SCA PREVENTION NEEDS ASSESSMENT AND PLANNING PROCESS
SUMMARY REPORT: 2018-2020

The purpose of this report is to outline the recent needs assessment and planning process created by the Department of Drug & Alcohol Programs (DDAP), in partnership with the Evidence-based Prevention and Intervention Support (EPIS) project at Penn State, and completed by Single County Authorities (SCA). This report aims to summarize the substance misuse problems and risk/protective factors most prioritized by SCAs across the state, while also discussing common themes related to assessing resources and developing an action plan.

Beginning in September 2018, DDAP unveiled a systematic and data-driven needs assessment process for the SCAs to evaluate their respective county's drug and alcohol problems. The process was constructed utilizing components from the Public Health Model, the Strategic Prevention Framework, and the Communities That Care model. Professionals from forty-seven (47) SCAs across sixty-seven (67) counties attended one of six (6) regional trainings before engaging in the process with their respective county's needs assessment team. This statewide roll-out was preceded by a pilot process that included three (3) individual county SCAs and a three-county joinder SCA. A graphic outlining the six-step process can be seen in Figure 1. From beginning to end (Phases A – F), the process took SCA's approximately fifteen (15) months to complete.

Phases A & B *"What are the problems?"* Consumptions & Consequences	**Phase C** *"Why are the problems occurring?"* Risk/Protective Factors	**Phase D** *"Why are the problems occurring HERE? "* Contributing Factors
Phase E *"What resources are available?"* Resource Assessment	**Phase F** *"What are we going to do?"* SMART Goals & Action Planning	**Phase G** *"Is our plan having its desired impact?"* Plan Implementation & Evaluation

Figure 1

PHASES A & B of the Needs Assessment focused on analyzing county specific consumption and consequence data, and was designed to assist each SCA in answering the question, "**WHAT** are the problems in our county?" In Figure 2, per the county SCAs, you will find the most prioritized youth consumption behaviors across the state – with alcohol (38%), vaping (31%) and marijuana (20%) comprising the majority of the youth consumption problems. [1] Youth alcohol use was identified as a priority for 60 counties, vaping for 48 counties and marijuana for 31 counties. When SCAs prioritized a consequence in their problem

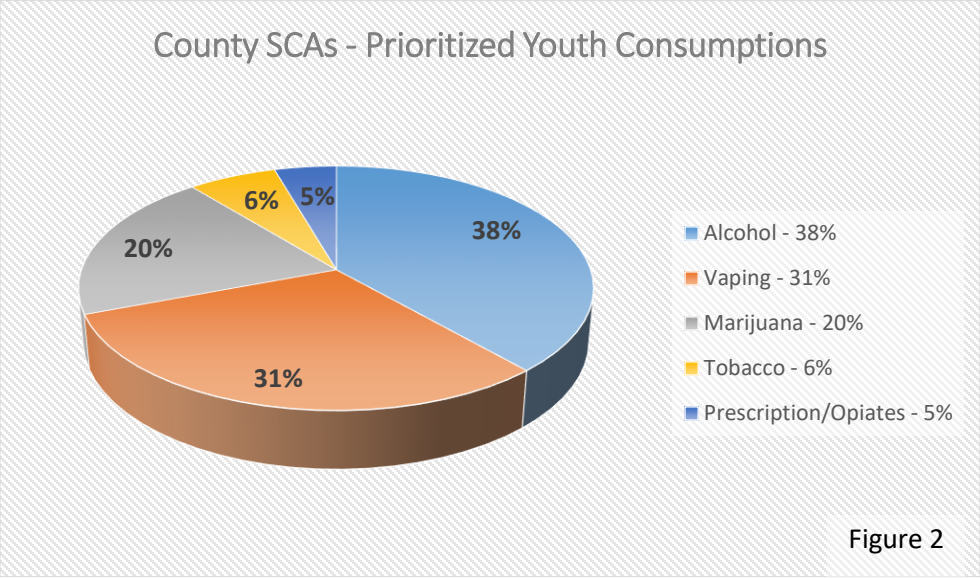


Figure 2

[1] The percentage associated with each substance represents the frequency in which it was prioritized, as compared to all of the **youth** problems across each county (SCAs selected a range of one to six problems within each county).

statement (such as youth DUI arrests or juvenile liquor law violations) the substance most influencing that consequence was included in this summary report within its respective consumption category.

