

Indicated Prevention: Bridging the Gap, One Person at a Time

William W. Harris, B.S., C.A.D.C. II* & Jan Ryan, M.A.**

Abstract—In 2007, Riverside County, California, after identifying a gap between the substance abuse prevention and treatment services it offered to individuals, developed the Individual Prevention Services (IPS) program to fill that gap. Over the past two years, the IPS program has provided individualized prevention services on a one-on-one basis at all seven of the county's substance abuse treatment clinics. The IPS program is provided to those individuals who are at highest risk for developing substance abuse related problems, i.e., those individuals who have some history of substance use/misuse, but have not yet reached a point where treatment is indicated. This unique "one person at a time" prevention service is provided at no cost to individuals in all age groups (from age 12 to senior citizens) and is based, in part, on a local student assistance model that offers over 20 years of proven results.

Keywords—brief intervention, Brief Risk Reduction Interview and Intervention Model (BRRIM), Continuum of Services System Re-Engineering (COSSR) Task Force, indicated prevention, prevention service agreement

Filling the gap in the continuum of services between substance abuse prevention services and treatment services has always been challenging. This is especially true in a county-operated substance abuse services setting where treatment and prevention funding come from different sources and fiscal accountability requires strict separation of funding for the provision of treatment and prevention services. Additionally, providing prevention services to

individuals is a new concept for most substance abuse programs and can create operational challenges in areas such as funding, space, and staffing, and the programmatic challenge of designing a referral process, intervention, and data collection plan. Although this type of service has typically only been seen in school-based Student Assistance Programs or corporate Employee Assistance Programs, the Riverside County Prevention Program viewed these challenges as an opportunity to significantly increase access to publicly-funded prevention services for individuals. Moreover, sources of new funding for innovative programs are hard to come by and, when they are available, access to them is extremely competitive. Therefore, when designing a service to fill the gap between prevention and treatment services, the critical overall challenge is to build a sustainable system using existing resources.

*Prevention Services Coordinator, Riverside County Department of Mental Health, Substance Abuse Program, Individual Prevention Services (IPS) Program, Riverside, CA.

**Prevention Consultant, Redleaf Resources Consulting and Training, Palm Springs, CA.

Please address correspondence and reprint requests to William Harris, Riverside County Department of Mental Health, Substance Abuse Program, Individual Prevention Services Program, 3525 Presley Avenue, Riverside, CA 92507; email: wwharris@rcmhd.org; phone: (951) 782-2400; fax: (951) 682-3576.

The Riverside County Department of Mental Health – Substance Abuse Program (DOMH-SAP) met both the operational and programmatic challenges with its newly developed Individual Prevention Services (IPS) program. The goal was to identify individuals who traditionally fell in the “gap” between prevention and treatment. Prevention services were co-located at existing county-operated substance abuse clinics, which had funding, space, and staff members. Using extant referral processes, individuals are offered a 90-minute interview called the Brief Risk Reduction Interview and Intervention Model (BRRIM; developed by Jan Ryan and Jim Rothblatt, Redleaf Resources). During the interview, the participant’s internal and external strengths, resources, and needs are identified to create a personalized Prevention Services Agreement for further education and support. Two Center for Substance Abuse Prevention (CSAP) strategies, Problem Identification/Referral and Education (Federal Register 1993), meet the needs of the population of individuals at high risk for substance abuse and related problems. The entire process is based on cognitive behavioral theory and combines the evidence-based practices of motivational interviewing, risk and protective factors, stages of change, and screening and brief intervention. With the support and assistance from the State of California Department of Alcohol and Drug Programs (ADP) and the state-funded Community Prevention Initiative, and without the addition of any new funding, Riverside County was able to strengthen their continuum of service so that individuals could receive the screening and education they needed to reduce the harm caused by their substance abuse and related problems.

BACKGROUND

Understanding Basic Prevention Funding, Populations, and Strategies

Understanding the county’s size and basic funding formula was the first step to comprehending just how important it was to manage available prevention funding carefully. Riverside County, located in Southern California, is the fourth largest county in California in both area and population, with an estimated population of 2.1 million (U.S. Census Bureau 2009). The Riverside County Substance Abuse Program, under the direction of the Riverside County Department of Mental Health, has, since 1992, received a large portion (currently two thirds) of its substance abuse prevention and treatment (SAPT) program funding from the federal government’s Substance Abuse and Mental Health Services Administration (SAMHSA) in the form of a SAPT block grant. Twenty percent of the funds received through the grant are mandated for prevention strategies. The remainder may be used for treatment or prevention. Of greater importance, the amount of treatment dollars released is proportionately tied to the amount of available prevention dollars actually utilized. Therefore, the way that

a large county like Riverside manages the prevention funds directly impacts availability of treatment funds.

