

Chapter 12: Prevention

The purpose of this chapter is to describe prevention services, including existing resources, strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

A. Existing Resources

ODMHSAS uses the public health approach for prevention services, using a theoretical framework of risk reduction and protection enhancement to guide the development of prevention services across the state. By studying the characteristics of individuals, their families, and their environment, ODMHSAS develops risk and protection factor assessments for communities, giving them the resources to create community specific prevention programs. Risk factors are characteristics of individuals, their family, school, and community environments that are associated with increases in alcohol and other drug use, delinquency, depression and anxiety, teen pregnancy, school dropout, and violence. Factors associated with reduced potential for drug use and other problem behaviors are called protective factors. Protective factors encompass family, social, psychological, and behavioral characteristics that can provide a buffer for the children and youth. These factors mitigate the effects of risk factors that are present in the child or youth's environment. ODMHSAS prevention services focus on decreasing risk factors, such as the availability of alcohol, drugs, and firearms, family conflict, and youth rebelliousness. Such risk factors may lead to problem behaviors within youth. By decreasing risk factors, it is possible to simultaneously promote the development of protective factors. Problem behaviors related to risk factors include substance abuse, delinquency, violence, teen pregnancy and school dropout. These assessments also enable communities to identify protective factors that need improvement in order to increase community youth's bond to a healthy society. Protective factors include opportunities for pro-social involvement, recognition for pro-social involvement, and attachment to family and peers with healthy beliefs and clear standards.

To study risk and protective factors, ODMHSAS sponsors the biennial Oklahoma Prevention Needs Assessment (PNA) Student Survey to measure risk and protection variables, as well as gather information on youth's perceived availability of substances, substance usage, and antisocial behaviors. Results from this survey can be compared to two national surveys to evaluate or assess how Oklahoma ranks in relation to risk and protective factors and negative behaviors. During the off years of the PNA survey, Oklahoma students participate in the national Youth Risk Behavior Surveillance System (YRBSS) survey. The YRBSS also collects data on substance use and negative behaviors. In combination, these two surveys allow ODMHSAS and local communities to develop area and problem specific prevention programs.

ODMHSAS contracts with a network of 18 Area Prevention Resource Centers (APRCs). APRCs use trained prevention staff to serve all 77 Oklahoma counties and to provide information dissemination, education, community-based activities, and other prevention strategies. Three specialty centers provide services for specific populations throughout the state: the American Indian Institute, the African American Institute, and

the Latino Community Development Center. A fourth specialty center providing education about fetal alcohol spectrum is also funded, as is a mentoring program for high-risk children referred through the juvenile justice system. ODMHSAS supports a statewide resource center, the Oklahoma Prevention Resource Center (OPRC), which serves as a clearinghouse for print materials and has a lending library of audio-visual resources.

ODMHSAS oversees the Governor's portion of Title IV: Part A funding for the Safe and Drug-Free Schools and Communities Act. These are discretionary funds to support substance abuse prevention and violence prevention in schools and communities. The Oklahoma State Department of Education oversees the Title IV SFDFS portion of the State Grant to local education agencies (school districts) to promote education in the same areas. The OSDE also offers technical assistance, monthly videoconferences and an annual Safe and Healthy Schools Training Conference for adults to promote research-based programs and strategies and offers regional training sessions. The purpose of these federal dollars provide prevention education and early intervention for alcohol, tobacco, other substances and violence prevention. (At this time, these dollars are in jeopardy for 2007-2008 due to Congressional cuts). The schools depend on these funds for classroom instruction materials, teacher training, school safety and security measures, background checks of personnel, parent education and curriculum purchases for Pre-Kindergarten through twelfth grade. Data collection on risk behaviors and on risk and protective factors is gathered through the OSDE's Annual Incident Report form, the ODMHSAS's Prevention Needs Assessment Survey and the OSDH's Youth Risk Behavior Survey. Planning at the state level is coordinated through these agencies.

Community-based strategies are an important prevention approach for the APRCs. Each APRC is required to collaborate with and provide support to at least five community coalitions in their service areas. Environmental approaches are also used, with an emphasis on social policy change related to youth access to tobacco and alcohol. Local coalitions, with guidance from the APRC, work with tobacco and alcohol outlets to educate them about youth access. Local coalitions and APRC also offer alternatives including drug-free dances, after-prom drug-free activities, leadership skill building, and programs promoting youth community volunteerism.

