DBHR Prevention Redesign

Key Objectives

August 17, 2010

The following Division of Behavioral Health and Recovery (DBHR) Prevention Redesign objectives are identified as primarily a "community" or "state" related responsibility. The bullets under each objective outline the minimal standard to participate in Cohort 1 of the Prevention Redesign Initiative (PRI). The benchmark under each objective is the recommended as ideal in the PRI as we move forward. It is recognized that many communities will not be able to meet all the benchmarks for all objectives immediately due to financial limitations. Key themes received (highlighted below) are general comments received by DBHR during PRI planning sessions in the fall of 2009.

1. Establishment of a community coalition (community)

    - Specific substance abuse prevention focus
    - Minimum: Eight out of 12 Drug-Free Community sectors represented, including a chemical dependency treatment provider. Sectors include; law enforcement, religious/fraternal organizations, civic/volunteer groups, healthcare professionals, state/local/tribal government, substance abuse organizations, youth under the age of 18, parents, businesses, media, schools, and youth-serving organizations.
    - *Benchmark:* All 12 sectors must be represented with different people for each sector, and will include chemical dependency treatment, mental health and primary health care providers.

    Key Themes Received

    - Challenging for some communities to identify and engage all of the sectors required by the Drug-Free Community Grant application.

- Training needed to support coalition development.
- Need clear roles for coalition membership and leadership.
- Encourage broad representation and participation.

2. Identification of a community coordinator (community)

- Coordinator must be identified for each community selected
- Minimum .5 FTE community coordinator
- *Benchmark:* 1.0 FTE community coordinator

Key Themes Received

- Need to allow for leveraged funds to support coordinator position.
- Resources not adequate to support 1.0 FTE for each community.
- Job descriptions need to be clear and reasonable.

3. Define and select communities (community)

- Communities must be described in geographic terms or at-risk populations which can be described demographically.
- Communities must have baseline data describing the extent of the substance abuse problem that places their residents at risk for substance abuse issues. The identified communities must also have the ability to measure change in risk/protection as well as prevalence of substance abuse.
- Communities are not expected to be county-wide as they need to be small enough to measure community-wide change with limited resources. Examples include: towns, small cities, communities surrounding a rural school district or urban school building.
- Schools within the community will participate in the Washington State Health Youth Survey on a biennial basis.

- *Benchmark:* Community risk and protective factors, as well as substance abuse prevalence rates can be measured with existing databases; including Washington State Healthy Youth Survey, and archival data collected in the CORE GIS.

Key Themes Received

- Need to consider allowing for defined communities that are not geographic in nature.
- The defined community needs to have access to baseline and on-going measurements.
- May need to consider neighborhoods in large urban settings.
- Schools, law enforcement, and places of worship are all considered important elements of a community.
- Need to find ways of identifying traditionally underserved communities.

4. Implementation of environmental, public awareness, direct service, and capacity building strategies (community)

- Each community will have some level of capacity building, an environmental strategy, as well as a public awareness and direct service evidence-based approaches.
- *Benchmark:* Identified communities will invest in capacity building activities, a minimum of two environmental strategies per year, one public awareness campaign relating to a priority drug issue in their community and multiple direct service evidence-based approaches.

Key Themes Received

- Need a balance between community capacity building, environmental strategies and direct service work.

- Evidence-based Programs do not meet the needs of all populations.
- Need to leverage resources within the community in order to have a comprehensive plan – DBHR resources are limited.

5. School-based prevention specialist (community)

- A minimum of 1.0 FTE school-based Prevention/Intervention (P/I) specialist is employed in the identified community.
- Student assistance model develop by OSPI will be followed.
- P/I specialist will be actively involved in the community coalition.
- *Benchmark:* A minimum of 1.0 FTE P/I specialist is employed for every 1,000 middle and high school students in the identified community.

Key Themes Received

- DBHR funds do not need to pay for the entire FTE, leverage funds by local schools and the ESDs are critical. What is important is the FTE located in the defined community.
- It is important to have the ESDs supervise the assigned P/I specialists.
- P/I specialist need to be active members of the community coalitions.

