



PREVENTION FOR A HEALTHY ARKANSAS



12/31/2012

Strategic Plan for Five Years



This Strategic Plan was prepared with a grant from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention administered through Arkansas Department of Human Services, Division of Behavioral Health Services and approved by the Arkansas Alcohol and Drug Abuse Coordinating Council

Prevention for a Healthy Arkansas

STRATEGIC PLAN FOR FIVE YEARS

Arkansans will be drug-free and mentally healthy

The vision is very complex in its simplicity. It is rooted in a mission to:

- Educate citizens,
- Empower communities,
- Encourage collaboration, and
- Enhance prevention efforts through community mobilization to foster a healthy and positive environment.

In order to reach such a broad vision, it is imperative that a collaborative effort be undertaken by state agencies and communities alike in order to improve the lives of our fellow citizens in Arkansas. Certain core values are inherent in that effort. These include:

- Every person matters.
- Families matter.
- Empowered people help themselves.

The Division of Behavioral Health Services provides leadership and devotes resources to facilitate:

- Effective prevention;
- Quality treatment; and
- Meaningful Recovery

Introduction

In September 2011, the Arkansas Department of Human Services, Division of Behavioral Health Services received a Strategic Prevention Enhancement grant and set out to develop just such a collaborative effort. A meeting was held at the C.H. Vines 4-H Center in Ferndale Arkansas with representatives of professional associations, state agencies, community organizations, and special services agencies.

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), FY2011 Strategic Prevention Framework State Prevention Enhancement grant (SPE grant) is designed to strengthen and extend SAMHSA's national implementation of the Strategic Prevention Framework (SPF), support states in strengthening and enhancing their current prevention infrastructure and to foster more responsive and interactive state prevention systems. The SPE grant is intended to support states and territories in building prevention capacities and enhancing prevention efforts by aligning the prevention infrastructure through the myriad State agencies offering prevention programs or providing direct prevention services and collaborating with other prevention stakeholders in the state to reduce the effect of substance abuse.

The Arkansas Department of Human Services (DHS), Division of Behavioral Health Services (DBHS) Prevention Section is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse service in Arkansas. The Arkansas DBHS understands that substance abuse exists within the context of a larger environment and must be addressed by a collaborative effort across multiple agencies and sections; hence it is currently in the process of integrating the services of its main four sections - Prevention, Treatment, Recovery and Mental Health - for a more comprehensive behavioral health service.

The Arkansas Strategic Prevention Framework State Prevention Enhancement Grant (SPF SPE) project will enhance the state prevention infrastructure by bringing together State agency policy makers, health care providers, and public health personnel to be trained on the use of the Strategic Prevention Framework (SPF) planning process for planning future efforts. The plan will also strengthen and support the efforts of behavioral health providers, key stakeholders, and regional and community-level prevention coalitions.

Along with the goals and objectives of the strategic plan, this document includes some basic prevention theory and knowledge, a list of recommended evidence-based programs and strategies, and information about available data used for making effective decisions for community based work preventing substance abuse while promoting mental health. A description of the process used in development of the plan is also included.

The Strategic Prevention Framework process was followed to guide discussions and develop this plan. The process was also presented to various organizations and agencies throughout the state. A further discussion of the process can be found on page 21.

The plan is arranged to show the overarching goals of reducing alcohol use, prescription drug use, and suicide along with tobacco use. These goals also address enhancing collaboration among state agencies and community sectors while improving and increasing the prevention workforce.

A goal of this project is to align the State prevention infrastructure through State agencies, health care, and public health, which will be measured by future projects utilizing braided funding and joint efforts. A diverse workforce made up of health care professionals, public health professionals, and State agencies that are trained in the SPF and utilizes prevention practices within its scope of work will be a measure of this project. Another goal is to identify prevention data funded by the State and to data systems together so that communities will have easy access to prevention data for planning prevention activities.

In order to accomplish these goals, specific objectives and strategies which address underlying steps have been arranged according to the Strategic Prevention Framework process. For example, strategies for collecting data are listed under the first SPF step of assessment and the strategies tie to Goal of assessment. Strategies for the goals of collaboration and workforce development are listed under the SPF step for capacity building. Many of the objectives and strategies are cross-cutting and serve as conduits to establish skills and abilities to address the overarching goals in a broad sense.

The DBHS Prevention Section has developed this five- year strategic prevention enhancement plan to strengthen the behavioral health infrastructure and to enhance the health and safety of Arkansas citizens through the reduction of the overall impact of behavioral health problems.

The plan reflects year-long efforts by five workgroups formed from that initial meeting; four Capacity Building/Infrastructure Enhancement workgroups and an Evidence-based practices workgroup were developed to address the issues of:

- Training and Technical Service,
- Coordinated Services,
- Data Collection, and
- Evaluation

The Arkansas Alcohol and Drug Abuse Coordinating Council, because of its established membership of key leaders, were asked to serve as a policy consortium to provide oversight of this project and move the plan forward.

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WHAT IS PREVENTION?

Prevention is defined as interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder. (Preventing Mental, Emotional and Behavior Disorders Among Young People, National Research Council and Institute of Medicine, 2009)

The same report defines mental health promotion as interventions that aim to enhance the ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, well-being, and social inclusion to strengthen the ability to cope with adversity. The report also strongly recommended that prevention and promotion work hand-in-hand to provide the best environment for youth and young people.

Prevention begins within communities by helping individuals learn that they can have an impact on solving their local problems and setting local norms. Prevention emphasizes collaboration and cooperation, both to conserve limited resources and to build on existing relationships within the community. Community groups are routinely used to explore new, creative ways to use existing resources.

Prevention is part of a broader health promotion effort, based on the knowledge that addiction is a primary, progressive, chronic, and fatal disease. As such, it focuses on creating population level changes, within the cultural context, in order to reduce risks and strengthen ability to cope with adversity.

Comprehensive prevention efforts target many agencies and systems, and use many strategies in order to have the broadest possible impact. Therefore, evaluation is crucial in order for communities to identify their successful efforts and to modify or abandon their unproductive efforts.

Much of Arkansas' prevention work is based on the risk and protective factor approach to prevention of problem behaviors developed from the work of Drs. J. David Hawkins and Richard F. Catalano and their colleagues at the University of Washington. This approach addresses risk factors in important areas of daily life: 1) the community, 2) the family, 3) the school, and 4) within the individual themselves and their peer interactions. Many of the problems behaviors faced by youth – delinquency, substance abuse, violence, school dropout and teen pregnancy – share many common risk factors. Thus, reducing those common risk factors will have the benefit of reducing several problem behaviors.

Building coordinated prevention efforts through collaboration with state agencies, community organizations and special populations offer multiple strategies provide multiple points of access and coordinate and expand citizen participation in community activity as a most promising approach to preventing alcohol and other drug problems and youth related violence. A comprehensive approach to a particular problem or behavior is an effective way to achieve the desired permanent behavior or normative change.

Although there are a significant number of effective prevention programs and strategies across the Nation, they have not been coordinated to work together or fully integrated within our overall health care systems. All health-related prevention efforts should recognize and address the interrelated impact of mental health and substance use on overall well-being. (Description of a Modern Addictions and Mental Health Service System, SAMHSA, 2010)

Prevention Categories

Institute of Medicine's categorical definitions listed below.

Universal

These interventions are targeted and are beneficial to the general public or a general population. Two subcategories further define universal interventions:

- **Universal Indirect** provides information to a whole population who has not been identified as at risk of having or developing problems. Interventions include media activities, community policy development, posters, pamphlets, and internet activities. Interventions in this category are commonly referred to as environmental strategies.
- **Universal Direct** interventions target a group within the general public who has not been identified as having an increased risk for behavioral health issues and share a common connection to an identifiable group. Interventions include health education for all students, after school programming, staff training, parenting class, and community workshops.

Selective

This category of prevention interventions targets individuals or a population subgroup whose risk of developing mental or substance abuse disorders is significantly higher than average (prior to the diagnosis of the disorder). Examples of interventions include group counseling and social/emotional skills training for youth in low-income housing developments, and a clinician facilitated group discussion that provides education and support to families with parental depression.

Indicated

These interventions target individuals at high risk who have minimal but detectable signs or symptoms of mental illness or substance abuse problems (prior to a DSM IV diagnosis¹). Examples include programs for high school students who are experiencing problem behaviors such as truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

STRATEGIC PREVENTION FRAMEWORK



To meet the cross-system approach that health promotion and disease prevention demand, the U.S. Department of Health and Human Services has developed the Strategic Prevention Framework (SPF). The SPF implements a five-step process known to promote youth development, reduce risk-taking behaviors, and prevent problem behaviors across the life span. It is designed to build on science-based theory and evidence-based practices. To be effective, the SPF supports that prevention programs must engage individuals, families, and entire communities to achieve population level change. The SPF steps are used to:

1. Assessment – Determines needs, resources and causes of community issues
2. Capacity – Development of skills and knowledge for community members to address issues
3. Planning – Determines the best practices, strategies and action plans to be used to address issues
4. Implementation – The actual work done to address the issue
5. Evaluation – Reviews the process of implementation so adjustments can be made in the process, records success, and determines if goals were met.

SUMMARY OF ARKANSAS PREVENTION INFRASTRUCTURE

The Prevention Section of the Division of Behavioral Health Services (DBHS), Department of Human Services (DHS) is the single State agency responsible for substance abuse prevention in the State of Arkansas.

Funding for prevention services in Arkansas is solely through the Substance Abuse Prevention and Treatment (SAPT) Block Grant, Strategic Prevention Framework State Prevention Enhancement Grant (SPE) and a grant for State Epidemiology Workgroup (SEW). The State government does not allocate any general revenue to DBHS Prevention Section for prevention services.

The mainstay of DBHS Prevention Services is the 13 regional Prevention Resource Centers (PRCs) that function as intermediary structures to mobilize, facilitate, and support communities in planning, developing, implementing, and sustaining effective efforts to prevent and reduce alcohol and other drug abuse. The PRC provide technical assistance to local service providers, schools, agencies, and organizations within their respective regions. The PRCs promote evidence-based prevention programs to their communities by working with county coalitions, policy makers and other stakeholders in their regions.

The States' data infrastructure, includes the Arkansas Prevention Needs Assessment (APNA) Survey administered to Arkansas' youth in grades 6, 8, 10, and 12 to measure students' alcohol, tobacco and other drug (ATOD) use, antisocial behavior and delinquency, mental health, and violence. APNA Reports are accessible on line at the ADAP web site at <http://preventionworksar.com/Home.aspx>; The Risk Factors for Adolescent Drug & Alcohol Abuse in Arkansas (ARF) is a compilation of data reported by various state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Division of Youth Services, etc.) which compilation provides DBHS providers, communities, schools, agencies, and organizations with readily accessible data needed for effective planning of prevention efforts. This report can be assessed online at <http://preventionworksar.com/RiskFactorsData.aspx>; The CORE Alcohol and Drug Survey was developed in the late 1980s by the U.S. Department of Education and advisors from several universities and colleges to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four-year institutions. More information on the CORE survey is available online at <http://www.siu.edu/departments/coreinst/public.html/>; The Arkansas State Police Highway Safety Office publishes annual reports that include information about vehicle and motorcycle accidents in a variety of situations (e.g. involving alcohol, inclement weather, varying road conditions, and different times of day) for both fatal and non-fatal crashes. These reports also include trending for year and age of driver as well as county and city statistics. Full reports can be found at http://www.asp.arkansas.gov/hso/hso_index.html; The State Epidemiological Workgroup (SEW) acquires and analyzes data from various sources, including but not limited to APNA survey, Alcohol Epidemiology Data System, Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavioral Surveillance System (YRBSS), CORE Alcohol and Drug Use Survey, National Survey on Drug Use and

Health (NSDUH), National Vital Statistics System (NVSS), and State Tax Data. More information on the State Epidemiological profile can be found online at <http://preventionworksar.com/StateEpidemiologicalWorkgroupSEW.aspx>; and the Prevention Reporting Management Minimum Data Set (MDS).

DBHS Prevention Section provides training opportunities for individuals interested in substance abuse prevention through the MidSouth Summer School and the MidSouth Prevention Institute (PI). More than 800 substance abuse professionals attend the annual MidSouth Summer School 5-day conference. The MidSouth PI conducts annual needs assessment of the workforce and provides substance abuse training statewide throughout the year.

DBHS Prevention Section collaborates with the Arkansas Colligate Drug Education Consortium (ACDEC) to provide opportunities for individual college and university campuses to initiate and maintain ongoing ATOD prevention and education programs.

The Arkansas Prevention Certification Board (APCB) is another agency devoted to the promotion of effective substance abuse prevention. APCB is an affiliate of the International Certification Reciprocity Consortium (ICRC) and provides the testing opportunities for Arkansans wishing to be certified in substance abuse prevention services.

DBHS Prevention Section contracts with RTI International to conduct monitoring and evaluation activities at the State and community levels to ensure that the prevention programs are achieving the milestones of assessment, capacity building, planning, and implementation. To track progress of prevention services, RTI evaluators conduct both process and outcome evaluations. RTI also provides technical assistance to DBHS Prevention Section staff and coalition members on needs assessment and evaluation.

In terms of personnel, the DBHS Prevention Section currently has three permanent staff, including the Program Coordinator, Project Officer, and an Administrative Assistant.

STATE INFRASTRUCTURE NEEDS IDENTIFIED

1. Need to source more funding from the state government and braiding of funds with other agencies.
2. Increase collaboration among behavioral health organizations
2. Restructuring of the technical assistance system at the regional/community level
3. Comprehensive data management system
4. Need for more behavioral health training and certification capacity
6. Need for more prevention services staff at the state and local levels.

COMMUNITY LEVEL BEHAVIORAL HEALTH NEEDS IDENTIFIED

Regional meetings were conducted around the state by the Prevention section of the Division of Behavioral Health as a listening tour. The aim of these meetings was to bring community members together to discuss behavioral health issues within their communities. Participants were asked to discuss major behavioral health issues seen in the counties how these issues have impacted their communities, why the communities believed the issues were occurring and what infrastructure and resources they have in place to tackle these issues. The participants were also asked what training and assistance they needed from DBHS. These meetings involved the first two stages of a five-step approach to data-driven practice: Assessment, Capacity-building, Planning, Implementation and Evaluation



Throughout the series of community focus group meetings held around the state, certain topics of concern consistently arose. Chief amongst those was parenting education and parent involvement in their children's lives. Alcohol and prescription drug misuse was also consistently expressed as a problem in communities. Homelessness was discussed at every meeting as either a major problem or a consequence of another problem. Suicide, technology, and social media also regularly appeared as issues or consequences.

Lack of community resources and barriers to accessing community resources were reoccurring themes also. The rural nature of Arkansas, coupled with the poverty level, cause

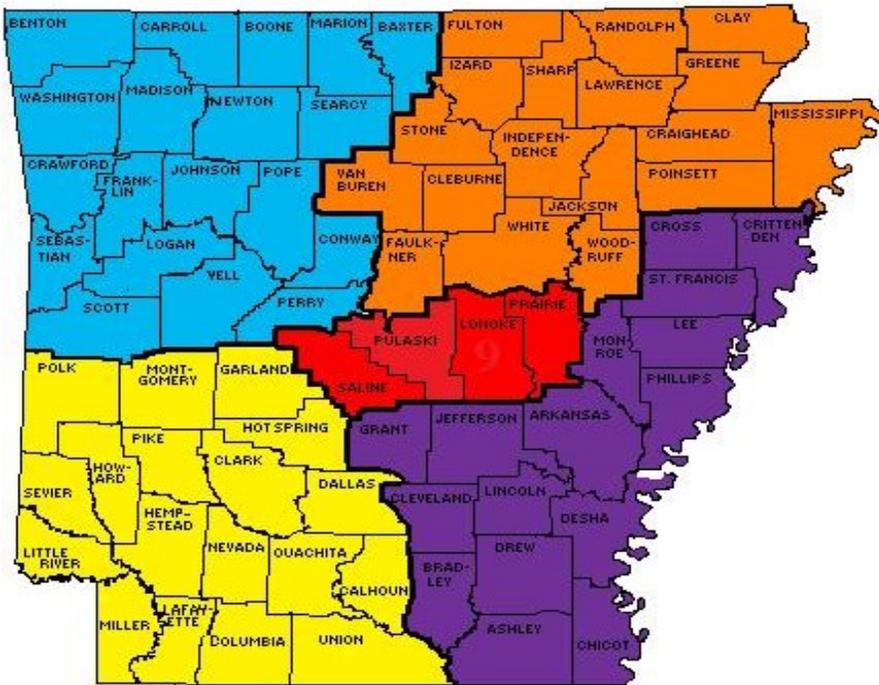
transportation to be a major barrier as many people in need of behavioral health services either do not have vehicles, cannot afford gas, or do not have access to public transportation to travel to prevention, treatment, and recovery resources. The number of people per square mile varies from 500 to 12, therefore, the number of service providers vary as well with some locations having many providers and some have very few.

Community meetings were held in the following five cities representing northwest, northeast, central, southeast and southwest communities in the state:

- Northwest Arkansas (Huntsville, Madison Co.) – Religiosity, inadequate mental health services, high alcohol use rate
- Northeast Arkansas (Walnut Ridge, Clark Co.) – lack of mental health treatment resources, breakdown of family unit and prescription drug abuse
- Central Arkansas (North Little Rock, Pulaski Co.) – Lack of community resources, breakdown of family structure and stigma for seeking services

- Southeast Arkansas (Dumas, Desha Co.) – education, economic hardships, and cultural issues
- Southwest Arkansas (Hope, Clark Co.) – lack of community networking, lack of parental involvement and lack of transportation.

See appendix VII for top three of the factors participants listed as major contributors to behavioral health issues in each of the regions.



Each meeting also brought forth unique issues as well. Religiosity as a risk factor rather than a protective factor was brought out in a discussion of how treatment is sometime not sought or dogma gets in the way of the faith-based community working together. Loss of identity by young men in a particular culture was a concern as they move from family to girlfriend’s home without working, possessing property or having responsibilities that lead to life purpose. Hunger came forth in more than one meeting as an issue. Teen sexual health was linked to behavioral

health through substance use, peer pressure, and stress of unplanned pregnancies.