The next step is to develop an understanding of how the federal guidelines have improved prevention design and identified gaps in service. From the date of its establishment through the present, SAMHSA’s Center for Substance Abuse Prevention (CSAP) directed that any prevention strategies developed by counties such as Riverside County conform to one of the following six categories (Federal Register 1993):

- Information Dissemination,
- Education,
- Problem Identification and Referral,
- Community-based Processes,
- Alternative Activities
- Environmental Prevention.

During this time, funding for providers tasked with implementing these six CSAP-approved strategies was limited to interventions directed at the population in general and not individuals at high risk.

In 2006, the California Department of Alcohol and Drug Programs (CAADP) established the Continuum of Services System Re-Engineering (COSSR) Task Force to provide recommendations to the department on re-engineering the system of alcohol and other drug (AOD) prevention, treatment, and recovery services in California. Based on the recommendations of this task force, the State of California embraced the Institute of Medicine’s (IOM 1994) three targeted categories of substance abuse prevention populations, as defined by Gordon (1987), and included them in their recommended continuum of services (CA ADP 2006).

- **Universal population:** The general public or a segment of the entire population with average probability of developing a disorder, risk, or condition.
- **Selective population:** Specific subpopulations whose risk of a disorder is significantly higher than average, either imminently or over a lifetime.
- **Indicated population:** Identified individuals who have minimal but detectable signs or symptoms suggesting a disorder.

SAMSHA first proposed utilizing these guidelines in December 2002 (Federal Register 2002). Now, for the first time, monies obtained by the county through the SAPT block grant were available for the development of substance abuse prevention strategies at the individual level.

In 2005, the CAADP notified the substance abuse programs of all 58 counties in California regarding SAMHSA’s intent to introduce the use of the Strategic Prevention Framework (SPF). The SPF provided a systematic approach to evidence-based, outcome-oriented prevention planning at the county level. Local counties were directed to submit their SPF documents for ADP approval by mid-July 2007. The SPF process was an extraordinary opportunity to use the

new IOM prevention populations to define who is served, to implement all six CSAP-defined strategies to define how they are served, and to show how the newly designed web-based data system, California Outcomes Measurement Service for Prevention (CalOMS Prevention), improves capacity to track outcomes. The SPF process allowed the Substance Abuse Prevention Program of Riverside County to evaluate its existing continuum of service model and the ability of that model to serve the needs of the three CSAP/ADP-identified population categories.

Problem Solving: Using Basic Prevention Tools to Define the Problem and Solution

As a result of the SPF process, the county ascertained that adequate prevention programs and county and contractor services were in place to meet the needs of the “universal” population and a small segment of the “selective” population. However, community input determined that the “indicated” population, the population of individuals whose behavior put them at high risk for problems with alcohol and other drug use (IOM 1994), was unserved. More specifically, the county determined that no prevention/intervention services existed to meet the needs of individuals caught in the gap between its existing prevention and treatment services, i.e., those individuals who, though they were experiencing substance usage problems, had not yet reached a level of substance abuse severity where diagnosis and/or treatment was indicated. In short, no funded programs were available for individuals whose severity of substance abuse problems did not rise to the level of a referral for a diagnostic assessment. Individuals had to get worse—become fully involved in substance abuse and/or addiction—to meet the criteria established for receiving the far more costly treatment services available. Because there were no other options available, often when these individuals presented at Riverside’s substance abuse clinics for services, they were either turned away or were enrolled in a 16-week treatment program that was inappropriate for their needs. Both were unacceptable solutions; however, the new IOM definitions addressed this specific gap in services and, for the first time, clearly identified these persons who needed service and defined the services they needed as falling within the prevention area.

Challenges

There were two sets of challenges in instituting services for the indicated population: operational challenges and programmatic challenges. The operational challenges required using existing resources to expand services, which meant utilizing extant funding, space, and staff. Programmatic challenges included following the current state and federal guidelines for prevention, which meant using the existing referral process, then offering an evidence-based and culturally sensitive prevention intervention, follow-up, and evaluation.

