SUBSTANCE USE PREVENTION PLAN

California Statewide Priorities for Recipients of the Substance Use Prevention, Treatment and Recovery Services Block Grant Primary Prevention Set-Aside

December 1, 2025 – December 30, 2030

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Center for Applied Research Solutions

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INTRODUCTION

Over the last decade, trends in youth substance use in California have declined overall. In fact, according to 2021-23 California Healthy Kids Survey data, the majority of key substance use indicators continued to decline, especially among 11th graders, where use was most prevalent. Still, alcohol remains the number one substance of choice among California's young people and the popularity of marijuana and the use of vaping devices for inhaling both tobacco and marijuana continue to warrant concern.

Additionally, California has an ongoing need to address the substantial health impacts associated with drug-related overdoses. According to the California Overdose Surveillance Dashboard, in 2023, 11,359 Californians (29 per 100,000; age-adjusted) died from a drug-related overdose, with 7,560 persons dying from an opioid-related overdose, 7,137 of those deaths were fentanyl-related.

In order to continue to see positive declines in youth substance, it is critical that we continue to support the substance use disorder (SUD) prevention field, In doing so, DHCS annually allocates approximately $60M total statewide of Substance Use Prevention, Treatment and Recovery Services Block Grant (SUBG), Primary Prevention (PPv) Set-Aside funding awarded to California by the Substance Abuse and Mental Health Services Administration (SAMHSA). This funding has been the long-time backbone of the SUD prevention infrastructure in California. DHCS provides this funding to each of California's 58 counties using a population-based methodology.

According to the Federal Code of Regulations (45 CFR Part 96), states are required to develop comprehensive programs that include a wide range of strategies delivered in various settings to reach both the general public and specific high-risk communities. The overarching goal is to reduce risk factors and increase protective factors that prevent the onset of substance use.

This Substance Use Prevention Plan (SUPP) is DHCS' overarching guidance for counties receiving PPv funding to use prevention science, theory and planning frameworks when making local programmatic decisions that best meet the individuals, families and communities they serve. This can be achieved through a collective statewide alignment with the following priorities:

- **Priority 1: Remain Grounded in Evidence-Based PPv Science**
  Build a strong statewide infrastructure grounded in PPv science emphasizing the utilization and alignment of SAMHSA's Strategic Prevention Framework (SPF) when establishing local objectives and selecting local strategies.

- **Priority 2: Promote Resilience and Engagement for Children, Youth, Families, and Communities**
  Adopt PPv approaches that promote healthy lifestyles, build resilience and foster engagement for the general population and focus populations.
- **Priority 3: Improve the Overall Health and Quality of Life for Individuals, Families, and Communities**
  Prioritize improving the range and quality of available PPv services and continuously seek to improve the quality of the services provided, ensuring they meet the needs of the communities and people we serve.
- **Priority 4: Strengthen the SUBG PPv Workforce**
  Strengthen the SUBG PPv workforce by providing quality training and technical assistance (TTA), developing PPv practitioner expertise, and adopting best practices to recruit and retain PPv staff and providers.

SUBG Primary Prevention Requirements

SAMHSA is the federal agency that establishes directives and allocates SUBG funds to state agencies. DHCS is the single state agency that administers the SUBG for California. DHCS must adhere to federal directives while developing its own vision and directives specific to California's statewide needs and trends for SUD PPv.

Federal Requirements

The federal directives defining PPv are as follows:

- The States shall expend not less than 20 percent for programs for individuals who do not require treatment for substance abuse, which programs 1) educate and counsel the individuals on such abuse and 2) provide for activities to reduce the risk of such abuse by individuals (U.S. DHHS, 2025, 96.124).
- Each State/Territory shall develop and implement a comprehensive prevention program which includes a broad array of prevention strategies directed at individuals not identified to be in need of treatment. The comprehensive program shall be provided either directly or through one or more public or nonprofit private entities. The comprehensive PPv program shall include activities and services provided in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk for substance abuse (U.S. DHHS, 2025, 96.125).
- Single state agencies must submit a plan (application) that provides information on the need for SUD prevention and a description of the State's comprehensive statewide prevention efforts, including the number of individuals being served in

the system, target populations, and priority needs, and provides a description of the amount of funds from the prevention set-aside expended on PPv (U.S. Congress, 2025, p. 39). States are required to report this information via an annual report to SAMHSA. Reports are required to be categorized using the SAMHSA Center for Substance Abuse Prevention (CSAP) strategies and the Institute of Medicine (IOM) prevention categories.

