"Leadership for a Healthy Arizona"

2005

Framework for Prevention in Behavioral Health

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Foreword

La Frontera Center, Tucson

The *2005 Framework for Prevention in Behavioral Health* is an update of a document created in 1996 by the Arizona Department of Health Services, Division of Behavioral Health Services (DBHS). Published by DBHS, the original *Framework for Behavioral Health* was used by many prevention providers as a reference, guide, and training tool.

This revised *Framework* establishes key directions for Division of Behavioral Health Services prevention programs for the years 2005 through 2011. The purpose of the *2005 Framework for Prevention in Behavioral Health* is to establish clear guidelines and expectations for Tribal and Regional Behavioral Health Authorities (T/RBHAs), their contracted prevention providers, and Tribal Contractors. This document is not intended to be a substitute for training regarding implementation of prevention programs.

The first chapter provides an overview of Arizona's behavioral health care system and the concepts of managed care upon which it is based as they apply to prevention. The purpose of this chapter is to provide an outline of the organization of the Division of Behavioral Health and how prevention fits into the overall system of behavioral health care.

The second chapter describes the Division of Behavioral Health's strategic plan for prevention. Goals for 2005 through 2011 are presented. This chapter communicates DBHS prevention system needs, goals for improvement, and the methods by which the DBHS intends to accomplish those goals.

The third chapter establishes the Division of Behavioral Health's prevention philosophy and establishes standards for prevention program development, implementation, and evaluation. This chapter is not an exhaustive review of current research, but rather a description of the basic expectations placed on RBHAs regarding program development.

The final chapter presents detailed requirements for Regional Behavioral Health Authorities and Tribal Contractors. RBHAs and Tribes that contract with the Division of Behavioral Health will reference this document for details regarding requirements and deliverables.

The appendices include definitions of terminology, references, and tools for planning, implementing, and evaluating prevention programs.

Arizona's Behavioral Health System

The Arizona Department of Health Services (ADHS) is the State agency responsible for assessing and assuring the physical and behavioral health of all Arizonans through education, intervention, prevention and delivery of services. The ADHS is home to the Division of Behavioral Health Services (DBHS) and its four clinical bureaus: Adult Services, Children's Services, Customer Service and Substance Abuse Treatment and Prevention.

DIVISION OF BEHAVIORAL HEALTH SERVICES

The goal of the ADHS/DBHS is to ensure a comprehensive, unified behavioral health care system for all Arizonans. DBHS is comprised of community behavioral health services and the Arizona State Hospital. It serves as the single state authority to provide coordination, planning, administration, regulation and monitoring of the state public behavioral health system. The DBHS has primary responsibility for administering a system of behavioral health care, which is responsive, individualized, compassionate, culturally sensitive and equally accessible. The comprehensive array of services are community based, culturally sensitive, family focused, and complement and foster the strengths of the client, bringing about the greatest degree of habilitation possible in a timely manner.

Phoenix Indian Center, Phoenix

DBHS is responsible for administering behavioral health services for several populations funded through various sources listed below:

- The State Medicaid agency, Arizona Health Care Cost Containment System (AHCCCS), contracts with DBHS to administer the behavioral health benefit for Title XIX and Title XXI acute care members. Additionally, DBHS contracts with Department of Economic Security (DES) to administer the behavioral health benefit for Developmentally Disabled Arizona Long Term Care System (DD ALTCS) eligible members.
- State law requires DBHS to administer community based treatment services for adults who have been determined to have a serious mental illness (SMI).
- DBHS administers behavioral health services funded through State funds and Federal block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). The federal block grants include the:
  1) Substance Abuse Prevention and Treatment (SAPT) and
  2) Community Mental Health Services (CMHS).

DBHS also administers other federal, state and locally funded behavioral health services.

The four clinical bureaus of the DBHS focus their energies toward providing leadership in activities designed to integrate and adapt the behavioral health system to more effectively meet the needs of Arizona. Each of the four clinical Bureaus and their responsibilities is described below.

The Bureau for Adult Services

The Bureau for Adult Services is primarily responsible for the oversight and monitoring of the provision of behavioral health services to persons with a serious mental illness and persons receiving services under the general mental health classification. Bureau staff members serve as liaisons to other state

and community agencies by providing technical assistance and training in such areas as individual service planning, case management, provider management, and agency administration.

The Bureau of Children's Services

The Bureau of Children's Services supports and monitors a statewide system for the delivery of comprehensive community-based behavioral health services for Arizona's children and adolescents.

In June 2001, the Federal Court in Tucson approved a settlement agreement between the ADHS, the Arizona Health Care Cost Containment System (AHCCCS) and the Plaintiff's attorneys, in the class action lawsuit known as Jason K. The settlement ended ten years of litigation focused on the delivery of behavioral health services to Title XIX eligible children in the state. Highlights of the agreement include the State's commitment to the Twelve Principles listed in Table 1 below.

Table 1: The Twelve Arizona Principles

The Twelve Principles:
1. Collaboration with the child and family
2. Achievement of functional outcomes for children
3. Success in school
4. Stable lives with families
5. Avoiding delinquency
6. Preparing to become stable and productive adults
7. Collaboration with other agencies and multi-systems
8. Access to a comprehensive array of services
9. Delivery of services in accordance to best practices
10. Services provided in home/community settings to the extent possible
11. Timeliness of services
12. Services tailored to child/family
13. Stability is essential: minimize multiple placements
14. Respect for cultural heritage
15. Services should support and train to enhance independence
16. Utilize natural supports available to the child and family

Customer Services Bureau

The Arizona Department of Health Services (ADHS) is responsible for addressing requests for information and concerns. The Bureau coordinates with Tribal and Regional Behavioral Health Authorities (T/RBHAs) to resolve problems and to assure an appropriate plan of action and resolution is achieved.

The Bureau of Substance Abuse Treatment and Prevention Services

The mission of the Bureau for Substance Abuse Treatment and Prevention Services (BSATPS) is to provide leadership, management and oversight of the statewide system of treatment services and behavioral health prevention programs aimed at reducing substance abuse problems and building resilient, substance-free families and communities in Arizona. The Bureau fosters partnerships with affiliated agencies in criminal justice, mental health, child welfare, schools, and public and primary health care to ensure timely availability of evidence-based treatment and prevention models that foster the development of healthy individuals, families and communities.

In addition the Bureau develops service guidelines and program standards addressing the special needs of communities and high risk populations, including women with young children, individuals with co-occurring mental health and substance disorders, offenders leaving prison settings and families involved in the child protective service system. The Bureau promotes development of evidence based treatment and prevention services through training and system development initiatives, and provides oversight and monitoring of treatment networks and prevention providers managed by T/RBHAs. The Bureau also plays an important role in managing state appropriations and the Federal Block Grant for Substance Abuse Prevention and Treatment.

Office of Prevention

The Office of Prevention works in partnership with T/RBHA prevention coordinators and Tribal Contractors to set statewide direction for the application and advancement of prevention programs and practices through consultation, technical assistance, and training.

REGIONAL BEHAVIORAL HEALTH AUTHORITIES

The ADHS contracts with T/RBHAs and Tribal Contractors to administer behavioral health services in the State. Regional Behavioral Health Authorities (RBHAs) are private, non-profit and for profit managed care organizations, which provide a full continuum of covered behavioral health services including prevention, early intervention, treatment, and recovery support services through a network of specialized, community-based subcontracted agencies.

Services are provided for people who reside in their geographic service area. Arizona is divided into six geographic service areas (GSAs). GSA one consists of Coconino, Navajo, Apache, Yavapai, and Mohave Counties. GSA two includes La Paz and Yuma Counties. GSA three is composed of Graham, Greenlee, Cochise, and Santa Cruz Counties. GSA four is comprised of Pinal and Gila Counties. GSA five is Pima County and GSA six is Maricopa County.

Regional Behavioral Health Authority Prevention Coordinators, 2004

T/RBHAs are responsible for the operation and coordination of the behavioral health service delivery network, including contracting and payment for a full range of behavioral health care and prevention services to children, adults with serious mental illness, adults with substance abuse/dependence and general mental health disorders and monitoring and improving the effectiveness of services. T/RBHAs are responsible for providing medically necessary behavioral health services to Arizona's Medicaid population and other groups of people. The ADHS works collaboratively with T/RBHAs to ensure that the full continuum of behavioral health services is available in all urban and rural areas of Arizona. Prevention is an essential part of this system, dedicated to decreasing the incidence of behavioral health problems.

Tribal Nations

DBHS has Intergovernmental Agreements (IGAs) with four Arizona Tribes to provide covered behavioral health services for Native Americans on reservations. These four tribes are the Navajo Nation, Colorado River Indian Tribes, Gila River Indian Community, and Pasqua Yaqui. Each Tribe with an Intergovernmental Agreement is responsible for implementing a prevention program. Other tribes receive behavioral health and prevention services from the local RBHA. Native Americans who live in non-reservation communities access prevention and treatment services through the RBHA system in the same manner as other Arizona residents.

PREVENTION FUNDING

Division of Behavioral Health prevention funding comes from two sources: state appropriations and the Federal Substance Abuse Prevention and Treatment Block Grant. The Bureau for Substance Abuse Treatment and Prevention is responsible for annual development and submission of the Substance Abuse Block Grant to the United States Substance Abuse and Mental Health Services Administration (SAMHSA). The Block Grant contains the annual allocation from Congress of federal funds to support substance abuse prevention, intervention and treatment services in the 50 states and 10 U.S. territories. Twenty percent of block grant monies are used to fund substance abuse prevention programs.

WHAT IS PREVENTION?

"Prevention" means the creation of conditions, opportunities, and experiences that encourage and develop healthy, self-sufficient children and that occur before the onset of problems.

- Arizona Revised Statutes 8-201.23

Prevention programs funded through the ADHS/DBHS decrease the prevalence and severity of behavioral health problems among populations that do not have a diagnosable behavioral health disorder. Common, diagnosable behavioral health disorders in Arizona include substance abuse, depression, and childhood behavior problems. Prevention is accomplished by developing the strengths of individuals, families, and communities. Precursors of behavioral health disorders are called risk factors and are discussed further on pages 24 through 31 of this document.

DBHS refers to the Arizona Revised Statutes (ARS) and Federal Regulations to define prevention. DBHS receives funding for prevention from State Appropriations and from the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

The ARS define prevention as "the creation of conditions, opportunities, and experiences that encourage and develop healthy, self-sufficient children and that occur before the onset of problems." The ARS definition refers only to children because it is located in the children's statutes. Although the ARS definition speaks for many programs, it does not accurately describe *all* of Arizona's prevention programs, particularly those that serve adults. For this reason, DBHS also uses the broader definition of prevention provided by Federal Regulations that creates the block grant to states for substance abuse.

Primary Prevention Programs are those directed at individuals who have not been determined to require treatment.

- Federal Register 96.125

The SAPT block grant requires 20% of funds awarded to Arizona be used to fund primary prevention. The definition of prevention provided by Federal Regulations is: "Primary Prevention Programs are those directed at individuals who have not been determined to require treatment."

Prevention in the DBHS system uses evidence based strategies and research on protective and risk factors (explored thoroughly in chapter 3) as a basis for prevention efforts.

The Continuum between Prevention and Treatment

Prevention is part of a continuum of behavioral health services that includes treatment and recovery support, which strives to accomplish the same goals of healthy individuals, families, and communities. In Arizona's behavioral health system, prevention, treatment, and recovery support providers often use similar strategies to achieve their respective ends. The main difference is the targeted population. Prevention targets people who do not have a diagnosable behavioral health problem and who are not enrolled in the behavioral health system. Treatment targets persons with diagnosable behavioral health disorders of sufficient severity to require symptom focused services and recovery supports. These individuals are assessed and enrolled in the behavioral health system. Both prevention and treatment systems provide education about topics related to wellness such as communication skills or stress management and are invested in collaboration, but the implementation and targeted audience differs between prevention and treatment.

Valle Del Sol, Phoenix

Collaboration

In the treatment system, the collaborative process is called Child and Family Teams or Adult Clinical Teams. The teams are a group of people that includes, at a minimum: the behavioral health recipient, his/her family, any caregiver, a behavioral health representative, and any individuals important in the behavioral health recipient's life and who are identified and invited to participate. This may include, for example, teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches, community resource providers, representatives from religious communities, agents from other service systems like Child Protective Services or the Division of Developmental Disabilities. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child or adult consumer, and by which individuals are needed to develop and coordinate an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the behavioral health recipient.

In the prevention system, the collaborative process is called community development. Community development is a strategy whereby key stakeholders in a community (including families, youth, schools, behavioral health, etc…) come together to assess community needs and collaboratively plan and implement prevention activities.

Environmentally focused: *A program, which addresses the conditions in the environment, which contribute to health*

Environmentally focused and community-wide strategies are utilized to change conditions for the entire population. Prevention programs aid communities and families in developing and implementing high quality and low cost answers to their own problems. Through primary prevention focused environmental strategies that are targeted at the entire population, everyone has an opportunity to benefit, ultimately decreasing the costs to the State.

Target population

Prevention works with entire communities, schools, and other systems to establish conditions that support the development and maintenance of healthy behavior. While individuals and families are part of those efforts, the goals and strategies target entire towns, ethnic/cultural communities, tribes, schools, counties, school districts, senior centers on classrooms to change the conditions in those systems to affect the behavioral health of large numbers of individuals in each system.

Treatment works with individuals and families who have already developed behavioral health problems and works to restore them to good health. As part of the same continuum of services, prevention and treatment work together to ensure that persons who need behavioral health treatment receive those services. When prevention professionals encounter individuals and families who need more intervention, they are referred for treatment services.

MANAGED CARE IN ARIZONA

The Division of Behavioral Health Services strives to create a seamless continuum of behavioral health services to meet the needs and promote the health of Arizonans using the most cost effective strategies available. Arizona's approach places emphasis on the empowerment of communities to address issues of concern. A comprehensive, evidence based system of prevention services reduces costs for treatment services by delaying onset, decreasing prevalence, and reducing the severity of behavioral health problems. Prevention reduces the number of enrolled members for T/RBHAs, and helps communities and families develop and implement meaningful, sustainable and low-cost solutions.

Managed care organizations invest in the health of the communities to reduce the costs associated with substance abuse and other risk factors. The success of each RBHA is inherently tied to the health and well being of the population living within its' Geographic Service Area (GSA). Prevention is the most cost-effective way to address substance abuse (Caulkins, Rydell, Everingham, Chisea, and Bushway, 1999). The integration of prevention services into the behavioral health system is therefore essential in reducing risk factors associated with specific disorders.

Table 2: Prevention Objectives in Managed Care

Prevention objectives in managed care:
➤ Reduce the incidence and prevalence of behavioral health disorders in the population. ➤ Reduce demand and need for more expensive and intensive treatment services. ➤ Increase preventive 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 precursors to behavioral health. ➤ Promote the health and well being of communities and community members.

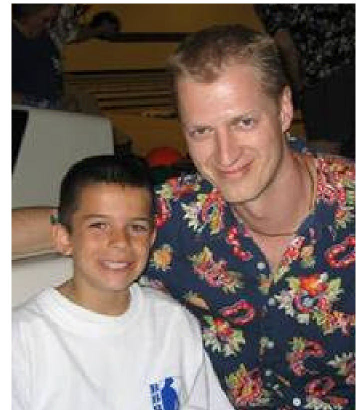
Strategic Directions for Prevention

Prevention changes conditions, recognizes and builds upon the power of the community to bring out the best in its citizens. Underlying prevention efforts is the belief in the innate resilience of people and in the community's capacity to address its own needs. Prevention in behavioral health is a fluid, dynamic approach to helping communities meet the ever changing needs of their citizens and creating conditions that support healthy people, families and communities. This chapter outlines guiding principles, strategic issues, and DBHS prevention system goals for the next five years.

GUIDING PRINCIPLES

Arizona's Department of Health Services/ Division of Behavioral Health Services' (ADHS/DBHS) strategic goals for prevention of behavioral health problems are grounded in a core set of values. While they share common philosophies with other behavioral health principles (see the description of the Twelve Arizona Principles on page 9 of this document) they are unique to prevention. They are presented below for the purpose of helping Regional Behavioral Health Authorities and prevention providers understand DBHS' approach to prevention.

