



CROSSWALK THE LANGUAGE AND FRAMEWORKS OF PUBLIC HEALTH AND PREVENTION

**Alcohol & Other Drug Prevention Partners Workgroup #1
Concepts & Connections**

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Background

In 2015, the Oregon Health Authority (OHA) reorganized and transitioned alcohol and drug prevention responsibilities to the Public Health Division (PHD). While this was a significant change for all involved, it was also an opportunity to leverage additional resources, grow a robust statewide comprehensive program and strengthen coordinated leadership at the state and locally for alcohol, tobacco and other drug prevention in Oregon. In 2016, OHA embarked on a statewide prevention partner outreach and engagement process (described below) to gather input to inform their approach, including opportunities to work more collaboratively, the best ways to continue to solicit input to inform alcohol and drug prevention work, and the most effective ways to communicate changes.

Methods

Beginning in late 2016, In the first phase of the Prevention Partner Outreach, Coraggio Group gathered input through stakeholder listening sessions conducted in Portland, Roseburg, Coos Bay, Pendleton, Bend, and Milwaukie, as well as via an online survey. Participants included alcohol, tobacco, and other drug prevention coordinators and stakeholders, tribal prevention staff, community coalition representatives and local public health staff. In all, they heard from 109 individuals.

A second round of outreach followed that included 23 individual stakeholder interviews, in-person workshops in Eugene and Newport, and three online workshops. There were 48 participants in the second round of outreach, bringing the total number of participants to 157.

Participants in the second round of workshops helped to refine some of what was learned in the first round of outreach, and identified areas of opportunity for Oregon Health Authority to consider in moving forward. Coraggio Group produced a list of the top opportunities, and through workshops at the Grantees and Contractors conference, as well as through workshops held in La Grande and Redmond, these opportunities were prioritized and three were chosen for immediate work:

- Crosswalk the language and frameworks of public health and prevention
- Establish and clearly communicate state-wide strategies, goals and priorities
- Collaborate with prevention partners to re-imagine how prevention happens in Oregon

Collaboration

The purpose of this first workgroup, Crosswalk the Language and Frameworks of Public Health and Prevention, was to foster collaboration while evaluating the frameworks and language commonly used in the prevention field, identifying the connection points, and illustrating how they relate to one another.

Acknowledgments

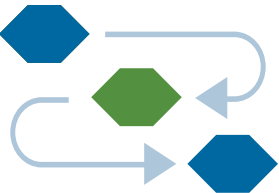
This workgroup was composed of the members listed below. They collectively participated in two webinars, a two-day in-person work session, and a follow-up revision work session over the course of April-June, 2018.

WORKGROUP MEMBERS

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Introduction from Workgroup 1

The “Crosswalk the Language and Frameworks of Public Health and Prevention” workgroup started with an agreement that words and frameworks matter because they guide and direct how we spend limited resources to prevent alcohol and other drug misuse. Together, the words and frameworks direct us to prioritize our most valued resource—our workforce and our time. We also recognize that while we use the same words, the ways we use them are sometimes different or slightly nuanced. We spent time contemplating these differences, learning the historic context and background on how language and frameworks are used.

We reviewed eight of the most commonly used frameworks for guiding and directing funding priorities in public health and alcohol and other drug prevention. This resulted in a visual graphic of how local, tribal, state mental and public health authorities, and nonprofits are getting work done to achieve improved health outcomes.

Our deliverables include a visual crosswalk of frameworks from the fields of prevention and public health and a list of concepts used across our professions with a description of how the concept is applied in practice. For example, the word ‘policy’ might be used differently in the two fields. Our hope is that a shared understanding of concepts will allow practitioners to work together to reduce alcohol and other drug use, and prevent chronic diseases, especially addiction and that the tools will aid in facilitating shared understanding. The increased understanding of language and frameworks will continue to inform and make more specific our conversations as we to strive for an Oregon that is better for all.

Community Definitions

For this document, we define the Alcohol, Tobacco and Other Drug (ATOD) Prevention professionals and Public Health professionals as individuals who work at the state or community level to prevent alcohol, tobacco and other drug misuse and the secondary health effects of misuse, including addiction and other chronic diseases. ATOD professionals may be employed by tribal health departments, county or municipal departments or by other partners such as nonprofits or Drug Free Community organizations. Public health professionals similarly are employed by tribal health departments, state and local public health authorities, and by other community-based organizations.



Concept Crosswalks



Concept: Policy
Alcohol, tobacco and other drugs (ATOD) prevention and public health professionals agree policy is critical to promoting and sustaining long-term health outcomes, and can protect and support health across a population and in specific settings. Policy is what sustains environmental and systems changes initiated in communities. In the ATOD Prevention field, policy is one component of a comprehensive approach used to create community-level change, but does not always drive the work effort and resources. Policy change is also one component of a comprehensive approach in public health, and is an output that often drives resource allocation and priorities.



Concept: Protective Factors
Protective factors help both ATOD and Public Health professionals understand and highlight specific community assets that support optimal health. ATOD prevention professionals use the Risk and Protective Factor (RPF) framework as an assessment tool to work with community partners to identify risk and protective factors in a community, select and prioritize strategies for community planning and evaluate results. Within public health, the protective factors are sometimes described as community strengths, assets or social determinants of health, and are often used to inform state and local policy priorities and identify community-based strategies. The Risk and Protective Factor model addresses characteristics which affect the likelihood of negative behavior outcomes, including substance abuse, delinquency, violence, teen pregnancy, and school dropout. Social determinants of health are more closely connected with specific health and disease outcomes.