- The Block Grant will not be used to supplant State funding of alcohol and other drug (AOD) prevention and treatment programs (U.S. DHHS, 2025, 96.123)
- Submit an assessment of need in the State for authorized activities, both by locality and by the State in general which will include the following (U.S. DHHS, 2025, 96.133):
  - States shall submit data which shows the incidence and prevalence in the State of drug abuse and the incidence and prevalence in the State of alcohol abuse and alcoholism. The State shall also provide a summary describing the weaknesses and bias in the data and a description of how the State plans to strengthen the data in the future.
  - States shall provide a detailed description of current prevention and treatment activities in the State. This report shall include a detailed description of the intended use of the funds relating to prevention and treatment. As to PPv activities, the activities must be broken down by strategies used, such as those provided in section 96.125, including the specific activities conducted. The State shall provide the following data if available: the specific risk factors being addressed by activity; the age, race/ethnicity and gender of the population being targeted by the prevention activity; and the community size and type where the activity is carried out. As to all treatment and prevention activities, including PPv, the State shall provide the identities of the entities that provide the services and describe the services provided.
  - States may describe the need for technical assistance to carry out Block Grant activities, including activities relating to the collection of incidence and prevalence data identified in this section.
  - States shall establish goals and objectives for improving substance abuse treatment and prevention activities and shall report activities taken in support of these goals and objectives in their application.
- In its annual report States must describe the existing SUD workforce, including with respect to prevention, treatment, and recovery, and workforce trained in

treating co-occurring substance use and mental health disorders (U.S. Congress, 2025, p. 39).

DHCS Commitments

In response to the federal requirements outlined above, DHCS commits to the following when implementing SUBG PPv funding:

- DHCS acknowledges the importance of prevention and dedicates 25 percent of the total SUBG Grant for the purpose of PPv.
- DHCS recognizes that each community is uniquely different and therefore the SUPP contains multiple objectives to allow counties to select multiple strategies based on local need that align with the SUPP.
- DHCS holds responsibility for providing the resources to collect data from SUBG-funded entities so DHCS can prepare and submit the SUBG application, develop a statewide needs assessment and SUPP, in adherence to federal reporting requirements.
- DHCS provides reporting and guidance materials and training and technical assistance to counties and PPv-funded organizations on how to follow DHCS goals and requirements, and how to adopt evidence informed implementations.
- DHCS strives to invest in, analyze and use data to guide statewide substance use prevention policy and decision making and outcome measures. This is accomplished through 1) convening a statewide epidemiological workgroup, 2) making available a resource of evidence-based and community-defined programs, and 3) investing in evaluation at the state and local levels.
- DHCS will regularly collaborate with other state agencies, workforce certifying bodies and field experts engaging in a multipronged approach that addresses the workforce shortage in the SUD prevention field.

County Responsibility

- Counties are responsible for creating a comprehensive SUD PPv service delivery system, provided in a variety of settings for both the general population as well as targeting sub-groups who may be at risk of substance use; and, in accordance with federal requirements, for the allowable use of the SUBG PPv funding.
- Counties are responsible for adopting evidence-based or community-defined SUD PPv strategies or policies that reduce risks and promote protective factors at the individual, relationship, community or societal levels
- Through its local assessment process, counties are responsible for using locally informed qualitative and quantitative data (such as epidemiology) to determine

issues affecting their community or population. And, according to the FY 2026-27 SUBG Block Grant Application, priority should be given to the following focus populations:

- Youth (including transitional age youth)
- Housing insecure and/or justice-involved individuals
- Military personnel
- Rural and frontier communities
- Community populations for environmental prevention activities (in school and community)

» Through local assessment, counties are responsible for identifying risk and protective factors and understanding what causes or prevents local conditions by studying behaviors, environmental factors, genetics, or other social drivers of health (SDOH) that result in poor health outcomes.

» Through partnerships with local health jurisdictions, community-based organizations or other entities, counties should build and foster relationships and readiness to develop, implement and sustain their local comprehensive prevention service delivery system.

» Counties may leverage other funding sources when adopting prevention strategies that achieve common outcomes and create multiple protective factors that exist within broader behavioral health by adopting evidence-based and community-defined strategies that focus on creating strong family bonds, supportive school and community environments, and empowered and socially connected young people.

» To adhere to federal guidance, counties will align with at least one of the following goals in their local planning:

- Reduce past 30-day use of alcohol, prescription drugs and/or marijuana
- Reduce heavy and binge alcohol use among youth
- Change perceptions of harm of alcohol, marijuana and/or other drugs
- Promote disapproval of alcohol and drug use among youth
- Reduce the consequences associated with substance use (e.g. drug-related mortality)

» Counties will report their strategies and proposed expenditures for the use of SUBG PPv funds to DHCS and the required data needed for federal reporting per the *DHCS Data Quality Standards* via ECCO.

STRATEGIC PREVENTION FRAMEWORK FOR CALIFORNIA

This section provides a high-level overview of the next steps that DHCS and its prevention partners will engage in over the course of the planning cycle. These collective action items are intended to support SUBG PPv funded entities as they prepare for increased involvement and collaboration at the county and community levels.

Research and two decades of experience utilizing SAMHSA's SPF in California has shown that effective prevention must begin with an understanding of complex issues such as risk and protective factors, as well as individual, family, community and societal impacts so that the state and counties can make informed decisions.

