

Substance Abuse Prevention in New Mexico:
Science, Policy & Practice,
Evaluation, and Cost-Effectiveness

A Supplemental Report to
“Substance Abuse in New Mexico:
A Public Health and Public Safety Perspective”

July 14, 2006

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EXECUTIVE SUMMARY

The costs of substance abuse in the United States are very high: hundreds of billions of dollars a year for treatment, law enforcement, health care, and lost productivity. It contributes to a range of health problems and is associated with many social problems. New Mexico has one of the highest rates of substance abuse in the nation, with severe consequences for the well being of our residents. The following document represents the Prevention Advocates (PA) subcommittee's work to provide a supplement to "Substance Abuse in New Mexico: A Public Health and Public Safety Perspective" more comprehensively addressing the critical role of prevention in addressing the substance abuse problems in New Mexico.

Prevention is a public health strategy that reduces negative health outcomes by targeting populations rather than by treating individuals. While there is clearly an important role for individual treatment, no public health problem has ever been solved by treating the victims of the disease or disorder; it is only by going upstream and addressing *causes* that the problem can be alleviated. Prevention focuses on individuals and families not yet in the throes of substance abuse, but who may be showing symptoms of moving in that direction unless certain measures are taken. Prevention also focuses on communities because individuals and families do not exist in a vacuum but are embedded in environments that influence their behavior.

Prevention should be one of the cornerstones of any forward thinking plan to address substance abuse because it is an extremely cost effective strategy, often returning \$16-18 in benefits for every dollar invested. New Mexico has long been a national leader in substance abuse prevention, and has received national attention as one of the few states able to demonstrate successes such as decreased student alcohol and drug use and increased protective factors such as disapproval of drug use. While many state agencies are responsible for this work, the New Mexico Department of Health/Behavioral Health Services Division (DOH/BHSD) has set the pace for other state agencies by implementing evidence-based programming and comprehensive outcome evaluations. New Mexico has developed many culturally competent prevention programs, including five programs that have received national recognition for their effectiveness.

Despite these successes, the prevention community currently faces significant challenges related to integrating the prevention/public health paradigm into the behavioral health care model currently being implemented in New Mexico through Value Options (VO). These include developing a common language and definition of prevention, strengthening the workforce, building coalitions and collaborations, and adapting the reimbursement system.

To address these challenges and maintain New Mexico's role as a national leader in evidence-based substance abuse prevention, the PA first recommends that the Collaborative work with the PA, VO, Local Collaboratives, and the state prevention system to develop strong local and statewide partnerships that will ensure that standards and systems already in place are supported and strengthened. Second, we recommend that these entities work together to more clearly define prevention services and their role in the state's broader behavioral health system, and to educate all stakeholders about the importance of prevention. Lastly, we recommend that prevention funding continue to be distributed by both community need and use of evidence-based strategies, and that the State explore strategies to further incorporate prevention funding into the Collaborative.

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BACKGROUND: WHY THIS DOCUMENT IS NECESSARY

The Prevention Advocates (PA) are a subcommittee of the Interagency Behavioral Health Planning Council's (BHPC) Capacity, Program Development and Research Committee. The PA is charged with assuring a seamless transition of any Department of Health/Behavioral Health Services Division (DOH/BHSD) substance abuse prevention services that are relocated to Value Options (VO). This group has been meeting since early 2005 to study various issues related to the professional practice of substance abuse prevention in New Mexico.

In January 2006, the PA met with State of New Mexico Behavioral Health Manager Dr. Leslie Tremaine and representatives of VO to address concerns regarding the Interagency Behavioral Health Purchasing Collaborative's (Collaborative) transition of prevention services to VO. At this meeting, state and local prevention managers and specialists gave a presentation entitled "Why Prevention Matters in Our Communities" and offered recommendations on how to better incorporate prevention into the transition of services to VO. A frank and candid discussion followed concerning the Collaborative's strong commitment to prevention and VO's willingness to better address the role of prevention services.

Follow-up with Dr. Tremaine also addressed the lack of serious prevention articulation within the report "Substance Abuse in New Mexico: A Public Health and Public Safety Perspective." Dr. Tremaine again stressed the value of prevention services and invited the PA to provide additional information regarding prevention in three possible formats: 1) creating an addendum to the current report; 2) revising the current report; or 3) creating a supplemental report. At the PA's February 2006 meeting, the subcommittee reached consensus that a supplemental report would best communicate the role and importance of prevention while avoiding the biases of the treatment paradigm, philosophy, and practices.

The following document represents the PA subcommittee's work to develop this supplemental report and to proactively align prevention services with the work of the Collaborative and VO.

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INTRODUCTION: WHAT IS PREVENTION

Understanding Public Health and Prevention Policy

The last century is replete with public health achievements based on prevention, resulting in a dramatic improvement in the life expectancy and health of people in the United States. Since 1900, the average lifespan has lengthened by more than 30 years, 25 of which are attributable to advances in public health (MMWR Weekly, 4/2/99). Other advances include the control of infectious diseases (e.g. TB), motor-vehicle safety (e.g. seatbelts), fluoridation of drinking waters to reduce cavities, flu vaccines (e.g. shot-clinics for the elderly and other high-risk groups), and recognition of tobacco use as a preventable cause of disease (e.g. indoor clean-air initiatives). What these measures have in common is they employ a public health focus as the means to reduce morbidity and mortality: interventions were applied to the entire population (everybody who drank water, or all drivers and passengers in moving cars) even though the entire population wouldn't have been affected/injured (developed oral health problems or been in accidents).

