Cultivating Programs That Work

Operating Standards for DMHAS funded Prevention & Health Promotion Programs

Thomas A. Kirk, Jr., Ph.D.
Commissioner

Dianne Harnad, MSW, CPP-R
Director of Prevention and Intervention
Acknowledgements

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A special thanks to the City of Philadelphia who graciously shared a draft of their Core Standards for Youth Programs and Implementation Manual, which served as a model of excellence for this project.

Lastly, the committee would like to recognize the Department of Mental Health and Addiction Services, and its Prevention Division, under the direction of Commissioner Thomas A. Kirk, Jr., Ph.D. and Dianne Harnad, MSW respectively, for their steadfast commitment to improving prevention practice in the state. It is through this commitment to identifying and providing state-of-the-art practice that Connecticut residents will achieve a higher quality of life.

Obtaining Additional Copies

Copies of the standards may be obtained, free of charge, from the Connecticut Clearinghouse at:

334 Farmington Avenue
Plainville, CT 06062
(860) 793-9791
1-800-232-4424

Electronic Access

The standards can be accessed electronically through the DMHAS website at www.dmhas.state.ct.us or the CT Clearinghouse website at www.ctclearinghouse.org.
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Message from the Commissioner

We are very pleased to release updated Operating Standards for DMHAS Prevention and Health Promotion Programs. These standards and practice guidelines are up-to-date and in line with the current goals of DMHAS, the State Prevention Council, and The Center for Substance Abuse Prevention. It is anticipated that with the help of each funded prevention provider, and through consistent utilization and monitoring, the standards and practice guidelines will help move Connecticut’s prevention efforts to a higher level of excellence.

There is much work being done at the federal level in the prevention arena around issues of workforce development, professional standards, credentialing, licensure, and program standards. Connecticut has the opportunity to be at the forefront in many of these areas by continuing to strive for increased accountability, capacity, and effectiveness of our funded prevention and health promotion programming. Operating standards and practice guidelines are one tool for helping us achieve a common prevention language, a well-defined level of quality, and ultimately healthier people and communities.

The DMHAS Prevention Division, in collaboration with CT’s Prevention Resource Links and the Standards Development Committee, will be offering information and technical assistance sessions during the month of October. Specific dates and locations will be sent to all DMHAS prevention programs in the near future.

We look forward to hearing from you regarding the standards. Future revisions of this document will be based on the feedback received. Thank you for all your efforts in helping to create quality prevention services for Connecticut.

Thomas A. Kirk, Jr., Ph.D.
Commissioner
Department of Mental Health and Addiction Services
INTRODUCTION
“Prevention is an active process of creating conditions and fostering personal attributes that promote the well being of people” (Wm A. Lofquist, 1989 AYD Publications). The DMHAS Prevention Operating Standards have been developed to serve as a guide to prevention professionals as they undertake the “active process” of “creating conditions” within their programs and communities that “promote the well-being” of those with whom they encounter.

*Cultivating Programs That Work: Operating Standards for Prevention and Health Promotion Programs* has been developed for programs funded by the Department of Mental Health and Addiction Services’ Prevention Division. The standards, practice guidelines and supporting documents link state-of-the-art prevention theory to effective, comprehensive and accountable prevention practice. Implementation of the standards should result in positive outcomes for programs, staff and participants.

**The over-arching purpose of the standards is to develop a set of expectations for excellence in prevention programming. Additional purposes are to:**

- Create a common language among CT Prevention communities.
- Promote the inclusion and participation of all relevant agencies and individuals in the design and delivery of prevention services.
- Establish consistency in the assessment, design and implementation of prevention services.
- Ensure a standard of professional practice that incorporates continuous professional development.
- Guarantee a minimum standard of service for all participants.

What the DMHAS Prevention Operating Standards are *not* is a one-size-fits-all, prescriptive formula for all programs. Hence, the title and theme of this document. Effective program planning, implementation, evaluation and administration is a *cultivation process* requiring specific ingredients, precision and care. Appropriate tools allow programs to prepare, grow, and improve in a manner that results in an ideal fit of people and services. In recognition of this, it is expected that some standards and practice guidelines may not be applicable to all programs. Implementation of the standards and guidelines will be individualized by programs. Other agencies providing prevention services may find it helpful to adapt this document for their funded prevention programs.
The mission of DMHAS is to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect. Alcohol, tobacco, and other drug (ATOD) prevention, violence prevention, and health promotion services are placed under the Prevention/Intervention Division within the DMHAS. Prevention activities within DMHAS have historically been based on public health and risk/protective factor models. Programs have also used the empowerment model as promulgated by the Center for Substance Abuse Prevention (CSAP).

Among the CT state agencies with prevention resources, the mission for prevention is to build a systems approach to strengthen local capacity and to support local empowerment in meeting needs and implementing prevention programs. DMHAS fosters the development of comprehensive culturally appropriate programs based on scientifically defensible principles and targets both individuals and the environments within which they live. Program philosophies incorporate experiential learning, asset assessment and building, development of resiliency skills, and advocacy for constructive social and systems changes that support prevention services and encourage positive and healthy behaviors relative to alcohol, tobacco and other drug use.

In 1995 DMHAS, in conjunction with CT prevention provider agencies and organizations developed and implemented its first Prevention Program Operating Standards. These standards established a minimum level of program operation intended to reflect quality substance abuse prevention programs. The operating standards articulated a service philosophy that promoted the concept of health promotion as a means of building on the strengths and positive resources of individuals, families, schools, and communities throughout the State of Connecticut to prevent the use, misuse, or abuse of legal or illegal substances.

The purpose of the original standards was to provide assurances to the public that alcohol and drug abuse prevention and early intervention programs are regulated under a set of minimum standards established by DMHAS. This document builds upon the original standards, expanding on the application of prevention theory to a broader array of behavioral health issues including alcohol, tobacco, and other substance use and abuse, violence, gambling, and promoting mental wellness and recovery.
To begin the process of revising the existing DMHAS Prevention Operating Standards, DMHAS sought volunteers from its funded programs to participate on a Prevention Standards Development Committee. This opportunity allowed prevention professionals to be involved in identifying essential indicators of quality prevention programming, creating operational standards, and defining the process of development, review and implementation of the new standards. A series of meetings was scheduled and a preliminary search for Prevention Standards from other states began. It was at this time that a draft of Core Standards for Philadelphia’s Youth Programs (October 2001, City of Philadelphia Division of Social Services Office of Children’s Policy) was discovered. The clarity of tone, content and format of Philadelphia’s standards captured our attention and ultimately served as a model for Connecticut’s document.

The committee concluded that the Operating Standards should serve as a handbook that could respond to the question, “If I’m going to run a really good prevention program, what should I be doing around program administration, implementation, planning, etc.?” Discussions ensued regarding the structure of the document, the inclusion of components of the science of prevention, and the utilization of implementation tools.

The Committee was quick to reach consensus on the scope of the standards and set the following objectives:

- The standards must be **broad** enough to address the vast areas of prevention practice such as substance abuse, violence, HIV, teen pregnancy, gambling, mental health, wellness, and recovery.

- The standards must be representative of the **diverse** populations that prevention programs serve.

- The standards must be developed, **to the extent possible**, to address prevention **across the lifespan**. This document is intended to complement existing standards of practice-enhancing them with a prevention and health promotion perspective.

- The standards must be **available** to DMHAS’ state agency partners. The Prevention Standards Development Committee determined that all state agencies providing prevention services would 1) be invited to participate in the review of the Standards; and, 2) have a final draft made available to tailor to their specific discipline or area of service (i.e., education, social services, child protective services, etc.).

- The standards must be a **fluid** document, one that is flexible and evolutionary.

- Finally, the standards must be a document that is **useful**. This is not intended to be a document that is shelved. It should serve as a resource to programs, a tool to assist in self-examination and continuous improvement.
The Prevention Unit of DMHAS recognizes that its Operating Standards and Practice Guidelines must be rooted in a set of basic principles and core values that supports a framework for prevention that is positive, strength-based, and developmental. Positive youth development, resiliency, asset-building, and risk and protective factors are not programs, but parts of a framework that support the development of healthy communities, youth and families. Together, they are an approach, an organizing framework for a number of activities that promote the strengths, or assets, that reside in people, their families, and their communities. The philosophy embraced by the standards development committee is for the standards to, 1) recognize programs as resources, 2) support an interchange between programs, and 3) be implemented in a spirit that acknowledges each agency’s unique mission and goals.

To build upon the prevention infrastructure that already exists, the committee focused on ensuring that the Standards incorporated the work of the State Prevention Council, including the goals set forth in the 2002 Statewide Comprehensive Prevention Plan, and the results of the community conversations held during the statewide Listening Tour (completed in 2002 by the Commission on Children and The Governor’s Prevention Partnership).