Since 2006, California has utilized SAMHSA's SPF as a best practice planning framework to communicate the dynamic, data-driven planning process that supports effective PPv work. Previously, all 58 California counties were contractually required to have a strategic prevention plan based on SPF. However, some counties struggled to do this effectively due to limitations such as staff turnover, administrative burden and competing priorities. Therefore, DHCS assumed responsibility for developing a statewide plan. However, through this process, DHCS recognized that while utilizing the SPF process at the state level could strengthen and streamline the infrastructure, there are still local decisions to be made so that as a state we are still meeting the vast needs of the people and communities we serve.

The SPF consists of five steps and two guiding principles (see *A Guide to SAMHSA's Strategic Prevention Framework*).

The five steps are as follows:

- Assessment: Identify local prevention needs based on data (e.g., What is the problem?)
- Capacity Building: Build local resources and readiness to address prevention needs (e.g., What do you have to work with?)
- Planning: Find out what works to address prevention needs and how to do it well (e.g., What should you do and how should you do it?)
- Implementation: Deliver evidence-based programs and practices as intended (e.g., How can you put your plan into action?)
- Evaluation: Examine the process and outcomes of programs and practices (e.g., Is your plan succeeding?)

The two guiding principles must be integrated throughout SPF:

- Cultural Competence: The ability of an individual or organization to understand and interact effectively with people who have different values, lifestyles, and traditions based on their distinctive heritage and social relationships.
- Sustainability: The process of building an adaptive and effective system that achieves and maintains desired long-term results.

In development of the SUPP, the State Epidemiology Workgroup (SEW), county behavioral health preventionists and other field experts, were asked to provide qualitative and quantitative data to inform planning and, specifically, the SEW provided feedback on previous iterations of the SUPP. Below is a summary of feedback.

Qualitative Assessment Methodology

DHCS derived qualitative findings from listening sessions, county indicators from preceding county strategic plans, and a formative analysis considering alignment with the Behavioral Health Services Act (BHSA) goals, and SAMHSA's FY 2026-27 SUBG application.

Listening Sessions

DHCS conducted eight listening sessions from July 8 to July 25, 2024. Participants included PPv providers and partners, tribal partners, youth, adult community members, and individuals representing diverse communities. Conceptual key findings are:

- Community Engagement and Collaboration: Community engagement is necessary to enhance the PPv system delivery in the areas of outreach, coalition building, support, policy change, and youth-led PPv efforts.
- Workforce Development: A workforce development initiative that offers TTA, incentives and mentorship and fosters a nurturing collaborative work environment that includes transparency, open communication, self-care promotion, and respect is essential to ensure a long-term, qualified, and skilled SUD PPv workforce.
- Funding and Resources: Adequate funding is essential for implementing an effective, flexible SUD PPv system delivery that meets changing SUD PPv needs and supports youth development and community-based initiatives.
- Evaluation and Assessment: Consistent assessment and evaluation methods and enhanced reporting requirements are necessary to help counties evaluate program effectiveness, ensure data-driven decision making, inform future initiatives and funding, and achieve long-term outcomes.
- State-Level Guidance: A coordinated statewide media presence and standardized

statewide education curricula can promote long-term outcomes. Counties need more guidance on ways to use SUBG funds and understand how funding mechanisms can be flexible to allow for adaptation, as permitted by the federal government.

County Strategic Prevention Plans

DHCS compiled the most common indicators within county Strategic Prevention Plans (SPPs) for the different data types: contributing factors, consumption, and consequences. The number in parentheses reveals how many counties included the indicator in their SPPs.

- Contributing Factors: perception of harm (46), ease of access (30), family/peer connectedness or supports (18), disapproval of use (8)
- Consumption: Decreased use (20), binge drinking (16), past 30-day use (15), age of onset (7), lifetime use (5)
- Consequences: Fatalities while under the influence (7)

County Population Behavioral Health Measures

Through BHSA, counties are required to adopt priority statewide behavioral health goals. For consideration, the priority statewide goals that align with SUBG PPv funding include but are not limited to:

- Improving access to care
- Prioritizing housing insecure and justice involved individuals
- Serving young people impacted by the child welfare system i.e. foster youth

Additional Goals include:

- Improving Social Connection
- Improving quality of life (for SUD prevention creating healthy lifestyles)
- Increasing school engagement

FFY 2026-27 SUBG Application

In drafting this SUPP, DHCS used the SUBG Application Guide for federal fiscal year 2026-27 to inform the themes for DHCS priorities and to learn about the most current federal directives. They are as follows:

- A Whole-Person Vision for Health
- Bold, Coordinated State Action
- Commitment to Data and Evidence
- Sustainability
- Access to Care, Integration, and Care Coordination

- Person-Centered Care
- Program Integrity

The most current block grant application can be found on SAMHSA's website.