ODMHSAS is a leader within the Governor's Statewide Council on Substance Abuse Prevention Advisory Council (CAAC). The CAAC is funded by a federal CSAP grant and has brought new focus on building a cross-agency strategic prevention framework using a public health approach. Other agencies involved include the Department of Health and the Department of Human Services, the Oklahoma Commission on Children and Youth (OCCY), the Alcohol, Beverage and Law Enforcement (ABLE) Commission, the Office of Juvenile Justice, the University of Oklahoma, the Oklahoma office of the US Drug Enforcement Agency, the State department of Education, and the Center for the Application of Prevention Technologies (CAPT). Each agency has responsibility for areas related to each agency's mission; the subjects addressed include violence prevention, teen pregnancy prevention, suicide prevention, school dropouts, and depression and anxiety. The Governor's Council has developed a strategic plan focusing on substance abuse, and the next round of CSAP funding will be used to broaden the strategic plan beyond substance abuse to other problem behaviors associated with substance abuse.

ODMHSAS oversees the Governor's Safe and Drug Free Schools and Communities (SDFSC) program. The program is designed to support local education agencies, community-based organizations, and other entities working on substance use and violence prevention. This program complements the Oklahoma Department of Education's SDFSC Program by providing a comprehensive prevention planning process and on-going collection of prevention needs assessment survey data.

In September 2005, ODMHSAS was awarded \$1.2 million over 3 years from SAMHSA's Center for Mental Health Services, authorized by the Garrett Lee Smith Memorial Act, to develop and implement youth suicide prevention programs. Oklahoma proposed to utilize this grant funding to implement the portions of the state plan on youth suicide prevention, including: implementation of evidence-based suicide prevention programs in local communities, tribal organizations, and institutions of higher learning for youth ages 10-24; coordination of prevention efforts statewide; strengthening collaboration among key stakeholders; evaluation of effectiveness; and development of a sustainability plan.

In October 2005, Governor Henry selected a team of seven individuals to attend a national meeting to address the serious problem associated with underage drinking. As a result of this meeting, Governor Henry created a fifteen-member Task Force on Prevention of Underage Drinking by executive order. As outlined in the executive order, the Governor's Task Force is charged with conducting a comprehensive study on the effect of underage drinking in Oklahoma. The overall purpose for the study is to have in place reasonable and effective strategies, policies, practices, and programs to reduce and prevent underage drinking. The goal is to reverse the alarming current use of alcohol by almost half of youth (compared to the national average of 44.9%), and to reduce the number of teens who report consuming alcohol before their thirteenth birthday (one of every four youth). ODMHSAS provides staffing for the Task Force and serves as the chair over the Task Force.

Other Oklahoma agencies also serve as valuable resources in the area of prevention. The Oklahoma Highway Safety Office receives a grant from the US Department of Justice, Office of Juvenile Justice and Delinquency Prevention for the

Oklahoma Enforcing Underage Drinking Laws Program, called Project Under 21. Project Under 21 provides training for law enforcement and community members on enforcing underage drinking laws and environmental strategies for underage drinking prevention. The mission of Project Under 21 is to eliminate under 21 drinking and stop any person, anywhere, anytime, anyplace from providing alcohol to anyone under 21.

The Oklahoma Department of Education, through funding from the US Department of Education, administers **Safe and Drug-Free Schools and Communities (SDFSC)** program in schools districts across the state. The SDFSC (Title IV, Part A of the Elementary and Secondary Education act of 1965) is a critical part of the national effort to ensure academic success for all students. The SDFSC program includes a variety of activities designed to prevent school violence and youth drug use, and to help schools and communities create safe, disciplined, and drug-free environments that support student academic achievement. The purpose of the SDFSC is to support programs that: (1) prevent violence in and around schools; (2) prevent the illegal use of alcohol, tobacco, and drugs; (3) involve parents and communities and (4) are coordinated with related Federal, State, school, and community efforts and resources to foster a safe and drug-free learning environment that promotes student academic achievement.

Healthy Families Oklahoma (HFO) is a collaborative effort of the Oklahoma State University Cooperative Extension Service, Oklahoma Committee to Prevent Child

Abuse, Oklahoma State Department of Health (OSDH), Office of Child Abuse Prevention, and other organizations. There are serious social, economic and health problems that families in Oklahoma face every day (e.g., economic stresses including lack of affordable housing, inadequate child care, and limited access to social supports). Such problems can overwhelm some families. HFO works as a parent education/parent support program for first time overburdened parents. Its goals are to systematically identify overburdened parents in need of support, enhance family functioning, promote positive parent-child relationships, and promote healthy childhood growth and development.