It is anticipated that dialogue resulting from the roll-out of these standards to a broader audience of prevention professionals will articulate a clear set of principles or core values that are measurable and can act as a guide to the application and implementation of effective “prevention program standards and practices”.

In addition to the aforementioned values and principles, DMHAS’ Prevention Standards and Practice Guidelines address, to the extent possible, SAMHSA’s National Registry of Effective Programs and Practices (NREPP) criteria for effective programs (See Appendix A for criteria).
ACHIEVING THE STANDARDS
The CT Prevention Operating Standards are divided into eight categories critical for all prevention programs: Human Relationships, Program Planning, Program Activities, Program Settings, Health and Safety, Program Implementation, Program Administration, and Evaluation.

Each category within the standards document includes the following:
- Definition of the category;
- Functions of the category;
- Results of effective practices in the category;
- Standards, or goals of practice for the category; and
- Practice Guidelines, or recommendations for the most appropriate approach, for achieving each standard.

Practice guidelines are assigned a Level, depending on their significance and priority in working towards meeting the related standard:

- **Level 1**
  
  **Minimum Practices:** Level 1 practice guidelines define minimum practices that should be in place at the start of a program in order to qualify for DMHAS funding. In certain circumstances, and in collaboration with DMHAS, agencies may have up to one year to fully comply with level 1 practice guidelines.

- **Level 2**
  
  **Critical Practices:** Level 2 practice guidelines are critical practices for providing quality prevention programming and must be in place by the end of a program’s first year, unless otherwise noted.

- **Level 3**
  
  **Recommended Continuous Improvement Practices:** Level 3 practice guidelines are recommended practices for continuous program improvement. Not all level 3 practice guidelines are applicable to all programs. Programs will decide, in collaboration with their DMHAS representative, which guidelines apply to their program and a reasonable plan towards achieving them.

The practice guidelines are guidelines for effective practices. It is expected that the implementation of these guidelines will vary by program, but should be based on theory, current research and best practices. A limited number of Tools and Resources available for implementing the standards and guidelines are included.

**Appendices** provide additional information to further clarify the practice guidelines and provide specific examples of plans and practices.

A **Self-Assessment Tool** is available to assist programs in assessing their status toward achieving the practice guidelines and the operating standards.
DMHAS’ goal is to have all DMHAS funded prevention programs meeting the minimum practice guidelines (level 1) within six months of dissemination of the standards. New programs applying for DMHAS prevention funds will be required to show how they are implementing level 1 practice guidelines prior to receiving funding, typically during bidding and contracting processes. All DMHAS funded programs will receive hard and electronic copies of DMHAS’ Operating Standards for Prevention and Health Promotion Programs, including the standards and practice guidelines, tools and resources, a self assessment tool and a feedback form.

Information and training on the Operating Standards will be provided by the DMHAS Prevention Staff to ensure that the standards and practice guidelines are understood and can be made operational by each program.

Technical assistance will be provided by DMHAS and CT’s Prevention Resource Links as a follow-up to the initial training. At this phase, programs will develop a plan for meeting the standards. A self assessment tool is available for assisting in this process. Once a plan for meeting the standards has been developed, each program will assess and document their progress, successes, and challenges toward achieving the identified guidelines. Programs experiencing significant challenges with implementing the guidelines and meeting the standards will receive individualized assistance from their assigned DMHAS representative.

DMHAS prevention programs will play an integral role in the diffusion of DMHAS’ Prevention Standards through existing local, regional and statewide networks. Learning communities, technical assistance sessions and program site visits will facilitate diffusion of the standards by enhancing knowledge exchange between programs, while successful programs may assist in the diffusion of the standards and practices among agencies within the state and beyond.
THE STANDARDS
Human relationships are interactions that provide a continuous process of connection, which is an essential element of human development. Building positive relationships among youth, staff, families and the community creates strong effective programs where people can thrive.

Positive relationships result in staff and participants that are engaged in the program and actively involved in the planning, implementation, administration and overall success of the program. Without positive human relationships, it is difficult for programs to be successful.
HUMAN RELATIONSHIPS

The primary functions of human relationships are to:

- Provide a continuous process of
  - Connection,
  - Gratification of needs: physical, psychological and spiritual,
  - Communication,
  - Socialization,
  - Support for learning and discovery, and
  - Problem solving, community building, and negotiation of power.

- Nurture and foster growth and contribution to the health and welfare of the community.
- Provide support and encouragement to participants to choose healthy and productive lifestyles and make positive changes in their behaviors and attitudes.
- Lay the foundation for program success.

The results of effective human relationships are:

Participants, staff, and community members:

- are respectful, trusting, caring, and friendly.
- are not only involved in the program but also are engaged because they feel valued and appreciated.
- learn their ideas matter and develop their interests, talents, and abilities among others who care.
- have opportunities to design, implement, and evaluate their program, thereby sharing the responsibility of what and how they contribute to their community.
- learn to appreciate the concerns, interests, and opinions of others
- learn that we are interconnected and that by sharing our gifts and skills we can work together to make a difference in the world.
- grow through stages of consciousness from “passive onlooker” to “participatory consciousness” to a “mentoring consciousness” which impacts the person and the community.
**Standard 1.1:** Interactions between participants and agency representatives are positive.

**Practice Guidelines:**

A. Staff is intentional about participants feeling welcome and comfortable.

B. Each participant has access to at least one staff member who provides support for his/her progress over time.

C. Each participant knows how to access program staff and resources.

D. Staff is accepting of the range of participant’s feelings and abilities (e.g., active listening).

E. Staff is intentional about discovering the range of each participant’s abilities, valuing special interests, skills, and talents.

F. Staff and experienced program participants introduce these Human Relationship standards to newer participants, at the beginning of each program, as a way of validating that Human Relationships are an integral part of program and community growth.
**Standard 1.2:** Participants are encouraged to make choices, develop personal responsibility, and interact with staff and other participants in meaningful ways.

**Practice Guidelines:**

A. Staff guides participants in learning how to make informed and responsible choices.

B. Staff and participants work together to create ground rules for behavior, which include both logical and natural consequences.

C. Confidentiality, rules, and guidelines are made clear and agreed upon by staff and participants.

D. Participants are encouraged to become equal partners by serving in key roles such as members of boards and committees that address important aspects of the program’s operations and work.

E. Participants are acknowledged when they cooperate, share, care for materials, or join in activities. Furthermore, examples of mutual assistance, respect, patience, and achievement of personal goals are rewarded in some way.

F. Staff supports participants’ ability to respect, cooperate and negotiate differences with each other.
**Standard 1.3:** Family and community members are active partners in the life of the program.

**Practice Guidelines:**

A. Staff actively explores, and applies knowledge gained, regarding the unique cultural and social background of family and community members.

B. The program demonstrates an “open-door” policy where family and community members feel welcome to visit the program site.

C. Staff have opportunities and are encouraged to network with other community providers.

D. Family and community members are informed of program issues through effective communications and have opportunities to be active participants in program events.

E. Staff, family and interested community members work together as a team to establish a “community web of support” for each participant.

F. Well defined and meaningful volunteer opportunities are made available to family and community members.

G. When possible, community members are welcome to use program facilities for activities that support a common mission.
**Standard 1.4:** Staff interacts with participants as partners in the learning and teaching process.

**Practice Guidelines:**

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<tbody>
<tr>
<td>A.</td>
<td>Staff varies the approaches they use to facilitate participant learning.</td>
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<tr>
<td>B.</td>
<td>Staff facilitates the development of the “6 C’s”: Confidence, Character, Connection, Competence, Culture, and Contribution through a cooperative learning process that supports opportunities for frequent conversations and exercises that build these competencies.</td>
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<tr>
<td>C.</td>
<td>Staff are adept at using open ended questions to facilitate the creative thinking of participants.</td>
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<td>D.</td>
<td>Staff shares skills and resources with participants to expand their knowledge and ability to solve problems.</td>
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<td>E.</td>
<td>Staff provides opportunities for participants to 1) explore their perceptions and concerns with regard to personal, racial and ethnic identity, and 2) practice methods of dealing with all types of discrimination including race, gender, national origin, class background, and sexual orientation.</td>
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2. PROGRAM PLANNING

Planning is the essential key to maximizing the effectiveness of services and achieving the mission of the organization. The standards in this category can guide the creation of prevention programs to meet the needs of children, adolescents, adults, seniors, families and the community in order to achieve the desired outcomes.
PROGRAM PLANNING

The primary functions of program planning are to:

- Connect a program’s mission and strategic plan to its services.
- Carry out a logical and systematic process for designing, implementing, and evaluating program services that fulfill the program’s mission.
- Provide a detailed framework and roadmap for the implementation of program services.
- Provide an opportunity for participants, staff, management, and other stakeholders to have a voice in how services are implemented.
- Increase the potential of reaching the desired program outcomes.
- Utilize feedback regarding program successes and limitations in programming.