- Prevention is a process of helping people to engage in healthy behaviors throughout their lifespan.
- Prevention changes levels of protective and risk factors that influence the development of many problem behaviors.
- Comprehensive prevention takes place on multiple levels: individual, family, organization, system of care and service delivery, community, and region.
- Collaboration with all sectors of the community: families, schools, neighborhoods, treatment providers, behavioral health recipients, and other organizations, is essential to successful prevention efforts.
- Prevention should empower communities, families, and individuals to work together to sustain community behavioral health.
- Creativity and innovation are crucial to successful implementation of prevention programs.
- A skilled and knowledgeable workforce is a critical element of effective prevention.
- Cultural, community, and strengths based approaches are the foundation of effective prevention programming.
- Prevention programs should be culturally and linguistically appropriate, open, inclusive and affirming at each point in the process with no barriers to participation.
- Continuous evaluation and modification is necessary to achieve desired outcomes.



Big Brothers Big Sister of Central Arizona, Phoenix

STRATEGIC ISSUES

Strategic issues are key behavioral health related challenges that DBHS intends to address over the next five years. These issues emerged from an assessment of the DBHS prevention system's current strengths and weaknesses, as well as the behavioral health challenges faced by Arizona. Although Arizona has developed a comprehensive prevention system, several service gaps need to be filled.

Suicide

Arizona had the sixth highest suicide rate in the nation (American Association of Suicidology, 2002). Rates are exceptionally high among Native American men and White men over the age of 65. Geographic isolation and a lack of evidence based programs targeting these groups have been barriers to providing suicide prevention services.

The Bureau for Substance Abuse Treatment and Prevention has initiated implementation of State Bill 1125, which established the suicide prevention program within the ADHS. In implementing the legislation, the Bureau has the responsibility for overall development and coordination of suicide prevention and awareness activities and programs within the ADHS, other state and local agencies and the community.

Members of the Arizona Suicide Prevention Coalition, 2004

In 2004, ADHS hired a State Suicide Prevention Coordinator and began funding suicide prevention projects across Arizona. Evidence based practices used in primary prevention of suicide overlap with evidence-based practices to prevent substance abuse by their focus on common risk prevention programs to include suicide prevention elements. Prevention efforts addressing suicide need to target high-risk groups. Work with high-risk groups needs to be culturally competent. Both the development and implementation of prevention programs need to consider the specific cultural characteristics of high-risk populations.

The State Suicide Prevention Coalition coordinates efforts to prevent suicide in Arizona. Providers who implement DBHS funded suicide prevention projects are expected to coordinate efforts with the State Coalition.

Child Abuse and Neglect

Annually, thousands of Arizona children are removed from their homes because of abuse or neglect perpetrated by their parents or guardians (Arizona Department of Economic Security, 2003) Prevention has an important role in reducing the incidence of child abuse and neglect through changing community conditions of parent isolation and other risk factors. The prevention system will continue to target communities with high indicators of abuse and neglect to address this issue at the protective and risk factor level, before neglect or abuse occurs. One protective factor, which has considerable impact on this issue, is parent and child attachment.

Alcohol, Tobacco, and Other Drug Abuse

"the 2004 Arizona Youth Survey results indicate that marijuana use during the past month has decreased across all grade levels ... In addition, alcohol use during the past month has also decreased among all grades"
-Arizona Criminal Justice Commission, 2004

Arizona has made great strides over the past decade in the prevention of substance use. New technology and training has enabled many prevention programs in Arizona to become experts at applying science to their programs. As evidence of effectiveness, use of illegal drugs among high school youth dropped from 2002 to 2004. The percentage of retailers found to sell tobacco illegally to minors has also dropped significantly over the past decade.

Specific issues that are still of concern include high rates of youth experimentation with substances, drug trafficking across the Arizona-Mexico border, the growth of methamphetamine use in rural and tribal communities, and environmental conditions contributing to substanceuse.

The 2004 Arizona Youth Survey showed that approximately 41% of Arizona high school aged youth have experimented with illegal drugs (Harrison, 2004). Prevention programs in Arizona need to continue to address protective and risk factors related to youth use of illegal substances. Risk and protective factors, which should be targeted statewide include: community disorganization, perceived harm of substance use, and favorable attitudes toward substance use and other anti-social behaviors, and family attachment.

Methamphetamine is a highly addictive drug that poses an increasing threat to the health and safety of Arizona's Native American communities. Methamphetamine dealers have increased targeting of tribal communities. Culturally based prevention efforts targeting Native American populations should increase to combat this problem.

The Federal Drug Enforcement Administration considers Arizona a major "stronghold" for drug traffickers (Drug Enforcement Administration, 2004). Arizona's border with Mexico presents a unique challenge. Because the border region is rural, law enforcement resources are scarce. ADHS will work over the next five years to improve the capacity of prevention providers along the border to meet the challenging needs of their communities in a culturally competent manner.

Pima Youth Partnership, Sells

A requirement of the Substance Abuse Prevention and Treatment Block Grant, a major source of funding for DBHS prevention programs is the Synar Amendment, which focuses on reducing youth access to cigarettes and other tobacco products. The statute requires Arizona to enact laws making it illegal for youth younger than 18 to purchase tobacco products, and requires the ADHS to conduct annual random inspections to determine merchant compliance with state law. Arizona proves its compliance with help from prevention providers who form teams that conduct inspections of vendors across the state using 16 year old youths. Prevention providers need to continue collaborative relationships with tobacco prevention and vendor education efforts.

Maintaining and Enhancing Skills of the Prevention Workforce

Prevention programs are only as effective as the people who plan and implement them. Training for paid and volunteer personnel must be strategically expanded within each region to build community capacity to design and implement comprehensive prevention efforts. Training must occur at two levels: first for all prevention partners, including grassroots groups, and second on an ongoing basis for prevention personnel who plan, deliver, supervise and evaluate prevention programs.

Areas needing improvement include evaluation, cultural competency, research-based services, and comprehensive programming. It is necessary for prevention providers to develop their ability to work with diverse communities and populations. This involves learning how to use local resources and communities to adapt curricula, training, recruitment and retention methods, and strategies to the targeted population.

Southern Arizona AIDS Foundation, Tucson

In coordination with RBHAs, DBHS will assess the training needs of prevention providers and develop opportunities for training to meet those needs. Training opportunities should be convenient to providers and unobtrusive to programming. DBHS will therefore, develop capacity for providers and RBHAs to provide core competency trainings regionally.

Advancing Evidence-Based Approaches to Prevention

All programs should be grounded in research and based upon a thorough assessment of the community. Evidence based strategies, with adaptation for culture, should be used to change conditions at the protective and risk factor level before problems emerge. Efforts should be coordinated and relevant to the community and its members, who should have the role of partners rather than clients.

Community Development *is the creation of conditions that promote the well being of an entire community*

Successful prevention efforts are simultaneously directed towards multiple domains, individual, family, organization, systems of care and service delivery, community and region (Kumpfer and Alvarado, 2003). RBHA emphasis should be on providing services in all domains rather than only individual and family. Individually targeted strategies such as life skills training and support groups are a costly, limited means to changing conditions. Prevention programs need to target natural leaders and others who can carry the prevention message to a larger audience. DBHS has defined ten prevention strategies that can be utilized by prevention providers and RBHAs in a comprehensive program. Each strategy is defined in Table 5 of the next chapter. Improvements in a community's climate, systems of care and quality of life are sustained only when its members are actively involved in the change process.

Community development facilitates the participation of citizens, businesses and organizations. Prevention programs in behavioral health should take a leadership role in promoting community wellness by involving various sectors of the community as partners.

Effective prevention programs are designed to meet the unique needs and build upon the strengths of the populations with which they partner. Beyond understanding, appreciation and

responsiveness to cultural values and differences, cultural inclusion involves embracing and incorporating the culture's strengths and values.

Evaluating Effectiveness

The taxpayers of Arizona have the right to know the money they have invested in prevention services is making a difference. Evaluation measures the effectiveness and quality of services provided, identifies organizational strengths, identifies underserved populations, highlights gaps in services, and helps prevention providers to be more cost effective. Evaluation is key to determining whether programs are effective in preventing behavioral health problems. It also provides an opportunity for mid course correction to ensure goals are achieved.

Evaluation of prevention programs in the DBHS network will continue to improve. Areas of focus over the next five years will include:

- Development of consistent outcome evaluation methods via use of Center for Substance Abuse Prevention (CSAP) Core Evaluation Instruments by all providers when appropriate instruments are available
- Development of outcome evaluation methodology for community mobilization efforts
- Determination of cost-benefit information for all prevention programs
- Collection and analysis of statewide evaluation data
- Increased training and technical assistance for providers on evaluation and development of objectives related to risk and protective factors

Phoenix Indian Center, Phoenix

More details related to evaluation may be found in the next chapter.

GOALS

DBHS has established four goals for 2005-2011 in its prevention system.

Goal 1
Reduce the prevalence of risk factors associated with child abuse, substance abuse, and suicide in Arizona.

Action Steps

1. Provide technical assistance and training to T/RBHAs and Tribal Contractors in evaluation, evidence based practices, and culturally based programming.
2. Provide training and incentives to RBHAs to develop programs, which target underserved groups with high risk factors for suicide, substance abuse, and child abuse.
3. Develop and implement a public education campaign to increase awareness of healthful behaviors, problem behaviors, and available services.
4. Obtain or provide technical assistance in environmental strategies for RBHAs and providers.

Goal 2
Increase the knowledge, skills, and abilities of the prevention workforce.

Action Steps
1. Track professional competence via the annual evaluation report.
2. Provide training to providers in needs and resource assessment methods.
3. Train RBHA prevention coordinators, DBHS prevention staff, and key provider staff to provide core prevention and advanced protective and risk factor trainings.
4. Provide training to all tribal contractors and TRBHA providers in core prevention and advanced protective and risk factors.
5. Provide training in adaptation to meet the needs of underserved, culturally diverse, and/or high-risk populations.
6. Monitor professional supervision and training of prevention practitioners.

Goal 3
Improve coordination of prevention services and other resources

Action Steps
1. Continue state level coordination of prevention efforts through the Behavioral Health and Aging Coalition and the Suicide Prevention Coalition.
2. Monitor provider and RBHA involvement in coordination of local prevention services.
3. Provide opportunities for treatment professionals to learn about, observe, collaborate with, and to participate in prevention efforts.
4. Facilitate a statewide prevention coalition for tribal prevention providers

Goal 4
Increase use of evaluation to improve programs.

Action Steps
1. Collect and compile statewide results from core instrument evaluations.
2. Identify providers that need technical assistance around evaluation.
3. Provide training to providers, Tribal Contractors, and T/RBHAs in collection of and communication about outcome data.
4. Produce and distribute an annual DBHS prevention system evaluation report.

Program Standards

An emphasis on training, evaluation and dissemination of information on best practices has established a substantial knowledge and experience base in effective prevention. This chapter summarizes research informing the science of prevention, core elements of effective prevention, and program standards.

Successful prevention programs are carefully planned using the process outlined by the Arizona Logic Model:

1. Community needs and resource assessment
2. Development of goals and objectives based on protective and risk factors
3. Program design including selection of strategies and development of an implementation plan
4. Evaluation

Table 3: The Arizona Logic Model

Needs/ resources	Goals and objectives	Program Design		Evaluation
		Strategies	Implementation Plan	
➤ Community needs and resources are assessed ➤ A target population high need and fewer resources is selected ➤ High risk factors and/or low protective factors among the target population are identified	➤ Goals and objectives are based on results of the needs and resource assessment ➤ Goals and objectives describe intended changes in risk and protective factors of the targeted population	➤ Strategies and evidence based practices are selected and used to meet program goals and objectives	➤ The plan describes how the strategies and approaches will be implemented and includes strategies for participant engagement and staff training	➤ Changes in objectives are measured ➤ Changes are made to the program design and implementation based on the evaluation

The Arizona Logic Model is a tool used to diagram the logic informing the design of a prevention program. The Model involves four steps: assessment of needs and resources, formation of goals and objectives, program design, and evaluation. Regional Behavioral Health Authorities strategically identify communities with high need and low resources. A comprehensive needs and resource assessment is a tool used to select a target population and risk or protective factors targeted for change. Based on the needs and resource assessment, prevention programs establish goals and objectives. Goals and objectives should be directly linked to protective and risk factors targeted for change. Program design involves selection of strategies, application of evidence based practices, and development of an implementation plan. The selection of strategies is based on the target population and established objectives. Arizona has ten prevention strategies, which may be used for programming. Further information related to these strategies is presented later in this chapter. Finally, evaluation is a key component for prevention programming. Evaluation can help a program to understand where strengths and weaknesses lie and how improve the implementation.

Pima Youth Partnership, Marana

NEEDS AND RESOURCES

A community needs and resource assessment is a process by which information is gathered about conditions within a community and used to develop prevention programs. Community needs and resource assessments are conducted by providers, RBHAs, and DBHS for the purpose of developing programs which meet the needs of communities, geographic service areas, and the state. The assessment gathers information regarding the needs and resources of community members as well as opinions of cultural experts or informants/insiders from the respective community.

Resources for designing a needs and resource assessment:

- The Community Tool Box: http://ctb.ku.edu/tools/en/chapter_1003.htm
- Getting the Lay of the Land on Health: A guide to using interviews to gather information (key informant interviews) http://www.accessproject.org/downloads/final%20dociment.pdf.
- Center for Substance Abuse Prevention Technical Assistance Bulletin You Can Manage Focus Groups Effectively http://www.health.org/govpubs/MS495/
- Center for Substance Abuse Prevention Technical Assistance Bulletin Conducting Focus Groups with Young Children http://www.health.org/govpubs/MS501/

The needs and resource assessment informs selection of a target population as well as development of program goals and objectives. A target population is the group of people for whom a prevention program is designed. Target populations are selected by considering which populations have the greatest need (as indicated by high prevalence of risk factors, low prevalence of protective factors) and comparing that to resources available to that population (existing programs, grants, other agencies). Risk and protective factors are discussed in detail on pages 24-31.

Goals and objectives are established which state a program's intention to increase protective factors or decrease risk factors related to the target population.

Needs and resource assessments can be conducted using a number of methods including gathering of social indicator data, key informant interviews, focus groups, surveys, and/or public forums. During the needs assessment process, community members are addressed as resources that inform the development of the program.

Social Indicators

Social indicators are measures of the prevalence of protective and risk factors and social problems based on archival data from records collected and kept by agencies. Indicators are used to establish an overall picture of trends related to substance abuse, suicide, child abuse, crime or other conditions within a specified geographic area. An assessment consists of gathering data and/or vital statistics about community, county or state conditions such as crime rates, rates of adolescent pregnancy, deaths due to substance abuse, maternal use of alcohol or other drugs during pregnancy, etc. RBHAs use social indicator data including AHCCCS eligibility rates and utilization data to target communities and populations for prevention programs.

Big Brothers Big Sisters of Central Arizona, Phoenix

Social indicator data can be gathered from web sites, government publications, organizational databases, and formal surveys conducted by organizations. Social indicators are often referred to as archival data on some web sites. Table 4 lists several resources for Arizona specific social indicator data.

Table 4: Social Indicator Resources

Source	Information	Location
US Census	Poverty rates, residential stability/mobility, distribution of ethnic groups, percent of community that speaks English, percent of families headed by a single parent, unemployment rate	http://www.census.gov/
Arizona Department of Economic Security	Child abuse reporting and investigation prevalence	http://www.de.state.az.us/dcyf/cps/report.asp
	Demographic, economic, and population statistics	http://www.workforce.az.gov
Regional Behavioral Health Authorities	AHCCCS eligibility rates and prevalence of behavioral health disorders among enrolled populations	See contact information for each RBHA posted on the DBHS website: http://www.azdhs.gov/bhs/index.htm
Arizona Department of Health Services	Public health and vital statistics data:	http://www.azdhs.gov/vit_dir.htm
Arizona Department of Education:	The Youth Risk Behavior Survey, Test scores, dropout rates, violations and other information to be reported on a school or school district basis	http://www.ade.state.az.us/schooleffectiveness/chss/
Annie E. Casey Foundation	Kids Count Report (education, health, and economic conditions)	http://www.aecf.org/kidscount/databook/
Arizona Criminal Justice Commission	Arizona Youth Survey (protective and risk factors by county)	http://www.acjc.state.az.us

Key Informant Interviews

Key informant interviews are structured interviews conducted by prevention professionals with persons in the community such as politicians, activists, parents, and non-profit agencies. In key informant interviews, community members' opinions about needs and resources are documented.