At each community meeting, participants were asked the following questions:

- What are the five biggest substance abuse and mental health problems in your county? Put these inside a large circle in the middle of each page.
- What are the consequences for each of the problems? Place the consequences in smaller circles attached to each of the large circles.
- What factors cause these five problems? Place these in small circles either attached to the large circle or attached to the consequences.
- Are there common factors or consequences you see in each of the five problems?

TRAINING NEEDS IDENTIFIED

The Mid-South Prevention Institute (MSPI) administers an annual training needs assessment and provides a statewide report on training and technical assistance needs. The training needs assessment survey is given to substance abuse prevention providers, substance abuse treatment providers, mental health treatment providers, law enforcement personnel, Department of Education staff, Department of Community Correction staff, Department of Health Staff, social workers and counselors and other stakeholders.

The top ten (10) training needs as identified by survey respondents based on Prevention Workforce Needs Assessments in September 2011 are as follows:

	# of Respondents	Training Needs Identified
1.	320	Conducting a community assessment
2.	310	Creating and maintaining coalitions and partnerships
3.	308	Using Institute of Medicine categories to select the appropriate strategy
4.	147	Writing grant applications for funding
5.	120	Assessing community needs and resources
6.	116	Developing interventions
7.	108	Describing the process of addiction
8.	108	Knowledge of current trends in drug use patterns
9.	106	Creating a sustainability plan
10.	106	Maintaining proficiency in technology, facilitation and presentation skills

See appendix VIII for MidSOUTH Prevention Institute 2011 Training Survey and statewide reports.

PRIORITY SUBSTANCE ABUSE PREVENTION NEEDS (RFA Section 2.3.1a)

According to a report by PIRE as quoted in the Arkansas Epidemiological Profile, Arkansas has the fourth highest percentage of underage alcohol consumption when compared to other states. Fortunately, significantly fewer Arkansans age 12 to 20 reported binge drinking when compared to the national population. The Arkansas Prevention Needs Assessment still indicated alcohol is the most used drugs by students in 6th, 8th, 10th, and 12th grade despite efforts to lower the usage rate during the Strategic Prevention Framework State Incentive Grant. Arrest by adults for both public drunkenness and liquor law violations have increased. Alcohol remains the most common reason that adults seek treatment with 39% of residential treatment admissions being for alcohol.

For these reasons, **alcohol** is the first priority to be addressed in this strategic plan.

According to the Arkansas Epidemiological Profile, a significantly higher percentage of Arkansas youth consume tobacco products than the broader youth population in the United States. While cigarette use among youth has declined, it remains the most common type of tobacco product consumed. Use of chewing tobacco, snuff, and dip has remained unchanged among youth. Arkansas youth begin smoking at a very young age compared to national figures and this younger age of initiation may be a major contributing factor to the higher smoking rates of adults. As a percentage of their age group, more young adults (18 to 25) use tobacco products than older adults do. Younger adults are less likely to believe that smoking poses a great risk to their health than other adults in Arkansas. Overall, as a percentage of the total population, fewer adult Arkansans accept that smoking poses a risk to their health than other U.S. residents. Smoking prevalence varies significantly with education and income. The least educated and lowest-income Arkansans are far more likely to smoke.

Tobacco will be the second priority to be addressed in this strategic plan.

Arkansas has a slightly higher percentage of nonmedical use of pain relievers in the past year for both teen and adult populations compared to national percentages. At one time, Arkansas had the fastest growing trend for this use in the nation. Sedative use appears to be higher among Arkansas school children than in the rest of the nation. The Arkansas rate of drug-induced deaths was higher than the national rate. Arkansas National Guard ranks high compared to the nation for positive drug screens. Treatment for opiates such as pain relievers is the third most common reason for admission to residential treatment.

Although much work has been done to lower usage of **prescription drugs**, much is still to be done and therefore, prescription drugs will remain a priority to be addressed in this strategic plan.

Substance abuse may be associated in half of suicide cases. Suicide is the 11th leading cause of death in Arkansas. People with alcohol problems constitute about 20% of suicides. Youth who report substance abuse are at higher risk for suicide. According to a recent report from the Office of Coordinated School Health, 14% of high school students seriously considered attempting suicide and 10% actually attempted suicide. There were 1692 attempted suicides across all ages in 2010 according to the Arkansas Department of Health's Injury Prevention section.

While the exact level of connection to the use of substances mentioned above has not been determined, it is known that a significant number of Arkansas National Guard units served multiple deployments during the conflicts in Iraq and Afghanistan. They return home with injuries (both physical and mental) which increase their risk of misusing substances, especially alcohol and prescription drugs. The Arkansas National Guard also ranks high in the nation for suicides. The stress on the family members at home was also tremendous and increases risk factors related to substance abuse.

Because of deeply held values and norms within the state, those residents with sexual orientations other than heterosexual are often isolated and intimidated. Therefore, more concrete data about this population has been hard to obtain. Antidotal data from youth within this population report an increased risk for both substance abuse and suicide. Therefore **suicide**, especially among these special populations, will be a priority within this strategic plan.

SHORT TERM AND LONG TERM CONSEQUENCES (RFA Section 2.3.1b)

Because Arkansas has a relatively high uninsured population, this means an increasing number of adults may have difficulty accessing services that could help them or that the burden for treating those with substance abuse will be increasingly shifted to the state. This cost shift may come in the form of higher demand for public mental health and substance abuse services or increased demand placed on the criminal justice system.

Substance abuse is also associated with many adverse health consequences. There is a high prevalence for chronic disease such as high blood pressure, diabetes, and heart disease. Poor mental health is one of the many risk factors to substance abuse and Arkansas youth experience major depressive episodes at a rate higher than national level for those ages 12-25. Both physical and mental health can be linked to specific cause of mortality in Arkansas. Of the top five causes of death in Arkansas, four may be caused or exacerbated by alcohol, tobacco, and other substance abuse. Thus, there is the potential for a portion of these health costs to also be shifted to the public responsibility via the Medicaid programs. The recession had already brought an increased number of new enrollees to Medicaid related programs and there is reason to anticipate a further increase in enrollees under the Affordable Health Care Act.

While these increased costs are primarily felt at the state level, there is a trickle-down effect for the communities through taxation. The following discussions of consequences are felt at both the state and community levels. At the community level, some are short-term and immediate effects with a pattern of behavior having the long-term consequences. It is the pattern of behaviors that cause the state level consequences.

Alcohol

According to the CDC, motor vehicle accidents are the leading cause of death among youth. In 2011, 26% of high school students reporting riding in a car or other vehicle driven by someone who had been

drinking alcohol and 8% of students who reporting drinking said that they had driven a car or other vehicle when they had been drinking.

The rate of alcohol- or drug-related traffic crashes was 1.4 per 1,000 population and the rate of crash injuries was 0.9 and the rate for crash fatalities was 0.1 per 1,000 in 2010. While there has been an 18% increase in alcohol-or drug-related traffic crashes, there has been a 45% decrease in alcohol-or drug-related injuries. This paradox may be partially explained by seat belt violations becoming a primary offense during the time.

In addition to legal problems and driving related injuries or death, alcohol abuse poses health risks. It can alter the still developing brain and lead to dependency even at an early age. The data suggests an association between alcohol use and lower academic performance. Heavy drinking can lead to health problems such as liver disease, pancreatitis and high blood pressure. Liver Disease was the 13th cause of death in Arkansas and hypertension was the 12th.

Alcohol abuse is also linked to high-risk sexual practices that can lead to pregnancies and sexually transmitted disease. Arkansas had a teen pregnancy rate over 1,700 in 2010 and there were 20,584 cases of sexually transmitted disease. Drinking during pregnancy is especially hazardous to the unborn child. While the number of women using alcohol while pregnant has been decreasing in Arkansas, the number of women pregnant while in treatment has increased.

Tobacco

Because the effects of tobacco consumption can take many years to manifest, the primary consequence for youth is the social effect of tobacco infractions at school which takes away time that the students would have devoted to study. In 2010, over 600 tobacco infractions occurred at the elementary and middle school level and over 2,000 at the high school level. This early age of initiation establishes life-long unhealthy habits which result in the health consequences seen in adults.

According to the American Cancer Society, an estimated 2,660 Arkansas developed lung or bronchial cancer in 2011. Additionally, approximately 2,030 Arkansans died of lung or bronchial cancer in 2011 that they had developed previously. Smokeless tobacco has been associated with increased risk of cancer of the oral cavity, gum disease and tooth decay. Insurance costs cause employers and non-smoking employees to be subsidizing the health care cost for smoking decisions.

Drug-related consequences

Arkansas had a narcotic arrest rate of 5.4 per 1,000 population age 18 and older and 3 per 1,000 for population under 18 in 2009. Over 30% of students reported laws and norms that favor drug use. Approximately 21% of arrests for drug possession involved barbiturates, narcotics, or stimulants.

The Arkansas rate of drug-induced deaths at 14.1 per 100,000 was higher than the national rate of 12.6 in 2008 and reflected a significant increase from the 2007 rate of 11.8.

DATA-DRIVEN GOALS AND OBJECTIVES (RFA Section 2.3.2)

Goals and objectives serve to ensure that strategies and activities selected for implementation will meet the needs identified during the assessment and capacity building phase of a planning effort. The Prevention Section of the Division of Behavioral Health Services, Arkansas Department of Human Services through the SPE efforts will strive to accomplish the following goals and objectives for the SFY 2013 through 2017.

Goal 1. Lower the reported 30 day alcohol usage rate according to the Arkansas Prevention Needs Assessment from 16.3% in 2011 to 13.3% by 2016.

Training and Technical Assistance Objective:

- Increase public awareness of FASD, its consequences and that it is preventable along with increase educator understanding of the signs and symptoms of FASD and the required accommodations.
- Expand youth efforts for leadership and advocacy by increasing the knowledge and skills involved in prevention and community mobilization so that youth will become recognized advocates for themselves and their peers.
- Increase collaboration with Alcohol Beverage Control including coordinated merchant trainings and increase board responsiveness to communities desires surrounding private club permits.
- Develop curriculums and provide Training of Trainers (TOTs) on topics centering on collaboration, community mobilization, and community requested topics. Obtain parenting curriculums and provide TOTs for Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.

Coordination of Services Objective:

- Expand Arkansas Collegiate Drug Education Consortium's role in order to increase services to college age youth by increasing involvement of colleges in local coalitions and increasing coalitions' involvement with students.
- Initiate connection with the Arkansas Retail Beverage Association to solicit involvement by their merchant members in a social host law awareness campaign.
- Re-establish of the Arkansas Underage Drinking Prevention Taskforce to serve as an advocacy group.
- Develop a network of support providers focused on the LGBTQ population to enhance support network through consistent and strategic statewide services for LGBTQ concerns such as suicide and increased risk of substance abuse.
- Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
- Restructure current regional technical assistance system to focus on local community training and parent education. Incorporate integrated services and cross-training in

- workforce development. Provide local funding for leveraged direct services to the community.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process.

Data Objective:

- Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered through the LGBTQ consortium.
- Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Analyze information collected during DASEP screenings to create aggregate data about adult usage risk factors.

Evaluation Objective:

- Implement standardized collection processes and expected measures for process and outcome data.

Goal 2. Lower the reported 30 day smokeless tobacco usage rate according to the Arkansas Prevention Needs Assessment from 5.6% in 2011 to 3.6% by 2016 and the cigarette usage rate from 8.8% in 2011 to 6.8% in 2016.

Coordination of Services Objective:

- Enhance coordination with Arkansas Dept. of Health Tobacco Prevention and Cessation and Arkansas Tobacco Control Board to coordinate trainings to create more community responsiveness.
- Initiate coordination with Arkansas Chapter of American Lung Association and the American Cancer Society to solidify coordinated efforts to reduce tobacco use.
- Expand youth efforts for leadership and advocacy by increasing the knowledge and skills involved in prevention and community mobilization so that youth will become recognized advocates for themselves and their peers.
- Restructure current regional technical assistance system to focus on local community training and parent education. Incorporate integrated services and cross-training in workforce development. Provide local funding for leveraged direct services to the community.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process

Training and Technical Assistance Objective:

- Coordinate efforts between Arkansas Tobacco Control Board, Arkansas Beverage Control, and DBHS for joint merchant education.
- Coordinate efforts around awareness campaign about law against smoking in cars with young children.
- Develop curriculums and provide Training of Trainers (TOTs) on topics centering on collaboration, community mobilization, and community requested topics. Obtain

parenting curriculums and provide TOTs for Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.

Data Objective:

- Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered through the LGBTQ consortium.
- Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Combine the Arkansas Prevention Needs Assessment and Youth Tobacco Survey.

Evaluation Objective:

- Implement standardized collection processes and expected measures for process and outcome data.

Goal 3. Lower the reported 30 day usage rate for prescription drugs according to the Arkansas Prevention Needs Assessment from 4.4% in 2011 to 2.1% by 2016.

Coordination of Services Objective:

- Continue and enhance efforts by State Drug Director's office, Rotary, and law enforcement to raise community awareness through Monitor, Secure and Dispose campaign and biennial drug take-backs.
- Develop a network of support providers focused on the LGBTQ population to enhance support network through consistent and strategic statewide services for LGBTQ concerns such as suicide and increased risk of substance abuse.
- Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
- Restructure current regional technical assistance system to focus on local community training and parent education. Incorporate integrated services and cross-training in workforce development. Provide local funding for leveraged direct services to the community.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process

Training and Technical Assistance Objective:

- Provide training about prevention to physicians and other healthcare providers for a greater understanding of science of addiction and prescription drug issues related to over prescribing.
- Provide training about prevention to law enforcement, especially school resource officers, for better understanding of youth drug trends, behaviors, and appropriate environmental prevention strategies.
- Provide training about prevention to PE and health teachers who are primarily responsible for substance abuse prevention in classroom so that students will receive consistent messages statewide.
- Work with addiction studies graduate students and Arkansas Dept. of Education to publish and make trainings about prevention available to all teachers so that they have a

- better understanding of the science of addiction and how to work with individuals from substance addicted home.
- Expand youth efforts for leadership and advocacy by increasing the knowledge and skills involved in prevention and community mobilization so that youth will become recognized advocates for themselves and their peers.
 - Develop curriculums and provide Training of Trainers (TOTs) on topics centering on collaboration, community mobilization, and community requested topics. Obtain parenting curriculums and provide TOTs for Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.

Data Objective:

- Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered through the LGBTQ consortium.
- Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Coordinate with the Arkansas Health Department to review data collected about prescribing trends through the Prescription Drug Monitoring Program.

Evaluation Objective:

- Implement standardized collection processes and expected measures for process and outcome data.

Goal 4. Lower the number of attempted suicide reported by the Arkansas Department of Health Injury Prevention from the 2010 rate of 1692 to 1400 by 2016.

Training and Technical Assistance Objective:

- Collaborate with Army One Source to provide training to social services providers, faith-based organizations and veterans support organizations about effects on veterans, families, and other impacted by war for better understanding of the behavioral health care needs of this special population.
- Provide training on suicide screenings to community providers and promote awareness of suicide as a preventable health issue by developing a better understanding the relationship between self-harm and mental health and substance abuse issues.
- Develop curriculums and provide Training of Trainers (TOTs) on topics centering on collaboration, community mobilization, and community requested topics. Obtain parenting curriculums and provide TOTs for Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.
- Train and provide technical assistance to the Arkansas Behavioral Health Policy Advisory Council to help this consumer advisory committee understand prevention and promotion of wellness.

Coordination of Services Objective:

- Develop a network of support providers focused on the LGBTQ population to enhance support network through consistent and strategic statewide services for LGBTQ concerns such as suicide and increased risk of substance abuse.
- Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
- Restructure current regional technical assistance system to focus on local community training and parent education. Incorporate integrated services and cross-training in workforce development. Provide local funding for leveraged direct services to the community.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process

Data Objective:

- Coordinate data about suicide attempts collected by the Arkansas Department of Health, crisis call placed to the Arkansas Crisis Center and cause of death data collected by the Arkansas State Crime Lab.

Evaluation Objective:

- Implement standardized collection processes and expected measures for process and outcome data.

PROCESSES AND PROCEDURES USED FOR PLAN DEVELOPMENT (RFA Section 2.3.4)

The Arkansas DBHS Prevention Section developed this Strategic Prevention Plan to contribute to meeting the overall mission of DBHS as well as specific outcomes in the behavioral health system. The prevention planning process is inclusive of community and state level stakeholders and takes into consideration the many needs and issues relating to behavioral health infrastructure, capacity and gaps in service throughout the state.

Following the award of the Strategic Prevention Framework State Prevention Enhancement (SPE) grant, the Prevention Section of Arkansas Division for Behavioral Services, Department Human Services obtained agreement from the Arkansas Alcohol and Drug Abuse Coordinating Council to serve as the State Policy Consortium (see State Policy Consortium members in appendix VI) and also convened a Stakeholders meeting as part of the requirements for the grant.

The Stakeholders kick-off meeting was held on September 22, 2011 and the theme of the meeting was 'Developing an Arkansas Prevention and Wellness Strategy'. More than 60 participants representing many agencies involved in substance abuse prevention attended the meeting. Stakeholders were briefed about the goals of the grant which include strengthening and extending SAMHSA's national implementation of the Strategic Prevention Framework; enhancing and aligning the prevention infrastructure through the myriad State agencies offering prevention programs or providing direct prevention services; and fostering more responsive and interactive state prevention systems.

From the stakeholders meeting, four (4) Capacity Building/Infrastructure Enhancement workgroups and an Evidence-based practices workgroup were formed. The different workgroups developed four (4) mini-plans that were submitted to SAMHSA/CSAP in December 2011 and revised in August 2012. The capacity building workgroups include;

- Coordination of Services Workgroup
- Technical Assistance and Training Workgroup
- Data Collection, Analysis and Reporting Workgroup
- Performance/Evaluation of Efforts Workgroup

An Evidence-based practices workgroup was developed to identify and select evidence-based programs and strategies that would address identified behavioral health needs and conceptual fits with the dynamics of Arkansas communities. Evidence-based strategies were selected to meet goals and objectives and will be implemented by the State and by community coalitions.