Operational Challenges: Funding, Space, and Staffing Solutions

Funding. When initially assessing the possibility of beginning an indicated or individual prevention program within Riverside County DOMH-SAP, one of the first questions that arose was how the program was to be funded. When funding for 2006 (the year prior to this program’s inception) was analyzed, it was found that a total of approximately \$670,000 per year was being spent at the seven county-operated substance abuse clinics on prevention services. This amount was spent primarily on the CSAP strategies of Information Dissemination and Community-based Process. There were also six private contractors throughout the county who were funded for a total of \$690,000 providing the same prevention services as the clinics along with Environmental Prevention. In moving through the SPF process at that time, it became apparent that this duplication of services between contractors and clinics was unnecessary. With community input through the SPF process, it was determined that the contractors were well equipped to provide Information Dissemination, Community-based Process, and Environmental Prevention strategies sufficient to meet the needs of the entire county. This meant that the \$670,000 that had been used at the county-operated substance abuse clinics could then be diverted to the newly created Individual Prevention Services (IPS) program. This provided the funding necessary to operate this program.

Space. The county determined that co-locating prevention services at its seven existing substance abuse treatment clinics was the best approach to identifying those individuals in this newly designated “indicated population.” These clinics, which are spread geographically throughout the county, were in constant receipt of individuals referred for substance abuse treatment by law enforcement, public health, schools, and families. Historically, it was in these same seven clinics that the “good news – bad news” was being delivered. Individuals referred for services were given the “good news” that they were not yet at a point in their substance use where treatment was indicated, and the “bad news” that no funding existed to help them reduce the harm caused by their substance abuse or to avoid continuing their use to the point of becoming addicted. With the incorporation of the indicated (individual) population into the funded continuum of services in 2007, Riverside County’s seven county treatment clinics were then able to offer prevention services to these individuals.

Staff. Four certified substance abuse counselors who were currently employed at various county substance abuse clinics were assigned to serve as prevention specialists at the clinics. These individuals were selected based on their interest in the program, and on their merit as successful and personable substance abuse counselors. The four individuals underwent specialized training for this work as described later in this article. They initially provided services at six of the county’s seven substance abuse clinics.

Programmatic Challenge: Separating Prevention Screening From Treatment Assessment

Relevant current state and federal guidelines for prevention offered the foundation for designing a referral process for the indicated, or individualized, prevention service, now called the Individual Program Service (IPS). By definition, indicated prevention targets individuals who have minimal but detectable signs or symptoms suggesting a disorder (Gordon 1987). Historically, both the referral agencies and the referred individuals expected one service from the county substance abuse clinic—treatment. The first meeting with the client was called many names: intake, screening/assessment, or diagnosis. The typical result was a diagnosis and referral to a level of treatment, the only service then available to individuals.

With state-funded Community Prevention Institute training and technical assistance, Riverside County staff learned to separate *screening*—the process used to determine if education can reverse behavior, from *assessment*—the process used to determine a diagnosis for treatment. In the past, all individuals who presented themselves for services at the clinics filled out an application form and were then directed to a treatment professional for further diagnostic assessment. With the new protocol, individuals still fill out the application form; however, the form is first reviewed by staff and the individual is then moved in one of two directions.

If on the application form the individual indicates that they had a prior treatment episode (e.g., a previous diagnosis of a substance use/abuse disorder) or if they are being mandated for treatment from the State of California Parolee Services Network (PSN), Prop. 36 (the 2000 California law mandating treatment in lieu of jail for nonviolent drug possession offenders), or Child Protective Services/Department of Public Social Services, then they are scheduled with a treatment professional for diagnostic assessment. All other individuals are moved through Prevention Services for screening.

Another challenge that the county faced was the development of a prevention intervention that was grounded in evidence-based practice. The federal definitions of the CSAP strategies of Problem Identification/Referral and Education provided the foundation for the intervention, follow-up, and evaluation. The goal of a prevention-focused screening process is to see if the individual would benefit from education. Unlike treatment-based tools such as the Addiction Severity Index (ASI), which are disease focused, and as such are used to provide treatment clinicians with an assessment of the severity of a client's illness, the tool the Prevention Specialists needed was one that would help them quickly identify the individual's strengths and internal and external resources, with the ultimate goal of reducing harm by addressing high-risk behaviors.

Riverside County had an existing model of individual prevention service delivery with many years of success and

documented evidence demonstrating that a system can prevent substance abuse and reduce risk behaviors one person at a time (Anderson et al. 2007; Roberts 2005). A federal Safe Schools/Healthy Students Initiative grant, funded from 2002 through 2005, created a successful collaboration between the DOMH-SAP, members of the law enforcement community, the Riverside County Office of Education, and the Desert Sands Unified School District to demonstrate that a component of the Desert Sands Student Assistance Program could be replicated in eight school districts to build access to prevention for over 100,000 students. An innovative team in the Desert Sands District had used basic motivational interviewing research to create a structured interview to work with youth/families as the first step of their prevention services. This was the first large demonstration of the effectiveness of the "family conference," an individualized prevention service using a prevention-based screening tool, now called the Brief Risk Reduction Interview and Intervention Model or BRRIM (Anderson et al. 2007; Rolfe et al. 2004).