Key informant interviews are a key component to establishing a culturally based prevention program. The community needs and resource assessment should take community members and cultural resources into account (i.e. local non-traditional and traditional healers and teachers) and should be informed by cultural experts or informants/insiders from the respective community.

Surveys

A survey involves asking people to answer questions about their behavior, perceived needs, and/or perceived resources. The Arizona Youth Survey conducted by the Arizona Criminal Justice Commission is an example of a survey. It is administered to thousands of youth throughout Arizona every other year and measures protective and risk factors related to teens and teen risk behavior. The Arizona Criminal Justice Commission web site is listed in Table 4.

Public Forums

Another form of assessment is called the public forum. A public forum is a meeting where community members who are insiders/cultural experts/delegates provide their opinions about community needs and resources. Another term for public forum is town hall.

Focus Groups

A focus group is an interview with a small group of people who have common characteristics. Group members should be representative of the target population, and/or considered experts regarding the target group. The group is interviewed using a standard set of questions about their perceptions of conditions, needs, and resources in the community

GOALS AND OBJECTIVES

Identified needs, stated in terms of protective and risk factors, are the basis for establishing the goals and objectives of a prevention program.

Goals are broad overarching statements about the purpose of the program based on the targeted protective and risk factors. For example, a prevention provider who completed a community needs and resource assessment that indicated social competence is a risk factor among the targeted population, would select the risk factor of social competence. The stated goal for a program targeting this protective factor would be "Increase social competence of program participants."

Objectives are specific statements, which measures immediate change in participant knowledge, attitudes, beliefs or behavior. Objectives are measurable and time limited, which means the objective, describes the specific element that will be measured for change and the time frame within which change will happen. The prevention program, used in the example above, would choose to change an element of social competence as its objective. An example of the objective could be "Increase participant use of assertive communication by twenty percent upon participant completion of ten sessions. This objective states the behavior to improve: assertive communication, the measurement: 20%, and the time of measurement: completion of ten sessions. The figure below shows how an identified need becomes a targeted risk or protective factor and then becomes further in the following pages) serve as a guiding framework for selecting the prevention program target population, goals, objectives and strategies. Helpful resources on how to write goals and objectives are listed in the margin of this page.

Resources for writing goals and objectives:

- *CSAP's Western Center for the Application of Prevention Technologies http://casat.unr.edu/bestpractices/eval3.htm*
- *CSAP's Prevention Pathways On Line Courses http://pathwayscourses.samhsa.gov/*
- *Community Tool Box http://ctb.ku.edu/tools/en/sub_section_main_1087.htm*

Linking Needs to Program Goals and Objectives

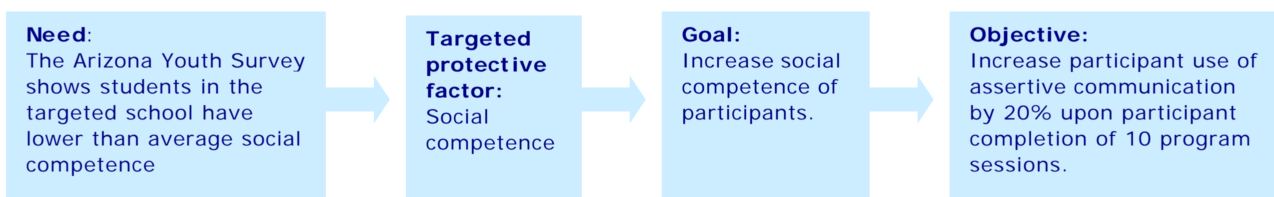


Table 5 summarizes protective and risk factors grouped into five domains: community, family, institutional, individual, and peer and relationship. Some risk and protective factors such as socio-economic deprivation, mobility, and parental absence are not conditions conducive to change by prevention programs. These factors are therefore useful in a goal and objective.

Protective and risk factors (discussed selection of a target audience, but are not appropriate for use in creation of goals and objectives. Risk and protective factors, which are used in creation of goals and objectives, are those factors that may be changed by a prevention program such as social competence or authoritative discipline.

Table 5: Protective and risk factors.

Domain	Protective Factors	Risk Factors
Community	Access to community resources Opportunities for meaningful participation and community service Healthy beliefs and clear standards for behavior	Socio- Economic Deprivation* Laws and norms favor substance use or other problem behaviors Mobility* Discrimination and devaluation* Community disorganization
Family	Secure attachment Authoritative discipline Family involvement Caregiver monitoring Belonging Family support Traditional cultural values	Low family attachment/ bonding Family conflict and violence Parental absence* Family management problems Abuse, neglect, or rejection* Caregiver behavioral health problems* Family attitudes favor substance use and other problem behaviors
Institutional (School, Work, Senior Care Home, Faith Based Organization)	High expectations Opportunities for success Strengths focused Challenge with support Caring, supportive relationships Cooperative learning Opportunities for involvement Safety	Lack of opportunities for social interaction Poor discipline Low expectations Lack of comfort
Individual	Temperament* Empathy School success Intelligence* Self efficacy Problem solving skills Good coping skills Social competence Cultural pride Autonomy Physical health* School connectedness Religion /spirituality Sense of purpose/ future	Temperament* History of problem behavior* Impulsiveness and rebelliousness Poor self esteem Anti-social attitudes and beliefs Low commitment to school Poor coping skills Disability, poor physical health, chronic illness, pain* Low perceived harm of problem behavior Genetic factors* School failure Transitions* Prenatal exposure to alcohol, tobacco, or drugs*
Peer and Relationship	Bonding to a positive adult Bonding to positive peers	Loss of relationship* Peer pressure Social failure Perceived isolation Friends/ partners who use substances or engage in other problem behavior

*Protective and risk factors marked with an asterisk may be useful in selection of a target population, but not in establishing goals and objectives for DBHS prevention programs.

Risk Factors

The chance a person will develop behavioral health problems is influenced by the interactions between multiple biological, psychological, and social factors. Risk factors are conditions correlating with the development of behavioral health problems.

Risk factors, which cannot be changed by a prevention program such as history of problem behavior, temperament, and transitions, are used to identify target populations who are vulnerable to developing substance abuse or other behavioral health problems. Other risk factors, which are easily changed by a prevention program such as low expectations, peer pressure, and social failure, are used to establish prevention program objectives.

Community

Socio-economic deprivation

The stress that poverty places on individuals and families correlates with the onset of behavioral health problems (Agerbo, Nordentoft, and Mortenson, 2002; Greenberg, O'Brien, Weissberg, Zins, Resnil, Fredericks, and Elias, 2003; Hansen, Giles, and Fearnow-Kenney, 2000; Hawkins, Catalano, and Miller, 1992; Kumpfer, 1999; Romer, 2003; Thomas, Leicht, Hughs, Madigan, and Dowell, 2003; White and Jodoin, 2004; Zaslow, Caulkins, and Halle, 2000).

Community disorganization

Living in communities with high population density, limited employment opportunities, high crime rates, physical deterioration, and low neighborhood cohesion, creates greater risks for child abuse and neglect, drug abuse, trafficking of drugs, delinquency, violence and other behavioral health problems (Agerbo, et al., 2002; Gliatto and Raj, 1999; Hansen, et al., 2000, Romer, 2003; Hawkins, et al., 1992; Kumpfer, 1999).

Discrimination and devaluation

Discrimination and devaluation in American society, differing levels of assimilation, cultural or language barriers to receiving services, or unfavorable expectations from society, correlate with the development of behavioral health problems (Brounstein and Zweig, 1999; Fashola and Slavin, 2002, Rutter and Soucar, 2002).

Community norms favorable to substance use or other problem behaviors

Rates of substance use are higher in communities where alcohol and other drugs are inexpensive, easily available and acceptable (Brounstein and Zweig, 1999; Hawkins, et al., 1992).

Mobility

Communities with high rates of resident mobility are at greater risk for crime and substance use (Bollinger, 2003).

Family

Family conflict and violence

Marital discord, domestic violence, conflict between caregivers and dependants, and divorce are risk factors for abuse, neglect, delinquency, substance abuse, depression, and suicide (Bethea, 1999, Bollinger, 2003; Brounstein and Zweig, 1999; Hawkins, et al., 1992; Kumpfer, 1999; Winters, August, and Leitten, 2003; Portes, Sandhu, and Longwell-Grice, 2002).

Low attachment and bonding

Lack of closeness is correlated with onset of behavioral health problems (Eley and Stephenson, 2000; Kirby, Bachrach, Blum, Brindis, Cashin, Darroch, and Gomez, 2001; Kumpfer, 1999; Guo, Hill, Hawkins, Catalano, and Abbott, 2002, Hawkins, et al., 1992).

Family management problems

Lack of knowledge about how to care for dependants and unrealistic expectations are risk factors for abuse, neglect and substance abuse. Disciplinary practices that are overly permissive, inconsistent or severe are correlated with behavioral health problems (Kumpfer, 1999; Mihalic, Fagan, Irwin, Ballard, and Elliott, 2004).

Family attitudes favor substance use or other problem behaviors

Family use of and permissive attitudes toward substance use are correlated with substance use (Hansen, et al., 2000; Kumpfer, 1999).

Parental absence

Absence from a parent due to separation, divorce, incarceration, or death is a risk factor for the development of behavioral health problems in youth (Bethea, 1999; Romer, 2003).

Caregivers with behavioral health problems

Substance abuse is present in 40-80% of families in which abuse or neglect takes place. Youth are more likely to engage in problem behaviors when their parents or caregivers use substances (Kidd and Kral, 2002; Robertson, David, and Rao, 2003; White and Jodoin, 2004; Brook, Zheng, Whiteman, and Brook, 2001; Hansen, et al., 2000; Hawkins, et al., 1992; Thomas, et al. 2003).

Abuse, neglect, or rejection

Abuse, neglect, and rejection by caretakers of youth or elderly are risk factors for substance abuse, suicide, and other behavioral health problems (Bethea, 1999; Winters, August, and Leitten, 2003; Kumpfer, 1999; Reid 1993; Hops, 2003; Hawkins, et al., 1992; Hansen, et al., 2000).

Institutional

Low expectations
There is a correlation between teacher expectations and youth academic performance. Teachers treat students differently when they believe those students to be unintelligent or troubled (Brounstein and Zweig, 1999; McKenna and Ortiz, 1988; Mihalic, et al., 2004).

Lack of opportunities for social interaction
School, work, and care home environments contribute to risk when the people in those environments lack opportunities for social interaction (Lackney, 1990).

Poor discipline
Overly permissive, authoritarian, and inconsistent disciplinary practices in schools create environments in which youth are more likely to engage in problem behaviors (Brounstein and Zweig, 1999).

Lack of comfort
School, work, and care home environments are a risk factor when the people in those environments are uncomfortable, lack privacy, are overcrowded, have loud noise or poor air flow (Lackney, 1990; McKenna and Ortiz, 1988).

Peer and relationships

Perceived isolation
A perceived lack of social support is a risk factor for depression, substance abuse and suicide (Blow, 2002). In young mothers, social isolation is a risk factor for depression and abusing or neglecting their child or children (Newcomb and Felix-Ortiz, 1992).

Social failure
Shy or aggressive youth who are rejected by peers are at risk to develop behavioral health problems (Brounstein and Zweig, 1999; Winters, et al., 2003; Kumpfer, 1999; Hawkins, et al., 1992; Robertson, 2003; Zettergen, 2003, Aber, 2003; Hansen, et al., 2000; Zaslow, at al., 2000).

Friends/partners who use substances or engage in other problem behavior
Having friends who use substances is one of the strongest predictors of substance use in youth. Youth who experience the suicide of a peer are more likely to attempt suicide. (Gest, et al., 1999; Hawkins, et al., 1992; Aber, 2003; Winters, et al., 2003; Kumpfer, 1999; Zattergren, 2003; Hansen, et al., 2000; Zaslow, et al. 2000; Kidd and Kral, 2002; White and Jodoin, 2004)

Loss of relationship
Adults who experience the death or divorce of a spouse, or a child leaving home are at greater risk for suicide (Rutter, 2002; Reid, 1993; Gliatto and Raj, 1999; Agerbo, et al., 2002).

Individual

History of problem behavior
Aggressive children are more likely to engage in substance abuse or other negative behaviors. The younger a person is when initiating use of alcohol and other drugs, the greater the chance of developing an addiction. For older adults, a history of substance abuse is a risk for suicide. People who have previously attempted suicide are at greater risk of completing suicide (Kumpfer, 1999, Robertson, David, and Rao, 2003; Romer, 2003; Diekstra, 1995; Winters, et al., 2003; Tremblay, Masse, Pagani, and Vitaro, 1996, Hawkins, et al., 1992; Catalano, Berglund, Lanzak, and Hawkins, 2002; Bollinger, 2003; Gliatto and Raj, 1999; White and Jodoin, 2004; Agerbo, et al., 2002; Romer, 2003).

Anti-social attitudes and beliefs
Alienation from the societal values, dishonesty, and rebelliousness predict substance abuse, school drop out, and delinquency (Kumpfer, 1999; Newcomb and Felix-Ortiz, 1992; Aber, Brown, and Jones, 2003)

Low commitment to school
Youth are more likely to engage in harmful behaviors such as substance abuse when they do not feel committed to school (Hansen, et al. 2000 Overpeck, Brenner, Trumble, Trifletti, and Berendes, 1998; Kumpfer, 1999).

School failure
Academic failure during childhood is predictive of later adolescent and adult behavioral health problems (Brounstein and Zweig, 1999; Hansen, et al., 2000).

Transitions
Changes in school or employment, retirement, death of a spouse, and menopause are times of stress (Robertson, David, and Rao, 2003; Zaslow, et al., 2000).

Poor coping skills
Stress combined with poor coping skills is a risk factor for suicide, substance abuse, and perpetration of abuse or neglect against children and/or elders (Bethea, 1999; Bonnie, 2003; White and Jodoin, 2004; Hansen, et al., 2000).

Poor self esteem

Low self esteem, self dislike, and self criticism are risk factors for perpetration of abuse and neglect, suicide and suicidal ideation (Rutter 2002).

Low perceived harm

People are more likely to use alcohol or other drugs when they perceieve the harm to self to be negligible (Hawkins, et al., 1992; Blow, 2002; Brounstein and Zwieg, 1999).

Disability, changes in physical health, chronic illness, pain

Poor physical health and physical disabilities are risk factors for abuse neglect, substance abuse, depression, and suicide (Blow, 2002; Kidd, 2002; Waren, 2002).

Temperament or cognitive style

Sensation seeking, rumination, pessimism, anti-social behavior, aggression, high tolerance of deviance, resistance to authority, hyperactivity, and irritability are all correlated with development of substance abuse and other behavioral health problems (Brounstein and Zweig, 1999; Hawkins, et al. 1992; Kumpfer, 1999; Romer, 2003; Catalano, et al., 2002; Romer, 2003).

Prenatal exposure to alcohol, tobacco, and other drugs

Substance use during pregnancy and infancy predisposes children to later aggressive behavior and substance abuse and suicide (Williams, 2004; Mihalic, et al. 2004; Bollinger, 2003).

Genetic factors

There is evidence of an inherited biological predisposition and genetic link to the development of alcoholism, depression, and other behavioral health problems (Hawkins, et al., 1992; Blow, 2002).

Impulsiveness and rebelliousness

People who are impulsive, rebellious, hostile and/or lack inhibition are more likely to engage in dangerous risk taking behaviors such as substance use, violence, or suicide (Brounstein and Zweig, 1999; Hansen, et al., 2000; Robertson, et al., 2003; White and Jodoin, 2004; Dykeman, Daehlin, Doyles, and Flamer, 1996).

Protective Factors

Protective factors are personality, family, and environmental buffers that help people to thrive despite risky environments. Prevention programs seek to bolster people, families, and communities' strengths and innate capacity for learning and success by building on strengths.

Community

Opportunities for meaningful citizen participation and community service

When community members have opportunities to become involved in their community and make positive change, they take ownership of and pride in the community (Catalano, et al., 2002; White and Jodoin, 2004; Kumpfer, 1999).