6. Communities distributed statewide (community)

- Each county will identify a minimum of one community. Depending on the size of the county, more than one community is expected to be identified.
    - Counties under 195,000 people = 1 community
    - Counties between 195,000 and 700,000 people = 2 communities

    - Counties between 700,000 and 1,500,000 people = 3 communities
    - Counties over 1,500,000 people = 4 communities
- Counties/ESDs will be phased into the PRI in three cohorts. The first cohort will begin July 1, 2011. DBHR is targeting 12 counties and no more than 18 communities in Cohort 1.
- Those counties with expectations of three or more communities will only be expected to identify two communities if chosen as part of Cohort 1. If the county and ESD agree to identify all required communities in the first year, they will be supported by DBHR.
- *Benchmark:* All counties/ESDs will be actively participating by the beginning of FY2013.

Key Themes Received

- Flexibility is needed to continue some county-wide environmental and capacity building efforts.
- Need to leverage other state and local resources in defined communities.
- Important to reach as many communities as possible, and still maintain sufficient programming and policy work to realize community-level change.

7. Resources match outcomes (community/state)

- Performance-based contracts will be tied to community prevention planning and program implementation outputs.
- *Benchmark:* Performance-based contracts will be tied to community substance abuse outcomes.

Key Themes Received

- Limiting the number of communities funded by fully resourced comprehensive plans with DBHR funds is not necessary, leverage funds need to be counted on more.

8. DBHR technical assistance/support (state)

- Community coalition development
- Strategic planning, evaluation and reporting
- Social marketing/public awareness
- Substance abuse prevention/mental health promotion
- *Benchmark:* DBHR staff will have the technical expertise to support providers in their efforts to organize communities, develop strategic plans, select programs/practices/policy development work, and report/market their progress and incorporate mental health promotion strategies where appropriate.

Key Themes Received

- Access to community technical assistance was a key element in the SPF/SIG Project.

9. Evaluating program and community-level change (community)

- All programs will need to report into the Performance-Based Prevention System (PBPS); those serving individuals age 10 and older will report into the PBPS using assigned measures tied to their program/practice objectives.
- Environmental strategies will be reported in the PBPS.
- Community level change will be tracked using HYS and Core GIS Data.

- HYS will be implemented in all schools within the identified community.
- *Benchmark:* All program/practice/policy efforts supported by DBHR funds will be reported in the PBPS, which will generate real-time reports.

Key Themes Received

- Measuring progress and success is important.
- Not a lot of time spent on this objective to date with redesign stakeholders group.

10. Workforce development (community/state)

- Prevention certification offered in Washington State.
- Substance abuse prevention specialists training offered in Washington State.
- Annual Prevention Summit.
- Athena website for prevention professionals in Washington State.
- *Benchmark:* Direct-service providers are trained in the programs they are offering. Each agency receiving DBHR prevention funds will have at least one CPP on staff.

Key Themes Received

- Training and workforce development is important.
- Stakeholder group did not spend time discussing thoroughly

"What Works" (community/state)

- A minimum of 50% of programs/practices/policies must be evidence-based per the list maintained by the Center for the Application of Prevention Technologies (CAPT).
- Principles of prevention for all programs

- *Benchmark:* 75% of program groups of programs/practices/policies must be evidence-based, based on CAPT list, or a Washington State specific listing TBD.

Key Themes Received

- It is important to keep some flexibility for innovation and adaptation.
- Field needs to continue to follow research and principles being adopted nationally and learn from our work in Washington State.
- Stakeholder group did not spend time discussing thoroughly

11. Compliance with Synar (community/state)

- Communities will support Synar compliance activities locally.
- *Benchmark:* All counties will support their local health departments in Synar compliance activities such as; retail compliance checks and retailer education.

Key Themes Received

- If counties are expected to continue to support the local Synar work, they will need some flexibility to maintain for level of work at a county-wide level.

*Seek opportunities in Healthcare Reform (community/state)

- DBHR staff and providers will establish a workgroup, or use the Cohort 1 learning community to study potential collaborative opportunities between substance abuse prevention, mental health promotion, and primary health care.
- *Benchmark:* At least one co-developed/selected and co-funded substance abuse prevention/mental health promotion project in each community on an annual basis will be implemented.

*Healthcare reform was passed by congress since the PRI stakeholder workgroup met in the fall of 2009. It is essential that the PRI following the direction currently being formulated at the state and federal level.

Key Themes Received

- This is a new item and will be discussed at future meetings.