In order to prioritize youth problems, SCAs analyzed data from the PA Youth Survey (PAYS), PA Uniform Crime Report, PennDOT Crash Fact & Statistics Report, PA Department of Education Safe Schools Report and other localized data sources that were available to them. In order to narrow the focus on their most pressing issues, SCAs were trained to apply the concepts of **Magnitude** *(Which is the largest or impacting the most people?),* **Severity** *(How bad is the outcome? Is it resulting in mortality? Is it more costly?),* **Time-trends** *(Is the problem getting better or worse over time?)* and **Comparison** *(How does the problem compare to other counties and/or the state?)*.

In **PHASE C**, SCAs began to identify the most problematic risk factors (or lowest protective factors) within their respective counties. Through data analysis (primarily of risk/protective factor data in their county specific PAYS report) and with consideration to the problems identified in PHASES A AND B, SCAs applied the concepts of **Level of Importance** *(How much is the risk/protective factor influencing the problem?) and* **Changeability** *(Is there adequate capacity to change the risk/protective factor in a reasonable amount of time?)* to help answer the question, "**WHY** are the problems occurring in our county?". As you can see below in Figure 3, Low Perceived Risk of Alcohol, Tobacco and Other Drugs (ATOD) (27%), Access & Availability and/or Perceived Availability (18%), Laws & Norms Favorable to ATOD Use (14%), and Parental Attitudes Favorable to ATOD Use (14%), were the risk factors most frequently selected by the SCAs for their youth substance use problems.[2]