Concept: Evidence-based (*Note: this does not recognize differences in how Tribal Best Practices are applied)
The fields of ATOD prevention and public health both agree that leveraging evidence-based practices is critical to be good stewards of limited public resources and to achieve health outcomes that benefit people across Oregon and in our communities. In the ATOD prevention field, the depth of evidence used to determine if a program or strategy is evidence-based has varied, often allowing for more promising practices to be used in the field. Both fields recognize the importance of cultural relevancy, health equity, and community engagement when planning and implementing evidence-based strategies.



Concept: Prevention (see Framework Overviews)
Prevention is the act or practice of keeping something from happening. Related to behavioral and physical health, prevention refers to a body of strategies used to prevent poor health outcomes and is critical to address addiction, chronic disease, and secondary health effects of alcohol, tobacco, poor nutrition, and physical inactivity.

The concept of prevention is a foundational public health practice. The field of ATOD prevention uses terms from the Institute of Medicine Model to describe the focus of prevention interventions. The field of public health typically categorizes prevention strategies, as well. Prevention interventions are described as: Universal prevention (ATOD prevention) = Primary prevention (public health); Selected and Indicated prevention (ATOD prevention) = Secondary/tertiary (public health). As such, prevention strategies can be used at the individual and organization levels, and through community and population-wide strategies as well.



Concept: Health Promotion

Health Promotion covers a wide range of policy, system, environmental and communication strategies that promote health, increase healthier options and reduce access to unhealthy options. Health promotion strategies both protect health and prevent root causes of disease and addiction. Health promotion also includes communication and media practices, along with health education, raising awareness, and social norming. Health Promotion strategies also help build community capacity and support for the implementation of population-wide interventions that improve health.



Concept: Capacity-Building (see also community mobilization)

Capacity is having adequate capability, knowledge, resources, and skills to act. Capacity building is the process of increasing the capacity to act. Capacity-building focused on the workforce aiming to increase knowledge, skills and capabilities among ATOD, public health professionals and community members to improve community conditions and health outcomes. Capacity-building creates systems change, strategic alignment, buy-in, and strong stewardship of resources. As part of the Strategic Prevention Framework, capacity-building refers to increasing the community's ability, knowledge, and will to improve community conditions to achieve better health outcomes and prevent alcohol and other drug misuse. Capacity building in this context is part of community mobilization. In public health, capacity building is often linked to core competencies like policy, planning and communications.



Concept: Community Mobilization (See also capacity building)

Community mobilization occurs when community organizations and community leaders take action to promote or advocate for a policy, system or environmental change to achieve a common goal. ATOD prevention professionals also use community mobilization to mean community members taking action to provide and sustain long-term support to implement the change or program. Public health professionals, similarly rely on community mobilization to achieve policy, system and environmental changes. Strategies to mobilize community may vary across disciplines, however the end goal to empower communities to achieve health through shared action is common among both ATOD and public health professionals.



Concept: Community Engagement

Community engagement (notably different from community mobilization) aims to ensure diverse and broad community representation in assessment, planning, evaluation, and decision-making. It ensures impacted communities and stakeholders are part of community health solutions. Some examples of community engagement include, but are not limited to, community-based participatory research, coalition and advisory structures, community health assessments, community health improvement planning, public meetings and listening sessions.

