

Kansas Substance Abuse Prevention Mini-Grants

Request for Proposals (RFP)

Kansas Family Partnership

Applications are due by Noon (CST), February 13, 2012

Funding Range: Up to \$10,000

Send questions to kspfamart@kansasfamily.com by February 3, 2012. Answers will be posted on www.kansasfamily.com by February 7, 2012.

Please submit your application via email to kspfamart@kansasfamily.com by Noon February 13, 2012.

Funding Source: Kansas Department of Social and Rehabilitation (SRS) Services/Disability and Behavioral Health Services – Addiction and Prevention Services

Announcement

Kansas Family Partnership announces the release of a Request for Proposal (RFP) to fund a minimum of 20 mini-grants to Kansas coalitions through grant funding from the Kansas Department of Social and Rehabilitation Services (SRS), Division of Disability and Behavioral Health Services, Addiction and Prevention Services. The purpose of these mini-grants is to assist coalitions in their efforts to reduce underage alcohol use (defined as past 30-day alcohol use and binge drinking among students in grades 6, 8, 10 and 12) and/or past 30-day cigarette use and/or past 30-day smokeless tobacco use.

Grants will range from \$3,000 to \$10,000 depending on their scope and estimated reach. This grant program is intended to support efforts that are tied to larger on-going efforts and not to be used for one-time events. The grant period will be from March 1, 2012 to June 15, 2012.

Who can apply?

To be eligible to apply community coalitions must be registered on the Kansas Family Partnership coalition registry website at www.kansasfamily.com. **Registration will be available on this website by February 2, 2012.** Information required for registry includes the following: coalition name, contact information, and county. Additional information may also be entered into the registry such as membership roster, vision and mission statement, assessment data, logic model, strategic plan and evaluation plan.

Community coalitions are comprised of parents, teachers, law enforcement, businesses, religious leaders, health care providers and other community leaders and activists. Coalitions mobilize at the local level to make their communities safer, healthier and drug free.

Strategy Development Successful applicants must use the Strategic Prevention Framework (SPF) to develop, implement and evaluate research-based prevention strategies. The SPF process involves assessment of local data to establish targets for addressing alcohol, tobacco and other drugs (ATOD) prevalence and priority risk/protective factors, building local capacity to address prevention issues and enhancing community mobilization and readiness, developing a strategic plan, logic model, and action plan detailing evidence-based prevention strategies to be implemented, and evaluating effectiveness. A more detailed summary of the Strategic Prevention Framework can be found in **APPENDIX C**.

A summary document of ineffective strategies is included in **APPENDIX D**.

General Requirements

As part of project requirements, grantees are asked to complete the following activities:

1. Examine KCTC data and based on that data identify 1-2 risk or protective factors (also referred to as influencing factors or intervening variables) that contribute the most to the incidence of underage alcohol or tobacco use.
2. Complete a logic model (i.e. theory of change) on **APPENDIX A** (and an action plan (including a timeline and outcomes (what by when by whom) to address the prioritized risk and protective factor(s) through a set of activities that includes at least one environmental prevention strategy (e.g., policy or practice changes), that will affect the community, family, school, and/or individual/peer domain.

Reporting – Progress reports will be due on April 20th, May 20th and a final report will be due on June 30th.

Budget – Funds should be used to implement programs, policies and/or practices that address the reduction of 30-day alcohol use, binge drinking, cigarette or smokeless tobacco use among youth. Because these mini-grants are from Federal funding sources, OMB Circular A-133 applies to allowable costs. These funds cannot be used for the following budget items:

- Food
- Out of state travel costs
- Board retreats
- Events/materials that are used solely for the purpose or promoting the coalition
- Equipment
- Political advertisements or costs associated with lobbying

Application – Cover Sheet

(Each section must be completed to be considered responsive)

Amount Requested: _____

Title of Project: _____

County (s) Included in this Project: _____

Coalition Name: _____

Primary Contact: _____ Email: _____

Fiscal Contact: _____ Fiscal Email: _____

Address: _____

City: _____ Zip Code: _____

Phone Number: () _____ Fax Number:() _____

(This section must be completed if your coalition is not a 501 (c) (3).)

Fiscal Agent: _____

Fiscal Agent Contact Person: _____

Address: _____

Email: _____

Phone Number: () _____ Federal I.D. No. (F.E.I.N) _____

NOTE: A letter of support or memorandum of agreement from the fiscal agent if the fiscal agent is an organization or agency other than the coalition must be included.