The Oklahoma State Department of Health (OSDH) administers a wide variety of prevention services, including tobacco, injury, teen pregnancy, violence, substance abuse, sexually transmitted diseases, child abuse, and lead poisoning. Through a national initiative of the W.K. Kellogg and Robert Wood Johnson Foundations, OSDH received funding to transform and strengthen public health infrastructures. The initiative, called Turning Point, is founded on the idea that diverse groups working together can better identify and influence the determinants of health. Turning Point exemplifies the Institute of Medicine's vision of public health by promoting what society can collectively do ". . . to assure the conditions for people to be healthy." Turning Point starts at the local level, building broad community support and participation in public health priority setting and action. Turning Point begins with what some would call "social capital," engaging and linking affected people at the local level. Turning Point is anchored in two convictions: communities have strength and everyone has a stake in public health. Oklahoma Turning Point and the efforts of many individuals are working to improve the health of Oklahomans through education, planning and action. Currently there are 52 Turning Point partnerships that serve 49 counties. Areas of prevention include identifying and implementing incentives to promote and support prevention, identify gaps, adopting the Centers for Disease Control and Prevention's school health model as the standard for Oklahoma schools, establishing an obesity prevention program, educating the community about efforts to enhance healthy lifestyle choices, and developing and implementing processes that identify community needs, assets, and barriers to good health.

The Children First Program, also funded by OSDH, has the mission to produce healthy family members and enhance a family's ability to care for itself. Oklahoma families are encouraged through Children First to seek early and continuous prenatal care, to grow and develop personally, and to encourage the involvement of fathers, grandparents, and other supporting persons in parenting. This program works to achieve its mission through promoting goals that lead to improved pregnancy outcomes, improved child health, improved child development, strengthened bond between child and parent, achievement of personal goals, and improved utilization of and collaboration with community resources

OSDH also promotes child guidance programs that are comprised of three professional components designed to provide a continuum of services to build healthy family relationships and enhance child development. These include Behavioral Health Services, Early Childhood Development and Parent Education Services, and Speech, Language and Audiology Services. The types of services available to families and community child care providers include consultation regarding children's development, learning and behavior, and family relationships; training for parents and professionals on

techniques and skills to promote optimal child and youth development and strengthen family interactions; screening and early identification of children with developmental delays, hearing loss, or behavioral issues; and educational services for children and youth to promote the development of appropriate personal, social and interaction skills.

In addition, OSDH is responsible for several other services and programs that promote building strong families, children, and youth. Within OSDH, the Maternal and Child Health Service (MCH) provides state leadership, in partnership with key stakeholders, to improve the physical and mental health, safety, and well-being of the Oklahoma maternal and child health population. MCH's Adolescent Health Program implements teen pregnancy prevention strategies through community-based teen pregnancy prevention projects; provides adolescent health clinic services in county health departments; develops programs that reduce risk-taking behaviors of adolescents (violence, suicide, unintentional injury, substance abuse); promotes the health of adolescents through education, technical assistance and training for parents, grandparents, teens, schools, communities, and health and youth service providers; and provides leadership for a legislatively mandated youth suicide prevention task force, providing technical assistance in assessment, policy development and assurance of services assists communities and organizations in promoting and building resilience in youth. OSDH is also responsible for the Oklahoma Abstinence Education Project and Bullying Prevention.

The Oklahoma Commission on Children and Youth (OCCY) was created by the Oklahoma State Legislature for the purposes of providing independent oversight of the children and youth service system. OCCY assists local communities in the development of partnership boards to improve and increase needed services for children and their families and provides leadership on children's issues by testing models and demonstration projects for effective services. The mission of the OCCY is to improve services to children by facilitating joint planning and coordination among public and private agencies,, monitoring of the children and youth service system for compliance with established responsibilities,, and entering into agreements to test models and demonstration programs for effective services. In 2005, 40 Community Partnership Boards, representing 46 counties, developed local plans to address the concerns of children and families in their communities. Community Partnership Boards (CPBs) include citizens, service providers, prevention specialists, faith community representatives, and business leaders. CPBs are making a difference in their communities through the development of collaborative projects by using shared resources and conducting community needs assessments to support the development of comprehensive community driven services.

