Prevention Framework for Behavioral Health

Bureau of Prevention
Division of Behavioral Health
Arizona Department of Health Services

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September 1997

The *Prevention Framework for Behavioral Health* builds on past and current prevention efforts to chart future directions for Arizona's prevention programs. It includes information on best practices to reach new strategic goals. It sets priorities for behavioral health prevention initiatives and encourages closer collaboration and coordination to stretch our limited health care dollars. Perhaps most important, it highlights the essential role of every individual as a partner and a resource for community-wide prevention efforts.

Recent years have brought a dramatic increase in society's awareness of the problems associated with mental health and addiction disorders. Private citizens, businesses, and public organizations have become more willing to make the prevention of these problems a personal and national priority.

We know that when we provide opportunities for people to develop interpersonal skills, problem solving ability, autonomy, high expectations, and a sense of a bright future, there can be tremendous gains in the health and well-being of the entire population. We also know that strategies which focus on organizing the community around behavioral health issues can provide people with powerful tools to improve the health of their families and the safety of their neighborhoods.

The lessons we have learned from prevention will be increasingly important in the era of health care reform. Prevention points to new approaches in managed behavioral health care that can improve health care outcomes. The field of prevention also offers concrete ways to improve the quality and effectiveness of health, education, and criminal justice services by reducing the incidence and prevalence of behavioral health problems.

Prevention offers a singular opportunity for creating long-term solutions to the health and social problems that affect every community. We invite you to become involved in this public health challenge. By joining together, we can capitalize on the energy, enthusiasm, and opportunities created by prevention to improve the quality of life for all Arizonans.

Rhonda Baldwin
Assistant Director, DBHS

Patricia Chavez Anaya
Bureau Chief, Bureau of Prevention

Leadership for a Healthy Arizona

FOREWORD

This document is designed for the many dedicated and talented individuals who are involved in Arizona's behavioral health prevention efforts. They grapple daily with preventing problems related to mental illness and substance abuse disorders, and experience the rewards of forging partnerships with communities and private industry to produce tangible improvements in our quality of life.

The *Prevention Framework for Behavioral Health* is the product of a collaborative effort between the Bureau of Prevention, Regional Behavioral Health Authority directors and prevention coordinators, local prevention providers, members of the Children's Behavioral Health Council, the Arizona Department of Health Services Management Team, the Division of Behavioral Health Management Team, and colleagues from various offices within the Arizona Department of Health Services. Input from these individuals helped to shape the material presented in the *Prevention Framework for Behavioral Health* and to establish the priorities presented in this publication.

There are three important reasons for publishing the *Prevention Framework for Behavioral Health.*

First, this document creates a ready reference for Arizona's behavioral health prevention programs. It brings together in one place the important directives and guidelines that are used by behavioral health prevention programs funded by the Division of Behavioral Health of the Arizona Department of Health Services.

Second, the *Prevention Framework for Behavioral Health* establishes new, strategic directions for future behavioral health prevention initiatives. The strategic directions seek to place prevention programs on firm footing by championing best practices for results-oriented, cost-effective preventive services within the changing public health field and the emerging managed behavioral health care system.

The third and most important reason for publishing this document is to promote the active involvement of all citizens and all community sectors in shaping the future of our communities. While it is essential for the Arizona Department of Health Services, Regional Behavioral Health Authorities, and behavioral health prevention providers to take on leadership roles, Arizona's future health and well-being requires the collaborative effort of all citizens.

EXECUTIVE SUMMARY

OVERVIEW

Prevention is the creation of conditions, opportunities, and experiences which encourage and develop healthy, self-sufficient people.

The *Prevention Framework for Behavioral Health* builds on past and current prevention efforts to chart new directions for Arizona's prevention programs. It includes information on best practices to reach the new strategic goals. It sets priorities for behavioral health prevention initiatives and encourages closer collaboration and coordination to stretch our limited health care dollars. Perhaps most important, it highlights the essential role of every individual as a partner and a resource for community-wide prevention efforts.

The lessons from prevention will be increasingly important in the era of health care reform. Prevention points to new approaches in managed behavioral health care that can improve health care outcomes for health plan members, help providers more effectively target their efforts, and assist insurers in containing costs.

This document is the product of a collaborative effort between the Bureau of Prevention, Regional Behavioral Health Authority directors and prevention coordinators, local prevention providers, members of the Children's Behavioral Health Council, the Arizona Department of Health Services Management Team, the Division of Behavioral Health Management Team, and colleagues from various offices within the Arizona Department of Health Services. Input from these individuals helped to shape the information and the priorities presented in this publication.

The information in the *Prevention Framework for Behavioral Health* can be used to promote the continued development of community and state comprehensive prevention systems. It can serve as a reference manual for best practices in prevention, help to identify training needs, guide the planning and development of prevention programs, facilitate collaborative action to achieve results-oriented, cost-effective prevention services, and help to collect and share information about program results.

STRATEGIC DIRECTIONS

Arizona faces many pressing health and social problems. We know from research and experience that mental health disorders and substance abuse are often intertwined with issues such as violence, teen pregnancy, HIV/AIDS, child abuse, and domestic violence. To be successful, we cannot address these problems in isolation from each other.

Research and experience show that certain steps are essential to the successful outcome of a prevention effort. These steps form the foundation of the strategic directions for behavioral health prevention in Arizona over the next five years:

By the Year 2000, behavioral health prevention programs in Arizona will encompass...

- A comprehensive, research-based approach.
- A special emphasis on community mobilization within the overall array of prevention strategies.
- Full integration of prevention in Arizona's managed care system for behavioral health.
- Citizen-directed and results-oriented planning and evaluation.
- New training and technical assistance opportunities to expand the expertise in Arizona's communities and to involve and educate citizens and professionals.

Everyone has a role in prevention. No one organization or government agency can tackle these issues alone. It requires broad involvement with business, community groups, human service agencies, media, clergy, educators, health care providers, police, judges, and corrections personnel. In fact, all members of the community need to be involved in prevention.

The *Prevention Framework for Behavioral Health* promotes the active involvement of all citizens and all community sectors in shaping the future of our communities. While it is essential for the Arizona Department of Health Services, Regional Behavioral Health Authorities, and behavioral health prevention providers to take on leadership roles, Arizona's future health and well-being requires the collaborative effort of all citizens.

Prevention programs must be designed to meet the unique needs of the populations they serve. As we plan, implement, and evaluate prevention programs for Arizona's diverse populations, it essential that we take cultural considerations into account. Culture impacts the meaning that behavioral health issues have for the people who live in each community and explains why certain prevention programs may work somewhere, but will not work everywhere.

PREVENTION AND TREATMENT

Prevention is sometimes seen as being separate from, or even as an expendable "add-on" to, behavioral health services. In reality, prevention and treatment work toward the same goals: healthy individuals, families, and communities.

Both treatment and prevention seek to:

- Reduce the incidence and prevalence of behavioral health disorders.
- Reduce demand and need for more expensive and intensive treatment services.
- Improve functioning related to specific skill-building strategies.
- Heighten personal and community awareness of risk factors for behavioral health dysfunction.
- Increase preventive self-care.

Prevention not only is essential to reach long-term goals of community health, but it also complements and can improve the effectiveness of treatment. Treatment, in turn, is an essential resource for effective programming; although prevention programs can reduce exposure to risk and improve the health of target populations, treatment services must be available to meet the needs of individuals who do experience problems and require behavioral health treatment services.

The technologies of prevention and treatment are complementary. Assessment information for planning treatment services, such as demographics and needs of consumers, and system-specific data on treatment utilization can help identify target populations and risk factors. Experience in providing behavioral health treatment can suggest strategies and methods for reaching target populations.

SHARED SHORT TERM AND LONG TERM GOALS

Treatment and prevention both seek to produce short and long term effects through the application of a variety of strategies. Just as in the general public health field, the most effective prevention strategies are

those that support the development of protective factors and coping skills in individuals and families, and promote cultural and social change on the community level to reduce environmental risk.

Long term community-wide effects that are typically sought by both treatment and prevention advocates include reduction in:

1. Prevalence and incidence of alcohol, tobacco, and other drug use.
2. Social/behavioral health problems, such as teen pregnancy, child abuse, and violence.
3. Mortality/morbidity related to behavioral health problems.

Short term prevention goals are to reduce individual and environmental risk factors and to increase resiliency factors to attain individual and community wellness. These are accomplished through a variety of strategies, aimed at the individual, the family, and the community at large. Examples of short term goals and approaches that lead to the desired long term effects are described below.

Changes in an individual's perceptions, attitudes, and knowledge. Recent research demonstrates that reduced substance use in high school students is directly related to their attitudes and beliefs about substance abuse. Peer influences are paramount.

Skill-building. The development of abstinence and refusal skills, anger management, and vocational competencies all have been shown to have a positive impact on desired long term goals.

Changes in laws, policies, and community norms. Examples include raising the minimum drinking age to 21, alcohol-free "Operation Prom/Graduation" parties, and "designated driver" and "don't drink and drive" campaigns.

Changes in the availability of alcohol, tobacco and other drugs, and firearms. Risk factors addressed by these strategies include the accessibility of alcohol outlets and cigarette vending machines, the training and business practices regarding the sale of alcohol and tobacco to minors, and enforcement of community laws related to firearms.

Media campaigns. Statewide alcohol media campaigns convey health consequences messages for pregnant women, and provide warning labels on alcohol beverage containers and cigarette packages.

Family-based services. These include: prenatal care and family-oriented projects such as parent training, home visits, and maternal substance abuse; family-focused projects designed to enhance parent-child interactions, parenting, and other family management skills; family and daycare-focused projects designed to promote learning readiness; and the development of social skills.

Community development. Areas that are addressed include: availability of alternative activities for high risk youth and families; easy access to quality health care, social services and other community resources such as housing, child care, employment, and recreation; and projects such as peer leadership, conflict resolution training, and opportunities for positive peer relationships and healthy lifestyles offered through clubs, civic groups, schools, and religious organizations.

"One-shot" education efforts are not effective. Information alone is not enough. Information on behavioral health issues must be presented within the context of a comprehensive prevention program with multiple strategies. As with all learning, effective programs need to provide a variety of opportunities for youth and adults to acquire new information and to practice new skills.

SYSTEMS CHANGE

Improvements in a community's climate, systems of care, and quality of life are sustained only if the people who live in the community are actively involved in the change process. Prevention must give a special emphasis to community mobilization for community wellness by inviting and involving the different sectors of the community as partners in prevention programming.

All effective prevention efforts are grounded in a community empowerment approach which:

- Identifies the population by health issues and community concerns and considers participants as community members, systems, or groups (*versus* "cases," "patients," or "consumers").
- Involves natural helping networks in the community, in partnership with professionals.
- Emphasizes integration and cooperation.
- Recognizes and values ethnic and cultural differences.
- Develops positive interactions in systems and between systems.
- Utilizes needs-driven goal setting to set specific objectives and performance measures.

Behavioral health prevention programs in the future will have a fluid and dynamic approach to meet the ever-changing needs of communities. There will be a shift from concentrating on the disease model and individual issues, or solely building resiliency and reducing risks, to a focus on improving the conditions that support healthy people, families, and communities. Resource development will look within each community for contributions to assist the overall effort. Behavioral health prevention personnel will actively seek to bring private industry, schools, and other community organizations to the table to participate in collaborative planning and implementation of system-wide efforts.

Most important, behavioral health prevention will help all citizens see that they have a role in prevention. Behavioral health prevention is not a "delivery to" or a "do to," it is an "involvement of" all members of the community. Each person has a role in prevention, and in building the capacity in individuals, families, organizations, and communities to improve and sustain health and wellness.

Prevention provides a special opportunity to tap into a tremendous resource — the enthusiasm and expertise of the people who live in Arizona's communities — and offers great promise for the future health, safety, and quality of life in our state. Together, Arizona's behavioral health agencies, businesses, institutions, and citizens can form a powerful partnership to reach our collective vision: healthy communities that nurture the people who live in them.

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CHAPTER 1
INTRODUCTION

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Prevention is the creation of conditions, opportunities, and experiences which encourage and develop healthy, self-sufficient people.

The *Framework for Behavioral Health Prevention* brings together in one document the goals, requirements, and guidelines for Arizona's behavioral health prevention programs.

The purpose of this document is to:

- Establish strategic directions for behavioral health prevention in Arizona,
- Present models for designing and sustaining sound, effective prevention programs,
- Promote a coordinated approach for local planning, quality monitoring, and documentation of program results, and
- Facilitate state-level consolidation, comparison, and dissemination of information about Arizona's diverse behavioral health prevention programs.

The *Framework for Behavioral Health Prevention* sets key directions for FY 1995-1996 through FY 1999-2000. It begins with a chapter on the priorities for Arizona's prevention initiatives. This is followed by a chapter on comprehensive program design. The next chapter summarizes prevention program models which incorporate best practices in prevention programming. The final chapter highlights the historical foundation and present directions for behavioral health prevention programs in Arizona, and summarizes the next important steps to enhance community vitality and the personal well-being of all Arizonans. The appendices include information on terminology, references, and tools for planning, implementation, and evaluation.

This document emphasizes a research-based, interactive process for comprehensive prevention programming. It is intended to be a flexible guide that can be adapted to meet local needs. It is based on the philosophy that the optimal planning process employs a bottom-up approach within a statewide strategy that defines common principles, goals, and priorities for action. The guidelines presented in the following chapters seek to create continuity between planning done at the local level and statewide plans, and ensure that state-level planning does not preclude local decision-making.

Prevention provides a special opportunity to tap into a tremendous resource — the enthusiasm and expertise of the people who live in Arizona's communities — and offers great promise for the future health, safety, and quality of life in our state. Together, Arizona's behavioral health agencies, businesses, institutions, and citizens can form a powerful partnership to reach our collective vision: healthy communities that nurture the people who live in them.

CHAPTER 2
STRATEGIC DIRECTIONS FOR BEHAVIORAL HEALTH PREVENTION

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IMPORTANT DIRECTIONS FOR PREVENTION

Prevention initiatives in Arizona have received state and national recognition. In the past decade, the emphasis on training, evaluation, and dissemination of information on "what works" has established a substantial experience base in effective prevention programming. However, certain shifts in emphasis are needed to reach our goal of true systems change. Important directions for Arizona's prevention programs over the next five years are described below:

- *Renewed emphasis on comprehensive programming.* Program planners must make sure that work on individual projects contributes toward permanent changes in community systems and norms rather than temporary small-scale changes that remain only as long as there is funding to support them. A common pitfall to be avoided is "projectitis": becoming so absorbed in individual projects to help a small number of individuals with specific problems that the project's role in larger system change is lost. Prevention programs must have a clear overall design which articulates the rationale and choices for individual strategies and projects within the program.

- *Priority for prevention focused on all levels.* Research and experience demonstrate that prevention efforts must be simultaneously directed toward multiple levels to yield positive results. Programs should incorporate strategies targeted to each of six levels: individual, family, organization, systems of care and service delivery, community, and region. Past efforts typically focused on the first three levels (individual, family, and organization) and the *systems*, *community*, and *region* levels have had relatively less attention. More prevention resources need to be allocated to these levels in the future.

- *Expansion of the types of groups and institutions toward which strategies are directed.* Currently, at the organization level, most efforts focus on only one type of organization: schools. While it is important to continue school-based efforts, the range of organizations impacted by prevention programs needs to be expanded to include other institutions, such as private industry, agencies and clubs which provide positive recreational alternatives, and religious organizations.

- *Cultural competence in service planning, delivery, and evaluation.* Effective prevention programs are designed to meet the unique needs of the populations they serve. Developing an understanding, appreciation, and responsiveness to cultural differences is critical for reaching prevention program goals.

- *Full array of prevention strategies.* The Division of Behavioral Health Services defines nine prevention strategies which should be utilized in a comprehensive approach. These strategies are described in more detail in the next chapter. Regional Behavioral Health Authorities (RBHAs) should assess the mix of strategies that are currently employed and make adjustments as necessary to offer a full range of prevention strategies within each region.

- *A special emphasis on community mobilization.* Improvements in a community's climate, systems of care, and quality of life are sustained only if the people who live in the community are actively involved in the change process. Behavioral health prevention programs should take a leadership role in promoting community wellness by inviting and involving the different sectors of the community as partners in

prevention programming. Community mobilization, as a set of prevention strategies, facilitates the participation of citizens, businesses, and organizations in defining and achieving prevention goals which meet the unique needs of the community.

- *Full integration of prevention within the behavioral health managed care system.* Prevention is an essential part of a managed behavioral health care system. It is a critical element in creating healthy lifestyles and reducing costs associated with behavioral health problems. Further, the effective packaging of prevention and treatment services provides an opportunity to enhance service access, improve service quality, offer accountability to insurers and enrollees, and promote the effectiveness of behavioral health care services. The connection between prevention and treatment is explored further in the next section of this report.

- *Priority for training at the local level.* Significant progress has occurred in building a cadre of prevention experts. Prevention training for paid and volunteer personnel must be continued and expanded within each region to build community capacity to design and implement comprehensive prevention programming. Training must occur at two levels. First, training should be made available to all program collaborators, including grassroots groups. Second, ongoing training is needed for the behavioral health prevention personnel who plan, deliver, supervise, and evaluate prevention programs.

- *Collection and reporting of impact evaluation data.* Current data collection and reporting focuses on process and outcome evaluation to document the types of prevention services that are provided, the characteristics of program participants, and short-term results. An approach for conducting impact evaluation must also be implemented. Specific guidelines are presented in *Arizona 2000*:

  > *Every prevention and health promotion program should specify: a) the health benefits to be achieved in both the short- and long-term; b) the processes to be changed to produce those benefits; c) the measures of the benefits; d) the procedures to be used to collect cost-savings data and the cost-savings measures to be examined; and e) the procedures to be used to collect data on the cost of the program.*

PREVENTION AND MANAGED CARE

THE CONNECTION BETWEEN PREVENTION AND TREATMENT

Prevention and treatment ultimately work toward the same goals: healthy individuals, families, and communities. Prevention is sometimes seen as being separate from, or even as an expendable "add-on" to, behavioral health services. Prevention is essential to reach long-term care goals of community health and to reach the immediate goal of reducing penetration into the behavioral health treatment system. The health of the community and the reduction of demand for treatment services are important goals of managed care and prevention.

Treatment, in turn, is an essential resource for effective prevention programming. Preventionists can look to treatment professionals for specific clinical insights into the problems and behaviors that individuals and families demonstrate in treatment. Behavioral health clinicians are in a unique position to provide valuable information on predominant illnesses, symptomatology and manifestations in behavior which are idiosyncratic to a given community, geographic region, disorder, or population. Clinicians and behavioral

health administrators are an effective resource for identifying unmet prevention needs of behavioral health consumers.

Treatment providers can assist in the identification of precursors or risk factors to mental illness and behavioral disorders. In this manner, prevention programs can then more effectively address those precursors, whether individual, familial, or environmental, which place people and communities at risk for behavioral health problems.

THE ROLE OF PREVENTION IN A MANAGED BEHAVIORAL HEALTH CARE SYSTEM

Prevention plays a crucial role in a managed behavioral health care system. When managed care organizations are capitated (at risk) for an identifiable population, they then are inherently tied to the health and well being of that population. There exists significant financial incentives for capitated managed care organizations to attend to and to promote the health of its eligible members and the communities in which they live.

In a capitated managed care environment, the managed care organization is contracted to provide services for a defined population. In Arizona, behavioral health managed care organizations (RBHAs) are capitated based on numbers of eligible persons in their geographic or catchment area. They are contracted for a predetermined amount and are obligated to provide medically necessary services to those eligibles in need. In some geographic areas in Arizona, the managed care organization subcapitates to a subcontracted provider or provider network. In these instances, the provider organization is at risk for the health of its agreed service area population. The medical loss ratio in a capitated managed care system determines the proportion of contracted funds expended on service provision. In a capitated system, while the managed care organization is at risk to provide all the services necessary, the organization is also incentivized through the ability to retain funds left unspent.

Therefore, the managed care connection to prevention is quite fundamental. The capitated managed care organization by its nature has a significant investment and stake in the health and well-being of its consumers and any potential future members. Prevention's role in this type of a managed care environment is to assist with the identification of those risk factors which lead to behavioral health problems and to reduce those risk factors. Prevention is additionally well-positioned to support those factors which increase resiliency to assist individuals, families, and communities to remain healthy so as to not require costly treatment-related services. Managed care organizations do well to invest in the health of the communities which they are charged with serving. Prevention and preventive care is the vehicle to maximize limited resources and attain optimal individual and community health.

PREVENTION OBJECTIVES IN MANAGED CARE

Specific prevention objectives in managed care include:

- Reduce the incidence and prevalence of behavioral health disorders in the population served by the managed care organization.
- Reduce the demand and need for behavioral health treatment services.
- Increase preventative self-care among eligible members.
- Improve individual and family functioning through specific skill building strategies.

- Address and mitigate community, environmental, and other conditions which are demonstrated precursors to behavioral health disorders.
- Through community mobilization, create and foster networks and resources which ultimately increase quality of care and related services.
- Promote the health and well-being of communities and community members.

PRIORITIES FOR PREVENTION IN ARIZONA

The Bureau of Prevention, working with Regional Behavioral Health Authorities and local prevention providers, has established strategic goals and objectives for Arizona's prevention programs. Each has implications for prevention policies, programs, and practices. Following is a summary of the strategic directions for FY 1995-1996 – FY 1999-2000.