The results of effective program planning are:

- Staff and participants thoroughly understand what the program intends to accomplish and how it intends to accomplish this.
- Well implemented programs that run smoothly and are meaningful to participate in.
- Programs meet the needs of participants.
- Program implementation is refined, based on programmatic feedback and evaluation.
- Programs achieve their desired outcomes.
**Standard 2.1:** Program Planning is comprehensive in scope.

**Practice Guidelines:**

A. Program planning is based on the program’s and organization’s philosophy and mission.

B. Program planning and the resulting activities are theoretically driven, based in research, developmentally appropriate, and reflect the cultures of the program participants and the broad diversity of human experience.

C. Program planning utilizes a logic model approach (see Appendix B for a sample logic model) to develop a strategic prevention framework that:
   1. Begins with needs and resource assessments and development of an evaluation plan
   2. Mobilizes or builds capacity;
   3. Includes a strategic plan which includes selecting and implementing prevention interventions that target either a universal, selected, or indicated population;
   4. Moves to implementing an evaluation plan; and
   5. Utilizes feedback and evaluation results to improve program implementation and enhance results for participants.

D. Program participants, including youth, are actively involved in program and activity planning.

E. Staff documents the planning process and keeps the documentation on file.

F. Program Planning integrates data from annual needs assessments that includes the needs, capacities, and readiness of participants and the larger community.
**Standard 2.2:** Programs are structured to identify, enhance and build protective factors (assets) and reduce risk factors within multiple life domains.

**Practice Guidelines:**

A. Programs are designed to decrease participants involvement in risky behaviors and increase involvement in healthy behaviors by addressing risk and/or protective factors in multiple life domains (see Appendix C for risk and protective factors by domain for programs serving youth.)

B. Program planning utilizes a holistic approach by using multiple prevention strategies (see Appendix D for the six CSAP strategies).

**Standard 2.3:** Program planning is a continuous and circular process that incorporates participant satisfaction to improve the quality and range of services provided.

**Practice Guidelines:**

A. An integral component of program planning is the development of an evaluation plan to monitor and assess the actual benefits to participants, i.e. its success in reaching its stated programmatic goals and objectives.

B. Participants are integral partners in the evaluation and continuous program improvement cycle.

C. Program planning continually integrates results of customer satisfaction measures into updating and refining program planning processes.
Standard 2.4: All program elements are asset-based and holistic.

Practice Guidelines:

A. Programs are structured to engage staff and participants as both teachers and learners and are encouraged to share their skills and talents to enhance program activities and outcomes.

B. The program utilizes learning strategies that validate the knowledge and skills that participants bring to the program and engage their creativity.

C. Programs are designed to address as many of the complex and multi-faceted needs of participants as possible, including personal, social, economic, cultural, relational, recreational, academic and as appropriate spiritual.

D. Community assets and resources are utilized to strengthen and enhance the program.
3. PROGRAM ACTIVITIES

Program activities are those essential components of prevention programming which invite participants to actively acquire the skills and knowledge to make healthy lifestyle choices. Program activities are where knowledge becomes experience.
PROGRAM ACTIVITIES

The primary **functions** of program activities are to:

- Provide participants with the opportunity to practice the skills needed to make healthy lifestyle choices, ultimately linking program participation to the achievement of program objectives and outcomes.
- Build capacity through the identification of strengths.
- Intervene early and at important stages and transitions.
- Intervene in appropriate and multiple settings and domains (home, school, community, environment).
- Focus on all levels of risk, with special attention to those exposed to high risk and low protection.

The **results** of effective program activities are:

- Participants experience multiple and varied opportunities to acquire new skills and self-awareness.
- Participants learn by doing.
- Achievement of:
  - **Confidence**: participants are confident in applying new skills when confronted with challenging situations.
  - **Connection**: participants feel connected to other supportive individuals, their families, members of their communities, and relevant institutions within their communities.
  - **Competence**: participants feel secure in attempting new approaches and are inspired to expand their level of capability.
  - **Contributions**: participants are provided the opportunity to share new knowledge and skills with other individuals, families, members of their communities.
  - **Culture**: participants are encouraged to recognize, and embrace their own and others’ cultural, social and physical identities; and honor the diversity of family traditions, values and beliefs that each participant brings to the program.
  - **Character**: participants are provided the opportunity to discover and convey an honest sense of self, courage, and strength of mind.
Standard 3.1: Activities are comprehensive and meet the needs of the target population(s).

Practice Guidelines:

A. Activities are provided under multiple prevention strategies and lead to desired outcomes. (See Appendix E for a list of activities by strategy)

B. Activities reinforce objectives that address relevant risk and protective factors. (See Appendix C for risk and protective factors for youth)

C. Activities help participants identify and/or build their developmental assets.

D. Activities are varied and are provided in accordance with the identified target population (universal, selected, indicated). (See Appendix F for IOM definitions)

E. Activities are meaningful and engaging.

F. Activities reflect and communicate a sensitivity to and respect for cultural, ethnic and gender differences.
   1. Materials reflect the culture and are delivered in the predominant language of the target population.
   2. Program services are delivered by staff that reflect the culture of the target population.
   3. Activities are developmentally appropriate and their appropriateness is continually assessed as participants needs change.

G. Substance abuse prevention activities are designed and implemented to address multiple domains: individual, family, peer, school, community, and social/environmental and are based on scientifically defensible principles. (See Appendix G for CSAP’s principles by domain)
Program setting is the physical indoor and/or outdoor environment where a program occurs. The look and feel of program settings influences participants’ interest, behavior and success in the program. Participants do not feel welcome, appreciated or safe in program settings that are uncomfortable, disorganized and poorly equipped.
PROGRAM SETTINGS

The primary functions of program settings are to:

- Develop and sustain a safe, welcoming, and comfortable atmosphere for the persons being served by the program and for the staff who are implementing the program.
- Provide the adequate space and necessary equipment for program activities to run smoothly and meet program goals and objectives.
- Provide an environment that allows program staff and participants to take initiative and become fully engaged in program activities.

The results of effective program settings are:

- Program staff and participants felt safe, secure, and supported by the environment.
- Program space and materials encourage creativity, partnership, and positive development for staff and participants.
- The greater community recognizes the program as an accessible setting that provides a valuable service to its constituents.
Standard 4.1: The program’s indoor space meets the needs of program participants.

Practice Guidelines:

A. Sufficient space is available for confidential participant/staff interactions.

B. There is enough room for all program activities. If necessary, study space with tables, chairs, and computer access is provided.

C. The space is arranged for the range of activities planned and offered in the program, allowing for various activities to occur at the same time with limited disruption.

Standard 4.2: The program’s outdoor space meets the needs of program participants.

NOTE: These standards apply only to programs that include an outside component.

Practice Guidelines:

A. If the program does not have access to its own dedicated outdoor space, nearby public space is available and it is safe.

B. Dedicated outdoor space, permanent playground/athletic equipment and outdoor furniture is accessible, suitable and large enough for the sizes and abilities of all program participants.

C. Appropriate safety matting is in place under and surrounding outdoor equipment to meet national playground safety standards.

D. Each program participant has an opportunity to participate in outdoor activities on a daily basis for at least 30 minutes, subject to weather conditions.

E. The outdoor area is suitable for a wide variety of activities including active and quiet pastimes.
**Standard 4.3:** The program setting allows participants to take initiative and explore their interests.

**Practice Guidelines:**

A. The program setting reflects the cultural and ethnic heritage and the work and interests of program participants.

B. Some areas have soft, comfortable furniture for participants to relax in.

C. Participants can arrange materials and equipment to suit their activities.

D. Participants can easily get materials out and put them away by themselves.

NOTE: It is understood that programs located in facilities in which their program is not the primary user may be unable to meet some of these guidelines.

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**Standard 4.4:** The program’s setting meets the needs of staff.

**Practice Guidelines:**

A. There is enough room in the indoor space.

B. The work environment includes a place for adults to take a break or work away from participants, has an adult-sized bathroom, and provides a secure place for staff to store personal belongings.

C. Staff has access to adequate and convenient storage for program supplies and materials.

D. The work environment for staff, including activity rooms is comfortable, well organized, and in good repair.
Those conditions that programs create which allow staff and participants to exist and grow absent of risk of personal harm. Without a healthy and safe environment, staff and participants will not feel free to fully participate in program activities.
HEALTH AND SAFETY

The primary functions of health and safety are to:

- Provide an environment and services that are clean, well maintained, and in compliance with public health regulations.
- Provide an emergency plan that is well managed, accessible, and understood by all staff and participants.
- Provide a code of conduct for staff and participants for maintaining a healthy, balanced lifestyle.