B. Strengths

Oklahoma's prevention services use selective and universal prevention approaches and activities to delay or avert the use of alcohol, tobacco, and other drugs among communities, families and individuals. In order to fulfill federal block grant requirements, prevention services supported by ODMHSAS use Evidence-based Practices (EBPs). Evidence-based prevention practices have been developed, tested and found to be effective in preventing substance abuse and other problem behaviors. Some EBPs that ODMHSAS providers are currently using include: Community Mobilizing for

Change on Alcohol (CMCA), Parenting Wisely, Guiding Good Choices, Al's Pals, Parents Who Care, Community Mobilization, Communities That Care, and Media Advocacy.

ODMHSAS has developed a number of collaborative initiatives. One such collaboration involves the University of Oklahoma Southwest Prevention Center, which is developing a pre-school program called Growing Up Strong (GUS). GUS is being tested in several schools across the State. Research results will be used to ensure the effectiveness of the program, with the goal of having GUS adopted as a model program by the federal Center for Substance Abuse Prevention (CSAP).

There is also a Statewide Epidemiological Outcomes Workgroup funded by CSAP that is headed by the Oklahoma State Epidemiologist. The goal of this workgroup is to systematically collect, analyze, and report substance use in the state Oklahoma. The report will include incidence and prevalence rates of substance abuse, national outcomes measures for the state of Oklahoma, and other related data. This information will be used by Oklahoma agencies and communities for planning, monitoring, and evaluation of substance abuse prevention services.

Project Under 21 is a collaborative effort with the Oklahoma Highway Safety Office that brings together teams of high school students and adults to learn about under-21 drinking, impaired driving crashes, and other alcohol-related issues. Teams spend a week together developing action plans to be implemented in their communities. ODMHSAS is also partnering with the Oklahoma Highway Safety Office on a media campaign for home University of Oklahoma and Oklahoma State University football games. The campaign includes underage drinking prevention messages broadcast during games and the distribution of prevention resources.

On July 1, 2006, the Oklahoma Prevention of Youth Access to Alcohol Law went into effect throughout the state. This law is designed to decrease the availability of alcohol to individuals under the age of 21. The Prevention of Youth Access to Alcohol Law created a local revolving fund for municipalities. Local municipalities can enact ordinances prescribing the maximum fines, and \$50 from each alcohol fine or deferral fee will go into a local municipality fund. This fund can then be used to defray costs for enforcement of laws related to juvenile access to alcohol, other laws related to intoxicating substances, and traffic-related offenses involving intoxicating substances. In addition, the law includes provisions for a revolving fund for underage drinking prevention to ODMHSAS for programs and campaigns to educate the public and law enforcement about the dangers and consequences of providing alcohol to minors.

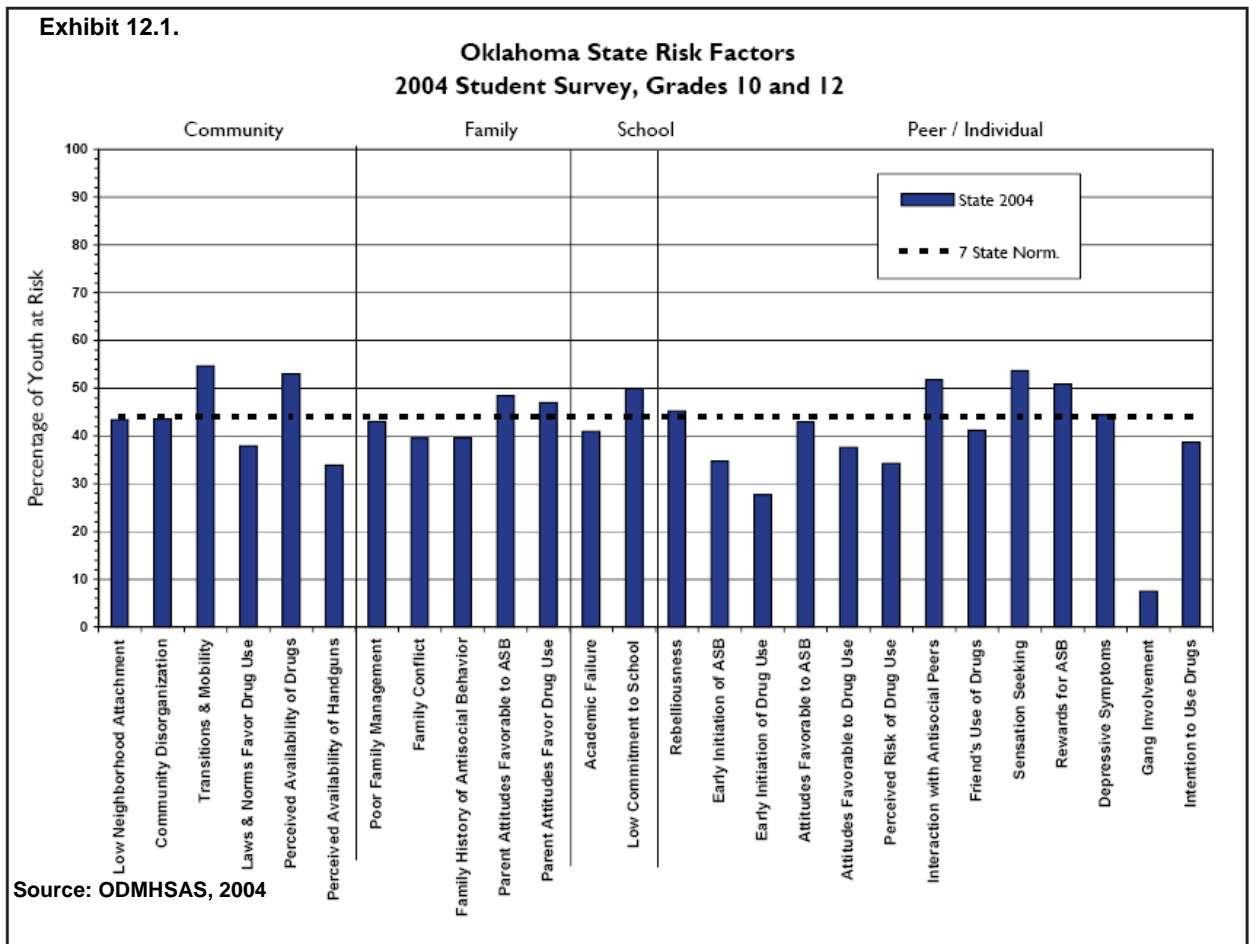
While it is noted in the section below on Needs/Existing Barriers that there is a general need for more collaboration between the substance abuse and mental health fields and among other state agencies, the suicide prevention program has been cited as an example of successful collaboration among substance abuse, mental health, and the Department of Health.