Substance abuse policy approaches are increasingly incorporating the population-based behavioral change strategies of prevention into the larger substance abuse system. While there is clearly an important role for individual treatment, no public health problem has ever been solved by treating the victims of the disease or disorder; it is only by going upstream and identifying and addressing causes (risk factors) that the problem will be alleviated. As the theoretical frameworks in the public health and prevention fields have been evolving based on applied empirical research, we know that these broad-based public health interventions are cost-effective and efficient strategies for reducing the rate of substance abuse. While prevention itself is much older, thirty years of prevention policy have demonstrated that this approach is a critical component of any well-planned substance abuse system.

A Useful Analogy

A rather simple example demonstrates the value of population-based preventive interventions. An elementary teacher noticed that many of her students were squinting to see what she wrote on the board. She was concerned about their eyesight and called upon the school nurse to assess each student to see if they needed glasses. The nurse responded that while some students would likely need glasses, the teacher could take immediate steps to increase the whole classes' ability to see the board. First, even in daylight, turn on the lights to increase brightness and reduce shadows. Second, write larger. Third, move the students with the most trouble seeing to the first couple of rows. Fourth, change the color of the chalk to something easier to read. The teacher followed the nurse's advice and it took care of most of the students' problems. The remaining few were given more time-consuming vision tests and eventually got glasses. The nurse's recommendations were based on simple, common sense public health concepts that targeted the whole population in a cost effective way.

Substance Abuse Prevention Defined

The DOH/BHSD definition of prevention is short and relatively simple, but it clearly delineates the scope of New Mexico's commitment to prevention:

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Alcohol, tobacco and other drug abuse prevention is an active process that promotes the personal, physical and social well being of individuals and families not in need of treatment and enhances healthy communities.

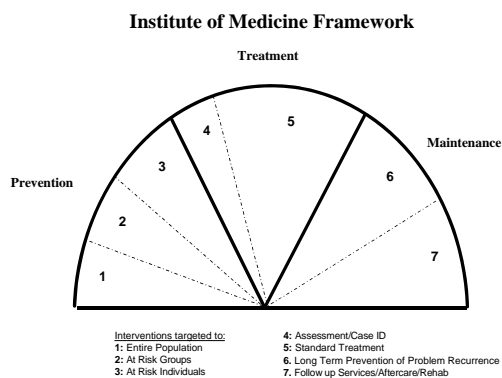
Public health views the entire population as its clientele, and prevention services are the first line of defense against substance abuse, the front-end on a continuum of care ranging from prevention to treatment to maintenance. The DOH/BHSD definition focuses on individuals and families not yet in the throes of substance abuse, but who may be showing symptoms of moving in that direction unless certain measures are taken. It also focuses on healthy communities because individuals and families do not exist in a vacuum but are embedded in communities that influence their behavior.

The Institute of Medicine's Continuum of Services

To implement the above definition of prevention, the DOH/BHSD utilizes the federal Institute of Medicine (IOM) model. This is a unifying model that links prevention and treatment services and professionals by building on the notion of risk and emphasizing the potential movement of individuals through a continuum at various life stages. The IOM model categorizes prevention strategies into three types, depending upon the population addressed:

- *Universal*: address the entire population—without regard to risk—with messages and programs aimed at preventing or delaying problem behaviors and emotional and/or behavioral disorders.
- *Selective*: serve subsets of the population that are at risk for problem behaviors and emotional and/or behavioral disorders such as children of alcoholics, dropouts, and students who are failing academically.
- *Indicated*: prevent the onset of emotional and behavioral disorders among individuals at extremely high risk, who do not meet the clinical criteria for addiction but who exhibit other risk behaviors, early danger signs (failing grades), or who have already begun experimenting with substances (alcohol and other gateway drugs).

The following pie chart is a visual representation of the IOM continuum. Universal, selected, and indicated prevention are shown in slices 1, 2, and 3, followed by treatment and maintenance.



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Effective substance abuse prevention strategies are shown below by site and target population:

SCHOOL, FAMILY, AND COMMUNITY-BASED PREVENTION STRATEGIES		
Universal Prevention: General Population	Selective Prevention: At-Risk Subgroups	Indicated Prevention: High-Risk Individuals
School or Community-Based Programs		
<ul style="list-style-type: none"> • Information/education: Media campaigns; Health education; School assemblies • Competency/skills training, youth development programs: Social influence; Normative education; Life/social skills training; Assertiveness training; Communication skills; Decision making; Anger/stress management • School management changes: School policies; Instructional changes 	<ul style="list-style-type: none"> • Alternative programs: Skills training; After school classes; Special groups for children of alcoholics; Sports/recreation; Mentoring • Competency/skills training: Cultural pride; Tutoring • Peer leadership • Peer resistance • Parent-peer groups 	<ul style="list-style-type: none"> • Alternative programs: Mentoring • Peer leadership/resistance • Parent-peer groups • Peer counseling: Student assistance; Student crisis lines; School support groups • Competency/skills training: Cultural pride; Tutoring • In school suspension • Alternative classes/schools
Family-Based Programs		
<ul style="list-style-type: none"> • Parent education: Groups; Lectures; Curricula • Parent involvement programs • Parent skills training • Family skills training 	<ul style="list-style-type: none"> • Parenting skills training • Family skills training • Family case management • Parent support groups 	<ul style="list-style-type: none"> • Family skills training • Parent-peer groups for troubled youth: <i>Tough Love</i> • Parent self-help groups • Structured family therapy: Family therapy; Family case management
Community-Based Programs		
<ul style="list-style-type: none"> • Public awareness campaign • Information clearinghouse • Community coalitions: Community task forces; Church-sponsored youth groups • Policy change or enforcement • Community Norms Change • Reduced Availability of Substances 	<ul style="list-style-type: none"> • Alternative programs: Youth/teen clubs; Mentoring • Tutoring 	<ul style="list-style-type: none"> • Alternative programs: Rites of passage programs; Gang and delinquency prevention activities • Skills training: Job skills training; Job apprenticeships