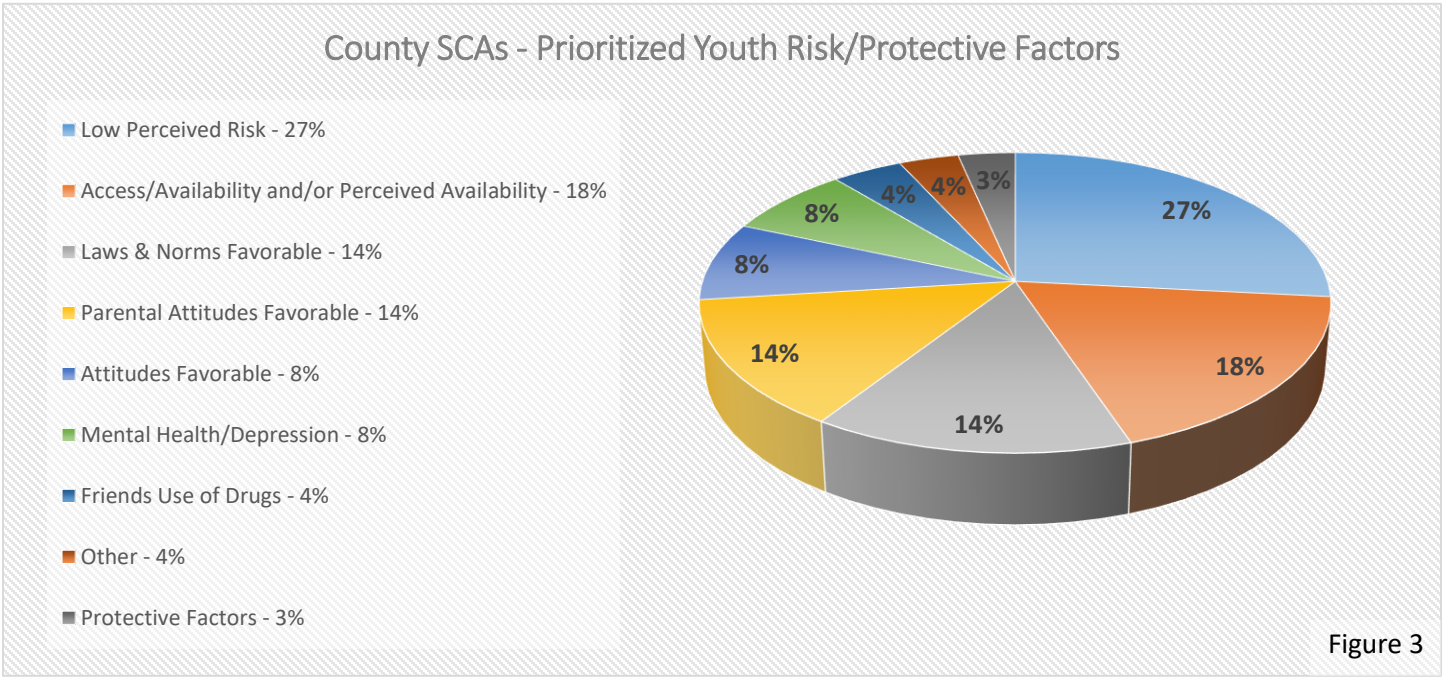


Figure 3

[2] The percentage associated with each risk/protective factor represents the frequency in which it was prioritized, as compared to all of the **youth** risk/protective factors prioritized across the state (SCAs were asked to prioritize one to three risk/protective factors per problem).

In addition to prioritizing youth problems, SCAs also analyzed adult level data and selected at least one adult problem. As you can see in the Adult Consumptions graph, Figure 4, alcohol (43%) and opioids (40%) were by far the two most frequently prioritized adult consumptions behaviors across the state.[3] Alcohol use was identified as a priority for 38 counties and opioid misuse a priority for 35 counties. When SCAs prioritized a consequence in their problem statement (such as adult DUI arrests or overdose deaths) the substance most influencing that consequence was included in this summary report within its respective consumption category as a consumption.

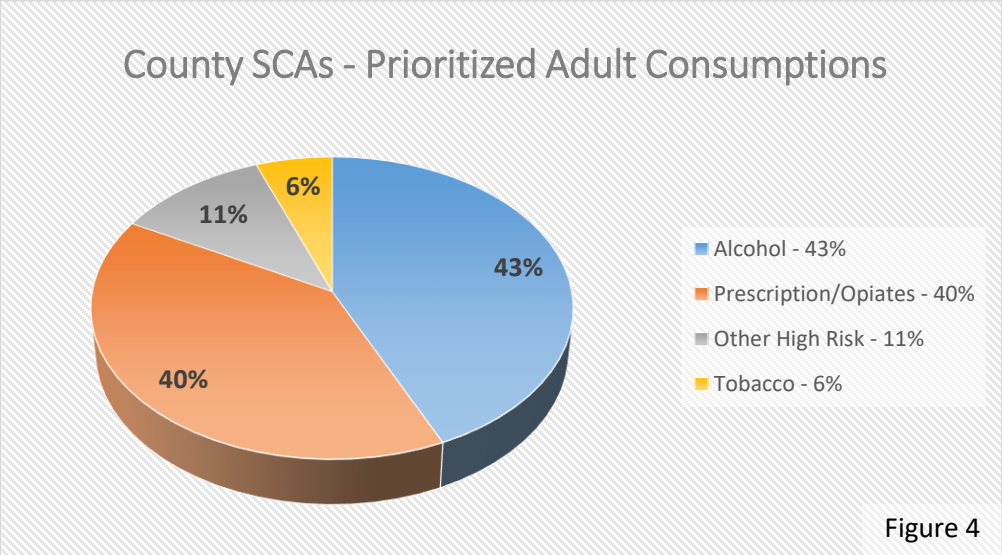


Figure 4

SCAs accessed data from the Behavioral Risk Factor Surveillance System (BRFSS), the National Survey on Drug Use and Health (NSDUH), PA Uniform Crime Report, PennDOT Crash Fact & Statistics Report, PA Poison Control Centers, an *Analysis of Overdose Deaths* report prepared by the University of Pittsburgh & the DEA Philadelphia Division, and other localized sources that were available to them. The concepts of **Magnitude**, **Severity**, **Time-Trends** and **Comparison** were applied to narrow the adult problems.