The results of effective health and safety are:

- Participants and staff feel safe and secure as they participate in the program.
- Participants feel safe traveling to and from the program.
- Participants learn how to practice habits for a healthy lifestyle.
- Parents/Guardians and other family members feel comfortable allowing youth/children to participate in program activities.
**Standard 5.1:** There are no known health or safety hazards.

**Practice Guidelines:**

A. The agency has on file a copy of the specific health regulations that apply to the type of programs and participants in the setting and is aware of the requirements for implementing those regulations.

B. Procedures for trash removal, cleaning, and maintaining restrooms are in compliance with public health regulations.

C. Unsafe areas are fenced off or otherwise off limits.

D. A code of conduct for smoking, appropriate attire, and behavior is clearly posted and includes the expectation that the environment is free from coercion, intimidation, ridicule, and other put-downs.

E. For programs with youth volunteers, volunteer activities and duration complies with state labor and education regulations.

F. For programs employing youth, employment type and duration complies with state labor regulations.

G. Transportation is provided in compliance with all legal requirements for vehicles and drivers.

H. Suspected abuse, harassment, or neglect is reported as stipulated by Connecticut statutes.

I. Food/menus are culturally and developmentally appropriate and are sensitive to any dietary restrictions of the participants.

J. Foods are served and stored in compliance with state health regulations.
HEALTH AND SAFETY

**Standard 5.2:** Emergency Management policies and procedures are in place to keep participants safe.

**Practice Guidelines:**

A. Agencies have an emergency plan that is in accordance with state and local regulations, i.e. drills, policies.

B. Staff receives training in emergency procedures, annually, or as otherwise required by other regulatory bodies.

C. Participants and staff have regular opportunities to practice safety response and emergency procedures with a frequency that, at a minimum, meets state and local regulations.

D. Each participant has an emergency contact on file and has an opportunity to report any significant health conditions for their file. Procedures for notification of identified emergency contact are understood by staff and participants.
6. PROGRAM IMPLEMENTATION

Program implementation describes the tools and structures needed to move planning into action. Without sufficient structures such as: consistent organization, sufficient materials, effective communication of standards and expectations, and links to the community, it is difficult to carry out services and activities.
PROGRAM IMPLEMENTATION

The primary functions of program implementation are to:

- Provide purpose, support, and structure to the program.
- Serve as a framework that supports the body of program activities.
- Deliver the program plan to the population it’s designed to serve.
- Move planning into action resulting in specific outcomes.

The results of effective program implementation are:

- Programs function with a balance of freedom and structure.
- Participants and communities are provided with the services that are needed to develop skills, increase resiliency, and promote health and well-being.
- Services are provided so that goals are achieved.
- Increased credibility of the program and those associated with it.
- Program activities are dynamic based on monitoring, feedback and evaluation.
**Standard 6.1:** Programs have an implementation plan that is flexible, considers program participants, and achieves desired outcomes.

**Practice Guidelines:**

A. A program action or implementation plan exists which includes, at a minimum, objectives, activities, staff responsible, timelines, and outcomes for the program.

B. Resources are expended in a manner which is consistent with the implementation plan.

C. There is a process for re-allocating unused funds based on meeting the goals of the program.

D. Adaptation to the plan should evolve from valid and comprehensive review.

E. Adaptation to the plan involves the funding source and other stakeholders.

F. There are processes in place to ensure fidelity to the implementation plan i.e., use of curriculum checklists, log books, staff notes.

G. Participants, including youth, have an active role in the development, implementation and revision of the action or implementation plan.

H. There is a process for providing feedback from the implementers and participants to the planner i.e., for the allocation of unused resources.
**Program Implementation**

**Standard 6.2:** There are sufficient and appropriate materials to support program activities.

**Practice Guidelines:**

A. Materials are allocated in a manner that ensures sufficient supply for the number of participants.

B. Materials are developmentally and culturally appropriate for the participants in the program.

C. Materials promote the program’s mission.

D. Materials are engaging and reflective of participant’s interests.

E. Materials are reviewed with reasonable frequency to ensure that they are current, complete, and in good condition.

**Standard 6.3:** The program communicates expectations for positive change.

**Practice Guidelines:**

A. Objectives of the program are shared with the participants in a way that links activities with measurable improvements.

B. Program participants’ improvements are measured.

C. The program regularly recognizes and celebrates each participants’ achievements.

D. Programs promote and reinforce the connection between hard work, high expectations for oneself, and productive citizenship.

E. The implementation plan includes a method of promoting program successes with stakeholders (community, funders, legislators, etc.)
**Standard 6.4:** The program builds links to the community.

**Practice Guidelines:**

A. The program has a plan to build linkages with the community and other stakeholders.

B. The program develops and maintains relationships with community providers who may be sources of referrals and staff draws from these community resources to enhance program offerings.

C. Staff informs and assists interested participants with contacting appropriate services.

D. The staff plans and implements activities to help participants get to know the larger community.
7. PROGRAM ADMINISTRATION

Program administration is the act of directing or managing a program. It is the ingredient that nourishes and supports a program, helping it to become healthy, vibrant, and effective. Without stable, well-managed program administration, programs and facilities will not be maintained properly, financial resources sources will falter, staff will become frustrated and discouraged, and participants and community members lose confidence in the program.
PROGRAM ADMINISTRATION

The primary functions of program administration are to:

- Develop and sustain a stable, qualified workforce.
- Develop and manage financial resources.
- Develop, coordinate, and monitor policies, procedures, and systems to guide program operations.
- Develop open communication and accountability to other administrative levels or governing bodies.

The results of effective program administration are:

- The program provides a safe, secure, and supportive environment for staff and program participants.
- The program is well coordinated, runs smoothly, and offers a consistent level of quality services.
- Staff are knowledgeable, skilled, and empowered to carry out their responsibilities.
- The Board of Directors is informed, supported, and supportive.
- The program has the necessary financial support to support its operations.
- Youth, families, community members, staff, and managers responsible for the governance of the program feel a joint sense of ownership and pride in the program.
- Participation in and satisfaction with the program is high because the program has structures in place that reflect and respond effectively to community and individual needs.
**Standard 7.1:** The prevention program has in a prominent place the agency’s mission and is accountable to and consistent with that mission.

**Practice Guidelines:**

A. A written mission statement sets forth the program’s philosophy and goals and is posted where the public can see.

B. Prevention representatives (prevention program staff, participant or other stakeholders) are involved in the development and periodic review of the agency’s mission and strategic plan.

C. Prevention representatives participate in educating/informing the administration and governing body of prevention programs, and emerging trends and issues.

D. Prevention representatives participate on the agency’s governing body.

**Standard 7.2:** Staff is professionally qualified to work in prevention and adheres to the principles of the Code of Ethical Conduct for Prevention Professionals.

**Practice Guidelines:**

A. Staff not certified in prevention will possess the knowledge, skills, and attitudes needed to effectively work in the prevention performance domains which they are assigned, as defined by the competency standards found in the current International Certification and Reciprocity Consortium’s Certified Prevention Specialists Role Delineation Study.

B. All staff receive and sign-off on the Code of Ethical Conduct for Prevention Professionals. (See Appendix H for the Code of Ethics)

C. Staff members working (20 or more hours a week) in a DMHAS funded prevention or intervention program shall meet the minimum standards for an Associate or Certified Prevention Professional, as established by the CT Certification Board, within three years of hire. (See Appendix I for requirements)

D. Program staff are trained and experienced in providing culturally competent services specific to their assignment.
**Standard 7.3:** Staff and volunteers receive appropriate support.

**Practice Guidelines:**

A. A written job description that outlines job qualifications and responsibilities is reviewed with each new staff member or volunteer.

B. Written personnel policies and written program policies and procedures, including emergency and confidentiality policies, are reviewed with staff and volunteers.

C. Prevention Program Operating Standards are reviewed by new staff members and volunteers.

D. New staff is given a comprehensive orientation to the program philosophy, schedules, principles, and practices. Orientation should also include an overview of current prevention concepts and program strategies, theory, research, best practices, and funding policies and requirements.

E. A qualified Prevention Supervisor is appointed by the agency Director or Board of Directors to provide support and supervision to paid staff and volunteers working in prevention programs. A Prevention Supervisor shall meet one of the following qualifications:
   - Associate Prevention Professional
   - Certified Prevention Professional
   - Certified or Licensed Alcohol and Drug Counselor who has documented alcohol and other drug prevention work experience
   - Relevant Masters level professional who has documented alcohol and other drug prevention work experience.