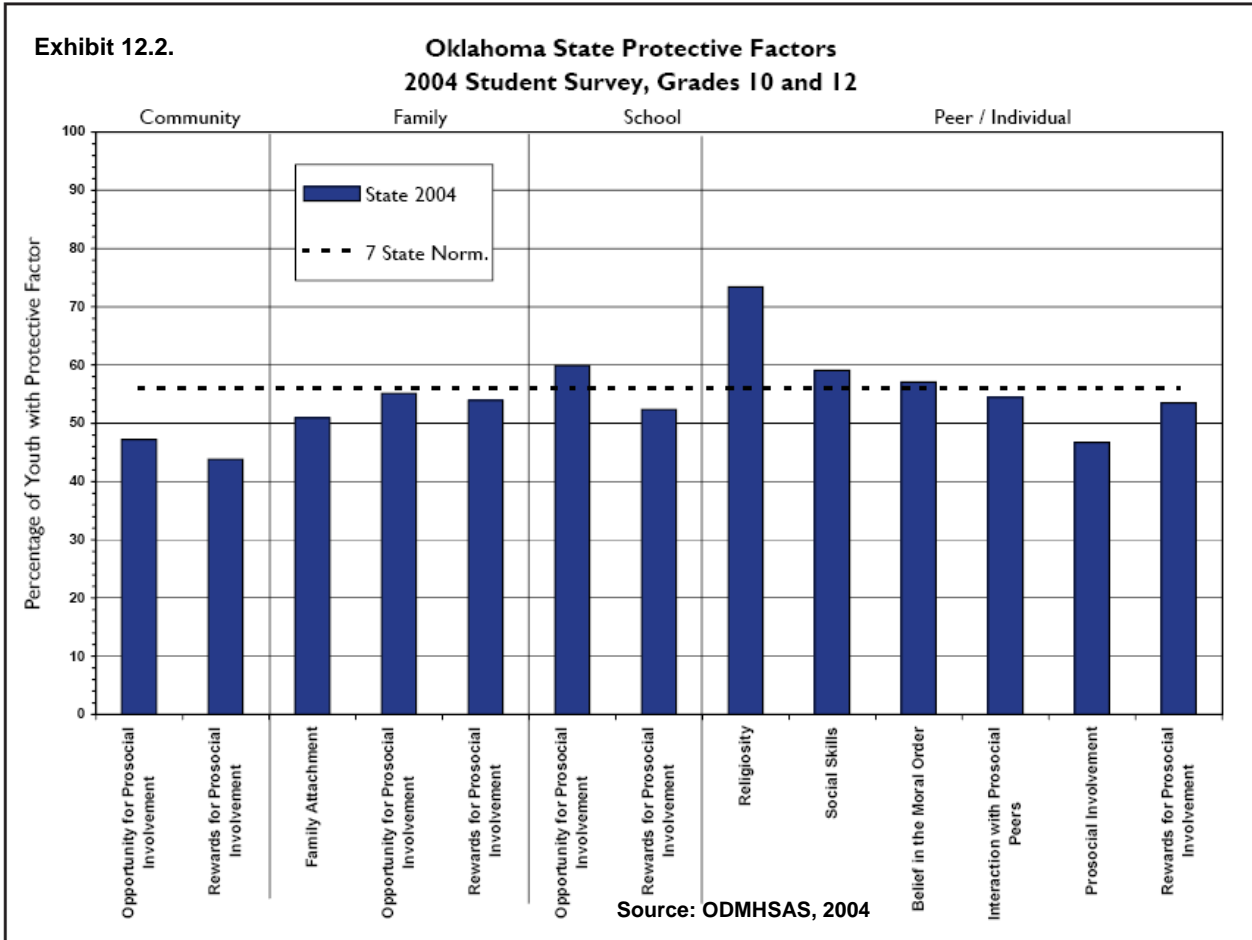
C. Needs and Existing Barriers

As previously discussed above, in order to design prevention programs around existing needs, communities need to know the incidence and prevalence of youth substance use, antisocial behaviors, as well as other risk and protective factors. During spring 2004, approximately 9 percent of students in grades 6, 8, 10, and 12 voluntarily completed the Oklahoma Prevention Needs Assessment (PNA) survey (n=16,752 students; ODMHSAS,

2004). With survey locations spread across the state, needs of specific locations and subpopulations can be estimated. Risk and protective factor comparisons can be made between youth in Oklahoma and youth from the seven other states (Colorado, Illinois, Kansas, Maine, Oregon, Utah, and Washington) who have taken the same survey. These comparisons reveal that Oklahoma students have similar levels of risk compared to students in other states (see Exhibit 12.1.). Oklahoma high school students were higher than the 7-state norm for 8 of the 26 scales. The risk factors that pose the greatest risk for Oklahoma youth were transitions and mobility, perceived availability of drugs, low commitment to school, sensation seeking, parental favoring attitudes towards ASB, drug use, and interaction with antisocial peers.

Oklahoma high school students also report a lower level of protective factors than students from the 7-states for 9 of the 13 protective factor scales (see Exhibit 12.2.). For students in Oklahoma, all the indicators for community and family protective factors were below the 7-state average. Only 31 percent of the protective factors exceeded the 7-state average. Indicators that are most alarming to Oklahoma include community rewards for pro-social