Consistent with the youth process, SCAs also identified the underlying risk and/or protective factors for their adult problems. As outlined in the *Adult Risk Factors* graph below in Figure 5, those most prioritized were Access/Availability and/or Perceived Availability (22%), Low Perceived Risk (21%) and Laws/Norms Favorable (16%).[4] Once again, the concepts of **Level of Importance** and **Changeability** were applied to assist SCAs with their selection of risk and/or protective factors. *Note: Building additional capacity for the identification, measurement and prioritization of adult level risk and/or protective factors will be an ongoing area of focus for DDAP and EPIS.*

[3] The percentage associated with each substance represents the frequency in which it was prioritized, as compared to all of the **adult** problems across each county (SCAs selected at least one adult problem for each county).

[4] The percentage associated with each risk/protective factor represents the frequency in which it was prioritized, as compared to all of the **adult** risk/protective factors prioritized across the state (SCAs were asked to prioritize one to three risk/protective factors per problem).

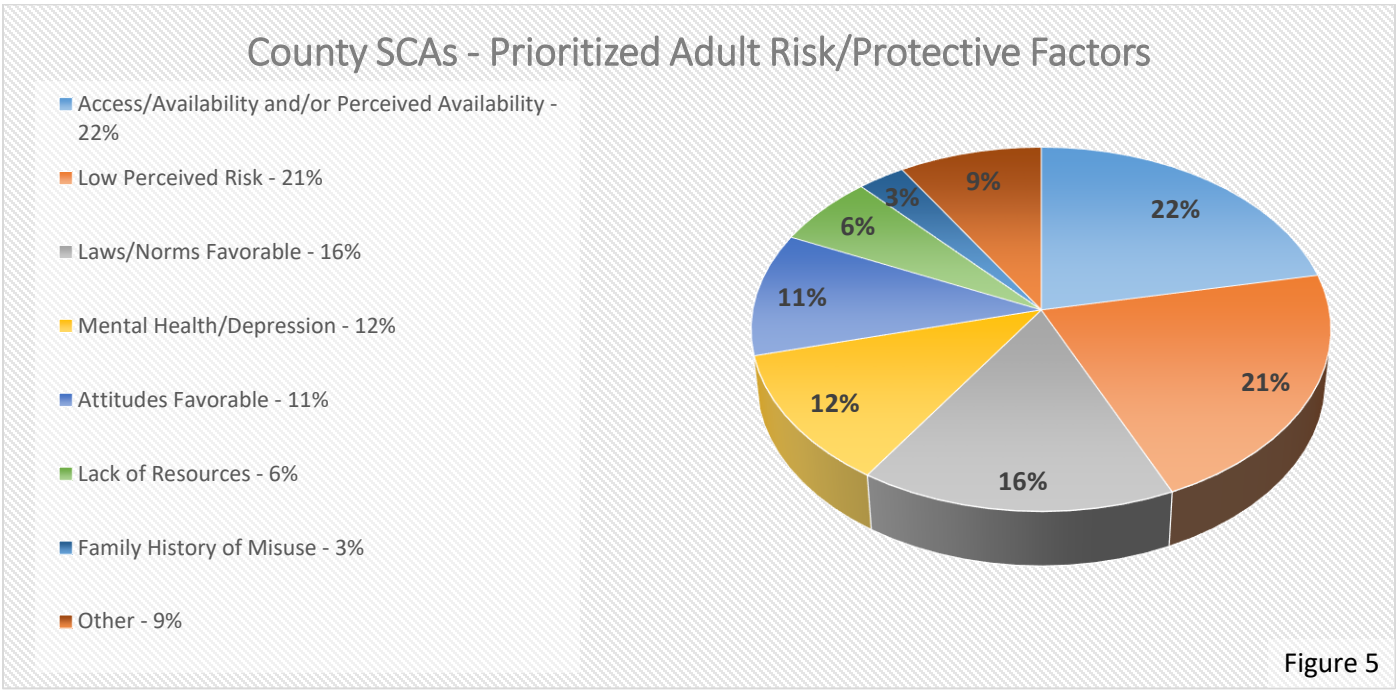


Figure 5

In **PHASE D**, SCAs were tasked with answering the question, "**WHY** are the problems occurring **HERE**?", leading to the prioritization of localized contributing factors, and ultimately to the completion of a logic model for each problem. In order to identify and prioritize contributing factors for each county, teams organized and executed Community Conversations by selecting a target audience and developing carefully shaped questions related to each problem and its underlying risk/protective factors. SCAs had the option to hold focus groups, one on one interviews, town hall meetings or disseminate surveys to collect qualitative feedback.

