16.3: Applying the Nursing Process to Community Health

Community health nurses apply the nursing process to address needs of individuals, families, vulnerable populations, and entire communities. See Figure 16.7[1] for an illustration of the nursing process in community health nursing.

![Figure 16.7 Nursing Process in Community Health Nursing](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/16%3A_…)

**Assessment**

The community health nurse typically begins a community health needs assessment by determining what data is already available.[2] As previously discussed in the “Community Health Concepts” section, national, state, county, and local health needs assessments are widely available. **Secondary analysis** refers to analyzing previously collected data to determine community needs.

Community health nurses may also engage in primary data collection to better understand the community needs and/or study who may be affected by actions taken as a result of the assessment.[3] **Primary data collection** includes tools...
such as public forums, focus groups, interviews, windshield surveys, surveys, and participant observation.

Public Forums

**Public forums** are gatherings where large groups of citizens discuss important issues at well-publicized locations and times. Forums give people of diverse backgrounds a chance to express their views and enhance understanding of the community’s specific needs and resources. Forums should be planned in a convenient location with accessibility to public transportation and child care. They should also be scheduled at convenient times for working families to gain participation from a wide range of populations.

Focus Groups

**Focus groups** are a systematic method of data collection through small-group discussions led by a facilitator. Participants in focus groups are selected to represent a larger group of people. Groups of 6-10 people with similar backgrounds or interests are interviewed in an informal or formal setting. Focus groups should be scheduled at several dates and times to ensure a broad participation from members of the community. Here are advantages of focus groups:

- Community member involvement in assessing and planning community initiatives is encouraged.
- Different perceptions, values, and beliefs by community members are explored.
- Input can be obtained from specific subpopulations of the community. Example of subpopulations include young mothers caring for infants, individuals receiving home hospice care, individuals struggling to find housing, residents of the prison system, individuals coping with mental health disorders, or residents in group homes.

Interviews

**Interviews** are structured conversations with individuals who have experience, knowledge, or understanding about a particular topic or issue. **Key informant interviews** are conducted with people in key positions in the community and have specific areas of knowledge and experience. These interviews can be useful for exploring specific community problems and/or assessing a community’s readiness to address those problems.

Advantages of interviews include the following:

- They can be conducted in a variety of settings (e.g., homes, schools, churches, stores, or community centers).
- They are low cost and generally have low dropout rates.
- Respondents define what is important from their perspective.
- It is possible to explore issues in depth, and there is an opportunity to clarify responses.
- They can provide leads to other data sources and key informants.
- They provide an opportunity to build partnerships with community members.
- Data can be compared among local government officials, citizens, and non-government leaders.

Interviews can have these disadvantages:

- Interviews can be time-consuming to schedule and perform.
• They require trained interviewers.
• There is a potential for interviewer bias to affect the data collected during the interview.
• Rapport must be established before sensitive information is shared.
• It is more time-consuming to summarize and analyze findings.

Windshield Surveys

A windshield survey is a type of direct observation of community needs while driving and literally looking through the windshield. It can be used to observe characteristics of a community that impact health needs such as housing, pollution, parks and recreation areas, transportation, health and social services agencies, industries, grocery stores, schools, and religious institutions.

View the following YouTube video of a windshield survey—: Windshield Survey Nursing.

Surveys

Surveys use standardized questions that are relatively easy to analyze. They are beneficial for collecting information across a large geographic area, obtaining input from as many people as possible, and exploring sensitive topics. Surveys can be conducted face to face, via the telephone, mailed, or shared on a website. Responses are typically anonymous but demographic information is often collected to focus on the needs of specific populations. Disadvantages of surveys can include the following:

• Surveys can be time-consuming to design, implement, and analyze the results.
• The accuracy of survey results depends on who is surveyed and the size of the sample.
• Mailed surveys may have low response rates with higher costs due to postage.
• They offer little opportunity to explore issues in depth, and questions cannot be clarified.
• There is no opportunity to build rapport with respondents.

Participant Observation

Participant observation refers to nurses informally collecting data as a member of the community in which they live and work. This is considered a subjective observation because it is from the nurse’s perspective. Informal observations are made, or discussions are elicited among peers and neighbors within the community.