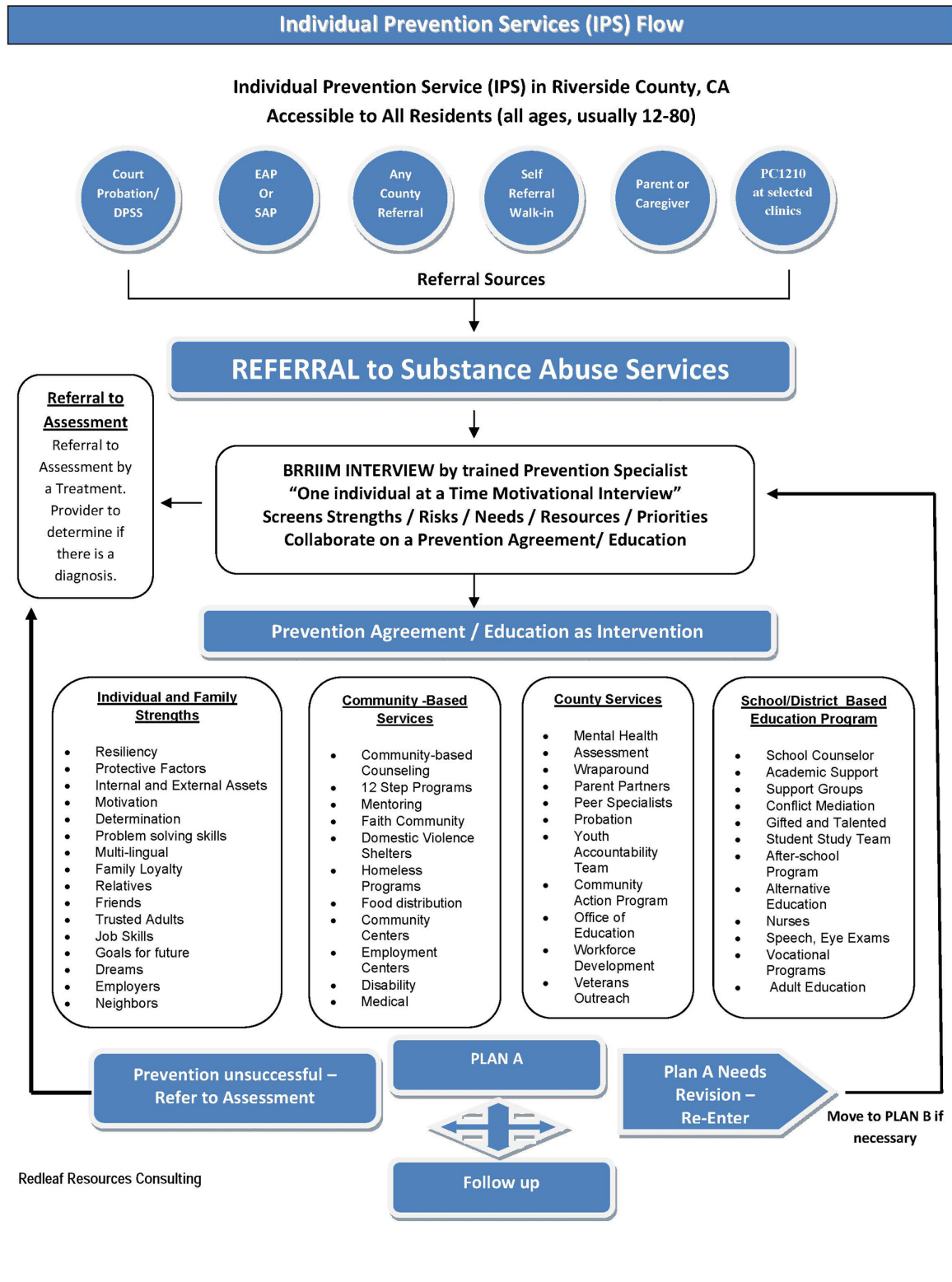
As critical partners in the Desert Sands program, Riverside County DOMH-SAP staff wondered whether the successes realized in the Safe Schools/Healthy Students Initiative program could be replicated on a county-wide basis. DOMH-SAP recognized that with modification, the individual prevention model could meet many of the challenges it faced in the development of a prevention intervention at the individual, or indicated, level. Accordingly, the County of Riverside contracted with the developers of the BRRIM process for training and assistance to modify the Desert Sands program, with the goal of incorporating the modified program into the county's continuum of service. The work product of that effort became the county's new Individual Prevention Service (IPS) program (see Figure 1).