Healthy beliefs, clear standards for behavior

People conform to the expectations of society. When the community clearly communicates healthy expectations regarding behaviors such as substance use, youth are less likely to engage in that behavior (Brounstein and Zweig, 1999).

Access to community resources

Easy access to quality health care, social services and other community resources such as housing, child care, employment, and recreation are conditions that protect people from developing behavioral health problems (Thomas, et al., 2003; Kumpfer, 1999).

Horizon Human Services, Stanfield

Family

Secure attachment
Bonding and secure attachment between caregiver and child is crucial to healthy development and prevention of abuse and neglect (Thomas, et al., 2003; Catalano, et al., 2002; Romer, 2003; Hawkins, et al., 1992; Mihalic, et al., 2004).

Authoritative parents
Families in which consistent non violent discipline is used and limits are set on behavior are more protective for youth (Kumpfer, 1999; Mann, 2003; Thomas, et al., 2003 Bollinger, 2003; Kumpfer, 1999; Sale, Sambrano, Springer, and Turner, 2003; Thomas, et al., 2003; Hansen, et al. 2000; Romer, 2003 Zaslow, et al. 2000).

Belonging
The perception that one has a family (natural or not) to which one belongs and in which one can find acceptance and emotional support is a protective factor for all persons (Catalano, et al., 2002; Brook, Zheng, Whiteman, and Brook, 2001; Thomas, et al., 2003; Hawkins, 1992; Romer, 2003).

Traditional cultural values
Families, which have strong cultural traditions and values, are more protective for youth (White and Jodoin, 2004).

Family support
Family support and encouragement co rrelates with better school performance and avoidance of behavioral health problems (Brounstein and Zweig, 1999; Kumpfer, 1999; Romer, 2003).

La Frontera Center, Tucson

Caregiver monitoring and supervision
Children are less likely to engage in harmful or dangerous behaviors when their caregiver knows where they are and what they are doing. Children perform better in school when caregivers monitor homework and television viewing (Romer, 2003; Hansen, et al., 2000; Zaslow, et al., 2000; Sale, Sambrano, Springer, and Turner, 2003).

Institutional

Opportunities for success
Schools that promote the mental health of children, focus on mastery of material, and give children opportunities to experience success are more protective (Brounstein and Zweig, 1999; Hansen et al, 2000).

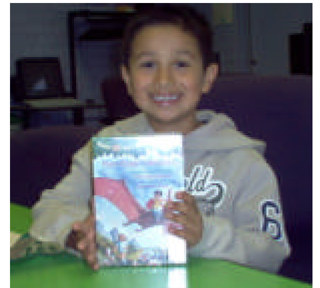
Challenge with support
People excel in environments in which they are challenged to perform and provided the tools and support to be successful in their activities (Hansen et al., 2000).

Caring relationships
Institutions, in which staff members demonstrate caring through support, respect, and compassion, have more successful members (Hansen et al., 2000).

Opportunities for involvement
When people have opportunities to actively participate in the formation of policy in a school, religious setting, or care home, people develop a stronger relationship with the institution (Brounstein and Zweig, 1999; Sale, Sambrano, Springer, and Turner, 2003).

Safety
People in institutional environments are more likely to engage in healthy behaviors when they feel safe (Lackney, 1990).

High expectations
Belief in people's innate intelligence, resiliency, talent and capacity for success is correlated with success. This concept is related to working from a strengths based perspective (Brounstein and Zweig, 1999; Hansen et al., 2000; McKenna and Ortiz, 1988).


Boys and Girls Clubs of the East Valley, Tempe

Family involvement
People perform better in schools when their families are actively involved (McKenna and Ortiz, 1999).

Interactive learning
Providing youth with opportunities to engage in collaborative and cooperative learning is a well-documented approach to improving youth success in school (Hansen, et al, 2000).

Individual

Empathy
Empathic people are less likely to engage in violence. They are more likely to relate to the needs of dependants, and therefore, less likely to abuse or neglect (Hansen, et al., 2000).

Problem solving skills
The ability to generate alternative solutions to problems is correlated with resiliency (Brounstein and Zweig, 1999).

School success
Successful school performance is correlated with healthy behavioral outcomes (Kirby, et al., 2001; Robertson, 2003; Romer, 2003; Brounstein and Zweig, 1999).

Physical health
Overall good physical health is a protective factor (Brounstein and Zweig, 1999, Thomas, et al., 2003; White and Jodoin, 2004; Zaslow, et al., 2000)

Intelligence
High intelligence is correlated with staying in school (Thomas, et al., 2003; Mihalic, et al., 2004).

Self-efficacy
People with a sense of control and confidence in themselves and their ability to make decisions are less likely to engage in harmful behaviors (Bridges, 2001; Zaslow, Caulkins, and Halle, 2000; Thomas, et al. 2003; Kirby, et al., 2001; Mihalic, et al., 2004; Catalano, et al. 2002).

Temperament
Temperament is related to how people respond to stress and change as well as how they seek stimulation. People who are optimistic and hopeful that problems may be overcome are more resilient to the development of behavioral health problems (Mihalic, et al., 2004; Hawkins, et al., 1992; Thomas, et al., 2003; Brounstein and Zweig, 1999).

Cultural Pride
The combination of knowledge, pride, and belonging to a cultural group moderates the effects of discrimination (Lee, 2005; Kumpfer, 1999; Kulis, Napoli, and Marsiglia, 2002; Marsiglia, Kulis, and Hecht, 2001; Miller, 1999).

Autonomy
The ability to be your own person and make age appropriate decisions is essential to behavioral health (Kirby, et al., 2001; Hansen, et al., 2000; Thomas, et al., 2003; Mihalic, et al., 2004)

Sense of future/purpose
Individuals who have a plan for the future, sense of hope, and/or purpose are less likely to engage in negative behaviors (Kirby et al., 2001; White and Jodoin, 2004; Hansen, et al., 2000).

Social competence
Children with good social skills are more likely to make friends and get social support (Zaslow, et al. 2000; Thomas, et al. 2003; Catalano, et al., 2002; Hansen, et al., 2000; Brounstein and Zweig, 1999).

School connectedness
Youth who enjoy going to school are more likely to have positive behavioral health outcomes (Hawkins, et al., 1992; Newcomb, 1992).

Religion/spirituality
Active participation in a religious institution is correlated with positive behavioral health (Newcomb, 1992; Thomas, et al., 2003; Brook, 2001; White, 2004; Bollinger, 2003; Robertson, 2003; Romer, 2003).

Coping skills
Coping skills (flexibility, the ability to adapt, recognition of danger, ability to imagine the future, and capacity to deal with stress) correlate with positive behavioral health outcomes and (Bridges, 2001; Catalano, et al., 2002; Thomas et al., 2003).

Peer and Relationships

Bonding to peers
Having a relationship with peers who engage in healthy behaviors is a protective factor. When peers engage in pro-social behavior, children are also more likely to do so (Romer, 2003; Thomas, et al., 2003; Brook, Zheng, Whiteman, and Brook, 2001; Tani, Chavez, and Deffenbacher, 2001).

Bonding to an adult
The development of warm, supportive relationships and social bonds to pro-social adults during childhood appears to inhibit substance use. (Kumpfer, 1999; Kirby, et al., 2001; White and Jodoin, 2004; Brounstein and Zweig, 1999).

Prevention programs focus on enhancement of protective factors for the purpose of preventing and/or delaying the onset of substance abuse and other mental health conditions. Prevention programs select protective and risk factors to target based on a comprehensive assessment of needs and resources of the community and target population. Many risk and protective factors (for instance social competence and coping skills) can be changed by prevention programs and are appropriate for using to create program goals and objectives. Some risk and protective factors cannot be changed through behavioral health prevention programs (for example socioeconomic deprivation and genetics) and are therefore inappropriate for use in establishing program goals and objectives.

Protective and risk factors are common to many disorders. Rather than functioning in isolation, there exists a dynamic interaction among them that undergoes modification and change throughout the life span.

PROGRAM DESIGN

Program design involves selection of strategies, application of evidence based practices and development of an implementation plan.

Strategies

Strategies are specific, research-based approaches for achieving project objectives. The overall program design should identify *all* strategies required to reach the goals and objectives of each program. Some resources needed by a community may already be available through other providers. A community needs and resource assessment (as described on pages 21-23) and collaborative planning can ensure comprehensive prevention takes place, while duplication is eliminated.

The strategies selected for implementation should be based on the target population selected for intervention and the goals and objectives of the program.

Effective programs offer the target population multiple opportunities in a variety of settings to learn and practice healthy behaviors. RBHAs must incorporate the entire range of research-based strategies into their prevention system. Researched based prevention strategies have a strong theoretical design, have been evaluated and demonstrated effectiveness. Within a community, strategies in multiple domains should be used and matched to the specific problems and needs of the community. 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. The choice of strategies will be influenced by the age, gender, culture, and socioeconomic status of the target population (Alaniz, Davis, Neal, Weissberg, Kumpfer and Seligman, 2003; Gardner, 2001; Hansen, et al., 2000; Nelson, Wethues, and Macleod, 2003; Benard, 2001; Hawkins, 2003; Kumpfer, 1999; Kumpfer, 2000; Kumpfer and Alvarado, 2003; Schinke, 2002; Nation, Crusto, Wandersman, Kumpfer, Seybolt, Morrisey-Kane, and Davino, 2003; Greenberg, O'Brien, Weissberg, Zins, Resnil, Fredericks, and Elias, 2003; Greenberg, Domittrovich, and Bumbarger, 2001).

Comprehensive:
A prevention program, which is comprehensive, uses multiple strategies and targets multiple domains of risk and protective factors.

La Frontera Center, Three Points

Table 6 summarizes the prevention strategies used by Division of Behavioral Health prevention programs. When using any of the education strategies (training, family support, community education, life skills), prevention programs need to have a written curriculum. The curriculum should describe in detail what is taught and how it is taught. Curriculum materials and methods selected need to be developed with age, development, and learning stage of participants considered. Curricula developed by providers should undergo an annual review and revision based on process and outcome evaluation data gathered.

In the appendices to this document are a series of checklists corresponding to each of the strategies. The checklists are intended to be guidelines and are not program requirements. The strategies used need to be implemented in sufficient scope, intensity and duration to accomplish the program goals and objectives.

Table 6: Division of Behavioral Health Prevention Strategies

Arizona Prevention Strategy	***Description***	***Corresponding CSAP Strategy***
Training	Training provided to behavioral health professionals, school staff, volunteers, medical professionals, care home staff and others to enhance knowledge or skills related to working with youth, families, aging populations, or communities.	Education **Written curricula need to be used.*
Family Support and Education	On going, sequential, educational sessions targeted to parents, family members and/or caretakers of children, persons with disabilities, or seniors.	
Life Skills Development	On-going, long-term educational activities that develop or improve life skills such as decision making, coping with stress, problem solving, conflict resolution, and/or resistance skills.	
Community Education	One time workshops that assist individuals or community groups in developing or improving critical life skills such as decision making, coping with stress, values awareness, problem solving, conflict resolution, and/or resistance skills. ** This strategy must be used in combination with other strategies. It may not be used in isolation.*	
Public Information and Social Marketing	Presentation of accurate messages and promotional material on substance abuse, suicide, child rearing, care giving and other behavioral health issues. May include health fairs, development and distribution of electronic or print media, public service announcements and other related methods.	Public Information
Personal and Cultural Development	Activities that provide challenging and positive growth experiences and opportunities to practice skills learned in a natural environment. Includes cultural ceremonies, art, camping, ropes courses, team building activities, etc... This strategy must be used in combination with other strategies. It may not be used in isolation.	Alternatives
Mentorship	Activities in which positive role models provide support and guidance to assist individuals in achieving personal growth.	
Peer Leadership	Activities that reinforce leadership capabilities of participants, develop skills, peer facilitation of education workshops, and community service learning.	
Community Development	Development of a grassroots movement to address community protective and risk factors related to behavioral health. Includes establishment and maintenance of collaborative relationships with key stakeholders. Activities target entire populations.	Community Based Process
	Involvement in coalitions/community groups, which explore ways to enact policies that will create environmental change.	Environmental

Prevention Theories

Many theories inform prevention practice. Five that are particularly important to practice include Institute of Medicine Model, cultural competency, human development, community development, and learning theories.

Institute of Medicine Model

The Institute of Medicine Model describes three types of populations a prevention program might target: universal, selected, and indicated. A universal prevention program targets the entire population regardless of degree of risk for developing a behavioral health problem. A selected prevention program targets persons with specific risk factors. Indicated prevention programs target persons at high risk for behavioral health problems, but who do not have a diagnosable behavioral health problem. RBHA prevention systems target programs to universal, selected, and indicated audiences. Table 7 provides definitions of universal, selected, and indicated prevention.

Table 7: Universal, selected, and indicated prevention

Type of Program	Description
Universal	Programs that target people at large and use strategies designed to reinforce pro-social norms and levels of affiliation with family, school and community, increase perception of safety and personal effectiveness, improve family nurturing and management techniques and teach social, problem solving and conflict management skills.
Selected	Selected programs target populations with known personal, family, school or community risk factors. Prevention strategies are tailored to both the population and the specific risk factors present in the population. Selected prevention is intended to mitigate the effects of various risk factors through multiple, complementary interventions targeting the community, family and individual. Common strategies for selected prevention include skill building; mentoring and personal development activities intended to alter the conditions that increase susceptibility to substance use.
Indicated	Individual programs target persons whose behavior or circumstances warrant attention and redirection but whose behavior does not meet diagnostic criteria for a behavioral health problem. Indicated prevention services are sometimes referred to as "early intervention" and include a selection of specific participants and higher levels of involvement over a greater period of time.

Cultural competence

As the lens through which people view their world, culture is an important element of prevention program design and implementation. Culture represents the shared values, norms, traditions, customs, arts, history, folklore, music, religion, and institutions of a group of people. Culture includes age, gender, and sexual orientation.

Effective programs celebrate the diversity and culture of participants, and thoughtfully consider the needs of the target population. They are based on the developmental stage of the target audience, have clear objectives, and provide good staff training.

Effective prevention programs build on the strengths of the targeted population. Educational materials are available in the primary language of participants and include examples pertaining to participants' culture. The curricula are culturally appropriate and responsive to participants.

Prevention programs need to establish credibility and trust with the population served by hiring staff that come from and reside in the communities served (Roosa, et al. 2002). Participants become more engaged in the program when they perceive that program staff members understand and care about them, their families, their community, and issues (Trimble, et al., 2001). Additionally, staff members who are culturally and demographically representative of the target population are more effective.

Human development

Human lifespan development theories explain the normal process of maturing. Each stage has specific physical, mental, and social tasks and is a foundation for the next. The functioning within any particular stage is partly determined by the extent to which tasks were completed in previous stages. Each stage of development is important, and leaves a unique imprint on a person's life. The success with which each person meets the challenges of each stage influences whether the outcome will be continued growth, delayed growth, or dysfunction. Developmental tasks and examples of prevention strategies for each stage are summarized in Table 8.

Table 8: Developmental stages and strategies prevention providers use.

DEVELOPMENTAL STA GES AND PREVENTI ON APPROACHES		
Stage	**Developmental Goal**	**Examples of Prevention Approaches**
Prenatal and Perinatal (Conception to Age 1)	Form basic trust.	1. Referrals to prenatal care and screening for developmental delays. 2. Parent support and education in the topics such as: nutrition, play, child development, soothing a crying baby, self-care, caring for a sick baby, delivered via group, individual, or home visitation. 3. Facilitation of parent-child bonding.
Toddler (Ages 1-2)	Develop a healthy relationship to authority and achieve autonomy.	1. Facilitation of parent-child interactions 2. Parent support and education in helping children develop autonomy, discipline, and child development delivered via group, individual, or home visitation.
Young Childhood (Ages 3 to 6)	Develop a sense of initiative in pursuing goals.	1. Parent support and education in discipline and child development 2. Life skills education in identifying and naming feelings and emotions, communication skills, and resolving conflict
Late Childhood (Ages 7 -12)	Establish a sense of competence and self-worth.	1. Classroom based life skills programs on: communication, conflict resolution, decision-making skills, stress management, and normative education. 2. Cooperative/collaborative learning 3. Tutoring and mentoring 4. Service learning
Adolescence (Ages 13 to 18)	Establish an identity separate from parents.	1. Leadership, peer education, and service learning projects, which teach problem solving, decision-making, and social skills, and establish positive peer group memberships. 2. Clubs, civic groups, schools, and religious organizations.
Early Adulthood (Ages 18 to 40)	Form an intimate relationship without losing own identity.	1. Training in organizational skills and relationship skills 2. Support in parent role
Middle Adulthood (Ages 40- 65)	Develop meaning in life.	1. Civic involvement 2. Support in parent/caregiver role
Maturity (Ages 65+)	Feel a sense of fulfillment.	1. Multigenerational mentoring programs 2. Community service

Erickson (1963)

Transitions from one developmental stage to another are challenging and stressful. They are a time of increased risk for people of all ages and therefore a good target for prevention programs. Key transitions in life include: change in school, retirement, new child, menopause, and others.

