Oregon Department of Human Services &
Oregon Health Authority
Addictions and Mental Health Division

Addictions and Mental Health Division Prevention Services: Vision, Mission, Goals and Objectives

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PREVENTION VISION

Healthy Oregonians

PREVENTION MISSION

To promote age appropriate social, emotional and behavioral development by providing evidence-based prevention programs, policies and practices (EBP) throughout Oregon

PREVENTION PRINCIPLES

POPULATIONS TO BE SERVED

1. Prevention strategies and programs shall address all Oregonians.
2. The IOM categories of populations shall guide the delivery of strategies and programs. The IOM categories are the general population, groups determined to be at higher risk and individuals who are demonstrating the early signs of health and behavioral problems.
3. Prevention strategies and programs shall address individuals along the entire age continuum. A key concept in the development of the continuum is the right program at the right time for the right person.
4. The strategies and programs shall be culturally appropriate for the diverse populations in Oregon.

SYSTEM

5. State, county and community key leaders must endorse and advocate for prevention as a way to foster healthy Oregonians
6. Current prevention science shall guide the prevention system, strategies and programs.
7. The prevention system shall utilize the research-based predictors of positive healthy behaviors and the problem behaviors.
8. Evidence-based programs, policies and practices that have been proven to increase the factors for positive behaviors and reduce the risk factors for problem behaviors shall be implemented with fidelity
9. Multiple strategies in multiple domains (community, family, school and individual – peer) shall be utilized to gain the synergy across the domains and achieve the desired outcomes.
10. Community-based prevention shall be data driven and address community needs identified by the communities. Problems and programs can not be determined by external sources and imposed on the community.

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11. Reliable and valid methods for measuring the key health issues and problem behaviors, and the predictors of these problems are essential. The Student Wellness Survey administered in the 6th, 8th and 11th grades and the Oregon Healthy Teens Survey administered in the 8th and 11th grades are essential in determining the prevention needs at the state, county, tribe and community levels.
12. Prevention workforce development shall be an ongoing priority.
13. To gain the desired effects of the prevention initiatives there must be adequate and sustained funding that is not at the mercy of downturns in the economy.
14. Partnerships across state, county and city agencies are essential in achieving the desired effects of prevention.

OUTCOMES

15. Evaluation is an essential and integral part of the prevention system. The evaluation system shall focus on process and outcome results. The system shall be maintained over time to demonstrate the desired outcomes. The evaluation findings shall be used to direct the prevention system.
16. Evaluation methods shall be used to measure population change, e.g. 8th grade youth alcohol consumption in the past 30 days and program level change, e.g. participant's changes in knowledge, skills, attitudes and behaviors as a result of participating in a prevention program.
17. Prevention strategies and programs shall be implemented and maintained with fidelity. Fidelity will be measured on an ongoing basis and deficiencies in implementation fidelity corrected in a timely manner.

PREVENTION GOALS AND OBJECTIVES

There are four interrelated goals for prevention including

- Goal 1 – Research Driven;
- Goal 2 – Data and Outcome Driven;
- Goal 3 – Gold Standard Programs, Policies and Practices; and,
- Goal 4 – Highly Knowledgeable and Skilled Workforce.

Goal 1
Research Driven

Prevention shall be driven by the latest behavioral and health research in an effort to maximize the effects of the prevention services throughout Oregon.

Objectives

1.1 Partnerships with Oregon and national behavioral and health researchers and organizations shall be formed by July 2010 and maintained over time. Researchers and organizations include but are not limited to Oregon Research Institute – Tony Biglan and Carol Metzler, Oregon Social Learning Center – Mark Eddie and Charles Martinez, Oregon State University Public Health Department – Brian Flay,

University of Oregon Substance Abuse Prevention Program – Tom Favareau and Department of Education Jeff Sprague, Oregon Health Sciences University – One Sky Center, University of Washington Social Development Research Group – David Hawkins and Richard Catalano. Quarterly meetings will be held. Meeting locations will be rotated through the different research organizations and providers in an effort to network. Six Prevention Coordinators will form a Prevention Research to Practice to Research workgroup (PRP) to guide the input from the prevention community. Metric: meetings and attendance at meetings. Increased collaboration between researchers and practitioners

1.2 Annually beginning in September 2010 researchers and the PRP will host a summit for the prevention coordinators and interested individuals to inform the prevention community of the current research findings. Metric: summit and post survey of participants to judge value added, learning and intended applications of the researchers.

