PCP (phencyclidine or phenylcyclohexyl piperidine). Other non-classified hallucinogens include MDMA (3,4-methylenedioxymethamphetamine; also commonly referred to as molly or ecstasy) and salvia.[27]

» **Inhalants:** Inhalants produce chemical vapors that are inhaled to induce psychoactive or mind-altering effects. They are found in common household products such as paint, aerosol products, cleaning fluids, and others. Commonly called huff, rush, and whippets, their effects wear off quickly, leading some to repeated use.[27]

» **Sedatives:** Sedatives are a broad class of prescription medications that slow the activity of the central nervous system.[28] Common types include benzodiazepines and barbiturates. Sedatives are used to treat a variety of conditions, including anxiety, insomnia, tension, seizures, and panic disorders. They can also be used as an anesthetic. The potential for addiction is very high.

» **Hypnotics:**[29] Hypnotics are a class of drugs used to induce and/or maintain sleep. Common brands include Ambien, Halcion, Lunesta, Seconal, Sonata, and Benadryl. Benadryl is also found in many over-the-counter remedies for allergies, colds, and headaches.

NOTE:

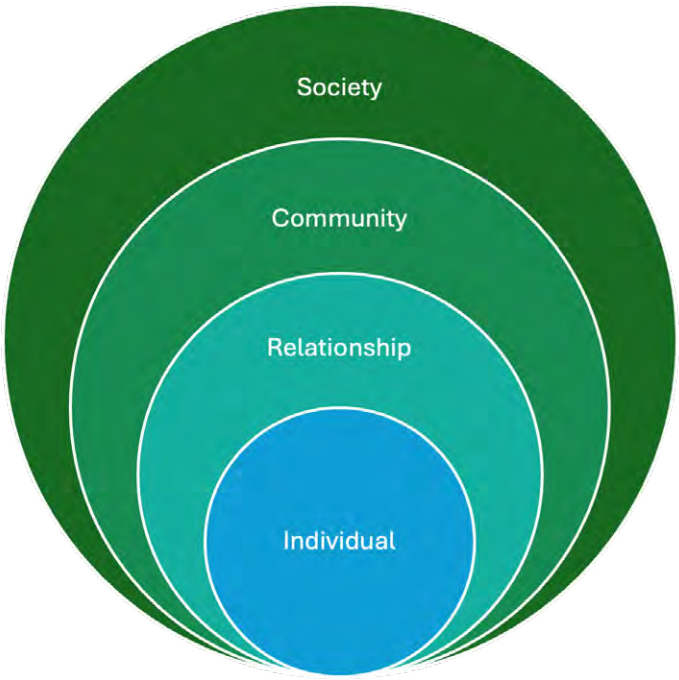
The DSM-5 also lists caffeine and tobacco as commonly used and misused drugs.

NOTE:

In the prevention field, substance use disorder (SUD) is generally recognized as the behavioral health condition targeted by prevention efforts. Licensed clinicians are more specific and may refer to someone as having "cannabis use disorder" or "alcohol use disorder" or "caffeine use disorder," etc. [32]

SOCIO-ECOLOGICAL MODEL

The Socio-Ecological Model identifies the domains in which people interact with their environments.[9] These include the individual, relationship, community, and society levels. It is best to visualize them as concentric circles—the smallest domain exists within each larger domain, and so forth.



Each domain holds unique influences on a person's behavior, including risk and protective factors related to substance use and misuse and behavioral health. Understanding these domains can help appropriately map prevention efforts.

The **individual domain** refers to a person's characteristics or circumstances such as genetics, age, income, and health.

The **relationship domain** is considered a person's social circle – peers, family (whether biological or "chosen" family), close friends, co-workers, teachers, and others.

The **community domain** refers to the locations of the individual and where their relationships occur such as a person's neighborhood, school, and place of work.

The **society domain** covers broader factors including the influence of social and cultural norms and the policies that govern a person's community.

The Socio-Ecological Model is a useful tool alongside other frameworks such as the Social Drivers of Health, the Strategic Prevention Framework, the Continuum of Care, and others.

You will notice that the domains of the Socio-Ecological Model are aligned with the domains of the Risk and Protective Factor Model. This is covered in the following section.

For more information on the Socio-Ecological Model, you can check out the following resources:

» CDC: About Violence Prevention

» UNICEF's Global Multisectoral Operational Framework (PDF)

RISK AND PROTECTIVE FACTOR THEORY

Background

Risk and protective factor theory is a framework used to understand why certain individuals or groups are more likely to experience specific challenges. Risk factors are conditions at the biological, psychological, family, community, or cultural levels that increase the likelihood of negative outcomes. In contrast, protective factors are conditions at these same levels that either reduce the likelihood of negative outcomes or mitigate the impact of risk factors. These protective factors can also be seen as positive counteracting influences.