F. Staff and volunteers receive ongoing supervision and feedback. Staff members receive at least one annual written performance review.

G. Youth leaders receive ongoing feedback and support and must always be supervised.

H. Staff is provided with a forum for sharing their ideas and/or concerns regarding the program.
Standard 7.4: Staff development plans, appropriate to the job position and requirements, are maintained for all employees.

Practice Guidelines:

A. Staff not certified in prevention will have the opportunity to complete the number of training hours required to obtain certification.

B. Certified staff will have the opportunity to complete the minimum number of hours needed for re-certification.

C. All staff receives training in the following areas: 1) current prevention research, best practices and effective strategies, 2) curriculum and activity planning and implementation and 3) the DMHAS Prevention Operating Standards.

D. Incentives are created to support staff development.

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Standard 7.5: Staff-participant ratios permit the staff to meet the needs of participants and to provide appropriate supervision.

Practice Guidelines:

A. Each program will identify appropriate staff-participant ratios for the services provided. Staff ratios will be based on model program guidelines, fidelity instruments, and/or state/federal requirements. When no requirements exist, ratios will be based on the service provided, the needs of the target population, and ability of staff to provide appropriate supervision.
Standard 7.6: Program policies and procedures are responsive to the needs of youth, families, and other members of the community.

Practice Guidelines:

A. The program administrator is required to complete a program cultural competency plan for prevention programs.

B. A grievance policy is established and posted.

C. A confidentiality policy is established and consistently enforced.

D. Participant records are stored in a locked filing cabinet, or are double locked if the agency is required to do so under federal confidentiality laws.

E. The program’s hours of operation are based on program participants’ needs.

F. The program has a written plan regarding input from persons served, including how input is obtained, how input is reviewed, and how it is used to changes policies and practices.

G. Programs collecting participant health information, as defined by the Health Insurance Portability and Accountability Act of 1996, will comply with the required regulations to ensure protection of participant records.
**Standard 7.7:** The administration provides sound management of the program.

**Practice Guidelines:**

A. The financial management of the program supports the program’s goals.

B. The agency has policies and procedures for the operation of the prevention program that are annually updated and include:
   - Organizational charts for the prevention programs;
   - Description for each of the prevention programs provided, including the prevention theory and research on which it is based, goals, measurable objectives, intended outcomes, risk and protective factors targeted, and description of intervention fidelity (how consistent delivery of the intervention is assured);
   - Descriptions of target population(s) and criteria for identifying appropriate program participants;
   - Process for handling referrals to and from other organizations;
   - Procedures for transporting program participants, if applicable;
   - Procedures for obtaining and releasing information on program participants; and
   - Procedures for reporting suspected child, elder and/or domestic violence abuse.

C. The organization complies with the legal requirements and regulations of all governmental authorities and legally binding authorities.

D. The administration involves staff, board, families, youth, and community members in long-term planning, which guides daily decision making, and is informed of progress.

E. A project sustainability plan exists.

F. Program participants and affected community members and groups, are provided thirty-day advance written notice if an agency is closing a program. A copy of the notice of closing is sent to the DMHAS Purchased Services Unit and to the Prevention Services Unit.

G. The prevention program is programmatically and fiscally closed out according to the DMHAS contract requirements.
Program evaluation is the systematic collection and analysis of data needed to make informed decisions about a specific program or intervention.

Effective evaluations determine whether programs are implemented as planned, result in positive outcomes for participants, and assist in the continual quality improvement of the program.
PROGRAM EVALUATION

The primary functions of evaluation are:

- Informed decision-making
- Helping program participants
- Accountability
- Sustainability

The results of effective evaluation are:

- Determination of what worked and what didn’t can help make changes for the better
- Continuous improvement in management and service delivery
- Confirmation that program objectives were met
- Demonstration that funds are spent appropriately and efficiently
- Gaining of support for program funding

Source: http://preventionpathways.samhsa.gov/eval/default.htm
Standard 8.1: Programs have a comprehensive evaluation plan outlining how services are systematically assessed.

Practice Guidelines:

A. The development of the evaluation plan is part of the program planning process and includes the active participation of all key stakeholders, including program participants.

B. The evaluation plan is sensitive to the culture of the participants served and includes components to measure the cultural appropriateness of the program.

C. The evaluation plan includes each of the following elements:
   - Type of evaluation (process, outcome/impact, cost)
   - Identification of evaluation questions
   - Timeframe
   - How data will be collected
   - Types of instruments that will be used
   - Kind of permission needed to collect data on youth participants
   - How data will be analyzed
   - Identification of comparison group
   - Type of evaluation reports that will be produced

D. The evaluation plan is updated and adapted as needed to respond to the results identified at each stage of the evaluation.

Source: http://preventionpathways.samhsa.gov/eval/default.htm
**Standard 8.2:** The implementation, or fidelity, of the program is monitored and assessed through a process evaluation.

**Practice Guidelines:**

A. A process evaluation is conducted to ensure that the program is implemented as designed, to help identify strengths and weaknesses, and to attribute success to the program. Specific areas to document in the process evaluation are:

1. Participant information
   - Demographics
   - Methods of recruitment
   - Actual attendance (“dosage”: how much, how often)
   - Attrition
2. Program issues
   - Planned and unplanned adaptations
   - Cultural problems/issues
   - Indicators of unmet needs/resources development
3. Implementation problems/issues
   - Organizational capacity
   - Community readiness
4. Un- or under-realized outcomes
   - The differences between expected and actual change (outcomes).

B. A fidelity instrument is completed and reviewed to ensure that core components are implemented as planned. Consult as needed with the program developer.

C. Adaptations to a program should include the following:
   - A review of the theory behind the program to be sure that it is consistent with the findings from your needs and resources assessment.
   - A review of your needs assessment to single out those characteristics of your target population that are truly unique and assess whether adaptation is needed to address those unique characteristics.
   - An analysis of the core components of the evidence-based program, in conjunction with a review of the needs assessment, to determine which components need to be adapted.
   - Thorough documentation of the adaptations.
Standard 8.3: The outcomes and impacts of the program are monitored and assessed through an outcome evaluation.

Practice Guidelines:

A. A logic model is developed that describes the logical linkages among program resources, conditions, strategies, short-term outcomes, and long-term impact. It specifies the theory of, or pathway to, change and describes immediate, intermediate, and long-term outcomes (see Appendix A).

B. Programs need a clear and concise evaluation contract or plan with an experienced and capable evaluator. The evaluator can be a staff member or an outside evaluator.

C. The outcome evaluation assesses whether the objectives were achieved and the extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement.

D. When results are less than anticipated, the action plan is reviewed for faulty implementation.

E. The changes measured in the general substance abuse problem is documented on the logic model and/or action plan.

F. Findings from the evaluation are shared with key stakeholders in the community.
Standard 8.4: Programs are continuously improved, and thus sustained, based on the results of evaluation and quality assurance processes imbedded in each of the categories identified in the operating standards (e.g. human relationships, program planning, activities).

Practice Guidelines:

A. Programs assign a staff member who is responsible for overseeing quality assurance processes.

B. A quality assurance plan is developed which includes ways in which the program will assess continuous improvement in each category of the standards.

C. Result of the quality assurance processes will be shared with staff and appropriate shareholders and be used to continuously improve the program.

D. Programs develop a marketing plan, outlining how results of the program will be shared, to ensure ongoing promotion of the program and enhance sustainability.
RESOURCES


CSAP's Prevention Platform—www.preventionplatform.samhsa.gov

Connecticut Assets Network—www.ctassets.org

Connecticut Certification Board (CCB)—www.ccb-inc.org

Connecticut Clearinghouse—www.ctclearinghouse.org

Connecticut Department of Mental Health and Addiction Services—www.dmhas.state.ct.us


Governor’s Prevention Partnership—www.preventionworksct.org

HIPPA Regulations and Information—www.hhs.gov/ocr/hipaa

IC&RC Prevention Specialist Role Delineation Study Order Form—www.icrcaoda.org/pubs.htm

Multicultural Leadership Institute—60 Connolly Parkway - Bldg 12 - Suite 101 Hamden, CT 06514 Tel: (203) 281-1347


Connecticut Prevention Network (regional action councils)—www.ctprevention.org

Rice Virtual Lab in Statistics—www.ruf.rice.edu/~lane/rvls.html

Search Institute’s Lists of Developmental Assets—www.search-institute.org

Seeing Statistics—www.seeingstatistics.com

Action/Implementation Plan—what translates the conceptual map represented by the logic model into an operational plan, detailing the key tasks and activities to be completed, including the measurement of outcomes.

Adaptation—the addition or deletion of program components, change in the nature of these components or changes in the way they are administered.

Agency—any public or privately constituted organization that provides addiction prevention services in the State of Connecticut.