Clinical Preventive Services

Another helpful model is the Clinical Preventive Services (CPS), which includes three areas of focus deriving from the disease model:

- *Primary* prevention is the prevention of disease or reduction of risk of disease among healthy people without signs and symptoms of disease, illness, or injury. Examples include; immunizations, counseling to prevent risky behaviors like tobacco use, and promoting healthy diets, exercise, or seat belt use.
- *Secondary* prevention is the early diagnosis and prompt treatment of disease through screening people for previously unknown or asymptomatic conditions. Results from screening are increased when those selected are known to be at relatively greater risk,

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based upon certain risk factors like age, race, or risk exposure. Examples include: mammogram tests, sickle cell tests, or tests for hearing loss.

- *Tertiary* prevention takes place in situations where a person is known to have the disease. Activities are geared to slow down disease progression, reducing risks of recurrences or complications, and prolonging life.

New Mexico now emphasizes the IOM continuum over the CPS model because of the IOM's unifying characteristics that provide a more robust perspective on strategies to address substance abuse. However, the CPS model is helpful in understanding the various target populations of prevention strategies.

Cost-Effectiveness of Preventive Interventions

A recent document from CSAP's Data Coordinating Center entitled "Cost and Benefit Analysis of Substance Abuse Prevention Interventions (Aug. 2005) provides critically vital data for policy-makers regarding the value of prevention programs. This reports states in its Executive Summary that the cost of substance abuse to society is far too high:

- The national annual resource and productivity cost of substance abuse was \$512 billion in 1999. Alcohol abuse was responsible for \$192 billion, tobacco was responsible for \$168 billion, and other drug abuse for \$152 billion.
- Including the more-difficult-to-measure costs that capture (1) the impact of substance abuse on the quality of life of those harmed by the abuse and (2) the health cares costs and productivity losses of victims who were involved in alcohol-attributable crashes even though they had not been drinking, the societal cost of alcohol abuse rose to \$569 billion in 2000 and of drug abuse to \$104 billion.
- The societal costs of one high-risk youth's career of binge drinking are \$68,000, of a high-risk youth's career of smoking \$412,000, and of a high-risk youth's career of cocaine or heroin abuse is \$893,800.

Effective prevention can reduce these costs. The federal government has a system entitled the National Register of Effective Prevention Programs and Practices (NREPP). According to CSAP, if we use the best evidenced NREPP programs for the 12-14 years olds, it would result in declines of 4.7% from starting to drink, 4.0% from using marijuana, 2.8% from trying cocaine, and 4.4% from smoking. Further, the average school-based NREPP program costs \$220 per pupil, but **returns an estimated \$18 per dollar invested**. All 11 school-based life skills programs that were analyzed have impressive cost benefits—with an average return exceeding 16 to 1. From a comprehensive substance abuse strategic plan perspective, it is clear that the front-end of prevention is an investment that will pay for itself and ought to be one of the cornerstones of any forward thinking plan.

CSAP's Six Prevention Modalities and the Historical Context

The federal Center for Substance Abuse Prevention (CSAP) is an arm of the Substance Abuse and Mental Health Services Administration (SAMSHA). CSAP works with states and communities to develop comprehensive prevention systems that create healthy communities, including supportive work and school environments, drug-and crime-free neighborhoods, and

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positive connections with friends and family. CSAP developed six prevention modalities developed over 30 years in response to changing needs and increasing evidence about what works. Our current knowledge about the successes and limitations of these modalities now provides the architecture for evidence-based substance abuse prevention throughout New Mexico and the nation.

The *information* modality emerged in the mid-1960s shortly after marijuana moved out of the inner-cities and into the suburbs and rural communities. Educational strategies such as “pamphlet prevention” taught youth about the dangers of drugs. Yet rates of drug use continued to climb because kids were intentionally using drugs to “get high.” Thus, the *alternatives* modality came into being to show youth that yoga, karate, meditation, and hobbies were different ways to “get high.” Unfortunately, many youth would get high with drugs (usually marijuana) and then engage in the “non-drug” alternatives. The information and alternatives modalities clearly needed something more. A move to *affective education* focused more on self-concept enhancement and values clarification to help kids feel better about themselves and therefore stay off drugs. Yet marijuana use continued to rise (it peaked in 1978 with about one in eight high school seniors using daily). Influenced by angry, scared parents, policymakers implemented *early intervention* strategies in schools, targeted at kids who were already using drugs. Student Assistance Programs (SAP) were modeled much like EAPs in the workplace. Marijuana usage finally leveled off, although at an extremely high level.

It soon became the accepted thinking that schools couldn’t do it alone, and *community mobilization* focused on the need for all systems that impact our youth to get involved: schools, law enforcement, the faith-community, local governments, recreation programs, and other non-profits. This approach incorporated the previous four modalities and was primarily an effort at mainstreaming them. This was more of a process approach rather than a content approach, and it set the stage for current thinking about prevention. The last modality added to CSAP’s strategy signified a major change in the prevention paradigm. *Environmental change* began taking root in the late 1990s as more policy-makers and local prevention providers realized that the first five modalities did not provide enough “dosage” to sustain gains. In contrast to the other service-delivery based modalities, environmental change has the potential to bring about long-term improvements by identifying and changing the conditions in a variety of domains (e.g. schools and communities) that contribute to substance use.