RBHA prevention planning should include a continuous progression of prevention efforts that meet identified needs from the prenatal stage of life until death. Prevention is most effective when adapted to the developmental stage of the participants (Alaniz, et al. 2001; Weissberg, Kumpfer, and Seligman, 2003; and Martin, 2003).

Children and families identified by prevention programs, as needing more intensive services will be referred for treatment or other community services.

Community development

Community development is the creation of conditions that promote the well being of an entire community. Effective prevention programs involve partnerships with key stakeholders and are integrated into regular, ongoing community processes, coalitions, and strategic planning. Community development strategies work to influence community norms, promote public safety and reduce the availability of drugs.

When community members become involved in making decisions about their environment, they develop ownership for their environment and become invested in ensuring that good decisions are made and followed through.

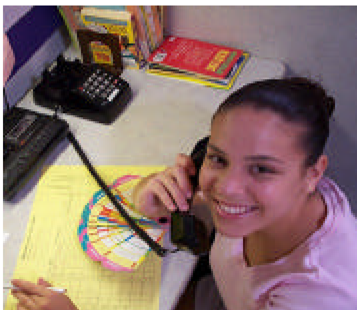
Coalitions involved in prevention planning should have a formal set of bylaws that outlines the process for influencing design, implementation, and evaluation of the prevention program. Prevention programs should establish a community-based coalition (from community members of targeted population) to assist in the design, implementation, and evaluation of their programs.

"There is not any of these things that we can do by ourselves. It really is about creating partnerships, connections and relationships."
-Beverly Watts Davis

Learning Theories

Effective prevention programs are interactive, and use a variety of hands on teaching tools such as role-play and role modeling. They ask participants to practice new skills between sessions. The method used to teach educational material needs to be appropriate for the target population's culture, developmental stage, and stage of change. For instance, a culturally competent prevention program may use small group cooperative activities to teach a concept rather than whole group discussions, which are more competitive in structure.

Social learning theory postulates that people learn best by observing the actions of persons who are like them (Hill, 1990). Peer facilitated education is therefore more effective in helping people learn new skills. Opportunities for cooperative or collaborative learning exercises help people to learn more effectively (Kohn, 1993).



Child and Family Resources, Tucson

Prevention participants must be exposed to a preventative intervention for a sufficient duration of time in order to stimulate behavior change in that participant. Short-term prevention programs tend to have short-term effects. For maximum behavior change, prevention programs targeting individuals, families, or students in schools should be at least 16 hours in duration. The length of time should increase with the level of risk of the target population. For example, a prevention program targeting all 10th graders in Casa Grande would be 16 hours in length, while a prevention program targeting adolescents who are pregnant or parenting would be 40 hours in length. Booster

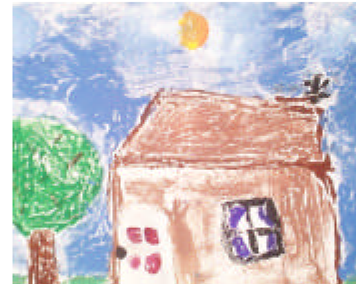
sessions including reinforcement of key concepts should be offered to reinforce lessons learned. Prevention programs should take place over multiple years offering age appropriate support and education to persons throughout their entire lifespan (Webster-Stratton and Taylor, 1998; Hansen, 1998; Silverman and Flener, 1995; Nelson, Wethues, and Macleod, 2003; Greenberg, O'Brien, Weissberg, Zins, Resnil, Fredericks, and Elias, 2003; Gardner, 2001; Kumpfer, 1999 Seligman, Schulman, De Rubeis, and Hollon, 1999; Kirby, et al., 2001 Farrer, 2004; Nelson, Wethues, and Macleod, 2003; Greenberg, Domittrovich, and Bumbarger, 2001; Thomas, et al., 2003).

Implementation plan

An implementation plan is a practical document, which lists the steps that will be taken to carry out a prevention program. The implementation plan should address steps to be implemented, responsible parties, timeline for completion, participant engagement and staff training.

Evidence based programming

Effective prevention programs are comprehensive and collaboratively developed. They use a multi-component approach to target protective and risk factors in each domain and use a variety of strategies. They reduce the most significant risk factors faced by the targeted community or population (Aber, et al., 2003; Farrer, 2004; Gardner, 2001; Hansen, et al., 2000; Nelson, et al., 2003; Robertson, et al, 2003).



Horizon Human Services, Stanfield

Development of Arizona prevention programs is based on research studies that indicate support for the method to be used as well as a thorough understanding of the target community. While DBHS recognizes the importance of using effective prevention strategies, *exclusive* use of Nationally recognized "model programs" is not endorsed. However, all DBHS programs will be based on scientific evidence. In addition, all programs will strive for the highest degree of competence and enthusiasm in program implementation in order to get the most impact from all programs. The context in which prevention is implemented especially the relationships developed in the course of program implementation is a critical component of every successful program (Hansen et al., 2000).

Arizona is home to a variety of high quality, research grounded, innovate prevention programs. Innovation and adaptation are important to appropriately meet the needs of Arizona's diverse population and unique issues. Arizona's innovative programs need to carefully document and evaluate their efforts.

Participant and volunteer engagement

Recruitment and retention of participants and/or volunteers within a program is key to the effectiveness of the program. Participant engagement should be an important component of the implementation plan.

In order for a target population to be engaged in a prevention program, they must first be aware that the program exists. Marketing a program to a target audience is therefore a key initial step in participant engagement. Successful marketing strategies consider where target population gets information that they consider to be reliable. One of the most important ways people get information is word of mouth, which means that also marketing to people who interact with the target population is important. People are more interested in participating in a program when they view the program as credible. A key

Casa De Esperanza,
Green Valley

indicator of a prevention program or staff persons' credibility in a community is long term commitment to the wellness of the community and respect for community members' knowledge and values (Roosa, Dumka, Gonzales, and Knight, 2002; Trimble, et al., 2001).

Attendance in a prevention program depends on a variety of factors including convenience and reason to attend. Programs, which are located in geographically accessible places with consideration to transportation needs of the target population, are more attended. When programs are not in locations easily accessed by participants, programs need to consider relocating or providing convenient transportation. Programs, which are implemented during meal times, should provide food or snacks. Programs, which target persons with young children need to consider provision of child care (Webster-Stratton and Taylor, 1998, Kirby, et al., 2001, Kumpfer, 1999).

Participants need to have a reason to attend, which is accompanied by a belief that there will be a benefit to attending. Conveying benefits of participation should be part of the marketing of the program and an on-going consideration of the program. Participants need to know that staff care about them and their attendance. Frequent communication between program staff and participants via phone, correspondence and other means is an effective way to remind participants about the program and maintain their interest.

Prevention programs should be interesting, fun, and challenging for participants and volunteers. Participants and volunteers should gain something from participating. This gain is not material, but can be an intangible reward, which stimulates intrinsic motivation, such as the perception that the information and skills they learn in the program are worth learning, a feeling of doing something positive for others gained through volunteer work or supporting an important cause. Other intrinsically motivated reasons for participating in a prevention program include curiosity, opportunities to: build friendships, get support, have fun, or develop new skills (Kohn, 1993).

Participants are more engaged in a program when they have input into how that program is implemented. Participant input can be collected at a variety of stages in program implementation from the needs assessment process through process evaluation of the program (described further in the following pages).

Programs need to carefully outline steps for engaging their target population in their implementation plan. This includes what steps will be taken to engage participants and who will be responsible for carrying out those steps.

Staff training

Prevention programs need to offer training for staff and volunteers to develop skills and minimum competencies for successful implementation of the program (Please see page 45 in the next chapter of this document for a list of competencies for prevention professionals). Prevention professionals need to be supervised and coached by a supportive administration (American Association of Suicidology, 1999; Mihalic, 2000; Webster-Stratton and Taylor, 1998; Fashola and Slavin, 1997; Schinke, Brounstein, and Gardner, 2002). Programs need to identify and plan for any required or necessary trainings to prepare staff to work with identified target population.

EVALUATION

Program evaluation is a tool prevention professionals use to learn about program strengths and weaknesses and to make adjustments to improve the quality of services provided. Program evaluations should measure both processes and outcomes. Practical evaluations provide feedback that encourages programs and communities to augment their efforts where successful and to modify or abandon unsuccessful efforts.

No single, standardized evaluation format is appropriate for evaluating each and every prevention initiative. Evaluations measure change for each prevention program's objectives. Changes in the objectives, which are based on specific protective and risk factors, are evaluated to determine program effectiveness.

Yavapai Regional Medical Center, Prescott

The process evaluation measures how the program is being implemented, including for example a description of the target audience, strategies used as well as participant engagement and satisfaction.

Outcomes (short and long term) determine if goals and objectives are being met. Outcome evaluations measure changes in participant perceptions, attitudes, knowledge, behaviors, and risk or protective factors. Outcome evaluation use core evaluation instruments. Core evaluation instruments are a set of common evaluation tools used by programs in Arizona and across the United States. A list of Arizona's core evaluation instruments is named on page 48.

An impact evaluation is a third type of evaluation, which measures prevalence and incidence of behavioral health problems and large-scale change. Impact evaluations evaluate the long-term effect of prevention on populations. Governments, universities, and private research organizations conduct impact evaluations.

Table 9: Examples of indicators for process, outcome, and impact evaluation

PROCESS	OUTCOME	IMPACT
Short-Term Effects Measured by all programs, RBHAs, and DBHS		Long-Term *Community-Wide* Effects
Description of: ➤ Target audience served ➤ Prevention services delivered ➤ Staff activities planned/performed ➤ Participant engagement and satisfaction	Changes in: ➤ Perceptions ➤ Attitudes ➤ Knowledge ➤ Behaviors ➤ Risk or protective factors ➤ Use of core evaluation instruments.	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

Process

Process evaluation assesses whether the program was implemented as planned and with quality. The process evaluation is descriptive. It provides information about the people served by the program, and documents program 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.

Process evaluations are descriptive in nature, providing:

- Information about participants
- Documentation of program, activities, materials, and staffing
- Information about program quality
- Tracking of program costs
- A descriptive base for program replication
- Attendance by each participant
- Program duration
- Degree to which participants were actively involved
- Cultural competence, responsiveness and appropriateness of the program
- A measure of satisfaction with the program and implementation
- Effectiveness of the program with the targeted population.

Process evaluation involves the following steps:

1. Establish a protocol for recording participant demographic information and for documenting actual program implementation
2. Train staff in the protocol
3. Collect data
4. Organize the data in a database
5. Summarize totals
6. Make changes to the program design and implementation as needed

Outcome

Outcome evaluations focus on the extent to which a program's short and long-term measurable goals and objectives have been met and changes in protective and risk factors targeted by the program are evaluated.

Outcome evaluation involves the following steps:

"It doesn't matter which strategy you employ, the key issue is did it work?"
-Dr. H. Westley Clark

1. Establish program goals and objectives based on the targeted protective and risk factors.
2. Select or design a method to measure changes in objectives related to protective and risk factors. Both quantitative and qualitative methods can be used, and may include surveys, focus groups, interviews, observations and archival data. DBHS funded prevention programs are required to use a core evaluation instrument to evaluate their program.

Core evaluation instruments are quantitative instruments. Where a core evaluation instrument is not applicable, RBHAs may request DBHS approval to use an alternative evaluation. When measures must be translated from English to another language, care must be taken to be sure that both versions have equivalent meaning. In some cases, this will require changing the wording in English so that translation is possible. Prevention professionals need to always be cautious about the literacy of the participants. Reading the measures aloud while participants read to themselves and provide answers is a useful strategy to avoid embarrassing situations and random responding by those who cannot read.

3. Collect data
4. Organize the data in a database
5. Interpret findings from the process and outcome evaluations
6. Use findings to make improvements to the program

Impact

An impact evaluation measures long-range changes in health risk behaviors, and changes in individual and community health and wellness. Assessing the ultimate impact of prevention programming is done 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.

Improvement of Program Quality

The Arizona Logic Model includes a feedback loop to provide quality improvement both during the program and output and outcome successes at the end of the program. Evaluation results should be used to make ongoing changes and improvement.

Program improvement should focus on answering the following questions:

- What program components worked well and should be continued in future implementation?
- What program components did not work well and could/should be improved?
- Were there components that did not work well for specific populations?
- How can staff increase their effectiveness in implementing the program and working with participants?
- Do results show the program makes a difference?

CONCLUSION

Evidence based prevention programs assess community needs, use science to inform their practice, provide thorough training and supervision to staff, evaluate outcomes, and use process and outcome evaluations to inform program improvement.

T/RBHA and Tribal Contractor Requirements

This chapter outlines the *minimum* requirements for Regional Behavioral Health Authorities (RBHAs), Tribal Behavioral Health Authorities (TRBHAs), and Tribal Contractors' prevention programs. T/RBHA is used here to refer to both TRBHAs and RBHAs. The term "Tribal Contractor" refers to any Tribal Nation that is not a TRBHA, but has an Intergovernmental Agreement (IGA) with the Arizona Department of Health Services, Division of Behavioral Health to provide prevention services.

PROGRAM ADMINISTRATION

Each T/RBHA and Tribal Contractor must designate at least one prevention program coordinator. RBHA prevention coordinators must meet all administrative level competencies within one year of hire. RBHAs must have representation in all DBHS facilitated RBHA Prevention Coordinator meetings. TRBHAs and Tribal Contractors must attend at minimum two prevention coordinator meetings annually.

SAFETY STANDARDS

T/RBHAs and Tribal Contractors ensure that the prevention program or staff does not endanger the health, safety, or welfare of children in their programs. The following are *minimum* requirements from ADHS for T/RBHAs and Tribal Contractors in the area of safety.

Fingerprinting and background checks

T/RBHAs and Tribal Contractors confirm that all staff, contractors, volunteers or other persons delivering prevention services to persons under the age of 18 have applied for or received a class I or II fingerprint clearance card by the Arizona Department of Public Service, before providing prevention programs (per Arizona Revised Statutes 36-425.03). Individuals who have been denied a class I ***and*** II fingerprint clearance card may not provide unsupervised services to **youth** in a program contracted by DBHS.

Casa De Esperanza, Green Valley

CPR/First Aid

T/RBHAs and Tribal Contractors confirm that at least one staff member current in First Aid Certification and at least one staff member current in Cardio Pulmonary Resuscitation Certification (CPR) is present at all times on facility premises, on field trips or while transporting children in a facility's motor vehicle or a vehicle designated by the licensee to transport children. A single staff member with current certification in both first aid and CPR may meet this requirement. Prevention programs will maintain a first aid kit accessible to staff members. First aid kits should be available in vehicles when transporting participants.

Prohibited Objects/ Substances

T/RBHAs and Tribal Contractors prohibit the use or possession of the following items when a prevention program participant is on facility premises, during hours of operation, or in any motor vehicle when used for transportation of program participants:

1. Any beverage containing alcohol
2. A controlled substance
3. A firearm

Insurance

RBHAs and Tribal Contractors ensure prevention programs secure and maintain the minimum insurance outlined in the DBHS provider manual

Facilities

RBHAs confirm that the following health and safety inspections take place for any facilities owned, leased, or rented by that provider to provide prevention services, according to the following schedules, and make any repairs or corrections stated on an inspection report.

A. Sanitation inspections, conducted a minimum of every 12 months by a local health department.
B. Gas inspections, conducted a minimum of every 12 months by a plumber holding a plumbing business license issued by a local government.
C. Fire inspections, conducted a minimum of every 36 months by a local fire department or the State Fire Marshal.