By the Year 2000, behavioral health prevention programs in Arizona will encompass ...

- **A Comprehensive Approach.** Behavioral health prevention programs will follow best practices in prevention programming. Goals will be clearly defined, objectives will be targeted to specific needs, a full array of strategies will be activated, strategies will be implemented at all levels, and approaches will be coordinated, research-based, and relevant to community members.
- **Community Mobilization.** Behavioral health prevention planners and providers will place a special emphasis on community mobilization within the overall array of prevention strategies.
- **Full Participation In The Behavioral Health Continuum of Services:** Prevention will be fully integrated into Arizona's managed care system for behavioral health.
- **Citizen-Directed and Results-Oriented Planning and Evaluation.** Members of the community will be included in all phases of program planning and evaluation. Behavioral health prevention programs will develop and implement an approach for impact evaluation of prevention programs statewide.
- **New Opportunities for Training and Technical Assistance.** Prevention programs will expand through training the number of individuals involved in prevention and the level of expertise in each community to design, implement, and provide technical assistance for local research-based prevention programs. Regional roundtables or other community-based forums will be utilized to involve and educate citizens and professionals.

A VISION FOR THE FUTURE

The guidelines in this document provide direction for accomplishing Arizona's strategic directions for prevention:

1. All prevention efforts are grounded in a community empowerment approach which:
   - Identifies the population by health issues and community concerns and considers participants as community members, systems, or groups (*versus* "cases," "patients," or "consumers").
   - Involves natural helping networks in the community, in partnership with professionals.

- Emphasizes integration and cooperation.
- Recognizes and values ethnic and cultural differences.
- Develops positive interactions in systems and between systems.
- Utilizes needs-driven goal setting to set specific objectives and performance measures.

2. Agencies, organizations, groups, and advocates coordinate and collaborate in a systems-level approach for planning, implementing, and evaluating prevention programs.

3. A comprehensive approach is employed to focus on six levels: individual, family, organization, systems of care and service delivery, community, and region.

4. The focus is on the entire population (neighborhood, organization, community).

5. Known risk factors and resiliency factors are identified for the target population.

6. Risk factors and resiliency factors to be addressed by the prevention program are determined, with a focus on the risk factors and resiliency factors appropriate to participants' developmental stage.

7. Strategies to reduce each targeted risk factor and to promote each targeted resiliency factor are selected.

8. Evaluation measures to collect, analyze, and report process, outcome, and impact data are integral parts of program planning and implementation.

Behavioral health prevention programs in the future will have a fluid and dynamic approach to meet the ever-changing needs of communities. There will be a shift from concentrating on the disease model and individual issues, or solely building resiliency and reducing risks, to a focus on improving the conditions that support healthy people, families, and communities. Resource development will look within each community for contributions to assist the overall effort. Behavioral health prevention personnel will actively seek to bring private industry, schools, and other community organizations to the table to participate in collaborative planning and implementation of system-wide efforts.

Most important, behavioral health prevention will help all citizens see that they have a role in prevention. Behavioral health prevention is not a "delivery to" or a "do to," it is an "involvement of" all members of the community. Each person has a role in prevention, and in building the capacity in individuals, families, organizations, and communities to improve and sustain health and wellness.

CHAPTER 3
PREVENTION PROGRAM DESIGN

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OVERVIEW

This chapter provides information on seven topics related to prevention program design:

- Prevention Definition
- The Planning and Evaluation Cycle
- Comprehensive Needs Assessment
- Target Populations
- Prevention Strategies
- Program Evaluation
- Program Standards and Personnel Competencies

PREVENTION DEFINITION

The Division of Behavioral Health Services (DBHS) Bureau of Prevention defines prevention as *the creation of conditions, opportunities, and experiences which encourage and develop healthy, self-sufficient people.* Effective prevention programs are built upon four basic premises:

- Prevention strategies must be comprehensively structured to reduce individual and environmental risk factors and to increase resiliency factors to attain individual and community wellness.
- Community involvement is a necessary component of an effective prevention strategy; a shared relationship among all parties is essential in the promotion of behavioral health prevention efforts.
- Prevention must be intertwined with the general health care and social services delivery systems within the community.
- Prevention approaches and messages that are tailored to differing population groups are most effective.

These premises form the foundation of the standards, concepts, and methods described in this chapter. Research on prevention programs consistently points to the need for a *comprehensive* approach. The four components of a prevention program discussed in the following sections are defined as follows:

- Program: A *program* is the overall, combined effort of an organization to meet the long-range prevention goals for the individuals, families, organizations, and communities in the region.
- Project: A *project* is a specific initiative targeted to a specific population. For example, one project might be designed for isolated elderly in the community to build supportive networks and reduce the incidence of depression and other problems. Each project uses a number of strategies to achieve its aim.

- Strategies: *Strategies* are specific, research-based approaches for achieving project objectives. For example, if a project goal is to provide youth in the target population with an opportunity to form a caring relationship with a non-parent adult, one strategy might be mentoring.

- Activities: *Activities* are the individual events or processes which take place when a strategy is employed. For example, one activity for the community mobilization strategy is the collection of demographic and problem indicator data.

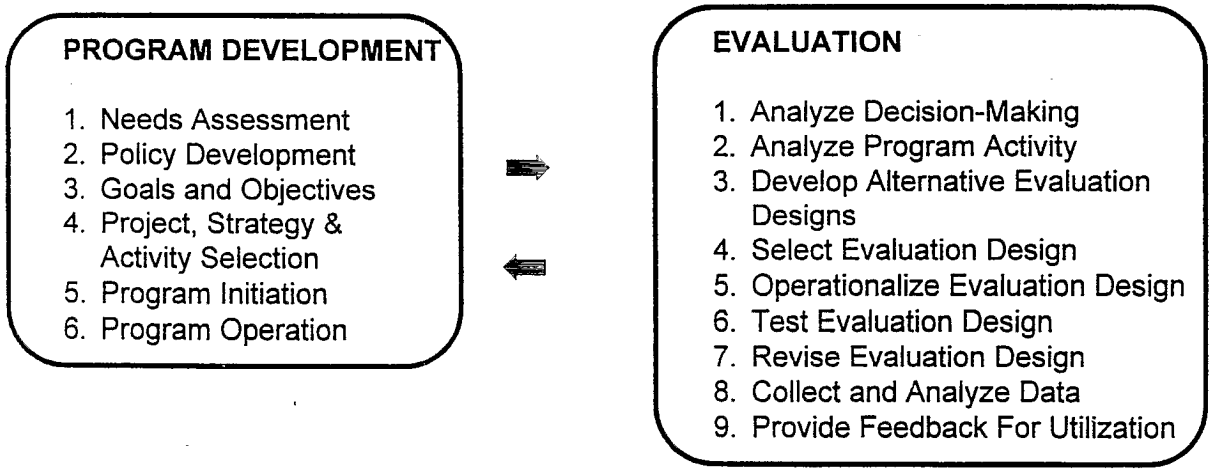
These components are brought together in a planning, implementation, and evaluation process.

THE PLANNING AND EVALUATION CYCLE

The key to success is a systematic, realistic planning effort. The process generally includes the following steps:

- Statement or review of mission and principles,
- Needs assessment,
- Development of goals and objectives,
- Design of action/implementation plan,
- Assignment of leadership tasks,
- Implementation,
- Evaluation, and
- Program revision based on evaluation findings.

The process is ongoing and interactive. The program development component focuses on defining, developing and implementing a plan of action to achieve the desired results. The evaluation component assesses the degree to which the desired results are attained. Information from program evaluation helps to improve the program, and guides decisions on whether to continue, expand, modify, or eliminate specific projects, strategies, or activities. The chart below displays the dynamic interaction between these two functions.



COMPREHENSIVE NEEDS ASSESSMENT

The first step in the planning and evaluation cycle is performing a needs assessment. A comprehensive prevention needs assessment involves:

- Gathering information from the community on *perceptions* of behavioral health issues and priorities.
- Determining the *incidence and prevalence* of behavioral health problems.
- Identifying *existing behaviors and conditions* within a population that *predict* future behavioral health problems (risk factors) or *reduce the likelihood* of behavioral health problems (resiliency factors).
- Assessing *resources* available to the population that can modify these behaviors and conditions.
- Identifying the extent and types of *unmet needs*.
- Assessing the *readiness* of the population and the agencies serving the population to implement new preventive initiatives.
- Examining the *demographic composition* of the target population.
- Identifying *opportunities and barriers* related to prevention services and programs.

Assessment information serves many useful planning and management functions. It can be used to:

- *Compare prevention needs and resources* to identify specific prevention needs, types of services which exist to meet the needs, patterns of use of services, actual and potential accessibility of services, social and economic costs of providing different types of services, gaps in services, and service duplication.

- *Establish baseline data* against which future progress can be compared.

- *Modify resource allocation methods* to meet the differing needs of a variety of parties, each with potentially different goals.

- *Improve accountability* by tracking costs and outcomes of prevention efforts.

- *Promote a comprehensive system* of behavioral health care resources which integrates prevention into the full continuum of services.

- *Improve collaboration and communication* between organizations.

At a minimum, six key sets of data should be included by RBHAs in resource assessment:

- Current social indicators and trends related to behavioral health problems.
- Dollar figures of money spent on prevention by source, target population, program, project, and strategy.
- Risk and protective factors targeted by each program.
- The strategies used by each program.
- Target population of each program.
- Number, age, race and ethnicity, and gender of people actually served by each program.

ASSESSMENT DATA COLLECTION TECHNIQUES

There are a variety of data collection techniques for community needs assessments. These are summarized below. The first two techniques, population surveys and social indicator data collection, are the most widely used. The reasons for their widespread use are relatively low cost, ease of implementation, and greater reliability. The remaining techniques, collectively labeled "key informant/expert discussions," are traditionally used to supplement survey and social indicator data by providing much more detailed and descriptive interpretations of a situation. The quality of the data received through these techniques relies primarily on the ability to include participants truly representative of the target communities and the ability of the planners not to bias the responses through interviewing methods.

- Social Indicator Collection
- Population Survey
- Key Informant/Expert Discussions: Individual Interviews or Questionnaires
  - Key Informant
  - Stakeholder
  - Client-Centered
- Key Informant/Expert Discussions: Group Information Gathering/Sharing
  - Focus Group
  - Community Forum
  - Nominal Group Process
  - Delphi Technique
  - Advisory Groups and Task Forces
- Key Informant/Expert Discussions: Analytical/Non-Intrusive Methods
  - Analytical/Non-Intrusive Methods
  - Participant Observation/Ethnographic Studies
  - Content Analysis
  - Social Network Analysis

TARGET POPULATIONS

Effective prevention programs are modified to meet the unique needs of the populations they serve. The following chart provides a guide for identifying population groups which might be included in the needs assessment.

TARGET POPULATIONS
Planning Checklist

☐ *General Population*	Neighborhood; Community; Region
☐ *Age*	Youth: Prenatal/Neonatal; Infants & Toddlers; Preschool; School-Age Youth Adults: Young Adults; Adults; Older Adults
☐ *Communication*	People for Whom English Is a Second Language Literacy
☐ *Ethnicity, Race & National Origin*	African-American; American Indian; Asian; Caucasian; Hispanic; Other
☐ *Gender*	
☐ *Geographic Factors*	RBHA/Tribe Service Areas Urban/Rural Districts/Neighborhoods High Growth/Declining Population Areas Border Areas (AZ/Mexico, State/Reservation)
☐ *Marital/Family/Household Status*	
☐ *Other Target Populations*	Children of Adults Receiving Behavioral Health Treatment Services Individuals at Different Income Levels New Immigrants Migrant Populations Out of School Youth People with Developmental Delays and Disabilities Potential Gang Members Pregnant Teens

PROGRAMMING FOR DIVERSE POPULATIONS

Culture affects us all. It is the lens through which we view both the internal and external worlds. Culture often cuts across traditional racial and ethnic designations used to categorize people. We can make cultural distinctions between urban and rural communities, between economic groups, or between those who are included or excluded from participation in community institutions.

Culture is the means by which people define themselves individually and as members of groups. It helps them interpret and make sense of the world. It guides them as they interact with, respond to, and influence people, events and conditions in their environment. Culture impacts the meaning that behavioral health issues have for the people who live in the community. Culture explains why certain prevention programs may work somewhere, but will not work everywhere.

Culture is an essential consideration when defining the community. It is important to recognize that there are many different groups involved in the prevention process, and they may have different viewpoints. Acknowledging divergent perceptions, and developing an understanding and appreciation of cultural differences, is critical to facilitating the process of coalition building.

In behavioral health prevention, the following are some of the realms directly influenced by culture:

- *Views of health and what it means to be sick.* For example, behavioral patterns that might indicate a drinking problem are considered normal recreational activity in some communities and among some groups.

- *Reward and status systems.* How people view the future, and their coping strategies, are greatly influenced by their culture and have a direct influence on their motivation to become drug-free.

- "*Rites of passage.*" In some communities, learning to "hold one's liquor" or joining a gang is viewed as a rite of passage for young males. In other communities, these patterns are contrary to cultural norms and traditions.

- *Role models and mentors* who have real meaning for the people in the community are influenced by culture in terms of whether they are seen as appropriate and viable.

- Other areas where there may be cultural differences among populations include:
  - Experience and/or communication of pain or problems,
  - Labels for symptoms or indicators,
  - Beliefs about the problem(s) and/or causes,
  - Attitudes about prevention providers and/or other community organizations, and
  - Personal involvement and responsibility.

Behavioral health issues affect us all — but not to the same degree or in the same way. In a perfect world we would have the money, time, and support to implement all needed strategies to meet the needs of all identified target populations. In reality, programs must choose their priorities and target resources to where the need is greatest. Each program must take into account who is most affected and how the program can effectively address the needs of the target populations. The culture of each target population is an important consideration when selecting the particular mix of strategies for reaching each group.

PREVENTION STRATEGIES

Sound prevention approaches build on the insights and principles of prevention program models. A comprehensive program should employ a multi-component effort that seeks to reduce the most significant risk factors faced by the target group. It also should increase protective factors to offset the risks that cannot be changed by the program's intervention.

As an example, a prevention project might be designed for children whose parents are experiencing behavioral health problems. Strategies might include: a special daycare component; home visits which focus on parenting skills; mentoring; after-school activities with peer-led exercises; and links to schools and social services. Taken together, these strategies could mitigate the impact of stressors resulting from family issues and nurture the health and resiliency of the children who are in the program. More information about risk and resiliency, and summaries of other prevention program models, are presented in the next chapter.

Comprehensive programs consider the following criteria when selecting specific strategies:

- A mix of strategies. The most effective programs provide the target population with multiple opportunities in a variety of settings to learn and practice healthy behaviors. Using a combination of strategies has the added advantage of meeting the needs of a more diverse audience and accommodating a greater number of the factors that are necessary for a prevention effort to be successful.

- Strategies offered at multiple levels. Prevention programs are most effective when they employ complementary strategies at each of six levels: 1) individual; 2) family; 3) organization (such as a school or an employer); 4) systems of care and service delivery (such as health care or recreation); 5) community; and 6) region. See Appendix H, *Prevention Strategies for Multiple Levels of Influence*, for a matrix to plan strategies for each of the six levels.

- Strategies appropriate for the target population. Strategies should be matched to the specific problems and needs of the community. The choice of strategies will be influenced by the age, sex, culture, and socioeconomic status of the target population.

- Collaborative linking of strategies. The overall program design should be all-inclusive in terms of identifying *all* strategies required to reach the goals and objectives of each project. The next step is to select which of these strategies will be provided directly. Some strategies may already be available through other providers. A collaborative agreement with other providers is one way the program's strategies could be joined with the efforts of the other providers to eliminate duplication and achieve program goals. See Appendix I, *Prevention Strategies for Collaborative Planning*, for a matrix to plan the collaborative linking of strategies.

- Resource availability. Strategies vary in the intensity, frequency, and duration of the activities necessary to successfully implement the strategy. The level of expertise needed to implement a strategy is another consideration when assessing resources. While strategies should not be eliminated as potential project elements simply because resources are scarce, it is important — as a practical matter — to consider the availability of resources required to implement a particular strategy. Creative use of existing resources and alternative combinations of strategies are two options for selecting a project's mix of strategies.

RBHAs and behavioral health prevention providers should consider incorporating the following range of research-based, contract-reimbursable prevention strategies into their prevention projects.

ADHS/DBHS PREVENTION STRATEGIES	DESCRIPTION (All prevention services are reported in 15-minute increments)	CODES (Applicable for subvention reimbursement only. Do not report or claim for Title XIX reimbursement.)
Training	Training provided to behavioral health or other prevention professionals for the purpose of enhancing the preventionist's skills, thereby improving the quality of prevention programs. May include training of trainers or professional seminars, and must include goals and objectives based on a training needs assessment.	S5002
Public Information & Social Marketing	Prevention public information/social marketing. Presentation of accurate targeted messages and promotional material on substance abuse and mental health issues, including suicide and teen pregnancies, to increase awareness of behavioral health. May include information seminars, electronic and print media.	S5003
Community Education	Prevention community educational sessions with clear goals and objectives designed for a specific target group. Must be on-going sequential learning that promotes a change in attitude and behaviors that may lead to behavioral health problems.	S5004
Parent/Family Education	Prevention parent/family educational sessions aimed at parents and family members. May be ongoing, sequential sessions or workshops with defined goals and objectives. May include early childhood development, parenting skills, parent/child communication, and healthy families.	S5005
Alternative Activities	Prevention alternative activities that provide challenging positive growth experiences, leading to the development of self-reliance and independence. Programs offer healthy alternatives for leisure/free time within the community setting.	S5006
Community Mobilization	Prevention community mobilization activities directed toward the development of an ongoing grassroots movement to deal effectively with behavioral health issues within the community. Must include these activities: 1) Developing partnerships with schools, businesses, Governor's Alliance Against Drugs; 2) Resource Networking; 3) Developing Neighborhood Coalitions; 4) Training and Technical Assistance to Coalitions; 5) Community Needs Assessment.	S5007
Life Skills Development	Prevention life skills development activities that assist individuals in developing or improving critical life skills. Must be ongoing, sequential learning activities or sessions that focus on the development of skills in decision making, coping with stress, values awareness, problem solving, conflict resolution, resistance skills, and self-esteem.	S5008
Peer Leadership	Prevention peer leadership skills development through the pairing of trained and supervised peers with others. Must have a curriculum. May include a variety of activities designed to reinforce leadership capabilities.	S5009
Mentorship	Prevention mentorship through the use of positive role models to provide support and guidance to assist individuals in achieving personal growth. Usually matches a young person with an adult, who provides guidance to that person re-establishing and maintaining a positive relationship through a variety of activities.	S5010

PROGRAM EVALUATION

No single, standardized evaluation format is appropriate for evaluating each and every prevention initiative. Evaluations must be designed according to the nature of the specific effort and the particular set of goals and objectives.

Program evaluation should be responsive and useful to program planners, managers, and other stakeholders. It should be technically sound, cost-effective, and conducted in a fair and ethical manner. Practical evaluations provide the kind of feedback that encourages programs and communities to redouble their efforts where successful and to modify or abandon less successful efforts.

Prevention programs should conduct three types of evaluation:

- *Process Evaluation.* The process portion of prevention program evaluation is descriptive in nature. It provides information on the people served by the program, and documents the program's activities, materials, and staffing. Process evaluation provides information on milestones reached during implementation; monitors scheduling and quality; tracks program costs; and creates a descriptive base for program replication. Process evaluation enables comparisons between the program plan and its actual implementation, and provides opportunities to adjust and refine the program as needed along the way.

- *Outcome Evaluation.* The outcome portion of prevention program evaluation focuses on the extent to which the program's short-term, measurable goals and objectives have been met. Some goals may be affective in nature, such as satisfaction with the program. Some goals may be cognitive in nature, such as gains in knowledge or skills. Some goals may be behavior-based, such as a reduction in unexcused absences from work or school. Outcome evaluation documents and discusses short-term effects regarding attitudes, knowledge, and behavior; qualitative factors believed to have affected the program; and unexpected outcomes, both positive and negative.

- *Impact Evaluation.* The impact portion of program evaluation examines the long-range changes in health risk behaviors, and changes in individual and community health and wellness. Assessing the impact of comprehensive prevention programming must be done holistically from a community-wide perspective. As a part of the impact evaluation process, the extent to which the highest priority goals of the community have or have not been achieved are examined. Impact evaluation serves the overall purpose of determining whether the program had the desired effect on behavior, such as a decrease in the number teenage pregnancies.

The following chart gives examples of indicators for process, outcome, and impact evaluation.

	TYPE OF EVALUATION		
	PROCESS	OUTCOME	IMPACT
Focus of Evaluation	Short-Term Effects		Aggregate or Cumulative Long-TermCommunity-Wide Effects
Potential Indicators of Effectiveness	Description of: • Target audience • Prevention services delivered • Staff activities planned/performed • Financing resources utilized • Scheduling • Participation by other organizations	Changes in: • Perceptions • Attitudes • Knowledge • Actions: Drug use Truancy School achievement Involvement in community activities Policy modifications	Changes in: • Prevalence and incidence of alcohol, tobacco, and drug use • Prevalence and incidence of other behavioral health problems, such as teen pregnancy, child abuse or violence • Mortality/morbidity related to behavioral health problems • Youth/parent involvement in community

EVALUATION PLAN

A written evaluation plan for each prevention program is prepared and updated annually. Basic elements of the plan include:

- Statement of the goals and objectives to be evaluated.
- Description of how the goals and objectives are linked to the target population and identified needs, including risk and resiliency factors.
- Summary of the planned implementation process.
- Specification of measures and indicators for the process, outcome, and impact portions of the evaluation.
- Data sources.
- Data collection procedures.
- Data analysis and reporting processes.