NARRATIVE

(Not to exceed **5 pages**, use 12 pt. Arial Font, 1 inch margins, number pages and title sections)

1. Community Assessment: (20 points) (1 page limit). Provide a description of the need for the proposed project. Please include a description of each of the following:

- (a) a clear definition of the community you will serve (county, city, town etc.);
- (b) resources and gaps in resources;
- (c) the problem supported by your data, and;
- (d) a citation of data sources. This section must include documentation of county or regional level data, results from community forums or surveys, or requests by the community for services, especially those triggered by recent events. You may want to access data from the Kansas the Communities that Care website at www.ctcdata.org. Statewide data may be included if it is used for comparison to your targeted geographical area.

2. Project Description: (25 points) (2 page limit). Describe the purpose of your project and identify how the project will address the need above. Explain how you will achieve the stated purpose including:

- (a) detailed description of the planned activities or events including the steps you will take to complete the project,
- (b) the target population and an estimate of the number of people who will be reached through this project,
- (c) describe how the proposed project fits in with the overall mission and strategy of the coalition and how it may be continued,
- (d) the timeline of activities and when the project will start and end, and;
- (e) include your evaluation plan in your timeline and action steps.

Please use the attached logic model (APPENDIX A) (not included in the page limit)

3. Organizational Experience and Capacity (20 points) (1 page limit). Describe your coalition's experience in delivering prevention or youth oriented programming. Include a description of past collaborative efforts and current partners. Identify key staff who will be working on the project and include job descriptions or staff roles.

4. Budget: (20 points) (Not included in page count) Provide a detailed listing of the proposed budget for this project. Include a budget narrative for each line item and show a breakdown of all expenses. Be sure line items are consistent with the services to be delivered as addressed in the Project Description. List **any** in-kind resources and identify the contributing organization and their monetary value that will support this project. **(APPENDIX B)**

5. **Evaluation: (15 points) (1Page Limit).** Describe the participant or program level evaluation that will be used to determine the effectiveness of this project.

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APPENDIX A – Logic Model – Please use this example as a guide for developing your logic model.

Patterns of Use		Influencing Factors		Strategies
What ?	Where and How?	But Why?	But Why Here?	
<p><i>What are the patterns of consumption (alcohol, binge drinking, cigarettes or smokeless tobacco) for regular (30-day) use?</i></p> <p>Overall, 35 % of students (those in grades 6,8, 10, and 12) report past 30-day alcohol use;</p> <p>65% of students in grade 10 report past 30-day alcohol use;</p> <p>59% of students in grade 12 report past 30-day alcohol use:</p> <p>40% of females versus 30% of males report past 30-day alcohol use;</p> <p>No distinctions notable by race or ethnicity.</p>	<p><i>For this pattern of use, where and how is it taking place?</i></p> <p>Of students who reported past 30-day alcohol use, 41% indicated that they gave someone else money to buy it, and 26% indicated that someone 18 years old or older gave it to them, suggestion that these are the primary sources of alcohol.</p> <p>Of students who reported past 30-day alcohol use, 42% indicated that they consumed alcohol at a friend's home and 23% indicate their own home, suggesting that these are the primary locations in which underage drinking takes place.</p>	<p><i>What are the influencing factors for use?</i></p> <p>Low Family Involvement and Functioning</p> <p>Social Access</p>	<p><i>Why does this influencing factor exist specifically in our community?</i></p> <p>Contributing Factors:</p> <p>Low Family Involvement and Functioning:</p> <ol style="list-style-type: none"> 1. Poor parental supervision of and monitoring 2. Lack of clear family rules and consequences regarding underage drinking <p>Social Access:</p> <ol style="list-style-type: none"> 1. Youth obtain alcohol in unsupervised settings such as field parties 2. Youth obtain alcohol from older friends who purchase it for them 3. Youth obtain alcohol from their own home 4. Youth obtain alcohol from friends who work at convenience stores and do not card. 	<p><i>What can we do about these influencing factors? How can we make a difference?</i></p>

APPENDIX B - BUDGET

Project Coordination_____

Consultant_____

Supplies_____

Printing_____

Postage_____

Travel _____

Other _____

Total Budget:_____

Budget Narrative –Please explain budgeted items and how each contributes to the project.

APPENDIX C – STRATEGIC PREVENTION FRAMEWORK (SPF)

Step 1: ASSESSMENT - *Profile population needs, resources, and readiness to address needs and gaps.*

Assessment involves the collection of data to define problems within a geographic area. Assessment also involves mobilizing key stakeholders to collect the needed data and foster the SPF process. Step 1 also involves an assessment of readiness and leadership to implement policies, programs, and practices.