Sociocultural Considerations

When analyzing community health needs, it is essential to do so through a sociocultural lens. Just as an individual’s health can be influenced by a wide variety of causes, community health problems are affected by various factors in the community. For example, a high rate of cancer in one community could be related to environmental factors such as pollution from local industry, but in another community, it may be related to the overall aging of the population. Both communities have a high rate of cancer, but the public health response would be very different. Another example related
to mental health is related to various situational factors affecting depression. A high rate of depression in one community may be related to socioeconomic factors such as low-paying jobs, lack of support systems, and poor access to basic needs like grocery stores, whereas in another community it may be related to lack of community resources during frequent weather disasters. The public health response would be different for these two communities.

Nurses must also recognize and value cultural differences such as health beliefs, practices, and linguistic needs of diverse populations. They must take steps to identify subpopulations who are vulnerable to health disparities and further investigate the causes and potential interventions for these disparities. For example, mental health disparities pose a significant threat to vulnerable populations in our society, such as high rates of suicide among LGBTQ+ youth, reduced access to prevention services among people living in rural areas, and elevated rates of substance misuse among Native Americans. These disparities threaten the health and wellness of these populations.

Key points to consider when assessing a community using a sociocultural lens include the following:

1. Have the trends of assessment data changed over time? What are the potential causes for these changes in this community?
2. How does the community’s needs assessment data compare to similar communities at local, county, state, and national levels? What target goals and health initiatives have been successfully implemented in other communities?
3. What vulnerable subpopulations are part of this community, and what health disparities are they experiencing? What are potential causes and solutions for these health disparities?
4. Input from members of vulnerable subpopulations must be solicited regarding their perspectives on health disparities, as well as barriers they are experiencing in accessing health care.

Diagnosis

Similar to how nurses individualize nursing diagnoses for clients based on priority nursing problems identified during a head-to-toe assessment, community health nurses use community health needs assessment data to develop community health diagnoses. These diagnoses are broad, apply to larger groups of individuals, and address the priority health needs of the community. Resources such as Healthy People 2030 can be used to determine current public health priorities.

A community diagnosis is a summary statement resulting from analysis of the data collected from a community health needs assessment. A clear statement of the problem, as well as causes of the problem, should be included. A detailed community diagnosis helps guide community health initiatives that include nursing interventions.

A community diagnosis can address health deficits or services that support health in the community. A community diagnosis may also address a need for increased wellness in the community. Community diagnoses should include these four parts:

- The problem
- The population or vulnerable group
- The effects of the problem on the population/vulnerable group
• The indicators of the problem in this community

Here are some examples of community health diagnoses based on community health needs assessments:

• **Community Scenario A**
  - **Assessment data:** The local high school has had a 50% increase in the number of teen pregnancies in the past year, causing high school graduation rates to decrease due to pregnant students dropping out of high school.
  - **Community diagnosis:** Increased need for additional birth control and resources for prevention of pregnancy due to lack of current resources, as evidenced by 50% increase in teen pregnancies in the last year and a decrease in graduation rates.

• **Community Scenario B**
  - **Assessment data:** Fifty percent of residents of an assisted living facility were found to have blood pressure readings higher than 130/80 mmHg during a health fair last week at the facility.
  - **Community diagnosis:** Increased need for education about exercise and diet and referrals to primary care doctors for residents of an assisted living facility due to increased risk for mortality related to high blood pressure, as evidenced by a high number of residents with high blood pressure during a health fair.

• **Community Scenario C**
  - **Assessment data:** The local high school has had two cases of suicide in the past year.
  - **Diagnosis:** Increased need for community education regarding suicide prevention and crisis hotlines, as evidenced by an increase in adolescent suicide over the past twelve months.

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**Outcome Identification**

Outcomes refer to the changes in communities that nursing interventions and prevention strategies are intended to produce. Outcomes include broad overall goals for the community, as well as specific outcomes referred to as “SMART” outcomes that are specific, measurable, achievable, realistic, and with a timeline established.

Broad goals for communities can be tied to national objectives established by Healthy People 2030, as previously discussed in the “Community Health Concepts” section.

Healthy People objectives are classified by these five categories[^1]:

- Health Conditions
- Health Behaviors
- Populations
- Settings and Systems
- Social Determinants of Health

SMART outcomes can be created based on the objectives listed under each category. For example, if an overall
community goal is related to “Drug and Alcohol Use” under the “Health Behaviors” category, a SMART outcome could be based on the Healthy People objective, "Increase the proportion of people with a substance use disorder who got treatment in the past year." Based on this Healthy People objective, an example of a SMART outcome could be the following:

- The proportion of people treated for a substance disorder in Smith County will increase to 14% within the next year.