Reducing Risk and Increasing Resiliency

One of the most important developments in substance abuse prevention theory and programming in recent years is the focus on risk/protective factors as a unifying descriptive and predictive framework. Taken together, the concepts of risk and resiliency enhance our understanding of how and why youth initiate or refrain from substance use. Although not all risk and protective factors are amenable to change—genetic susceptibility to substance use, for example—research demonstrates that their influence can often be assuaged or enhanced.

Risk factors are biological, psychological/behavioral, and social/environmental characteristics such as a family history of substance use, depression or antisocial personality disorder, or residence in neighborhoods where substance use is tolerated. The more risk factors present for a child or youth, the more likely it is that she or he will experience substance use and related problems in adolescence or young adulthood (Bry & Krinsley, 1990; Newcomb & Felix-Ortiz,

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1992). The more that risks in a child's life can be reduced—by effectively treating mental health disorders, improving parents' family-management skills, and stepping up enforcement of laws related to the sales of illicit drugs to minors or to drinking and driving—the less vulnerable that child will be to subsequent health and social problems (Hawkins, Catalano, & Miller, 1992).

Yet exposure to even a substantial number of risk factors in a child's life does not necessarily mean that substance use or other problem behaviors will inevitably follow. Many children and youth growing up in presumably high-risk environments emerge relatively problem-free because of *protective factors* such as solid family bonds or the capacity to succeed in school (Hawkins et al., 1992; Mrazek & Haggerty, 1994). Among these resilient children, protective factors appear to balance and buffer the negative impact of risk factors (Anthony & Cohler, 1987; Hawkins et al., 1992; Mrazek & Haggerty, 1994; Wolin & Wolin, 1995). The research on protective factors explores the positive characteristics and circumstances in a person's life and seeks opportunities to strengthen and sustain them as a preventive device. From a substance abuse prevention perspective, protective factors function as mediating variables that can be targeted to prevent, postpone, or reduce the impact of use.

Risk and protective factors exist at every level at which an individual interacts with others and the society around him or her. Based on more than 30 years of study, researchers have delineated 6 domains that each has specific subcategories of risk:

- Individual biological and psychological dispositions, attitudes, values, knowledge, skills, problem behaviors
- Peer norms, activities, bonding
- Family function, management, bonding
- School/work bonding, climate, policy, performance
- Community bonding, norms, resources, awareness/mobilization
- Society/ norms, policy/sanctions environmental

New Mexico's prevention system also uses the youth development framework. Youth development is the process through which adolescents seek to and are assisted in meeting their needs and building individual assets or competencies that will enable them to become successful, confident, and self-reliant adults. It is a framework that focuses on capabilities, strengths and developmental needs, and views young people as resources. Programs that apply a youth development approach target the physical, social, cognitive, vocational, and moral areas of a young person's life. It is an ongoing process in which young people are engaged and invested. Youth development programs help youth to deal with the challenges of adolescence and prepare them for the independence and responsibilities of being parents, workers and citizens.

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**DOH/BHSD: NEW MEXICO'S PRIMARY DELIVERER OF EVIDENCE-BASED
SUBSTANCE ABUSE PREVENTION SERVICES**

Many state agencies work on prevention efforts in New Mexico. The Public Education Department (PED) School Health Unit administers the State's Title IV Safe and Drug Free Schools school-based funding. The Children, Youth, and Families Department (CYFD) Family Services division administers the State's federal Enforcing Underage Drinking Laws (EUDL) programs and other OJJDP programs. The EUDL program works with communities and law enforcement to add this vitally important deterrence strategy to the prevention toolbox. The Department of Finance and Administration (DFA) administers DWI Programs, as does the Traffic Safety Bureau. The DFA, their local county DWI Planning Councils, and TSB utilize a variety of prevention and deterrence strategies such as sobriety checkpoints, saturations patrols, and school-based curriculum. Yet it is the Department of Health that leads most of the substance abuse prevention efforts in the state.

The Department of Health: A Rich Tradition of National Prevention Leadership

The New Mexico Department of Health (DOH) has long been a national leader in substance abuse prevention, and the department houses a number of divisions with strong reputations and demonstrable outcomes related to substance abuse prevention.

The Behavioral Health Services Division (BHSD) sets the pace for other state agencies, from certifying prevention professionals to providing technical assistance for exporting their MIS systems. It is in large part because of the work of BHSD that New Mexico is viewed by the federal agencies as one of the more innovative states in the country in solving its substance abuse problem. The division has led the State's pioneering efforts to use outcome (impact) evaluations and has demonstrated that the state's evidence-based prevention programs work when implemented correctly and with fidelity.

The Public Health Division (PHD) also has a strong national reputation, and is viewed as a national trendsetter because of the division's outstanding evidence-based tobacco and alcohol control programs and approaches. The division offers alcohol control policy and epidemiology technical assistance. Through the efforts of PHD, New Mexico was an early adapter of the now national ".08" Blood Alcohol Control (BAC) standard for drunk-driving and an early advocate and beneficiary of increasing alcohol taxes not only as a funding mechanism for New Mexico's County DWI Planning Councils, but as a policy approach to reducing high-risk drinking. The Master Settlement has provided up to \$5 million dollars to prevent tobacco use in New Mexico, and the Tobacco Use Prevention and Cessation (TUPAC) programs employ performance-based contracts and evaluations in their prevention initiatives. Smaller prevention programs address family violence, suicide, injury prevention, and school health programs.