Step 2: CAPACITY BUILDING. *Mobilize and/or build capacity to address needs.*

Building capacity involves the mobilization of resources within a community. A key aspect of capacity building is convening key stakeholders, coalitions, and service providers to plan and implement sustainable prevention efforts in Steps 3-4 of the SPF. The mobilization of resources includes both financial and organizational resources as well as the creation of partnerships. Readiness, cultural competence, and leadership capacity are addressed and strengthened through education and systems thinking. Additionally, capacity building should include a focus on sustainability as well as evaluation capacity.

Step 3: STRATEGIC PLANNING. *Develop a comprehensive strategic plan.*

Planning involves the development of a strategic plan that includes policies, programs, and practices that create a logical, data-driven plan to address the factors identified in a specific community that are contributing to underage drinking. The planning process produces strategic goals, objectives, and performance targets as well as logic models and preliminary action plans. In addition to the strategic goals, objectives, and performance targets, Step 3 also involves the identification and selection of evidence-based strategies that include changes in policies, programs, and practices that will reduce underage drinking.

Step 4: IMPLEMENTATION. *Implement evidence-based prevention programs, policies, and practices.*

Implementation involves taking action guided by the strategic plan created in Step 3 of the SPF. If action planning, or the selection of specific policies, programs, and practices, was not completed in full during the planning process in Step 3, it should occur in Step 4. Step 4 also includes the creation of an evaluation plan, the collection of process measure data, and the ongoing monitoring of implementation fidelity.

Step 5: EVALUATION. *Monitor, evaluate, sustain, and improve or replace those that fail.*

Evaluation involves measuring the impact of the SPF and the implemented programs, policies, and practices. An important part of the ongoing process is identifying areas for improvement.

APPENDIX D – INEFFECTIVE PREVENTION STRATEGIES

Just as research has identified key elements of effective drug prevention strategies, research has also identified strategies that **do not** appear to reduce alcohol, tobacco, and other drug use. These strategies include:

- scare tactics and moralistic appeals;
- curricula that rely solely on information about drugs and their dangers;
- curricula that only work to promote self-esteem and emotional well-being, without providing training in resistance skills and normative education;
- single shot assemblies and testimonials by former addicts may reinforce a negative norm that “everyone uses drugs” at some point in their lives.

Source: Drug Strategies (1999). Making the grade: A guide to school drug prevention programs. Washington, D.C.: Levine and Associates, Inc.

Avoid these strategies that have been shown to be ineffective in reducing substance use:

- Counseling students, particularly in peer-group context. This does not reduce substance use or delinquency.
- Offering alternative activities such as recreation and community service activities without additional comprehensive strategies.
- Programs focusing on information dissemination, fear arousal, and moral appeal as they are also not effective prevention strategies.

Source: U.S. Department of Education, (2000). Key School-Linked Strategies and Principles for Preventing Substance Abuse and Violence.

Unproven Programs—CSAP’s Western Center for the Application of Prevention Technologies

The following programs and strategies for which multiple research results failed to support program effectiveness for identified problem behaviors. **However, they may be used as one component of a comprehensive prevention program.**

Alternative Activities (e.g. Midnight Basketball, Drug-Free Dances)

(The following is an excerpt from “Selected Findings in Prevention: A Decade of Results from the Center for Substance Abuse Prevention, 1996, pp.27-28)

Recreational and cultural activities, known generically as “alternative activities” often are regarded as attractive enhancements of prevention programs. Community prevention planners sometimes describe such activities, including organized sports and elaborate field trips, as the “hook” that attracts youth participants to community-based prevention programs. The implication is that other activities, such as skills training, are more essential components of prevention programming.

A national cross-site evaluation of community prevention partnerships conducted by CSAP found that alternative activities were cited as the single largest expense for roughly one-third of the partnerships. At least in terms of their relative cost, drug-free recreational and cultural activities often appear to dominate the agenda of community-based substance abuse prevention.

Despite a continuing lack of scientific evidence for their effectiveness, some prevention professionals believe that drug-free recreational and cultural activities that incorporate social skills development and mental health promotion are core elements in the prevention of substance abuse. The Center for Substance Abuse Prevention believes in conducting more focused research to resolve the issue of the appropriate role for alternative activities in the overall prevention agenda.

For more information, order the following free document:

A Review of Alternative Activities and Alternative Programs in Youth-Oriented Prevention, CSAP Technical Report #13, Center for Substance Abuse Prevention, 1996. Order form SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), 800-729-6686, and request publication order no. "PHD 731".

Drug Abuse Resistance Education (DARE)

The following is an excerpt from Preventing Crime: What Works, What Doesn't, What's Promising, Office of Justice Programs and the University of Maryland, Department of Criminology and Criminal Justice, 1997, p. 5-32 to 5-36.