View the [Healthy People 2030 Objectives](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/16%3A…) and [Community Objectives](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/16%3A…).

### Planning Interventions

Nursing interventions for the community can be planned based on the related Healthy People category and objective. For example, based on the sample SMART outcome previously discussed, a planned nursing intervention could be the following:

- The nurse will provide education and materials regarding evidence-based screening practices for substance use disorder in local clinics.

Community health nursing interventions typically focus on prevention of illness with health promotion interventions. After performing a community health needs assessment, identifying priority problems, and establishing health goals and SMART outcomes, the nurse integrates knowledge of health disorders (e.g., diabetes, cancer, obesity, or mental health disorders) and current health risks in a community to plan prevention interventions.

There are two common public health frameworks used to plan prevention interventions. A traditional preventive framework is based on primary, secondary, or tertiary prevention interventions. A second framework, often referred to as the Continuum of Care Prevention Model, was established by the Institute of Medicine (IOM) and includes universal, selected, and indicated prevention interventions. Both frameworks are further discussed in the following sections.

### Primordial, Primary, Secondary, Tertiary, and Quaternary Interventions

Preventive health interventions may include primordial, primary, secondary, tertiary, and quaternary prevention interventions. These strategies attempt to prevent the onset of disease, reduce complications of disease that develops, and promote quality of life.

#### Primordial Prevention

**Primordial prevention** consists of risk factor reduction strategies focused on social and environmental conditions that affect vulnerable populations. In other words, primordial prevention interventions target underlying social determinants of health that can cause disease. These measures are typically promoted through laws and national policy. An example of a primordial prevention strategy is improving access to urban neighborhood playgrounds to promote physical activity in children and reduce their risk for developing obesity, diabetes, and cardiovascular disease. See Figure 16.8 for an image of a neighborhood playground.
Primary Prevention

Primary prevention consists of interventions aimed at susceptible populations or individuals to prevent disease from occurring. An example of primary prevention is immunizations. \(^{(17)}\) Nursing primary prevention interventions also include public education and promotion of healthy behaviors. \(^{(18)}\) \(^{(19)}\) See Figure 16.9 for an image of an immunization clinic sponsored by a student nurses’ association.

Secondary Prevention

Secondary prevention emphasizes early detection of disease and targets healthy-appearing individuals with subclinical forms of disease. Subclinical disease refers to pathologic changes with no observable signs or symptoms. Secondary prevention includes screenings such as annual mammograms, routine colonoscopies, Papanicolaou (Pap) smears, as well as screening for depression and substance use disorders. \(^{(20)}\) \(^{(19)}\) Nurses provide education to community members about the importance of these screenings. See Figure 16.10 for an image of a mammogram.
Tertiary Prevention

Tertiary prevention is implemented for symptomatic clients to reduce the severity of the disease and potential long-term complications. While secondary prevention seeks to prevent the onset of illness, tertiary prevention aims to reduce the effects of the disease after it is diagnosed in an individual. For example, rehabilitation therapy after an individual experiences a cerebrovascular accident (i.e., stroke) is an example of tertiary prevention. See Figure 16.11 for an image of a client receiving rehabilitation after experiencing a stroke.

The goals of tertiary prevention interventions are to reduce disability, promote curative therapy for a disease or injury, and prevent death. Nurses may be involved in providing ongoing home health services in clients’ homes as a component of interprofessional tertiary prevention efforts. Health education to prevent the worsening or recurrence of disease is also provided by nurses.
Quaternary Prevention

Quaternary prevention refers to actions taken to protect individuals from medical interventions that are likely to cause more harm than good and to suggest interventions that are ethically acceptable. Targeted populations are those at risk of overmedicalization. An example of quaternary prevention is encouraging clients with terminal illness who are approaching end of life to seek focus on comfort and quality of life and consider hospice care rather than undergo invasive procedures that will likely have no impact on recovery from disease.

See additional examples of primordial, primary, secondary, tertiary, and quaternary prevention strategies in Table 16.3a.