PROGRAM STANDARDS AND PERSONNEL COMPETENCIES

Arizona's program standards and personnel competencies provide a foundation for program planning, implementation, and evaluation. These standards and competencies were developed under the authority of A.R.S. 36-3421 by the Children's Behavioral Health Council with the involvement of both state and local level prevention staff.

At the time the draft set of standards was completed, the Arizona Drug and Gang Policy Council identified the need to develop minimum competencies and skills for preventionists. It was evident that minimum competencies and skills were interrelated with program standards, and that it would be beneficial to the field of prevention if the two were combined in one document. The resulting collaborative effort produced the 1994 *Prevention Program Standards*, in which minimum competencies and skills are embedded within the program standards.

Arizona's *Prevention Program Standards* provides specific guidelines for prevention programs. The *Prevention Program Standards* also include: Code of Ethical Conduct for Prevention Professionals; Skills and Competencies for Volunteers; and Skills and Competencies for Professionals. The five program standards focus on:

- Participants' Rights and Responsibilities
- Program Development and Evaluation
- Program Implementation and Integration
- Continuum of Care
- Responsibility for Lasting Outcome

The *Prevention Program Standards* highlights the statutory mandates and policy priorities for including prevention programs as an integral part of the comprehensive children's behavioral health system. The standards establish expectations for Arizona's behavioral health prevention providers based on principles for effective, quality, and comprehensive prevention programming.

Appendix C contains the full text of the *Prevention Program Standards*. The standards provide a basis for prevention training and program administration and are an important resource for program development.

CHAPTER 5
PREVENTION PROGRAM MODELS

CHAPTER 4
PREVENTION PROGRAM MODELS

OVERVIEW

Researchers have developed models for prevention planning, implementation, and evaluation. Each contributes options and approaches that can be adapted to local needs to create a unique, comprehensive program design.

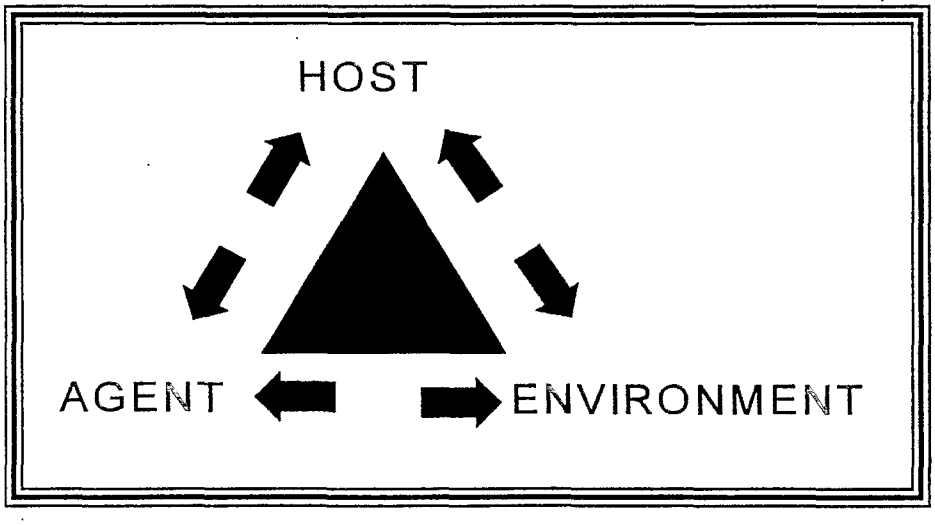
There are several reasons why these prevention program models are important. First, each model offers proven strategies. Prevention programs that incorporate research-based strategies maximize their likelihood of success. Second, these models can help prevention programs to make wise and cost-effective decisions about how to best utilize their program's limited resources. Third, by using the program models, preventionists can avoid approaches that have been proven to be ineffective or counter-productive.

This chapter begins with an overview of the Public Health Model, which was the foundation of early prevention programs. The next section describes three *systems-level* models: the Technology of Development Model, an Open Systems Model, and the Community Mobilization Model. This is followed by descriptions of *individual-level* models: the Developmental Model, and Risk and Resiliency Models.

PUBLIC HEALTH MODEL

Prevention has its roots in the public health model, which applies theory and experience with preventing disease to the prevention of behavioral health problems. The public health model explains behavioral health problems in terms of three causative factors: the host, the agent, and the environment.

PUBLIC HEALTH MODEL



Host. For prevention, the host is each person in the target population. The target population may be the public at large. Alternatively, the target population may be a specific group of individuals who are selected

according to a criterion such as age or exposure to a set of risk factors. In either case, the host is defined as the individual(s) and his or her knowledge, attitudes, behavior, and susceptibilities to the agent. Historically, host-oriented primary prevention strategies targeted youth in school settings. Substance abuse prevention initiatives that have focused on the host included: teaching skills that champion healthy lifestyles; promoting "Don't Start" perspectives; and providing factual knowledge concerning alcohol, tobacco, and other drugs. Host-focused strategies for adults have included media awareness and designated driver campaigns.

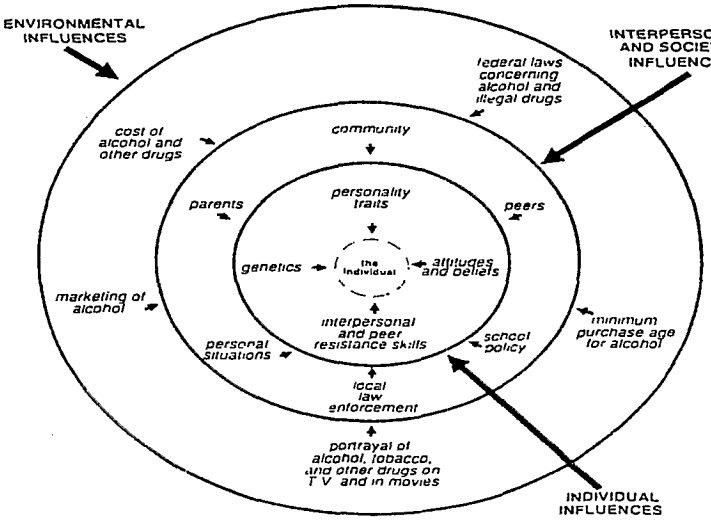
Agent. In substance abuse prevention, the agent is the substance. Public health advocates have had some success in influencing legal agents such as alcohol and tobacco. Requiring warning labels on alcoholic beverage containers and cigarette packages are examples of these successes. Public health advocates also have focused on illegal agents such as illicit drugs. The national "War on Drugs" campaign focused primarily on the agent. A controversial program in the 1970s that sprayed marijuana fields in Mexico with a potent insecticide that made humans ill is another example of focusing on the drug as the agent.

Environment. The environment is comprised of physical, social, cultural, political, and economic aspects. It includes the structures, climate, and forces which shape the context, setting, consequences, frequency, and quantity in which the agent is used. Within the public health model, environments include schools, families, neighborhoods, and communities, as well as the broader social and cultural environments that are influenced by legislation, pricing, advertising, and media portrayals of human behavior.

A Multi-Factor Approach. The public health model demonstrates that programs which depend exclusively on teaching the host, altering the agent, or changing the environment oversimplify the complexities of living in society today. Each factor — the agent, host, and environment — must be considered for effective prevention.

SYSTEMS-LEVEL MODELS

Systems-level models focus on the "big picture" to describe how the action of each component and the interaction between components can be optimized to achieve the prevention program's goals and objectives. The diagram below displays a system-level model for addressing substance abuse problems in the community.



PREVENTION:
AN EXAMPLE OF
A SYSTEMS APPROACH

Source: *Prevention Plus II*, Center for Substance Abuse Prevention

SYSTEMS-LEVEL: THE TECHNOLOGY OF DEVELOPMENT

THE TECHNOLOGY OF DEVELOPMENT

The Technology of Development, until recently called the Technology of Prevention, is an effort to create a new and different concept and approach to prevention work. The dominant idea of prevention in many people's minds has been "stopping something from happening", a reactive notion in the remedial, deterrence, or problem-solving realm.

The term *development* is defined as "an active process of creating conditions and fostering personal attributes that promote the well-being of people." It is clearly distinct in both concept and practice from "stopping things from happening", problem-solving, and deterrent efforts.

The Technology of Development has three undergirding principles:

- **The Principle of Participation**: When people have an opportunity to participate in decisions and shape strategies that vitally affect them, they will develop a sense of ownership in what they have determined and they will have a commitment to seeing that decisions are sound and strategies are useful, effective, and carried out. This theory is basic to a democratic society.

- **The Principle of Responsibility**: Strictly and practically speaking, no person can ever be *responsible for* another person. One can only be responsible for oneself *in relation to* another person. How one takes responsibility for oneself in relation to other people helps determine the quality of the relationship. When people agree to work together toward mutually desirable goals that promote their mutual well-being, a sense of *corporate* or *community responsibility* emerges. This theory is basic to good interpersonal relations.

- **The Principle of Changing Conditions**: When people work together to create conditions that promote their mutual well-being, not only is a clear sense of the common good strengthened and pursued, but the individuals involved are provided opportunities for personal growth and development as well. This theory is basic to effective community development.

The Technology of Development is made up of six interacting models:

- **The Arenas of Action.** The Arenas of Action model helps to conceptualize the notion that the ultimate purpose of all human service activity is the creation of conditions that promote the well-being of people.

- **The Elements of Change.** This model describes and helps people understand the current reality (what's happening now) and the new reality (the vision, goal, outcome). It emphasizes indicators to gauge progress in moving from the current reality to the new reality. It directs attention to answering the questions, "Are our actions clearly connected to our condition analyses and indicators?" and "Do our actions have a high probability of getting us to the new reality?".

- **The Spectrum of Attitudes.** The Spectrum of Attitudes focuses on the nature and quality of relationships between and among people. Three attitudes make up the Spectrum: (1) people viewed as objects; (2) people viewed as recipients; and (3) people viewed as resources. There are behaviors which can be related to each of these attitudes. This part of the technology explores the differences between these attitudes and their related behaviors.

- **The Levels of Networking.** Networking focuses on the nature and quality of relationships between and among individuals, groups, and organizations. This part of the Technology of Development explores the kinds of interorganizational working relationships that are developed in the interest of promoting positive change at three levels:

  - Level I Networking — Awareness Building and Information Sharing
  - Level II Networking — Planned Extension of Organizational and Community Resources
  - Level III Networking — Cooperative Creation of New Resources and Realities

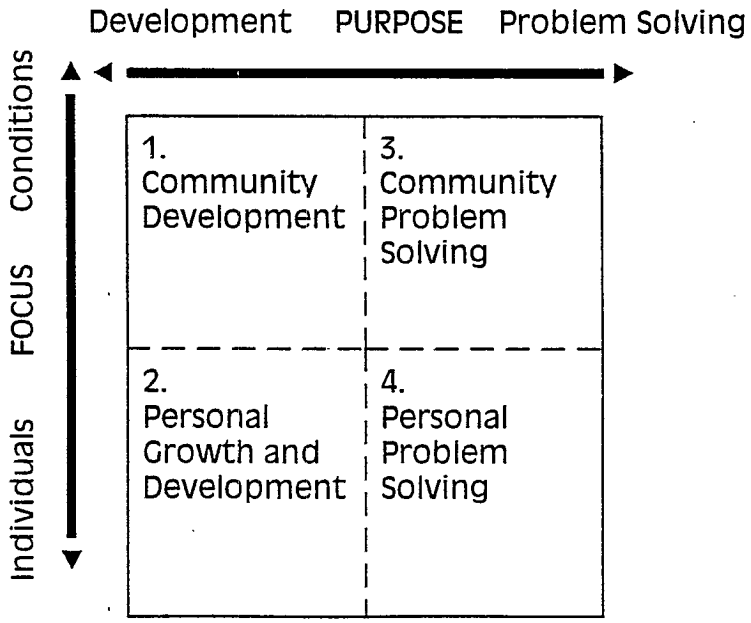
- **The Sources of Design.** This model considers the Prescribed Structure and Developmental Process forces which work to shape and design the ways things are done.

- **The Planning of Strategy.** The process of strategic planning is an ongoing endeavor that engages people in using over and over again what they have learned. With each new cycle the learning deepens, and those involved can become a *learning community*. As this work unfolds and succeeds, it becomes an experience in *community development*.

ARENAS OF ACTION

As one of the six interacting models that make up the Technology of Development, the Arenas of Action explains why the ADHS/DBHS Community Mobilization strategy is so important.

Quadrant 1 is Community Development. Work in the other three quadrants, when successful, will lead ultimately to the creation of conditions that promote well-being. The model helps to conceptualize the idea that development work can start in the problem-solving arenas and move purposefully into the development areas. Most important, the model calls for many fundamental changes in the way we think about and carry out human services to put more emphasis on starting in Quadrant 1.



Key words used in the model are defined below:

Development is an active process of creating conditions and fostering personal attributes that promote the well-being of people.

Problem Solving is a reactive, corrective effort to bring about change where there is a recognized problem.

The *Purpose Continuum*, across the top of the graphic, includes the possibilities which extend from development to problem solving as defined above.

The *Focus Continuum*, down the left side of the graphic, begins with the individual and expands to include groupings of people, such as the family, the peer group, the neighborhood, the school, and larger arenas through the city, the county, the state, the nation, the world.

The quadrants in the Arenas of Action model can be used to conceptualize general types of programs, where a program is a set of activities designed to achieve a specific purpose or outcome.

ARENAS OF ACTION		
General Program Type	**Description**	**Quadrant**
SERVICE ROUTINES	These are predetermined steps through which people go with few exceptions (e.g., regular appointments as part of a treatment program). They are usually focused on individuals, though they may be within a group context. Service routines are often prescribed, but can be developmental with prescribed structures.	Most often found in Quadrant 4, and within a single organization.
STRUCTURED ACTIVITY SETS	Planned regiments in which people participate, such as a curriculum, merit badge requirements, or a sport team. They are usually focused on personal or individual growth, though frequently in a group context. Structured activity sets are often prescribed, but can be developmental within prescribed structures.	Most often found in Quadrant 2, and within a single organization.
NARROW INITIATIVES	Specially designed efforts, usually narrowly focused on a specific purpose and outcome, such as a substance abuse task force. Frequently, though not necessarily, these initiatives are concerned primarily with problem solving (e.g.,Neighborhood Watch). They are often primarily developmental, though they can use prescribed models, and often are in response to a crisis.	Most often found in Quadrant 3, and involve interorganizational networking.
BROAD INITIATIVES	Broadly focused strategies designed to impact major issues, conditions or populations, such as a community-wide effort to strengthen and support families. While usually not a crisis response, a crisis might be the stimulus. These initiatives are highly developmental and build from the ground up. They can occur within bounded areas, such as a family, organization, school building or district, a neighborhood, city, county, state or nation, or international in scope.	Most often found in Quadrant 1, and involve interorganizational networking.

SYSTEMS-LEVEL: OPEN-SYSTEMS MODEL

The Open Systems model was developed to help organizations and communities respond to undesired and complex social conditions. It is a down-to-earth, useful, and potentially universal approach for assessing dynamic and open social systems. The Open Systems model provides a process for multiple-strategy prevention programming where resulting outcomes and impacts cannot be attributed to a single strategy. This method promotes integration of the design, assessment, and monitoring of each strategy to maximize its anticipated results *within the context* of its contribution to the total prevention effort.

Appendix F, *An Open Systems Model for Prevention Programs*, discusses the dynamics of the Open Systems model and provides detail on the planning and evaluation approaches used in this model.

SYSTEMS-LEVEL: COMMUNITY MOBILIZATION MODEL

Community Mobilization incorporates concepts for effective programming from many models and is based on the principles for comprehensive prevention programs. It represents a conceptual leap in prevention practice from separate niches of activity to a fully integrated, multi-system model.

Prevention providers' community mobilization activities are an ADHS/DBHS contract-reimbursable prevention strategy, and are described further on Page 16. Community mobilization is also a priority of the ADHS/DBHS Bureau of Prevention and is included on Page 6 in the discussion of strategic directions for behavioral health prevention in Arizona.

The Southwest Regional Center for Drug-Free Schools and Communities developed a framework with six developmental stages for communities engaged in a community mobilization process:

- Stage 1: Entry/Initiating
- Stage 2: Readiness
- Stage 3: Assessment
- Stage 4: Planning
- Stage 5: Implementation
- Stage 6: Sustaining/Reinforcing/Replanning

The framework includes action steps to accomplish each stage, suggested mobilization strategies or tactics for all stages, desirable outcomes at every step, and areas in which groups may need support as they progress through the stages. In practice the process is not linear. Groups may move back and forth between stages as they work toward their goals. Appendix G displays a chart which details the action steps, strategies, outcomes, and support needed for each of the six stages.

Communities often mobilize when an issue or problem gains visibility and galvanizes citizens to take action. As an example, some of the typical issues that motivate community action to prevent *substance abuse* include:

- Community norms and practices related to the use of alcohol, tobacco, and other drugs, including drinking and driving.

- Local and regional pro-use messages on billboards, radio, and television, and in movies and the print media.

- The availability of alcohol and other drugs.
- The location of alcohol outlets and cigarette vending machines.
- The training and business practices of those selling or serving age-restricted products such as alcohol and tobacco.
- The enforcement or lack of enforcement of relevant laws, ordinances, and curfews.
- School policies and practices regarding school and business prevention efforts, consequences for the use of alcohol, tobacco or other drugs, and school climate.
- The allocation of resources (dollars, materials, and personnel) to address community problems.
- The development of alternative activities for youth, families, and other populations with special needs.

Community members can and must be involved in community prevention programs. Only involved and empowered individuals will make the long-term commitment necessary to accomplish the goals of social and environmental change.

INDIVIDUAL LEVEL: DEVELOPMENTAL MODEL

OVERVIEW

In the normal process of maturing, children and adults must make decisions about risky behaviors such as alcohol and tobacco use. The developmental model provides insights for selecting strategies which will help people to make healthy choices when faced with the many complex, and sometimes conflicting, pressures of society today. This model suggests that preventionists should match the program design and activities to participants' stage of development.

CHILDREN AND THE DEVELOPMENTAL MODEL

In psychological terms, children pass through a series of developmental stages. Underlying the concept of developmental stages is the idea that there is a typical pattern of growth. However, there is no right or universal way to pass through the developmental changes. Each child's pattern of growth is unique to the child and his or her environment. All stages are shaped in important ways by powerful socioeconomic and other cultural influences.

Each developmental stage has specific physical, mental, and social tasks. These tasks interrelate, and each is part of the overall growth process. Within each developmental stage, a child faces key developmental tasks and developmental crises. Each stage acts as a foundation for the next, so that the functioning within any particular stage is partly determined by the extent to which tasks have been completed and crises are resolved in previous stages. Each stage of development is important in its own right, and each leaves a unique imprint on a person's life. Transitions from one developmental stage to another are often times of challenge and stress. The success with which each child meets the challenges of each stage influences whether the outcome will be continued growth, delayed growth, or dysfunction.

Child development is grouped into five stages. The developmental tasks and examples of prevention strategies for each stage are summarized in the chart below.

DEVELOPMENTAL STAGES		
Stage of Development	**Developmental Tasks**	**Examples of Prevention Approaches**
All Ages	Resolution of the emotional issues of dependency, authority, initiative, and competence.	• Community projects designed to provide recreation, social, religious and cultural opportunities; access to health, education, economic development, and social services; and supportive networks for families who are isolated from the community.
Stage 1: Prenatal & Perinatal (Conception to Age 1)	Attachment to parents and other caregivers; Sense of trust. The goal of this stage is to form a basic trust of the environment.	• Prenatal care and family-oriented projects such as parent training, home visits, and maternal substance abuse treatment.
Stage 2: Babyhood and Toddlerhood (Ages 1)	Separate sense of self; Autonomy (versus doubt). The goal of this stage is to develop a healthy relationship to authority, yet maintain the newly established sense of "me" and "I".	• Family-focused projects designed to enhance parent-child interactions, parenting, and other family management skills.
Stage 3: Young Childhood (Ages 3 to 6)	Learning about and testing the environment outside of the family world; Initiative in interacting with others. The highest goal at the beginning of this stage is to "get my own way", progressing to "do what I am told" by the end of the stage.	• Family and daycare-focused projects designed to promote learning readiness and the development of social skills.
Stage 4: Late Childhood or Preadolescence (Ages 7 to 12)	Industry; Physical, mental, and social competence. Skills include interpersonal and group relationship skills, and concrete operational mental skills of classifying, ordering, reversing, and self-evaluation. The goal of this stage is a sense of competence and self-worth. The highest goal for this stage ranges from the ethics of fairness to interpersonal conformity.	• Meaningful, challenging opportunities for youth to contribute to their family, school, peers, and community in developmentally appropriate ways such as cooperative learning, tutoring, home-school projects, and structured community-based activities for youth.
Stage 5: Adolescence and Early Adulthood	Establishing identity and avoiding identity diffusion; Independence, authority, and initiative. Values of this stage are commitment, loyalty, and devotion. The goal is to complete the processes of separation and individuation so as to ultimately leave home and create an authentic life based on a new, integrated identity.	• Projects such as peer leadership, cross-age teaching, conflict resolution training, family management instruction, and opportunities for positive peer relationships and healthy lifestyles offered through clubs, civic groups, schools, and religious organizations.
Early Adolescence (Ages 13 to 18)	Physical, mental, and social maturation.	• Family, school, and community oriented projects which teach problem solving, decisionmaking, and social skills, and establish positive peer group memberships.
Late Adolescence to Early Adulthood (Ages 18 to 22)	Independent living, initial career decisions, internalizing morality, establishing intimate relationships.	• Targeted opportunities to promote vocation exploration, work experience, and community service; training which enhances interpersonal skills.