Community needs assessment meetings were held in five regions across the state to assess community readiness by identifying gaps in community behavioral health resources and needs in services, training and data collection and analysis. These meetings also assured community buy-ins because it allowed stakeholders to have an active part in the needs assessment, capacity building and planning process.

Numerous individual meetings with state agencies and organizations were held by DBHS staff. Plans created by those organizations were reviewed for commonalities to DBHS and CSAP initiatives.

A presentation of the Strategic Prevention Framework (SPF) was made to each of the groups involved in the planning process. All the groups were instructed to adhere to the components of SPF process during deliberations.

The Coordinating Council members participated in review and approval of the mini plans, and served on work groups that developed the recommendations and objectives for the plan. Recommendations in the “mini plans” were incorporated into the final goals and objectives in the State Prevention Enhancement Plan.

ARKANSAS'S STATE PREVENTION ENHANCEMENT (SPE) MINI-PLAN

PURPOSE

The Substance Abuse and Mental Health Services Administration (SAMHSA) grant requires the submission of four mini-plans for the Strategic Prevention Enhancement (SPE) grant from the Centers for Substance Abuse Prevention (CSAP). The four mini-plans include: Data Collection, Analysis and Reporting Plan; Coordination of Services Plan; Technical Assistance (TA) and Training; and Performance Management and Evaluation. The SPE grant will be used to act on the short-term and intermediate goals of these mini-plans and subsequently, on the longer term goals of a 5-year comprehensive state strategic prevention plan.

This document describes the potential framework for enhancing the Arkansas Behavioral Health System infrastructure by highlighting goals, implementing strategies and potential action plans for assessing internal processes, collaborating with other community and state organizations to identify types of prevention services and evidence-based programs(EBP), enhancing and developing new data collection processes, assessing training needs, and improving planning and evaluation methods needed to address the capacity for substance abuse prevention. The document also identifies responsible entities and time frames for addressing areas identified for enhancement within the state behavioral health system.

Information gathered during the process of mini-plan completion will serve as a roadmap for developing the 5-year strategic plan. The process is designed to be somewhat flexible to allow for adjustments in response to new information, resources, opportunities, and to best align the 5 year Plan with the Arkansas Behavioral Healthcare and Payment Improvement Initiative and the upcoming combined Block Grant application and plan.

See table below for list of acronyms used for responsible entities.

ADH	Arkansas Department of Health
AFMC	Arkansas Foundations for Medical Care
AG	Attorney General’s Office
AOS	Army One Source
APCB	Arkansas Prevention Certification Board
APNA	Arkansas Prevention Needs Assessment
CAR	Center for Artistic Revolution
CHC	Community Health Center
CSOC	Children’s System of Care
DASEP	Drug and Alcohol Safety Education Program
DBHS	Division of Behavioral Health Services
DCFS	Division of Children and Family Services
DHS	Department of Human Services
DHS IT	Department of Human Services Information Technology
DOE	Department of Education
DYS	Division of Youth Services
EBP	Evidence-based Programs and Practices
ISA	International Survey Associates
LGBTQ	Lesbian, Gay, Bi-sexual, Transgender, and Questioning
MISGRO	Minority Initiative Sub Grant Recipient Office
MSPI	MidSouth Prevention Institute
MSSS	MidSouth Summer School
NG	National Guard
PRC	Prevention Resource Centers
RTI	Research Triangle Institute
SDDO	State Drug Director’s Office
SEOW	State Epidemiological Outcome Workgroup
TPCP	Tobacco Prevention and Cessation Program
UALR	University of Arkansas at Little Rock
UAMS	University of Arkansas Medical Sciences
UAPB	University of Arkansas at Pine Bluff
UDTF	Underage Drinking Task Force
YTS	Youth Tobacco Survey

Data Collection, Analysis and Reporting Mini-Plan

The Data Collection, Analysis and Reporting Mini-Plan reviews current state data system, identifies gaps in infrastructure, and explores opportunities for developing new or enhancing current State data systems to collect, analyze and report aggregated outcome and consequence data within the state system and across multiple agencies. Areas identified for enhancement in this category include:

1. Improve knowledge of all data sets used within the behavioral health service system;
2. Improve knowledge of all available state specific behavioral health system data available publicly and shared across state agencies and other sectors;
3. Improve comprehensive DBHS data collection and reporting infrastructure for consistent, reliable and usage of prevention data collection tools, procedures and reporting over time;
4. Creation of an on-line resource for aggregated behavioral health data for accessibility and utility of substance abuse-related health outcome information;
5. Updating the State Prevention System profile to be user friendly; and
6. Creation of a Behavioral Health System Performance tracking method.

Goal 1: Identify and assess the utilization of current data sets by state behavioral health system programs and services.

Strategy: Undertake a systemic assessment of current data sets used by state prevention and mental health services to determine what data is used and what gaps in data or accessibility to data exist.

Action Steps	Responsible Entity	Timeline
Review existing data sets to determine specifics of data sets currently being collected.	DBHS, AFMC	Dec. 2012
Identify gaps in data.	DBHS, AFMC, ISA	Jan. 2013
Explore data available through state data warehouse.	DBHS, DHS IT	Jan. 2013
Development of data collection instruments for special populations.	DBHS, RTI	May 2013
Review feasibility of merging APNA and YTS.	DBHS, ADH	May 2013

Goal 2: Review current behavioral health data available publicly and shared across state agencies.

Strategy: Create surveys and meet with other agencies that collect behavioral health related data.

Action Steps	Responsible Entity	Timeline
Survey State Policy Consortium for data collected by represented agencies.	DBHS, RTI	Jan. 2013
Conduct meetings with identified state agencies to assess available data.	DBHS	Apr. 2013
<p>Goal 3: Explore the feasibility of creating a publicly-available site for the currently disparate data.</p>		
<p>Strategy: Create a web portal through which each data system can be identified and explained to make locating and using data easier and more effective.</p>		
Action Steps	Responsible Entity	Timeline
Determine materials for the website.	DBHS, AFMC	Oct. 2012
Purchase domain and create website.	DBHS, AFMC	Oct. 2012
Promote website.	DBHS	Oct. 2012
<p>Goal 4: Review and enhance current DBHS data infrastructure.</p>		
<p>Strategy: Review data collection capacity and reporting methods with a focus on (a) enhancing the ability to collect and report data in real time, (b) keeping data sets within DBHS rather than outsourcing.</p>		
Action Steps	Responsible Entity	Timeline
Meet with DBHS data section and DHS IT section to discuss possibility of developing a new or enhancing current State data systems to collect, analyze and report data at all levels.	DBHS, DHS	Jun. 2013
Review and recommend contract oversight and language to insure data “ownership” and rights remain with DBHS.	DBHS, DHS	Dec. 2012
<p>Goal 5: Review state prevention profile to meet the needs of the SPE project.</p>		
<p>Strategy: The State Epidemiological Outcome Workgroup (SEOW) will develop and use a mapping tool to evaluate current prevention network system and identify areas for enhancement to meet the goals of the SPE.</p>		

Action Steps	Responsible Entity	Timeline
Identify members and invite to participate in the SEOW.	DBHS, SEOW	Mar. 2013
Guide SEOW in creating a user friendly profile with root causes, consumption & consequences.	DBHS, SEOW	Mar. 2013
Determine other data sets necessary for mapping project.	DBHS, SEOW	Mar. 2013
Goal 6: Create a Behavioral Health System Performance Framework and dashboard.		
Strategy: Develop a dashboard to track strategic priorities and capture behavioral health Outcomes, Access to Services, Service Delivery, and Collaboration efforts.		
Action Steps	Responsible Entity	Timeline
Collaborate with DBHS data section, state hospital, mental health section, treatment and recovery to provide input on development of dashboard.	All DBHS sections	TBD
Develop a Crosswalk between SAMHSA's National Outcome Measure Domains (NOMS) and existing DBHS Prevention Databases	DBHS	TBD
Identify gaps in NOMS that are not in the existing Prevention Databases	DBHS	TBD
Determine procedures to capture the remaining NOMS Data sets	DBHS	TBD
Dedicate a staff member to maintain the Dashboard and update NOMS on a regular basis	DBHS	TBD

Coordination of Services Mini-Plan

Effective coordination of services includes concepts of behavioral system integration, multi-sectorial collaboration, leveraging prevention services and resources (including braiding funds), minimizing duplication of services and promoting evidence-based and cost-effective services. Areas identified for enhancement in this category include:

1. Creation of inter-relationships across agencies and sectors involved in substance abuse and mental health’s prevention, treatment, and recovery;
2. Improve knowledge of community capabilities for applying prevention and/or early intervention programs through coordination of efforts across sectors and disciplines;
3. Integrate existing behavioral health system networks, taskforces, and workforce; and
4. Promote State approved evidence-based prevention programs.

Goal 1: Identify current prevention services across Arkansas.		
Strategy: Meet with identified stakeholders to discuss ways of working collaboratively to capitalize on opportunities for cost savings from leveraging or braiding resources and services.		
Action Steps	Responsible Entity	Timeline
Identify existing partnerships.	DBHS, UALR, UAMS, UAPB, AHD (TCP and Injury Prevention), C.A.R, SDDO	Jan. 2013
Identify and enhance relationships with additional partners.	DBHS, DYS, DCFS, HIV, DOE, AG, Drug Courts, CSOC, CHC	Jan. 2013
Review and identify opportunities for leveraging resources and funding.	DBHS, Partner agencies	Jan. 2013
Goal 2: Determine methods for assessing community readiness in the state.		
Strategy: Meet with regional coalition members to assess community readiness to implement prevention programs.		
Action Steps	Responsible Entity	Timeline
Facilitate community meetings to discuss collaborative efforts and leveraging of resources.	DBHS, PRCs	Apr. 2013
Review results of coalition leadership and consortium		

survey.	DBHS, RTI, PRCs	Apr. 2013
Goal 3: Identify ways to enhance provider networks to share information, lessons learned and ways to make changes to benefit the whole system.		
Strategy: Identify current provider networks and explore ways to develop collaborative efforts between the networks.		
Action Steps	Responsible Entity	Timeline
Conduct meetings with established networks of DBHS funded providers.	DBHS, PRCs, DASEP, Treatment providers	Mar. 2013
Solicit partnerships through engaging other coalitions and stakeholders	DBHS, Statewide Providers, Primary Care Networks and TBD	Feb. 2013
Re-establish the Underage Drinking Task Force.	DBHS, UDTF	Mar. 2013
Revitalize Suicide Prevention Task Force.	DBHS, Suicide Prevention Task Force	Jul. 2013
Goal 4: Identify members and invite to participate in the evidence-based program workgroup.		
Strategy: Develop criteria for establishing state-approved evidence-based programs and strategies.		
Action Steps	Responsible Entity	Timeline
Determine criteria to select best fit evidence-based programs and strategies for Arkansas communities.	DBHS, EBP Workgroup	Jul. 2012
Research evidence-based program registries for best fit evidence-based programs and strategies for Arkansas communities.	DBHS, EBP Workgroup	Jul. 2012
Outline resource structure for approved and recommended evidence-based programs.	DBHS, EBP Workgroup	Jul. 2012

TA and Training Mini-Plan

The TA and Training Mini-plan identifies areas where the current state prevention TA and Training infrastructure for prevention services need improvements to provide greater responsiveness to the needs of the behavioral health system. Areas identified for enhancement in this category include:

1. Need for improved knowledge and skilled prevention workforce in the state;
2. Need for improved prevention trainings for common knowledge, awareness and capabilities by enhancing multidisciplinary and multi-sectorial training activities; and
3. Need for the creation of a comprehensive technical assistance and training systems responsive to the needs of communities, providers, and other stakeholders.

Goal 1: Improve and increase skills and knowledge of the prevention workforce.		
Strategy: Assess current prevention workforce training and identify ways to improve the prevention workforce capacity in the state.		
Action Steps	Responsible Entity	Timeline
Assess prevention training needs among DBHS staff and develop training module.	DBHS	Jan. 2013
Develop standardized prevention training to establish a common prevention knowledge base and shared interests across sectors and disciplines.	DBHS, MSPI	Jul. 2013
Develop a basic Prevention Model System guide and toolkit with additional modules for specific community sectors to meet their unique training needs.	DBHS, MSPI	Jul. 2013
Develop a marketing plan to increase training opportunities both online and onsite for prevention providers and other stakeholders.	DBHS, MSPI, APCB, MSSS	May 2013
Increase greater variety and access to onsite and online training offerings to community coalitions, providers and stakeholders.	DBHS, SWCAPT, MSPI, APCB	Jan. 2013
Explore ways to expand the use of technology to support training through the existing prevention contractor.	DBHS, MSPI	Jan. 2013
Provide more opportunities for Training of Trainers	DBHS, MSPI	Jul. 2013

(TOT) for current prevention providers. Revise orientation and training manuals for DBHS prevention staff.	DBHS	Jul. 2013
Goal 2: Restructure current TA and Training programs for behavioral health, prevention, and special populations.		
Strategy: Review the TA and Training system infrastructure to assess current training opportunities for commonalities in goals and identify any gaps.		
Action Steps	Responsible Entity	Timeline
Review current training programs to identify gaps.	DBHS, APCB, MSPI	Apr. 2013
Review annual workforce survey for most requested training topics.	DBHS, MSPI	Apr. 2013
Goal 3: Create training systems that include TA that are responsive to the needs of the communities, special populations, and paid workforce.		
Strategy: Identify additional trainings needed at the community level, for licensure, and for special populations such as LGBTQ and military families that are evidenced-based.		
Action Steps	Responsible Entity	Timeline
Conduct community level focus groups to assess training needs specific to special populations.	DBHS, PRCs, Coalitions	Jul. 2013
Conduct focus group with special populations such as LGBTQ groups and military families support groups to assess training needs and to identify potential implementation plan.	DBHS, C.A.R, MISGRO, NG, AOS	Jul. 2013
Meet with certification and workforce training system to establish a sequential core curriculum for licensure.	DBHS, APCB, MSPI	Jul. 2013
Review current TA system and explore feasibility of developing an on-line/electronic technical assistance system.	DBHS	Jul. 2013

Performance/Evaluation Mini-Plan

Performance management and evaluation system monitors program progress, measures performance and goals, identifies areas for service improvement, and evaluates systems to collect both process and outcome data. Areas identified for enhancement in this category include:

1. Need for comprehensive utility of the SPF for process and outcome measures;
2. Need for formative and summative methods to collect process and outcome data; and
3. Need of structure for integrating process and outcome measures into program development.

Goal 1: Review process and outcome measures as utilized in the Strategic Prevention Framework (SPF), to foster more responsive and interactive state prevention systems.		
Strategy: Assess data collection and reporting methods for inclusion of process evaluation and comparison of process to outcome.		
Action Steps	Responsible Entity	Timeline
Evaluate minimum Data Set process for additional data to be collected.	DBHS, AFMC	May 2013
Compare number of services provided per county to consumption and consequence data from Arkansas Prevention Needs Assessment.	DBHS, AFMC, ISA	May 2013
Goal 2: Review current evaluation efforts and identify strategies to enhance evaluation systems to ensure process and outcome data is being used as well as formative and summative methods.		
Strategy: Meet with evaluation of efforts contractor to review current performance management and evaluation methods with a focus on enhancing the system.		
Action Steps	Responsible Entity	Timeline
Provide technical assistance on use of data for formative assessment for effectiveness of program and use of data for summative outcomes of behavioral changes.	DBHS, MSPI, RTI	May 2013
Determine specific evaluation methods which can be replicated consistently.	DBHS	May 2013
Goal 3: Create a structure whereby process and outcome measures can be integrated into		

program development.

Strategy: Develop a structure to ensure consistency in the implementation of programs.

Action Steps	Responsible Entity	Timeline
Review fidelity checklists associated with evidence-based programs.	DBHS	Jul. 2013
Develop standardized evaluation forms.	DBHS, PRCs, RTI	Jul. 2013
Provide technical assistance on use of outcome measures.	DBHS, MSPI, RTI	Jul. 2013

RECOMMENDED EVIDENCE-BASED PROGRAMS AND STRATEGIES (RFA Section 2.3.5)

“Evidence-Based” means those practices that are based on accepted practices in the profession and are supported by research, field recognition, or published practice guidelines. These programs are prevention methodologies that have been developed and evaluated by experts using scientific processes. Evidence-based is also referred to as science-based and research-based models.

Environmental strategies are focused on changing aspects of the environment that contribute to the use of alcohol and other drugs. Specifically, environmental strategies aim to decrease the social and health consequences of substance abuse by limiting access to substances and changing social norms that are accepting and permissive of substance abuse. They can change public laws, policies and practices to create environments that decrease the probability of substance abuse.

Members of the Arkansas Strategic Prevention Framework State Enhancement Grant (SPE) Evidence-Based Practices (EBP) Workgroup recommended Evidence-based Programs and Strategies for Arkansas prevention providers through the result of collaborative efforts.