involvement and peer/individual pro-social involvement having the lowest levels of protection compared with the other states. The indicators with the highest protective factors for Oklahoma's youth are religiosity, school opportunities for pro-social involvement, and social skills.





On a state level, the results from the 2004 PNA survey revealed that 37.8 percent of students in grades 6, 8, 10 and 12 use some prohibited substance, including alcohol, tobacco, marijuana and other illicit drugs, either individually or in combination (see Exhibit 12.3.). Alcohol use presents the greatest problem among youth; 39.4 percent of surveyed 10th graders

and 49.9 percent of surveyed 12th graders report using alcohol in the past 30 days, and 55.3 percent of students report using it at least once in their lifetime.

With regard to age, tobacco and inhalants appear to present the greatest problem, with the average age of first use of cigarettes at 12.6 years, and the 30-day inhalant usage peaking at grade 8 (5.4%) and declining to 1.2% by grade 12. The use of alcohol generally begins around 13.1 years of age, with the first sip, and regular use of alcohol begins at 14.8 years. First use of marijuana is reported at age 14.2 years, six months before students indicated that they had begun drinking regularly (ODMHSAS, 2004).

While some of these percentages may appear to be small, they represent a large number of adolescents. There are approximately 500,000 Oklahomans aged 11-19 years. An estimated 10.7 percent of this age group (Grades 6-12) reported using alcohol and at least one other drug within the past 30 days. This translates to almost 55,000 adolescents. Thus the problem of alcohol and drug use among youth in Oklahoma is very significant.