Asset Building—the process of establishing or creating valuable qualities and resources intended to assist individuals, schools, communities and families to prevent addiction and related problem behaviors.

Behavioral Health—addiction and mental health services used in the context of a managed system of care.

Best Practices—strategies and programs that have been shown through rigorous research and evaluation to be effective at preventing and/or delaying substance abuse. By definition, all Best Practices are science-based or research based. In order to be a Best Practice program must be determined by consensus that the research findings are positive, credible and can be substantiated by another prevention researcher.

Core Values—enduring beliefs which an institution—and the people who inhabit it—hold in common and endeavor to put into action. Core values guide an institution’s staff, administrators and, to some degree, participants, in performing their work.

Center for Substance Abuse Prevention (CSAP)—the sole Federal organization with responsibility for improving accessibility and quality of substance abuse prevention services. The Center provides national leadership in the development of policies, programs, and services to prevent the onset of illegal drug use, underage alcohol and tobacco use, and to reduce the negative consequences of using substances.

CSAP’s Core Measures—a compendium of data collection instruments that measure those underlying conditions-risks, assets, attitudes, and behaviors of different populations-related to the prevention and/or reduction of substance abuse.

Cultural Competency—the capacity of individuals to incorporate ethic and cultural differences into all aspects of their work relative to prevention and health promotion.

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

DMHAS—the Department of Mental Health and Addiction Services.

Domain—the sphere of activity or affiliation within which people live, work, and socialize (e.g. self, school, peer, community, society)

Fidelity—the level of agreement (concordance) of a replicated program model or strategy with the specification of the original. On a continuum of high or low, where high represents the closest adherence to the developer’s design, it is the degree of fit between the developer-defined components of a substance abuse prevention intervention and its actual implementation in a given organizational or community setting. In operational terms, it is the rigor with which an intervention adheres to the developer’s model.
Goals—broad statements, each of which targets those things a prevention program needs to achieve in order to satisfy its mission or purpose in providing services.

Immediate Outcome—the initial change in a sequence of changes (from baseline) expected to occur as a result of implementation of a program.

Institute of Medicine—an organization within the National Academy of Sciences that acts as an advisor in health and medicine and conducts policy studies relevant to health issues.

Intermediate Outcome—the change that is measured subsequent to immediate change, but prior to the long-term changes that are measured at program completion.

International Certified and Reciprocity Consortium (IC&RC)—a not-for-profit voluntary membership organization comprised of certifying agencies involved in credentialing alcohol and drug abuse counselors, clinical supervisors and prevention specialists.

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

Measures—the tools used to obtain the information or evidence needed to answer a research question. They are similar to indicators, but more concrete and specific. Often an indicator will have multiple measures. Indicators are statements about what will be measured; measures answer the question about exactly how will it be measured.

Needs Assessment—a systematic process for examining the current conditions of a situation (such as substance abuse) and to identify the level of risk and protection in your community.

Logic Model—a graphic description of the components of a program that sets forth a chain of events in logical sequence that, if followed, would likely produce the desired results. Identifies needs/priorities, goals, objectives, outcomes, timelines, responsibilities and resources necessary.

Long-term Outcome—the change that results from the program over time.

Minimum Data Set (MDS)—a Data Collection System that allows direct service providers to track process level information such as: services and activities provided, program completion rates, strategies used, populations served, risk and protective factors targeted, and evaluation activities.

Objectives—statements of precise and measurable results the program intends to accomplish, within the context of a specific goal, during a specific period of time.

Outcomes—measures that assess program effectiveness, determine the extent to which a program makes a difference, and or identifies intervention/activities that have the greatest effect.

Parenting and Family Management—prevention education programs intended to provide aid to parents and families in reducing risk factors for addiction and to develop knowledge and skills to combat addiction and related problems within the family.

Participant—an individual, group or family enrolled in a prevention program.

Peer Education—services intended to combine both education and leadership activities aimed at providing peers with factual information and access to adult leaders that model appropriate behaviors, teach social skills and lead role reversals.
Positive Youth Development—prevention services that focus on enhancing the positive attributes and strengths of youth, as opposed to focusing on the deficits and problems behaviors for which they may be at risk.

Practice Guidelines—systematically developed recommendations for the most appropriate approaches for prevention services, developed to standardize practices and to facilitate decisions; guidelines are based on scientific evidence and expert opinion.

Prevention Certification—a process of credentialing prevention professionals based upon a set of practice standards and professional experience requirements published by the Connecticut Certification Board.

Prevention Program—a planned and recurring sequence of multiple, structured activities established to inform, educate, impart skills, deliver services, and/or provide appropriate referrals for other services, through the practice and application of recognized prevention strategies.

Prevention Strategies—the six defined methods and approaches used to meet SAPT block grant requirements for primary prevention funding. Strategies include: Information and Public Awareness; Skill Building/Development Education; Alternative Activities; Action Planning, Community Development and Capacity Building; Early Intervention (contained in standards for Clinical Preventive Services); and, Systems Change and Social Policy. Definitions for each Strategy are contained within the Prevention Standards.

Principle—a basic truth or law or assumption.

Process Measures—measures of participation, “dosage,” staffing, and other factors related to implementation. Process measures are not outcomes, because they describe events that are inputs to the delivery of an intervention.

Protective Factors—attitudes, behaviors, beliefs, situations, or actions that build resilience in a group, organization, individual, or community at risk for alcohol and other drug problems or other related problem behaviors.

Qualified Prevention Supervisor—a Certified Prevention Specialist who possesses sufficient working experience, knowledge, skills, and attitudes to effectively provide guidance and direction to other individuals in the practice of current prevention research, theory and best practices.

Recovery—a process of restoring or developing a positive and meaningful sense of identity apart form one’s condition and them rebuilding one’s life despite, or within the limitation imposed by that condition. Recovery is a person-centered approach and it thus may vary from person to person and within the mental health and addiction communities.

Resiliency—those protective factors that assist individuals to resist or avoid harmful behaviors.

Risk Factors—attitudes, behaviors, beliefs, situations, or actions that build resilience in a group, organization, individual, or community.

Service Population—a specific group or population to which prevention programs and activities are directed.

Staff Development—activities designed to improve staff competency and job performance, which includes continued or cross training that employs learning activities to develop, promote and evolve practices in areas of knowledge, skills and attitudes aimed at changing behaviors to enhance or improve job performance.

Stakeholders—members of the community who have a vested interest in the activities or outcomes of the program.
Standard—a statement that defines a goal of practice.

Strategy—an activity (e.g., policy) that can be implemented to achieve specific objectives and for which a strong evidence base may or may not exist.

Sustainability—the continuation of the program after the initial funding has ended.


Wyoming Department of Health Substance Abuse Standards (2002).
Theory—the degree to which programs reflect clear and well-articulated principles about substance abuse behavior and how it can be changed.

Intervention fidelity—how the program ensures its consistent delivery.

Process evaluation—whether program implementation was measured.

Sampling strategy and implementation—how well the program selected its participants and they received it.

Attrition—whether the program retained participants during its evaluation.

Outcome measures—the relevance and quality of measures for the evaluation.

Missing data—how the developers addressed incomplete measurements.

Data collection—the manner in which data were gathered.

Analysis—the appropriateness and technical adequacy of data analyses.

Other plausible threats to validity—the degree to which the evaluation considers other explanations for program effects.

Replications—number of times the program has been used in the field.

Dissemination capability—whether program materials are ready for implementation by others in the field.

Cultural- and age-appropriateness—the degree to which the program addresses different ethnic-racial and age groups.

Integrity—overall level of confidence that program findings are rigorous.

Utility—overall usefulness of program findings to inform prevention theory and practice.
Assemble data collection review team and define substance abuse problem
Identify and define:
- Target population or places for reduction
- Target population or places for prevention
Identify underlying risk and protective factors
Develop tentative theory of, or pathway to, change
Identify existing prevention resources that target problem and risk/protective factors
Perform needs/resources gap analysis

Examine internal resources, skills, readiness
Build collaboration through teaming and networking
Examine community resources and readiness: external capacity

Determine domain(s) of concentration and prioritize risk and protective factors
Examine program options
Address cultural relevancy
Explore fidelity/adaptation balance
Select “best-fit” program option
Choose to innovate

Develop logic models for overall program, components
Develop action plans for documentation
Document, review, improve quality
Revisit fidelity and adaptation issues as necessary

Report immediate and intermediate outcomes
Outline process evaluation from action plans
Assess long-term outcomes/general impact
Communicate outcomes to key stakeholders to build support for sustained prevention efforts
Re-measure outcomes at 12-18 months when possible, and supplement final report if necessary
A. Programs targeting the **individual and peer domain** will aim to address some or all of the following risk and/or protective factors:

- Number of close friends who youth who use ATOD regularly.
- Youth perceptions of the extent to which it is wrong to engage in ATOD use.
- Youth perceptions of the extent to which ATOD use is harmful to their health.
- Youth perceptions of the ease or difficulty of obtaining ATOD for their own use.
- Youth self-report of the extent to which they engage in a variety of other anti-social behaviors.
- Youth self-report of involvement in positive social activities in school and in their community.