The purpose for recommending EBPs is to identify and select evidence-based programs and strategies to assist Arkansas substance abuse prevention providers:

- Move towards evidence-based programs, practices or strategies
- Increase the use of evidence-based programs, practices or strategies
- Have access to evidence-based prevention programs, practices or strategies
- Invest in “what works” in an effort to demonstrate more positive outcomes and more effective and efficient utilization of limited prevention resources.
- Improve prevention program outcomes
- Future funding preference may be given to EBP providers

The following criteria were used to select the best fit evidence-based programs and practices for Arkansas prevention providers:

1. Evidence of effectiveness: have at least some documented evidence of effectiveness, and preferably have been rigorously tested and shown to have positive outcomes in multiple peer-reviewed evaluation studies.
2. Conceptual fit with the community’s prevention priorities: specifically address one or more of the risk factors for substance abuse identified within the community or target population, have evidence of effectiveness within a similar community or target population and have been shown to drive positive outcomes.
3. Practical fit with the community’s readiness and capacity:
4. Ability to implement with fidelity
5. Cultural fit within the community: programs likely to conform with the norms in Arkansas communities
6. High likelihood of sustainability within the community

Based on this, the following programs were selected (see appendix VI for Evidence-based Programs and Practices Matrix):

Evidence-based programs

1. Al's Pals
2. Big Brothers Big Sisters Community Mentoring
3. Brief Alcohol Screening and Intervention for College Students (BASICS)
4. Caring School Community
5. Community Trials
6. Families and Schools Together
7. Guiding Good Choices
8. Lead and Seed
9. Life Skills Training
10. Lion's Quest
11. Olweus Bullying Prevention Program
12. Parenting Wisely
13. Project Alert
14. Project Northland
15. Second Step
16. Strengthening Families
17. Team Awareness

The following strategies were selected (see appendix -- for table of evidence-based strategies)

Policy Change Strategies

1. Policies to Require Merchant Training
2. Community Event Alcohol Use Regulations
3. Public Availability Policies
4. Social Host Ordinance
5. Advertising Restrictions

Enforcement Strategies

1. Alcohol Outlet Compliance Checks
2. Sobriety Checkpoints to Enforce Impaired Driving Laws
3. Shoulder Tap Surveillance
4. Party Patrols
5. Enforcement of open container laws

Media/Communication Strategies

1. Alcohol Warning Signs
2. Retail Outlet Recognitions
3. Social Norms Misperceptions Campaigns
4. Counter-Advertising
5. Social Marketing

IMPLEMENTATION TIMELINE AND PLAN (RFA Section 2.3.7)

2013	2014	2015	2016
Re-establish Underage Drinking Task Force	Establish MOU's with partner agencies	Develop leveraged funding opportunities	Develop common funding applications
Develop LGBTQ consortium	Expand ACDEC program	Develop LGBTQ and Veteran's surveys	Combine APNA and YTS
Restructure TA system	Develop community training curriculums and conduct TOTs	Train partner sectors about addiction	Standardize process and outcome measure collection process
Conduct TOTs for parenting curriculums	Restructure workforce training	Train community providers about suicide	Outreach to Beverage Retailer on social host campaign
Outreach to additional partner agencies	Coordinate Veteran's services		Coordinate suicide data sources
Coordinated merchant education		Coordinate merchant training	

The first year of this strategic plan will be used to solidify relationships with partner agencies and begin the development of leveraged funding opportunities including the procedure and legal processes necessary for implementation of combined data collection, data sharing, and funding applications. Timing of current contracts also make it possible to set in place a restructured technical assistance system during the first year, but, this timing also causes changes in survey methods and restructure of workforce development systems to be delayed the latter years of this plan.

Curriculum development, marketing campaign development, and data collection methods will also occur during the latter years as the items are developed within the DBHS system or jointly with partners from other agencies and education organizations.

Study is underway for combining the Youth Tobacco Survey, given randomly to select schools, and the Arkansas Prevention Needs Assessment, given annual as a census survey of students in grades 6th, 8th, 10th, and 12th statewide. Implementation of a combined survey could begin in 2016.

Grants for direct community services are released on an annual basis from DBHS but are released on a multi-year basis from partner agencies. Those agencies recently awarded community grants and leveraged funding using a combined application cannot occur until 2016. Preparation for work with the military is set to be ready for implementation by the time of the massive troop return in 2014. Training of providers and coordination of services will be completed prior to that December timeline.

The LGBTQ consortium will be in place by December 2013. Input on data to be collected and best ways to administer a survey about usage rates within this population will come from the consortium. Actually survey administration will begin in 2015.

With the re-establishment of the Underage Drinking Task Force in 2013, a media campaign and relationship can be developed with the Beverage Retailer's Association for promotion of the social host law using the theme of "We don't sell to minors. You don't provide to minors."

The concept of a combined merchant education process for both tobacco and beverage control laws were piloted in 2012 with success. Expansion of this project will be completed by 2013.

Re-establishment of the Suicide Prevention Task Force will provide the assessment of service gaps, training needs, and data gaps necessary to train providers by 2015 and coordinate data by 2016.

EVALUATION PLAN (RFA Section 2.3.8)

Outcome measures noted at each of the strategic goals will be the ultimate indicator of success. These outcomes will be determined by a review of the Arkansas Prevention Needs Assessment and by Department of Health statistics. Social indicators published in the Archival risk Factors annually will be used to expand the causes and consequences associated with the targeted goals of alcohol use, prescription drug use, tobacco use, and suicide. The SEW group will be analyzing cause, consumption, and consequence data for trends and patterns of behaviors related to the target areas.

Process data will be collected in the Prevention Reporting Management Minimum Data Set to determine participation in meetings, trainings, and partner outreach. Minutes and relevant documentation such as results of brainstorming activities and specific project management plans will be maintained and reviewed by the partner agencies on a regular basis.

Another primary measure of the success of this plan will be the outputs generated. Memorandums of Understanding will be developed between partner agencies to assure that all parties understand their respective roles. Combined funding processes and applications will evaluate the efforts to leverage resources. The community comments will be used to modify and improve the application process. New surveys and combined surveys will be reviewed for ease of administration and the ability to continue collecting trend data while gaining new insight into behavior trends. The surveys are reviewed annual for appropriateness to collection of information needed for planning processes ad well as information needed by the diverse funding streams.

All trainings opportunities that are part of this plan include pre-post tests and surveys to determine changes in knowledge and attitude about the information received. This will include the training of direct service providers, community technical assistance providers and vendors selling tobacco and alcohol.

Another anticipated outcome of this plan is better identification of prevention resources at both the state agency and provider levels. The collection of MOU's will determine the increase in knowledge of resources as well as the improved collaboration among the resources. It will also identify gaps in services, therefore, generating need to explore enhancing existing resources or development of new

resources. This, in turn, may create the need for redistribution of funding or restructure to service provision.

ACTION/SUSTAINABILITY PLAN (RFA Section 2.3.9)

DBHS as an agency is going through a restructure process during the move to integrate substance abuse and mental health grants to develop a comprehensive behavioral health plan. Substance abuse funds have been provided oversight and coordination of services by the legislated body of the Arkansas Drug Abuse Coordinating Council. This Council served as the Policy Consortium for the State Prevention Enhancement grant because its makeup mirrored the grant requirements. Mental health funding was reviewed by the Arkansas Behavioral Health Planning Advisory Council. These two bodies will continue to provide oversight and coordination as the block grants merge. Inroads have been made during the SPE process to build coordination bridges between prevention service providers and funders at the state level and will continue as efforts are evaluated and enhanced.

Following the integration to behavioral health, the next logical step is the integration of physical health for a holistic approach. Therefore, workforce development through existing structures such as UAMS, UALR, UCA, and UAPB will continue to be expanded.

Data collection and analysis will be maintained and enhanced from consumption and consequence data to more cause and effect efforts through the SAPT funded contract for the SEOW workgroup. The data collected and the resulting analysis will be maintained on the prevention web portal www.preventionworksar.com which was created during the SPE process. Technical assistance and prevention resources will also be provided via this web portal.

Action steps include:

- Regional meetings with community key stakeholders first as a listening tour to hear their concerns and suggested solutions and then as a way to develop community buy-in for the strategic plan while scheduling necessary technical assistance and training visits.
- Expand the Arkansas Suicide Prevention Task Force, including additional members representing emerging groups in support of veterans and LGBTQ, to determine training, data and coordination of service needs.
- Re-establishment and expansion the Underage Drinking Task Force, which had dissipated, to provide the opportunity to clarify and update the strategic plan for addressing underage drinking, provide technical assistance and necessary data so that they can be effective advocates for underage drinking prevention policies.
- Coordinate Army One Source, SATI, and other military related behavioral health efforts with different veterans' organizations and the military family support programs to determine training, data, and coordination of service needs.
- Restructure of the prevention technical assistance system and workforce development agencies to provide working applications of integrated services in order to streamline the process. Bring data collection processes into DBHS infrastructure.

- Continue well-functioning prescription drug addiction efforts being spearheaded by the State Drug Director's and expand efforts to include emphasis on finding preventive solutions including training of healthcare professionals and health educators.
- Planning and training with the Arkansas Behavioral Health Planning Advisory Council, a group of local community providers, consumers, families, and concerned citizens focused on behavioral health issues with the objective of the meeting being to explain the SPF, current prevention efforts, proposed future prevention efforts and hear input on gaps that concern the group.
- Develop a consortium linking geographically separated LGBTQ support organizations to discuss training about prevention planning process, risk factors, data collection methods and a statewide network of services.
- Develop MOUs based on common language and shared goals for leveraged funding opportunities using either a combined application or common processes.

DATA SYSTEM *(RFA Section 2.4)*

Arkansas is a data rich state but more work needs to be done toward integrating the data to gain an overall view of the issues that impact both substance abuse and mental health.

A primary source of data for youth usage rates and risk factors is the Arkansas Prevention Needs Assessment, an annual survey conducted in the majority of public schools, which is based on the Communities That Care theory of change. The survey has been conducted on a census basis with 6th, 8th, 10th, and 12th graders since 2002. This allows for trend data that encompasses youth throughout their entire secondary career.

Currently, a random sample survey is done each year at different locations in the state as the Youth Risk Behavior survey through the CDC and Arkansas Dept. of Education. The Arkansas Department of Health conducts the Youth Tobacco Survey.

AFMC, the SAPT funded contractor for the State Epidemiological Workgroup, continues a comprehensive assessment of data that is currently available through State, national, and local agencies, and advocacy groups in collaboration with other workgroup members as it pertains to the topics in SAMHSA Initiative #1 Goals and SPE special topics.

- Relevant topics are
 - Substance abuse
 - Mental health risk factors
 - Underage drinking and adult problem drinking
 - Suicides, attempted suicides, and suicide risk factors especially for military family members and LGBTQ youth
 - Prescription drug misuse/abuse

AFMC has received data related to resources for substance abuse prevention and recovery within each drug abuse prevention region. This information has been synthesized into a database which includes region, county and other demographic information. The data will be subsequently placed on the web portal preventionworksar.com and will be searchable by county so that these resources are readily

available to providers, parents or other stakeholders. Approximately 800 resources are listed in the resource guide now under development and additional resources will be included as identified.

Data gaps, especially among adults, military and their families, and LGBTQ, have been identified and further work to develop data collection methods and locations is needed. By developing a consortium of LGBTQ support providers, a place and group which can administer a survey or other methodology will become available. Data is being collected for military but utilization of the data needed to be reviewed.

Data analysis for a better understanding of causes rather than just consumption and consequences will continue to be emphasized and developed as the SEW matures and expands and the DBHS data management section completes the creation of the Behavioral Health System Performance Framework and Dashboard.

Appendix I

Guiding Principles

1. Prevention is prevention is prevention. That is, the common components of effective prevention for the individual, family, or community within a public health model are the same – whether the focus is on preventing or reducing the effects of cancer, cardiovascular disease, diabetes substance abuse or mental illness.
2. Prevention is an ordered set of steps along a continuum to promote individual, family, and community health, prevent mental and behavioral disorders, support resilience and recovery, and prevent relapse. Prevention activities range from deterring diseases and behaviors that contribute to them, to delaying the onset of disease and mitigating the severity of symptoms, to reducing the related problems in communities. This concept is based on the Institute of Medicine (IOM) model that recognizes the importance of a whole spectrum of interventions.
3. Cultural competence and inclusiveness in working with populations of diverse cultures and identities is necessary to provide effective substance abuse prevention programming.
4. Resilience is built by developing assets in individuals, families, and communities through evidence-based health promotion and prevention strategies. For example, youth who have relationships with caring adults, good schools, and safe communities develop optimism, good problem-solving skills, and other assets that enable them to rebound from adversity and go on with life with a sense of mastery, competence, and hope.
5. Prevention begins within communities by helping individuals learn that they can have an impact on solving their local problems and setting local norms. Prevention emphasizes collaboration and cooperation, both to conserve limited resources and to build on existing relationships within the community. Community groups are routinely used to explore new, creative ways to use existing resources. All sectors of the community, especially parents and youth, are needed in successful prevention work. Members of the education, law enforcement, public health and health care communities are critical partners in substance abuse prevention efforts.
6. The Spectrum of Prevention is a broad framework that includes seven strategies designed to address complex and significant public health problems. These include a) influencing policy and legislation, b) mobilizing neighborhoods and communities, c) fostering coalitions and networks, d) changing organizational practices, e) educating providers, f) promoting community education, and g) strengthening individual knowledge and skills.
7. Common risk and protective factors exist for many substance abuse and mental health problems. Good prevention focuses on those common risk factors that can be altered. For example, family conflict, low levels of basic school readiness, and poor social skills increase the risk for conduct disorders and depression, which in turn increase the risk for adolescent substance abuse, delinquency, and violence. Protective factors such as strong family bonds, social skills, opportunities for school success, and involvement in community activities can foster resilience and mitigate the influence of risk factors. Risk and protective factors exist in individuals, the family, the community and the broader environment.
8. Systems of prevention services works better than prevention silos. Working together, researchers and communities have produced a number of highly effective prevention strategies and programs. Implementing these strategies within a broader system of services increases the likelihood of successful, sustained prevention activities. Collaborative partnership enables communities to leverage scarce resources and make prevention everybody's business.

Prevention efforts are more likely to succeed if partnerships with communities and practitioners focus on building capacity to plan, implement, monitor, evaluate, and sustain effective prevention.

9. Substance abuse prevention shares many elements of commonality with other related fields of prevention (i.e. juvenile delinquency prevention, adolescent suicide prevention). Collaboration and cross training across the prevention field is needed to maximize resources (both human and material).
10. Prevention specialists need a set of core competencies and a commitment to lifelong learning to stay current with the rapidly evolving knowledge and skill base in our field.
11. Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts. A strategic prevention framework can facilitate community identification of needs and risk factors, adopt assessment tools to measure and track results, and target outcomes to be achieved. A data-driven strategic approach maximizes the changes for future success and achieving positive outcomes.
12. Evaluation is crucial in order for communities to identify their successful efforts and to modify or abandon their unproductive efforts.



Appendix II

Center of Substance Abuse Prevention's Six Prevention Strategies

Listed below are the six strategies, an explanation of each, and examples of the types of activities appropriate to each strategy:

1. **Information Dissemination:** This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples: clearinghouse/information resource centers, media campaigns. Speaking engagements, and health fairs.
2. **Education:** This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem-solving, interpersonal communication, and systematic and judgmental abilities. Organizational infrastructure, planning, and evaluation skills are part of capacity development education. There is more interaction between facilitators and participants than in the information strategy. Examples: Coalition training and peer leader/helper programs.
3. **Alternatives:** This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities and to discourage the use of alcohol and other drugs. Examples: Recreation activities, drug-free dances and parties, and community service activities.
4. **Problem Identification and Referral:** This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity to determine if a person is in need of treatment. Example: Employee Assistance programs, student assistance programs, and DWI/DUI education programs.
5. **Community-based Process:** This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses grassroots empowerment models using action planning and collaborative systems planning. Examples: Community teambuilding, multi-agency coordination and collaboration, and accessing services and funding.
6. **Environmental:** This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population. Example: Modifying alcohol and tobacco advertising practices, product pricing strategies, and promoting the establishment of review of alcohol, tobacco, and drug use policies.

Strive to include at least three of the six prevention strategies in each activity or event!

Appendix III Public Health Approach

The focus of public health is on the safety and well-being of entire populations by preventing disease rather than treating it. The Institute of Medicine defines public health as “what we, as a society, do collectively to assure the conditions for people to be health.”



Key Characteristics

- Promotion and prevention
- Population based
- Risk and Protective factors
- Multiple contexts
- Development perspective
- Planning Process

Promotion and Prevention

Promotion is providing opportunity to optimize well-being and allow people to take responsibility for their own wellness.

Prevention aims to reduce behavioral problems by addressing the risk factors.

Population based

A public health approach concentrates on the health of the entire population, rather than at the individual level.

Risk and Protective Factors

The public health approach addresses those factors that contribute to the positive or negative health of a population.

Multiple contexts

The public health approach utilizes the multiple reams of individual, community and society which impact the population’s health.

Development perspective

A public health approach takes into consideration and uses interventions appropriate to the development stage of the target population.

Planning Process

The public health approach uses a strategic planning process to determine the actions to be taken and the benefits.

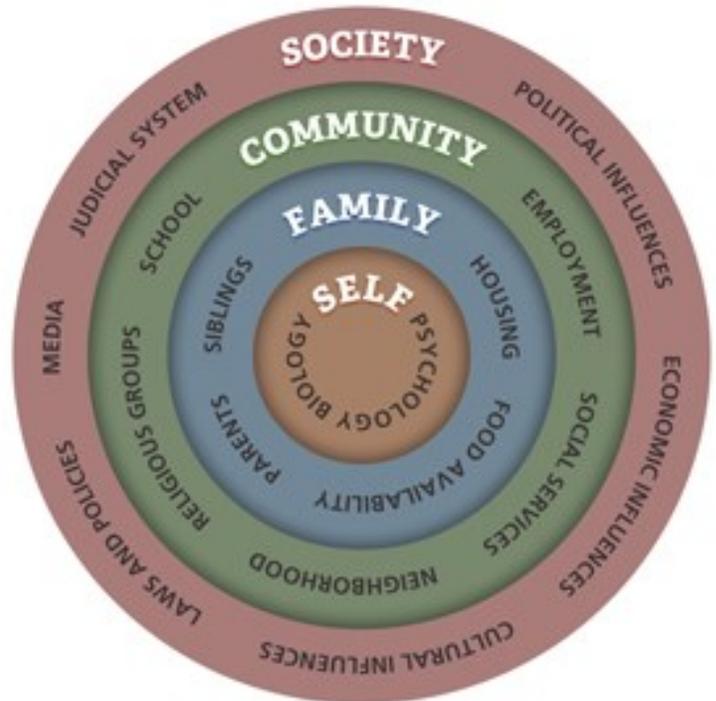
Appendix IV

Risk and Protective Factors Exist in Multiple Contexts

Individuals come to the table with **biological and psychological** characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health problems. Individual-level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors might include positive self-image, self-control, or social competence.

But individuals don't exist in isolation. They are part of families, part of communities, and part of society. A variety of risk and protective factors exist within each of these contexts. For example:

- In **families**, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision; a protective factor would be parental involvement
- In **communities**, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and after-school activities
- In **society**, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include policies limiting availability of substances or anti-hate laws defending marginalized populations, such as lesbian, gay, bisexual, or transgender youth



Practitioners must look across these contexts to address the constellation of factors that influence both individuals and populations: targeting just one context is unlikely to do the trick. For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults. A more effective—and comprehensive—approach might include school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training.