ADULTS AND THE DEVELOPMENTAL MODEL

Adults also go through developmental stages where they face conflict and must resolve the emotional issues of dependency, authority, initiative, and competence. These stages often accompany major life transitions such as marriage, parenthood, midlife, and retirement. Effective prevention programs that serve adults match their strategies to the specific needs, issues, and stage of development of their target audience.

INDIVIDUAL-LEVEL: RISK AND RESILIENCY MODELS

OVERVIEW

Research on *risk factors* and *protective factors* offers important insights for the design of effective programs. These fields represent very different but essential perspectives. Both are part of a comprehensive approach to prevention.

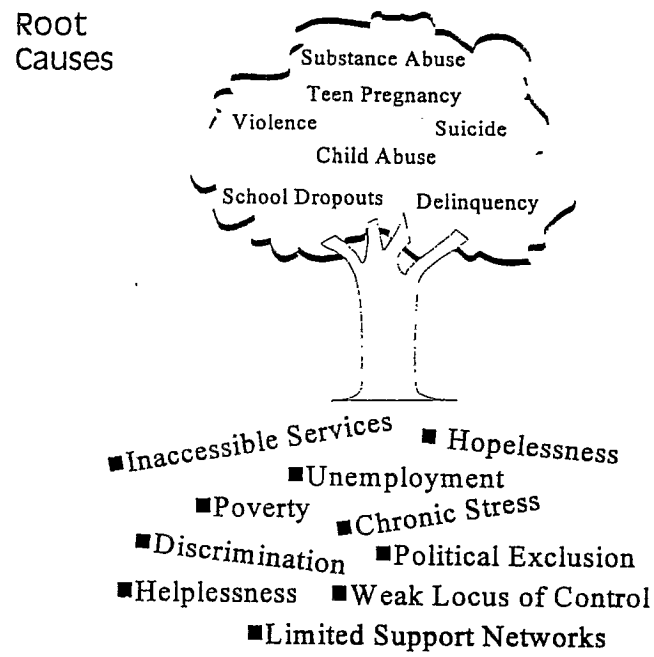
Risk factor research stems from a problem perspective. By studying youth and adults with identified problems, researchers have discovered the multiple causes (etiology) of problem behavior.

Resiliency factor research looks at youth and adults who are at risk but have not developed disease or dysfunction. Resiliency researchers study people who are "invulnerable", "stress resistant," or "resilient" to discover those factors that are responsible for these qualities.

Research studies from the past 30 years show that these two approaches, when taken together, can significantly reduce behavioral health problems and measurably improve the quality of life for individuals and communities.

RISK FACTORS

Researchers have identified certain conditions and situations called *risk factors* which precede and predict the later development of behavioral health problems. Prevention programs which focus their efforts to specifically address these risk factors have had promising results in reducing the incidence and severity of behavioral health problems among individuals who participate in the program. Risky behaviors such as adolescent use of alcohol, tobacco, and other drugs can be reduced by strategies that buffer or reduce the effects of risk factors which precede the onset of these problems.



There are several important cautions to keep in mind when applying the risk factor model. These include:

- Risk factors are only predictors for future problems. It is not a foregone conclusion that a population which is exposed to one or more risks will develop behavioral health problems. Many children and adults who live under adverse conditions associated with risk factors are healthy and well-functioning individuals.

- While risk factors can be helpful in identifying populations who are vulnerable to developing substance abuse or other behavioral health problems, risk factors are not necessarily predictive for an individual.

- Prevention programs should exercise caution to ensure the risk factor approach does not create an additional risk by labeling participants.

- The more risk factors that are present, the greater the risk of behavioral health problems. Further, risk factors have a multiplier effect. For example, when only one risk factor for substance abuse is present, the degree of risk is not much greater than when no risk factor is present. When two risk factors exist, the risk increases by fourfold. When four risk factors are present, researchers have found that the risk of substance abuse is ten times greater.

- Current research efforts are examining the role of specific risk factors in the etiology of behavioral health problems. We do know that risk factors are interrelated. Research provides evidence that youth substance abuse is associated with delinquency, teenage pregnancy, violence, and school failure. Guiding

principles for prevention programs from this knowledge emphasize the importance of taking a comprehensive approach with multiple strategies at multiple levels.

Risk factors identified through research can be grouped into four major categories: Community Environment, Family Environment, Institutional (school and work) Environment, and Individual and Peer Factors. A list of risk factors is presented below.

RISK FACTORS

Domain	Factors
Community Environment	Laws and norms favorable toward substance use, firearms, and crime
	Availability of alcohol, tobacco, and other drugs
	Poverty
	Lack of employment opportunities
	Neighborhood disorganization
	Transitions and mobility
	Minority status involving racial discrimination, culture devalued in American society, differing generational levels of assimilation, cultural and language barriers to receiving services, and unfavorable expectations from society
Family Environment	Alcohol, tobacco, and other drug dependency of parent(s)
	Family history of problem behavior
	Poor and inconsistent family management practices
	Family instability
	Parental absenteeism due to separation, divorce, or death
	Children at home without adult supervision more than three hours a day
	Family conflict and violence
	Lack of family rituals
	Low family attachment and bonding
Institutional (School & Work) Environment	Negative climate
	Policy not defined or enforced
	Poor performance/academic failure
	Lack of commitment to the institution
	Transitions between schools or jobs
Individual & Peer Vulnerabilities	"Difficult" temperament with negative mood states, withdrawal, or aggression
	Alienation and rebelliousness
	Friends who engage in problem behavior
	Early display of problem behavior
	Constitutional factors, including heredity
	Limited proficiency in English
	Greater reliance on and influence by peers than parents
	Early first use of drugs

Not every risk factor can be impacted by a prevention program. For example, a family's prior history of behavioral health problems or a community's past actions regarding enforcement of laws related to underage tobacco use cannot be changed. After the risk factors most salient for the prevention program's target population are identified, the prevention program must determine which factors can be mediated, moderated, or changed to reduce the overall risk.

RESILIENCY FACTORS

Resiliency research explores why some children who experience severe stress and adversity grow to become healthy, productive, competent adults. Resiliency researchers ask the question, "Why do some individuals succeed despite the presence of factors that often lead to failure?" In a nutshell, resiliency is about people who beat the odds.

Resilient people see other people as resources. They have the capacity to solve problems, participate positively in their family and community, act autonomously, and have a sense of purpose and future. A resilient child is able to resist pressures to use illicit drugs, withstand coercion to join gangs, and cope with added stressors created by a harsh environment. A resilient child is much more likely to be connected to adult-led, structured youth programs; to have a family that sets standards and exercises control; to hold strong educational commitments; to hold positive values such as concern for the poor, value on sexual restraint, and helping people; and to be surrounded by adult care, concern, and support both in the family and school contexts.

Researchers who study stress-resistant children have identified a number of *resiliency factors*. These are important personality, family, and environmental buffers which help youth to survive risky environments. Prevention programs based on resiliency research seek to instill these qualities in all youth in high-risk environments. The goal is to bolster children's natural strengths and innate capacity for learning and success by teaching new skills for living in a difficult environment.

Resiliency research offers several important considerations for prevention programs:

- Resilient children have "clusters" of protective factors, not just one or two.

- Individually, each resiliency factor may have only a small impact on reducing problem behavior. Collectively, however, the presence of multiple resiliency factors can have a sizeable impact on reducing problems. For example, one recent study of high risk youth found that 80 percent of those with fewer than six resiliency factors reported involvement in serious delinquency. This contrasted with youth with nine or more resiliency factors. Only 25 percent of this second group reported involvement in serious delinquency.

- The one factor common to all clusters is a consistent, trusting relationship with an adult.

- Resilient children have internal and external "assets" which help them to thrive despite the presence of factors which create risk. Internal assets include values, commitments, and competencies that help an individual succeed 'on one's own'. External social assets include *support* (such as communication with parents, access to caring non-parent adults for advice and support, and a positive school climate), *control* (including parental standards and discipline, time at home, and positive peer influence) and *structured time use* in extracurricular activities, community programs, and religious organizations.

Resiliency factors identified by researchers are grouped by category in the following list.

RESILIENCY FACTORS

Domain	Factors
Community Environment	Clear community standards that support healthy behavior
	Pleasant, safe neighborhood
	Opportunities for meaningful citizen participation and community service
	Supportive networks and social bonds
	Easy access to quality health care, social services and other community resources such as housing, child care, employment, and recreation
	Flexible service providers who put clients' needs first
Family Environment	Sufficient family income
	Structured and nurturing family
	High warmth/low criticism parenting style (versus an authoritarian or permissive style)
	High value placed on education
	Fewer than four children in family
	Two or more years between the birth of each child
	Supportive social networks
	Shared family responsibilities
Institutional (Work & School) Environment	Goal setting and mastery are encouraged
	Participation and responsibility are promoted
	Leadership and decisionmaking opportunities are provided
	Active involvement of students/workers is fostered
	Healthy behaviors and social climate are supported
Individual & Peer Factors	Positive outlook
	Healthy expectations
	Bonded to conventional groups
	Respectful of authority
	Involved in drug-free activities

Risk-factor research and resiliency-factor research work together hand in glove. Risk factor research looks at deficits which create vulnerable individuals. Resiliency research explores the assets which enable individuals to thrive under very harsh circumstances. Taken together, the risk-factor and resiliency-factor models identify complementary approaches to simultaneously reduce risks and enhance resiliency of the target population.

CHAPTER 5
ARIZONA'S BEHAVIORAL HEALTH PREVENTION SYSTEM

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ARIZONA'S BEHAVIORAL HEALTH PREVENTION SYSTEM

INTRODUCTION

Behavioral health prevention services were established by the Arizona Department of Health Services in the 1970's. Today's prevention programs and the strategic directions presented in this document build upon the foundation of these early models and initiatives.

HISTORICAL NOTES ON PREVENTION IN ARIZONA

With leadership from the Arizona Department of Health Services (ADHS), Arizona's behavioral health agencies in the 1970s and 1980s retooled and expanded the design and operation of their prevention programs. The public health model offered a theoretical framework for planning and evaluating prevention efforts. Ongoing research and field studies provided other important considerations that were folded into program initiatives. These included:

- **Strategies**. Research from drug education programs in the 1960s showed that only teaching young people about drug effects and hazards does not always have the desired or intended effect. Early drug education efforts from that era typically educated students by displaying marijuana and other illicit drugs and discussing the dangers associated with their use. Often, information was provided at a special school assembly or in a one-time class presentation by a guest speaker. The risks sometimes were exaggerated, in what is referred to today as "scare tactics." Researchers found that drug education programs failed to reduce drug use and sometimes contributed to its increase. These findings provided principles for later prevention programs:
  - Information provided by programs must be accurate to retain program credibility.
  - Information alone is not enough. It must be presented within the context of a comprehensive prevention program with multiple strategies.
  - "One-shot" education efforts are not effective. As with all learning, effective programs need to provide multiple opportunities for youth and adults to acquire new information and to practice new skills.
- **Clear "no use" message for youth**. School-based programs in the late 1970s took an "affective" approach. Alcohol and other drug use by youth was described as "experimentation" and was viewed as a normative process of adolescent development. Students were taught problem-solving and decision-making skills to make responsible choices about alcohol. Research results and changes in national policies shifted this focus to a "social psychological" or "social influence" model that emphasized peer influences, abstinence, and refusal skills.
- **Multiple approaches for multiple populations**. Risk-focused approaches of the late 1970s and early 1980s focused on the individual and were based on a disease model for prevention. The disease concept focused on personal vulnerability, be it genetic, biochemical, psychological, or social/cultural

in nature. Under this view, the principal prevention strategies focused on prevention education and early intervention. Prevention education was intended to inform program participants about the disease of addiction and to teach people about the early warning signs so that they could initiate treatment as soon as possible. Efforts focused on "high risk" populations and attempted to correct a suspect process or flaw in the individual, such as low self esteem or lack of social skills. Research findings from studies of these programs showed this approach was not applicable or effective for all populations.

- **A Multi-Level and Multi-Systems Focus**. Prevention projects in the 1980s that incorporated the risk focus into a broader approach involving family, school, and community systems had more success. This focus was expanded in the latter part of the 1980s and 1990s to also incorporate attention to the process of interactions, the methods by which programs were implemented and operated, and the ability of programs to meet developmental needs for support, respect, and belonging.

- **Coordinated efforts at multiple levels**. Research from the 1980s also highlighted the relatedness and causal links between specific behavioral health problems such as substance abuse, teenage pregnancy, and violence. Studies pointed to the importance of focusing on the common roots of these problems. Research also emphasized the importance of expanding the design of prevention programs to incorporate strategies targeted to the entire community in addition to individual-focused strategies for specific populations within the community. The most effective community efforts were multi-tiered, with strategies planned *by* community members to reduce supply through policy changes as well to reduce demand through coordinated action. Examples of supply-reduction prevention strategies included raising the minimum drinking age to 21 and alcohol-free "Operation Prom/Graduation" parties for high school seniors. Demand-reduction strategies included school prevention programs and community-based parenting classes.

PAST ADHS BEHAVIORAL HEALTH PREVENTION INITIATIVES

During the past two decades, ADHS behavioral health has provided direction for multi-tiered prevention programming to build on research and field experience. Important directions and initiatives for behavioral health prevention in Arizona have included:

- **Comprehensive Local Prevention Programs.** ADHS behavioral health contract requirements and technical assistance have been continuing mechanisms to help community organizations build solid prevention programs.

- **Grassroots Involvement**. ADHS behavioral health has long recognized that "people support what they help create" and "local people are the best source for solving local problems." Prevention staff were encouraged to involve community representatives in the planning and operation of their programs. Grassroots involvement also was promoted at the state level. For example, when the parent movement emerged in the early 1980s, ADHS behavioral health took the lead by providing technical assistance to parent groups forming throughout the state and by organizing teams of parents to attend national training.

- **Prevention Training for Youth and Adults**. ADHS behavioral health was instrumental in bringing the national School Team Training approach to Arizona. Behavioral health was a major sponsor of the first statewide Teen Institute. ADHS behavioral health has been a lead sponsor for statewide prevention conferences. ADHS behavioral health staff developed training modules for professionals in the new field of prevention to build staff expertise and to provide tools for local prevention programs. One of these

modules, *Keys To Healthy Aging*, was selected as a national model that was incorporated into the national training system and disseminated by the National Clearinghouse on Alcohol and Drug Information.

- **Media Campaigns**. ADHS behavioral health has sponsored a number of statewide alcohol media campaigns, including health consequences messages for pregnant women, refusal skills for adult women, and abstinence messages for youth.

- **Planning and Evaluation**. ADHS behavioral health staff have been key proponents of building theory- and research-based prevention programs. In addition to disseminating planning and evaluation guidance through training and conferences, ADHS behavioral health staff have helped to guide multi-disciplinary policy and program development. One example is the School Chemical Abuse Prevention Interagency Committee, which operated in the 1980s to bridge school and community efforts.

BEHAVIORAL HEALTH PREVENTION TODAY

Prevention remains a priority for state, regional, and local behavioral health agencies. The following sections describe current initiatives of these organizations.

ARIZONA DEPARTMENT OF HEALTH SERVICES

The mission of the Arizona Department of Health Services (ADHS) is to assess and assure the physical and behavioral health of all Arizonans through education, intervention, prevention, delivery of services, and the advancement of public policies that address current and emerging health issues in a manner that demonstrates efficiency, effectiveness, integrity and leadership.

ADHS public health priorities and program directions are published in a document titled *Arizona 2000*. This document identifies nine priority areas. Each priority area is linked to specific objectives of the national *Healthy People 2000*. The *Arizona 2000* document provides strategic direction for ADHS, with a goal of working toward achievement of *Arizona 2000* through partnerships with private and public stakeholders.

Many of the *Arizona 2000* priority areas pertain to behavioral health prevention. Target objectives have been established for:

- teenage pregnancy prevention,
- HIV education for public school students,
- the prevention of diseases related to lifestyle (including reduced prevalence of tobacco use and a reduction in the number of youths who abuse alcohol and other drugs),
- controlling the growth in health care costs by reducing the need and demand for health services through cost-effective preventive care and health promotion initiatives,
- increasing the proportion of members of special populations who have sufficient knowledge about the range of available programs and services,
- preventing child abuse and domestic violence, and
- violence and suicide prevention.

ADHS PREVENTION SERVICES

Prevention is a priority for ADHS. Behavioral health prevention is distinct from, but clearly related to, a number of other prevention-oriented efforts within the Department. These are described in Appendix D, *ADHS Activities Related to Behavioral Health Prevention.*

DIVISION OF BEHAVIORAL HEALTH SERVICES

The mission of the Division of Behavioral Health Services (DBHS) is to continually improve the effectiveness and efficiency of a system of behavioral health care in order to meet the needs of the people of Arizona.

The DBHS *Action Plan* outlines objectives for key directions in seven areas:

- Financial Management and Contracting;
- Planning;
- Information Systems and Reporting;
- Policy and Procedure Development;
- Training;
- Quality Management and Program Monitoring; and
- Service Delivery.

BUREAU OF PREVENTION

Many of the DBHS objectives listed above relate to all offices within DBHS, including the Bureau of Prevention. In addition, there are prevention-specific objectives for which the Bureau of Prevention has lead responsibility. Work on each objective is underway. The five prevention objectives are summarized below.

1. **Develop a process for producing a state plan for prevention.** The *Framework for Behavioral Health Prevention* fulfills this objective. As noted in the introduction to this document, the plan is designed to be used as a framework which emphasizes "bottom-up" planning and coordination.

2. **Develop and implement guidelines for evaluating prevention programs.** This objective includes determining evaluation models, assisting Regional Behavioral Health Authorities (RBHAs) in determining process outcome indicators for prevention programs, developing an evaluation report format for RBHA contract requirements, developing policies and procedures, developing and providing training on the evaluation of prevention programs, and incorporating guidelines into annual program monitoring and formal reviews.

3. **Implement prevention program standards.** These standards have been completed and are presented on Page 18 of this document.

4. **Develop a training schedule for all prevention providers to provide information on the prevention matrix and use of the documentation form.** This objective was completed in 1995, with ongoing follow-up technical assistance provided at monthly Prevention Coordinator meetings.

5. **Establish three pilot projects which address the sale of tobacco to minors.** A Request for Proposals was issued and contractors were selected in 1994. Project monitoring and coordination at the state level with the Tobacco Coalition and internal ADHS programs is ongoing.

Key directions for the Bureau of Prevention are also contained in the DBHS 1996 Substance Abuse Block Grant application. These are summarized below:

- Provide prevention programs to discourage the abuse of alcohol and drugs.
- Increase the knowledge of prevention staff working at the regional behavioral health authorities.
- Provide socially accepted alternatives for high risk youth by increasing understanding of substance abuse, gang recruitment, and gang related activities.
- Promote healthy community social structures that positively affect the life of community residents.
- Establish prevention programs that adhere to agreed upon, positive values.
- Staff prevention programs with properly experienced and educated prevention specialists.

The Bureau of Prevention works in partnership with RBHA prevention coordinators to actively disseminate information on best practices in prevention programming and to promote systems development. Specific initiatives include:

- Monthly meetings of RBHA prevention coordinators for planning and technical assistance.
- Training and technical assistance to RBHAs and prevention program providers in the community mobilization model.
- Training for prevention program staff in comprehensive prevention programming. A variety of training events have been provided by the Bureau of Prevention including: Training of Trainers for Preventionists; Innovations in Prevention; and Un Encuentro, focused on prevention in the Hispanic community.
- Technical assistance in planning and operating prevention programs, covering such areas as the *Prevention Program Standards*, prevention service codes, and other contract issues.
- Leadership for statewide behavioral health planning and monitoring.
- Participation in collaborative efforts with other ADHS offices, other state agencies, and RBHAs.

The Bureau of Prevention guides improvements in the quality of prevention programs. Significant changes have occurred over the past five years. Future directions will build upon the strengths of the existing behavioral health prevention system as it compares to the past:

- **Accountability**. Prevention programs today are more outcome-oriented and emphasize performance measurement. Accountability is enhanced with automated information systems, onsite monitoring, peer review processes, and annual site visits.

- **Interagency Coordination and Collaboration**. ADHS and RBHAs leverage resources to expand the opportunities for training and technical assistance, and for streamlining the staffing and management of prevention programs and initiatives at state, region, and community levels.