Prevention program premises and furnishings will be maintained free from dirt, disease, and odor. Exceptions to requirements for facilities may be made at the discretion of the T/RBHA and Tribal Contractors.

Transportation

When providing transportation to prevention program participants in a motor vehicle, RBHA prevention providers must:

1. Ensure that the motor vehicle has a current registration with the Arizona Department of Transportation.
2. Not permit any person to be transported in a truck bed, camper, or trailer attached to a motor vehicle.
3. Require all vehicle passengers to use age and size appropriate restraint systems.
4. Carry a first aid kit, fire extinguisher, and water sufficient for the needs of each passenger.
5. Carry written permission from a parent or guardian for each youth transported.

Suspected Abuse or Neglect

T/RBHA and Tribal Contractor prevention program staff will document and report all suspected or alleged cases of child abuse or neglect to Tribal Social Services, Child Protective Services, Adult Protective Services or to a local law enforcement agency.

CULTURAL COMPETENCE STANDARDS

T/RBHAs and Tribal Contractors ensure culture is a consideration in all decisions pertaining to programming and staff competencies. Each RBHA follows procedures regarding cultural competency as well as National Standards on Culturally and Linguistically Appropriate Services (CLAS) 4-7.

Among these requirements are the following:

1. Prevention providers, T/RBHAs, and Tribal Contractors will assess the targeted populations' cultural preferences and include those preferences in the development of the prevention program; it's goals and strategies.
2. Each population or community targeted to receive prevention services must be involved in the design, implementation, and evaluation, of the program. This may be demonstrated by active involvement in a community-based coalition, where program participants or family members are involved in the coalition and members of the coalition have decision-making authority.
3. T/RBHAs and Tribal Contractors ensure prevention programs recruit, retain, and promote at all levels of the organization, a culturally competent, diverse staff and leadership that are representative of the demographic characteristics of the targeted population.
4. RBHAs ensure all prevention staff professionals receive cultural competency orientation within one year of hire and at least three hours of training in cultural competency annually thereafter.
5. RBHAs are required to include information in their annual report about how cultural competency is addressed, in program and how the annual training requirement has been met.
6. RBHAs ensure participants receive from all staff members, effective services that are provided in a manner compatible with their cultural health beliefs, practices, and preferred language.
7. Programs that serve limited English proficiency populations must have resources in the primary language of the target population, including bilingual staff, bicultural staff, printed and audiovisual materials.
8. RBHAs evaluate program quality and outcomes related to diverse populations.
9. Each RBHA will annually analyze process evaluation data to evaluate the effect of activities undertaken towards developing a culturally competent service delivery system.
10. T/RBHAs and Tribal Contractors collect demographic data including race, gender, and age of participants, monitor service delivery to diverse individuals within the targeted community or population, and assess the satisfaction of participants and ensure minority responses in the tabulation of satisfaction surveys.
11. RBHAs monitor provider and program compliance with DBHS and national CLAS standards 4 through 7 at least once annually. RBHAs may refer to the ADHS/DBHS provider manual for monitoring standards.

CLAS Standards 4-7

4. *Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation*
5. *Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services*
6. *Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. family and friends should not be used to provide interpretation services (except on request by the patient/ consumer)*
7. *Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area*

WORK FORCE DEVELOPMENT STANDARDS

T/RBHAs and Tribal Contractors ensure a minimum level of competency for prevention providers. Table 10 lists core competencies for prevention. T/RBHAs and Tribal Contractors will have evidence that all prevention program staff have achieved the beginning level competencies within a year of beginning to provide prevention services. Evidence may consist of: competency tests, prevention specialist certification, employee evaluations, work samples, training certificates, course credit, or documentation. Professional training and supervision must be provided to all prevention providers and should be documented by the provider agency.

Table 10: Minimum competencies for prevention program staff in the DBHS network.

	Beginning Level (First year)	Advanced Level (2-5 years) Meets all beginning level requirements as well as the following:	Administrative Level All beginning and advanced level requirements and the following:
Theoretical Knowledge	1. Risk factors by domain 2. Human development 3. Ethics 4. Risk and/or protective factors targeted by own program 5. How objectives relate to protective and risk factors 6. How program strategies affect protective and risk factors 7. Elements of culturally competent services, cultural awareness, and cultural competency models 8. Consciousness of own cultural background and how this effects interaction with participants 9. Learning styles and interactive teaching methods 10. Definitions of: ➤ Resiliency, risk and protective factor ➤ Needs and resource assessment ➤ IOM categories ➤ Process, outcome, and impact evaluation	1. Logic model development 2. Pathways for behavioral health outcomes 3. How a prevention program changes risk or protective factors 4. The relationships between risk and protective factors, behaviors, and culture 5. Science based strategies 6. Program adaptation for culture	1. How to design a comprehensive substance abuse prevention system 2. Adaptation for culture 3. Cultural competence 4. Building a logic model around a risk/protective factor 5. Curricula development
Program Implementation knowledge and Skills	1. Documentation of activities 2. Knowledge of program goal, strategies, and outcomes 3. Behavior management skills 4. Public speaking, communication, training, and facilitation skills 5. Effective recruiting and retention techniques 6. Follows an implementation plan 7. Mandatory reporting laws 8. Community resources 9. Signs indicating need for treatment and referral procedures 10. Communication skills 11. Professional boundaries and ethics 12. Safety Practices 13. Implementation of DBHS prevention strategies	1. Cultural adaptation 2. Diverse communication styles 3. Develop an implementation plan and logic model 4. Facilitates: ➤ Community meetings ➤ Resolution of conflict	1. Supervision skills 2. T/RBHA contract requirements 3. Grant and/or contract development skills 4. Selects strategies matching needs and objectives 5. Monitors cultural and linguistic responsiveness 6. Database development 7. Train others in beginning and advanced level skills and knowledge
Assessment and Evaluation	1. Summarizes results of a local community needs assessment 2. Collects process and outcome evaluation data	1. Measurable objectives 2. Community needs and resource assessment design and implementation 3. Written description of program outcomes 4. Evaluation implementation	1. Use of evaluation to change program design and implementation. 2. Data analysis 3. Cultural and linguistic assessment of programs 4. Assessment of staff training needs

PROGRAM MONITORING

Prevention program monitoring requirements for T/RBHAs are outlined below. Table 11 provides a summary of the minimum requirements for prevention program and provider monitoring.

1. T/RBHAs have written contracts with all subcontractors used to provide prevention services. This contract ensures accountability of prevention programming. Subcontracts for prevention services must contain the following provisions:
    - Incorporation by reference this document, the ADHS Framework for Prevention in Behavioral Health.
    - Specification of the work to be performed; type, duration and dosage (i.e. contact hours) of the prevention strategy to be delivered; and number of participants to be served.
    - Description of the evaluation methods and instruments to be used and specific reporting requirements.
    - Description of the method and amount of payment for satisfactory completion of services.
    - Reference to the Substance Abuse Prevention Treatment (SAPT) Block Grant requirements.
2. RBHAs conduct one visit to 100% of prevention sites or providers each year, with additional visits as needed. Site visits should include interview(s) with program staff, observation of program activity, and review of training and supervision records. TRBHAs may use alternative monitoring methods at their discretion. T/RBHAs and Tribal Contractors must participate in at least one site visit by DBHS staff persons annually and other visits as requested.
3. RBHAs formally evaluate the quality of each prevention program in their network once annually. RBHAs may evaluate each program using a sample of participants. The evaluation will include an analysis of process and outcome data.
4. RBHAs provide written feedback to prevention programs at least once annually noting successes and providing recommendations for improvement.
5. RBHAs will keep copies of provider developed curricula on file as long as it is being used for prevention programming funded from DBHS.
6. T/RBHAs and Tribal Contractors will have on file a written description of each prevention program implemented with DBHS funds in their region. This description will include:
    - A logic model in the Arizona Logic Model format
    - A plan for engaging the target population in the program
7. RBHAs will have a written evaluation plan for each prevention program, which is updated annually. Basic elements of the plan include:
    - Statement of the goals and risk and protective factor based objectives to be evaluated
    - Brief 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, and outcome, and impact portions of the evaluation
    - The name of the core evaluation instrument used or a copy of any approved alternative evaluation instrument
    - Data sources
    - Data collection procedures
    - Data analysis and reporting processes

The Partnership, Tucson

More details about evaluation are provided in the previous chapter.

Table 11: Summary of minimum RBHA monitoring requirements

Monitoring Element	Minimum Requirement
Written contracts	1 per prevention provider
Site visit ➤ Interview with program staff ➤ Review of training and supervision records	1 per prevention provider annually
Program evaluation	1 per program annually
Written feedback to providers	1 per provider annually
Curricula on file	Each provider developed curricula
Program description including: ➤ Logic model ➤ Engagement plan ➤ Evaluation plan	1 per program

EVALUATION REQUIREMENTS

T/RBHAs and Tribal Contractors monitor and collect data to ensure the efficacy and accountability of prevention programming. T/RBHAs are required to collect data in five areas for reporting to ADHS:

1. Needs and resource assessment
2. Participants
3. Workforce development
4. Program methodology/workplan
5. Outcomes

Details on the minimum data required for collection in each area are described below. This data may be collected via site visits, quarterly and/or annual reports, an ongoing data collection system, or other methods.

Needs and Resource Assessment

T/RBHAs design prevention programs in response to community needs identified through a formal needs and resource assessment process.

Definition

A Needs and Resource Assessment is a summary of information about current conditions within a community that underlie the need for preventative interventions.

Reported to ADHS

T/RBHAs: Each T/RBHA completes a formal, comprehensive assessment of its coverage areas needs and resources on a regular basis at least once *every three years* or prior to issuing a new T/RBHA wide prevention request for proposals (RFP), timed so results can shape the RFP. A written concise summary of that comprehensive assessment will be forwarded to ADHS within the annual end of the year report.

Pima Youth Partnership, Catalina

Minimum data collected

The formal community assessment addresses both needs and resources for the coverage area and includes

- Direct consumer and provider input (i.e., focus groups, questionnaires)
- T/RBHA utilization and eligibility data and the prevalence of behavioral health disorders among behavioral health recipients
- Social indicator data specific to the region served (i.e., Arizona Youth Survey, other archival data)

Other archival data should be included as needed. Data should be as recent as possible and no older than three years unless necessary data is not otherwise available. Data summarized in the needs assessment includes:

1. The prevalence of social indicators for protective and risk factors related to substance abuse, suicide and child abuse in each county of their region.
2. Perceived needs of targeted population
3. Existing resources dedicated to the targeted population
4. Trends related to behavioral health problems
5. Epidemiological data pertaining to the prevalence of suicide, substance abuse, and child abuse in each county of their region
6. Results of the Arizona Youth Survey and Youth Risk Behavior Survey
7. Protective and risk factors targeted by each prevention program in their region
8. Information about the low income population in the targeted region

Participants

T/RBHAs and Tribal Contractors collect basic, process information regarding the persons who participate in their program.

Definitions

- ***A recurring program participant*** is someone who attends an ongoing prevention program or effort, such as a community coalition, on a regular basis.
- ***A single program participant*** is someone who attends those activities once or twice, or someone who attends a stand-alone prevention event such as a health fair or community celebration.
- ***A completed program participant*** is someone who has participated in a prevention program and completed the program as defined by the RBHA.

Child and Family Resources, Tucson

Reported to ADHS

1. ***T/RBHAs*** Report once annually by August 31 for the previous state fiscal year to the ADHS/DBHS Office of Prevention.
2. ***Tribal Contractors*** Report once quarterly by the 15th of the month following the quarter in which services were provided – July 15, October 15, January 15, and April 15.

Minimum data collected

1. ***Recurring program participants***
   - Number of people served by age, ethnicity, and gender
   - The target population of each program.

2. ***Single service program participants***
   - Estimated number by age, gender, ethnicity

3. ***Completed program participants***
   - Number by gender, age, ethnicity

Pima Youth Partnership, Marana

4. ***Number of referrals to treatment and other community based services.***

* In cases where a provider covers multiple counties, these numbers are reported separately for each county.

Workforce Development

Activities that increase staff knowledge of prevention and improve staff skills in delivering prevention services.

Reported to ADHS

T/RBHAs and Tribal Contractors: Annually by August 31 of the past fiscal year to the ADHS/DBHS Office of Prevention.

Minimum data collected

1. Number of individual staff members providing prevention services
2. How many have completed requirements for beginning staff
3. How many have completed requirements for advanced staff
4. How many have completed requirements for administrative staff
5. Training workshops offered by the T/RBHA for prevention staff
6. Verification that each provider has documented professional supervision has been provided to prevention staff.

Program Methodology/ Work Plan

Reported to ADHS

T/RBHAs & Tribal Contractors Report once annually by August 31 for the previous state fiscal year to the ADHS/DBHS Office of Prevention.

Minimum data collected

1. Amount of ADHS funds expended in each strategy area per program, using ADHS strategy categories (see Page 31).
2. Protective and risk factors targeted by each program.
3. The strategies used by each program.
4. Names of all curricula used.

Outcomes

An outcome evaluation measures immediate changes in participant attitudes, knowledge, and behavior. All DBHS prevention *programs* are required to demonstrate progress toward achieving proposed outcomes. Each program must be evaluated for outcomes at least once annually. Programs may choose to evaluate a program using a sample of participants rather than all participants.

Reported to ADHS

***T/RBHAs & Tribal Contractors**:* A summary of outcomes for each program is reported at minimum once annually no later than August 31 following the state fiscal year in which services were provided. Information reported to DBHS on outcomes is subject to change.

Minimum data collected

Each program must evaluate for changes in protective and risk factors targeted by their program using at least one **core evaluation instrument**. If the program is unable to find an appropriate ADHS core evaluation instrument, then that program may use an alternative instrument with approval by the T/RBHA *and* ADHS. T/RBHAs are required to report at least one outcome per program in their annual report to ADHS. Table twelve provides a list of the required core evaluation instruments. Each RBHA is required to use each of these instruments to evaluate at least one program in their GSA.

Table 12: Summary of required core evaluation instruments

Construct:	Name of Scale:	This instrument measures:	Programs serving the following populations must use this instrument
Perception of risk/ Harm of Substance Use	Monitoring the Future/Perceived Harm	Opinions of physical harm/risk from substance abuse	Youth in grades 8 to age 21
Attitudes Toward Substance Use	Student Survey of Protective and risk Factors/ Favorable Attitudes Toward Drug Use	Student's attitudes toward drugs	Youth in grades 6 to age 21
Parent/Child Bonding	Parent-Child Affective Quality/Parent Report	Parent’s positive reinforcement/affection	Parents
Sense of Community	Sense of community index	An individual’s psychological sense of community	High schools, communities
30 Day Substance Use	Monitoring the Future Survey/ 30 Day Use	Substance use in the past 30 days, as well as questions regarding quantity.	Youth in grade 8 to age 21

Table 13: RBHA Reporting Requirements

Type of Data	Reported to ADHS:	Minimum data collected:
Needs and Resource Assessment	Once every 3 years	➤ The prevalence of social indicators for protective and risk factors related to substance abuse, suicide and child abuse in each county ➤ Perceived needs and behavioral health trends ➤ Existing resources ➤ Epidemiological data pertaining to the prevalence of suicide, substance abuse, and child abuse in each county ➤ Results of the Arizona Youth Survey and Youth Risk Behavior Survey ➤ Protective and risk factors targeted by each prevention program
Program Descriptions	Annually on 6/30	➤ Logic models for each program in the Arizona Logic Model format (see page 20) ➤ Description of how cultural competency has been addressed for each program. ➤ The target population of each program ➤ A paragraph describing the program plan for engaging the target population ➤ The name of the core evaluation instrument used or a copy of any alternative evaluation instrument
Process evaluation	Annually on 8/31	➤ Number of recurring, single service, and completed participants served by age, ethnicity, and gender ➤ Evaluation of program quality ➤ Referrals to treatment and other community-based services.
Workforce Development	Annually on 8/31	➤ Number of prevention staff ➤ Number of prevention staff who have completed beginning, advanced, and administrative training requirements ➤ Training workshops offered by the T/RBHA for prevention staff ➤ How the annual cultural competency training requirement has been met. ➤ Verification that professional supervision has been provided to each staff person
Program methodology	Annually on 8/31	➤ Amount of ADHS funds spent in each strategy area per program ➤ Protective and risk factors targeted by each program ➤ The strategies used by each program ➤ Name of curricula used
Evaluation Plan	Annually on 8/31	➤ 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, and outcome, and impact portions of the evaluation ➤ Data sources, collection procedures, and reporting processes
Outcomes	Annually on 8/31	➤ Summary and analysis of outcome data for each ***program.*** ➤ Describe outcomes related to diverse populations.