Appendix V

Policy Consortium Members

Category	Appointee	Agency
Arkansas Drug Director	Fran Flener	Governor's Office
Alcohol and Drug Abuse Prevention	Ann Brown	Office of Alcohol and Drug Abuse Prevention
Statewide Law Enforcement	Colonel Winford Phillips Alternate: Lt. Jerry Digman	Arkansas State Police
Education	Dr. Tom Kimbrell Alternate: Tammy Harrell	Department of Education
Highway Safety	Dan Flowers Alternate: Ronald Burks, Chief	AR Highway and Transportation Department
Prison System	Ray Hobbs Alternate: Robert A. Parker	Department of Corrections
Finance	Richard Weiss Alternate: Ann Purvis	Department of Finance & Administration
Military	Major General William D. Wofford Alternate: LTC Marcus Hatley	National Guard
Attorney General	Dustin McDaniel Alternate: Laura Shue	Attorney General
State Crime Laboratory	Kermit Channell Alternate: Richard Gallagher	State Crime Laboratory
Blood Alcohol Levels	Laura Bailey Alternate: Kent Williams	Blood Alcohol Testing Program, Department of Health
Probation	David Eberhard	Department of Community Correction
Court System	J. D. Gingerich	Administrative Office of the Courts
Police Chief	Chief Everett Cox	Tillar Police Department
County Sheriff	Sheriff Marty Moss Cleburne County	Cleburne County Sheriff Department
Drug Court Judge	Judge Joe Griffin Miller County	Drug Court
Prosecuting Attorney	Larry Jegley Alternative: Jonathan Ross	Pulaski County Prosecuting Attorney
Private citizen not employed by the State or Federal government	Dennis Emerson	Poyen School District
Director of a publicly funded alcohol and drug abuse treatment program	Dr. Rob Covington	Horizon Adolescent Treatment
School drug counselor	Katrina Cavaness	Monticello Public Schools
Director of a drug abuse prevention program	Reverend Edna Morgan	Healing Place Ministries
DWI program	Jim Allen	Family Service Agency, Inc.
Health Professional	Charlotte Denton	University of Arkansas at Monticello
At Large Members	Teresa Belew	Private Citizen
	John Wiles	Person in Recovery
	Vivian Ozura	Private Citizen
	North Elliott	Narcotics Anonymous

Appendix VI

Recommended Evidence-based Programs and Strategies

↓ = Decrease

↑ = Increase

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
<p>Al's Pals: Kids Making Healthy Choices. The curriculum helps young children regulate their own feelings and behavior; creates and maintains a classroom environment of caring, cooperation, respect, and responsibility; teaches conflict resolution and peaceful problem-solving; promotes appreciation of differences and positive social relationships; prevents and addresses bullying behavior; conveys clear messages about the harms of alcohol, tobacco, and other drugs; and builds children's abilities to make healthy choices and cope with life's difficulties.</p> <p>Web Site(s): http://www.wingspanworks.com/educational_programs</p>	<p>Ages 0 to 12.</p> <p>Black or African American; Hispanic or Latino; White.</p> <p>School; other community settings.</p>	<p>↓ Alcohol use ↓ Tobacco use ↓ Other drug use</p>	<p>↑ social-emotional skills ↑ Problem-solving ↑ Healthy decision making ↑ Social competence ↑ Prosocial behaviors ↓ Antisocial behavior ↓ Aggressive behaviors</p>	<p>↓ Bullying Behavior ↓ Violence</p>	<p>Curriculum kit - \$685 each; 2-day core training at centralized location - \$300 per person; 2-day core training on site \$6,500 for a group of 24, or \$8,000 for a group of 30, plus trainer travel costs; Seven 2-hour online core training sessions - \$325 per person or \$4,300 for a group of 15; Free ongoing technical assistance/consultation; Evaluation services package \$300 per classroom for online data entry, or \$400 per classroom for paper data entry.</p>
<p>Big Brothers Big Sisters Mentoring Program. Designed to help participating youth ages 6-18 ("Littles") reach their potential through supported matches with adult volunteer mentors ages 18 and older ("Bigs"). The program focuses on positive youth development, not specific problems, and the Big acts as a role model and provides guidance to the Little through a relationship that is based on trust and caring.</p> <p>Web Site(s): http://www.bigbrothersbigsisters.org</p>	<p>Ages 6 to 17.</p> <p>Black or African American; Hispanic or Latino; White; American Indian or Alaska Native.</p> <p>Other community settings</p>	<p>↓ Initiation of drug use</p>	<p>↓ Aggressive behaviors ↑ Social competence ↑ Social achievement ↑ Family relationships ↓ Skipping school ↑ Complete homework</p>	<p>↓ Violence</p>	<p>Membership fee Varies depending on site resources (minimum of \$150,000 per year for 3 years). Agency Information Management (AIM) System \$2,000-\$12,000 depending on the number of youth served</p>

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
<p>Brief Alcohol Screening & Intervention in College Students (BASICS). Prevention program for college students who drink alcohol heavily and have experienced or are at risk for alcohol-related problems. BASICS is delivered in an empathetic, nonconfrontational, and nonjudgmental manner and is aimed at revealing the discrepancy between the student's risky drinking behavior and his or her goals and values. Web Site(s): http://depts.washington.edu/abrc/basics.htm</p>	<p>Ages 18 to 25. Asian; Hispanic or Latino; White; American Indian or Alaska Native. Schools</p>	<p>↓ Frequency of alcohol use ↓ Quantity of alcohol use ↓ College Binge Drinking</p>			<p>\$30 for Program manual; Training video - \$250. 2- to 3-day, off-site training \$4,000 per site per day; 1-day workshops \$4,000 per site; Technical assistance \$4,000 per site per day. Training (or supervision by trained personnel is recommended to implement BASICS and depending on staff experience, it can be completed in 1 to 2 days.</p>
<p>Caring School Community (NREPP). Universal elementary school program designed to create a caring school environment, supportive relationships, and collaboration among students, staff, and parents. Web Site(s): http://www.devstu.org/csc/videos/index.shtml</p>	<p>Ages 6 to 12. Asian; Black or African American; Hispanic or Latino; White School</p>	<p>↓ Alcohol use ↓ Marijuana use</p>	<p>↑ Social achievement ↑ Academic achievement ↑ Concern for others ↓ Disciplinary referrals</p>		<p>Teacher's package (including quality assurance materials) \$225 per grade level, or \$1,500 for K-6 combined; Principal's package \$425 each; Read-aloud libraries (10 trade books) \$61-\$72 per grade level; 1-day workshops \$2,600 per day; Follow-up visits \$2,600 per day.</p>
<p>Community Trials Intervention To Reduce High-Risk Drinking. Multicomponent, community-based program developed to alter the alcohol use patterns and related problems of people of all ages. The program incorporates a set of environmental interventions to help communities reduce alcohol-related accidents and incidents of violence and the injuries that result from them. Web Site(s): http://www.pire.org/communitytrials/index.htm</p>	<p>Ages 13 and older Black or African American Hispanic or Latino Other community settings</p>	<p>↓ Alcohol use patterns and related problems ↓ Alcohol-related traffic crashes ↓ Alcohol-related assaults</p>		<p>↓ Violence</p>	<p>\$0–10,000 Costs will vary by community. Implementation materials, training, technical assistance/consultation, and quality assurance materials Contact the developer</p>

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
<p>Families and Schools Together (FAST). Multifamily group intervention designed to build relationships between families, schools, and communities to increase well-being among elementary school children. Participants in the multifamily group work together to enhance protective factors for children, including parent-child bonding, parent involvement in schools, parent networks, family communication, parental authority, and social capital, with the aim of reducing the children's anxiety and aggression and increasing their social skills and attention spans.</p> <p>Web Site(s): http://familiesandschools.org http://cfsproject.wceruw.org/fastprogram.html</p>	<p>Ages 0 to 12.</p> <p>Black or African American; Hispanic or Latino; White.</p> <p>School; other community settings.</p>	<p>↓ Substance abuse</p>	<p>↓ Child problem behaviors ↑ Child social skills ↑ Academic competencies ↑ Family relationships ↑ Social functioning</p>	<p>↓ Violence</p>	<p>Training package \$6,045 plus travel expenses. The training package includes all required implementation materials, training, the licensing fee, ongoing technical assistance, and an evaluation package.</p>
<p>Guiding Good Choices (GGC). Drug use prevention program that provides parents of children in grades 4 through 8 with the knowledge and skills needed to guide their children through early adolescence.</p> <p>Web Site(s): http://www.channing-bete.com/ggc</p>	<p>Ages 6 and older</p> <p>White.</p> <p>School</p>	<p>↓ Lifetime marijuana use ↓ Lifetime alcohol use ↓ Tobacco ↓ Other drugs use</p>	<p>↓ Rate of depression ↓ Delinquent activities ↑ Family relationships ↑ Social functioning</p>		<p>Core program kit \$839 each; Family guide \$13.99 each; 3-day, on-site training \$4,200 for up to 12 people, plus travel expenses; On-site T/A \$1,200 per day or \$600 per half-day, plus travel expenses Pre- and posttests is free.</p>
<p>Lead and Seed. A youth empowered, environmental approach to preventing and reducing alcohol, tobacco and drugs in a community https://www.alutiiq.com/capabilities/lead-seed/</p>	<p>Elementary and High school</p> <p>School</p>		<p>↑ human, technical and financial capacities ↑ advocacy skills ↑ leadership, efficacy and environmental skills</p>		<p>Contact developer for pricing information. https://www.alutiiq.com/capabilities/lead-seed/</p>

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
<p>Life Skills Training. School-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors. Web Site(s): http://www.lifeskillstraining.com</p>	<p>Ages 13 to 17. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School</p>	<p>↓ Alcohol use ↓ Cigarettes ↓ Marijuana use ↓ Inhalants</p>	<p>↓ Delinquency ↓ Fighting ↓ Aggression</p>	<p>↓ Violence</p>	<p>Grade level curriculum set \$175-\$275 depending on grade level; Elementary Program CD-ROM (available for some grade levels) \$45.95 each; Smoking and biofeedback DVD \$20 each; 1-day, on-site workshop \$200 per participant for up to 20 participants, 2-day, on-site workshop \$250 per participant for up to 20 participants; Pre- and posttest instruments is free.</p>
<p>Lion's Quest (NREPP). Multi-component, comprehensive life skills education program designed for school-wide and classroom implementation in grades 6 to 8. The goal of the program is to help young people develop positive commitments to their families, schools, peers, and communities and to encourage healthy, drug-free lives. Web Site(s): http://www.lions-quest.org</p>	<p>Ages 6 to 17. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School</p>	<p>↓ Past month alcohol use ↓ Past month chewing tobacco ↓ Lifetime marijuana use</p>	<p>↑ Academic performance ↑ Handling peer conflicts ↓ Misconduct ↑ Social functioning</p>	<p>↓ Violence</p>	<p>Student book \$5.95 per student; Parent book \$3.95 per parent; 2-day, on-site training \$180-\$330 per person plus travel expenses; 2-day, off-site training (includes starter set of implementation materials) \$425-\$500 per person; Electronic consultation \$50 per hour; Unit tests and evaluation tools is free.</p>
<p>Olweus Bullying Prevention Program. The <i>Olweus Bullying Prevention Program</i> is designed to improve peer relations and make schools safer, more positive places for students to learn and develop.</p>	<p>Ages 5 to 15. School</p>			<p>↓ Existing bullying problems ↓ New bullying problems ↑ Peer relations at school</p>	

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
<p>Parenting Wisely. A set of interactive, computer-based training programs for parents of children ages 3-18 years. The programs aim to increase parental communication and disciplinary skills.</p> <p>Web Site(s): http://www.familyworksinc.com</p>	<p>Ages 0 to 17.</p> <p>Black or African American; White; Non-U.S. population</p> <p>Other community settings</p>	<p>↓ Substance abuse</p>	<p>↓ Child problem behaviors ↑ Parental sense of competence ↑ Family relationships ↑ Social functioning</p>		<p>American Teens program kit \$659 each; Online version of American Teens program \$39.95 with quantity discounts for bulk purchases of passwords; 1-day, on-site training \$3,000 per site; free technical assistance by phone or email.</p>
<p>Project ALERT. Prevention program for middle or junior high school students that focuses on alcohol, tobacco, and marijuana use. It seeks to prevent adolescent nonusers from experimenting with these drugs, and to prevent youths who are already experimenting from becoming more regular users or abusers.</p> <p>Web Site(s): http://www.projectalert.com</p>	<p>Ages 13 to 17.</p> <p>American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White.</p> <p>School</p>	<p>↓ Alcohol use ↓ Tobacco use ↓ Marijuana use</p>	<p>↑ Family relationships ↑ Mental health promotion</p>		<p>Curriculum in e-reader format with online videos and files for posters that can be projected is free; Free on-line training; Toll-free phone support, online resources, and ALERT Educator newsletter; Free fidelity instrument and alignment and assessment tools.</p>
<p>Project Northland. Multilevel intervention involving students, peers, parents, and community in programs designed to delay the age at which adolescents begin drinking, reduce alcohol use among those already drinking, and limit the number of alcohol-related problems among young drinkers.</p> <p>Web Site(s): http://www.hazelden.org/web/guest/projectnorthland</p>	<p>Ages 6 to 17.</p> <p>American Indian or Alaska Native; White.</p> <p>School</p>	<p>↓ Tendency to use alcohol ↓ Past-week alcohol use ↓ Past-month alcohol use ↓ Peer influence to use alcohol ↑ Reasons not to use alcohol ↑ Parent-child communication about alcohol</p>	<p>↑ Family relationships</p>		<p>Grade 6-8 curricula \$195 each; \$429 for grade 6-8 curriculum set; \$549 for grade 6-8 curriculum set plus program guide; 3-day, on-site basic or refresher training \$6,200 per site plus travel expenses; 3-day, off-site basic or refresher training \$600 per participant; Technical assistance \$100 per hour.</p>

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
<p>Second Step. A classroom-based social-skills program for children 4 to 14 years of age that teaches socioemotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. Web Site(s): http://www.cfchildren.org</p>	<p>Ages 6 to 12. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School.</p>	<p>↓ Substance abuse</p>	<p>↑ Social competence ↑ Prosocial behavior ↓ Incidence of negative behaviors ↓ Aggressive behaviors ↓ Antisocial behaviors</p>		<p>Curricula kits, sets and videos \$39 - \$619; 2-day training at a regional location \$525 per person; 2-day, on-site training \$7,500 for up to 25 participants; 1-day, on-site training \$4,000 for up to 40 participants; Free limited telephone/email technical assistance.</p>
<p>Strengthening Families. A family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3-16 years old. Web Site(s): http://www.strengtheningfamiliesprogram.org</p>	<p>Ages 6 to 17; 26 to 55. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White; Non-U.S. population Home; school</p>	<p>↓ Substance abuse</p>	<p>↑ Family relationships ↑ Mental health Promotion ↑ Social functioning</p>		<p>CD containing materials for one age group: 3-5, 6-11, or 12-16 years \$450 each; 2-day, on-site group leader training and one SFP CD master set \$3,650 plus travel expenses for 2 trainers for groups of 35 or fewer; 2-day, on-site group leader training and one SFP CD master set \$3,050 plus travel expenses for 1 trainer for groups of 15 or fewer; Evaluation services \$1,950-\$12,000 annually depending on number of participants and number of evaluation reports; Fidelity site visits \$1,500.</p>
<p>Strengthening Families Program: For Parents and Youth 10-14. For parents and youth, a family skills training intervention designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds. Web Site(s): http://www.extension.iastate.edu/sfp</p>	<p>Ages 6 to 12; 26 to 55. White. School.</p>	<p>↓ Lifetime alcohol use ↓ Lifetime smoking ↓ Lifetime marijuana use ↓ Lifetime drunkenness ↓ Using alcohol without parent permission</p>	<p>↓ Aggressive behavior</p>		<p>Program materials \$1,109 per set for 6-10 facilitators; 3-day, on-site or off-site staff training and technical assistance \$6,000 for up to 30 people, including travel expenses; Fidelity observation checklists is free</p>

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
Team Awareness. Customizable worksite prevention training program that addresses behavioral risks associated with substance abuse among employees, their coworkers, and, indirectly, their families.		↓ Drinking ↓ Job-related hangovers	↑ Spiritual health ↑ Willingness to seek help		

↓ = decrease

↑ = increase

Sources:

1. SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP): <http://nrepp.samhsa.gov/>
2. Institute of Medicine (IOM). Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities, March 2009. <http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx>
3. APPI. (2010). Clinical manual of prevention in mental health. Washington, D.C. American Psychiatric Publishing.

Appendix VII

Strategic Prevention Enhancement Community Meeting

Huntsville Behavioral Health Meeting

November 9, 2012

Participants at the behavioral health community meeting in Huntsville drew a picture of a region struggling with poverty and its related homelessness and hunger, untreated behavioral health issues, and substance use issues.

Gaps in mental health services stemmed from a lack of trained professionals which leads to misdiagnosis, lack of funding to pay for treatment, geographic limitations make it difficult for clients to reach services, fear of losing their employment and stigma. One particular mental health issue, depression, brought many topics together including violence, stigma, family dysfunction, social isolation, and job loss which lead to the poverty related issues and eventually substance use. Other consequences of depression could be suicide, job loss, divorce, violence, and jail. Participants also reiterated the fact that substance abuse may lead to the problems mentioned above.