Prevention efforts that aim to reduce negative outcomes should focus on addressing the most relevant risk factors while strengthening the protective factors connected to the issue at hand.

Key Insights [30]

1. **Risk and Protective Factors Operate Across Multiple Domains**
   Risk and protective factors exist within various domains, including the individual, relationships (family, peers, and others), community, and society. These domains overlap and interact with each other. While some researchers identify more domains, the five listed here are key examples of where risk and protective factors can be found.

   a. **Individual Domain:** This includes genetic, biological, and psychological characteristics that either make someone vulnerable to or resilient against behavioral health challenges. Risk factors in this domain might include genetic predisposition to substance use or prenatal alcohol exposure, while protective factors could include self esteem, refusal skills, or strong social skills.

   b. **Family Domain:** Risk factors here can include poor supervision, child abuse, having incarcerated family members, or living with relatives who face behavioral health issues such as substance use disorders or mental health conditions. Protective factors include consistent parental involvement, good supervision, and open communication within the family.

   c. **Peer Domain:** Risks in this domain include susceptibility to peer pressure, rejection by peers, or associating with peers who engage in substance use. Protective factors include a strong sense of self-efficacy, refusal skills, involvement in substance-free after-school activities, and opportunities to pursue personal interests.

   d. **Community Domain:** Risk factors in communities might involve living in neighborhoods affected by poverty, violence, food insecurity, lack of transportation, or limited access to health care. Protective factors include the availability of community resources like faith-

based organizations, after-school programs, job training, food banks, and affordable health care services.

e. **Societal Domain:** At a societal level, risk factors can include laws and social norms that support substance use, economic instability, and broader social or structural conditions that may negatively affect individuals and communities. Protective factors include policies that limit substance availability, efforts to promote healthy societal norms, and actions that strengthen community health, safety, and well-being.

2. **Risk and Protective Factors Are Correlated and Cumulative**
   Risk factors are often correlated with one another, meaning individuals who experience one risk factor are likely to encounter others. Similarly, risk factors tend to be negatively correlated with protective factors, meaning that individuals with multiple risk factors are less likely to have protective factors in their lives. The effects of risk and protective factors also tend to accumulate. Young people exposed to multiple risk factors are more likely to develop behavioral health issues, while those with several protective factors are at a lower risk.

3. **Risk and Protective Factors Influence Individuals Over Time**
   Risk and protective factors can have lasting effects throughout an individual's life. For instance, factors like poverty or family dysfunction in early life can contribute to mental health or substance use challenges later on. Additionally, factors in one domain (such as family) can influence or be influenced by factors in other domains. Research shows that effective parenting can help mitigate the effects of multiple risk factors, such as poverty, divorce, or parental mental illness.

Using a Shared Risk and Protective Factor Approach:[31]

SAMHSA identifies a fourth key feature in risks and protective factors: individual factors can be associated with multiple problem behaviors. What does this mean? Simply put, even though prevention interventions are frequently designed to address a single behavioral health outcome, they can often impact several risk and protective factors that are associated with multiple outcomes.

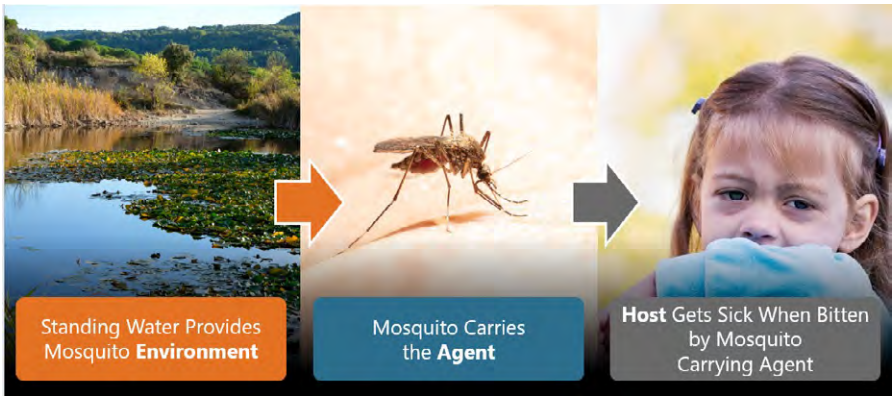
A shared risk and protective factor approach acknowledges that numerous risk and protective factors are associated with many health and quality-of-life outcomes, including substance use and misuse prevention. As a result, an appropriately selected substance use and misuse primary prevention program or policy, especially in the context of evidence-based strategies, may not only impact substance use outcomes, but also additional outcomes such as mental health, violence prevention, trauma prevention, and more.