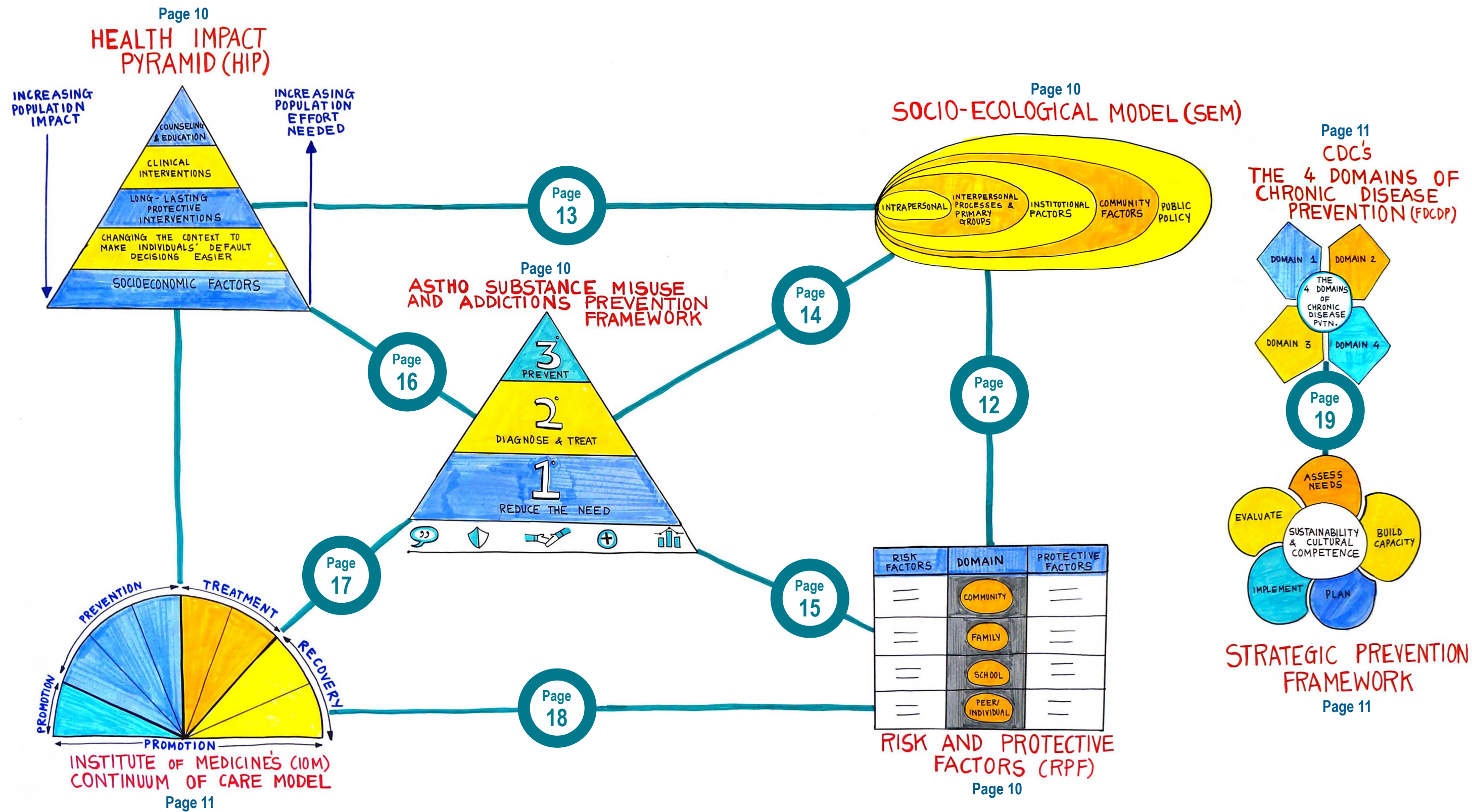


Concept: Professional Certifications/Credentials

Certifications and credentials indicate that a professional understands, and in some cases, has demonstrated experience in a set of core tenets in a particular field and uses a shared language between practitioners. Common credentials and certifications in the ATOD prevention and public health fields include:

- Certified Prevention Specialist (CPS)
- Certified Health Education Specialist (CHES)
- Certified Public Health (CPH)
- Master's in Social Work (MSW)
- Master's in Public Health (MPH)
- Master's in Public Administration (MPA)

Overview of Frameworks Crosswalk



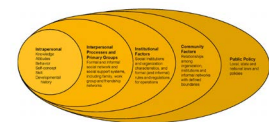
Framework Summaries

Frameworks are visual representations of a system or process that help to explain the relationships between aspects and components of prevention work. The following seven frameworks are not the only ones used in the prevention field, but the Workgroup identified these seven as those most commonly used and referenced, and focused their efforts on them.

RISK FACTORS	DOMAIN	PROTECTIVE FACTORS
Individual factors - Genetic predisposition - Neurochemical and hormonal imbalances - Psychological factors - Personality traits - A history of previous substance use - Mental health conditions	Individual	Individual factors - Resilience - Coping skills - Social support - Healthy lifestyle choices - Mental health treatment
Family factors - Family history of substance use - Family conflict - Family structure - Family roles - Family values - Family expectations	Family	Family factors - Family support - Family communication - Family boundaries - Family roles - Family values - Family expectations
School factors - Academic achievement - Social skills - Peer relationships - Teacher relationships - School climate - School safety - School policies	School	School factors - Academic achievement - Social skills - Peer relationships - Teacher relationships - School climate - School safety - School policies
Community factors - Social norms - Cultural values - Economic conditions - Physical environment - Transportation - Healthcare access - Law enforcement - Media influence	Community	Community factors - Social norms - Cultural values - Economic conditions - Physical environment - Transportation - Healthcare access - Law enforcement - Media influence

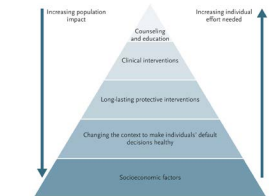
1. Risk and Protective Factors (RPF)

The RPF framework was developed in the 1990s and emphasizes the importance of all domains (individual, family, school, and community). All people have individual characteristics that make them vulnerable to or resilient in the face of behavioral health issues. Because people exist within their communities and larger society, a variety of risk and protective factors operate within each of these contexts.



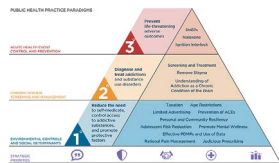
2. Socio-Ecological Model (SEM)

The SEM portrays multiple levels of influence on a person’s behavior. This model considers the complex interplay between an individual’s influence on their own behavior to the social and environmental influences on a person’s behavior. The Socio-ecological model is helpful in understanding the range of factors that protect health or put people at risk for poor health. This model emphasizes behavior change at all levels, but places public policy as the most influential on behavior change across a population, while emphasizing other levels of influence that are particularly powerful on individuals.



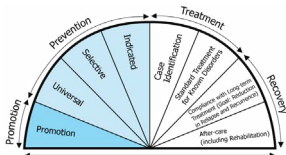
3. Health Impact Pyramid (HIP)

The HIP is a 5-tier pyramid used to describe the impact of diverse types of public health interventions. At the base of the pyramid are interventions with the greatest potential impact and often include efforts to address social determinants of health. In ascending order are interventions that change the context to make individuals’ default decisions healthy, clinical interventions that require limited contact but confer long-term protections, ongoing direct clinical care, and health education and counseling at the top.