Quantitative Assessment Methodology

DHCS received reports from a select number of SEW members responsible for collecting and analyzing California-specific data. As mentioned in the introduction, data used in the needs assessment included, but were not limited to, the California Healthy Kids Survey and California Opioid Surveillance Dashboard. Below are brief key findings from these two datasets that provide a high-level statewide outlook when comparing state and local data for some of the outcome indicators mentioned in the County Responsibility section on Page 8 of this plan. More expansive data can be provided through local technical assistance through DHCS' contracts with WestEd.

Alcohol

Current Alcohol Use. Current alcohol use (one drink or more in the past 30 days) has been steadily declining over the past decade. For 2019–21, rates were down further by one point in 7th grade (3%), by three points in 9th grade (7%), and two points in 11th grade (14%). These represent the lowest recorded levels among high school students since the start of these surveys.

Current Binge Drinking. The percentage of students who reported having five drinks in a row at a single setting in the past 30 days has also been steadily declining since 2011-13. By 2019-21, binge drinking is nearly non-existent among 7th graders at 1%. Binge drinking was down another point in high school grades and is now only reported by 3% of 9th graders and 7% of 11 graders. These percentages are less than half of what they were in 2013-15.

Marijuana and Vaping

Marijuana use among students has showed a marked declined compared to 2017–19 data. Among 7th graders, current use was down by half to 1.5%, while 9th and 11th graders saw a decrease, reaching 6% and 12% respectively. These figures are very similar to alcohol use rates, continuing a trend observed in 2017–19. Usage also declined across all three common methods of marijuana ingestion (smoking, vaping, and oral ingestion), except for vaping among 11th graders, which remained unchanged. About one-fifth of high school students reported ever vaping, and they were more likely to have vaped marijuana than a nicotine or tobacco product.

Since 2017–2019, 30-day use of a vaping device has dropped significantly by half among 7th graders, falling to 2%; declined by three percentage points among 9th

graders to 6%; and decreased by one point among 11th graders to 10%. These vaping rates remain much higher than those for cigarette smoking, likely reflecting a shift away from traditional cigarettes and toward vaping. This trend may also be influenced by the broader range of substances, especially marijuana, that can be consumed through vaping devices.

Opioids Including Synthetic Opioids

Data from the California Department of Public Health (CDPH) suggests that after an alarming rise in synthetic opioid-related deaths between 2018 and 2023, there has been a slight downward trend. While this may be promising, deaths resulting from poly-substance use, such as mixing opioids with methamphetamine, have risen across all age groups.

Other data from the SUBG-required *Statewide Needs Assessment and Planning Report* were also used to inform the priorities and goals of this SUPP and to examine the incidence and prevalence of substance use in California. They included data from additional data sources such as the California Health Interview Survey and the National Survey on Drug Use and Health, both of which are widely used to determine prevention needs.

DHCS recognizes the critical importance of robust, data-informed planning for SUD PPv and will utilize its SEW and other statewide data partners to support local epidemiological need by:

- Enhancing Data Analysis & Interpretation: Identifying and analyzing the most reliable and relevant data sources, including existing surveillance data and newly available post-COVID assessments, to provide comprehensive epidemiological profiles and identify emerging trends. The SEW will focus on translating complex data into actionable insights for program design and improvement.
- Improving Outcome Measurement: Providing recommendations and developing criteria for counties to build local epidemiological profiles, establishing robust assessment methodologies that move beyond process evaluation to include outcome evaluation and demonstrating the impact of SUPP-funded initiatives.
- Facilitating Knowledge Exchange: Fostering a collaborative environment where SEW members share best practices in data collection, analysis, and program evaluation and integrate them into statewide assessment and evaluation efforts.

Capacity Building

To support statewide capacity for SUD prevention, DHCS will provide ongoing TTA for counties as they examine their local readiness and resources to align with SUPP priorities, goals and objectives.

Currently, DHCS is working toward the following capacity building tasks in preparation for SUPP implementation.

- Expanding the Substance Use Prevention Evidence-Based Resource (SUPER), California's resource for youth substance use evidence-based and community-defined evidence programs and practices.
- Updating online TTA courses through the Advance Behavioral Health Prevention California that cover PPv competencies and providing.
- Revitalize the SEW.

Planning

Problem Statement and Goals

To respond to federal and state priorities, the SUPP adopts the overarching problem statement and goals. Per assessment findings, DHCS will continue to prioritize SUBG SUD PPv efforts toward opioids (including fentanyl), cannabis, and alcohol.

Problem Statement: Alcohol, Cannabis and Opioid (including fentanyl) consumption, risky behaviors, and negative consequences of substance use remain a challenge.

Goals:

- Reduce past 30-day use of alcohol, prescription drugs and/or marijuana
- Reduce heavy and binge alcohol use among youth
- Change perceptions of harm of alcohol, marijuana and/or other drugs
- Promote disapproval of alcohol and drug use among youth
- Reduce the consequences associated with substance use (e.g. drug-related mortality)

Implementation

As mentioned previously, counties must examine local conditions, identify risk and protective factors, work in high need communities, and select evidence-based or community-defined practices that meet individual, family and community needs.