- **Primary Prevention and Systems Development**. Prevention programs today focus on strategies to impact the root causes of behavioral health problems. Crosscutting prevention efforts address the underlying issues that powerfully affect many behaviors, rather than narrowly focusing on the categorical manifestations of problems such as substance abuse, mental illness, or domestic violence. The emphasis is on health promotion and community wellness.

Other successes and accomplishments of the Bureau of Prevention include the following policy documents and initiatives:

- Prevention program standards,
- Minimum competencies and skills for prevention personnel,
- RADAR Associates in each region,
- Prevention service codes matrix and documentation form,
- Coordination guidelines booklet developed in partnership with the Arizona Department of Education,
- Shift to community-based program development and operation, and
- Direct line of communication between RBHAs and ADHS for technical assistance, with a guidance (versus prescriptive) focus.

REGIONAL BEHAVIORAL HEALTH AUTHORITIES

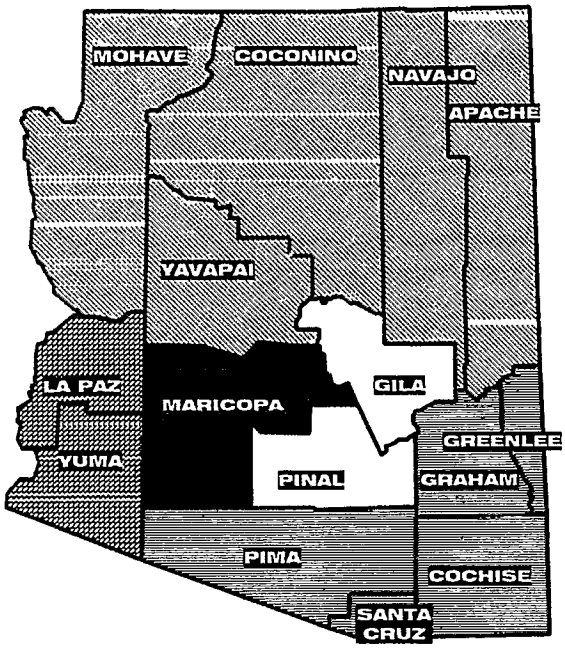
OVERVIEW

Regional Behavioral Health Authorities (RBHAs) are private, non-profit corporations that are funded and designated by the Arizona Department of Health Services to plan, implement, fund, monitor, and authorize behavioral health services within their geographic service area(s). RBHAs are responsible for providing a full continuum of prevention, early intervention, and treatment services through a network of specialized, community-based subcontractor agencies.

GEOGRAPHIC SERVICE AREAS

Arizona is divided into six geographic service areas, which are served by five RBHAs. The following map displays the RBHA geographic service areas.

ARIZONA
Regional Behavioral Health Authority (RBHA)
GEOGRAPHIC SERVICE AREAS



Regional Behavioral Health Authority (RBHA)	Map Key
BHS Behavioral Health Services	
ComCare Community Partnership for Behavioral Health Care	
CPSA Community Partnership of Southern Arizona	
NARBHA Northern Arizona Regional Behavioral Health Authority	
PGBHA Pinal Gila Behavioral Health Association	

RBHA PREVENTION RESPONSIBILITIES

Each RBHA designs and implements prevention programs in response to needs identified through an annual needs assessment process. Common features of regional approaches planned for FY 95-96 are summarized below and described in more detail in Appendix E.

- Utilize a structured and thorough planning process to assess community prevention needs.
- Identify and deliver training and technical assistance to meet the needs of providers.
- Assist provider agencies in determining the best evaluation model for their prevention programs.
- Utilize regional prevention program evaluations for program development and quality improvement.
- Identify successful and replicable prevention program strategies.

- Serve as the region's link to the national Regional Alcohol and Drug Awareness Resource (RADAR) Network.

- Establish and maintain collaboration between the RBHA and other organizations involved in prevention.

- Provide prevention program information to the Arizona Prevention Resource Center for the annual statewide Program Inventory.

PREVENTION WORKS IN ARIZONA

The recommendations outlined in this document are ambitious, but the scope and severity of behavioral health problems requires an ambitious plan.

Arizona's prevention initiatives must focus their efforts in three important ways. Programs need to incorporate:

- *Universal preventive strategies* targeted to the general public or a whole population group that has not been identified on the basis of individual risk. Universal prevention strategies seek to change the underlying social conditions that are precursors to behavioral health problems.

- *Selective prevention strategies* targeted to individuals or a subgroup of the population whose risk is significantly higher than average.

- *Indicated preventive strategies* targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms but who do not meet diagnostic levels at the present time.

Further, research and experience show that certain steps are essential to the successful outcome of a prevention effort. The steps, discussed earlier in this document, are summarized below:

- Know the target population,
- Set realistic goals,
- Find the empirical evidence which exists to support the prevention effort,
- Develop a sound conceptual framework for the effort,
- Involve key individuals and organizations in planning and implementation,
- Design and implement the effort to build on and support related efforts,
- Ensure there are sufficient resources for accomplishing the objectives of the effort,
- Assure that the effort is timely and has enough breadth, exposure, and impact to make a difference,
- Utilize quality control measures to ensure that the effort is executed well,
- Build in continuous tracking, documentation, evaluation, and feedback.

The backbone of a successful statewide prevention system in Arizona is a comprehensive approach that is directed to six levels: the individual; family; organization; systems of care and service delivery; community; and region. At each level, individual-focused models and system-focused models are used to develop and refine each program. Programs are implemented by drawing from an array of ten research-based, contract-reimbursable prevention strategies. The diagram on the next page shows one way to conceptualize the linkages and interactions of this comprehensive approach to prevention.

APPENDICES

APPENDIX A:
Selected Bibliography

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APPENDIX C:
Prevention Program Standards

Adopted 3/18/94 by the Children's Behavioral Health Council under authority of A.R.S. 36-3421

CONTENTS:

Philosophical Principles

Prevention is the creation of conditions, opportunities and experiences which encourage and develop healthy, self-sufficient people.

Effective prevention programming:

- Is based on a sound, long and short term planning process which includes a needs assessment and incorporates relevant state-of-the-art research into program policy, implementation and evaluation. The planning process must involve and be representative of the multiple systems within a community.

- Provides opportunities for people to be meaningfully involved in the design, selection, planning, implementation and evaluation of the prevention strategies.

- Meets the specific needs of individuals and groups that include components which are ethnically- and culturally-relevant and age-appropriate. In addition, the services must be accessible to the population being served.

- Utilizes multiple social systems and levels within the community in a collaborative effort. Each system's involvement is necessary but not sufficient by itself to ensure the maximum success of the program. In order to impact a full range of target populations, all relevant social systems must be included.

- Develops a written document which establishes specific and measurable goals and objectives that are family focused. The goals and objectives are based on the needs assessment and are tailored to reflect specific action plans appropriate for the target populations.

- Includes a marketing component that advocates prevention by showcasing its positive effects within the community and the respective target populations. It also includes a strategy for heightening public awareness because increased public awareness can serve as a catalyst for gaining public support and involvement.

- Involves the use of multiple strategies to accomplish its goals and objectives and has a positive effect on the target populations. Strategies include information, education, social competency skills, alternatives, environmental change, and social policy change.

- Addresses all segments of the population, including all age groups and social classes. Takes into account the unique and special needs of the community and provides strategies targeting special populations, e.g., youth, high-risk groups, cultural, ethnic, and gender-specific groups. The impact and interrelatedness of each group upon the other should be recognized and emphasized in program development.

Purpose of the Program Standards

The following standards were developed to ensure consistency in the provision of adult and child behavioral health prevention services throughout the State of Arizona. The specific purpose of the standards are:

1. To ensure that the foregoing philosophical principles are incorporated into a comprehensive system of care for children and families;

2. To establish consistency in the assessment, design, and implementation of prevention services;

3. To guarantee a minimum standard of care for all children and their families needing behavioral health prevention services;

4. To provide standards for program quality and to encourage commitment to a meaningful evaluation process;

5. To support family and community involvement in all aspects of prevention programming;

6. To ensure the active participation of all agencies and individuals responsible for the well-being of children and families;

7. To encourage continuity of care and coordinated service delivery for children receiving prevention/early intervention services.

Purpose of Minimum Skills and Competencies Guidelines

The Minimum Skills and Competencies Guidelines for prevention volunteers and staff were developed to ensure consistency in the level of knowledge and skills of persons providing prevention services throughout the State of Arizona. The specific purposes of the minimum skills and competencies guidelines are:

1. To define and ground preventionists' capabilities in theory, knowledge, and practice;

2. To promote continued professional development;

3. To provide guidance for prevention program administrators when developing job descriptions, and recruiting and hiring staff and volunteers;

4. To establish guidelines for new staff and volunteer orientation and ongoing inservice training plans, as well as documentation of education and training received;

5. To provide information for planning by colleges and universities offering pre-service education for persons who work in prevention, including counselor and teacher training programs, as well as for the development of paraprofessional and advanced certification programs for preventionists;

6. To ensure consistency in contracting and monitoring of contracts by funding agencies regarding staff and volunteer competencies to provide state-of-the-art prevention services and meet contracted agreements;

7. To support community task forces, alliances, and other community prevention groups in assessment of their technical assistance and training needs.

Standard A: Participant's Rights and Responsibilities

The dignity and rights of children, families, and adults participating in prevention/early intervention programs shall be protected.

Guideline 1. The program shall have a written explanation of the civil rights and responsibilities of children, adolescents, adults, and parents and the means by which these rights are protected and exercised.

a. The right to all available services without discrimination because of race, creed, color, sex, age, handicap, national origin, or marital status.

b. The right to be informed of all rights, in the language of the participant's choice.

c. The right to a humane treatment environment that affords protection from harm, appropriate privacy, and freedom from verbal or physical abuse.

d. The right to a smoke free environment as stated in the agency's policies and procedures.

Guideline 2. Parents, guardians, or caretakers responsible for the child/adolescent shall be advised of their rights to a grievance process. Participants shall have the right to assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial procedure.

Guideline 3. The program shall specify in writing the process for review of program goals and objectives by responsible parents, guardians, or caretakers prior to implementation.

Guideline 4. The program shall ensure that the child, adolescent, or adult, and parents, guardians, or caretakers are accurately informed of the program goals and objectives.

Guideline 5. The program shall specify in writing the process for maintaining confidentiality of program participants and records.

a. Staff and volunteers shall understand and uphold the principles of confidentiality when information about a participant is requested, released and utilized.

b. When requesting information from a participant, the staff/volunteer has the responsibility to clarify why the information is needed, how it will be used, and who will have access to the data collected.

c. There shall be a way for the participant to correct or amend the information to ensure its accuracy and completeness before it is released.

d. The participant must understand whether or not the receiving party has the right to pass the information to a third party. The participant must have the right to specify that this not be done without his/her knowledge and consent.

e. The participant should be fully informed of any repercussions that might occur should he/she (1) grant permission for the disclosure or (2) not give permission.

f. The participant should be advised that the consent for release of information is time-limited and revokable. He/she should be advised how this can be withdrawn and be given periodic opportunities to do so.

g. The participant's consent for release of information must be in writing on a "Release of Information Consent Form."

h. Staff and volunteers may share information about a participant with other agency employees on an "as needed" basis. This type of sharing is not a breach of confidentiality in accordance with the Family Education Rights and Privacy Act (FERPA) of 1974.

I. Staff and volunteers must be informed of the consequences should confidentiality be breached as it relates to the participant's right to privacy.

Guideline 6. The program shall ensure that all staff and volunteers working with participants adhere to the Code of Ethical Conduct for Prevention Professional presented on Page C-9.

Standard B: Program Development and Evaluation

In order to provide quality and effective prevention programs, a systematic and comprehensive method of development and evaluation shall occur.

Guideline 1. The prevention program shall develop a long and short term plan relevant to the needs of the community.

a. A needs assessment shall be included in the planning process.

b. Current and valid research will be utilized in the development of program policy and program implementation.

c. The program will develop a written document which establishes specific, realistic, measurable goals and objectives that are family focused.

Guideline 2. The prevention strategy adopted within a community must meet the specific needs of its respective individuals.

a. Components of the program will be ethnically and culturally relevant as well as gender specific.

b. Members of the community will be involved in all phases of the program development evaluation.

c. All programs shall be accessible to the populations being served.

Guideline 3. The prevention program will utilize multiple social systems and levels within a community in a collaborative effort.

a. In order to effect change, the program design will include, when appropriate, a plan for transfer of ownership to the community itself.

b. Collaboration will be evidenced by the utilization of services and resources in the community (e.g., coordinating councils of the Children's Behavioral Health Council, involved citizens groups, etc.).

Guideline 4. The prevention program will have as an integral component, a comprehensive method of evaluation.

a. Scientific and current research methods will be incorporated in the evaluation component.

b. The outcome of the prevention program shall be evaluated in order to identify components, strategies, etc., that were successful and effective.

c. Evaluation methods shall measure effectiveness in relation to the scope, intensity, and duration of the prevention program.

d. Evaluation shall be included as part of the program proposal.

Standard C: Program Implementation and Integration

Effective prevention programming shall involve the use of multiple strategies implemented in sufficient scope, intensity and duration to accomplish its goals and objectives and have a positive effect on the target population.

Guideline 1. A community needs assessment shall determine the need for prevention and intervention services; shall determine the appropriate prevention/intervention strategies to meet assessed needs; and access resources to implement the strategy.

Guideline 2. A written document shall be established for the program with realistic and measurable goals and objectives.

a. The goals and objectives shall be based on the needs assessment.

b. Goals and objectives shall be family focused.

c. Action plans developed shall be appropriate to the target population.

Guideline 3. A process shall be developed for identifying the target populations. This process shall include the selection criteria or other identifying characteristics.

Guideline 4. Prevention programs shall incorporate training modules for staff and volunteers to develop minimum skills and competencies for successful implementation of the programs. Skills and competencies to be addressed:

a. Core functions which include: Communication; community involvement; implementation of strategies; and record keeping.

b. Knowledge competencies: Life-span development; prevention approaches, philosophies and methods; community and early intervention.

c. Skills competencies: Communication; training and teaching skills; facilitation skills; implementation of strategies; networking/collaboration; evaluation and re-assessment; and personal growth and development.

See Skills and Competencies for Volunteers and Professionals beginning on Page C-11 for supplemental information for Guideline 4.

Guideline 5. Strategies may include information, education, social competency skills, alternatives, environmental change, and social policy change.

a. A prevention program should have a philosophy compatible with the identified needs, mores, and values of the community.

b. Prevention programs shall be based on valid research and/or studies that indicate support for the strategy to be used.

c. Prevention programs shall be ethnically and culturally relevant and age appropriate.

d. The prevention program shall be accessible to the target population being served.

e. The prevention program design shall be progressive, developmental, and specify its intent.

f. Realistic time lines shall be developed for program implementation and evaluation.

Guideline 6. Prevention programming shall be integrated into regular, ongoing community processes or services.

a. Preferably, programs will be offered in participants' natural environment.

b. Integration also includes referral linkages and collaborative community planning.

c. Children and families identified by prevention programs as needing more intensive services shall be referred for treatment.

Standard D: Continuum of Care

Effective prevention programming recognizes the need for social change to support healthy communities. Programming addresses the needs for inclusion and addresses all segments of the population. It also takes into account the unique and special needs of the community. The recognition of the interrelatedness of

strategies and target population is recognized and respected. These strategies represent a continuous progression of efforts that meet identified needs from the prenatal stage of life until death. This continuum is divided into three areas which include prevention, intervention and treatment.

Guideline 1. Effective programming reflects comprehensive planning. Programming shall incorporate:

a. A sequence of education/information programs which are appropriate to the target population and reflect overall goals and objectives.

b. Youth and adult social competency skills development program.

c. Strategies for the provision of alternative youth activities pre and post school day hours and weekends.

d. Examination of environmental issues and strategies to impact these issues, i.e., creation of safe school zones.

e. Social policy strategies to create ongoing public awareness, data collection, collaborative sponsorship of programs, and funding opportunities.

f. Community accountability for oversight of the scope, intensity, and duration of this effort are recommended via development of community councils and alliances.

Guideline 2. All programs should be accountable for the following considerations:

a. The unique and special needs of the community, i.e., language, physical disabilities, and cultural norms.

b. The location of programming should be communicated in a variety of media creating greater accessibility of communication.

c. Location of program activities should be geographically accessible with consideration to transportation needs of the target population.

Guideline 3. A continuous progression of efforts shall be seen as equally important.

a. Primary Prevention has as its purpose to promote health and well being for everyone. Strategies may include a focus on community environmental conditions, build skills, provide support infrastructures, and promote awareness. These strategies may focus on a given population from the neonate to the elderly.

b. Secondary Prevention may also be called early intervention and has as its purpose to intervene at early signs of problems, reduce crisis, and change troubling behaviors. Strategies may include assessment and referral, crisis intervention, and skill development to prevent further difficulty.

c. Traditionally known as tertiary prevention, treatment is a category that has as its purpose to reconstruct or rehabilitate identified participants. Strategies typically include treatment of symptoms and skills for rehabilitation.

d. These can be seen as a continuum of care particularly when an adult is in treatment and this may impact children and youth as a prevention measure.

e. This continuum of care promotes prevention from cradle to grave. Prenatal maternal health is essential as is substance abuse prevention with the elderly.

Standard E: Responsibility for Lasting Outcome

Effective prevention programming is an essential component of an overall health promotion effort which provides a variety of services along a continuum of care. Within this continuum is the understanding that prevention is a shared responsibility between the community, and state and national agencies. Community level ownership and responsibility are the essential elements in program planning, implementation, and evaluation. Effective programming documents its philosophical theory, methods, and procedures such that other organizations may utilize these concepts in further program development.

Guideline 1. The sequence of prevention programming should be based on strategies regarding a continuum of care. These considerations include:

a. Phase of individual development.

b. Phase of community development.

Guideline 2. Prevention programming reflects shared responsibility between community, and state and national agencies. Programming should be accountable for assuring:

a. Grassroots, broad community representation.

b. Balance of representation cross age (including youth), ethnicity, religion, and gender.

c. Assuring inclusion for participation of community members is the accountability of the prevention provider.

Guideline 3. Programming is accountable for documentation of philosophy, methods, and procedures as well as evaluation outcome. Responsibility for this documentation assists development of prevention theory and practices. The act of communicating these outcomes to others in the field of prevention is a necessary contribution to overall effectiveness of this work.

Code of Ethical Conduct for Prevention Professionals
National Association of Prevention Professionals and Advocates (NAPPA)

PREAMBLE

The principles of Ethics are a model of standards of exemplary professional conduct. These Principles of the Code of Ethical Conduct for Prevention Professionals express the professional's recognition of his/her responsibilities to the public, to service recipients, and to colleagues. They guide members in the performance of their professional responsibilities and express the basic tenets of ethical and professional conduct. The Principles call for commitment to honorable behavior, even at the sacrifice of personal advantage. These Principles should not be regarded as limitations or restrictions, but as goals for which Prevention Professionals should constantly strive. They are guided by core values and competencies that have emerged with the development of the field.

PRINCIPLES

I. Non-Discrimination

A Prevention Professional shall not discriminate against service recipients or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition, or physical or mental disability, including persons testing positive for AIDS-related virus. A Prevention Professional should broaden his/her understanding and acceptance of cultural and individual differences, and in so doing render services and provide information sensitive to those differences.

II. Competence

A Prevention Professional shall observe the profession's technical and ethical standards, strive continually to improve personal competence and quality of service delivery, and discharge professional responsibility to the best of his/her ability. Competence is derived from a synthesis of education and experience. It begins with the mastery of a body of knowledge and skill competencies. The maintenance of competence requires a commitment to learning and professional improvement that must continue throughout the professional's life.

a. Professionals should be diligent in discharging responsibilities. Diligence imposes the responsibility to render services carefully and promptly, to be thorough, and to observe applicable technical and ethical standards.

b. Due care requires a professional to plan and supervise adequately any professional activity for which he or she is responsible.

c. A Prevention Professional should recognize limitations and boundaries of competencies and not use techniques or offer services outside of his/her competencies. Each professional is responsible for assessing the adequacy of his or her own competence for the responsibility to be assumed.

d. When a Prevention Professional is aware of unethical conduct or practice on the part of an agency or prevention professional, he or she has an ethical responsibility to report the conduct or practices to appropriate authorities or to the public.

III. Integrity

To maintain and broaden public confidence, Prevention Professionals should perform all professional responsibilities with the highest sense of integrity. Integrity can accommodate the inadvertent error and the honest difference of opinion. It cannot accommodate deceit or subordination of principle.

a. Personal gain and advantage should not subordinate service and the public trust. All information should be presented fairly and accurately. Each professional should document and assign credit to all contributing sources used in published material or public statements.

b. Prevention Professionals should not misrepresent either directly or by implication professional qualifications or affiliations.

c. A Prevention Professional should not be associated directly or indirectly with any services or products in a way that is misleading or incorrect.

IV. Nature of Services

Above all, Prevention Professionals shall do no harm to service recipients. Practices shall be respectful and non-exploitive. Services should protect the recipient from harm and the Professional and the profession from censure.

a. Where there is evidence of child or other abuse, the Prevention Professional shall report the evidence to the appropriate agency and follow up to ensure that appropriate action has been taken.

b. Where there is evidence of impairment in a colleague or a service recipient, a Prevention Professional should be supportive of assistance or treatment.

c. A Prevention Professional should recognize the effect of impairment on the professional performance and should be willing to seek appropriate treatment for himself/herself.