4. Association of State and Territorial Health Officials (ASTHO) Substance Misuse and Addictions Prevention Framework

The ASTHO Framework is based on the Health Impact Pyramid, and addresses substance misuse and addictions. This framework also calls out key strategies that must be applied throughout the pyramid: reduce stigma and change social norms; increase protective factors and reduce risk factors in communities; strengthen multi-sectoral collaboration; improve prevention infrastructure; and optimize the use of cross-sector data for decision making. This framework also aligns strategies across primary, secondary and tertiary



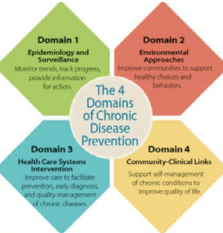
5. Institute of Medicine (IOM) Continuum of Care Model

The IOM model divides the continuum of health-related services into four parts: promotion, prevention, treatment, and recovery. The prevention category is divided into three classifications; universal, selective and indicated. Universal prevention strategies address the entire population. Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular group that is evidenced to be at higher risk for alcohol and drug misuse. Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who are showing early danger signs of alcohol and drug abuse.



6. Strategic Prevention Framework (SPF)

SAMHSA’s five steps and two guiding principles of the SPF offer grantees a comprehensive process for addressing the substance misuse/abuse and related behavioral health problems facing their communities. The five steps are: assessment, capacity, planning, implementation and evaluation. The effectiveness of the SPF begins with a clear understanding of community needs, engages community members in all stages of the model, ensures cultural relevancy, and addresses sustainability along each step.



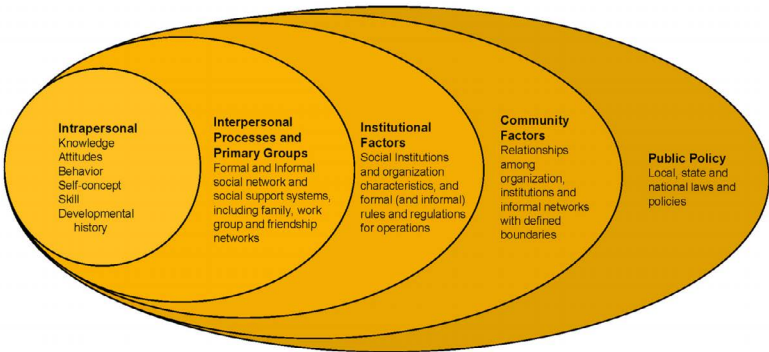
7. The Centers for Disease Control and Prevention’s (CDC) Four Domains of Chronic Disease Prevention

The CDC’s four domains of chronic disease prevention is a framework designed to inform modern efforts to prevent disease, help people lead healthier lives, and end health disparities. Much of the chronic disease burden is attributable to a short list of key risk factors, which most US adults have one or more of: high blood pressure, tobacco use and exposure to secondhand smoke, obesity, physical inactivity, excessive alcohol use, and diet low in fruit and vegetables and high in sodium and saturated fats. Risk factors must be addressed at two levels, the individual (including health care interventions) and the population level (including policy and environments that promote health). This framework optimizes public health efficiency for working across all four domains, epidemiology and surveillance, environmental approaches, health system interventions and community programs linked to clinical services.

Connection #1

Models: Risk and Protective Factors (RPF) & Socio Ecological Model (SEM)

RISK FACTORS <small>Risk factors increase the likelihood young people will develop health and social problems.</small>	DOMAIN	PROTECTIVE FACTORS <small>Protective factors help buffer young people with high levels of risk factors from developing health and social problems.</small>
<ul style="list-style-type: none">• Low community attachment• Community disorganisation• Community transitions and mobility• Personal transitions and mobility• Laws and norms favourable to drug use• Perceived availability of drugs• Economic disadvantage (not measured in youth survey)	COMMUNITY	<ul style="list-style-type: none">• Opportunities for prosocial involvement in the community• Recognition of prosocial involvement• Exposure to evidence-based programs and strategies (some are measured in youth survey)
<ul style="list-style-type: none">• Poor family management and discipline• Family conflict• A family history of antisocial behaviour• Favourable parental attitudes to the problem behaviour	FAMILY	<ul style="list-style-type: none">• Attachment and bonding to family• Opportunities for prosocial involvement in the family• Recognition of prosocial involvement
<ul style="list-style-type: none">• Academic failure (low academic achievement)• Low commitment to school• Bullying	SCHOOL	<ul style="list-style-type: none">• Opportunities for prosocial involvement in school• Recognition of prosocial involvement
<ul style="list-style-type: none">• Rebelliousness• Early initiation of problem behaviour• Impulsiveness• Antisocial behaviour• Favourable attitudes toward problem behaviour• Interaction with friends involved in problem behaviour• Sensation seeking• Rewards for antisocial involvement	PEER / INDIVIDUAL	<ul style="list-style-type: none">• Social skills• Belief in the moral order• Emotional control• Interaction with prosocial peers