Finally, the Division of Epidemiology and Response supports the DOH and many other state agencies with high-quality data on public health trends in New Mexico. With the support of the only CDC-funded alcohol epidemiologist in the country, the division makes data available on DWI and substance abuse. The division also oversees New Mexico's Youth Risk and Resiliency Survey (YRRS).

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A History of Federal Funding for Prevention

In 1998, the DOH/BHSD applied for and received a State Incentive Grant (SIG) for \$3 million a year for 3 years. These resources were used to build capacity to provide evidence-based prevention programming and to purchase evidence-based prevention programming throughout communities in New Mexico. Since that time, New Mexico has continually strengthened and built its prevention services by leveraging federal funding. In the current state fiscal year (06) the DOH/BHSD administers the following federal prevention grants:

- The federal Substance Abuse, Prevention and Treatment (SAPT) Block Grant is awarded by SAMHSA to states based on population and requires that at least 20% of funds are spent on prevention programming. The total Block Grant for New Mexico is approximately \$8.2 million and is awarded annually.
- The Governor's Portion of Safe and Drug Free Schools (approximately \$600,000 a year) is awarded by the United States Department of Education through the Safe and Drug-Free Schools and Communities Act based on state population. These funds are used to evaluate community needs and to design, implement, and evaluate high-quality evidence-based programs that can achieve measurable results. Community based programs are awarded funding to implement prevention programming that meet these criteria.
- The current State Incentive Enhancement Grant (\$750,000 a year for 3 years) was awarded in 2003. These resources are used to build capacity for communities to provide evidence-based prevention programming focusing on parents and families with children from birth to six years old in six communities in New Mexico.
- The Strategic Prevention Framework: State Incentive Grant (SPF-SIG) was awarded in 2004 (\$2.3 million a year for five years). This grant is described in more detail below.

The Strategic Prevention Framework (SPF): Planning for Success

SAMHSA's Strategic Prevention Framework (SPF) is a systemic community-based approach that aims to ensure that substance abuse prevention programs can and do produce results. Findings from public health research and evidence-based prevention programs are used to build capacity in communities to implement the SPF in order to:

- Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking;
- Reduce substance abuse related problems in communities; and
- Build prevention capacity and infrastructure at the state and community levels.

States use SPF-SIG funds to support local communities in achieving these goals by: conducting a community needs assessment and utilizing local data to identify problems; developing a strategic plan which includes the selection of evidence-based strategies to address the identified problems; implementing the selected programs; and evaluating the effectiveness of the programming.

Through the DOH/BHSD, thirteen communities in New Mexico have been awarded grants ranging from \$100,000 to \$150,000 dollars. The focus of these programs is on changing the

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community-level indicators related to underage and binge drinking of 15 to 24 year olds in the identified communities through the use of evidence-based environmental strategies. The NM SPF-SIG also focuses on *changing community norms*. (Norms are rules, usually unwritten, that provide the boundaries for our behavior.) Negative role modeling of adults drinking to get drunk/intoxicated provides a fertile environment for underage drinking. Many youth do not believe that their parents think underage drinking is harmful, and they do not believe that sanctions will be consequential if they are caught with alcohol or driving drunk (and they often are not). Thus, youth believe that the behavior is not harmful.

These SPF-SIG programs follow the environmental modality in that they do not seek to start more programs/services but instead focus on making changes in the local environments such as mobilizing for more effective enforcement activities, changing community norms favorable to risky use, increasing the perception of harm, enforcing underage drinking laws, and working with retailers to reduce underage purchases. Reducing alcohol outlet density and increasing alcohol taxes are two additional strategies that are evidence-based as well.

Science-Based Models, Best Practices, and NM Model Programs

In addition to the environmental work being done through the SPF-SIG, there are already many science-based prevention programs at the heart of New Mexico's substance abuse prevention efforts. Programs brought to New Mexico include nationally recognized efforts such as Reconnecting Youth, Botvins Life Skills, Effective Black Parenting, Dare To Be You, Right Start, Families and Schools Together, Strengthening Families, Project Northland, and Promoting Alternative Thinking Strategies.

There are also five prevention programs developed in New Mexico and funded through the DOH/BHSD that have received national recognition as Exemplary Substance Abuse Prevention Programs through a nation-wide competitive process sponsored by the National Prevention Network, the CSAP, and the Community Anti-Drug Coalitions of America. These exemplary prevention programs are:

- The Albuquerque Partnership (2000)
- Project Venture/National Indian Youth Leadership Project (2001)
- First Born Program/Gila Regional Medical Centers (2002)
- Connecting To Courage/Santa Fe Community College (2002), and
- Talking Talons Youth Leadership Program (2002).

Project Venture/National Indian Youth Leadership Project has now also obtained "model program" status, after an extremely rigorous process that involved a peer review protocol at the national level. Sponsored by SAMHSA, this awarded "model program" status designated to Project Venture after review of almost a decade of outcome studies is noteworthy. They now are included in the National Register of Effective Prevention Programs (NREPP). The program is now replicated in more than a dozen sites in New Mexico and sixty nationwide. First Born Program, developed in Grant County, now adopted by a major foundation and replicated in several counties in New Mexico.