V. Confidentiality

Confidential information acquired during service delivery shall be safeguarded from disclosure, including - but not limited to - verbal disclosure, unsecured maintenance of records, or recording of an activity or presentation without appropriate releases.

VI. Ethical Obligations for Community and Society

According to their consciences, Prevention Professionals should be proactive on public policy and legislative issues. The public welfare and the individuals's right to services and personal wellness should guide the efforts of Prevention Professionals who must adopt a personal and professional stance that promotes the well-being of all humankind.

SKILLS AND COMPETENCIES FOR VOLUNTEERS AND PROFESSIONALS

SKILLS AND COMPETENCIES FOR VOLUNTEERS

A. Core Functions

1. Communication:

   a. Willingness and ability to communicate with program staff, participants, etc.
      - Consult with staff
      - Share at staff meetings, etc.

2. Community Involvement:

   a. Understanding of community in which program is implemented, specific issues and cultures, ethnicity, etc.
      - Has access to community demographics

   b. Willingness to network with other agencies, groups, and people appropriate to the volunteer's job description
      - Use peer resources in other related agencies

3. Implementation of Strategies:

   a. Understanding of program to be implemented

   b. Review of training materials, curricula, literature, etc. relevant to the program

   c. Completion of required training

   d. Commit to agency and program expectations

4. Record Keeping:

   a. Maintain records as instructed by volunteer's supervisor
      - Current, legible, concise

B. Knowledge Competencies

1. Knowledge of Life-Span Development

   a. Knowledge of appropriate developmental levels and the ability to provide that information to participants in a positive manner
      - Training checklist of expectations and skills needed
      - Training program provided to cover developmental levels, high risk and self destructive behaviors

   b. Knowledge of dynamics associated with high risk and self-destructive behaviors

c. Knowledge of cultural competency, including implications of different prevention approaches for various cultural groups

d. Knowledge required to perform volunteer job
   - Job description for volunteers read and understood
   - Review agency policy and program manual

2. Knowledge of prevention approaches, philosophies and methods

a. Willingness to learn, understand and be committed to the area of prevention and the specific program strategies being implemented
   - Voluntary agreement signed

b. Knowledge and adherence to legal rights of participants

c. Knowledge of and adherence to ethical and professional standards of conduct

3. Knowledge of the Community

a. Ability to learn community resources, service providers and referral processes specific to the population being served
   - Uses community resources

4. Knowledge of Early Intervention

a. Knowledge of risk factors associated with participants in need of early intervention services and ability to make appropriate referrals
   - Identifies risk factors in caseload, i.e., family issues, school, peer, community, etc.
   - Makes appropriate referrals

C. Skills Competencies

1. Communication

a. Ability to be non-judgmental, non-critical, and accepting of other people

b. Ability to listen and to communicate in an empathic manner

c. Ability to convey information at appropriate comprehension levels

d. Ability to develop active listening skills, to interpret non-verbal behavior and to identify emotions and understand their sources
   - After beginning volunteer work, volunteer to observe other staff, be mentored and receive additional on the job training
   - Supervisor to observe and provide feedback

2. Training and Teaching Skills

a. Successful completion of any required training programs and attendance at inservices

b. Ability to present the program to participants in an orderly, organized and proficient manner

c. Ability to do public speaking as appropriate to the volunteer position

3. Facilitation Skills

   a. Ability to master facilitation skills, including group and individual

   b. Ability to conduct meetings
      - Ability to conduct meetings that accomplish predetermined goals

   c. Ability to resolve conflicts
      - Understands how to resolve conflict
      - Willing to talk about conflict and work toward resolution

4. Implementation of Strategies

   a. Ability to apply program goals and objectives to the target population
      - Identify goals and objectives, and measures progress
      - Set personal goals in working with agency and checks with supervisor to be sure they coincide with agency goals

5. Networking/Collaboration

   a. Ability to work cooperatively with participants, agency staff, and the community at large
      - Observed by the supervisor
      - Observations of participants and staff as reported to the supervisor

6. Evaluation and Re-Assessment

   a. Participate in program evaluation, evaluation of volunteer program, feedback to the agency, etc. appropriate to the situation
      - Participate

7. Personal Growth and Development

   a. Personally capable of managing stress, pressures and crisis on one's own life
      - Recognize stress in own life and takes steps to reduce stress

   b. Ability to successfully role model stress management, behavioral management and problem-solving techniques to participants
      - Observed by supervisor
      - Observations of participants and staff as reported to supervisor

   c. Willingness to gain additional knowledge. Topic areas may include human development, behavioral health, alcohol and other drug abuse, family dynamics, family violence, family dysfunction, etc.
      - Seek input and knowledge from staff
      - Take classes and/or attend workshops
      - Read and discuss relevant material

SKILLS AND COMPETENCIES FOR PROFESSIONALS

A. Core Functions

1. Assessment

   a. Conducting community assessments
      - Able to document the process and the outcome

   b. Conducting a literature search

   c. Organizing and analyzing of data

2. Program Development

   a. Setting goals and objectives

   b. Designing programs to met the needs of participants
      - Able to write measurable goals and objectives
      - Able to discuss assessment and plan

3. Communication

   a. Communicates verbally and in writing with staff, volunteers, participants and the community
      - Able to demonstrate successful communication in each area

4. Community Involvement

   a. Understanding and awareness of communities which could benefit from prevention strategies
      - Ability to determine target groups

   b. Address community diversity
      - Cultural
      - Religious
      - Economic
      - Geographic

   c. Networking with other agencies, organizations and community members

   d. Encouragement and utilization of community involvement in assessing, planning, developing and evaluating program

5. Implementation of Strategies

   a. Design and adaption of programs for specific populations

   b. Review training materials, curricula, and literature relevant to the program design

   c. Complete required training

6. Record Keeping

    a. Maintain records as instructed by supervisor and required by program
        - Current, legible, concise
        - Follow a method of securing data, assessing data and setting a plan
        - Meets legal scope of recording

7. Evaluation

    a. Participate in program evaluation design and implementation

8. Re-Assessment

    a. Utilize program evaluation information for continuous quality improvement
        - Uses data available from evaluation

B. Knowledge Competencies

1. Knowledge of Life-Span Development

    a. Growth and development including physical and psychosocial development

    b. Dynamics associated with high risk and self-destructive behaviors

    c. Group dynamics

    d. Cultural competency, including implications of different prevention approaches for various cultural groups

    e. Learning styles

    f. Specific high-level knowledge of those areas in which expertise is claimed

2. Knowledge of prevention approaches, philosophies and methods

    a. Philosophies supporting various prevention approaches

    b. Historical perspective on prevention efforts

    c. Current research and its practical applications as applied to identified populations

    d. Prevention's role in a continuum of care

    e. Accepted prevention program models and impact points

    f. Knowledge and adherence to legal rights of participants

    g. Knowledge of and adherence to ethical and professional standards of conduct

3. Knowledge of service providers and referral procedures

4. Program assessment and evaluation models and purposes

    a. Procedures and rationale for documentation

    b. Methods of collecting and organizing data

    c. The relationship of assessment to planning

    d. Evaluation instruments and their uses

5. Knowledge of Early Intervention

    a. Knowledge of risk factors

    b. Identification of persons in need of early intervention or treatment services

    c. Knowledge of early intervention's role within a continuum of care

6. Program Administration (optional)

    a. Supervision and leadership

    b. Proposal/grant writing

    c. Fiscal management

    d. Resource development

    e. Volunteer recruitment and utilization

    f. Participant rights and responsibilities

C. Skills Competencies

1. Community Assessment/Consultation

    a. Needs assessment

    b. Negotiation/conflict resolution

    c. Conducting meetings

    d. Advocacy

2. Communication

    a. Active listening

    b. Interpreting non-verbal behavior

c. Identifying emotions and understanding their sources

d. Responding to behavior that exceeds limits or violates agreed upon behaviors

e. Writing skills

f. Conveying information at appropriate comprehension levels

3. Training and Teaching Skills

   a. Training design and evaluation

   b. Public speaking and presentation skills

4. Program Design

   a. Determining appropriate content and materials

   b. Writing measurable goals and objectives

   c. Outlining program or curriculum

   d. Organizing materials and resources

5. Implementation of Strategies

   a. Applying stated goals and objectives

   b. Using appropriate prevention techniques for participants

6. Networking/Collaboration

7. Public Relations

   a. Articulation of purpose and role of prevention to communities, legislature, media and the public at large

8. Record Keeping and Interpretation of Data

9. Personal Growth and Development

   a. Personally capable of managing stress, pressures and crisis in own life

   b. Successful modeling of stress management, behavior management and problem solving to participants

   c. Ongoing participation in professional growth and development opportunities as appropriate to professional role. Such areas may include human development, behavioral health, alcohol and other drug abuse, family dynamics, family violence, family dysfunction, community collaboration, and communication.

APPENDIX D:
Arizona Department of Health Services — Activities Related to Behavioral Health Prevention

Arizona Center for Health Statistics, Office of Health Planning, Evaluation and Statistics.

One of the many valuable reports published by the Arizona Center for Health Statistics is the annual *Arizona Health Status and Vital Statistics*. This report provides statewide and county information on trends and patterns in the health status of Arizonans. In addition, the report compares Arizona's standing with respect to the health objectives for the year 2000.

Center for Prevention and Health Promotion.

The Center for Prevention and Health Promotion currently addresses substance abuse, with emphasis on tobacco; injury and disability prevention; chronic diseases; and border health. Center subprograms that are related to behavioral health prevention are listed below.

Office of Behavior and Community Health. The mission of this office is to promote a smoke-free Arizona by the year 2000 through collaboration with community groups, education, advocacy with the legislature, enforcement activities, and surveillance. Current projects include pilot programs aimed at restricting youth access to tobacco by targeting enforcement activities of retailers, and identifying and developing effective tobacco control programs.

Office of Border Health. The Office of Border Health creates collaborative partnerships with Arizona-Sonora border communities, develops public policy and programs, and establishes community-based strategies to improve the quality of life for people living in the border region.

Office of Injury and Disability Prevention. Key directions include: *Coordination* at all levels of disability prevention; *Community Education*; *Public Policy*; *Surveillance* system for each of the target populations that promotes local prevention activities and provides information to: assess the causes and consequences for disabling conditions, assess the need for services, and evaluate outcomes and impact; *Primary Prevention* to promote effective models; and *Prevention of Secondary Conditions*.

Epidemiology & Disease Control

Office of Chronic Disease Epidemiology. Responsibilities of this office include managing the Telephone Survey Center, which collects information from adults on health behaviors and prevention practices related to several leading causes of death. Risk factor data gathered in telephone interview includes cigarette smoking and alcohol consumption.

Community & Family Health Services

Planning and Evaluation Data (PED) Center. Offices within Community and Family Health Services began work in 1987 to integrate information systems in order to maximize resources and provide opportunities for sharing data. PED was established in September 1993 to encourage more systematic use of information. Major accomplishments included a new planning tool which incorporates Arizona 2000, Healthy People 2000, and the Office of Strategic Planning and Budgeting's mandated activities.

Office of Nutrition Services (ONS). ONS coordinates community education activities on nutrition related risk factors for the general and high risk population groups.

Office of Older Adult Health (OAH). OAH serves as the coordination arm for all older adult activities within ADHS, monitors and develops public health policy for aging within the state, and is the catalyst for promoting health and preventing disease and disability for Arizona seniors. OAH established a priority in 1994 to address senior suicide prevention. A newly established task force worked with OAH to create a curriculum for human service providers in detection, treatment, and referral of senior depression. The curriculum is used for ongoing training, offered at various locations throughout the state. In addition, the DBHS Medical Director worked with OAH to develop guidelines for physicians in detecting and treating senior depression. These guidelines have been disseminated to 4,500 primary care physicians in Arizona.

Office of Oral Health (OOH). OOH strives to promote the oral health and well-being of all Arizona citizens by the continued promotion, planning, implementation, and evaluation of preventive oriented programs serving high risk targeted populations. OOH targeted efforts include smokeless tobacco use.

Office of Women's and Children's Health (OWCH). OWCH provides services and facilitates systems development to improve the health of women and children. Some of the programs related to behavioral health prevention are listed below.

Um Comienzo Sano/Health Start trains lay health workers to provide services during pregnancy and four years after a child's birth for high risk children and families. The services include education about normal child development and parenting skills, and serve as a referral source for community services.

Arizona Healthy Mothers, Healthy Babies (HM/HB) improves the health status of mothers, infants, and children through the efforts of local coalitions and state level committees that address the education and service needs of the target population.

The **Injury Prevention Program** provides consultation and technical assistance on injury prevention, provides assistance in the development of community based prevention programs, and promotes program coordination among all public and private agencies involved in child and adolescent injury prevention throughout the state.

Arizona Self Study Project. This is a public/private sector collaborative effort to improve the quality of care and education of all children in Arizona's early childhood programs. The project provides consultation, technical assistance, and "Self Study" materials developed by the National Academy of Early Childhood Programs to programs selected by the sponsoring agencies.

Health Training in Child Care. This project provides a system for health and safety training and consultation for child care programs. The project's objectives include raising health and safety standards and improving health and safety practices in child care programs. The project is currently piloting a Train-the-Trainer curriculum.

Home Visiting for At-Risk Families. This project is funded by a one-time federal grant to identify, and develop a plan to integrate and coordinate, home-based visiting services for vulnerable children and their families in Arizona.

Adolescent Health Consultation. This helps state, county, and local agencies assess adolescent health needs and to develop programs to meet those needs. A major objective is for communities to mobilize and contribute to the development of integrated systems of services for adolescents. Accomplishments include establishing a 350-member multidisciplinary coalition; forming a

APPENDIX E:
FY 95-96 Regional Behavioral Health Authority (RBHA) Prevention Focus Areas

Each RBHA designs and implements prevention programs in response to needs identified through an annual needs assessment process. Common features of regional approaches planned for FY 95-96 are described below.

- **Utilize a structured and thorough planning process to assess community prevention needs.**
  - Include prevention as one focus of the annual needs assessment and planning activities.
  - Gather information on the community's problems through data such as police records, health department data, school information, DES statistics, and community surveys on behavioral health problems.
  - Conduct focus discussions and key informant interviews.
  - Link with other regional planning efforts.
  - Identify all prevention programming and associated activities in the region to include reviewing prevention program reports and surveying community organizations known to provide prevention programs.
  - Use information obtained during the needs assessment to identify gaps in the existing array of prevention services, including the need for additional cultural competence in the delivery of prevention services.

- **Identify and deliver training and technical assistance to meet the needs of providers.** Typically, RBHAs incorporate the following steps in planning, delivering, and evaluating prevention training:
  - Assess training needs through an annual formal survey.
  - Complete informal assessments of training needs as part of ongoing contract monitoring and participation in planning meetings.
  - Monitor prevention literature to identify best practices and compare them with providers' current practices to identify training needs.
  - Develop an annual training and technical assistance plan and distribute a training calendar to provider staff.
  - Provide help with administrative issues such as data collection and human resource management as well as technical assistance on prevention-specific topics.
  - Expect or require each provider to attend a specified number of trainings per year.
  - Tap expertise that exists within the regional system, access state training resources, and sponsor outside experts to come to the region to present training.
  - Deliver and/or arrange training and technical assistance for individual prevention providers, single communities, multiple communities, provider and community network members, advocates, and community teams.
  - Administer a standardized evaluation form at the end of every training.

- **Assist provider agencies in determining the best evaluation model for their prevention program.**
  - Make available literature and technical assistance on an ongoing basis.
  - Provide opportunities and establish expectations or requirements for participation in information sharing, discussion, and training regarding prevention program evaluation.
  - Identify and disseminate "best practices" models and tools.
  - Assist providers in the selection of an appropriate model.

- Develop, with community provider agencies, systemwide outcome measures and a consistent evaluation framework.
- Incorporate the RBHA's systemwide evaluation models into prevention evaluation protocols.

- **Utilize regional prevention program evaluations for program development and quality improvement.**
  - Identify the areas in which prevention programs are, or are not, meeting their process and outcome goals.
  - Research state and federal resources to develop "benchmarks" for comparative evaluation.
  - Work individually and collectively with providers to identify possible changes in program structure, content, or design which could enhance the provider's performance on outcome measures.
  - Include evaluation as a topic for site visits and quality assurance monitoring and provide recommendations for quality improvement as indicated.
  - Facilitate networking meetings of all providers to share evaluation results and to encourage providers to incorporate relevant evaluation results into their program planning and implementation.
  - Develop partnerships with other community systems to consult regarding overall community needs.
  - Address systemwide findings regarding unmet needs through the annual RFP process or mid-year shifts in program emphases.

- **Identify successful and replicable prevention program strategies.**
  - Develop multiple integrated strategies through: 1) needs assessment methods that are sensitive to changes in the characteristics of the community and emerging trends, problems, and issues; 2) program planning approaches that emphasize collaboration, integrated resources and programs; and 3) quality management activities.
  - Participate in DBHS Prevention Coordinators' meetings to share information about successful prevention models currently operating in Arizona.
  - Visit promising projects in other regions which have the potential for replication to obtain information and technical assistance.
  - Identify successful and replicable national and state prevention program strategies.
  - Attend state and national conferences and training at which prevention models are presented. Obtain detailed program descriptions, evaluation plans, and outcome studies for dissemination throughout the region.
  - Conduct evaluation at both the level of the individual subcontractor and at the aggregate level of system operation.
  - Identify and publish successful practices through the provider network both in written form and during systemwide meetings.
  - Encourage proposals from agencies for the replication of successful program models.
  - Require proposals to clearly define a research-based program design with evaluation outcome measures.

- **Serve as the region's link to the national Regional Alcohol and Drug Awareness Resource (RADAR) Network.**
  - Fulfill responsibilities as an Associate Member of the RADAR Network.
  - Provide a regional link to the State RADAR Network Center, the Arizona Prevention Resource Center (APRC).
  - Maintain a mini-library of prevention information.
  - Select, store, and distribute bulk literature including pamphlets, posters, and technical documents.

- Utilize the RADAR Network's PREVline electronic communication system to tap into CSAP's national data base, access information about emerging prevention issues, maintain communication with colleagues around the state, place e-mail orders for literature, and report distribution data to APRC.
- Participate in an on-site orientation to APRC and training workshops for Associate members.
- Conduct region-planned activities to meet local needs, such as: 1) operating a video lending library; 2) providing materials for and/or coordinating media campaigns; 3) publishing RADAR tidbits in an agency newsletter; 4) distributing materials to citizens and other organizations in conjunction with community mobilization efforts; and 5) utilizing a "Trainer of Trainers" approach to train key persons to assist in disseminating materials and informing the public of resources available.

- **Establish and maintain collaboration between the RBHA and other organizations involved in prevention.** RBHAs provide leadership to:
  - Serve as a catalyst for coordinated and collaborative prevention efforts within the region and each community within the RBHA's geographic service area.
  - Utilize the annual needs assessment process to facilitate the identification of persons and organizations that are interested in and able to coordinate the delivery of prevention services.
  - Create an information coordinating mechanism among network and non-network providers.
  - Seek opportunities for collaboration with prevention providers, and other local organizations and advocates engaged in promoting prevention activities, and providing a link to statewide efforts and resources.
  - Actively seek collaboration opportunities in ongoing contacts with providers, and public and private entities.
  - Network with professional membership organizations that have a relationship with prevention, such as the National Association of Social Workers and the American Public Health Association.
  - Collaborate actively with other community and regional organizations engaged in promoting prevention activities.
  - Give RFP selection preference to prevention organizations proposing collaborative or partnership-based programs and services.

APPENDIX F:
EVALUATION OF LOCAL PREVENTION PROCESSES —
An Open-Systems Model in Action

Prevention scientists and practitioners argue for use of multiple interventions, planned and implemented in concert, to serve as a catalyst and to sustain desired local change. Evaluation studies and methods addressing prevention practice, in contrast, have tended to focus on the *individual intervention*, or on sets of interventions considered one by one, as if their effects occurred in relative isolation from each other. Two potential consequences of this mismatch between prevention practice and evaluation methods are that evaluation feedback may be of limited value for improving prevention practice and that conclusions drawn from evaluation studies may be misleading.

In addition, evaluation techniques have tended to assume that the environments within which prevention interventions occur are relatively static and controlled. Yet most prevention activity occurs in dynamic and changeable environments under no single group's full control. Again, the mismatch has potential to limit the usefulness of evaluation for practitioners. Tools and approaches are needed for evaluating simultaneously occurring prevention activities which take place in complex and dynamic environments.

The challenge facing the evaluator of local change processes can be illustrated by a physical analogy. Imagine a still pond into which a perfectly round stone is dropped from a specific height. It is possible to study the resulting ripple effects using appropriate observation and measurement tools.

However, if the number of stones is increased, their shapes are varied, the heights of release randomly selected, and if some are thrown into the pond rather than gently released, the complexity of the ripple effect patterns in the pond will defy simple measurement. The observer will be hard pressed to attribute sub-patterns to any specific stone. Precise replication of the experiment will prove impossible. Furthermore, if several motors are placed in the pond and run at variable speeds to produce turbulent waves that interact with the ripple effects, is it even reasonable to attempt to assess the contribution of any single stone's being thrown into the pond?