1. Similarities:

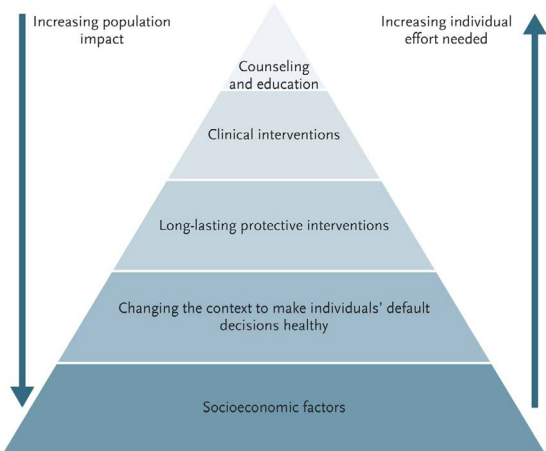
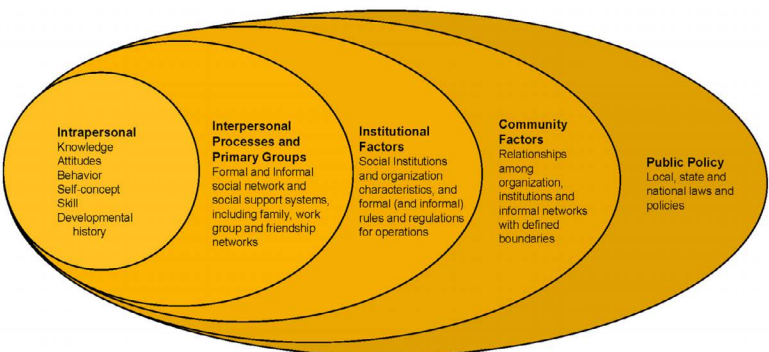
- Both emphasize protective and risk factors that influence individual behavior.
- Models are complementary
- Breakout of domains is similar...
 - SEM Intrapersonal = RPF Individual
 - SEM Interpersonal = RPF Peer/School/Family
 - SEM Institutional = RPF School & some RPF community
 - SEM Community = RPF Community
 - SEM Public Policy = RPF Community

2. Differences:

- The Socio Ecological Model (SEM), visually emphasizes public policy as the greatest influence on behavior across a population, but all levels are important for influencing individual behavior change. Risk & Protective Factors (RPF) displays the importance of all levels of influence equally.
- The RPF is specific to youth behaviors.

Connection #2

Socio Ecological Model (SEM) and Health Impact Pyramid (HIP)



1. Similarities:

- Both models emphasize that our health is influenced by our environment and that the greatest impact is achieved at the population level. SEM emphasizes the interdependence and multidirectional interplay between factors that affect health, whereas the HIP prioritizes contextual and social determinants of health.
- Both models span a spectrum from individual health to population health.
- Both models emphasize that health is socially constructed and that we influence our environment. Both models assume that we can work to change the social and environmental context.

2. Differences:

- HIP explicitly calls out that greater health impacts can be made for less effort and resources when focusing on population health (i.e. bottom of Pyramid).
- SEM drives home the interrelatedness that environment has on individual behavior.

3. Key Takeaways:

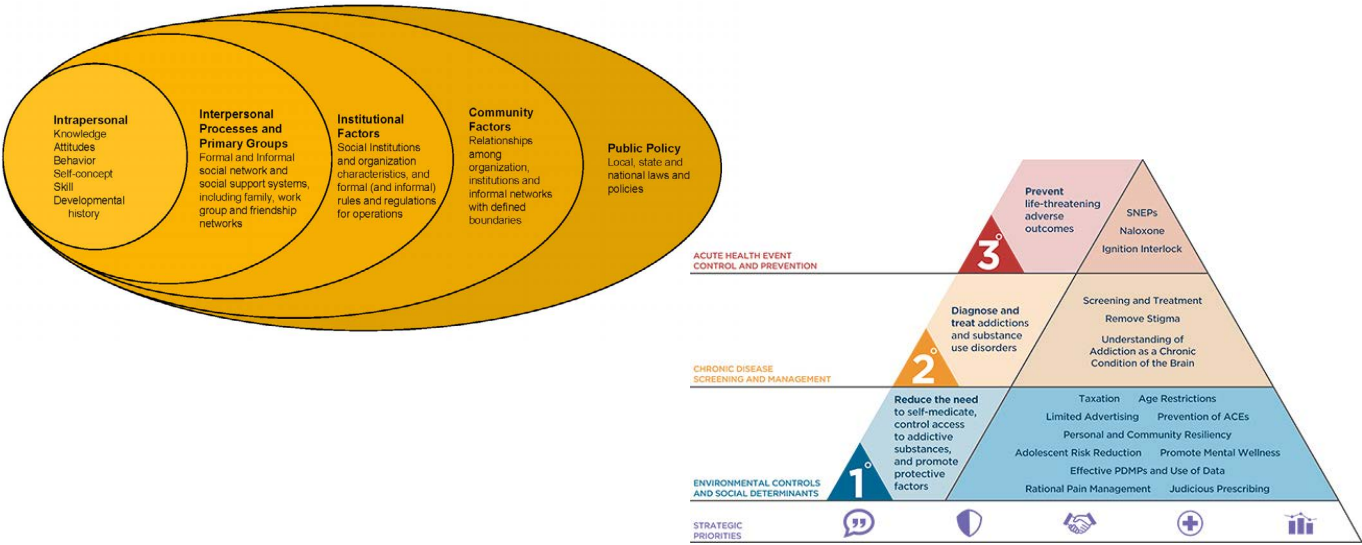
- Both models honor, value, and require multisector collaboration to achieve shared goals.
- Both models encourage systems thinking.

3. Key Takeaways:

- RPF doesn't assume a goal to move towards policy, however many communities use it assess needs and strengths of policies related to risky behavior.
- Both models honor, value, and require multisector collaboration to achieve shared goals
- Both models encourage systems thinking.

Connection #3

Socio Ecological Model (SEM) & ASTHO Substance Misuse and Addictions Prevention Framework



1. Similarities:

- The foundational elements of the ASTHO model (reduce stigma and change social norms, increase protective factors and reduce risk factors, strengthen multi-sectoral collaboration, improve prevention infrastructure, optimize the use of cross-sector data for decision making) are important for work in both A&D and public health fields. These elements provide a good foundation for any model. If these foundational elements are applied to the SEM, the model would be specifically relevant to alcohol and other drug prevention.