Table 16.3a Examples of Prevention Interventions

<table>
<thead>
<tr>
<th>Prevention Intervention Strategy</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primordial Prevention</td>
<td>• Increased tax on cigarettes</td>
</tr>
<tr>
<td></td>
<td>• Increased access to public walking paths and public parks</td>
</tr>
<tr>
<td>Primary Prevention</td>
<td>• Birthing and newborn classes for new parents at the local hospital</td>
</tr>
<tr>
<td></td>
<td>• Television commercials regarding the importance of the influenza vaccines</td>
</tr>
<tr>
<td></td>
<td>• Psychosocial health fairs in local malls or other public facilities</td>
</tr>
<tr>
<td></td>
<td>• Tobacco cessation public education sessions</td>
</tr>
<tr>
<td></td>
<td>• Television commercials about mindfulness classes at the community center</td>
</tr>
<tr>
<td>Secondary Prevention</td>
<td>• Blood pressure screening events</td>
</tr>
<tr>
<td></td>
<td>• Sexually transmitted disease screening in college students</td>
</tr>
<tr>
<td></td>
<td>• Mammograms for early detection of breast cancer</td>
</tr>
<tr>
<td></td>
<td>• Colonoscopies for early detection of colon cancer</td>
</tr>
<tr>
<td></td>
<td>• Free testing for people exposed to another individual diagnosed with COVID-19</td>
</tr>
<tr>
<td></td>
<td>• Screening for substance abuse disorders in high schools</td>
</tr>
</tbody>
</table>
• Screening for depression during annual physicals

Tertiary Prevention

• Cardiac rehabilitation for individuals who have experienced a myocardial infarction
• Occupational and physical therapy for individuals who experienced a cerebrovascular accident
• Diabetic foot care provided at the local community center
• Support groups for substance disorders in local churches

Quaternary Prevention

• Routine education provided about advance directives and “Do Not Resuscitate” orders during clinic visits, hospital admissions, and long-term care admissions
• Education provided about hospice care to clients diagnosed with terminal illness who are approaching end of life

In the United States, several governing bodies make prevention recommendations. For example, the United States Preventive Services Task Force (USPSTF) makes recommendations for primary and secondary prevention strategies, and the Women’s Preventive Services Initiative (WPSI) makes recommendations specifically for females. The Advisory Committee on Immunizations Practices (ACIP) makes recommendations for vaccinations, and various specialty organizations such as the American College of Obstetrics and Gynecology (ACOG) and the American Cancer Society (ACS) make preventative care recommendations. Preventive services have been proven to be an essential aspect of health care but are consistently underutilized in the United States. Nurses can help advocate for the adoption of evidence-based prevention strategies in their communities and places of employment.

Continuum of Care Prevention Model

A second framework for prevention interventions, referred to as the “Continuum of Care Prevention Model,” was originally proposed by the Institute of Medicine (IOM) in 1994 and has been adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA). See Figure 16.12 for an illustration of the Continuum of Care Prevention Model.
The Continuum of Care Prevention Model can be used to illustrate a continuum of mental health services for community members that includes prevention, treatment, and maintenance care:

- Prevention includes three types of strategies including universal, selective, and indicated interventions.
  - **Universal prevention:** Interventions designed to reach entire groups, such as those in schools, workplaces, or entire communities. For example, wellness sessions regarding substance misuse can be planned and implemented at a local high school.
  - **Selected prevention:** Interventions that target individuals or groups with greater risk factors (and perhaps fewer protective factors) than the broader population. For example, a research study showed that wellness programs implemented for adolescents who were already using alcohol or drugs reduced the quantity and frequency of their alcohol use and reduced episodes of binge drinking.
  - **Indicated prevention:** Interventions that target individuals who have a high probability of developing disease. For example, interventions may be planned for adolescents who show early signs of substance misuse but have not yet been diagnosed with a substance use disorder. Interventions may include referrals to community support services for adolescents who have violated school alcohol or drug policies.

- Treatment refers to identification of a mental health disorder and standard treatment for the known disorder. Treatment also includes interventions to reduce the likelihood of future co-occurring disorders.

- Maintenance refers to long-term treatment to reduce relapse and recurrence, as well as provision of after-care services such as rehabilitation.

See additional examples of prevention strategies using the Continuum of Care Prevention Model in Table 16.3b.