THE PUBLIC HEALTH APPROACH

The public health approach is one of the models for preventing substance use and misuse. This approach was originally developed to explain how diseases are transmitted. It has also been expanded to explain how behavioral health conditions spread. The public health approach describes a three-prong relationship between an environment, an agent, and a host.[32]

In a classic example of how diseases spread, the parasite that spreads malaria lives in standing water (the environment). Mosquitoes that require standing water to lay their eggs get infected by the parasite (the agent). The mosquito then bites a person (the host), and malaria spreads. To prevent malaria, standing water could be drained (changing the environment); mosquitoes could be killed by poison or predation thereby killing the parasite (changing the agent); or people could be vaccinated against malaria (changing the host.)

Applied to substance use prevention, the legalization of cannabis for adults in California in 2016 (a change in the legal environment) created an abundant supply of cannabis (the agent), as people who never grew cannabis suddenly legally could. This led to more youth (the host) having access to cannabis.



Prevention of cannabis use and misuse could involve changing the law or enforcing laws more consistently (changing the legal environment), limiting supply through law enforcement (changing the agent) or educating youth and adults about the possible harms to youth from using cannabis (changing the host).



WHAT DOESN'T WORK IN PREVENTION

People outside of the substance use and misuse prevention field may be most familiar with the types of "prevention" tactics that are the least effective. These methods are often intended to be eye-catching and can evoke strong emotion—hence the attention they receive—but they often lack the lasting effects aimed for in prevention and can even have the opposite of the desired effect. Below are some of the strategies that, while popular, are not effective for substance use and misuse prevention:[34, 35]

- **Highlighting the "bad" stuff:** Statistics are a powerful tool for educating the public and understanding the scope of a problem. You may have seen posters or public service announcements making statements such as "30% of college students binge drank in the last month!" While the information may be correct, and the poster or announcement will draw attention, messages like this can normalize the emphasized behavior—even when the behavior is in the minority. A more effective prevention method would flip the phrasing around: "70% of college students did NOT binge drink in the last month!" reminding college students that binge drinking is not the norm, and that they are capable of not engaging in the behavior.

- **Scare tactics and visually shocking demonstrations:** Events such as mock car crashes can evoke strong emotions. However, research around these events does not show any long-lasting effect on substance use behavior. These demonstrations can also be triggering for people who have experienced relevant traumatic events. Use of scare tactics about drug use can spark mistrust of a messenger, especially if the audience has knowledge of facts that contradict that message.

- **Single meetings and fact sheets:** While these strategies are easy to implement, one-time meetings and distribution of fact sheets are not shown to have long-lasting effects on behavior. Seeing a fact sheet that includes the "positive" effects of a substance can pique a young person's interest in trying that substance, even if the negative side effects are listed – and this does not leave any avenues to follow up with the audience. It's important to develop and implement follow-up strategies and action plans to support the desired effect with the priority population.

Fortunately, providers do not need to start from scratch to implement effective substance use and misuse prevention programs. Resources such as The Athena Forum's Best Practices Toolkit and others can be used to search for evidence-based programs and practices for substance use prevention that best fit the needs of the population you are working with.

For more information about ineffective prevention tactics, check out the resources used in this section:

- Washington State Health Care Authority: Prevention Tools—What Works, What Doesn't (PDF)

- Prevention Technology Transfer Center Network: What Research Shows Does Not Work in Substance Misuse Prevention (PDF)

SUBSTANCE USE PREVENTION EVIDENCE-BASED RESOURCE (SUPER)

The Substance Use Prevention Evidence-Based Resource (SUPER) is a centralized resource designed to provide California counties, behavioral health providers, and tribal entities with clear and concise information about evidence-based, promising, and innovative substance use prevention and mental health wellness and promotion practices.

SUPER has a searchable list of evidence-based and promising practices in substance use prevention for providers using prevention set-aside funds from the Substance Use Prevention, Treatment and Recovery Services Block Grant. Additionally, SUPER now features evidence-based and promising practices in mental health wellness and promotion that address risk factors associated with both mental health and substance use.

SUPER includes an overview of essential concepts in substance use prevention and mental health wellness and promotion, along with detailed information about prevention strategies, risk and protective factors, practice components, and levels of evidence to choose practices that best match conceptual fit, practical fit, and evidence of effectiveness that align with your county, community, and/or local prevention programming goals and outcomes related to SAMHSA-aligned foundational prevention knowledge. To support prevention planning, SUPER links to Prevention Resources and to Advance Behavioral Health Prevention California for training and technical assistance support related to SAMHSA-aligned foundational prevention knowledge.

What Are Evidence-based Practices (EBPs?)

EBPs are programs and practices that have documented empirical evidence (e.g., randomized controlled trials, peer-reviewed studies) of effectiveness in improving outcomes. EBPs are clinically reviewed and codified, and manualized to ensure implementation fidelity.[35]

What Is a Community-Defined Evidence Practices (CDEP?)

CDEPs are behavioral health practices that are developed by, adapted for, or strongly supported within a specific community. These practices are informed by community knowledge, experience, needs, and preferences and are intended to provide relevant and effective behavioral health support.[35]

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