- In many ways, the ASTHO framework aligns with the SEM in that it goes from individual to societal level. This directly applies to the number of people impacted.
- 2. Differences:
 - With each strategy in the ASTHO framework, strategies are required for all levels (individual to policy).ASTHO framework identifies some specific foundational work that is important to the ATOD field.
 - SEM is not specific to ATOD prevention.

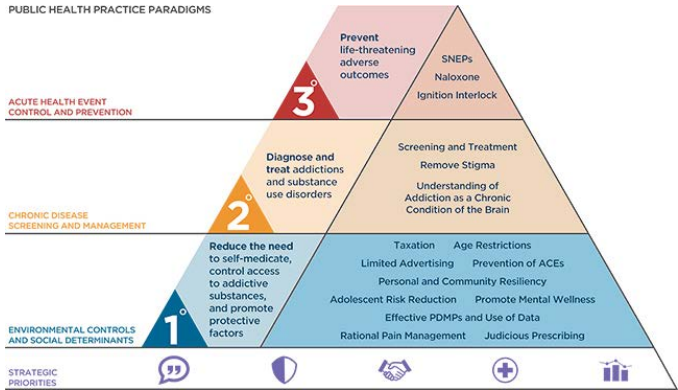
3. Key Takeaways:

- The ASTHO framework is split up into 1°2°3°domains of prevention. This is an important takeaway, as it shows that prevention exists at every level.
- The ASTHO framework could strengthen the SEM by highlighting the importance of addressing all levels.
- For example, to ensure access to naloxone for individuals with Opioid Abuse Disorder, you also need policies in place to support their recovery.

Connection #4

Risk and Protective Factors (RPF) & ASTHO Substance Misuse and Addictions Prevention Framework

RISK FACTORS Risk factors increase the likelihood young people will develop health and social problems.	DOMAIN	PROTECTIVE FACTORS Protective factors help buffer young people with high levels of risk factors from developing health and social problems.
<ul style="list-style-type: none">• Low community attachment• Community disorganisation• Community transitions and mobility• Personal transitions and mobility• Laws and norms favourable to drug use• Perceived availability of drugs• Economic disadvantage (not measured in youth survey)	COMMUNITY	<ul style="list-style-type: none">• Opportunities for prosocial involvement in the community• Recognition of prosocial involvement• Exposure to evidence-based programs and strategies (some are measured in youth survey)
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1. Similarities:

- ASTHO framework identifies some (not all) strategies to address risk and protective factors.
- RPF is called out as a strategic priority in ASTHO framework (foundational).
- Family level lines up with 2°prevention.
- Individual level lines up with 3°prevention.
- Community level lines up with 1°prevention.

2. Differences:

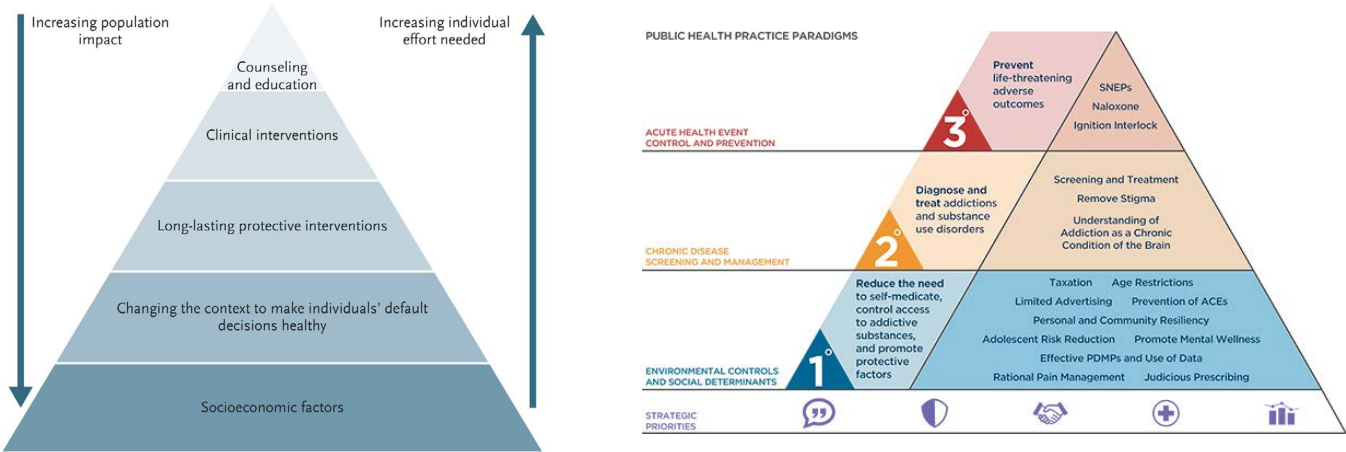
- ASTHO framework calls out the 1°2°3°domains of prevention.
- RPF model would use the results of an assessment to inform prevention strategies.
- The ASTHO framework highlights comprehensive strategies to address alcohol and drug misuse, while the RPF is best used for assessment and planning.
- The RPF is specific to youth behaviors.

3. Key Takeaways:

- RPF is embedded in ASTHO framework.
- ASTHO foundational elements are helpful to apply to all prevention strategies.