Initially, this service was offered at six of the county's seven substance abuse clinics. As mentioned above, four certified substance abuse counselors were selected as the initial Prevention Specialists who would be providing the services at the six clinics. In 2007, the seventh county clinic began providing the service and there are now seven Prevention Specialists, each dedicated to a particular clinic, who provide this service throughout the county. Each Prevention Specialist completed 40 hours of initial training under the guidance of one or both of the co-developers of BRRIM. Additionally, these individuals continue to receive monthly training updates to maintain model fidelity and integrity and to discuss any issues or concerns with their peers.

CSAP Strategy: Problem Identification and Referral using the BRRIM Interview

The BRRIM interview is the core component of the prevention intervention during the initial engagement with the individual or "participant," as they are known. This first engagement utilizes the CSAP strategy of Problem Identification and Referral. This strategy aims to identify those

FIGURE 1
Riverside County, CA, Individual Prevention Services (IPS) Flow



individuals who have indulged in illegal/age-inappropriate use of tobacco or alcohol or in first use of illicit drugs in order to assess whether their behavior can be reversed through education. The individual's family members and/or significant others are encouraged to attend the first meeting with the Prevention Specialist. Because family members are often involved, this initial meeting is sometimes referred to as the "family conference." If the participant is an adolescent, their parent(s) or guardian(s) may be present. If the participant is an adult, their spouse or other significant individuals may be present, or if a senior, a caregiver can be present. Because the original model was based on one used with a student population within a school or school district setting, some changes had to be made to accommodate the change to a county clinic setting. The first change was the creation of two separate interview models: an adolescent/young adult model used for participants under the age of 25, and an adult model used for those over the age of 25. Appointments for adolescents seeking services are usually made in the late afternoon time slots to allow for the individual to be seen after school has been dismissed.

The BRRIM interview is a neutral screening process in which the Prevention Specialist makes use of the structured BRRIM format to identify potential strengths, concerns, and needs in the participant's life; it is essentially a three-stage motivational interview process that takes about 90 minutes. As noted above, during the first stage of the interview, both the participant and, whenever possible, family members are present. It is during this stage that the Prevention Specialist establishes initial rapport with the participant and the family members. The Prevention Specialist begins an analysis of the participant's risk and protective factors through the use of questions in a structured interview format. The questions center on school/educational (emphasis for adolescents) and work history (emphasis for adults); family dynamics, including any history of family violence and/or addiction and treatment for mental health issues as well as current home climate; social/peer support; and current, recent, or ongoing stressors in the participant's life. These questions aim to identify assets in the participant's life that could help them meet their desired goals, as well as identify and address identified needs and concerns. At the conclusion of this portion of the process, the participant's significant family members are asked to leave the interview temporarily while the Prevention Specialist continues the interview one-on-one with the participant.

During this second stage of the interview, the Prevention Specialist addresses issues with the participant including drug use history, sexual history, criminal history, anger and other emotional issues, personal goals and aspirations, and any other possibly serious concerns. Not having the participant's family present during this part of the interview allows the participant to talk freely about sensitive issues and tends to further build trust between the Prevention Specialist and the participant. It is during this

stage of the interview that the Prevention Specialist identifies which "stage," using the Stages of Change model, the participant is at with regard to addressing identified needs and concerns. If during this stage, the participant indicates a significant level of substance abuse involvement, it is common for the Prevention Specialist to administer one or more of the standard screening instruments for substance abuse (Project Cork 2004). Most commonly, the CRAFFT is used with adolescents and the Michigan Alcohol Screening Test (MAST) and/or Drug Abuse Screening Test (DAST) is used with adults (Project Cork 2004). This additional data assists the Prevention Specialist once the planning stage of the interview is reached. Upon completion of this stage of the interview, the family members are asked to rejoin the interview. In summary, BRRIM is based on cognitive behavioral theory and is organized as a structured motivational interview that uses open and closed questions. These questions create a dialogue that reveals risk and protective factors, imparts the participant's readiness to change using the Stages of Change Model, and helps in designing a brief intervention that is unique to that individual.