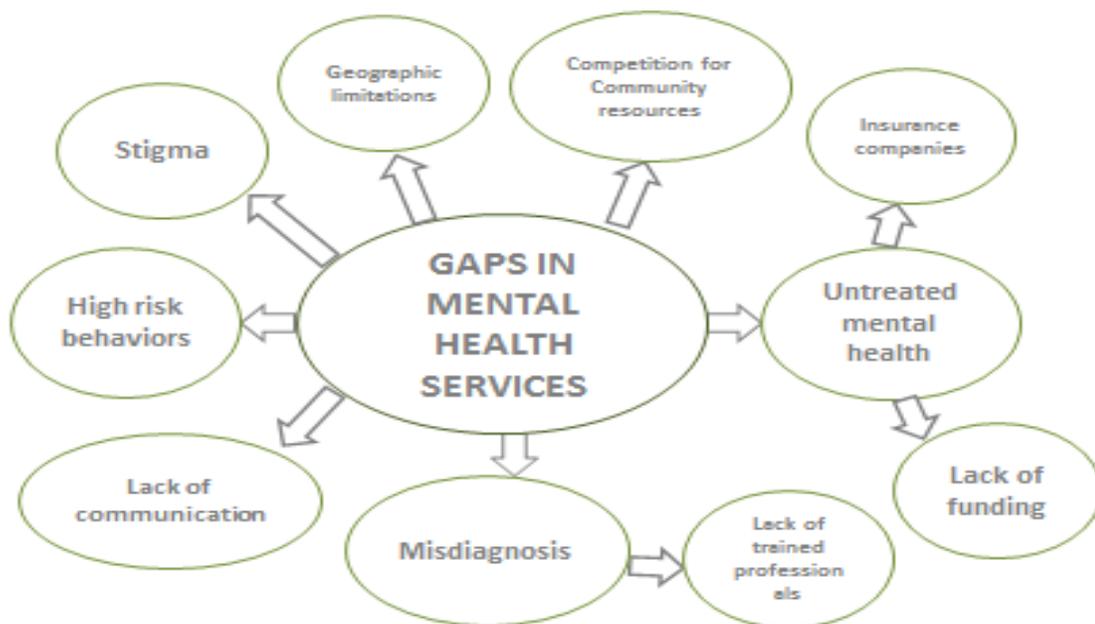
Alcohol abuse was identified as the main substance of abuse in this region. Reasons for high use rate were attributed to peer pressure, social acceptability, advertising, easy access and as an escape for other problems like poverty, unemployment, family problems and other behavioral health problems.

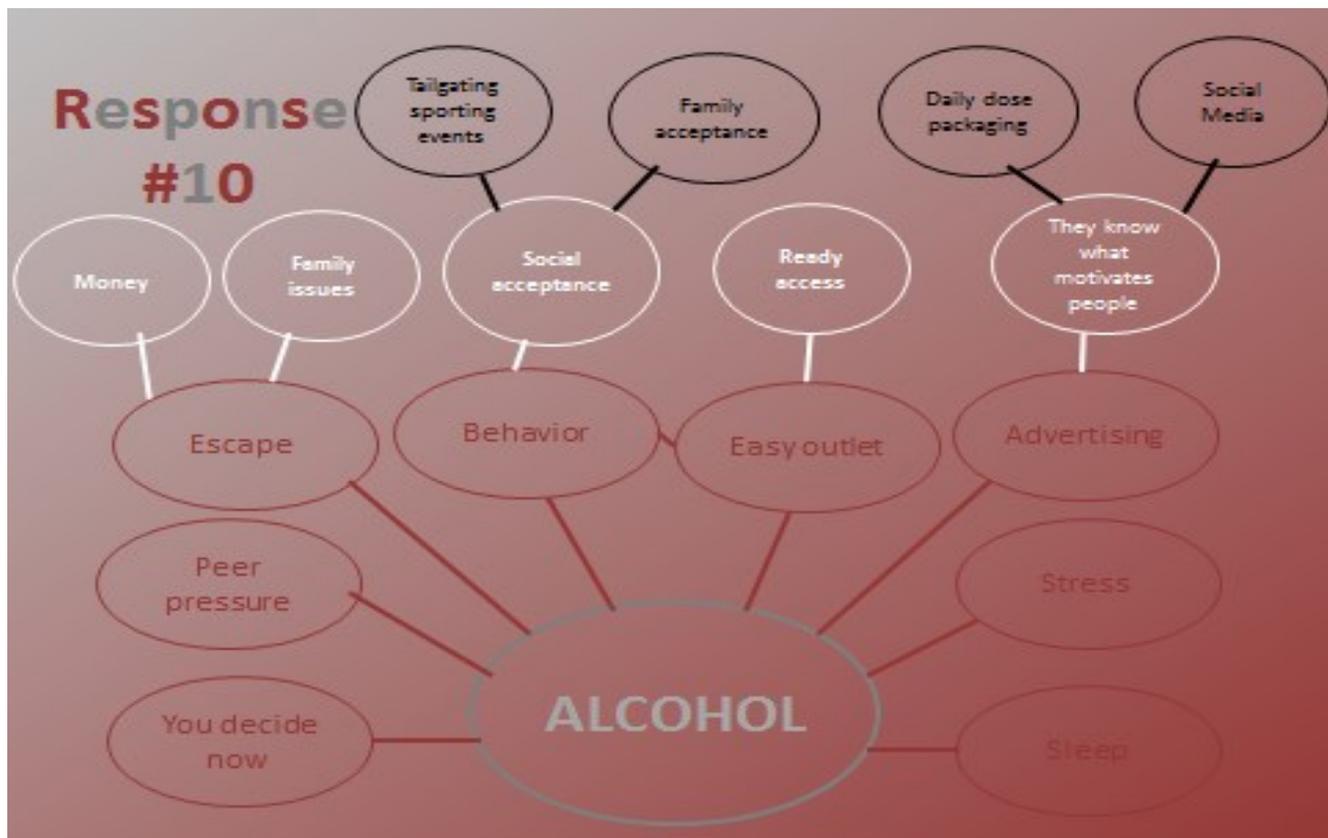
The issue of religiosity was brought forth as a contributing factor to substance abuse and mental health issues. This is due to the lack of training of faith-based leaders on substance abuse and mental health issues as they are sometimes responsible for members of their congregation or other community members not receiving help, because they believe they can just pray about the issues and be healed.

Response #1



Response # 2





Walnut Ridge Behavioral Health Meeting

November 30, 2012

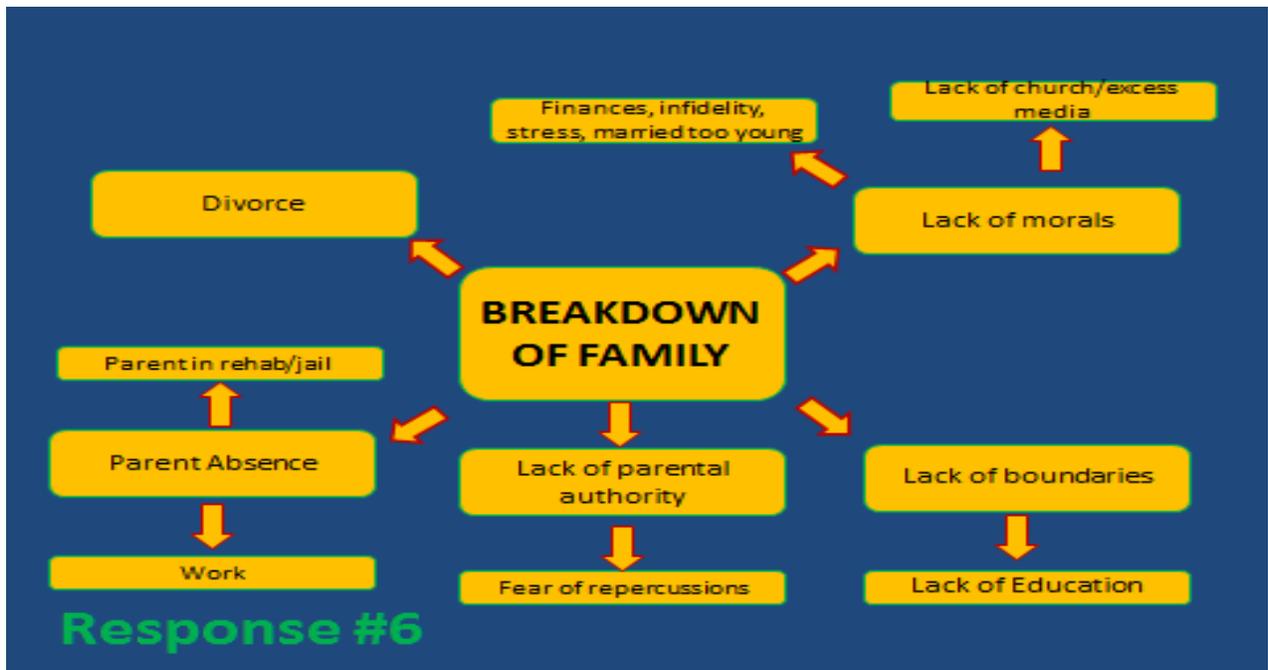
Lack of healthcare treatment included substance abuse treatment and mental health treatment. Participants mentioned the stigma attached with mental illness and a lack of cultural acceptance for seeking treatment. This lack of understanding and education caused people not to seek counseling and to self-medicate. Another resources that were identified as inadequate in this regions are drug courts.

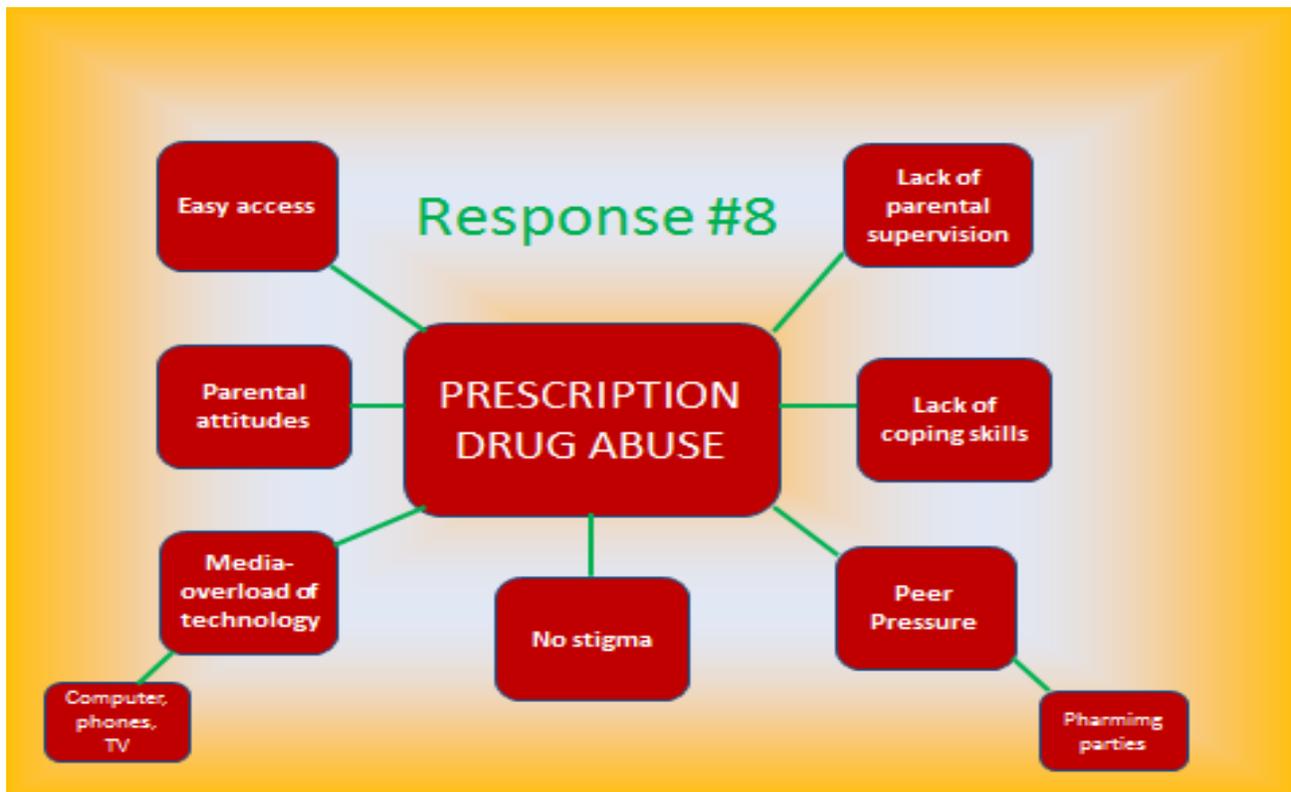
The participants stated that homelessness and hunger, mental health issues, poor physical health and low self-esteem could be consequences of contributing factors of a breakdown of the family unit. The contributing factors identified include parental absence, lack of parental authority, lack of parental skills and high divorce rates leading to single parent homes. This leads to home environment lacking stability and high risk for substance abuse.

Prescription drug abuse was sighted as a big problem in this region by participants. Reason for this problem were easy access, peer pressure, lack of stigma associated with, lack of parental awareness of harm from prescription drug abuse, technology and social media and lack of physician accountability. Breakdowns in both the medical community and in social systems were noted as biggest contributing factors to drug misuse. Other contributing factors for drug misuse were desire to please other and fit in

to a particular set, filling a void related to low self-esteem and lack of social skills, lack of resistance skills especially for students on their own for first time in unfamiliar environments, and negative neighborhood environments.

Lack of treatment resources and the environment in the home and community were the most often expressed concerns by the participants in this meeting. Economic issues were also noted but these impacted the community environment. While specific substance issues were listed as a major topic, the factors surrounding the substance use returned to the environment and resource issues.





Dumas Behavioral Health Meeting

December 11, 2012

The participants attending the meeting described a region with economic hardships, an education system that needs assistance and a breakdown in culture values that impacts both health and family function.

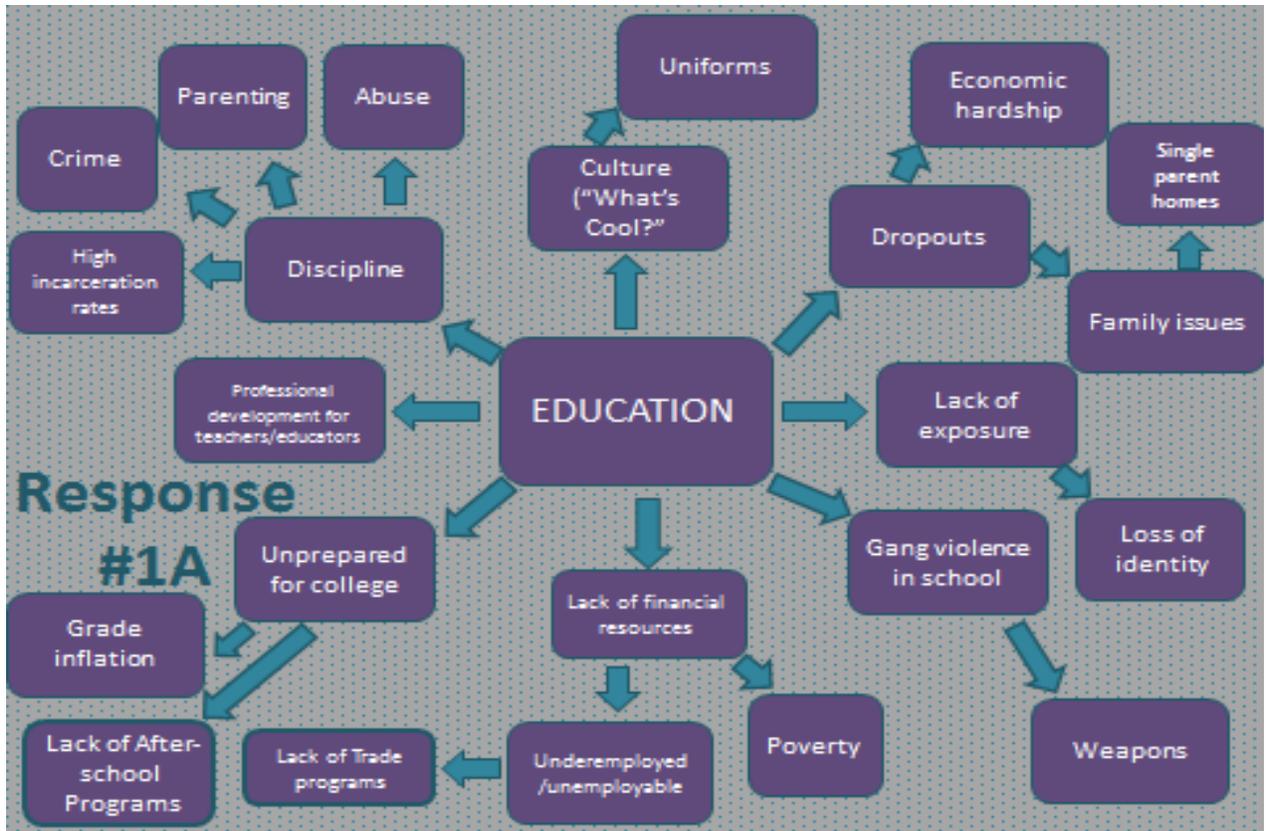
Economic hardship and education were closely tied together and seen as the major issues impacting the area, especially when it came to behavioral health and general wellness. Education issues included consequences such as dropouts, youth who were unprepared for college due to grade inflation and social promotion, professional development for educators, mainstreaming of special needs students, and lack of colleges and training programs for the trade. The educational consequences impacted both cultural issues such as parenting and the economic issues because of an unskilled workforce.

The economic hardships cause a lack of financial resources from unemployment or underemployment which leads to poverty which has a demonstrated effect on housing, education and health. Transportation was also discussed as both a drawback and a consequence. Without it, people cannot get to jobs and without jobs; they cannot afford vehicles and gas to get to jobs. Lack of industry and political leadership were seen as influences to the economic hardship issue. The stress factors related to economic problems exacerbated the mental health and substance abuse problems while reinforcing family dysfunction and crime rates.

A breakdown in culture and family values was perceived to be one of the major contributors to substance abuse in this region. This leads to family dysfunction which ultimately leads to substance abuse and mental and physical health issues. Issues noted included things like parents smoking weed with their kids, broken homes with single parents, abuse and neglect, and lack of respect and discipline. Teen pregnancy was also attributed to family dysfunction. Young men falling off society's grid was also brought up with the example given of young men who went from living with their family who provided a vehicle and insurance in the parents' name to living with a young woman where all bills are in her name and then the young man does not work.

Apart from substance abuse, the breakdown in family values was also seen as a major contributor to the high rates of incarceration and gang violence seen in this region. A lack of resources for reentry of ex-offenders was also noted as a contributing factor to substance abuse as it leads to unemployment and poverty.