The identification of contributing factors was a unique and flexible process, and on the following page you will find some of the most frequently prioritized contributing factors that cut across many substances and risk factors. They are categorized within the contributing factor categories in which they most align (SOCIAL NORMS, ENFORCEMENT/ADJUDICATION, SOCIAL ACCESS/AVAILABILITY, RETAIL ACCESS/AVAILABILITY, MENTAL HEALTH/DEPRESSION, OTER SOCIAL DETERMINANTS and PRICE/PROMOTION), and separated by youth and adult.

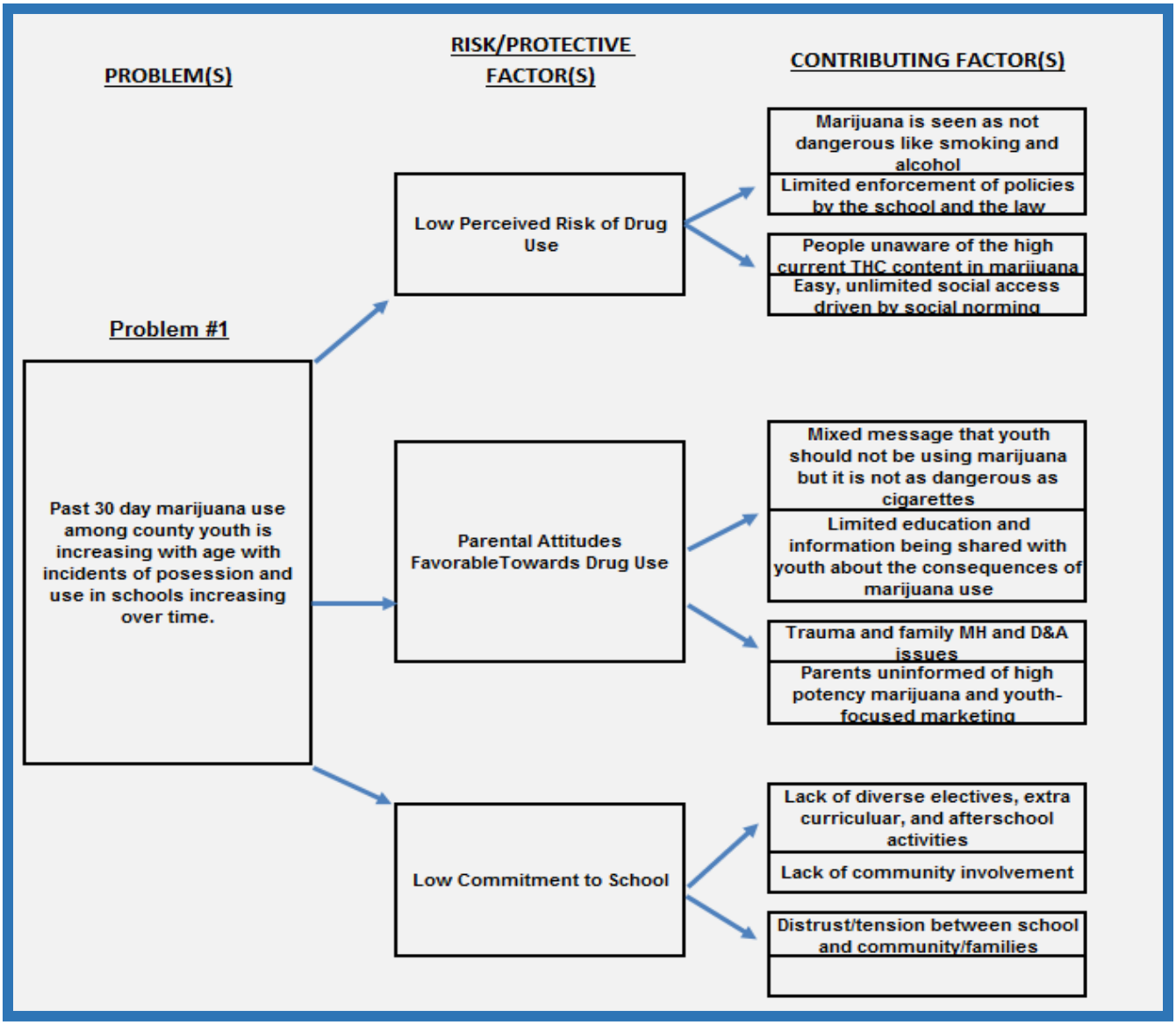
YOUTH CONTRIBUTING FACTORS

SOCIAL NORMS	ENFORCEMENT/ ADJUDICATION	SOCIAL ACCESS/AVAILABILITY	RETAIL ACCESS/AVAILABILITY	MH/DEPRESSION	OTHER SOCIAL DETERMINANTS	PRICE/PROMOTION
Social/Community Acceptance	Challenges in detectability	Sharing of prescriptions	Legalization /doctor prescription influencing acceptance	Self-medicating due to lack of healthy coping skills	Lack of youth awareness/education around risks of substance use/abuse	Social media promotes use as appealing/not harmful
Herd Mentality (Everyone is doing it)	Poor enforcement due to lack of resources	Substances non-secured in homes	Legal age purchasers provide to minors.	Perceived as an acceptable form of stress management	Lack of Resources (Transportation)	Vaping marketed as a safer alternative to smoking
Parental Acceptance	Inconsistent enforcement practices/consequences	Ease of accessibility from parents, siblings, family members, etc.	Over prescription by physicians		Lack of education regarding disposal and safe-storage	Marketing efforts directed at youth
Youth modeling adult/parent behavior	Poor parental enforcement and/or consequences	Adults willing to purchase substances for youth	Outlet density – Internet Sales/Availability		Boredom/social isolation due to few social activities	Local promotion of CBD oil, which many youth see as a marijuana product
	Lack of consequences for retailers/adults providing to youth	Unsupervised party locations	ID Issues -Use of Fake IDs to obtain		Parents lacking the skills to communicate about substance use	Use becoming more accepted by youth due to media

ADULT CONTRIBUTING FACTORS