Connection #5

Health Impact Pyramid (HIP) and ASTHO Substance Misuse and Addictions Prevention Framework



1. Similarities:

- Both models imply that the more we apply strategies in the bottom tiers, then the less time and resources will be needed for the top tiers. However, both models make clear that all levels are important.
- The base of both pyramids are focused on environment and social determinants.

2. Differences:

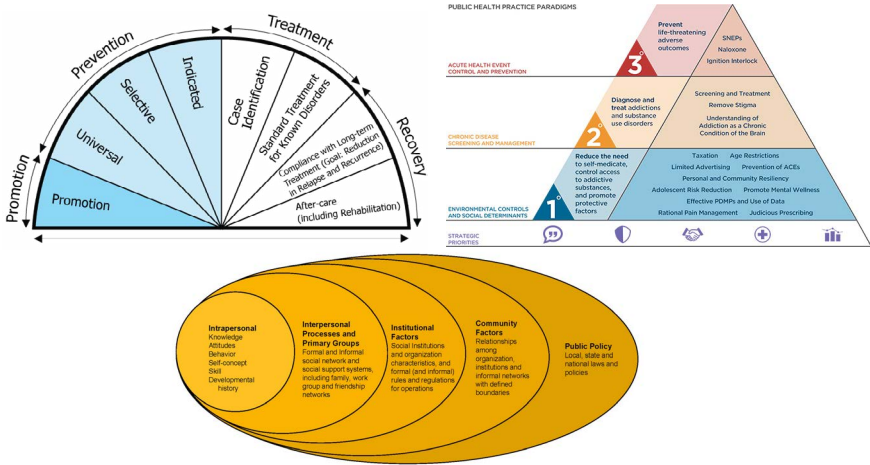
- ASTHO Model includes acute health event control for indicated populations.
- Both models use different rubrics. Instead of basing impact on population levels, the ASTHO model is based on 3 domains vs 5 domains (although the overlap is acknowledged).
- The top tiers of both models are different. The ASTHO model replaces counseling and education with a specific strategy involving systems intervention for preventing life-threatening outcomes.

3. Key Takeaways:

- The ASTHO model emphasizes responsibility for harm reduction and protection of secondary effects, since it was designed around substance abuse prevention.
- Systems-level action and multisector collaboration is required throughout both models.
- The key strategies (at the base of ASTHO model) are the same fundamental strategies you would use to work in both models.

Connection #6

Institute of Medicine (IOM) Continuum of Care Model, ASTHO Substance Misuse and Addictions Prevention Framework, and Health Impact Pyramid (HIP)



1. Similarities:

- All models call out the key components of a comprehensive system required to achieve shared impact.
- All address 1°2°3°prevention and multi-sector approaches impacting community and individuals.
- The ASHTO Model is an application of the HIP.
- All models require that interventions are tailored to level of risk based on the population scale.
- The community resiliency efforts in the universal domain of IOM model creates long-lasting changes and protections. This is directly aligned with the HIP and ASTHO.

2. Differences:

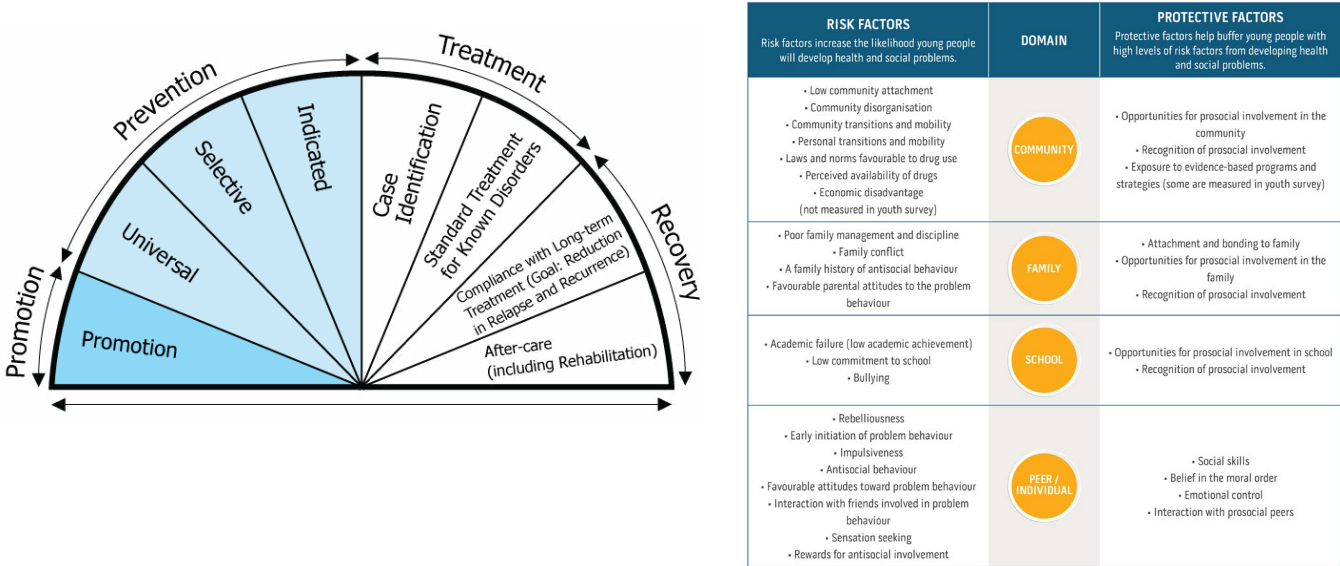
- IOM includes prevention across a spectrum while, ASTHO/HIP does not.
- Most of the HIP and ASTHO model is focused on population-based impact.
- The IOM describes the full spectrum of an individual's or population's relationship with substance abuse or other addiction, to include addiction and recovery. This helps with guiding identification of population groups and individuals with different needs and aligning needs of appropriate policies, programs and practices.