Imagine a pond into which a perfectly round stone is dropped. It is possible to study the resulting ripple effects using appropriate observation and measurement tools. However, if the number of stones is increased, their shapes are varied, the heights of release randomly selected, the complexity of the ripples will defy measurement.

The instinctive reaction of a textbook evaluator might be to insist upon a reduction of the complexity of the challenge before tackling it. This paper offers an alternative approach — founded on what some call the "new science" (1). Whereas an evaluator *qua observer* sitting on the edge of the pond and working with the analogy will be unable to grasp all that is going on in the pond, an evaluator *qua experimental designer*, using well-placed probes and other measurement devices, might be able to gather a lot of data. But synthesizing those data and resulting insights into a meaningful simulation moc or set of equations would be difficult, cost and likely provide only partial explanatio for what is going on in the pond.

In contrast, an evaluator *qua participa analyst* would shed outer g ments and jump head-first ir the pond. Establishing a floati or treading rhythm, and occ sionally getting hit with a sto or two, this type of evaluat would strive to capture a sense the total pond environment a the contribution of each stone that totality. Where appropri and feasible, he or she wou make drawings of local ripp patterns — with the aim of s perimposing these within a d namic collage entitled "The Po At Work." When invited, this evaluator wou shout out suggestions concerning ston throwing technique or offer throw-by-thr commentary on the events in progress.

This latter approach bears strong resei blance to action research (2), theory-ridd evaluation (3), force field analysis (4), a intentional evolutionary design (5). Whe the open-systems evaluation method pi sented in this paper may differ from these in practice rather than theory. Our aim is make evaluation a totally shared functic with the specific role of the "evaluatc distinguished from that of others primari by the former's constant preoccupation wi documenting what is going on, asking ha

questions such as "Is this what you are really trying to do?" and "What makes you think it is going to work?" and providing visual maps to allow anyone to see what is working and what is not. To make this feasible, a critical bond of trust must be formed and sustained among the evaluator, the program staff, and the community.

ENTER CSAP

For the past three years, the Training and Evaluation Branch of the Center for Substance Abuse Prevention (CSAP) has been promoting the development of an evaluation method for use with *multiple-intervention prevention programming* where resulting outcomes and impacts cannot be attributed to a single intervention. Referred to as "open-systems evaluation," the method promotes integration of the design, assessment, and monitoring of each intervention to maximize its anticipated results **within the context** of its contribution to the total prevention effort.

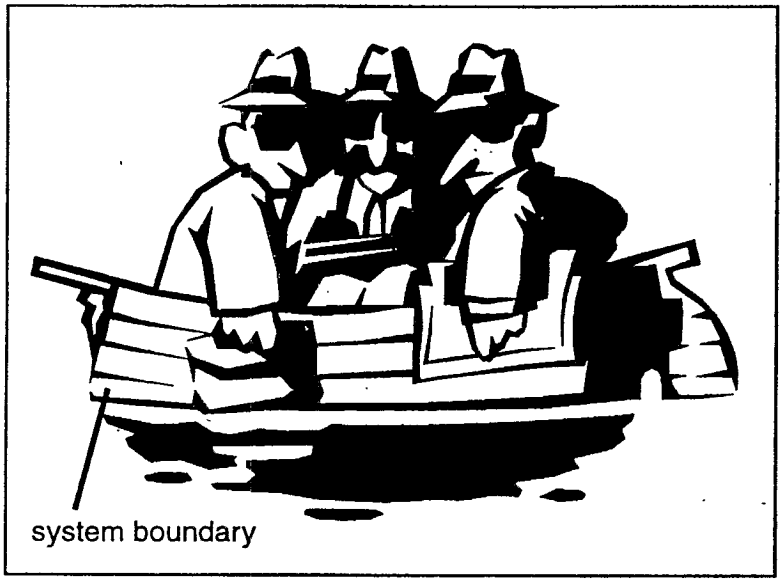

Figure 1: **A Closed System** (also a crowded one!)

The development work has been performed by staff of the Pacific Institute for Research and Evaluation (PIRE), under the leadership of Drs. Allan Cohen and Barry Kibel. They have collaborated with CSAP staff and contractors engaged in implementation of CSAP's Training System (CTS). Rather than importing an established methodology and applying or force fitting it to the problem, they have attempted to evolve a practical method for use in demonstrating how training contributes to community change. The resulting approach is being used to evaluate CSAP-sponsored training and technical assistance directed at community partnerships, state agencies, community volunteers, health service professionals and organizations, and others engaged in prevention.

While designed to assess the impact of training, the method has been generalized for use in assessing the full range of community prevention activities. CSAP-supported community partnerships in Santa Clara County (San Jose, CA); Pima County (Tucson, AZ), Berkeley, CA and Hampton, VA have adopted the approach to evaluate their efforts. The United States Army Drug and Alcohol Operations Agency is using it to assess pilot projects to demonstrate how Army installations can collaborate with surrounding civilian communities to tackle drug abuse among youths. The National Institute for Dispute Resolution selected the method to evaluate demonstration efforts in four cities that engage mediation and dispute resolution specialists in community problem-solving. The states of Kentucky and Connecticut have adopted it as their model of choice for evaluating local prevention programs.

Presentations of open-systems evaluation and its applications at conferences and workshops have drawn considerable interest and excitement. Simply stated, people in the field like the model. It makes sense to them. It makes evaluation seem down-to-earth and useful. The work also draws attention to the shortcomings of many of the evaluation frameworks currently in use. Accordingly, it arouses suspicion and skepticism among "traditionalists."

WHY OPEN SYSTEMS?

Critical to appreciating our approach is understanding key distinctions between open and closed systems. The term **system** refers to a physical or social unit made up of parts that interrelate with one another and are mutually dependent in their ability to function as a working whole. The combination of its parts gives a system properties or qualities not found within any of the individual parts. An automobile is a physical system, as is the human body. A family is a social system, as is the criminal justice system. The parts of physical systems are physically linked, whereas the parts of social systems are joined by legal or voluntary relationships.

Both physical and social systems vary in their relative **complexity**. The simplest physical systems have only a few parts, all of which are physical; increasingly complex physical systems include more intricate interacting physical parts that are all physically linked. The simplest social systems are made up of a few people governed by a limited number of rules or customs; increasingly complex social systems involve more people and more diverse rules and customs.

Both physical and social systems also vary in their relative *openness*. Most physical systems, even complex ones, tend to be closed. The parts of closed physical systems are designed to work together to serve one or a few related system functions. What distinguishes a closed system is that it is possible to draw a **system boundary** around all the pieces that combine to affect its workings (Figure 1). This affords a degree of control over that system. A simple electric circuit is an example of such a system.

Most social systems, however, are open systems, subject to outside influences and disturbances. Academic performance of students attending a public school, for example, may well be affected by social factors within and outside the boundaries of the campus that are not specifically related to the curricula or classroom. The "outside" factors affecting social systems may also extend to those in different time frames. For example, a newly arrived immigrant family may still be burdened by memories from the recent or distant past and strongly influenced by the traditional norms of its homeland. These

circumstances may be important to understanding that family and its involvement with, and responsiveness to, community change processes.

BEYOND SOLVE-IT MENTALITY

An important part of systems thinking is recognizing that only problems occurring within simple and closed systems can be solved with unique solutions (Figure 2). The goal, in such cases, is to make the system work by fixing the part or a connection between parts that is not working as intended. For example, when a leak is found in a plumbing system, the faulty part is replaced.

As systems become more complex, the ability to understand all the actual and potential systems dynamics is lost. When a problem occurs, a **suboptimization** strategy may be used. This means selecting from various options the solution that appears to work best given what is known or can be anticipated. In short, the systems-level problem is solved by viewing the system as less complex than it actually is. Frequently this leads to less than ideal results, as the solution may trigger a bigger problem elsewhere in the system or in a neighboring system.

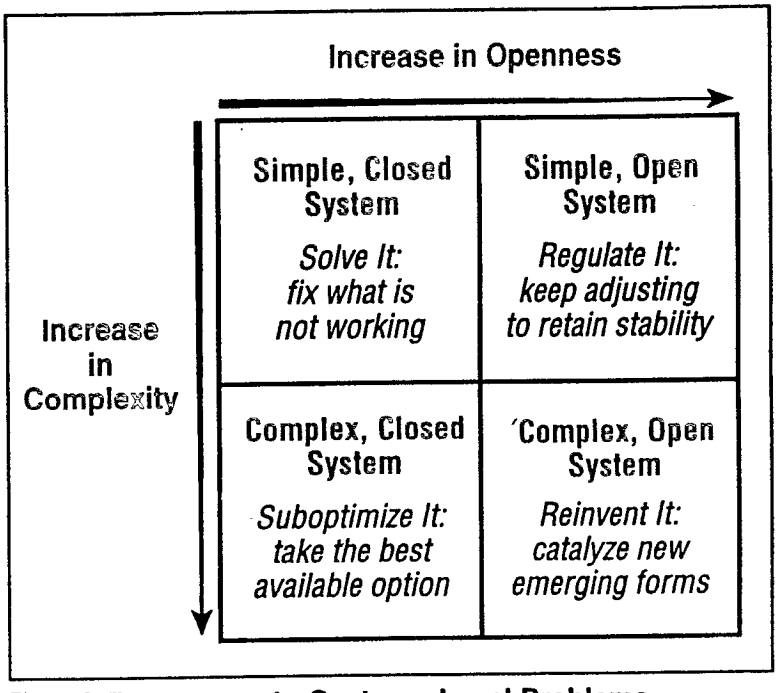

Figure 2: **Responses to Systems-Level Problems**

As a system becomes more open to outside influences, control over what happens within the system is lost. When a problem occurs, a **regulatory** strategy may be used. This means taking actions to buffer the system from the effects of these influences. An attempt is made to solve the systems-level problem by restricting the system to make it less open. A misbehaving teenager, for example, might be grounded for two weeks to keep the youngster away from influences that have contributed to the problem.

In a complex society, regulatory strategies can play critical roles in reducing systems-level problems. Increasing the legal drinking age to 21 in all states, for example, contributed to significant decreases in alcohol-related traffic fatalities involving youths. However, such strategies are not always possible if open, free market principles are to be maintained. For example, even if local beer advertising is controlled, people will still be influenced by national advertising campaigns and by beer-drinking heroes and heroines in the movies and on television. And observe how difficult it is to prevent unwanted drugs from getting into the nation, the cities, the neighborhoods, and the schools.

As a system becomes both more open and more complex, attempts to solve problems that emerge through quick fixes, suboptimization, and regulation become increasingly less likely to prove successful. Where a system is too open to be regulated, people acting to address problems in that system must become ever more flexible and creative to respond to changing conditions and unforeseen events. Where a system is too complex for problems to be fully understood and solved through a single, suboptimal strategy, people must address these problems through multiple, diverse, small-scale efforts linked within a shared vision for desired change. In short, system resources must be used creatively to continually reinvent the system.

The realities of the information age and global economy have forced private sector industries to operate in this way. The American automobile industry, for example, has had to redesign its products, retool its manufacturing plants, redefine the role of the work force, redirect its marketing strategies, and shift its vision for the future in order to remain profitable amid intense global competition. Challenges to the quality of community life associated with alcohol and other drug-related problems are forcing communities to respond in equally dramatic ways. One-time responses will not work; many responses over a sustained period are demanded. The open-systems evaluation method was developed to assist organizations and communities to design, implement, assess, and continually improve multiple-intervention responses to undesired and complex social conditions.

Illustrations of Suboptimization

As a result of increased funding, law enforcement efforts directed at drug dealers and users in 1988 led to an overload in the court system and overcrowding in jails, resulting in the early release of dangerous criminals. In balance, this may have yielded a net loss to society.

During the Carter Administration, spraying the marijuana crops in Mexico with paraquat led to a reduction in the supply of Mexican marijuana to the United States. But it set the stage for a dramatic rise in smuggling more potent marijuana from Colombia to America, and ultimately to the establishment of a dangerous Colombian drug cartel.

OPEN-SYSTEMS DESIGNS

There is a popular stereo-

type of the evaluator as a dispassionate outsider whose task is to stand apart from a program to observe, collect relevant data, and pass judgments on its successes and shortfalls (Figure 3). This stereotypical evaluator practices **onlooker** behavior. Such behavior may be feasible when dealing with tightly controlled experiments subject to rigid protocols and involving a single intervention (i.e., experiments occurring within relatively simple, closed systems). However, most prevention efforts cannot be designed or executed as tightly controlled experiments. The complexity of communities demands orchestration of multiple, overlapping, and interdependent activities. The openness of communities implies these activities will often change during design and implementation as adjustments are made to changing conditions and to factors beyond the locus of control of the community. In short, prevention takes place within relatively complex, widely open systems.

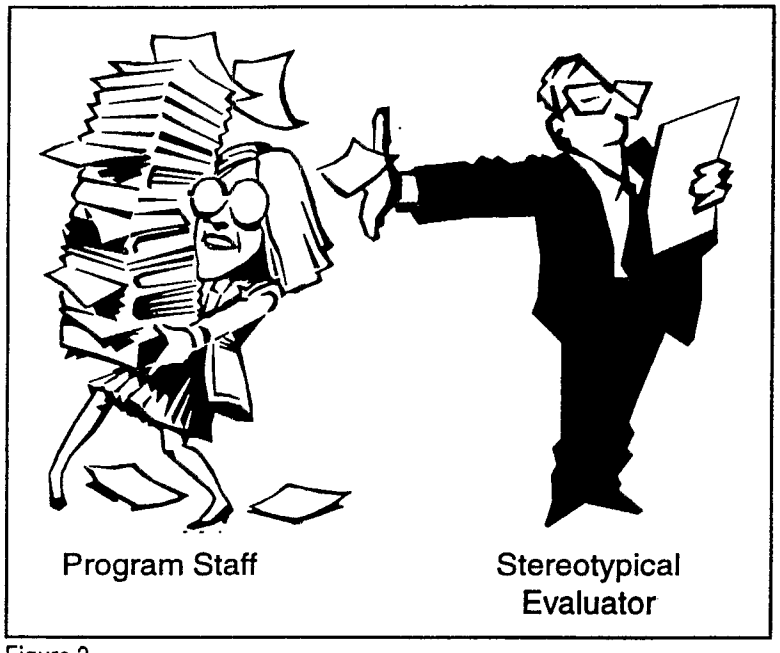

Figure 3

The research tools of the onlooker evaluator were not developed to handle complex situations of this sort. These tools are meant to be used where the relationships between actions and results are relatively predictable, well defined, and buffered from outside influences. As the relationships become more complex, and the results are subject to external factors (*i.e.*, the environment exhibits open-systems characteristics), it becomes increasingly difficult to use traditional tools to accurately assess the results of specific actions.

The open-systems evaluation method is intended for use in such complex situations, where the open-systems evaluator practices **participatory** rather than onlooker behavior (Figure 4). The evaluator poses critical questions whose answers help shape overall prevention strategies and individual actions. The experiences and expertise of the evaluator are also applied in helping find answers to these questions. The evaluator promotes the use of tools for designing, executing, and monitoring progress of specific interventions and general strategies, then trains the staff and community in their use. In this way, the evaluator becomes an integral part of the overall prevention effort, serving as a full partner to the staff and community.

Open-systems evaluators approach their role in a **pragmatic** way by trying to be as immediately useful as possible, as they also carefully document what is being aimed at, what is actually going on, and what the results appear to be. The evaluator offers advice and feedback to help ensure that program activities are consistent and complement each other, and that they are being implemented effectively and responsively. To accomplish this, the evaluator has to be an integral part of the process, not an onlooker.

Consider, as an analogy, the role of a quality assurance person on a Toyota or Saturn assembly line. Her job is to detect defects in production as soon as possible, ideally before they occur, and to make immediate corrections. She stops the assembly line rather than let flawed parts pass through. Moreover, every member of the production team is engaged in quality circles that have been established to improve quality, and each has authority to stop the assembly line. The evaluation function becomes a **shared responsibility**.

To illustrate, in the case of the Community Partnership of Santa Clara County the lead evaluator has been invited to serve as a key member of the strategic planning team and as the lead trainer and technical consultant to the partnership. Meanwhile, each member of the Partnership staff contributes in critical ways to the evaluation. For example, staff members have developed and maintain the database of community-member involvement in the Partnership or its alliance activities. They track these activities and report on successes and shortfalls. They meet regularly with the lead evaluator to discuss and analyze work in progress. Together with the lead evaluator, the staff have been co-creators of interview guides and protocols used for in-person and telephone interviews with key informants. They oversee the work of university students hired on a temporary basis to conduct telephone surveys associated with the evaluation. In short, the aim has been to create a seamless system where formative evaluation is totally integrated within the workings of the Partnership.

INTERIM VERSUS MAXIMUM RESULTS

The success of prevention efforts depends on a basic tenet of open-systems dynamics: change occurs only when interrelationships among system parts approach a **critical level of quality**. The open-systems approach argues against expecting immediate changes in complex, social systems. No simple solutions will be found.

The challenge is to carry out prevention efforts within an expanding number of geographic and functional areas where gradual, but persistent changes (*i.e.*, "small wins") occur. Within each such area, maximum and interim results are targeted. For example, interim results might include finding ways to use previously untapped resources or getting support and participation from key business or religious leaders. These interim successes may prove critical in building toward and reaching the maximum targeted results,

say, reducing underage drinking in the community. Steps for getting from interim results to maximum results are identified; where possible. The logic of these steps should be supported by theory or research findings. As the dynamics change due to local and outside factors, new program activities in existing or additional areas may be developed, and ongoing activities are appropriately adjusted. These activities are designed — or re-designed — to produce interim results that build systemically and strategically toward the targeted maximum results.

A prevention effort that is well conceived, supported by sound empirical evidence, and strategically planned can still fail if it is badly implemented. There are key features that must be included, training that must occur, and attention to important details at each step of implementation. Partial, weak, or haphazard implementation of any of its components can doom a well-designed effort. It may become necessary to reshape one or several components during implementation as events change and new conditions or opportunities emerge. As a consequence, the interim results may change and the maximum results that have been targeted may require refocus. Reshaping the effort doesn't indicate a faulty design; it is a recognition of the dynamics affecting the prevention effort and a sign that those implementing the effort are attuned to that changing environment.

THE RESULTS HIERARCHY

Critics of substance abuse prevention programs have tended to use statistics to judge success or failure. If a program does not lead, say, to measurable reduction in drug-related crime, alcohol-related traffic fatalities, or prevalence of drug use by teenagers, it is often considered a waste of money and effort. While agreeing that there are few, if any, societal problems that can be fully addressed through a single strategy, these critics still demand results — and the quicker the better. When communities or organizations promise to produce these ultimate results with one or a few programs, the criticism may be warranted. However, when an organization or community is tackling problems using sound strategic planning and quality management principles, it can be rightly argued that each of its activities and interventions must be assessed for its **contribution** to the total effort, and not in ultimate terms.

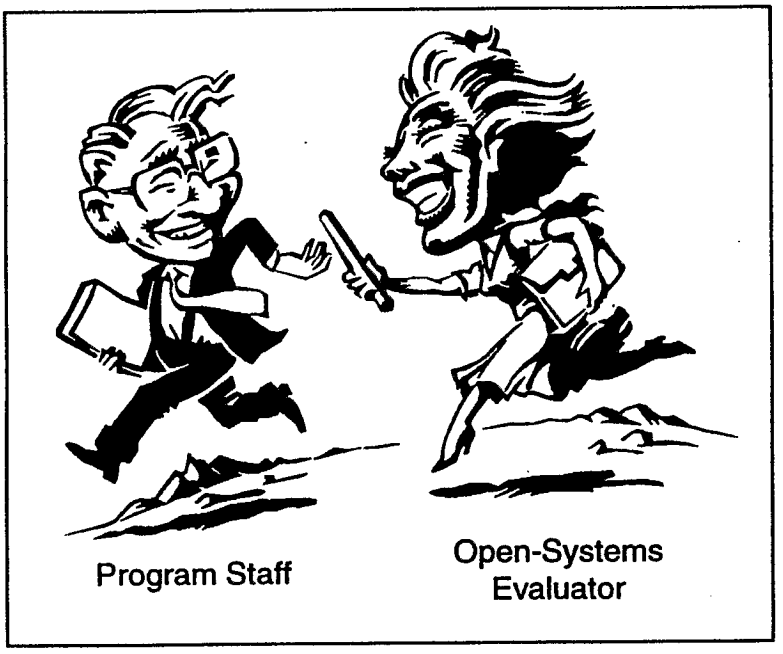

Figure 4

A systematic and reliable approach is needed to determine when and how to use various interventions, as well as to gauge their combined effectiveness in reducing ATOD problems. In open-systems evaluation, we rely on a **hierarchical mapping process** to test for gaps within programs and across programs that need to be filled by appropriate interventions. Results anticipated during the planning cycles and those realized during implementation are arrayed to create a clear picture of how each intervention contributes to the total effort. The mapping system reflects the open-systems view that change occurs through increasing critical quality.

A hierarchical model is posited (Table 1). Each level represents an advanced stage of prevention effort, with the higher levels being more desirable from the standpoint of alcohol, tobacco, and other drug problem reduction but also more difficult to reach. As activity at each level expands in quantity and strengthens in quality, a threshold is reached where activity at more advanced levels can be implemented and sustained.