Another major issue that arose during discussions of education, health, and substance abuse was a lack of structured recreational activities. Youth organizations such as Boys and Girls Clubs, Boy and Girl Scouts, and parks with walking trails or sports programs were all mentioned. Sustainability for these programs along with educational and economic programs were seen as a challenge because of funding that dries up and lack of structure.





North Little Rock Behavioral Health Meeting

November 11, 2012

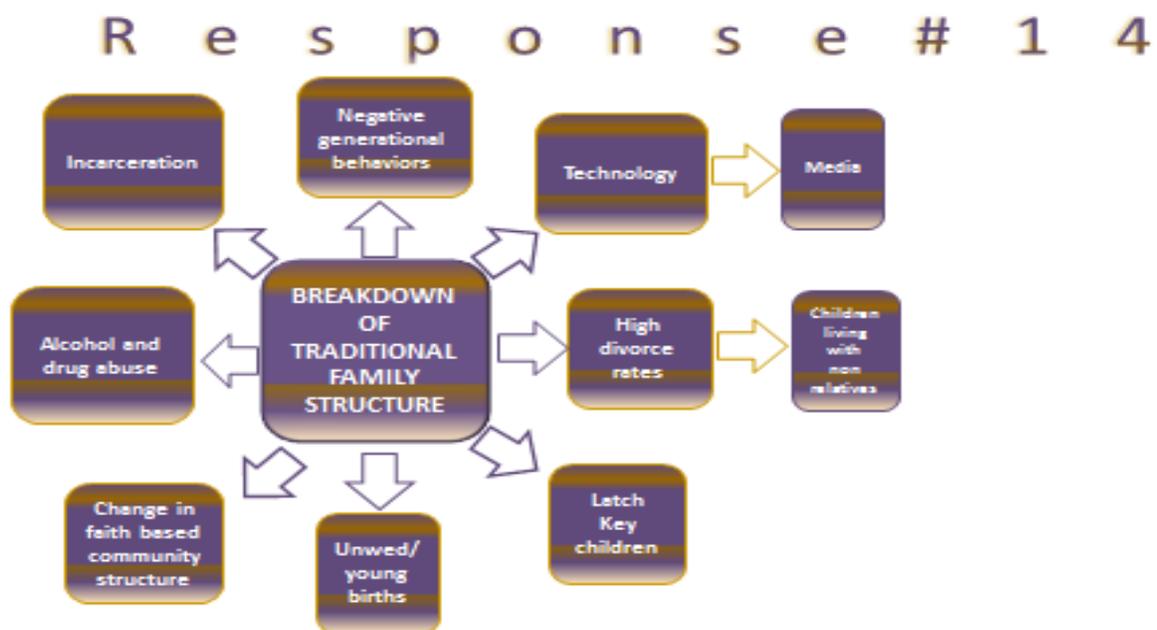
This community meeting covered a diversity of topics on risk factors for behavioral health issues. Lack of community resources, breakdown of family structure and stigma for seeking services were identified as the leading factors for substance abuse.

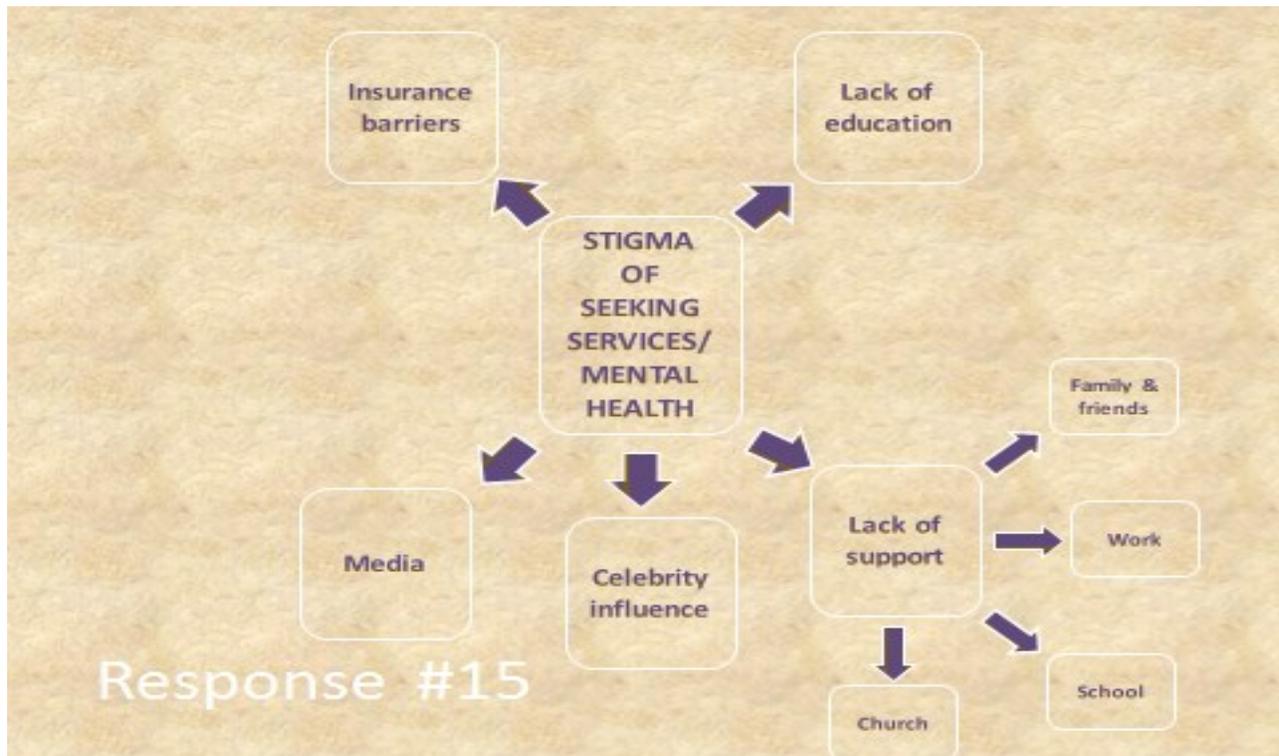
In some areas of this region there is a dearth of health behavioral health service. However in areas where services are available behavioral health providers do not communicate with each other and hence often operate in silos thereby giving a perception of lack of resources. This hinders referrals to appropriate facilities for such services.

A breakdown in the traditional family structure such as poor parenting skills, increase in single parent homes due to incarceration and high divorce rate, and a collapse of faith-based family units was identified as a huge factor in high substance use, misuse and abuse in this region.

Participants also identified stigma for seeking mental health and substance abuse prevention and treatment services as another factor contributing to substance abuse in this region. They pointed out that a lot of people do not seek such services as it may affect they current employment or ability to seek employment. Also the shame of being labeled as drug abuser or a psychiatric patient leads to self-medication or medicating with alcohol and other drugs.

Other factors identified as a consequence and risk factor for alcohol and drug abuse were homelessness especially among veterans, low graduation rates, poverty, lack of transportation, the legal system, race issues relating to unfair sentencing, and doctor shopping for prescription drugs.





Hope Behavioral Health Meeting

November 15, 2012

Primary concerns for high substance abuse expressed by the participants at this meeting centered on parenting and family involvement, lack of transportation, and lack of coordination or access to resources.

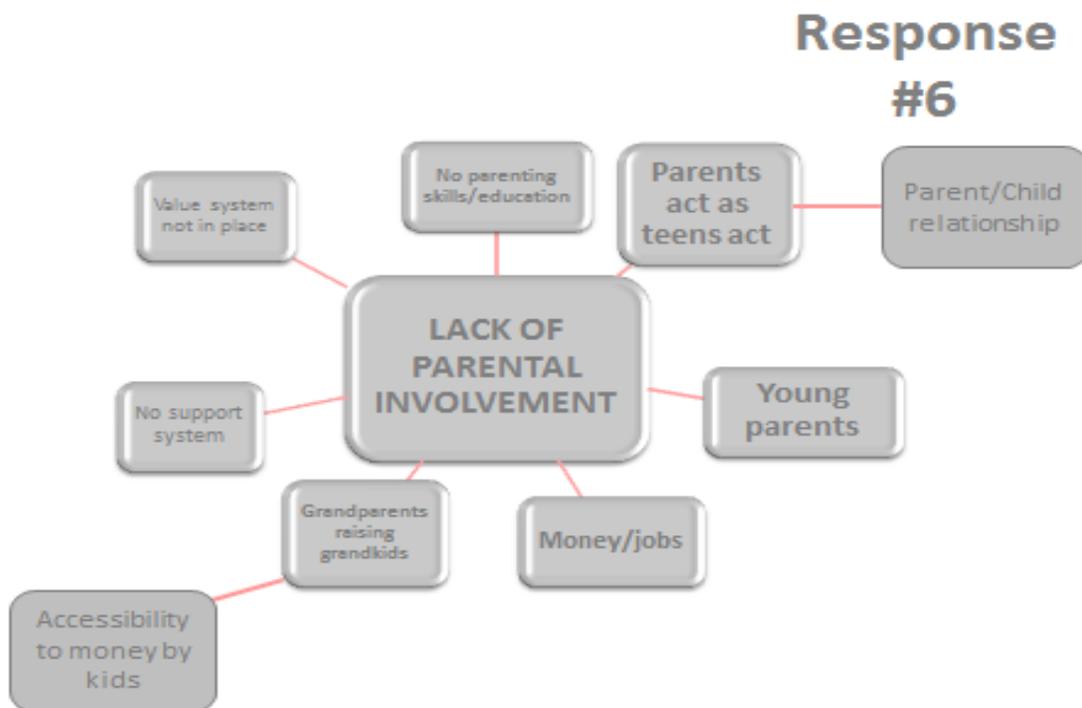
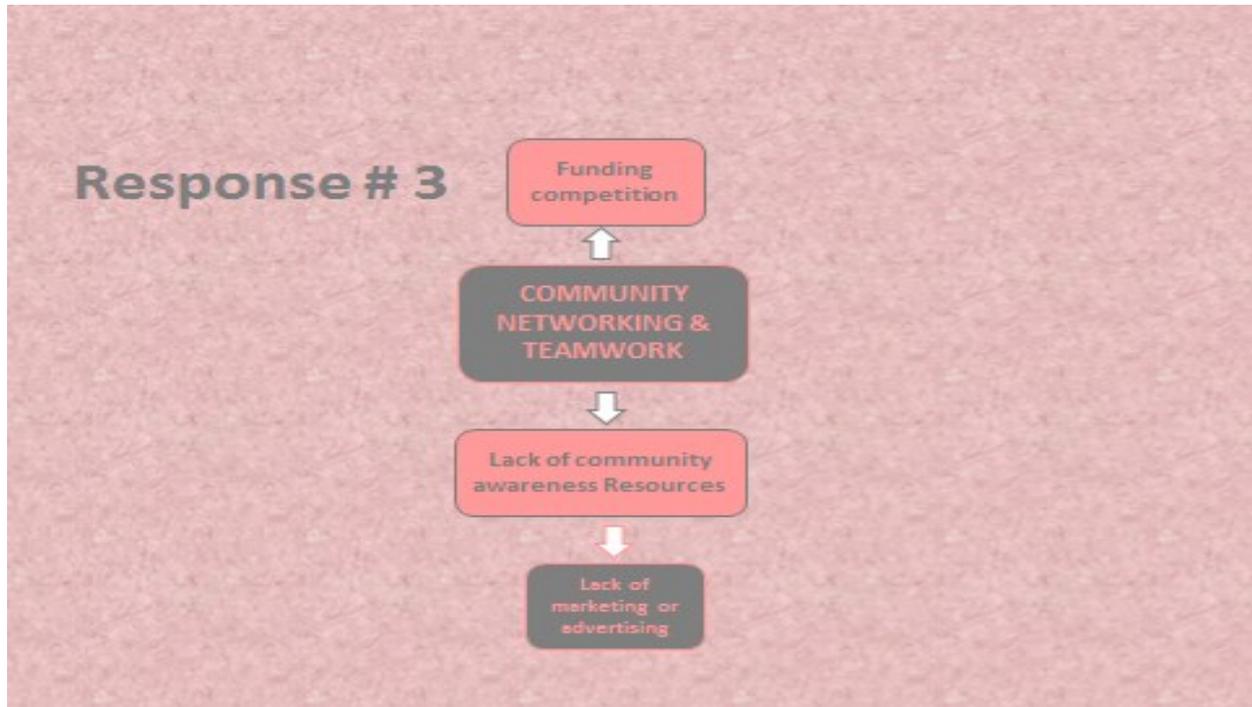
Parenting issues included a variety of factors such as parents feeling overwhelmed, fearing the system, or being self-absorbed. Participants talked about parent who act like teens or are teens themselves. Absentee parents were also mentioned due to incarceration, lack of father involvement, single parents having to serve in dual roles, and grandparents raising grandchildren. Parent education and lack of structure and skills were mentioned but it was also noted that parents who attend classes are sometimes labeled dysfunctional. Besides being a topic in itself, parenting was also seen as a risk factor for increased substance abuse in other topics.

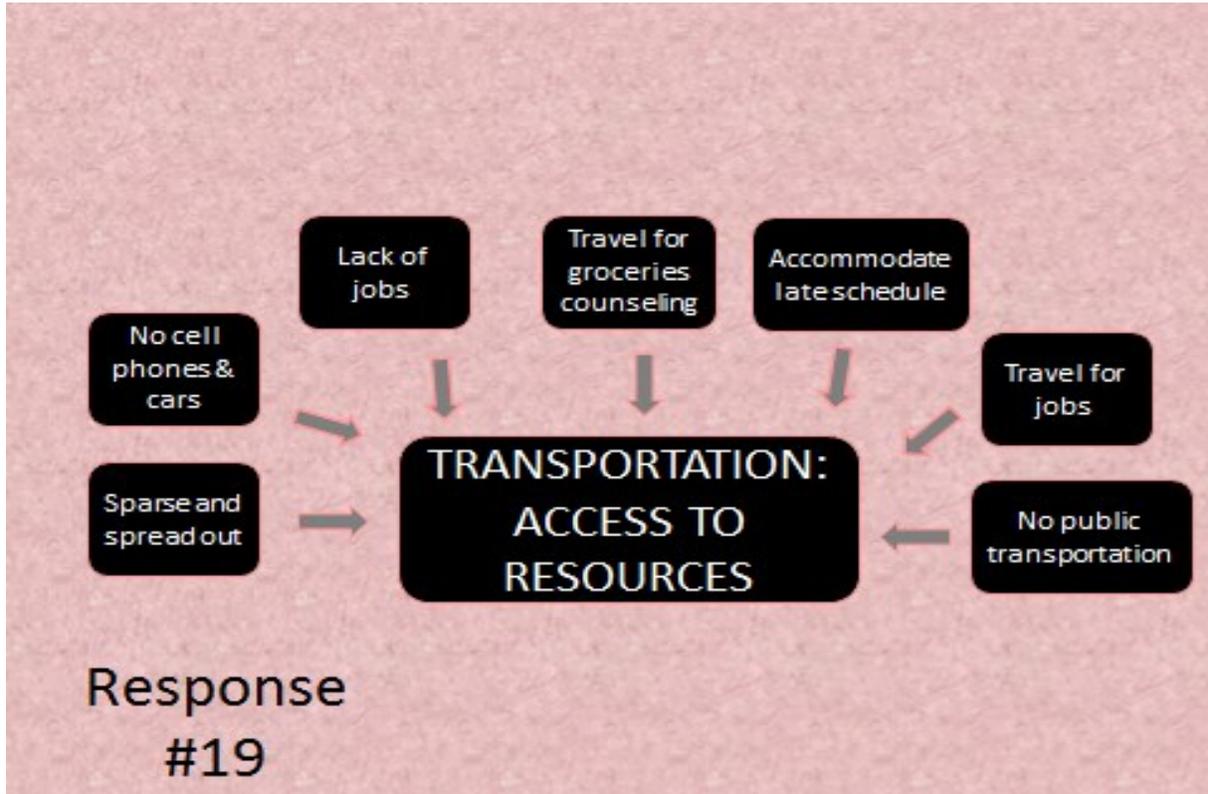
Due to the rural nature of these communities, lack of transportation was perceived to be a contributing factor to ATOD abuse. This limits access to prevention and treatment facilities, transportation to afterschool programs or facilities for alternative youth activities, to seek for employment, and even the purchase groceries. These limitations hence increase the risk of ATOD use as it leads to an increase in unemployment, inability to seek for healthcare and idleness especially among youths.

Lack of coordination and silos of services was seen as another major contributor of ATOD abuse. Participants explained that lack of collaboration among prevention providers themselves as well as with

prevention, treatment and mental health providers often lead to lack of services available within the communities.

Other factors identified were peer pressure, family and cultural norms, easy access, social media influences, limited behavioral health facilities, low self-esteem and lack of parental awareness of the dangers ATOD.





Appendix VIII

MidSOUTH Prevention Institute 2011 Training Survey

If you would like to complete the survey online go to <https://www.midsouth.ualr.edu/survey/Plsurvey2011.html>. Your time in completing this survey will provide the Prevention Institute with important information regarding the topics and locations for training which will assist us in planning upcoming workshops. It is very important that you complete **ALL** items. **Please submit your completed assessment to MSPI before Thursday, June 30, 2011.**

My work is **primarily (check only one)**:

- Education (teacher, counselor, administrator, school nurse)
- Prevention (prevention specialist, consultant, program administrator, ADAP)
- Correction/Law Enforcement (SRO, parole personnel)
- Volunteer
- Other not listed

What Arkansas County are you from: _____

Years of work experience: _____

I hold the following CPS or CPC certifications **(check only one)**:

- Certified Prevention Specialist (CPS)
- Certified Prevention Consultant (CPC)
- Enrolled in the process to become a CPS or CPC

Other certifications/licensures: _____

Please select the area you would most likely attend workshops, if offered **(check only one)**:

- Arkadelphia
- Fayetteville
- Jonesboro
- Little Rock
- Monticello

Please submit your completed assessment before Thursday, June 30, 2011

Via mail or by clicking the link below

UALR – MidSOUTH Prevention Institute

2801 S. University Avenue, PP-103

Little Rock, AR 72204-1099

<https://www.midsouth.ualr.edu/survey/Plsurvey2011.html>

Prevention Resource Center Coordinators ONLY: Please provide an additional sheet to recommend advanced topics in which you need training.