B. Programs targeting the **family domain** will aim to address some or all of the following risk and/or protective factors:

- Lack of or inconsistent parental discipline.
-Extent to which youth feel connected to their parents.
-Youth perceptions of the extent to which their parents feel it is wrong for youth to use ATOD.
-Youth reports of members of their family who use or have used ATOD.

C. Programs targeting the **school domain** will aim to address some or all of the following risk and/or protective factors:

- Extent to which youth feel connected and committed to school.
- Youth perceptions of the extent to which school ATOD policies are enforced.
- Frequency of school absenteeism.
- Level of youth academic achievement and school performance.

D. Programs targeting the **community domain** will aim to address some or all of the following risk and/or protective factors:

- Youth perceptions of the extent to which adults in the community condone ATOD use.
- Youth reports of adults they know who use ATOD.
- Availability and accessibility of alcohol and tobacco to youth and percent of retail outlets selling to youth.
Information Dissemination
Provides awareness and knowledge of the nature and extent of substance abuse and addiction and its effects on individuals, families, and communities. The strategy is also intended to increase knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

Education
Prevention education involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator and/or facilitator and the participants is the basis of its components. Services under this strategy aim to improve critical life and social skills, including decision making, refusal skills, critical analysis, and systematic judgment abilities.

Alternatives
Provide for the participation of target populations in activities that exclude substance abuse. The assumption is that constructive and healthy activities offset the attraction to or otherwise meet the needs usually filled by alcohol, tobacco, and other drugs and would therefore minimize or remove the need to use these substances.

Problem Identification and Referral
Aims to classify those who have indulged in illegal or age-inappropriate use of tobacco or alcohol and those who have indulged in the first use of illicit drugs and to assess whether their behavior can be reversed through education. It should be noted, however, that this strategy does not include any function designed to determine whether a person is in need of treatment.

Community-Based Processes
Aim to enhance the ability of the community to more effectively provide substance abuse prevention and treatment. Services in this strategy include organizing, planning, and enhancing the efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.

Environmental
Establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs by the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to service- and action-oriented initiatives.
INFORMATION DISSEMINATION
Clearinghouse/Information Resource Center
Health Fair
Health Promotion
Original A/V Material Developed
Original Printed Material Developed
Original Curricula Developed
Original Newsletters Developed
Original PSA’s Developed
Original Resource Directories Developed
A/V Material Disseminated
Printed Materials Disseminated
Curricula Disseminated
Newsletters Disseminated
PSA’s Disseminated
Resource Directories Disseminated
Media Campaigns Distributed
Speaking Engagement
Telephone Information Services Calls Received
Web Site Development
Web Site Hits

COMMUNITY-BASED PROCESS
Accessing Services and Funding
Assessing Community Needs
Community/Volunteer Services
Formal Community Teams
Community Team Activities
Training Services
Technical Assistance Services
Systematic Planning Services
Focus Groups
Community Funds Distribution

ENVIRONMENTAL
Environmental Consultation to Communities
Preventing Underage Sale of Tobacco and Tobacco Products
Preventing Underage Alcohol Beverage Sales
Establishing ATOD-Free Policies
Changing Environ. Codes, Ordinances, Regs and Legislation
Public Policy Efforts

EDUCATION
COSA Group
Classroom Education Services
Educational Services for Youth Group
Parenting/Family Management Services
Peer Leader/Helper Program
Small Group Session

ALTERNATIVES
ATOD-Free Social/Recreational Events
Community Drop-In Centers
Community Services
Youth/Adult Leadership Function

PROBLEM ID AND REFERRAL
Employee Assistance Program
Student Assistance Program
DUI/SWI/MIP Program
Prevention Assessment and Referral
Case Management
Universal preventive interventions are designed to reach the entire population, without regard to individual risk factors, and they generally are designed to reach a very large audience. Participants are not recruited to participate in the program and the degree of individual substance abuse risk of the program participants is not assessed. The program is provided to everyone in the population (national, local community, school, and neighborhood) regardless of whether they are at risk for substance abuse. General examples of universal preventive interventions include the use of seat belts, immunizations, prenatal care, and smoking prevention (IOM 1994). Examples of universal preventive interventions for substance abuse include substance abuse education for all children within a school district, media and public awareness campaigns within inner-city neighborhoods, and social policy changes, for example reducing availability by reducing the number of liquor outlets in a municipality.

Selective preventive interventions target subgroups of the general population that are determined to be at risk for substance abuse. Recipients of selective prevention interventions are known to have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group’s profile, but the degree of individual vulnerability or personal risk of members of the targeted subgroup generally is not assessed. Vulnerability is presumed on the basis of their membership in the at-risk group. Knowledge of specific risk factors within the target group allows program designers to address specific risk reduction objectives. Selective programs generally run for a longer period of time and require more time and effort from participants than universal programs. General examples of selective preventive interventions include home visitation and infant day care for low birth-weight children and annual mammograms for women with a family history of breast cancer (IOM 1994). Examples of selective preventive intervention for substance abuse include special clubs and groups for children of alcoholics, rites of passage programs for at-risk males, and skill training programs that target young children of substance-abusing parents.

Indicated preventive interventions identify individuals who are experiencing early signs of substance abuse and other related problem behaviors associated with substance abuse and target them with special programs. The individuals identified at this stage, though showing signs of early substance use, have not reached the point where a clinical diagnosis of substance abuse can be made. Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors such as school failure, interpersonal social problems, delinquency, and other antisocial behaviors, and psychological problems such as depression and suicidal behavior that increase their chances of developing a drug abuse problem. Indicated prevention approaches require a precise assessment of an individual’s personal risk and level of related problem behaviors, rather than relying on the person’s membership in an at risk group as in the selected approach. Programs are frequently extensive and highly intensive; they typically operate for longer periods of time, at greater frequency of contact and require greater effort on the part of the participants than do selective or universal programs. Programs require highly skilled staff who have clinical training and counseling skills or other clinical intervention skills. General examples of indicated prevention in the health field include training programs for children experiencing early behavioral problems, medical control of hypertension, and regular examinations of persons with a history of basal cell skin cancer (IOM 1994). In the field of substance abuse, an indicated preventive intervention would be a substance abuse program for high school students who are experiencing a number of problem behaviors, including truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

The above was taken from “Reducing Risks for Mental Health Disorders: Frontiers for Preventive Intervention Research.” National Institute of Medicine.
Activities that target the *Individual Domain* are based on the following scientifically defensible principles:

- Activities are interactive and may include cooperative learning, roleplays, and group exercises.
- Activities provide positive alternatives to help participants develop personal and social skills in a natural and effective way.
- Activities include problem identification and referral.
- Activities enhance participant’s social, psychological, emotional and cognitive development and maturation.

Activities that target the *Family Domain* are based on the following scientifically defensible principles:

- Activities target the entire family or complement youth-focused curricula with parent-focused curricula.
- Activities reflect an acknowledgement of, and address differential family acculturation and cultural and ethnic diversity.
- Activities help develop bonds among the parents/caregivers in the program by providing meals, transportation, and small gifts; sponsor family outings; and ensure cultural sensitivity.
- Activities include a parent or caregiver component to increase parental involvement.
- Activities include both parents/caregivers and children and offer sessions where parents and youth learn and practice skills.
- Activities include parent training regarding how to listen and interact/promote new skills in family communication through interactive techniques.
- Activities provide opportunities for participants to develop and improve parenting skills and child behavior with intensive support.
- Activities include parent training regarding how to use positive and consistent discipline techniques.
- Activities emphasize family bonding.
- Activities improve family functioning through family therapy when indicated.
- Activities employ strategies to overcome parental resistance to family-based programs.

Activities that target the *Peer Domain* are based on the following scientifically defensible principles:

- Alternative activities are structured and alternative events supervised.
- Design intensive alternative programs that include a variety of approaches and substantial time commitment.
- Activities communicate peer norms against use of alcohol, tobacco and other drugs and other risky behaviors.
- Activities involve youth in peer-led interventions or interventions with peer-led components.