SOCIAL NORMS	ENFORCEMENT/ ADJUDICATION	SOCIAL ACCESS/AVAILABILITY	RETAIL ACCESS/AVAILABILITY	MH/DEPRESSION	OTHER SOCIAL DETERMINANTS	PRICE/PROMOTION
Social/Community Acceptance	Low perceived risk of arrest/penalties	Sharing of prescriptions	Legalization /doctor prescription influencing acceptance	Self-medicating due to lack of healthy coping skills	Lack of education around risks of substance use/abuse	Media promotion of alcohol increasing adult use
Herd Mentality (Everyone is doing it)	Poor enforcement due to lack of resources		Over prescription by physicians	Perceived as an acceptable form of stress and mental health management	Lack of Resources (Transportation)	Promotion of medication by medical community
Peer pressure at social gatherings/events	Inconsistent enforcement practices/consequences		Outlet density – Internet Sales/Availability		Boredom due to few social activities that don't involve alcohol	

The objective in completing **PHASES A – D** was for SCAs to establish a comprehensive logic model that included a problem statement, underlying risk/protective factors and localized contributing factors. As you can see in the example below, the outcome indicators making up the problem statement include 30-day Marijuana Use (youth consumption), and Incidents of Marijuana Possession in Schools (youth consequence). Based on analysis and team discussion by this SCA, the underlying risk factors identified as most influencing those indicators are: Low Perceived Risk of Drug Use, Parental Attitudes Favorable Towards Drug Use and Low Commitment to School. Additionally, you will find up to four localized contributing factors aligned with each risk factor, as a result of the Community Conversations around this particular problem.



PHASE E involved the SCAs completing a Resource Assessment, and documenting the programs, practices or services that were being implemented within their county that met the needs of the underlying risk/protective factors and/or contributing factors for each problem. This work was very comprehensive and involved a high degree of collaboration across multiple sectors. Assessing the availability and quality of local resources was a crucial step to identifying the strengths and the gaps available in programming before moving forward.