In the final stage of the interview, a plan of action is formulated with input from all parties present. If the Prevention Specialist feels that the participant demonstrates excessive risk factors, excessive drug or alcohol use, or a lack of sufficient assets to build upon, then the Prevention Specialist will recommend that the participant be referred to a substance abuse treatment professional or other mental health professional for further diagnostic assessment. This referral is made within the same clinic often on the same day. On the other hand, if it appears that the participant's substance abuse history is such that a brief intervention through education may benefit them and they have personal assets in their life that would support this approach, the IPS process continues.

CSAP Strategy: Education - Prevention Service Agreement for Prevention

Education/Support. During this third stage of the BRRIM interview process, the participant, significant family members, and the Prevention Specialist enter into developing a Prevention Service Agreement (PSA), through which accord is reached in three areas:

1. What the participant is willing to do,
2. What the Prevention Specialist is willing to do, and, if present,
3. What the participant's family or significant others are willing to do.

In addition, if the Prevention Specialist has identified needs and concerns not addressed by the participant in the PSA, the Prevention Specialist may make certain recommendations to the participant as well as to their family. The PSAs, which are individualized and are not agenda driven, are built upon participant willingness to make identified behavioral changes. The agreement is formalized in a document that

is signed by all parties: the participant, the participant's family member(s), and the Prevention Specialist. A copy of the document is provided to the participant and family member.

As part of this process, the participant and Prevention Specialist determine if additional meetings are required. If indicated, the participant and Prevention Specialist will schedule subsequent meetings until both agree that the participant's goals have been met. These meetings utilize the CSAP strategy of Education to provide the participant with information on the harmful effects of drugs and alcohol. During these additional sessions, the Prevention Specialist will continue to utilize motivational interviewing techniques along with exercises that address any participant ambivalence and assist the participant in moving through the stages of change. The Prevention Specialist may also introduce activities drawn from cognitive behavioral therapy as "homework" to address self-defeating behavior or other types of flawed thinking patterns that may be present. It is during these additional sessions that the Prevention Specialist encourages the participant to utilize the protective factors and assets identified during the BRRIM interview to help facilitate the changes that they are looking for. The PSA is an iterative document and process. If the initial plan (Plan A) does not seem to meet the needs of the participant, then a second plan is created (Plan B), and, if needed, a third (Plan C), etc. until the needs of the participant have been met. Current data shows that on average, participants meet for an additional 3.4 meetings. The participant and Prevention Specialist determine when the intervention is complete based on the Prevention Specialist's and the participant's satisfaction that participant goals have been met as indicated in the PSA(s). The last face-to-face meeting with the Prevention Specialist is followed up with a phone call with the participant after two weeks. The participant is told at this time that they are always welcome to contact the Prevention Specialist in the future whenever they feel there is a need.

There have been several instances where, after the implementation of several Prevention Service Agreements, the participant has failed to make progress toward meeting set goals. In such instances, the Prevention Specialist may recommend that the participant be referred to a treatment professional within the clinic for a diagnostic assessment.

Additionally, if the family requests additional time with the Prevention Specialist after the initial interview, arrangements for such are made. In these family meetings, no confidential information about the participant is discussed, unless the participant has signed necessary release forms. These meetings are only intended to allow the family to become an ally in the prevention process and to educate them, as well.

A note on cultural sensitivity should be made here. Since Riverside County has a large Hispanic population, arrangements have been made to provide services in Spanish as needed. Several of the Prevention Specialists are bilingual

and can provide direct services in Spanish. For the other Prevention Specialists, an interpreter on staff within the clinic is brought into the interview and provides translation services. In such instances, the Prevention Services Agreement document is completed and delivered in Spanish and in English. This process has been successful and appears to meet the needs of the monolingual Hispanic population. Also worth mentioning with regard to cultural sensitivity, the BRRIM process focuses on the individual participant and it is the responsibility of the Prevention Specialist to learn from the participant and, whenever possible, the participant's family members, the specific cultural elements that will best serve the participant as identified strengths in addressing their needs and concerns.

All demographic information on the participant and their family, as well as information on the services provided and time involved, is collected and entered into the confidential CalOMS Prevention Data System. This is a web-based program that collects information on prevention services that are provided by individuals and agencies throughout California. This data is used to evaluate process outcomes and track the delivery of services provided.

RESULTS

During the first two years of the program's implementation, BRRIM interviews or family conferences were conducted for 1,158 participants. The average duration of these interviews was 1.8 hours. Of those, 692 (59.8%) were referred for diagnostic assessment and 466 (40.2%) were retained in the Individual Prevention Service (IPS) program and entered into Prevention Service Agreements (PSAs). Of those participants entering into PSAs, each was seen for an average of 3.4 additional sessions; the average duration of a session was 1.6 hours.