Table 14: Summary of Prevention Requirements for TRBHAs and Tribal Contractors

Type Requirement	TRBHA Requirement	Tribal Contractor Requirement	Minimum Standard
Program Administration	X	X	Designate a prevention program coordinator Attend at minimum two prevention coordinator meetings annually
Safety	X	X	Ensure the health, safety, or welfare of prevention participants. ➤ Minimum Class 2 fingerprint clearance for staff working with children ➤ At least one staff person with CPR or first aid certification on premises when participants are present ➤ Prohibit the use and possession of alcoholic beverages, controlled substances, and firearms on facility premises, during hours of operation, or in any motor vehicle used for transportation of program participants ➤ Minimum insurance outlined in the provider manual ➤ Report suspected abuse or neglect
Cultural Competence Standards	X	X	➤ Assess the community's cultural preferences for inclusion in program development, goals, and strategies ➤ Involve the community in the design, implementation, and evaluation, of the program ➤ Recruit, retain, and promote culturally competent, diverse staff representative of the targeted community ➤ Provide resources in the primary language of the community
Subcontractors	X	Not applicable	Written contracts with subcontractors used to provide prevention
Monitoring	X	X	➤ Participate in an annual DHS site visit and others as requested
Needs and Resource Assessment	Summary is due once every 3 years on 8/31	Not applicable	➤ Perceived needs and behavioral health trends ➤ Existing resources ➤ Protective and risk factors targeted by each prevention program
Program Descriptions	Due annually on 6/30	Due annually on 6/30	➤ Logic models for each program in the Arizona Logic Model format ➤ A description of how cultural competency is addressed in each program ➤ The target population of each program ➤ A description of the plan for engaging the target population ➤ The name of the core evaluation instrument used or a of an alternative evaluation instrument
Process Evaluation	Due annually on 8/31	Due Quarterly: ➤ July 15 ➤ October 15 ➤ January 15 ➤ May 15	➤ Number of recurring, single service, and completed participants by age, ethnicity, and gender ➤ Evaluation of program quality ➤ Number of referrals to treatment and other community-based services.
Workforce Development	Due annually on 8/31	Not applicable	➤ Number of prevention staff ➤ Number of prevention staff who have completed beginning training requirements ➤ Description of how the cultural competency training requirement has been met ➤ Training workshops attended by prevention staff
Program methodology	Due annually on 8/31	Due annually on 8/31	➤ Amount of ADHS funds spent in each strategy area per program ➤ Protective and risk factors targeted by each program ➤ The strategies used by each program ➤ Names of all curricula used
Outcomes	Due annually on 8/31	Due annually on 8/31	➤ Summary and analysis of outcome data for each ***program***

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Other State Prevention Systems

GOVERNOR'S DIVISION FOR SUBSTANCE ABUSE POLICY

Safe and Drug Free Schools and Communities
This program supports competitively funded after school and community based programs to prevent alcohol and other drug use, as well as youth violence.

Parents Commission on Drug Education and Prevention
The Parents Commission funds Parenting Programs to Prevent Youth Drug Abuse, Court-based programs, Youth Educating Parents, Drug-Free Workplace Parent Programs, School Based Parenting Initiative, Character Education, Assessment and Capacity Building.

State Incentive Grant
The purpose of the State Incentive Grant (SIG) is to provide evidence based prevention programs to youth.

GOVERNOR'S DIVISION FOR CHILDREN

Juvenile Accountability Incentive Block Grant
The Juvenile Accountability Incentive Block Grant (JAIBG) encourages the development of juvenile justice policies, procedures, and programs that promote juvenile accountability for criminal behavior.

Juvenile Justice Programs (Title II and V and Challenge)
This program supports delinquency and early intervention programs.

DEPARTMENT OF HEALTH SERVICES

Office of Injury and Disability Prevention
This program provides rape prevention education to students, professionals, and community members.

Tobacco Education and Prevention Program (TEPP)
Program services include print media; onsite training and technical assistance, face-to-face community outreach, and the Internet to reach the citizens of Arizona.

ARIZONA DEPARTMENT OF EDUCATION

Safe and Drug Free Schools and Communities
This program reduces violence and drug, alcohol, and tobacco use through prevention education in schools.

The Chemical Abuse Prevention Program
The Chemical Abuse Prevention Program reduces violence and drug, alcohol, and tobacco use through prevention education in schools.

The HIV/AIDS Prevention Program
The HIV/AIDS Prevention Program is funded by a grant from the Centers for Disease Control (CDC) to increase HIV/AIDS awareness and prevention education in schools.

School Safety Program
This is a state funded program that places probation officers/school resource officers in schools, provides law-related education to students and encourages positive interaction between students, staff and law-enforcement officers.

School Based Parenting Initiative
This initiative utilizes effective practice program curricula for parent education of substance abuse.

DEPARTMENT OF ECONOMIC SECURITY

The Healthy Families Arizona
The Healthy Families Arizona program is a proven approach to helping over-burdened new parents get off to a good start with their new babies.

Arizona Promoting Safe and Stable Families (PSSF)
These programs focus on improving parenting abilities, promoting safety of all family members, and creating stable, nurturing home environments.

Regional Child Abuse Prevention Councils
The Councils increase public awareness of the problem of child abuse and neglect through educational campaigns and advocacy for effective programs and policies.

Guidelines for Developing Evidence Based Prevention Programs

This appendix is a quick guide for developing evidence based, innovative prevention programs. Elements detailed in the checklists are not program requirements, but recommendations for more success based on the research informing evidence based practice. The Regional Behavioral Health Authorities determine on a program-by-program basis how these guidelines will be applied. For more detail regarding elements of evidence based practice in prevention refer to chapter 3. Since effective programs employ more than one of the strategies described in the following pages, please note that each page, which describes evidence, based elements of those strategies, is insufficient if used alone.

OVERALL PROGRAM DESIGN

Program planning

- ☐ A community needs and resource assessment has been completed
- ☐ Protective and risk factors targeted for change, audience, and strategies are selected based on a community needs and resource assessment and research evidence
- ☐ Goals and objectives are clearly written
- ☐ Program objectives target risk or protective factors
- ☐ Program objectives are relevant to the age, gender, culture, and developmental stage of participants
- ☐ Includes input from community members and/or the targeted population

Participant engagement

- ☐ Childcare is available as needed
- ☐ Transportation to the program site is available to participants
- ☐ Meals and nutritious snacks are provided
- ☐ Frequent, positive communication between program staff and participants takes place
- ☐ Tangible incentives are used to recognize accomplishments such as program completion
- ☐ Fun, social recreational activities are provided
- ☐ Home visitation (only to be used for family support and education programs for parents with young children and only with justification <u>and</u> RBHA approval)

Culturally based

- ☐ The program accommodates the language skills of participants
- ☐ Bicultural/bilingual staff members are hired for programs in which participants have limited English proficiency
- ☐ The program is offered in the preferred language of participants
- ☐ Staff members receive training in cultural competency and the culture of the community/ target population
- ☐ Program components are adapted to be consistent with and respectful of the cultural beliefs and practices of the target audience
- ☐ Program implementation is consistent with the cultural beliefs and practices of the target audience
- ☐ Conforms to CLAS standards 4-7 (see page 44)

Comprehensive

- ☐ The program uses two or more DBHS prevention strategies
- ☐ The program serves people in more than one domain (for example: families and individuals)
- ☐ The program is integrated into other community prevention efforts

Program site/facility

- ☐ Adequate space is provided
- ☐ The setting is inviting
- ☐ Noise level is low
- ☐ Program setting is sanitary

TRAINING & COMMUNITY EDUCATION

Service definition

Training Training provided to behavioral health professionals, school staff, volunteers, medical professionals, care home staff, and others to enhance knowledge or skills related to working with youth, families, aging populations, or communities.

Community Education One time workshops that assist individuals or community groups in developing or improving critical life skills such as decision making, coping with stress, values awareness, problem solving, conflict resolution, and/or resistance skills.

Targeted populations

Gatekeepers
Gatekeepers are people who have contact with an at risk population. For example parents, volunteers, sports coaches, and staff of businesses catering to the targeted population.

Professionals
Professionals are people who work with a targeted population. For example teachers, physicians, and geriatric care home staff.

Examples of training topics

Gatekeepers

- ☐ Suicide awareness
- ☐ Behavioral health problem identification and referral
- ☐ Community resources
- ☐ Cultural competency

Professionals

- ☐ Behavior/classroom management
- ☐ Problem identification and referral
- ☐ Conflict resolution
- ☐ High expectations
- ☐ Cultural competency
- ☐ Cooperative learning techniques

Examples of community education topics

Skills for youth

- ☐ Normative education
- ☐ Perceived harm of engaging in problem behavior
- ☐ Media literacy
- ☐ Emotions
- ☐ Critical thinking

Skills for persons of all ages

- ☐ Goal setting skills
- ☐ Decision making
- ☐ Problem solving
- ☐ Conflict resolution
- ☐ Social skills
- ☐ Stress management
- ☐ Reframing techniques
- ☐ Communication

Suggested teaching methods

The program uses multiple methods and learning styles to convey educational messages to participants. Program delivery uses two or more of the following:

- ☐ Group discussion
- ☐ Homework (take home activities)
- ☐ Humor
- ☐ Interactive, hand on activities
- ☐ Modeling behavior
- ☐ Role play
- ☐ Practice opportunities
- ☐ Prompting
- ☐ Workbooks
- ☐ Video taped vignettes

Curriculum materials, discussion, handouts, and activities

- ☐ Has a written manual describing the contents of each educational session, such that services could be replicated
- ☐ Training is provided in the preferred language of participants
- ☐ Training is relevant to the culture and developmental stage of the target population
- ☐ Uses examples and/or illustrations that are congruent with participant culture
- ☐ Training addresses multiple learning styles
- ☐ The training builds upon participant strengths

Note
The community education strategy must be used in combination with other strategies. It may not be used in isolation.

PUBLIC INFORMATION AND SOCIAL MARKETING

Service definition

Presentation of accurate messages and promotional material on substance abuse, suicide, child rearing, care giving and other behavioral health issues. May include health fairs, development and distribution of electronic or print media, public service announcements and other related methods.

Selection of a target population

- ☐ Selected based on a needs assessment
- ☐ Should be defined specifically
- ☐ Targeted participants are receptive to change

The message

- ☐ Targeted to a specific, clearly defined audience
- ☐ Comes from a source considered reliable by participants
- ☐ Consistent with experience of the target audience

Steps for development and implementation of a social marketing project

1. Develop clear specific objectives regarding changed in knowledge, attitudes, or behaviors
2. Define the target audience clearly. For example: Caretakers of disabled seniors, families of Native American adolescent males
3. Gather data regarding target audience knowledge, awareness, attitudes, behaviors, and readiness to change related to the program issue. Some ways to gather data include: focus groups, interviews, public forums, etc..
4. Select a media for delivery of the message, i.e. TV, radio, newspaper, church bulletins, movie theater ads, displays, bill stuffers, internet, yellow pages, sports arenas, bars, salons, brochures, billboards, newsletters, etc...
5. Create a message
    - Consider the desired tone – friendly, humorous, serious, etc...
    - Memorable sayings
    - What prompts will people need regarding behavior to change (what do they need to do when)?
    - How does the desired behavior fit with people's lives?
    - Message is consistent with experience of the target audience.
    - How is the cost of engaging in the behavior worthwhile?
    - How will engaging in the behavior result in positive consequences?
    - Simplify the message
6. Evaluate how well project goals and objectives were met

PEER LEADERSHIP

Service Definition

A variety of activities designed to reinforce leadership capabilities, skills development involving the pairing of trained and supervised peers of any age with others, peer facilitation of education workshops, service learning.

Examples of target populations

- ☐ Adolescents
- ☐ Parents
- ☐ Older adults

Examples of activities engaged in by peer leaders

- ☐ Education - facilitation of educational content
- ☐ Support – facilitation of formal support groups or informal peer counseling and support
- ☐ Tutoring of younger peers
- ☐ Planning social and recreational activities for peers
- ☐ Service learning/community service projects
- ☐ Mentoring other peers
- ☐ Grant writing
- ☐ Community needs and resource assessment/ formative evaluation
- ☐ Advocacy

Examples of training for peer leaders

- ☐ Problem identification and referral
- ☐ Community resources
- ☐ Group facilitation
- ☐ Public speaking
- ☐ Helping skills
- ☐ Grant writing
- ☐ Community resources

Program duration

- ☐ Participants remain involved with the program for longer than one year

FAMILY SUPPORT AND EDUCATION

Service definition

Ongoing, sequential, educational sessions targeted to parents, family members and/or caretakers of children, persons with disabilities, or seniors.

Examples of target populations

- ☐ Families with low birth weight babies
- ☐ Low income families
- ☐ Single parent families
- ☐ Adolescent parents
- ☐ New parents
- ☐ Families of persons with chronic illness or disability

Service provision

Services are provided in a setting comfortable to the family on average once weekly.

Examples of topics of education

A comprehensive family support and education program provides education in as many of the topics below as possible.

- ☐ Discipline (praise, non violent methods, setting limits, consistency) for parents and caretakers of children of all ages
- ☐ Supervision skills (establishing curfews, ensuring adult supervision of activities outside of the home, knowing child's friends, enforcing household rules; etc..)
- ☐ How to play with a child
- ☐ Problem solving
- ☐ Stimulation and education of children
- ☐ Stress management
- ☐ Conflict resolution
- ☐ Encouraging and supporting child autonomy
- ☐ Community resources
- ☐ Parent child bonding activities

Sample instructional methods

The program uses multiple methods to convey educational messages to participants including two or more of the following

- ☐ Group discussion
- ☐ Homework (take home activities)
- ☐ Humor
- ☐ Interactive, hands on activities
- ☐ Modeling behavior
- ☐ Role play
- ☐ Practice opportunities
- ☐ Prompting
- ☐ Workbooks
- ☐ Video taped vignettes

Curriculum materials, discussion, handouts, and activities

- ☐ A written manual describes each educational session, such that services may be replicated.
- ☐ Services are provided in the preferred language of participants.
- ☐ Materials are relevant to the developmental stage of the target population.
- ☐ Use examples and/or illustrations that are congruent with participant culture.
- ☐ Builds upon participant strengths.

Suggested program duration

- ☐ Behavior change is more likely when the education takes place for a minimum of 16 hours. The program has a longer duration for higher risk populations. Maximum benefit is achieved the longer participants are involved in the program.
- ☐ Booster sessions are offered.
- ☐ Participants remain involved with the program for longer than one year.

Note
Prevention services are provided *only* to persons and families that do not have a behavioral health problem and do not require treatment. Families and individuals with a behavioral health problem must be referred to treatment services.

PERSONAL AND CULTURAL DEVELOPMENT

Service Definition

Activities that provide challenging and positive growth experiences and opportunities to practice skills learned in a natural environment. Includes cultural ceremonies, art, camping, ropes courses, team building activities, etc. ...

Target populations

This strategy is appropriate for all populations. Participants should be grouped heterogeneously (mixed abilities, mixed risk levels).