Goal 2
Data and Outcome Driven

Prevention decisions shall be driven by data including epidemiological and survey data. Positive outcomes at the population and program participant level will be a priority combined with the analysis of the cost offset and return on investment. Training will be provided to counties, communities and tribes in utilizing data to inform decisions on the selection of evidence-based programs, policies and practices.

Objectives

2.1 AMH, with its partners, will maintain robust data sources including epidemiological, student and adult surveys. The sources will be tailored to be utilized by communities/counties/tribes for the purposes of planning and evaluating their prevention services. Metric: quarterly feedback from user groups and the Strategic Prevention Framework Epidemiological Workgroup (SPF-EPI).

2.2 Training will be provided on a regular basis to counties/counties/tribes in the utilization of data in identifying priorities and selecting EB3P. Metric: pre- post-surveys of participants to determine knowledge gain and review of county implementation plans to determine use of data in setting priorities

2.3 EPI, Student Wellness Survey and Oregon Healthy Teens Survey will be used to prioritize local problem behaviors and their research-based predictors. These priorities will drive the local decisions on which Evidence Based Programs, Policies and Practices (EBP) should be selected. Metric: Utilization of data to identify priorities and EBP.

2.4 Population and program participant outcomes will be essential metrics in the prevention system. Population outcomes will be assessed utilizing EPI, SWS and OHT data aggregated at the county state level. Program participant outcomes will be assessed utilizing pre-post surveys at the

program level and will be aggregated across participants and, in the case of multiple counties providing the same EB3P, across counties. Cost offset and return on investment estimates from recognized sources (e.g. Washington State Institute for Public Policy) will be utilized. Accepted methodologies will be used to determine trends. Metric: Data from the outcomes will inform the future decisions on prevention priorities at the state and county levels.

Goal 3
Gold standard Programs, Policies and Practices
Addictions and Mental Health Division will maintain a menu of Evidence-based Programs, Policies and Practices (EBP) that address the research-based predictors of the problem behaviors.

Objectives

3.1 To maintain and update a menu of (EBP) for communities and counties to chose from to address their prioritized predictors of the problem behaviors. The EBP menu will list the details of the EBP including identifying which predictors and problem behaviors they address, intended population – IOM category, CSAP six prevention strategies and resources for additional information on the EBP. Metric: a current menu of EBP that practitioners are utilizing.

3.2 To develop and maintain a menu of Tribal Best-Practices for use by the nine recognized Tribes in Oregon.

3.3 Fidelity assessment tools will be identified, and if needed developed, on the EBP for use by practitioners. The fidelity assessment tools will be posted on the AMH – Prevention EBP website. Metric: postings on the website and utilized by practitioners

3.4 Training will be provided to practitioners on the use of the implementation fidelity assessment tools for those EBP that are most commonly utilized. The training may be provided by the developer or a trainer who is skilled in the use of the instruments. Metric: trainings delivered, the number of participants utilizing the tools and a random check of the use of the tools.

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Goal 4
Highly Knowledgeable and Skilled Workforce
To maintain a highly knowledgeable and skilled prevention workforce throughout Oregon

Objectives

4.1 To provide skill-based training on a regular basis. The training will be prioritized to address the needs of practitioners seeking their Certified Prevention Specialist certification. Metric: All eligible prevention coordinators have their certification.