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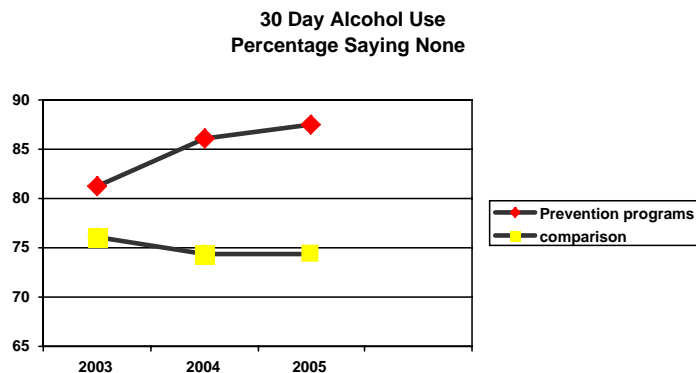
The History and Importance of Outcome Evaluation

Outcome evaluation was first introduced to prevention as a method to improve services. Philanthropic funding sources such as the Robert Wood Johnson Foundation asked grantees for comprehensive outcome evaluations and used this data to identify strategies that worked. CSAP took this data from Robert Wood Johnson Foundation and created community partnership grantees in the early 1990s. Outcome evaluation was a key component of the federal CSAP programs funded through this partnership initiative.

The DOH/BHSD was one of the first state agencies in the nation to request outcome evaluation of all contractors, and continues to use this information to identify changes over time in alcohol, tobacco, and other drug use among target youth. New Mexico is still one of the only States in the nation with a reliable survey assessment of risk and protective factors that all program grantees administer to participants before/ after the prevention program. This ensures that programs are accountable for their results, and provides evidence of program benefits (e.g. positive changes in behavior that can be linked to the prevention programs) and areas that might be improved. Outcome evaluation results can also be used to leverage more resources from funding sources.

Since 1999, over 4,000 youth in New Mexico have participated annually in a rigorous outcome evaluation study (Strategies for Success). Another 500 youth annually are part of a statewide comparison group drawn to match the characteristics of the program youth. Consistent, statistically significant positive outcomes in substance use behaviors and risk factors are found year after year: prevention program youth are showing trends in the desired direction while the comparison group is showing predictable increases in problem behaviors and use associated with experimentation in adolescence.

These statewide outcomes have brought New Mexico's prevention system broad national attention, as one of the few states able to demonstrate success across its system (e.g. student alcohol and drug use decreases and protective factors such as disapproval of drug use increase). The following graph illustrates that prevention program youth show marked increases in refraining from all alcohol use (in the past 30 days), especially in contrast to the outcomes of the comparison group.



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The Importance of Cultural Competency in Prevention Programming

One driver of New Mexico's nationally recognized success with prevention programs is that the State has embraced cultural competency. Culture consists of many attributes, including race/ethnicity, language, gender, disability and sexual orientation, and the Lewin Group, Inc., (2002) describes cultural competency as:

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations....

Given the diversity within New Mexico, program success is not possible without cultural competency, and the prevention system has demonstrated its ability to succeed for over ten years. There are three levels at which the New Mexico prevention system practices cultural competence: the state, community, and program levels. It has become an institutionalized practice at all three levels, and there is no doubt that this conscious effort has significantly contributed to our successes.

First, New Mexico has the only Native American developed evidence-based program in the nation, and has contracted with Nadine Tafoya and Associates to assist New Mexico's native communities in implementing evidence-based prevention programs while honoring participating tribes' values, traditions, and beliefs. Second, the State has also provided evaluation tools in Spanish to accommodate Spanish-speaking participants, and there are several SAMHSA-identified *promising* programs that serve the Hispanic population and have tremendous outcomes year after year. Third, cultural competence is included as a domain to prevention competencies that all organizations funded with BHSD/DOH dollars must adopt, and communities regularly adapt curricula to match the cultures receiving services while also maintaining program fidelity. Lastly, one of the most obvious practices of cultural competence at the program level is that staff reflects the culture of the community, often being long time or lifetime members of the community.

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WHERE TO GO FROM HERE: PREVENTION SYSTEM CHALLENGES

Although New Mexico's prevention system stands out as a national leader in implementing sound evidence-based practices, outcome measures, and cultural competency, there is still room for growth. There are significant challenges involved in achieving this growth and making the system more responsive to state and community needs, including but not limited to integrating the prevention/public health paradigm into the behavioral health care model currently being implemented in the state. These challenges include developing a common language for use throughout the system, strengthening the workforce, building coalitions and collaborations, and adapting to a new managed care funding environment.

The Language of Behavioral Health Services

The variation in the language and terms used by various stakeholders in the behavioral health field is a major challenge to more fully integrating the continuum of services. The pressing needs, gaps, and underlying issues in the system highlight the need for clarity of both definition and understanding, and the need to ensure that language and terms are applied consistently at various levels throughout the system.

Although commonly used, even terms like "prevention" will likely require additional proactive, constructive dialogue. While behavioral health is usually concerned with *individual* clients (and sometimes their families) already exhibiting various symptoms and problems, public health prevention programs are usually intervening with *populations* prior to the onset of symptoms and problems. Obviously, both are needed. Yet in order to have a fully integrated and functional behavioral health system, it is important to use common language to identify the target populations, strategies, and expected outcomes associated with each level of services in the continuum ranging from prevention to treatment to maintenance. This will help ensure that all parts of the system work cooperatively together to build a healthier New Mexico. Encouraging all individuals involved to grow in their own awareness and appreciation of the various roles, opportunities and challenges involved will help to establish an environment that promotes both an understanding of the differences in approach, areas of concern, responsibilities and assignments in the important work needing to be done. Population-based interventions such as prevention, while not incompatible with individual interventions such as treatment, are a very different way of viewing how to solve substance abuse problems. It could be at the very crux of our differences.