Administrative elements

- ☐ Activities are supervised by staff
- ☐ Activities are structured and well organized
- ☐ The setting is physically and emotionally safe
- ☐ Community and families are actively involved in the program
- ☐ Snacks or meals are provided as appropriate
- ☐ Transportation is provided
- ☐ Clear rules and responsibilities are established
- ☐ Activities center around a common theme
- ☐ Activities have quality instruction and content
- ☐ Academic and life skills instruction are embedded into activities
- ☐ More emphasis on cooperation and collaboration than competition
- ☐ Age appropriate challenges are provided
- ☐ Activities are lead by multiple instructors
- ☐ Activities are challenging and diverse enough to interest all participants and meet all learning styles
- ☐ Participants have opportunities for individualized and self directed learning
- ☐ Provide opportunities for participant self-reflection, evaluation and relationship building
- ☐ Participants receive constructive feedback about what was done well, how they can improve their performance in the future, and recognition for success
- ☐ Program activities recognize and build on participant strengths and talents

Role of participants

- ☐ Peers are used to lead at least some activities
- ☐ Participants have a leadership role in developing and selecting activities

Staff qualities

- ☐ Staff members are passionate about their work and develop caring relationships with participants
- ☐ Staff members have high expectations for participant ability and success

Examples of activities

- ☐ Games (cooperative)
- ☐ Cultural celebrations and traditional ceremonies
- ☐ Promotion of cultural identity and pride
- ☐ Gardening
- ☐ Camping and other outdoors/ nature activities
- ☐ Ropes courses
- ☐ Team building activities
- ☐ The arts
  - Visual arts
  - Music
  - Drama
  - Storytelling
  - Creative writing
  - Dance

Notes

This strategy was formerly called "Alternative Activities". No program should rely on this strategy exclusively. It is ineffective when used alone. This strategy must always be used in combination with other strategies. It is used to supplement other strategies and is an effective recruiting and retention tool.

LIFE SKILLS DEVELOPMENT

Service Definition

:

On going, long term educational activities that develop or improve life skills such as decision making, coping with stress, problem solving, conflict resolution, and/or resistance skills.

Target Population Information

This strategy is appropriate for all populations. Families need to be actively involved as much as possible. Involvement of parents does not need to be face to face, but may be achieved through homework, newsletters, and other materials.

Examples of Educational Topics

Skills for youth

- ☐ Normative education
- ☐ Perceived harm of engaging in problem behavior
- ☐ Self efficacy
- ☐ Empathy
- ☐ Media literacy
- ☐ Emotions
- ☐ Critical thinking

Skills for persons of all ages

- ☐ Resistance skills
- ☐ Goal setting skills
- ☐ Decision making
- ☐ Problem solving
- ☐ Conflict resolution
- ☐ Social skills
- ☐ Stress management
- ☐ Reframing techniques
- ☐ Communication
- ☐ Impulse control
- ☐ Nutrition

Methodological Suggestions

The program uses multiple methods to convey educational messages to participants including two or more of the following

- ☐ Group discussion
- ☐ Homework (take home activities)
- ☐ Humor
- ☐ Interactive, hands on activities
- ☐ Modeling behavior
- ☐ Role play
- ☐ Practice opportunities
- ☐ Prompting
- ☐ Workbooks
- ☐ Parent involvement via homework or newsletters or other means
- ☐ Video taped vignettes

Curriculum materials, discussion, handouts, and activities

- ☐ Has a written manual describing the contents of each educational session, such that services could be replicated
- ☐ Provided in the preferred language of participants
- ☐ Relevant to the developmental stage of the target population
- ☐ Use examples and/or illustrations that are congruent with participant culture

Program duration

- ☐ The initial education takes place over a minimum of 16 hours
- ☐ Booster sessions are offered
- ☐ The program has a longer duration for higher risk populations
- ☐ Participants remain involved with the program for longer than one year

Note

Youth should not be pulled out of class during the school day to participate in life skills programs

COMMUNITY DEVELOPMENT

Service Definition

Community development is the facilitation of a grassroots movement to address community protective and risk factors related to behavioral health. Includes establishment and maintenance of collaborative relationships with key stakeholders. Community development also includes active involvement in coalitions/ community groups, which explore ways to enact policies that will create environmental change. Activities target entire populations.

Coalition/ Collaboration Member Qualities

- ☐ Establishment of key partnerships with people who care about issues addressed
- ☐ Diverse coalition membership
- ☐ The coalition has strong leadership
- ☐ The coalition resolves conflicts successfully
- ☐ Coalition members should be committed to the coalition vision
- ☐ Recognition of community members and organizations for their contributions
- ☐ Frequent, positive communication between coalition members
- ☐ Consensus decision making
- ☐ Respect for diversity
- ☐ Frequent communication between coalition members
- ☐ Build relationships between coalition members
- ☐ 8 to 15 core members
- ☐ 50 or more volunteers

Examples of Coalition/ Collaboration Documents

- ☐ A written needs and resource assessment summary
- ☐ A written vision
- ☐ Written, clear goals and objectives
- ☐ Written strategic and operational plans for community prevention efforts
- ☐ A public information/ social marketing document produced annually regarding progress toward positive change in protective and risk factors or other community issues

Examples of Training for Coalition Members

- ☐ Conflict resolution
- ☐ Consensus building
- ☐ Collaborative decision making
- ☐ Facilitation skills

Examples of Targeted Environmental Changes

- ☐ Clarify community, school, or work policies regarding target issues
- ☐ Enforce or change laws related to target issues such as:
  - o Restriction of access to alcohol, tobacco, drugs, suicide means or other items.
  - o Minimum-purchase age.
  - o "Use and lose" laws (e.g., driver's license privileges)
  - o Ban or limit on pitcher sales.
  - o Limit on the amount of alcohol a single drink can contain.
  - o Stronger social host liability (holding adults responsible for parties that occur on their properties)
  - o Beer keg registration.
  - o Limited hours of sale.
  - o Increased taxation/price of alcohol, tobacco or other products.
  - o Allowing retailers to confiscate fraudulent IDs.
  - o Use of scannable IDs
- ☐ Restriction of access to alcohol, tobacco, drugs, or suicide means
- ☐ Improved access to treatment
- ☐ Increased community participation in prevention activities
- ☐ Advocacy for increased school based prevention programs
- ☐ Place obstacles in the way of risky behavior
- ☐ Remove obstacles to healthy behavior
- ☐ Raise the social and economic costs of risky behavior
- ☐ Lower the social and economic costs of healthy behavior

Six Phases of Community Development

1. *Early/ Initiating*
2. *Readiness*
3. *Assessment*
4. *Planning*
5. *Implementation*
6. *Sustaining/ Reinforcing/ Replanning*

MENTORSHIP

Service definition

Activities in which positive role models provide support and guidance to assist individuals in achieving personal growth.

Examples of mentoring relationships

- ☐ Traditional mentoring (1 adult -1 youth)
- ☐ Team mentoring (several adults work with small groups of youths)
- ☐ Group mentoring (1 adult to 2 -4 youths)
- ☐ Peer mentoring (older youth mentoring younger youth)

Recruiting, screening, and matching

- ☐ Mentors have a written job description
- ☐ Communicate program benefits
- ☐ Use a variety of marketing strategies.
- ☐ Written application is required
- ☐ Reference checks are conducted
- ☐ Check for police records
- ☐ Matches are based on common interests
- ☐ Consultation with those who know the youth to make the most suitable match
- ☐ Mentors and mentees have the opportunity to self-match through a group activity in which many potential mentors and mentees interact
- ☐ All parties should understand and agree to the of program terms and conditions
- ☐ Face to face interviews with mentor, mentee and parent or guardian
- ☐ Selection considerations: availability, reliability, caring, maturity, expectations of the relationship, flexibility, openness, communication skills, problem solving skills, boundaries, willingness to seek support, and the ability to relate to young people

Training, orientation, and ongoing support tips

- ☐ 6 hours of individual or group formal training
- ☐ Training topics: Rules, roles, and responsibilities; child development; communication skills; limit setting skills; relationship building; program overview; how to handle a various situations.
- ☐ A closing meeting should be held between the mentor and mentee when the relationship ends.
- ☐ Clarification of post mentoring contact policies and procedures.
- ☐ Offer continuous training
- ☐ Regular communication with participants, mentors and families
- ☐ Bring mentors together to share ideas and support

Examples of shared activities

- ☐Tutoring
- ☐Frequent phone contact between mentor, mentee and caregiver
- ☐Youth input in selection of activities
- ☐Provide occasional group activities
- ☐Reading and discussion
- ☐Hobbies, art, and sports
- ☐Recreational activities
- ☐Visiting local tourist attractions
- ☐Volunteering together

Program Duration (Dose)

- ☐ No less than 3 months with the ideal relationship taking place over 2 years or longer
- ☐ 3 contacts per month with each lasting 4 hours.
- ☐ 4-20 hours per month for group mentoring

Note
Mentoring activities should not interfere with school time.

Glossary

Accountability	Demonstrating a program achieves its targeted outcomes and uses resources effectively.
Activities	Individual events or processes that take place when a strategy is employed.
Adaptation	Changes made to a recognized best practice program such as: change in audience, setting, and/or intensity of program delivery ….in response to a local circumstance, need, or culture.
ADHS	Arizona Department of Health Services
AHCCCS	Arizona Health Care Cost Containment System
ARS	Arizona Revised Statutes. The laws of the State of Arizona.
ATOD	Alcohol, tobacco, and other drugs
Best practices	Strategies, activities and approaches that have been shown to be effective, through research and evaluation at preventing and/or or delaying substance abuse, violence, or other problem behaviors.
Capacity building	Developing organizational resources, infrastructure, support, and funding that will be needed for successful implementation of selected strategies, approaches and programs.
Child abuse prevention program	A prevention program, which targets at least three risk or protective factors for child abuse perpetration.
Children's behavioral health program	A program that provides children's behavioral health services and that is licensed by the department as a behavioral health service agency or that contracts with the department to provide children's behavioral health services (Arizona Revised Statutes).
Community development	The creation of conditions that promote the well being of an entire community.
Comprehensive prevention program	A prevention program, which is comprehensive, uses multiple strategies and targets multiple domains.
Core evaluation instruments	An evaluation instrument named on page 53.
CSAP	Center for Substance Abuse Preventio n
Cultural competence	A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals which enables that system, agency or those professionals to work effectively in cross cultural situations.
Cultural group	People who share values, norms, symbols, and ways of living that are repeated from one generation to another.
Culturally based	Developed in collaboration with or by the targeted population for the targeted population.
Culturally relevant	A prevention program, message, or strategy that is meaningful to the target population.
Culture	The shared values, norms, traditions, customs, arts, history, folklore, music, religion, and institutions of a group of people.
Curriculum	A written document which details the workshops, lessons, and/or presentations used in life skills education, parent education, community education, and/or training services.
DBHS	Division of Behavioral Health Services. A Division of the Arizona Department of Health Services.
DBHS prevention network	Providers and programs that receive funds from DBHS via the Regional Behavioral Health Authority.
Diversity	A condition in which members of a community have differences in race, ethnicity, language, gender, sexual orientation, or religion.
Domain	Contexts in which people interact. For example school, peer, family, and community.
Evaluation	Collection and use of program information for monitoring, program improvement, outcome assessment, planning, and policy-making.
Evidence Based	Programs or practices which have several of the characteristics listed below: replication, sustained effects, published in a peer reviewed journal, a control group study, cost benefit analysis, adequately prepared and trained staff, appropriate supervision, include assessment and quality assurance processes, consumer and family involvement, cultural, gender, and age appropriateness, and coordination of care.

Goal A broad statement describing the desired impact or outcome of a specific program.

Impact Long-term, overall effects of a program or intervention such as changes in behaviors or conditions.

Implementation plan A planning tool for prevention programs that lists tasks to be accomplished, parties responsible for ensuring tasks are accomplished, and anticipated dates of completion.

Indicated Prevention efforts targeting a population that is just beginning to engage in a problem behavior.

Innovative program A prevention program developed by a provider and grounded in prevention theory, research, and target population culture.

Key informant A person with the background, knowledge, or skills needed to contribute information relevant to a community needs assessment.

Linguistic competence The capacity of an organization and its personnel to effectively communicate with persons of limited English proficiency, those who are illiterate or have low literacy skills and individuals with disabilities,. This may include, but is not limited to, bilingual/bicultural staff and other organizational capacity such as telecommunication systems, sign or foreign language interpretation services, alternative formats, and translation of legally binding documents (e.g. consent forms, confidentiality and patient rights statements, release of information, member handbooks, and health education materials.

Logic model A chart that shows how the logical connections between the problems and/or needs relate to the actions taken to achieve the goals.

Long term program A prevention program, which takes place over multiple years and includes at least 16 hours of education.

May Indicates something that is not mandatory, but permissible. Same as should.

Monitoring Tracking services and structures that a program is accountable for accomplishing and/or maintaining to ensure that the program is being implemented as planned.

Must Indicates a mandatory requirement.

Needs and resource assessment Gathering information about current conditions within a community that underlie the need for preventative interventions. Researching the existing structures, programs, and other activities potentially available to assist in addressing identified needs.

Normative education Information regarding the actual numbers of persons who use substances and acceptability of use.

Objectives Measurable statements of the anticipated change in risk or protective factors.

Older adult A person who is age 55 or older.

Outcome The immediate desired change in attitudes, values, behaviors, or conditions. Stated in the following format: "By a specified date, there will be a change (increase or decrease) in the target behavior, among the target population."

Practice An activity or approaches that may be used in combination with other activities or approaches to constitute the intervention.

Pre-post test Evaluation instruments that assess change by comparing the baseline measurement taken before a program begins to measurements taken after a program has ended.

Prevention 1) The creation of conditions, opportunities, and experiences that encourage and develop healthy, self sufficient children and that occur before the onset of problems (Arizona Revised Statutes).

2) Prevention is an active process that creates and rewards conditions that lead to healthy behaviors and life styles (CSAP).

Primary prevention Strategies designed to decrease the number of new cases of a disorder or illness.

Process evaluation Assessment of activities implemented, quality of implementation, participant demographics, quality of participation, dosage, resources, staffing, and other factors. A process evaluation describes the inputs to program delivery, documents what programs actually do, and describes how implementation effectiveness is determined.

Program A set of prevention strategies, which address a common set of goals and objectives for a common target audience in one county.

Promising strategies — Programs, strategies or approaches that have been shown to produce intended, positive results and have met some but not all of the criteria needed in order to be considered a best practice program.

Protective factor — An attribute, situation, condition, or environmental context that develops resiliency in individuals and prevents the likelihood of ATOD use.

Provider — An organization that provides prevention services directly.

RBHA — Regional Behavioral Health Authority.

Recurring program participant — A person who is part of an ongoing prevention effort, whether that is a parenting class, a neighborhood coalition or a life skills group, etc.

Research based — Prevention strategies and/or practices, which have a strong theoretical design, have been evaluated and demonstrated effectiveness.

Resilience — The personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, and other stresses and to go on with life with a sense of mastery, competence, and hope (New Freedom Commission on Mental Health, 2003).

Risk and protective factor theory — A theory of how substance abuse occurs, and is prevented. Risk factors increase the chances a person will abuse substances or engage in other unhealthy behaviors. Protective factors reduce the chances that a person will abuse substances or engage in other unhealthy behaviors.

Risk factor — An attribute, situation, condition, or environmental context that increases the likelihood of ATOD use or abuse or other behavioral health problems.

SAMHSA — Substance Abuse and Mental Health Services Administration

Science-based — Strategies that are proven through research and evaluation to prevent the onset of behavioral health problems. Same as research based.

Secondary prevention — Prevention strategies designed to lower the rate of established cases of a disorder or illness in the population.

Selective — Prevention efforts targeting individuals whose risk of developing ATOD problems or engaging in other problem behaviors is higher than average.

Shall — Indicates a mandatory requirement.

Should — Indicates that something is recommended, but not mandatory. Same as may.

Single program participant — Someone just "passing through," at a health fair or who once or twice attends a community meeting, etc.

Social indicator — Measures of the prevalence of protective and risk factors and social problems based on archival data from records collected and kept by agencies.

Stakeholder — An individual or organization with interest or investment in a project and/or its evaluation.

Strategies — Specific, research-based approaches for achieving project objectives.

Substance abuse prevention program — A prevention program, which targets at least three risk or protective factors for substance abuse.

Suicide Prevention Program — A prevention program, which targets at least three risk or protective factors for depression or suicide.

Workforce Development — Occupational and Vocational Training; Job Development; Job Placement and Supportive and Follow Up Services for the unemployed, under employed and disadvantaged populations. Includes activities that-improve and increase prevention specialist's knowledge of prevention.

Target population — The group of individuals for whom a prevention program is designed and intended to have an impact.

Tertiary prevention — Strategies designed to decrease the amount of disability associated with an existing disorder or illness.

TRBHA — Tribal Regional Behavioral Health Authority.

Tribal contractor — A Tribe, which provides direct behavioral health, services such as prevention via an Intergovernmental Agreement (IGA) with DBHS.

Universal — Prevention efforts targeted to a population that has not been identified on the basis of individual risk.

"Leadership for a Healthy Arizona."

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