Given the relative infancy (two fiscal years old) of the program, results are limited at this time. Furthermore, past funding resources did not allow for the creation and maintenance of an extensive multiyear follow-up program. However, the county is gratified at the number of individuals who entered into PSAs in the two years of its existence. Prior to the establishment of the IPS program, all 466 of these individuals would have either been turned away from the treatment clinic with no plan for substance abuse prevention, or would have been inappropriately admitted to a 16-week outpatient treatment program. The latter was most often the case—the majority of individuals presenting themselves for services expected at that time to get treatment, even if it was not indicated. The savings to the county system alone from these 466 individuals not being admitted to treatment is enough to call this program a success. Within the county system, the average cost to provide a 16-week outpatient treatment program to one individual is approximately \$4,800. The average cost of one individual going through the prevention program is approximately \$1,011.

This represents a savings of \$3,789 per individual, or a total savings of \$1,765,674 for the county treatment program in the first two years of this program.

Additionally, input from participants in their follow-up interviews regarding their satisfaction with the services received has been overwhelmingly favorable; 95% of those interviewed indicated that they would seek prevention services again if needed, and 95% indicated that they would recommend these services to others. The appendix provides a case story as an example of how the county's prevention services operate.

Ongoing Challenges

Refinement of the Re-Engineered Continuum-of-Service Approach. Though the county has made considerable strides toward creating a continuum of service consistent with the California ADP core principles, leadership recognizes that there is much that remains to be done and we are challenged to work closely with our community and agency partners as we become more accustomed to the interactions needed to implement a successful continuum of service.

Program fidelity. Monthly group supervision keeps Prevention Specialists focused on developing solutions based on individual participant's strengths; it can be easy to slip back into problem-focused thinking. Training in evidence-based practices reinforced by sharing participant's successes serves as a constant motivation for the Prevention Specialists.

Early identification for self-referring participants. Access to services across the county has improved, but since most referrals come from county agencies, individuals who might benefit from the process may still be underserved. Therefore, educating the "universal" population remains an important part of the spectrum of prevention. Just as the public has learned the warning signs of strokes and heart attacks, it is our hope that we can find ways to teach the general population the early warning signs of substance abuse so that they will recognize those signs, know that help is available, and, if appropriate, self-refer to one of our clinics.

Next Steps

Evaluation. The County of Riverside has received funding that will allow Riverside County Prevention Services to engage a third party to conduct a thorough evaluation of the results of the IPS program. In February 2010, the Riverside County Individual Prevention Services Program was the recipient of one of this year's Service to Science Awards after being nominated by the State of California Department of Alcohol and Drug Programs. Service to Science is a national initiative from the United States Department of Health and Human Services supported by the SAMHSA's Center for Substance Abuse Prevention (CSAP). This was

a competitive application that honors new and promising interventions in the prevention field. As a result, Riverside County Prevention Services will be receiving technical assistance in establishing an evaluation protocol, in the hope of identifying one or more positive behavioral outcomes. Additionally, we would hope the evaluation process would allow us to demonstrate evidence of such outcomes through a quasi-experimental design.

Data collection and review. The program developers in Riverside will continue to work closely with the state staff to improve the confidential tracking of individual service using the new California Outcomes Measurement Service for Prevention (CalOMS Prevention).

CONCLUSION

Riverside County's project was initiated to fill a gap in the continuum of services for substance abuse with timely, seamless service delivery between prevention and treatment programs. The county's Individual Prevention Services staff wanted to implement a prevention program that offered a hopeful path to those individuals whose involvement with alcohol and other drugs had not yet reached the level where a diagnosis and/or treatment was in order. The goal, at the individual level, and with the help of the participant, was to stop the problem before it progressed. Despite the ambitious aim of offering the IPS countywide through the seven county substance abuse clinics, the project has met and exceeded our highest of expectations. Access to services is considered a success for the participants, staff, and the system.

As the program was implemented, three levels of change were anticipated:

1. Individual level: an increase in each participant's access to services,
2. Staff level: an increase in the capacity of Prevention Specialist staff to individualize prevention services and their ability to work collaboratively with treatment staff to create a seamless continuum of services.
3. System level: to integrate a spectrum of prevention into an expanded continuum of services.