An example of the current differences in language within the system is that behavioral health treatment settings generally refer to prevention activities directed at the "individual client" as "preventing a relapse" or "recurrence of a particular behavior", similar to what the prevention community calls the "secondary prevention" public health clinical model. Also, medical treatment settings generally refer to the "individual patient" as the client or consumer while prevention focuses upon health and disease as part of a set of physical, biological, and cultural sub-systems that continually affect one another.

The IOM framework has the potential to act as an appropriate unifying model to meet New Mexico's goals. It not only includes the various facets of prevention as described above (e.g. universal, selective, and indicated strategies and target populations) but also defined the various

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components of treatment (e.g. case identification and standard treatment for known disorders) and maintenance (e.g. compliance with long-term treatment and aftercare).

Prevention Workforce Issues: Standards/Credentialing, and Recruitment/Retention

Another major challenge is the composition of the prevention and treatment workforces. Both employ credentialed staff but prevention programs frequently employ coalition members to advance local prevention agendas and many of New Mexico's prevention providers have bachelors degrees in the liberal arts (e.g. sociology, political science) while our treatment allies often come out of a "harder" clinical degreed background (e.g. medicine, nursing, social work). The prevention community is working towards a model that acknowledges that our workers do require a unique skill set that includes the community-view, while also ensuring that there is a standard of excellence that defines the workforce.

There are two Boards in New Mexico that offer credentialing for Prevention Professionals: the New Mexico Credentialing Board for Behavioral Health Professionals (www.NMCBBHP.org) and the Albuquerque Area Inter-Tribal Council on Substance Abuse Certification Board. Credentialing is based largely on competence and experience in alcoholism and drug abuse services, rather than solely on academic achievement. NMCBBHP certification requires a total of 120 hours of practical training in five domains, with a minimum of ten hours in each.

Certification is a form of credentialing, a voluntary regulation of a profession. It is the process by which a non-government organization grants recognition to persons who have met certain standards. Certification is designed to promote and maintain integrity and quality. Authority comes from professionals working in substance abuse who share a common concern for standards of competence. The benefits of credentialing accrue to professionals, the general public, service recipients, and private and government organizations including the State of New Mexico. They include:

- Certification marks the professionals who specialize in the alcohol and other drug abuse prevention field.
- Opportunity for peer networking, involvement and impact via the Board and Case Presentation Method Evaluators.
- Increases professionalism and competence in the field.
- Employers use credentialing as a basis for advancement and/or request or require certification upon employment.
- Freedom to move to another State within the International Certification and Reciprocity Consortium (IC&RC) and automatically be granted the State's certification status via reciprocity.
- Recourse for the client / consumer who may have ethics complaint against a certified professional.

Currently, there are 28 Certified Prevention Specialists in New Mexico, 14 of which are Senior Certified Prevention Specialists. Yet there many more qualified individuals practicing prevention

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in New Mexico, and there is a great need to build certification capacity. There is also great need to build workforce capacity as a whole.

The Public Health Workforce Study (January 2005) indicated that recruitment and retention of qualified prevention specialists can be a challenge, mostly due to budget constraints and a lack of competitive wages – salaries are lower for public health practitioners as a whole than anywhere else in the system. Additional barriers include lengthy processing time for new hires and finding qualified candidates in some areas of the State (especially border counties that need qualified bilingual public health workers). The NM GAP analysis, however, also indicated that a positive work environment, consistent quality of supervision, flexible work schedule, and stable organizational environment were key factors in retaining employees once hired – all strengths that can be better leveraged to build a strong prevention workforce in New Mexico.

The Importance of Coalitions and Collaboration in Successful Prevention Programs

Although New Mexico has many accomplishments regarding local communities or state agencies working together to address the substance abuse problem—including the SPF—the current changes in the behavioral health system indicate that the prevention community will need to continue adapting and refining its strategies in order to meet the challenges facing the state.

First, community coalitions are broad-based groups consisting of multiple community services that use their collective energy, experience and influence to address substance abuse policy and practices within their neighborhoods, cities, counties and states. Coalitions develop strategies for addressing every aspect of substance abuse problems – prevention, intervention, treatment, aftercare and enforcement, but with a particular focus on prevention. The premise of community prevention coalitions is that communities must be organized and equipped to deal with their individual substance abuse problems in a comprehensive and coordinated manner. The purpose of coalitions is to increase citizen participation and strengthen comprehensive community anti-drug coalition efforts. Coalitions have the power and opportunity to implement the strategic planning framework that is the basis for successful substance abuse prevention program implementation, help prevent duplication of services, keep their partners and citizens informed of issues and successes in the prevention process, and make the most of limited funding dollars. Community coalitions demonstrate the definition of coalescence: the union of diverse things (and people) into one body or form or group. With coalescence, communities are able to experience success in the effort to reduce substance abuse in New Mexico. Coalitions are designed to:

- Reduce substance abuse among youth and, over time, among adults.
- To strengthen collaboration among federal, state, regional, and tribal governments, and within their representative communities.
- Enable communities to conduct data-driven, evidence-based prevention planning by accurate and timely information regarding state-of-the-art policy, practices and initiatives that are proven to be effective in reducing substance abuse among youth.
- Enhance intergovernmental collaboration, cooperation, and coordination among all service organizations within communities that demonstrate a long-term commitment to reduce substance abuse among youth and, over time, among adults.

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As these points suggest, local community coalitions must work with one another and with other governmental entities in order to fully leverage their strengths. The SPF highlights the tremendous work that is being done in this area, although additional efforts are also needed.