3. Key Takeaways:

- OHA's work across the agency (Public Health Division, Basic Health Program, Health Systems Division, etc.) touches on all of the strategies and interventions represented across the three models. Local communities can coordinate across IOM & ASTHO/HIP, as well.
- The recovery portion of the IOM model can be supported by "changing the context" (tier 2) of the HIP . Since most ATOD Prevention Coordinators don't work in the after-care direct intervention, these levels of all three of the models may not apply directly.
- Community resiliency and crisis prevention are helpful frames to think about PSE strategies in order to shift the context to a healthy default.

Connection #7

Institute of Medicine (IOM) Continuum of Care Model and Risk and Protective Factors (RPF)



1. Similarities:

- Domains or Categories in the IOM and RPF models are very similar.
- The RPF prompts you to look at interrelated factors that impact a behavior. In this way, the model is somewhat complex and requires lots of partners.

2. Differences:

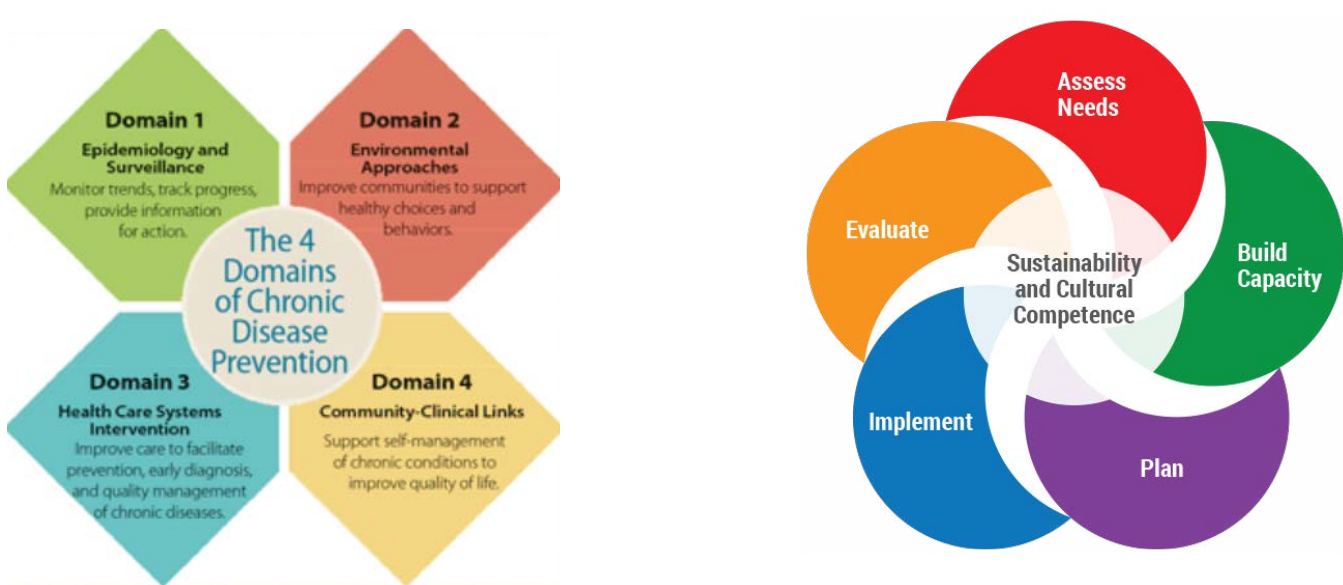
- The RPF is specific to youth behaviors.
- The selective and indicated domains of the IOM model allow us to examine disparities and different cultural needs.
- The RPF is primarily an assessment tool, while the IOM helps organize strategies across a continuum and is helpful for allocation of resources.

3. Key Takeaways:

- Both frameworks are complementary—the RPF is supportive of the IOM to inform the organization of strategies in the RPF framework.
- The IOM is helpful for highlighting prevention in the field of alcohol and other drug prevention.
- Both help practitioners to see the full picture.
- Both models assure a comprehensive approach for solutions within multiple sectors.
- Both models support targeted universalism. When addressing a problem within a specific population, everyone in the community will benefit.

Connection #8

Strategic Prevention Framework (SPF) and the CDC’s Four Domains of Chronic Disease Prevention (FDCDP)



1. Similarities:

- The SPF and FDCDP are both processes by which strategies are prioritized and organized. This is how we get things done, and both provide a framework for process measures.
- SPF and the FDCDP are planning processes just like Plan Do Study Act (PDSA) & other public health planning processes.

2. Differences:

- SPF is a tool/guide that is used to inform and make decisions for chronic disease prevention domains.
- Domain 1 of FDCDP supports needs assessment and evaluation of SPF.
- SPF is a process and FDCDP provides an organizational structure.

3. Key Takeaways:

- SPF is a valuable model to inform ATOD Prevention and public initiatives through organizing and guiding strategies, while emphasizing cultural competency and equity. SPF fosters a shared understanding of the process.
- The FDCDP implies that equity is foundational and capacity-building is necessary, but is not stated explicitly in this summary diagram.
- The FDCDP organizes the work so that all domains are necessary. The strategies from the SPF could be organized in to the FDCDP.
- Both require a multi-sector approach.



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