Activities that target the *School Domain* are based on the following scientifically defensible principles:

- Avoid relying solely on knowledge-oriented interventions designed to supply information about negative consequences.
- Activities correct misconceptions about the prevalence of use in conjunction with other education approaches.
- Activities involve youth in peer-led interventions or interventions with peer-led components.
- Activities give students opportunities to practice newly acquired skills through interactive approaches.
- Activities help youth retain skills through booster sessions.
- Activities involve parents in school-based approaches.
- Activities communicate a commitment to substance abuse prevention in school policies.
Activities that target the *Community Domain* are based on the following scientifically defensible principles:

- Activities are integrated, comprehensive prevention strategies rather than one-time community-based events.
- Activities occur in a controlled environment around schools and other areas where youth gather.
- Activities include structured time with adults through mentoring.
- Activities include opportunities for increased positive attitudes through community service.
- Activities include educating employers to the costs of workers’ substance use and abuse.
- Activities reflect and support the organization’s policy on substance abuse.
- Activities include representatives from every organization that plays a role in fulfilling coalition objectives.
- Activities result in the retention of active coalition members by providing meaningful rewards.
- Activities are designed to achieve specific goals and specific responsibility is assigned to subcommittees and task forces.
- Activities reflect planning and clear understanding for coalition effectiveness.
- Activities occur at the neighborhood level.

Activities that target the *Society/Environmental Domain* are based on the following scientifically defensible principles:

- Activities include community awareness and media efforts.
- Activities use mass media appropriately.
- Activities include broadcast messages frequently over an extended period of time and through multiple channels when the target audience is likely to be viewing or listening.
- Disseminate information about the hazards of a product or industry that promotes it.
- Activities include the promotion of replacement of more conspicuous labels.
- Activities include the promotion of restrictions on tobacco use in public places and private workplaces.
- Activities include the promotion of clean indoor air laws.
- Activities combine beverage server training with law enforcement.
- Activities include education of beverage servers’ regarding legal liability.
- Activities result in the increase the price of alcohol and tobacco through excise taxes.
- Activities limit the location and density of retail alcohol outlets.
- Activities employ neighborhood antidrug strategies.
- Activities are completed by community groups to provide positive and negative feedback to merchants.
CODE OF ETHICAL CONDUCT FOR PREVENTION PROFESSIONALS

The code of ethics is adapted from National Association of Prevention Professionals and Advocates (NAPPA). As an assurance that prevention professional have a clear understanding of the code, a prevention-specific ethics course incorporating this code and its principles is required for certification.

PREAMBLE
The Principles of Ethics are a model of standards of exemplary professional conduct. These Principles of the Code of Ethical Conduct for Prevention Professionals express the professional’s recognition of his responsibilities to the public, to service recipients, and to colleagues. They guide members in the performance of their professional responsibilities and express the basic tenets of ethical and professional conduct. The Principles call for commitment to honorable behavior, even at the sacrifice of personal advantage. These principles should not be regarded as limitations or restrictions, but as goals toward which Prevention Professionals should constantly strive. They are guided by core values and competencies that have emerged with the development of the field.

PRINCIPLES

I. Non-Discrimination

A Prevention Professional shall not discriminate against service recipients or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition, or physical, medical or mental disability. A Prevention Professional should broaden his understanding and acceptance of cultural and individual differences, and in so doing, render services and provide information sensitive to those differences.

II. Competence

A Prevention Professional shall observe the profession’s technical and ethical standards, strive continually to improve personal competence and quality of service delivery, and discharge professional responsibility to the best of his ability. Competence is derived from a synthesis of education and experience. It begins with the mastery of a body of knowledge and skill competencies. The maintenance of competence requires a commitment to learning and professional improvement that must continue throughout the professional’s life.

a. Professionals should be diligent in discharging responsibilities. Diligence imposes the responsibility to render services carefully and promptly, to be thorough, and to observe applicable technical and ethical standards.

b. Due care requires a professional to plan and supervise adequately and evaluate to the extent possible any professional activity for which he is responsible.

c. A Prevention Professional should recognize limitations and boundaries of competencies and not use techniques or offer services outside of his competencies. Each professional is responsible for assessing the adequacy of his own competence for the responsibility to be assumed.

d. Ideally Prevention Professionals should be supervised by Nationally Registered Prevention Professionals (NRPP). When this is not available, Prevention Professionals should seek peer supervision or mentoring from other competent Prevention Professionals.

e. When a Prevention Professional has knowledge of unethical conduct or practice on the part of an agency or Prevention Professional, he has an ethical responsibility to report the conduct or practices to appropriate funding or regulatory bodies or to the public.

f. A Prevention Professional should recognize the effect of impairment on professional performance and should be willing to seek appropriate treatment for himself.
III. **Integrity**

To maintain and broaden public confidence, Prevention Professionals should perform all responsibilities with the highest sense of integrity. Personal gain and advantage should not subordinate service and the public trust. Integrity can accommodate the inadvertent error and the honest difference of opinion. It cannot accommodate deceit or subordination of principle.

a. All information should be presented fairly and accurately. Each professional should document and assign credit to all contributing sources used in published material or public statements.
b. Prevention Professionals should not misrepresent either directly or by implication professional qualifications or affiliations.
c. Where there is evidence of impairment in a colleague or a service recipient, a Prevention Professional should be supportive of assistance or treatment.
d. A Prevention Professional should not be associated directly or indirectly with any service, products, individuals, and organization in a way that is misleading.

IV. **Nature of Services**

Practices shall do no harm to service recipients. Services provided by Prevention Professionals shall be respectful and non-exploitive.

a. Services should be provided in a way which preserves the protective factors inherent in each culture and individual.
b. Prevention Professionals should use formal and informal structures to receive and incorporate input from service recipients in the development, implementation and evaluation of prevention services.
c. Where there is suspicion of abuse of children or vulnerable adults, the Prevention Professional shall report the evidence to the appropriate agency and follow up to ensure that appropriate action has been taken.

V. **Confidentiality**

Confidential information acquired during service delivery shall be safeguarded from disclosure, including - but not limited to - verbal disclosure, unsecured maintenance of records, or recording of an activity or presentation without appropriate releases. Prevention Professionals are responsible for knowing the confidentiality regulations relevant to their prevention specialty.

VI. **Ethical Obligations for Community and Society**

According to their consciences, Prevention Professionals should be proactive on public policy and legislative issues. The public welfare and the individual’s right to services and personal wellness should guide the efforts of Prevention Professionals to educate the general public and policy makers. Prevention Professionals should adopt a personal and professional stance that promotes health.

Signature ________________________________ Date ________________
## Prevention Certification Requirements

<table>
<thead>
<tr>
<th>Certified Prevention Professional (CPP)</th>
<th>Associate Prevention Professional (APP)</th>
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<tbody>
<tr>
<td>For Applicant with a Bachelor’s Degree</td>
<td>For Applicant without a Degree</td>
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<tr>
<td><strong>Completed Application Packet</strong></td>
<td><strong>Completed Application Packet</strong></td>
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<tr>
<td>Employment: 4,000 hours in prevention work</td>
<td>Employment: 10,000 hours in prevention work</td>
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<td>For each year of college completed subtract 2,000 hours of work required up to</td>
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<tr>
<td>3 Letters of Reference - 1 supervisor, 2 colleagues.</td>
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<tr>
<td>Model Prevention Program</td>
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<tr>
<td>Signed Code of Ethical Conduct</td>
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<tr>
<td>Training hours: 100</td>
<td>Training hours: 126</td>
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<tr>
<td>24 hours in Community Organization</td>
<td>30 hours in Community Organization</td>
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<tr>
<td>18 hours in Planning and Evaluation</td>
<td>24 hours in Planning &amp; Evaluation</td>
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<tr>
<td>24 hours in Education and Skill Development</td>
<td>30 hours in Education and Skill Development</td>
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<tr>
<td>12 hours Public and Organizational</td>
<td>18 hours in Public and Organizational</td>
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<tr>
<td>12 hours Professional Growth &amp; Responsibility (6 in Prevention Ethics)</td>
<td>24 hours in Professional Growth &amp; Responsibility (6 in Prevention Ethics)</td>
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<tr>
<td>10 hours in Electives – Prevention (Cultural Diversity, Special Populations)</td>
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<td>IC&amp;RC Written Test</td>
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<tr>
<td>Supervised Practicum-120 hours (a minimum of 10 hours in each of the five prevention performance domains).</td>
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**For IC&RC reciprocity:**
- **Training:** 50 must be specific to ATOD
- **Work experience:** 2,000 hours of work experience must be specific to ATOD. Of these a minimum of fifteen hours of supervised experience is required in each of the IC&RC performance domains.

**For IC&RC reciprocity:**
- **Training:** 40 additional hours required.
- **Work experience:** 2,000 hours of work experience must be specific to ATOD. Of these a minimum of fifteen hours of supervised experience is required in each of the IC&RC performance domains.
SELF-ASSESSMENT TOOL