Private stakeholder groups that have agreed to participate in the SPF project and can leverage systemic change through their membership include: the Association of Counties' DWI Coordinators Affiliate, the Mentoring Partnership of New Mexico (lead agency, San Juan County Partnership), Mothers Against Drunk Driving (MADD), and New Mexico Voices for Children. In addition, the New Mexico Parents and Teachers Board of Directors adopted during April 2004 a resolution urging legislative action to reduce underage drinking. They can play a vital role in the project but must be supported at the state level as well.

The DOH is central to SPF implementation, and DOH/PHD programs can help provide outreach and planning support to communities to develop capacity for SPF activities. Yet with the behavioral health system redesign, interagency collaboration is needed. PED and CYFD have many resources that can be brought to the table, and these agencies already collaborate actively with BHSD on prevention initiatives (e.g. requiring that DWI preventionists acquire prevention certification from the BHSD-sponsored training program). Two other agencies that must be integrated into the project to maximize success include the Traffic Safety Bureau of the Transportation Department (which funds media and public awareness campaigns) and the Youth Conservation Corps, which funds numerous youth jobs programs around the State.

Local Collaboratives are also essential to developing a network of local efforts that align with the State's prevention philosophy but are also tailored to the needs of individual communities. As Local Collaborative efforts get off the ground, this is an ideal time to begin dialoging with local stakeholders about the role of prevention, the many accomplishments that prevention programs have already demonstrated, and the strategies to strengthen the prevention system with local input and dedication.

Although it is a challenge to get these systems to work together, it is a necessary step towards addressing the substance abuse problems in New Mexico.

Resources and Service Measurement

Inadequate resources are a challenge for New Mexico's prevention system that most people involved in the system are aware of. According to the Gaps Report, New Mexico spends \$24 million for mental health and substance abuse prevention services, yet the state would need to spend \$73 million for a good system and \$109 million for an ideal system. Yet the resource challenges go beyond the lack of funding; the very structure of how the prevention services are billed presents challenges, especially moving into a managed care model. Prevention providers rarely think in terms of fee-for-service—how does one bill for doing a presentation to the local board of county commissioners in hopes of persuading them to adopt an indoor clean-air ordinance—while treatment has long employed a fee-for service system of reimbursement. Thus, the prevention community is facing a paradigm shift in terms of reimbursement methods.

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CONCLUSION AND RECOMMENDATIONS

Solving the Problem

The substance abuse problems of New Mexico are daunting. The use of the gateway drugs of alcohol and tobacco by children and youth provide a springboard to the other illegal drugs that are costly and compromise the state's public health and safety. While vitally important, treatment is not a comprehensive solution. If we ever hope to make a dent in the vast substance abuse problems experienced by New Mexicans, we must intervene early and especially among the populations that demonstrate known risk factors. We must include prevention in discussions about strategic planning, and knowledgeable prevention professionals need to be at the table when decisions are being made about the behavioral health system.

As demonstrated in this report, the prevention system in New Mexico has many demonstrated accomplishments and a strong base upon which to continue developing our services. Furthermore, the prevention system has already made great strides towards many of the goals outlined in *Substance Abuse in New Mexico: A Public Health and Public Safety Perspective*—workforce competency and professional certification, program alignment with evidence-based approaches, and accountability including demonstrated positive outcomes and a data-driven approach to service planning. Yet our next challenges are to maintain these successes while integrating prevention into the continuum of behavioral health services overseen by the Collaborative, and to further incorporate prevention planning at the local community level to ensure an integrated system. The following recommendations address these challenges.

Recommendations

To maintain New Mexico's role as a national leader in evidence-based substance abuse prevention while pursuing the transformation of behavioral health services in the State, we recommend the following strategies:

- Develop a strong partnership between the PA, Local Collaboratives, and the state prevention system to keep state-of-the-art prevention initiatives moving forward while also fostering collaboration with and integration of our assessment, capacity, planning, implementation, and evaluation expertise into New Mexico's broader substance abuse system;
- Ensure that the Collaborative and VO actively support the Native American Initiatives currently in place and designed to provide the New Mexican Tribes and tribal communities and organizations with guidance and support for implementing best evidence-based prevention practices; and
- Ensure that the Collaborative and VO actively support the credentialing standards currently in place for prevention professionals, and that we are working together to continue addressing the workforce development, training, and certification needs of the prevention system at all levels in the state.

To foster development of a common language and terminology that is appropriate for both the prevention and treatment systems, we recommend collaboration between the PA, the Collaborative, and VO on:

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- Continue to address the language and terminology used to describe prevention services in order to ensure that the BHPC/VO and BHSD definitions of prevention are synonymous and clarify terms such as risk, resilience, universal, etc., in order to provide a unified system of prevention/treatment/maintenance in New Mexico;
- Development of a strong policy statement about the role of prevention in the Collaborative and why it matters, educating Local Collaboratives and the BHPC about prevention services in New Mexico, and developing a strategy to work together to promote prevention across the State.

To ensure that prevention funding continues to be distributed based on both community need and use of evidence-based strategies, we recommend that VO and the State of New Mexico continue to explore workable approaches to reimbursement for community-based prevention by:

- Maintaining an open dialogue between the Collaborative, VO, and the PA regarding challenges administering funds that are transferred as part of Phase II, and continuing to discuss strategies to incorporate additional prevention funds into the contract; and
- Enlisting the support of national experts such as the Southwest CAPT, CSAP, the CDC, the Technical Assistance Collaborative (TAC) and/or conducting a review of activities in other states/localities that would assist New Mexico in building on previous experiences to more effectively integrate prevention funds into the Collaborative's work.