To meet these needs, grantees must develop a comprehensive PPv program that includes activities and services provided in a variety of settings.

Individual-Based Services and Population-Based Efforts

SAMHSA requires state agencies to collect and report data by individual and population-based services. Individual-based services are tailored to the specific needs of individuals or small groups and often involve direct contact with the service recipients. The CSAP strategies Education, Alternatives, and Problem Identification and Referral

implement individual-based services. Population-based services aim to improve the health of entire communities or groups and often do not involve one-on-one interaction with service recipients. The CSAP strategies Community-Based Process, Information Dissemination, and Environmental implement population-based efforts. Counties must sustain the capacity to respond to community support requests for Information Dissemination and Community-Based Process (i.e. presentations, community consultation, coalition efforts, training, etc.).

The 45 CFR 96.125 categorizes these PPv efforts into six unique types of service, or strategies. PPv science also refers to the six strategies as the "CSAP 6." Each SUBG PPv funded program or services must fall into the following:

- Alternative Activities provide opportunities to participate in evidence-based or community-defined activities that exclude AODs. The purpose is to discourage use of AODs by providing alternative, healthy activities and empowering young people. The Friday Night Live youth leadership program is an example of an allowable Alternative activity.
- Community-Based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots coalition models using action planning and collaborative systems planning. Funding the establishment and ongoing facilitation of a coalition is an example of an allowable Community-Based Process strategy.
- Information Dissemination provides knowledge and increases awareness of the nature and extent of AOD use, use, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two. Media campaigns and health fairs are examples of information dissemination strategies.
- Education builds skills through structured, interactive, evidence-based or community-defined learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination. The Strengthening Families, Too Good for Drugs and the Winners Sankofa are examples of evidence-based SUD prevention education programs.
- Environmental establishes or changes written and unwritten community standards, codes, and attitudes. Its intent is to influence the general population's

use of AODs. Retailer compliance, laws and regulations and recognition is an example of an environmental change strategy.

- Problem Identification and Referral aims to identify individuals who have engaged in initial, illegal or age-inappropriate use of alcohol or other drugs. The goal is to assess if their behavior can be reversed through prevention education. This strategy does *not* include any activity designed to determine if a person is in need of treatment, and the county must have a prevention education program in place for the referral component of this strategy.

Institute of Medicine's Continuum of Care and Categories

In addition to SAMHSA's requirements to report services by CSAP strategy, states must also collect and report data on services by risk classification known as the Institute of Medicine's Continuum of Care or IOM Category.

"The IOM's continuum of care is a risk classification model that organizes and defines the wide scope of behavioral services. The system offers SUD practitioners one way to understand how their services fit within their wider field. It is organized according to four areas: promotion, prevention, treatment, and recovery. The SUPP will focus on SUD PPv even though the continuum applies to any behavioral health field (e.g., MH, substance misuse, problem gambling)" (SAMHSA, 2023, p. 1). Promotion efforts occur before and throughout the continuum and are designed to enhance the overall well-being and reduce risk factors before problems arise.

PPv identifies programs/services based on the risk level of individuals it intends to serve. The IOM categories are:

- Universal Direct: Prevention services/activities for service recipients who are present and are not receiving PPv services based on individual risk. Universal direct programs/services are individual-based programs/services. (PPv Strategies: Education, Alternatives).
- Universal Indirect: Prevention efforts where service recipients are not present and services support capacity building and awareness for the entire population, also referred to as population-based efforts. (PPv Strategies: Community-Based Process, Environmental, Information Dissemination).
- Selective: Prevention services/activities for individuals or a subgroup of the population whose risk of developing behavioral health disorders are significantly higher than average. Selective programs/services are individual-based programs/services. (PPv Strategies: Alternatives, Education, Problem Identification and Referral).
- Indicated: Prevention services/activities for high-risk individuals who are

identified as having minimal but detectable signs or symptoms that foreshadow a behavioral health disorder, as well as biological markers that indicate a predisposition in a person for such a disorder but who does not meet diagnostic criteria at the time of the intervention. Universal direct programs/services are individual-based programs/services. (PPv Strategies: Alternatives, Education, Problem Identification and Referral).

This may present an opportunity for SUD prevention providers to work across sectors with other agencies doing prevention, as these individual and population-based strategies address many different individual, family community and societal risks, but if a broad scope prevention strategy is implemental it can result in mutual impact and positive outcomes.

Evaluation

Where possible, the SEW and counties will also provide DHCS for the purpose of SAMHSA reporting, data on outcome measures as they align with SAMHSA requirements in the FY 2026-27 SUBG Application. The measures are as follows:

- Past 30-day use of alcohol, prescription drugs and marijuana
- Heavy and binge alcohol use
- Perception of harm of alcohol, marijuana and/or other drugs
- Disapproval of alcohol and drug use
- Consequences of substance use (e.g. drug-related mortality)

DHCS will work through its SEW to support counties with evaluation, developing a formal evaluation plan and toolkits that can be adapted locally.