Exhibit 12.3. Percentage of Oklahoma Youth (Grades 6, 8, 10, and 12) Reporting Use of One or More Substances in the Past 30 Days

Percentage Using Multiple Substances in the Past 30 Days					
Drugs Used in Past 30 Days	School Grade				
	Grade 6	Grade 8	Grade 10	Grade 12	Total
Any Substance	19.3	35.1	48.8	58.0	37.8
Alcohol	9.3	24.6	39.4	49.9	28.0
Cigarettes	7.5	15.3	23.3	29.2	28.0
Smokeless Tobacco	1.9	4.3	8.0	9.2	5.3
Tobacco (cig. or smokeless)	8.4	17.4	26.8	32.7	19.7
Marijuana	1.8	8.8	15.1	16.8	9.6
Tobacco and Alcohol	3.1	10.5	19.8	26.9	13.4
Tobacco and Marijuana	1.3	5.7	10.4	11.6	6.5
Alcohol and Marijuana	1.0	6.6	12.8	14.6	7.8
Marijuana and Tobacco and Alcohol (all three)	0.8	4.6	9.2	10.5	5.6
Alcohol and Any Other Drug	2.9	9.8	16.1	18.2	10.7
Alcohol and Any 1 Other Drug	1.9	5.9	9.4	10.8	6.4
Alcohol and Any 2 Other Drugs	0.6	2.1	4.0	4.7	2.5
Tobacco and Any Other Drug	3.1	8.2	12.7	14.7	8.9
Tobacco and Any 1 Other Drug	2.1	4.7	7.0	8.3	5.1
Tobacco and Any 2 Other Drugs	0.6	1.8	3.2	4.0	2.2

Source: ODMHSAS, 2004

As an indicator of violent behavior, the PNA survey asked about physical attacks and handguns. The survey revealed that 21.3 percent of students have attacked someone with

the idea of seriously hurting them at some point in the reporting student's lifetime, and 16.9 percent of students reported that they have attacked someone in the past 12 months. The survey also indicated that less than one percent of the students report taking a handgun to school in the past 12 months. Twelfth graders had the highest reports of taking a handgun to school at least once in the past month (1.2%) and the highest reports of carrying a handgun in their lifetime (6.3%).

Indicators for depression, suicidal ideation, and suicide attempts for Oklahoma youth come from the 2005 Youth Risk Behavior Survey (YRBS; CDC, 2004). The YRBS is administered to students nationwide in grades 9 through 12. The results indicate that 27.9 percent of Oklahoma students surveyed have stopped doing some usual activities within the past 12 months because of feelings of sadness or hopelessness that occurred almost every day for two weeks or more. Those students surveyed also indicated that during the past 12 months, 15.4 percent seriously considered attempting suicide, 12.4 percent made a plan to attempt suicide, and 7.9 percent actually attempted suicide.

Teenage sexual activity also requires prevention programs because of the risk for sexually transmitted diseases and teenage pregnancy. In addition, teenage sexual activity is associated with increased risk of school dropout, drug and alcohol use and incarceration. The YRBS results for Oklahoma youth revealed that 49.3 percent of students have had sexual intercourse, 17.8 percent of students have had intercourse with four or more people during their lifetime, and 6.5 had intercourse before age 13. Thirty-six percent of students indicated they had sexual intercourse with one or more persons during the past three months. Forced sexual intercourse is also a problem among youth, with 7.2 percent of students surveyed reporting being physically forced to have unwanted sex (CDC, 2004).

Prevention programs aimed at younger adults are also needed. The most recent mortality information for the state estimates alcohol related deaths at 294 per 100,000 for people age 18 – 24 years. The estimate declines for people age 25 – 44 years, with 169 alcohol related deaths per 100,000. The estimate increases with age, with 387 deaths per 100,000 for people 45 – 64 , and 1,136 deaths per 100,000 for people 65 and older (ODMHSAS, STNAP Phase III, 2005).

Young adults age 18 – 24 years have a higher rate of arrest for alcohol and drug related offenses compared to adults age 25 and older. In 2003, the rate of arrest for alcohol related offenses for people age 18 – 24 was 9,312 per 100,000, and the rate of arrests for drug related offenses was 5,823 per 100,000. The rate of arrest continues to decrease as people age, with a rate of 5,311 per 100,000 for alcohol, and 2,692 per 100,000 for drugs for people age 25 – 44. In contrast to these mortality and arrest data, young adults do not constitute the largest number of substance abuse clients served by ODMHSAS funded facilities. In 2004, people age 18 – 24 comprised 23 percent of ODMHSAS substance abuse treatment clients, while people age 25 – 44 comprised 61 percent, and age 45 and older, 16 percent (ODMHSAS, STNAP Phase III, 2005).