Thank you again for taking the time to complete this assessment.

Your responses will be used to plan upcoming workshops.

Core Competencies	Check <input checked="" type="checkbox"/> if you need training
Assessment:	
Creating and maintaining coalitions and partnerships	
Assessing community needs and resources	
Analyzing problems and goals	
Developing a framework or model of change	
Capacity:	
Building coalition leadership	
Increasing coalition participation	
Enhancing cultural competence	
Improving organizational management and development	
Planning:	
Developing strategic and action plans	
Implementation:	
Developing interventions	
Advocating for change	
Influencing policy development	
Writing grant applications for funding	
Evaluation:	
Evaluating initiatives	
Sustaining projects and initiatives	
ESSENTIAL PROCESSES	
Conducting a community assessment	
Developing a logic model (A picture of how an effort or initiative is supposed to work.)	
Creating an action plan	
Developing an intervention	
Creating an evaluation plan	
Creating a sustainability plan	
Prevention Knowledge & Responsibilities	
Using Institute of Medicine (IOM) categories to select the appropriate strategy	
Understanding models, theories, concepts and strategies of prevention	
Identifying human development/ life stages	
Listing and Describing risk and resiliency (protective) factors	
Developing measurable goals and outcome objectives	
Describing the process of addiction	
Knowledge of Center for Substance Abuse Prevention's (CSAP) 6 Prevention Strategies	
Knowledge of current trends in drug use patterns	
Practicing ethical behavior	
Adhering to legal and professional standards to protect the public and promote integrity of the profession	
Maintaining proficiency in technology, facilitation and presentation skills	
Knowledge of the National Outcome Measures (NOMs) (i.e. Abstinence from Drug/Alcohol Use, Return To/Stay in School)	



MidSOUTH Prevention Institute Prevention Workforce Needs Assessment Report - Statewide September 11

Statewide Results (n=339)

Top training needs as identified by participants based on Prevention Workforce Needs Assessments:

1.	320	Conducting a community assessment
2.	310	Creating and maintaining coalitions and partnerships
3.	308	Using Institute of Medicine categories to select the appropriate strategy
4.	147	Writing grant applications for funding
5.	120	Assessing community needs and resources
6.	116	Developing interventions
7.	108	Describing the process of addiction
8.	108	Knowledge of current trends in drug use patterns
9.	106	Creating a sustainability plan
10.	106	Maintaining proficiency in technology, facilitation and presentation skills



Appendix IX

Recommended Data Sources

State Epidemiological Workgroup (SEW) Statewide Profile

The Arkansas Epidemiological Statewide Profile report provides an overview of substance use consumption and consequence at both statewide and county levels. The purpose of the profile is to provide state policy-makers with a comprehensive picture of substance abuse challenges faced in Arkansas. Substance abuse data is compiled from various national and state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, etc.) to integrate information regarding the causes and consequences of the use of alcohol, tobacco, and other drugs in both adult and child populations. The profile includes a general population profile, information about factors that may contribute to substance abuse, and in an effort to determine the effect of substance abuse in Arkansas, health and economic consequences. Specific county level data is included for each of the 75 counties as a resource for community leaders throughout Arkansas. This report is posted online at <http://www.preventionworksar.org/>.

Arkansas Prevention Needs Assessment

The Arkansas Prevention Needs Assessment (APNA) student Survey is conducted annually. APNA uses the Communities That Care Student Survey instrument which is based on risk and protective factors and collects information on drug use and social indicators. Arkansas public school students in 6th, 8th, 10th, and 12th grades are surveyed. Each participating district is provided its own data results in district and building level reports (providing the number of participants is large enough for student anonymity). Data results are also published at the county, region, and state levels and posted on line for public access. The APNA data has become a major planning resource for communities, schools, and state agencies. APNA data is used by a variety of organizations for both state and community level planning. APNA Reports are accessible online at the DBHS website at <http://humanservices.arkansas.gov/dbhs/Pages/oadap.aspx>. Scroll down and the link is in the left-hand column.

Arkansas Traffic Crash Statistics

The Arkansas State Police Highway Safety Officer publishes annual reports that include information about vehicle and motorcycle accidents in a variety of situations (e.g. involving alcohol, inclement weather, varying road conditions, and different times of day) for both fatal and non-fatal crashes. These reports also include trending for year and age of drivers as well as county and city statistics. Full reports can be found at http://www.asp.arkansas.gov/hso/hso_index.html.

Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas (ARF)

The Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas is a compilation of data reported by various state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Division of Youth Services, etc.) Approximately 90 archival data indicators are collected annually and organized according to the following categories: Demographic data, Community Domain, Family Domain, School Domain, Peer/Individual Domain, and Consequences. The publication reports the data at the state region, and county levels. To depict data trends, the annual publication includes data for each of the most recent five years and for the 10th year back (six years of data). This compilation provides DBHS and communities, schools, agencies, and organizations with readily accessible data needed for effective planning of prevention efforts. It has also proven to be a valuable

resource for other fields, including treatment, youth services, etc. This report is posted online at <http://www.preventionworksar.org/>.

Behavioral Risk Factor Surveillance System (BRFSS)

The Centers for Disease Control (CDC) designed the BRFSS to collect information on health conditions and risk behaviors in the United States. It is currently the primary source of data for states and the nation on health-related behaviors of adults. The BRFSS is administered by the Arkansas Department of Health with assistance from the CDC. All states ask a set of core questions and have the option of adding modules designed by the CDC or asking their own (state-designed) questions. Households are selected randomly by the CDC. Data is collected monthly through telephone interviews with adults (aged 18 and older), and data is analyzed and reported by both the CDC and designated state agencies. Annual Arkansas BRFSS information can be found online at <http://brfss.arkansas.gov/>.

CORE

The CORE Alcohol and Drug Survey was developed in the late 1980s by the U.S. Department of Education and advisors from several universities and colleges to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four year institutions. The survey is administered by the CORE Institute at Southern Illinois University –Carbondale (SIUC). The survey includes several types of items about alcohol and drugs. One type deals with the students' attitudes, perceptions, and opinions about alcohol and other drugs and the other deals with the students' own use and consequences of use. There are also several items on students' demographic and background characteristics as well as perception of campus climate issues and policy. More information on the CORE survey is available online at <http://www.siu.edu/departments/coreinst/public.html/>.

Monitoring the Future (MTF)

Monitoring the Future is an ongoing study of behaviors, attitudes, and values of American secondary school students, college students, and young adults. Each year, a total of approximately 50,000 8th, 10th, and 12th grade students are surveyed (12th graders since 1975, and 8th and 10th graders since 1991). In addition, annual follow-up questionnaires are mailed to a sample of each graduating class for a number of years after their initial participation. MTF reports are available online at <http://www.monitoringthefuture.org/>.

National Survey on Drug Use and Health

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals age 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency within the U.S. Public Health, a part of the U.S. Department of Health and Human Services. Supervision of the project comes from SAMHSA's Office of Applied Studies (OAS). Data from the NSDUH provides national and state-level estimates of the past month, past year, and lifetime use of tobacco products, alcohol, illicit drugs, and non-medical use of prescription drugs. More information on the NSDUH is available online at <http://www.oas.samhsa.gov/states.htm>.

Appendix X

Acronyms and Terminologies

Acronyms

ADAP - Arkansas Office of Alcohol and Drug Abuse Prevention

AOD - Alcohol and Other Drugs

APNA- Arkansas Prevention Needs Assessment Survey

ARF - Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas

ATOD - Alcohol Tobacco and Other Drugs

BRFSS - Behavioral Risk Factor Surveillance System

CADCA - Community Anti-Drug Coalitions of America

CAPT - Center for the Application of Prevention Technologies

CDC - Centers for Disease Control and Prevention

CSAP - Center for Substance Abuse Prevention

DBHS - Arkansas Division of Behavioral Health Services

DEA - Drug Enforcement Administration

DFSCA - Drug-Free Schools and Communities Act

DHHS - U.S. Department of Health and Human Services

DOE - Department of Education

GPRA - Government Performance and Results Act

GIS - Geographic Information System

ICRC - International Certification Reciprocity Consortium

IOM - Institute of Medicine

MDS - Minimum Data Set System

MADD - Mothers Against Drunk Drivers

MTF - Monitoring the Future

NASADAD - National Association of State Alcohol and Drug Abuse Directors

NCADI - CSAP's National Clearinghouse for Alcohol and Drug Information

NIDA - National Institute on Drug Abuse (institute within NIH)

NIH - National Institute of Health

NPN - National Prevention Network

NREPP - National Registry of Evidence-based Programs and Practices

NSDUH - National Survey on Drug Use and Health

OJJDP - Office of Juvenile Justice and Delinquency Prevention

ONDCP - Office of National Drug Control Policy

PRC - Prevention Resource Center

SAPT - Substance Abuse Prevention and Treatment

SAMHSA - Substance Abuse & Mental Health Services Admin

SEOW - State Epidemiological Outcomes Workgroups

SPE - Strategic Prevention Framework State Prevention Enhancement Grant

SPF - Strategic Prevention Framework

SPF SIG - Strategic Prevention Framework State Incentive Grant

YRBS - Youth Risk Behavior Survey

Terminology

Alcohol and Drug Abuse Coordinating Council

A body created by legislation with the responsibility for overseeing all planning, budgeting, and implementation of expenditure of state and federal funds allocated for alcohol and drug education, prevention, treatment, and law enforcement.

Alternative Approaches

This CSAP strategy provides for the participation of target populations in activities that exclude substance use.

Binge Alcohol Use

Drinking five or more drinks on the same occasion (i.e. drinks are consumed at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Capacity Building

Increasing the ability and skills of individuals, groups, and organizations to plan, undertake, and manage initiatives. The approach also enhances the capacity of the individuals, groups, and organizations to deal with future issues or problems.

Coalition

Coalition is the full partnerships or collaborations among organizations or sectors that require sharing resources and leadership within a community in which each group retains its identity but all agree to work together toward a common goal of building a safe, healthy, and drug-free community on an ongoing basis.

Community Development

Community Development is indicated by collaborative, collective action taken by local people to enhance the long-term social, economic, and environmental conditions of their community. The primary goal of community development is to create a better overall quality of life for everyone in the community.

Community Readiness

Community readiness is the degree of support for or resistance to identifying substance use and abuse as significant social problems in a community.

Community-Based Approach

A prevention approach that focuses on the problems or needs of an entire community, be it a large city, a small town, a school, a worksite, or a public place. Other popular approaches include school-based, family-based, environmental prevention.

Community-Based Process

This CSAP strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration building, and networking.

Contributing Factors

A set of community specific issues that compromise the intervening variables. They are the key link to identifying prevention strategies.

Consequence Data

Consequence Data identifies the prevalence and incidence of substance use. It is the data we use to determine who, what, when, where, and how often.

Consumption Data

Consumption Data identifies the impact of substance use on the individual and society. Substance use consequence data includes impacts on health (e.g. hospital admissions), criminal justice (e.g. arrests, traffic crashes), and children and adolescents (e.g. school performance).

Culturally Appropriate

Activities and programs that take into account the practices and beliefs of a particular social or cultural group so that the programs and activities are acceptable, accessible, persuasive, and meaningful.

Cultural Competence

Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures.

Data Driven

A process whereby decisions are informed by and tested against systematically gathered and analyzed information.

Effectiveness

Refers to whether the intervention typically is successful in actual clinical practice. SAMHSA Effective Programs are well-implemented, well-evaluated programs that produce a consistent positive pattern of results (across domains and/or replications).

Efficacy

Refers to whether the intervention can be successful when it is properly implemented under controlled conditions

Environmental Approaches

This is a CSAP strategy that establishes or changes community standards, codes, and attitudes and thus influences the incidence and prevalence of substance abuse.

Environmental Factors

Environmental factors are external or perceived to be external to an individual but that may nonetheless affect his or her behavior.

Epidemiology

Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.

Evaluation

Evaluation is a process that helps prevention practitioners to determine the strengths and weaknesses of their activities so that they can make improvements over time. Time spent on evaluations is well spent because it allows groups to use money and other resources more efficiently in the future.

Evidence-based Programs

These are successful, well-implemented, and well-evaluated programs that have been reviewed by the National Registry of Effective Programs and Practices (NREPP) according to rigorous standards of research.

Evidence Based Strategies

These are successful, well-implemented and well-evaluated programs, practices or policies that address contributing factors and their related risk behaviors.

Environmental Strategies

Establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two sub categories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

Fidelity

Fidelity means maintaining the core components, framework, program elements, delivery schedule, and dosage/exposure as intended by the program developer. Ensuring programs maintain those core elements will enhance the likelihood that those original positive outcomes are achieved in a replication.

Heavy Alcohol Use

This is drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days. All heavy alcohol users are also binge alcohol users.

Indicated Prevention Measure

This is a prevention measure directed to specific individuals with known, identified risk factors.

Impact Evaluation

Impact evaluation is a type of outcome evaluation that focuses on the broad, long-term impacts or results of program activities. For example, an impact evaluation could show that a decrease in a community's crime rate is the direct result of a program designed to provide community policing.

Incidence

The number of new cases of a disease or occurrences of an event in a particular time period usually expressed as a rate, with the number of cases as the numerator and the population at risk as the denominator.

Intervention

An intervention is an activity or set of activities to which a group is exposed in order to change the group's behavior. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance abuse or substance abuse-related problems.

IOM - Institute of Medicine

A nonprofit national component organization of the National Academies of Science specifically created to advise national policy makers, and federal agencies on matters of biomedical science, medicine and health. Its mission is to improve health by providing unbiased, evidence-based and authoritative information and advice concerning science and health policy.

Logic Model

Logic Model is a pictorial representation of connections between the activities, strategies and methods and goals of an initiative or enterprise; a flow chart. It explains why the strategy is a good solution to the problem at hand and makes an explicit, often visual, statement of activities and results. It keeps participants moving in the same direction through common language and points of reference. As an element of work itself, the logic model can energize and rally support by declaring what will be accomplished, and how.

Measures

The tools used to obtain the information or evidence needed to answer a research question.

Needs Assessment

Activities that include surveys of various targeted populations, assessment of prevention resources within the state, studies of current outcome indicators, demographic analyses of social marketing data, and household and school surveys

Outcome

The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be short-term, intermediate, and longer-term outcomes.

Outcome Evaluation

A type of evaluation used to identify the results of a program's effort. It seeks to answer the question, what difference did the program make? It yields evidence about the effects of a program after a specified period of operation.

Outcome Measures

Assessments that gauge the effect or results of services provided to a defined population. Outcomes measures include the consumers' perception of restoration of function, quality of life, and functional status, as well as objective measures of mortality, morbidity, and health status.

Partnership

A partnership is a relationship where two or more parties, having common and compatible goals, agree to work together for a particular purpose and/or for some period of time.

Prevalence

The number of all new and old cases of a disease or occurrences of an event during a particular time period usually expressed as a rate, with the number of cases or events as the numerator and the population at risk as the denominator.

Prevention

Prevention is a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles

Preventionist

One who routinely practices prevention in his/her existing societal role, whether paid or volunteer, acting in a personal or professional capacity. Preventionists include parents, clergy, teachers, law enforcement, business owners, etc.

Process Evaluation

Evaluation design to document what policies and/or programs actually happened, detailing activities, participants involved, resources, methods of management, and other output indicators. It describes how the program operates, the services it delivers, and the functions it carries out. It addresses whether the program was implemented and is providing services as intended.

Program Evaluation

Program evaluation is the systematic collection of information to answer important questions about activities, characteristics, and outcomes of a program. Evaluation stages include design, data collection, data analysis and interpretation, and reporting.

Protective Factors

Protective factors are those characteristics that may strengthen resilience and thus guard against the occurrence of a particular problem.

Public Health Model

Public Health Model is a model that represents the interactions among the agent, host and environment. In substance abuse prevention, the agent is alcohol or drugs or the sources, supplies, and availability of alcohol and drugs. Hosts can be seen as the potential and/or active substance users. The environment is the social climate that encourages and supports the potential and/or actual use of substances. The public health model posits that all of these factors must be addressed together for prevention to be effective.

Quantitative Data

Quantitative data is numeric information that includes things like personal income, amount of time, or a rating of an opinion on a scale from 1 to 5. Quantitative data is used with closed-ended questions, where users are given a limited set of possible answers to a question. They are for responses that fall into a relatively narrow range of possible answers.

Qualitative Data

Qualitative data is a record of thoughts, observations, opinions, or words. Qualitative data typically comes from asking open-ended questions to which the answers are not limited by a set of choices or a scale. Qualitative data is best used to gain answers to questions that produce too many possible answers to list them all or for answers that you would like in the participant's own words.

Resilience

Resilience is either the capacity to recover from traumatically adverse life events and other types of adversity and achieve eventual restoration or improvement of competent functioning or the capability to withstand chronic stress and to sustain competent functioning despite ongoing stressful and adverse life conditions.

Risk Factors

Risk factors are characteristics associated with potential substance abuse problems. However, they are not necessarily the cause of the problem.

Stakeholder

A stakeholder is a person, group, organization, member or system that affects or can be affected by a community or an organization's actions.

Strategic Planning

A deliberate set of steps that assess needs and resources; define a target audience and a set of goals and objectives; plan and design coordinated strategies with evidence of success; logically connect these strategies to needs, assets, and desired outcomes; and measure and evaluate the process and outcomes.

Strategic Prevention Framework

The Strategic Prevention Framework (SPF) is a major SAMHSA initiative and includes five components: needs assessment, capacity, planning, implementation, and evaluation in an effort to encompass the state and all sectors of the community. This is the planning approach adopted by SAMHSA that is a required logic model process for grants supported by their funds.

Strategy

Strategies are types of activities (e.g., policy) that can be implemented to achieve specific objectives and for which a strong evidence base may or may not exist.

Universal Prevention Measure

A preventive measure directed to a general population or general subsection of the population not yet identified on the basis of risk factors, but for whom prevention activity could reduce the likelihood of problems developing.

Sources: Southwest Prevention Center, CADCA, SAMHSA/CSAP, DBHS