### Table 16.3b Examples of Continuum of Care Prevention Strategies

<table>
<thead>
<tr>
<th>Prevention Strategies</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Prevention</td>
<td>• Handwashing education and posters in bathrooms of community gas stations</td>
</tr>
<tr>
<td></td>
<td>• Parenting classes for new parents</td>
</tr>
<tr>
<td></td>
<td>• Flu vaccine clinics at a local church</td>
</tr>
</tbody>
</table>
**Selective Prevention**
- Backpack-buddy programs that provide food from schools to low-income families on weekends
- Concussion training programs for youth athletes and their parents
- Contact tracing procedures for individuals diagnosed with COVID-19

**Indicated Prevention**
- Exercise programs at the local senior center targeted for individuals with diabetes
- Food or clothing pantries established in a homeless shelter
- Screening and consultation for the families of individuals who are admitted to hospitals with alcohol-related injuries

Read [A Guide to SAMHSA’s Strategic Prevention Framework](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/16%3A_...) PDF for more about planning prevention strategies for substance misuse and related mental health problems.

### Culturally Competent Interventions

To overcome systemic barriers that can contribute to health disparities, nurses must recognize and value cultural differences of diverse populations and develop prevention programs and interventions in ways that ensure members of these populations benefit from their efforts.

SAMHSA identified the following cultural competence principles for planning prevention interventions:

- Include the targeted population in needs assessments and prevention planning
- Use a population-based definition of community (i.e., let the community define itself)
- Stress the importance of relevant, culturally appropriate prevention approaches
- Promote cultural competence among program staff

Review additional concepts related to culturally responsive care in the “Diverse Patients” chapter of Open RN *Nursing Fundamentals*.

### Evidence-Based Practice

It is essential to incorporate evidence-based practice when planning community health interventions. SAMHSA provides an evidence-based practice resource center for preventive practices related to mental health and substance abuse. See these resources, as well as examples of evidence-based programs and practices in the following box.

**Examples of Evidence Based Prevention Practices related to Mental Health and Substance Misuse**

- [Blueprints for Healthy Youth Development](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/16%3A_...): Youth violence, delinquency, and drug prevention and intervention programs that meet a strict scientific standard of program effectiveness
- [Evidence-Based Behavioral Practice (EBBP)](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/16%3A_...): A project that creates training resources to help bridge the gap
between behavioral health research and practice

- **SAMHSA’s Suicide Prevention Research Center (SPRC):** A best practices registry that identifies, reviews, and disseminates information about best practices that address specific objectives of the National Strategy for Suicide Prevention
- **The Athena Forum: Prevention 101:** Substance misuse prevention programs and strategies with evidence of success from the Washington State Department of Social and Health Services
- **National Institute on Drug Abuse: Preventing Drug Use Among Children and Adolescents:** Research-based drug abuse prevention principles and an overview of program planning, including universal, selected, and indicated interventions

View the [SAMHSA Evidence-Based Practice Resource Center](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/16%3A_Community_Health_Nursing/Nursing_Process_in_Community_Health_Nursing).  

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### Implementation

Community health nurses collaborate with individuals, community organizations, health facilities, and local governments for successful implementation of community health initiatives. Depending on the established community health needs, goals, outcomes, and target group, the implementation of nursing interventions can be categorized as clinical, behavioral, or environmental prevention:

- **Clinical prevention:** Interventions are delivered one-on-one to individuals in a direct care setting. Examples of clinical prevention interventions include vaccine clinics, blood pressure monitoring, and screening for disease.
- **Behavioral prevention:** Interventions are implemented to encourage individuals to change habits or behaviors by using health promotion strategies. Examples of behavioral prevention interventions include community exercise programs, smoking cessation campaigns, or promotion of responsible alcohol drinking by adults.
- **Environmental prevention:** Interventions are implemented for the entire community when laws, policies, physical environments, or community structures influence a community's health. Examples of environmental prevention strategies include improving clean water systems, establishing no-smoking ordinances, or developing community parks and green spaces.

### Evaluation

When evaluating the effectiveness of community health initiatives, nurses refer to the established goals and SMART outcomes to determine if they were met by the timeline indicated. In general, the following questions are asked during the evaluation stage:

- Did the health of the community improve through the interventions put into place?
- Are additional adaptations or changes to the interventions needed to improve outcomes in the community?
- What additional changes are needed to improve the health of the community?
- Have additional priority problems been identified?

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3. Community Tool Box by Center for Community Health and Development at the University of Kansas is licensed under CC BY NC SA 3.0.

4. A Guide to SAMHSA’s Strategic Prevention Framework by Substance Abuse and Mental Health Services Administration is available in the Public Domain.

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