Policies

Personal interviews and focus group participants expressed a desire for ODMHSAS to develop a clear definition of "prevention" that would apply to both the substance abuse and mental health service systems. Staff involved in the development and implementation of prevention strategies would like to see a more integrated prevention effort made possible by development of an agency-wide strategic plan for

prevention. Participants also suggested there is a need to develop prevention priorities within ODMHSAS.

It was noted that the term “prevention” tends to be used differently in the two fields. In substance abuse, primary prevention activities are used at the individual level and secondary prevention is done at the community, family, and school levels. Yet much of what is called “prevention” in the mental health field is actually early intervention. There are also differing views within the mental health field about whether mental illness is preventable, and, if so, what the appropriate prevention strategies (as opposed to early intervention approaches) might be.

Practices/Services

In 2005, ODMHSAS shifted priorities for prevention services based on federal requirements. All prevention services operate using the Strategic Prevention Framework (SPF), which allows communities to select evidence-based prevention programs, practices, policies and services based on the needs of the local community. The SPF allows APRCs to work with their communities in the following areas: assessment (assessing local needs), capacity (community mobilization and capacity building to address local needs), planning (developing a community action plan for prevention), implementation (implementing the prevention plan), and evaluation (determining if what they are doing is working). Through the SPF process, communities are taught to infuse sustainability and cultural competency into each step. The shift to the SPF approach of strategically looking at community and individual needs and providing prevention based on documented needs has been difficult for some prevention providers who may find moving away from current practices undesirable. ODMHSAS has been working with APRC providers to provide them with the necessary training and technical assistance to overcome this.

Some providers with contracts to operate Area Prevention Resources Centers (APRCs) expressed a lack of satisfaction with the program. “We didn’t have input into the design,” one provider said. “The model doesn’t really work well in rural areas.” Another provider said, “The way these contracts are set out does not work for our community. APRCs used to provide services to kids during school hours, but now we can only work with schools before or after school hours. Schools and parents don’t understand why we can’t give them the services they ask for.”

ODMHSAS responds that the APRC contracts are not designed to provide direct services to youth, but rather to provide comprehensive prevention services to using a community-based approach. APRCs are designed to provide training and technical assistance in order to increase capacity for communities and schools to prevention substance use and other problem behaviors. Many APRC providers have found it difficult to shift from an individual approach of working one on one with youth to a community based approach. ODMHSAS has been working with APRC providers to provide them with the necessary training and technical assistance to overcome this.

Workforce Development Issues

Prevention providers said that low salaries, a requirement for enhanced credentials, and a lack of training opportunities combined to make it difficult to keep good staff. It was noted that the entry-level requirements for APRC staff are a BA degree

plus certification as a prevention specialist, which requires 150 hours of CEUs and 120 hours of supervised work within 18 months of hire. “This is difficult because the department doesn't offer enough opportunities for training, so we have to pay out of pocket to get trained elsewhere,” a provider said. “We have to use program funds for training, and staff have to pay some training costs out of pocket. It takes a lot to train people, and then they leave because the pay is so low.”

ODMHSAS has recently polled their prevention workforce in order to gauge the capacity and identify need within the Oklahoma prevention network. The assessment will be used to identify training gaps, build a training cadre, and focus ODMHSAS's efforts in providing evidence based prevention training and technical assistance services.

Organization/Collaboration

ODMHSAS's contracts with APRCs have recently been modified to require them to work with existing community coalitions in order to broaden the APRC impact. Some prevention providers questioned the value of this approach. “The need to work with existing coalitions only limits us in the number of kids we can reach. It's hard, because these coalitions in the community are not always interested in prevention - they have other priorities. So we think this is not really very effective.”

ODMHSAS responds that community organizing is an EBP strategy and working within existing community based coalitions is an effective way to make prevention a community priority. Community level change impacts entire populations whereas traditional individual level prevention methods, such as school based programs, are limited in their scope.

Financing

One barrier to the development of prevention activities on the mental health side is a lack of available funding. The prevention program is largely funded by the Center for Substance Abuse Prevention (CSAP) of the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Currently, 20 percent of the SAPT Block Grant is earmarked for substance abuse prevention.

APRC providers said that that a lack of funding hampered their ability to provide enough quality prevention services. “We need more funding to meet the demands placed on us,” one provider said. “There are things we'd like to do but can't afford to do. APRCs have not received any funding increases in five years; we are expected to do more work without any new dollars.” Another provider said, “It is too much work for too little money- we can't meet people's needs with the current funding.”

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