Six levels are defined in what we term the Results Hierarchy. The lowest level is Motivation, which is characterized by activities that draw attention to a problem facing the local community. With sufficient motivation, an organization or community will usually move to the next level, which is called Focusing. Activity shifts from drawing attention to the problem to exploring ways of tackling it. As knowledge, skills, methods, and conceptual frameworks are acquired, confidence grows in the ability to tackle the problem. This leads to Action Preparation.

A series of dialogues occur, key supporters and collaborators are enlisted, plans are developed, and resources mobilized. Success at this level promotes Environmental Shifts. These are changes in law, policy, resource allocation, program activity, or options available to the community. If well conceived and appropriately enforced or promoted, these environmental shifts can lead to Outcomes (*i.e.*, changes to less risky behavior by growing numbers of people) and Impacts (*i.e.*, reduction in problems associated with these risky behaviors).

Associated with each level are **gatekeepers**. These are key persons or organizations whose support is needed to attain the targeted level of result in the hierarchy, or whose opposition can frustrate attempts to reach it. For example, advocates are needed to motivate people and organizations to tackle a particular ATOD problem; champions are then needed to mobilize people and resources to tackle the problem. While these gatekeepers have unique roles to play at specific levels, they can and do contribute to success at other levels as well. Good prevention strategy includes finding ways to engage the gatekeepers throughout the prevention effort.

TACTICAL GAP ANALYSIS

A clear focus is needed for success in any effort aimed at reducing and preventing alcohol, tobacco, and other drug problems. Choices and compromises must be made in a thoughtful manner without placing the integrity of the effort in jeopardy. Strategies must be used in ways that are consistent with the program's intentions and targeted results, and must always remain respectful and sensitive to cultural norms of the communities affected.

Sometimes prevention efforts are carried out without specifically defining the results intended. An organization might hear of another group's successful activity, consider it a good idea, and decide to replicate it. For example, an organization might decide to distribute bumper stickers or T-shirts with a catchy slogan without thinking through the goal of the effort. If the organization's goal is to increase public awareness and commitment to ATOD problem prevention, it must decide whether bumper stickers and T-shirts can, by themselves, accomplish this. The organization should decide what it wants its intended audience to be aware of and what is the best way to reach that audience. Only then can it pick the activities that best fit these criteria. A successful campaign might need to include newspaper articles, door-to-door leafleting, and radio and television spots.

Results Hierarchy

VI	**IMPACT**	Reduction in number of problem incidents (and corresponding increase in quality of life indices)
V	**OUTCOME**	Change in a person's behavior toward decisions and actions less likely to contribute to the problem
	GATEKEEPERS: Community-at-Large	
IV	**ENVIRONMENTAL SHIFT**	Change in law, policy, resource allocation, program activity, or available options
	GATEKEEPERS: Resource-Brokers and Opinion-Shapers	
III	**ACTION PREPARATION**	Dialogues conducted, key supporters and collaborators enlisted, plans developed, and resources mobilized
	GATEKEEPERS: Colleagues and Supporters	
II	**FOCUSING**	Knowledge, skills, methods, and conceptual frameworks acquired for addressing the problem
	GATEKEEPERS: Champions	
I	**MOTIVATION**	Attention drawn to a problem that needs to be addressed through prevention interventions
	GATEKEEPERS: Advocates	

Table 1

Tactical gap analysis is an examination of the maximum level of results anticipated from a project, and an assessment of project activities to ensure that their interim results will build to that level. The first step of the analysis is to examine the maximum results anticipated. If the results are only at levels I or II of the Results Hierarchy, project redesign is recommended to bring the results at least to level III (*i.e.*, **ACTION PREPARATION**). This reflects our contention that no prevention projects should be undertaken unless they actively engage people in working toward getting results; interest building and passive learning are simply not enough to warrant a project. Clearly some of the activities associated with a project can be motivational and skill-enhancing. The goal, however, should be set higher.

Next, the interim result-levels of each of the major project activities are examined. Do these activities build to the maximum results? If not, one or more activities need to be modified to push the interim results to a higher level.

Consider, as an example, a series of workshops which increase awareness of problems associated with secondary exposure to tobacco smoking and present strategies for addressing them. This is a level II maximum result (*i.e.*, **FOCUSING**). How can the project be enhanced to bring it to level III? One possibility would be to provide workshop participants with a kit of experiments that they could perform to demonstrate secondary effects to others. Another option might be to add a planning component to the workshop.

Three hypothetical projects are presented in Figure 5. For each, the maximum project results anticipated and the interim results likely from key activities are charted. What suggestions would you make for each project, based on this limited information? [Our solutions would be as follows: The interim results in case 1 will possibly allow the maximum results to be attained; but the maximum expected results are too low. The interim results in case 2 are not building toward the maximum results. Several of the major activities would need to be adjusted. The interim results in case 3 appear to be building toward the maximum results. Perhaps one of the major activities requires some beefing up.]

OPEN-SYSTEMS EVALUATION TOOLBOX

A series of project planning tools, performance checklists, and assessment instruments have been developed for use in designing and implementing projects. The tools help ensure thoughtful, strategic deliberation and timely project assessment. The success of single projects and the overall prevention effort rests in part on the effective use of these tools. The tools can be used as design aids before a project's implementation; as quality assurance aids during the

implementation; or as process and outcome assessments at appropriate times during the project. The open-systems evaluator works with program staff and community members, using these tools at appropriate points in the prevention programming process.

Project Blueprint. This one-page worksheet is used to lay out the project design at three levels: overall challenge, maximum results, and interim results, as explained next. Each project should be part of an "overall challenge" that this project, together with other projects, is attempting to meet. The measures of success for the overall challenge and the "maximum results" of the project itself must be clearly defined. The worksheet is used to capture these goals. It is also important to understand how the project's maximum results are to be attained. The project design might include, say, four major activities that need to take place to realize the project. These activities may occur simultaneously or in tandem, depending on the project. For each of these activities, the "interim results" also need to be defined and set down in the Blueprint.

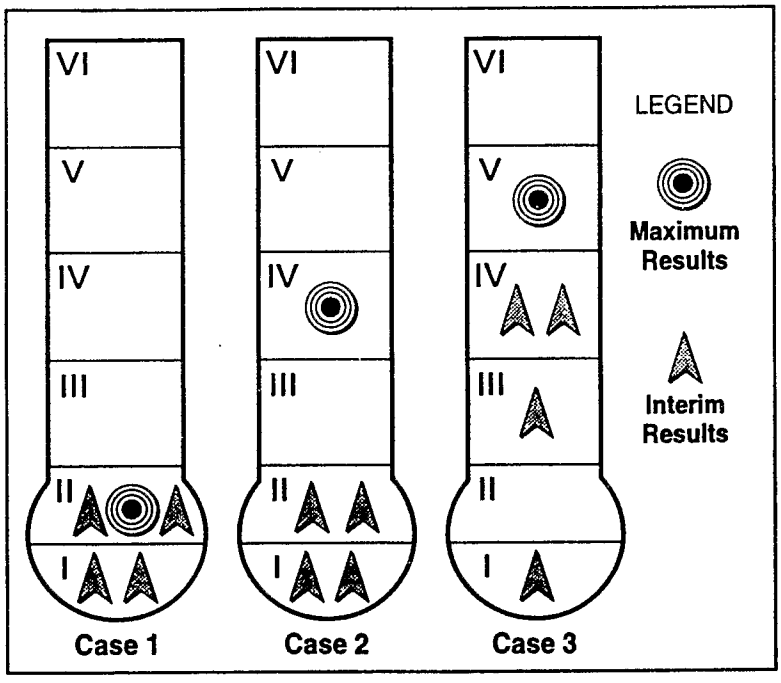

Figure 5

Project Logic Checklist. This worksheet is used to review the project's justification and underlying logic, as laid out in the Project Blueprint. The worksheet includes open-ended questions to be answered by the project staff with the assistance of the evaluator.

Activity Design Worksheets. These worksheets guide the project staff through the design of each major activity to pinpoint weaknesses or gaps. The worksheets are used during the initial design process and as a final check on the overall design before implementation. They also are used retrospectively to uncover ways to strengthen project designs for future use.

Quality Performance Checklist. This form is used to list the critical tasks that must occur before, during, and after each project activity. For each such task, the project staff and evaluator define one or more quality performance standards that will guide the task to the desired interim results. A completion date is set and a lead person is chosen to be responsible for the quality performance of the task. One column is used to check off each task as it is completed. If problems arise with any task, the staff reviews the remaining tasks in the activity to determine if they are still appropriate as designed.

Project Promotion Worksheet. This form is used to assess how buy-in and support might best be obtained from key gatekeepers. Open-ended questions are used to guide deliberation. The worksheet is reused for the same project if buy-in is required from diverse groups.

Trainee Feedback Instruments (Profile, Feedback, and Follow-up Forms). The forms are used to capture feedback from trainees before, during, and after project training events. These forms focus on factors associated with application of materials and skills gained from training. The forms are designed to capture changes in predisposition, capacity, and support for use of the materials, skills, and ideas presented. The full value of these forms is realized when they are used in tandem to track the influence of the training on trainees during and after the training event. The results provide trainers with immediate feedback and curriculum developers with input for future training designs.

STRATEGIC GAP ANALYSIS

A parallel set of activities and tools have been developed to assist organizations and communities with strategic planning. Referred to as open-systems planning-for-action, the planning framework leads to the identification of high-potential project concepts. Once identified, the open-systems evaluation toolbox is used to maximize the contribution of each project to the overall strategic effort.

Strategic gap analysis is the examination of the project mix to determine what additional projects are needed to ensure success in meeting the overall prevention challenge. The approach is similar to tactical gap analysis, with the focus shifting to achieving this challenge rather than on obtaining the maximum results for individual projects. The key is to obtain enough of these maximum results to build quantitatively and qualitatively to the level of the overall challenge.

To illustrate, a community is determined to reduce the number of deaths and injuries associated with alcohol use (Figure 6). It develops a five-pronged program consisting of an underage drinking deterrence project, a media campaign, increased roadside checks for drunk drivers on weekend evenings, a responsible beverage-server training program, and changes in local zoning ordinances to reduce the density of outlets selling alcohol in parts of the community where problem incidents are highest. The overall prevention challenge is a level VI result (*i.e.*, **IMPACT**). Project Blueprints would be com-

APPENDIX G:
A Framework for Community Mobilization

STAGE OF DEVELOPMENT	Action Steps *What communities do when they mobilize; descriptive*	Methods/Strategies *How communities mobilize; options from which to choose*	Outcomes *Expected results from actions of the community*	Support Needed *What support might help the group*
Stage 1: **Entry/Initiating**	One or more individual(s) see a need. These individuals identify and contact key people (including formal and informal leaders) and target significant constituencies for involvement (e.g., youth, ethnic minorities, elderly, etc.). A loosely formed group begins to develop. Group members: • begin preliminary definition of community • identify and contact existing groups • create/increase awareness and involve community	Responding to trigger events Supporting the emergence of natural or charismatic leaders Involving political/powerful/formal leaders Using media — public service announcements, specials on local news Seeking the support and leadership of key organizations or agencies Using powerful language when appropriate as a marketing tool ("drug-free") Initiating other awareness activities (beginning the appeal to the entire community)	A core group of people commits to continue the process of comprehensive, community-wide prevention (safety, access, opportunity) This group begins to: • identify its leaders • seek representation that reflects the entire community • seek community acknowledgment of the need for health promotion • identify issues of common concern	Technical Assistance: • how to get started • how to identify and engage critical individuals and groups • how to identify and develop leaders Materials: • general information on prevention • general information on social change and community Training: • activation • awareness-building • team-building

STAGE OF DEVELOPMENT	Action Steps *What communities do when they mobilize; descriptive*	Methods/Strategies *How communities mobilize; options from which to choose*	Outcomes *Expected results from actions of the community*	Support Needed *What support might help the group*
Stage 2: **Readiness**	Group begins to evolve into a coalition This emerging coalition begins to: • assess community's level of readiness to change • establish readiness to effect change among community members • activate the community (bringing people on board) • develop network and resource linkages • educate its own members relative to activation, the change process, and common issues The coalition continues to: • develop relationships with key individuals and groups • develop leadership among its members • identify issues of common concern	Take advantage of educational/training opportunities and materials Engaging key community legitimizers to invest themselves in issues of concern Engaging in team-building processes or activities Conducting large meeting(s) involving any community members wiling to attend Engaging in a visioning process for the community Establishing a preliminary impression of community readiness Pulling together assessment instruments Establishing and maintaining coalition record of their history and activities Recruiting new members through telephone calls, lunches, informal networking, etc. Conducting regular coalition meetings Choosing a name for coalition Establishing preliminary group norms	An intact, functional coalition (with some kind of organizational structure) is established This coalition embraces the need for the community at large to work together The coalition has begun to: • establish a common vision and a willingness to share that vision and involve others in it • identify common ground on issues, concerns, and strengths • establish inclusiveness as an important value • understand the benefits of collaboration	Technical Assistance: • facilitating meetings • marketing • awareness activities • team-building • networking • conflict resolution • consensus Materials: • facilitation • marketing • activation • team-building • group process • community mobilization and social change • visioning • consensus Training: • activation • team-building • group process • visioning • consensus

STAGE OF DEVELOPMENT	Action Steps *What communities do when they mobilize; descriptive*	Methods/Strategies *How communities mobilize; options from which to choose*	Outcomes *Expected results from actions of the community*	Support Needed *What support might help the group*
Stage 3: **Assessment**	Coalition completes the process of defining their target community Coalition begins to: • assess where their community stands on the issue(s) • identify and assess community resources • identify and assess current activities relative to issue(s) of concern • assess community safety, access, and opportunity • identify community policies/norms • identify service/resource gaps and needs • assess community problems and underlying causes • describe demographic variables for their community • work on an environmental/ social/economic assessment • assess their individual values	Conducting public meetings Conducting public polls and/or youth polls Conducting key informant survey or interviews Analyzing currently existing incidence and prevalence data Acquiring and analyzing what information social service agencies/schools will provide Recording and sharing assessment results Administering a "use" survey Holding public forums targeted at specific populations Developing an inventory of current programs Reviewing current research regarding what works Evaluating current programs and activities regarding what works Conducting field observations Conducting a normative analysis Conducting interviews — informal and formal	Individuals have established a personal investment in issue(s) of common concern. Coalition has established: • further identification of common ground • some kind of picture of the community's resources and problems • clear ideas of what needs to happen to bridge the gap between the vision and existing conditions Coalition is continuing to engage in: • broadening of its constituency • awareness-raising processes and activities aimed at the entire community • marketing of need/resources	Technical Assistance: • assessment • coalition-building • facilitation Materials: • assessment • defining community • coalition-building • facilitation • surveys • case studies • sample interviews • sample assessment tools • marketing Training • assessment • marketing • coalition-building • facilitation • leadership

STAGE OF DEVELOPMENT	Action Steps *What communities do when they mobilize; descriptive*	Methods/Strategies *How communities mobilize; options from which to choose*	Outcomes *Expected results from actions of the community*	Support Needed *What support might help the group*
Stage 4: **Planning**	Coalition identifies a team that engages in a systematic planning process This plan includes coalition maintenance and expansion Coalition continues to develop leadership	Examining and sharing community assessment information Defining coalition's unique role/mission Defining coalition's goal(s) Developing a community philosophy statement Developing action plans incorporating evaluation steps Revisiting norms/operating guidelines Negotiating roles and responsibilities of coalition members and the organizations they represent Recruiting new members (ongoing)	Individual efforts evolve into collective effort Team develops a written plan that reflects coalition members' priorities A common ground is clearly articulated The coalition establishes a commitment/willingness to carry out plan	Technical Assistance: • preparation for team training • planning • maintenance and expansion of team Materials: • planning • team maintenance and expansion • documenting efforts • evaluation • grant-writing • fund-raising Training: • planning • team-building • team maintenance and expansion • prevention strategies • social policy/norms • social change • prevention

STAGE OF DEVELOPMENT	Action Steps *What communities do when they mobilize; descriptive*	Methods/Strategies *How communities mobilize; options from which to choose*	Outcomes *Expected results from actions of the community*	Support Needed *What support might help the group*
Stage 5: **Implementation**	Coalition and community members: • implement action plan • monitor and assess progress	Developing methods for conflict resolution Continuing assessment Developing work groups or subcommittees as needed Conducting regular meetings Continuing to negotiate roles and responsibilities Getting commitment from relevant agencies/organizations/individuals to implement relevant parts of plan Celebrating and publishing successes Gaining broad-based support for plan	New needs (e.g., resources, technical assistance, training) are identified Values articulated earlier are now demonstrated Service delivery is established/ strengthened Community makes tangible movement toward goals Individual and group growth occurs Community members' needs are met Commitment to change expands beyond coalition members Community needs are met Networking is enhanced Community begins a paradigm shift	Technical Assistance: • overcoming unforeseen obstacles • team-building • conflict resolution • consensus • collaboration Materials: • prevention strategies • marketing • prevention information • social change and community mobilization Training: • assessment • social change • consensus • collaboration

STAGE OF DEVELOPMENT	Action Steps *What communities do when they mobilize; descriptive*	Methods/Strategies *How communities mobilize; options from which to choose*	Outcomes *Expected results from actions of the community*	Support Needed *What support might help the group*
Stage 6: **Sustaining/ Reinforcing/ Replanning**	Team replans Coalition: • builds a broad base of financial support for prevention initiatives • links needs assessment, program plan, and funding plan • continues to build relationships that support coordination and continue to cultivate common ground among organizations and individuals • conducts ongoing evaluation of the effectiveness and responsiveness of both the coalition and community-wide prevention initiatives • continues to inform and involve the public • addresses the issue of common customers (individuals or groups interacting with multiple systems in the community) • nurtures and supports itself and its members • continues leadership development	Engaging in grant writing Engaging in fund raising Performing ongoing needs assessment, evaluation, and feedback concerning coalition needs and activities Performing ongoing training and development of coalition Modifying coalition structure and leadership as needed Modifying coalition and community programs as needed Recognizing accomplishments of coalition members, both individual and organizational Continuing expansion Continuing team-building Continuing negotiation of roles Renorming as needed Engaging in conflict resolution as needed Celebrating and publishing successes	A functioning coalition is established and ongoing Prevention initiatives are ongoing Evaluation and modification of prevention initiatives are ongoing Measurable social change occurs Community demonstrates an enhanced capacity to deal effectively with emerging issues Community members experience increased safety, access, and opportunity	Data Collection Requirements: • outcomes and impact Technical Assistance: • team maintenance and expansion • conflict resolution • consensus • team-building • collaboration Materials: • team maintenance and expansion • conflict resolution • consensus Training: • team maintenance and expansion • conflict resolution • consensus • team-building • collaboration

APPENDIX H:
Prevention Strategies — Planning For Multiple Levels of Influence

LEVEL OF INFLUENCE	ADHS/DBHS PREVENTION STRATEGIES								
	Training	Public Information & Social Marketing	Community Education	Parent/Family Education	Alternative Activities	Community Mobilization	Life Skills Development	Peer Leadership	Mentorship
Individual									
Family									
Organization									
Systems of Care & Service Delivery									
Community									
Region									

APPENDIX I:
Prevention Strategies — Collaborative Planning By Type of Lead Agency or Organization

ADHS/DBHS PREVENTION STRATEGIES									
LEAD AGENCY OR ORGANIZATION	Training	Public Information & Social Marketing	Community Education	Parent/Family Education	Alternative Activities	Community Mobilization	Life Skills Development	Peer Leadership	Mentorship
Behavioral Health									
Primary Health									
Education									
Social Services									
Law Enforcement									
Government									
Business & Industry									
Media									
Civic & Voluntary									
Religious									
Recreation									

Prevention Framework for Behavioral Health I-1

APPENDIX J:
Monitoring Guidelines for Regional Behavioral Health Authority (RBHA) Prevention Programs

The Division of Behavioral Health Services uses the following criteria for evaluating prevention services in its Operations/Financial Reviews of Regional Behavioral Health Authorities:

1. Specified staff for prevention service development and delivery.
2. Established process for an annual evaluation of the program process against criteria, goals, and objectives elucidated in its RFP and business plan.
3. Process for identifying successful and replicable program strategies.
4. Review of outcome evaluation criteria, data elements and instruments, deliverables, and reporting of promising practices.
5. Standards to evaluate performance of prevention providers.
6. Specialized training events focused on prevention for RBHA and provider staff.
7. Assessment of the community for prevention needs.
8. Short and long term prevention plan relevant to the needs of the community.
9. Process for setting prevention priorities within the provider network for contract purposes.
10. Process for prevention providers to report their progress and annually analyze their programs required in their contract.
11. Organizations with which the RBHA collaborates.
12. Key elements the RBHA specifically monitors in prevention programs.
13. Holding regular prevention meetings.
14. Steps taken toward the process of becoming a Regional RADAR (Regional Alcohol and Drug Awareness Resources) Associate.
15. Current prevention providers and the types of programs funded (service codes).
16. Breakdown of prevention services contracted for per individual service code and their location.
17. Process to train/develop the prevention programs to meet the federal prevention initiatives.
18. Policies and procedures regarding prevention services.

19. Maintenance of expenditure data relevant to administration overhead for prevention allocations, such as training, staffing and services development.

20. Technical assistance with existing providers to expand services to meet unmet prevention needs where no appropriate programs exist.