Cultural competence

Derived from *A Guide to SAMHSA's Strategic Prevention Framework*, SAMHSA recognizes that health disparities pose a significant threat to many high need populations in our society. To address these disparities and create healthier communities, SAMHSA suggests implementing the following principles for prevention planners:

- Include the priority population in all aspects of prevention planning. For example, if you are developing a program for youth, they should have a voice in the strategic planning process.
- Use a population-based definition of community. California is uniquely different, as such, counties and communities should understand their local conditions and implement approaches that best meet the needs of their communities.
- Employ a workforce of prevention planners, evaluators and program staff that reflect the communities they serve.

Sustainability

In prevention, sustainability relates not only to the capacity of communities to maintain adequate levels of prevention programming over time but also ensures that those programs continue to have a positive impact on the persons they serve. Long term outcomes can take time, and outcomes can't always be easily measured. Also, substance use trends and local priorities can shift over time, as evidenced by the multiple shifts in state and federal level funding decisions. Adaptability is essential for long-term success as well as the ability to diversify a local grant portfolio. A collaborative commitment to continued strategic planning processes at the state and local level can track these trends over time.

PRIMARY PREVENTION SCIENCE

This section focuses on explaining each of the referenced theories and frameworks in the sections above. It is critical to understand these when engaging in local prevention planning. Additional, more specific trainings are available through the Advance Behavioral Health Prevention California TTA online platform.

Risk and Protective Factor Theory and the Socio-Ecological Model

Risk and Protective Factory Theory (RPFT) is a foundational framework in prevention science. RPFT helps to explain why some individuals or communities are more vulnerable to negative outcomes such as substance abuse. "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" (ABHPC, 2025, p. 34). Prevention specialists utilize RPFT when assessing data to identify risks and prioritize the protective factors that will address them.

To best meet the needs of the customer, prevention science combines RPFT with Urie Bronfenbrenner's Socio-Ecological Model (SEM). The SEM illustrates how multiple layers of influence shape human behavior and health outcomes. SAMHSA's FY 2026-27 SUBG applications states, "Decades of prevention science demonstrates that substance use, chronic disease, and mental health all share modifiable risk and protective factors at the individual, family, school, and community levels. Thus, prioritizing the prevention of substance use and related risk behaviors, promoting mental health, and creating opportunities for healthy lifestyles is a smart, cost-effective, and high-impact strategy to

actualize a healthy, safe, and thriving society" (p. 3). The SEM helps understand and identify health disparities by showing how systemic barriers within each SEM domain can impact individual and population level health.

PPv science utilizes the following SEM domains (ABHPC, 2025, p. 39):

- Individual: Characteristics or circumstances specific to the individual i.e. age, genetics, education, income, and health.
- Relationship: The individual's closest social circles i.e. family members, peers, teachers, and other close relationships that influence the individual's behavior.
- Community: The settings in which social relationships occur i.e. school, workplace, and community
- Societal: Societal factors that influence socio-cultural norms and the laws/policies that govern the community.

Prevention in Practice: RPFT and SEM

Let's examine cannabis use prevention risk and protective factors within a few SEM domains to demonstrate how prevention specialists can utilize RPFT and SEM to develop prevention efforts to address risk factors (Hawkins, 1992).

	PROTECTIVE FACTORS	RISK FACTORS
INDIVIDUAL/ PEER	☑ Self-efficacy to say no to substance use ☑ Future college aspirations ☑ Peer disapproval of marijuana use ☑ Involvement in sports and physical activity	☒ Antisocial behavior ☒ High sensation seeking ☒ Aggression ☒ Use of marijuana may lead to using other substances ☒ Use of other substances is associated with higher risk of using marijuana ☒ Perception of peer marijuana use ☒ Low perceived harm of marijuana use ☒ Genetics

From looking at the risk and protective factors within the Individual SEM domain, possible prevention efforts could be:

- To address anti-social, high sensation seeking, aggressive behaviors, and cannabis use, a prevention screening to determine if PPv is a good fit or if a referral for MH services and/or an SUD treatment assessment referral may be necessary.
- A sports/recreation program to alleviate antisocial/aggressive behavior and promote higher education for the individual.
- An AOD education program to address cannabis use leading to other substances and perception of harm for the individual.

	PROTECTIVE FACTORS	RISK FACTORS
SCHOOL	☑ School belonging ☑ School involvement ☑ Authoritative school environment ☑ School connectedness ☑ Remedial approach to marijuana policy violations	☒ Low policy enforcement ☒ Out of school suspension ☒ High absenteeism

The above table utilizes school as the SEM community domain. From looking at the risk and protective factors within the Community-School SEM domain, possible prevention efforts could be:

- A social/recreational program where staff and students interact to address high absenteeism and support school belonging/involvement/connectedness.
- Implement social, recreational, or educational programs as a replacement for out-of-school suspension that will promote decision-making skills for students to attend school.
- Create opportunities for youth led programs that focus on school/community restoration.
- Work with faculty, parents, law enforcement, campus security, and students to better enforce existing policies for youth cannabis use on school grounds.