The implementation of the IPS process in Riverside County has created access to individualized prevention, built the staff commitment to fidelity through ongoing training, made significant progress toward the goal of offering a continuum of services that bridges the gap between prevention and treatment, and improved county staff's understanding and support of prevention. Taking a "one-person-at-a-time" approach to prevention has educated each location's team of both prevention and treatment staff and our system partners about how all the services benefit and improve when prevention is available.

REFERENCES

- Anderson, M.B.; Crowley, J.F.; Hertzog, C.L. & Wagner, S. 2007, January. *Help is Down the Hall: A Handbook on Student Assistance*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.
- California Department of Alcohol and Drug Programs (CA ADP). 2006. *Continuum of Services Re-Engineering Task Force: Phase I Report*. Sacramento, CA: California Department of Alcohol and Drug Programs.
- Federal Register. 2002. Volume 67, No. 247, December 24.
- Federal Register. 1993. Volume 58, No. 60, March 31.
- Gordon, R. 1987. An operational classification of disease prevention. In: J.A. Steinberg & M.M. Silverman (Eds.) *Preventing Mental Disorders*. Rockville, MD: Department of Health and Human Services.
- Institute of Medicine (IOM). 1994. *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington, DC: National Academy Press.
- Project Cork. 2004. *Project Cork Online, Clinical Tools, Screening Tests*. Available at: http://www.projectcork.org/clinical_tools/index.html.
- Roberts, B. 2005. *Background Briefing Paper #5: Student Assistance Programs (SAPs). Governor's Prevention Advisory Council (GPAC) High Rate Underage Users Report*. Santa Rosa, CA: Community Prevention Initiative.
- Rolfe, M.; Austin, G.; Rutherford, R.; Hendrick, S.; Seave, P. & Phillips, J. 2004. *High Rate Underage Users: Need and Promise of a School-Based Solution. Governor's Prevention Advisory Council (GPAC) High Rate Underage Users Report*. Santa Rosa, CA: Community Prevention Initiative.
- U.S. Census Bureau. 2009. *State and County QuickFacts. Riverside County, CA, 2009*. Available at: <http://quickfacts.census.gov/qfd/states/06/06065.html>.

APPENDIX

**One Individual's Experience with the Evolving Continuum of Services in Riverside County: IPS Case Story
Provided by Pio Dingle, Prevention Specialist, Riverside County Substance Abuse Program**

The parents of a 15-year-old Hispanic high school sophomore were concerned about his declining grade point average, less time spent at home, increasing tendencies to "talk back," and recent positive drug test for marijuana. They brought their son into the Substance Abuse Program office, where he was assessed and placed in the Adolescent Outpatient Group. I have both treatment and prevention assignments in our clinic, so in my role as the group's treatment facilitator, I noticed that the youth was consistently unable to interact or relate at the level of other group members. I decided to speak with the participant after group one day to review his file and do a second diagnostic assessment. That second assessment did not result in a diagnosis indicating a referral for treatment.

I invited the family in for an Adolescent BRRIM Interview. Through the BRRIM interview, I learned that the youth had made many positive changes already, but he still had areas of his life he wanted to explore. We also discovered that one the reasons he struggled to stay alert in school (other than his initial marijuana use prior to his initial referral), was because there was little or no "buy-in" on his part toward the subject matter being taught. School had become unimportant except for his art classes. During the final stage of the interview, the participant, his family, and I developed his Prevention Service Agreement or "Plan A."

The participant was willing to: (1) continue to see me for eight more visits through the conclusion of spring break because he felt it would help him stay clean, (2) stay awake in school and

pay better attention, (3) work with me on refusal skills because he wanted to feel more comfortable telling his peers he didn't want to do drugs, and (4) develop his interests in art (drawing, tattooing, etc.).

The family was willing to: (1) participate during the intervention as requested, (2) continue to monitor the youth's behavior, (3) work on communication, and (4) drug test if necessary.

As the provider: I researched the top five tattoo establishments in Southern California, located one in San Diego, and then found links to each artist and his or her background. Two of the most sought-after artists had degrees in graphic art design. I shared this information with the participant and, as a result, he became interested in doing better in school, recognizing the importance of a good overall GPA to help him qualify for potential scholarships to study graphic arts in college. When he realized the importance of better applying himself in school, and had a reason to do so, he reported he found it easier to turn down drugs offered by friends or other teens.

Follow-up: I tried to follow-up with the participant during the summer, but the family phone had been disconnected. However, in October of 2009, the participant personally stopped by to say hello and thank me. He said that due to financial problems within the family, their phone had been disconnected for two months. He also shared with me the fact that his father had accepted a job offer outside of the area and the family was about to move.