4.2 Practitioners will gain their CPS certification within 2 years of employment in the prevention field. Metric: practitioners certified

4.3 Provide twice-yearly prevention summits that will have skilled-based training components. Metric: pre- post-surveys of summit participants

4.4 Provide quarterly meetings of researchers and practitioners to exchange information and form collaborative relationships. Metric: meetings conducted and collaborative relationships established

4.5 To explore the feasibility of specialty 'endorsements' to the CPS. The endorsement will require the successful completion of specialized training in a discipline, e.g. suicide prevention, and completion of a practicum under the supervision of a specialist in the specific discipline. Upon completion of the training and practicum a participant will be awarded a '*discipline* Prevention Specialist Endorsement (e.g. Suicide Prevention Specialist Endorsement).' Endorsements would be offered for prevention in the disciplines of tobacco, teen pregnancy, community mobilization (SPF or CTC), etc prevention. Metric: support from practitioners and ACCBO for endorsements, implementation of high quality skill-based training for practitioners and implementation of the practicum component so practitioners can gain the endorsement.

4.6 To explore the feasibility of an advanced CPS. A CPS-II would require advanced training, direct experience in prevention and endorsement of a CPS II or III. A CPS III would require additional advanced training, additional direct prevention experience and endorsement of a CPS III.

PREVENTION SYSTEM IMPLEMENTATION

Oregon is committed to community-based prevention system of services. To gain population change in the priority problem behaviors requires the investment and commitment of citizens in a communities and counties and members of the recognized tribes.

There are two similar community-based prevention frameworks in Oregon. The Strategic Prevention Framework – State Incentive Grant (SPF) was recently funded through a five year cooperative agreement with the Center for Substance Abuse Prevention. The second framework was implemented in Oregon in1988-89 through a National Institute on Drug Abuse research grant through the University of Washington. The program initially was titled Oregon Together and later was re-titled Communities That Care (CTC).

Both of these frameworks guide the implementation of the prevention mission, principles, business goals and objectives. Also guiding the implementation are the developments that occur from the biennial Legislative Sessions and changes in the overall system including the transition from the Department of Human Services to the Oregon Health Authority in July 1, 2011 and National Health Reform. Of special note is the passage of HB 3353 that formed the Alcohol and Drug Policy Commission. The commission will make recommendations to the Governor and Legislature on revisions to the alcohol and drug prevention, treatment and recovery services.

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Strategic Prevention Framework
The SPF provides a structure for coalitions and other broadly represented community organizations to identify the most pressing substance abuse problems in their community and at the state level.

SPF uses a data driven approach to understand what the most pressing problems are, who is affected most by the problems (consumption and consequences), why the problems are happening (contributing factors / predictions), and what Evidence-based Programs, Policies and Practices (EB3P) are most effective in addressing these problems and contributing factors / predictors. The guiding principle of this framework is that data on problems, resources, and readiness should guide the selection of EB3P.

Each community will in all probability a different set of outcomes targeted, but the goal is always community level change in substance use consumption patterns, consequences and contributing factors / predictions.

SPF has five interrelated steps that are shown below. There are also two key components central to each step; sustainability and cultural competence.

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Communities That Care

Communities That Care (CTC) is a prevention implementation framework for use at the community, county, tribal and state levels. The framework is grounded in the public health model and findings from the research on predictors of positive behaviors and problem behaviors in six major health and behavioral issues. The framework is data driven and utilizes EB3P to address the priority problem behaviors and predictors.

CTC has five phases that build on each other. The first phase Get Started assesses a community's readiness to engage and sustain the prevention framework. The second phase Get Organized assists the community in developing a 'Community Board' with six subcommittees to carryout the tasks of implementing the framework. The third phase Develop a Profile analyzes the student survey, EPI and archival data to determine the communities priority problem behavior and predictors of the behavior. Also, the profile creates an inventory of programs, policies and practices that directly address the priorities (resource mapping). The fourth phase Create a Plan aids the community in developing a plan to address the priorities. The plan includes the desired outcomes for the problem behaviors and predictors, the EB3P and participant outcomes and establishes an evaluation plan. The final phase Implement and Evaluate assists the community in implementing the plan and carrying out the activities in the evaluation plan. There are six separate structured trainings for community members to successfully carryout each phase.

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A five year random controlled research trial of CTC was completed in 2009. The five year study in 24 communities in seven state throughout the country showed significant results in reducing the initiation of three major health and behavioral problems; reduced initiation in alcohol use, tobacco use, smokeless tobacco use and antisocial behavior.

The *Communities That Care* Operating System