Summary

Using the criteria adopted for this report, D.A.R.E. does not work to reduce substance use. The program's content, teaching methods, and use of uniformed police officers rather than teachers might each explain its weak evaluations. No scientific evidence suggests that the D.A.R.E. core curriculum, as originally designed or revised in 1993, will reduce substance use in the absence of continued instruction more focused on social competency development. Any consideration of D.A.R.E.'s potential as a drug prevention strategy should place D.A.R.E. in the context of instructional strategies in general. No instructional program is likely to have a dramatic effect on substance use. Estimates of the effect sizes of even the strongest of these programs are typically in the mid- to high teens. D.A.R.E.'s meager effects place it at the bottom of the distribution of effect sizes, but none of the effects are large enough to justify their use as the centerpiece of a drug prevention strategy. Rather, such programs should be embedded within more comprehensive programs using the additional strategies identified elsewhere in this chapter.

Fear Arousal/Moral Appeal/Information Dissemination

The following is an excerpt from Preventing Crime: What Works, What Doesn't, What's Promising, Office of Justice Programs and the University of Maryland, Department of Criminology and Criminal Justice, 1997, p. 5-29.

Several meta-analyses and reviews of the effectiveness of school-based drug

prevention instruction have been conducted (Botvin, 1990; Botvin et al., 1995; Dryfoos, 1990; Durlak, 1995; Hansen, 1992; Hawkins, Arthur, and Catalano, 1995; Institute of Medicine, 1994; Tobler, 1986, 1992). Botvin (1990) traces the historical development of these programs. He shows that "information dissemination" approaches which teach primarily about drugs and their effects, "fear arousal" approaches that emphasize the risks associated with tobacco, alcohol, or drug use, "moral appeal" approaches which teach students about the evils of use, and "affective education" programs which focus on building self-esteem, responsible decision making, and interpersonal growth are largely ineffective for reducing substance use. On the contrary, approaches which include resistance-skills training to teach students about social influences to engage in substance use and specific skills for effectively resisting these pressures alone or in combination with broader-based life-skills training do reduce substance use. Curricula which focus on general life skills are typically longer than those which focus only on social resistance skills.

For more information, see the following:

Preventing Crime: What Works, What Doesn't, What's Promising, Office of Justice Programs and the University of Maryland, Department of Criminology and Criminal Justice, 1997, (800) 851-3420.

Self-Esteem Enhancement Programs

(The following is an excerpt from Selected Findings in Prevention: A Decade of Results. Center for Substance Abuse Prevention, 1997, pp. 11-12)

Background

Some addiction research of the 1960's and 1970's focused on the self-esteem portion of the self-concept model of personality, using such instruments as the Rosenberg Self-Esteem Inventory. Patients undergoing detoxification for alcohol or heroin dependence often revealed very low levels of self-esteem; theories were proposed to explain the apparent relationship between self-esteem and addiction. More recent analysis propose that the early studies were in fact developing a model of personalities undergoing detoxification rather than a model of a personality potentially susceptible to either addiction or substance abuse. Cocaine users in particular often exhibit unusually high levels of self-esteem before the onset of addiction. Nevertheless, many substance abuse prevention interventions continue to be based on the theory that self-esteem is a central issue to the onset of substance abuse (see, for example, Shcroeder, Laflin and Weis [1993]).

Implication

A 1994 consensus panel convened by CSAP, after reviewing all available evidence, concluded that improving adolescent self-esteem is not necessarily protective against substance use and that poor self-esteem alone is not predictive of future substance abuse. Increased self-esteem probably should not be used either as a measure of the effectiveness of a substance abuse prevention effort or as an objective of prevention efforts. Alternate psychological measures that may be more useful to prevention include

changes in such areas as positive self-concept, future orientation, family conflict, or self-perceived social competence.

Additionally, acquisition of competence in specific social and communication skills may have inherent protective value against substance rather than merely contributing to the problematic sense of self-esteem.

For more information, see the following: Selected Findings in Prevention: A Decade of Results. Center for Substance Abuse Prevention, 1997. To order a free copy, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) Phone: 800-729-6686, and request publication order no. SMA 97-3143.

APPENDIX D - Resources and Links

Coalitions – www.cadca.org

Data -

Kansas Communities that Care Survey - <http://beta.ctcdata.org/>

Monitoring the Future - <http://monitoringthefuture.org/>

Environmental Strategies –

<http://www.cadca.org/category/coalition-resourcestools/environmental-strategies>

Evidenced-based Programs -

<http://www.nrepp.samhsa.gov/>

Prevention Approaches –

<http://captus.samhsa.gov/prevention-practice/prevention-approaches>

