FY 25
Effective 7/1/2024

Prevention Collaboration Plan

Providers:

Beech Acres Parenting Center
Safe on Main
Solutions Community Counseling and Recovery Centers
Talbert House
Strategic Innovations Group
Warren County Educational Services Center

SECTION I: Rationale/Approach to Service

Prevention in Ohio is grounded in the public health model. The focus of the public health model is on the health, safety, and well-being of entire populations, rather than individual persons. A unique aspect of both the field and the model is that it strives to provide the maximum benefit for the largest number of people. Public health also draws on a science base that is multi-disciplinary, relying on the knowledge from a broad range of disciplines including medicine, epidemiology, sociology, psychology, criminology, education, and economics. This broad knowledge base allows the field of public health to respond to a range of conditions across populations.

Prevention aims to reduce the underlying risk factors that increase the likelihood of mental, emotional, and behavioral health disorders (MEB) and simultaneously to promote protective factors to decrease MEB health disorders. MEB health disorders include, but are not limited to, substance use disorders, mental illness, suicide, problem gambling, etc.

Along with the public health model, the Social Ecological Model creates a framework for prevention. The Social Ecological Model (SEM) is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion and prevention within organizations.

Prevention Services

Prevention Services are a planned sequence of culturally appropriate, science-driven strategies intended to facilitate attitude and behavior change for individuals and communities. They can be direct or indirect. **Direct Services** are interactive prevention interventions that require personal contact with small groups to influence *individual-level change*. **Indirect Services** are population-based prevention interventions that require sharing resources and collaborating to contribute to *community-level change*.

Prevention services involve a **continuum of coordinated efforts** developed within a comprehensive public health approach combining the use of the following **evidence-based strategies** in appropriate proportions.

Evidence-Based Strategies	
Prevention Education*	This strategy increases knowledge and skills, as well as influences attitude or behavior. This strategy does not include education provided as a component of treatment services.
Environmental Strategies*	This strategy seeks to establish or change standards or policies that will reduce the incidence and prevalence of behavioral health problems in a population.
Community-Based Process*	This strategy focuses on enhancing the ability of the community to provide prevention services through organizing, training, planning, interagency collaboration, coalition building, or networking. This strategy is essential to effectively implementing environmental strategies that will impact social determinants of health.
Alternatives	This strategy focuses on providing opportunities for positive behavioral support that reduce risk taking behavior and reinforce protective factors achieved through attachment and bonding to families, schools, communities, and peers. The opportunities are to be provided as part of a larger comprehensive prevention effort.
Information Dissemination	This strategy builds knowledge and awareness of the nature and extent of risk and protective factors related to MEB disorders and their effects on individuals, families, and communities.
Problem Identification & Referral	This strategy focuses on identifying individuals who exhibit behavior or risk indicators and referring them for prevention interventions, clinical assessment, or services. An example of this strategy is universal screening in a school.
***Only these strategies on their own constitute prevention. All other strategies must be used in conjunction with these main strategies**	

In addition to the evidence-based practices, the **continuum of coordinated efforts** includes mental health promotion and early intervention.

Additional Efforts on Prevention Continuum	
Mental Health Promotion	Universal efforts to enhance an individual's ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, well-being, and social inclusion, as well as strengthening their ability to cope with adversity by targeting skills (such as self-regulation, self-efficacy, goal setting, and building positive relationships) that build resiliency. **AND/OR** Actions to strengthen the policy environment and use of strategic communication for network building, stakeholder engagement, enhanced mental health literacy, and behavior change.
Early Intervention	A comprehensive developmental approach that is collaborative, culturally relevant, and geared toward skill development or increasing protective factors. **AND** Services and supports that are provided to individuals and families prior to receiving a clinical diagnosis, are usually included in the indicated category, and most often use education and problem identification and referral strategies, such as screening and brief interventions.

Primary prevention should include a variety of strategies that prioritize populations with different levels of risk. Specifically, prevention strategies can be classified using the **Institutes of Medicine (IOM) Classifications of Prevention**, which classifies preventive interventions by priority population.

Level of Risk	Target Population
Universal	Targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
Selective	Targeted to individuals or a subgroup of the population whose risk of developing mental, emotional, or behavioral disorders is significantly higher than average.
Indicated	Targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms that foreshadow an MEB disorder, as well as biological markers that indicate a predisposition in a person for such disorder prior to a clinical diagnosis.

SECTION II: Target Populations and Services

All prevention services by provider agencies must be carried out in accordance with OAC 5122-29-20.

Target population for any particular prevention intervention will vary based on the level of prevention (i.e. Universal, Selective, or Indicated) and the prevention strategy (i.e. Prevention Education, Alternatives, Community-Based Process, etc.). Though the target population may vary, it should be clearly defined *prior to* the implementation of any prevention intervention. In general, prevention services are non-client specific and should be available to all residents of Warren or Clinton Counties. Certain prevention programs and/or positions may focus on specific populations (i.e. Early Childhood Mental Health Consultants). These specific populations will be identified and clearly defined in any contractual document designated for that position.

Evidence-Based Practices

The provider must meet all of the requirements in OAC 5122-29-20(C)(2) when identifying evidence-based or evidence-informed prevention science. The services must demonstrate one of the following:

- A theory of change that is documented in a logic or conceptual model;
- A description of the intervention in a national registry or peer-reviewed journal;
- Documentation that the intervention has been implemented showing a consistent pattern of positive results **OR**
- Documentation that the intervention has been reviewed and found appropriate by a panel of informed prevention experts or key community leaders that includes a description of each reviewer's qualifications.

Prevention services must be administered to fidelity in accordance with appropriate, evidence-based programs. Variations in fidelity must be discussed with MHRB and documented as to how the modifications are taking place. It is expected that these services will be provided in a consistent, well-planned manner.

Staffing Requirements

Assigned staff shall meet the following minimum standards unless otherwise noted in the Individual Service Provider Responsibilities plan:

- Bachelor's degree
- Must have a prevention credential (RA, OCPSA, OCPS, OCPC) issued by the Ohio Chemical Dependency Board before providing prevention services. The CHES credential issued by the National Commission for Health Education Credentialing is also an acceptable prevention credential.
    - Individuals with a CHES are strongly recommended to obtain a prevention credential through the Ohio Chemical Dependency Board as well.
- Must be supervised by an individual with an appropriate credential as identified in OAC 4758-6 based on their level of prevention credential.
- Individuals are able to provide the services that they are permitted to supervise as per OAC 4758-6.

Staff will meet all necessary and applicable legal, licensing, credentialing, certification and/or registration criteria. Documentation of this will be present and maintained in each staff members' personnel files and available for review by MHRB if requested.

SECTION III: Target Outcomes

Target Outcome #1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Target Outcome #2: Build community support for and interest in a broad array of prevention services through workforce development, increased community capacity, and increased community readiness.

Target Outcome #3: Prevent suicides and attempted suicides among populations at high risk.

Target Outcome #4: Provide services to prevent, identify and treat those that are involved with vaping both in school and community.

Target Outcome #5: Continue to provide environmental scan and prevention work toward Problem Gambling