Implementation of RPFT and SEM Utilization

- Combine RPFT and SEM to understand and identify health disparities and ensure that needs identified through qualitative and quantitative data are being met with the appropriate program delivery.
- Utilize RPFT and SEM when analyzing data and prioritizing risk and protective factors to address individual and community needs.

Public Health Approach

The public health approach (PHA) is a framework used to prevent disease, promote health, and prolong life among populations rather than just treating individuals. The Centers for Disease Control and Prevention states that "At the core of PHA thrives the principle of social justice – that people have the right to be healthy and to live in conditions which support their health (2016)." It aims to identify risk factors for diseases and health conditions, implement interventions targeting those risks, and evaluate outcomes through surveillance and research. The PHA is the foundation of the Environmental Strategy as it exhibits key characteristics: population focus, prevention oriented, evidence-based, and cross-sector collaboration. The PHA emphasizes four core steps for population-based efforts. These four steps are also components within the SPF.

The PHA consists of an epidemiological model that explains the "actors" within PHA implementation. This model forms the foundation of epidemiology by guiding investigations into disease outbreaks and designing prevention strategies that break the chain of disease causations. It emphasizes that health is influenced not by a single factor but by the dynamic interplay among the agent, host, and environment.

- Agent: The agent is the cause of the disease or health problem. It can be a biological pathogen (bacteria, virus, parasite), a chemical toxin, or a physical factor (radiation, trauma). The agent must be present and capable of causing disease for illness to occur.
- Host: The host is the organism, often a human, that harbors the disease. Host factors include genetics, immunity, nutritional status, age, and behaviors that influence susceptibility or resistance to the disease.
- Environment: The environment includes external factors that affect the agent and the opportunity for exposure. This encompasses physical (climate, pollution), biological (vectors, reservoirs), social (housing, sanitation), and economic conditions.

The PHA systematically addresses health issues at the population level by focusing on population-based, Environmental PPv, cross-sector collaboration, data-driven decision-making, and broad community interventions to improve overall health outcomes.

The World Health Organization states that the PHA is about serving the greater good – the maximum benefit for the largest number of people.

Prevention in Practice: PHA in PPv

The legalization of cannabis illustrates how PHA is a foundational approach for PPv. The legalization of cannabis for adults (a change in the legal environment) created an abundant supply of cannabis (the agent), as people who never grew cannabis legally could. This led to more youth (the host) having access to cannabis. Prevention of youth cannabis use 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) (ABHPC, 2025, p. 36).

Evidence-Based and Community-Defined Evidence-Based Practices

DHCS commits to advance a quality PPv service delivery through the promotion of evidence-based practices (EBP). "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 (ABHPC, 2025, p 38)." In 2018, SAMHSA announced a new approach to EBPs focusing on TTA while ending its national EBP registry due to concerns around the validity to address the needs of individuals and the lack of cultural responsiveness.

To address this gap in service, DHCS immediately responded with the coordination of the Evidence-Based Practices Workgroup. This workgroup spearheaded findings and direction for EBP promotion in California, resulting in a partnership with University of California Los Angeles (UCLA) to create an EBP registry for California. In 2025, DHCS and UCLA launched the new SUPER, "a free online resource designed to promote the uptake and utilization of effective, innovative, and youth-centered substance use prevention programming across California" (UCLA (Website), 2025).

Adverse Childhood Experiences and Positive Childhood Experiences

"Adverse childhood experiences (ACEs) are stressful or traumatic events that occur between the ages of 0 and 17. ACEs can undermine a child's sense of safety, stability, and bonding, and can have effects that persist for years. ACEs are strongly associated with a wide range of health problems that can persist throughout a person's lifespan,

including an increased risk of substance misuse, serious emotional disturbances, and mental health disorders. The more ACEs a person has, the greater the risk for negative outcomes" (SAMHSA, n.d., p. 3).

To view ACEs through a protective factor lens, SAMHSA also introduces and defines protective and compensatory childhood experiences (PCEs): "positive experiences during childhood that can lessen the negative effects of ACEs. PCEs protect against harm, including mental or physical illness. Research shows that adults with many PCEs are healthier—physically, mentally, and emotionally—than adults with fewer PCEs, regardless of their ACEs. PCEs also buffer against intergenerational transmission of ACEs," (SAMHSA, n.d., p. 6). Research proves that PCEs are strongly associated with improved mental and physical health in adulthood (Villafuerte, 2023). In its literature, SAMHSA suggests ACEs framework which will prioritize upstream, trauma-informed efforts that promote resilience, and well-being. ACEs such as abuse, neglect, household dysfunction are strongly correlated with long-term behavioral health challenges, including SUDs. ACEs necessitates the implementation of PPv efforts to address root causes:

- Implement trauma-informed prevention curricula in youth-serving organizations (Education Strategy)
- Strengthen protective factors through family engagement, mentorship, and social-emotional learning (Education Strategy)
- Foster cross-sector collaboration among public health, education, behavioral health, and child welfare systems (Community-Based Process Strategy)

Adverse Childhood Experiences and the Role of Substance Misuse Prevention. NOTE: THIS DOCUMENT CONTAINS AN OUTLINE ON HOW TO INTEGRATE ACES INTO THE SPF ON PAGE 14.

Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma.

Social Drivers of Health

According to the Center for Medicaid and Medicare Services (CMS), 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. SDOH refers to community-level factors. They are sometimes called "social determinants of health." The way communities and individuals experience health and health care is not just based on access to medical services. It is also impacted by other factors that may support or create barriers to health and well-being. When implementing SUD PPv programs, it is an opportunity for agencies and communities to

work together to improve negative SDOH conditions. The system change efforts to address negative SDOH conditions and increase opportunities to live a healthier lifestyle are effective Environmental Strategies. Below are two examples of how to improve the local environment, thereby creating healthy and safe communities:

- Neighborhood and Built Environment SDOH domain:
  - Enforcement of AOD Laws: Collaboration with law enforcement to coordinate enforcement activities or modify/enhance existing laws. i.e. driver focused laws, sobriety checkpoints, social host ordinances, surveillance activities, underage-focused laws.
  - Public use, access, and availability: Substance use, access, and availability in public spaces i.e. land utilization and zoning, public space use and sales, substance disposal, school/workplace AOD policy.
  - Retailer Responsibility, Access, & Availability: Retailer compliance and/or regulations of product (including paraphernalia) advertising, sale, distribution, and delivery i.e. product distribution and delivery, retailer compliance and recognition, retailer laws and regulations.
- Education SDOH domain: The integration, development, modification, and/or implementation of system change efforts or school policies to improve the student's physical and academic well-being and access a positive educational experience. This can be effective in working with system-involved youth.

Strengthening the Substance Use Disorder Prevention Workforce

There are multiple professional pathways to working in the SUD prevention field. However, there continues to be an overall shortage of prevention professionals. Over the last several years DHCS and its partner agencies have created multiple pathways to fill these gaps. They are as follows:

California Certified Prevention Specialist

The International Certification and Reciprocity Consortium (ICRC) developed internationally recognized credentials and examinations for the PPv Specialist (PS). Certification requires:

- Possess 2000 hours of PPv experience.
- Complete 120 hours of education and 120 hours of supervision.
- Complete the ICRC PS examination.
- Agree in writing to the Code of Ethics and complete 6 hours of Ethics training.

Peer Support Specialist

A peer support specialist is an individual who draws on their own lived experience with mental health or substance use challenges to support others in their recovery journey. They provide practical assistance, mentoring, and advocacy by helping clients develop recovery goals, learn life skills, and find community resources. To become a certified specialist, an individual must meet the following qualifications:

- Be at least 18 years of age.
- Possess a high school diploma or equivalent degree.
- Be self-identified as having experience with the process of recovery from a mental illness or SUD, either as a consumer of these services or as the parent, caregiver or family member of a consumer.
- Be willing to share their experience.
- Have a strong dedication to recovery.
- Agree, in writing, to adhere to the Code of Ethics.
- Successfully complete the 80-hour training requirements for a peer support specialist through a California Mental Health Services Authority approved training entity.
- Pass the certification examination.

The two professional classifications below are certified through the Health Care Access and Information Agency, but sometimes these professionals work in the SUD prevention field. They are:

Community Health Worker

Community Health Workers are unlicensed, trained health educators that generally provide information, screening, referral and navigation services to Medi-Cal members. However, they are sometimes utilized in the community-based, non-Medi-Cal setting to provide support or education that educates people about living a healthy lifestyle or preventing injury or violence.

Certified Wellness Coach

The Certified Wellness Coach role is a new, certified position to increase our state's overall capacity to support the growing behavioral health needs of our youth in student health settings. It is designed to help build a larger, representative behavioral health workforce in California that has the training and supervision needed to engage directly with young people where they live, study and work.

Wellness Coaches will offer non-clinical services that support youth behavioral health and well-being, such as wellness promotion and education, screening, care coordination,

individual and group support, and crisis referral. The model will supplement and support existing behavioral health roles, fill gaps in the current behavioral health workforce, and create a larger and more diverse workforce with whom youth can connect. There are Certified Wellness Coach services that are billable through Medi-Cal, however, there are also non-Medi-Cal services in student health settings that are allowable expenditures of the SUBG PPv that a Certified Wellness Coach can provide.

DHCS remains committed to working across agencies to market these classifications as viable options when employing prevention professionals as well as a continued investment in making no-cost trainings available for continuing education as a PS through the Advanced Behavioral Health Prevention platform.

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