Due to variability between counties, some of the strengths identified in one county may have been classified as a gap or challenge in another county, which is to be expected throughout the state. That said, some of the common strengths that SCAs listed are as follows: strong community partnerships and collaboration; good implementation of evidence-based programming (which often included a variety of services across multiple domains, that aligned well with targeted risk and protective factors, and had minimal barriers to access); having the necessary resources, staffing and capacity

available for high quality implementation and sustainability; an overall awareness and buy-in for key issues; and positive school engagement in programming or services.

As it relates to the gaps and challenges, there were some apparent differences between rural and urban counties, especially as it relates to accessing programs and services, with rural counties recognizing geographic and transportation issues and urban counties identifying cultural and/or language barriers impacting program implementation. Some of the other gaps and challenges most identified were: lack of resources (funding, staffing, materials and sustainability); lack of adult prevention programming/services; varying levels of school engagement (within and across counties); poor program evaluation (outcomes measurement, fidelity monitoring, etc.); lack of collaboration with other community sectors; lack of parent and/or family programming and engagement; and the presence of community laws and norms that pose challenges to the buy-in or implementation of effective programming.

In **PHASE F**: SMART Goals and Action Planning, SCAs utilized their prioritized problems and risk & protective factors to set long-term goals (12 years) and intermediate goals (6 years), while establishing a comprehensive prevention action plan for each problem that includes programs that meet their specific county needs. SCAs were encouraged to build a balanced plan that addressed multiple domains (e.g. individual/peer, family, school, community), and also includes details related to implementation location, target population and process/outcome measurement for each program, practice or strategy.

In DDAP's review of approved plans, a clear strength involved a large number of SCAs providing prevention education around Low Perceived Risk of Drug Use, one of the most prioritized risk factors for youth across the state. There were also some strengths recognized in strategies to address Parental Attitudes Favorable to Drug Use, another commonly prioritized youth risk factor. An area for continued growth is further planning and consideration for adult-based prevention initiatives, regardless of risk factor – as this is a relatively new space for SCAs to focus their efforts. Additionally, addressing common environmental risk factors such as Access & Availability and Laws & Norms Favorable is an area for improvement moving forward. It is anticipated that through future education and collaboration, DDAP will be able to disseminate effective strategies developed from the field around adult-oriented prevention efforts and environmental strategies.

Following implementation and evaluation of their Action Plan, SCAs will have an opportunity to report their outcomes, and review and update their plan every two years (**PHASE G**). It is anticipated that a full needs assessment will occur approximately every six (6) years.

SCA TESTIMONIALS

Below are examples of feedback shared by SCAs and their needs assessment team members on the value and benefits of this process:

"This process gave us the opportunity to teach people about prevention."

"People have asked us for the data from our needs assessment to support their own work and projects."

"It was nice to be able to attach programs to needs – and it has allowed our staff and providers to see why they are doing things, as well as justify to others why they are doing what they are doing."

"The latter part of the process allowed us to be more strategic in our approach...not wanting to just scatter programming here and there, we were able to see when something is currently being implemented in several grades and/or locations, allowing us to build – rather than just implement strategies in isolation."

"This showed us a need to do more community-based prevention – not just school-based prevention."

"Completing this process validated some of what we were already doing, and we also learned some new things that we didn't realize were such a problem."

“Really made you think about the plan – thinking about gaps and how to fill them. It opened up opportunities for creative thinking and problem solving.”

“This process created an opportunity to collaborate with some community members we might not have met with before.”

“In our county, this allowed us to advocate for schools to implement PAYS that had not previously done so before, with good results.”

“Overall, this process allowed us to clearly identify specific needs and then implement appropriate programs or strategies to address the need(s).”

“We liked completing Phase D because it helped to validate the data-driven priorities that we selected in the previous steps.”

“Loved it! We were able to develop new relationship with individuals and organizations that we should have been partnered with prior.”

“Honestly, this process has been very challenging and at the same time rewarding. This is the first time in my 7 years here that so much thought has gone into our plans. The plans are ambitious and clearly show the need for collaboration with our business and industry to not only provide services but to obtain their “buy in” regarding the issues and the need for collaboration but also financial assistance in providing these much needed services! So thank you for the guidance and the challenge!”

Questions about the DDAP Prevention Needs Assessment can be directed to Grace Kindt at sadkindt@pa.gov, or Kris Glunt at ktg10@psu.edu.