BEHAVIORAL HEALTH IN PREVENTION

A REVIEW IN LITERATURE

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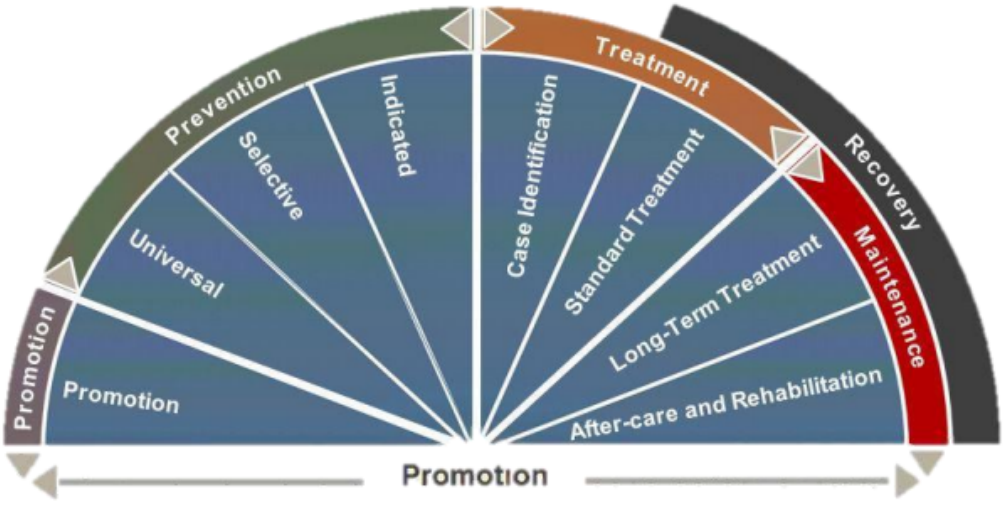
INTRODUCTION

The field of substance abuse prevention has undergone a significant shift in the past two or three decades. Since the implementation of a public health approach that aims for population-level (e.g., environmental) change through the utilization of the evidence-based Strategic Prevention Framework (SPF), substance abuse prevention has become more integrated with comprehensive approaches known as *behavioral health*.

SAMHSA describes **behavioral health** as the following: "a state of mental/emotional being and/or choices that affect health and wellness" (SAMHSA, 2012). Both individual people and entire communities make choices about affect wellness, such as individuals choosing to use drugs, alcohol and tobacco, or communities imposing laws that restrict access to alcohol. Common behavioral health problems include: substance use and abuse, mental and emotional disorders, and suicide. SAMHSA reports that roughly 20% of young people have "at least one or more mental, emotional, or behavioral disorder" (2012, p. 5). With almost 25 million Americans requiring treatment for a drug or alcohol problem, **behavioral health problems** cost the U.S. over $500 billion each year.

The **behavioral health system** describes the "service systems surrounding the promotion of mental health, the prevention and treatment of mental and substance abuse disorders, and recovery support" (p. 5). A key visual representation of the behavioral health system was developed by the Institute of Medicine. This **continuum of care** demonstrates the range of behavioral health services, from promotion and prevention to treatment and recovery.

THE CONTINUUM OF CARE – INSTITUTE OF MEDICINE



PURPOSE

The purpose of this review is to twofold. First, it is *to provide an overview of how behavioral health is aligned with substance abuse prevention.* To do so, three blue ribbon papers that provide a comprehensive overview of the field will be presented. These papers offer a valuable introduction to the relationship between substance abuse prevention and behavioral health. The product of a collaborative effort by some of the top minds in the field, each paper can also serve as a source of additional information for direct service providers, administrators, and others. In addition to presenting them individually, a synthesis of common themes across these papers is provided. This synthesis will attempt to provide information about how the field of public health views the relationship between behavioral health and substance abuse prevention.

The secondary purpose of this review is *to provide examples of substance abuse prevention programming that is aligned with behavioral health.* This includes an exploration of how communities are working to integrate behavioral health and substance abuse prevention programming through a focus on three prevention programs: Peer-Led Recovery (PROSPER); Communities that Care (CTC); and Parent Management Training (PMT). After these individual examples are presented, a synthesis of themes from these programs is provided.

Finally, general conclusions are drawn about the current state of behavioral health in prevention programming, and how substance abuse prevention can further align itself with larger behavioral health concerns.

BLUE RIBBON PAPERS

UNLEASHING THE POWER OF PREVENTION (HAWKINS ET AL, 2015)

There is a huge need for a public health system in which behavioral and physical health are integrated for total physical, mental, and emotional well-being. According to the authors, behavioral health problems such as anxiety; depression; self-injury; alcohol, tobacco, and other drug use; violence; and dropping out of school affect millions of young people. Hawkins reported, "Behavioral health problems in childhood and adolescence take a heavy toll over a lifetime, with significant impacts on rates of economic independence, morbidity, and mortality" (p. 2). The economic consequences of behavioral health problems, such as "depression, conduct disorder, and substance abuse," cost this country almost $250 billion per year (p. 2). The consequences of behavioral health problems are not distributed evenly; for example, one scholar estimates that 83 percent of Native American/American Indian deaths could be attributed to behavioral health problems. Homicide rates are 14 times higher for African-American youth than for whites (Hawkins, p. 2).

The authors, however, are also clear to report that three decades of prevention research suggest that even serious behavioral health problems can be prevented. For example, Hawkins et al note that research has pointed out both environmental risk factors that can predict long-term behavioral health challenges *and* protective factors that can minimize risks (p. 3). However, in order to achieve these objectives, the field of prevention must scale up effective prevention programming aimed at all segments of the population: universal, selected, and indicated. While universal prevention

programming is designed to benefit all young people, selected and indicated programs are aimed at those with higher risks. By ensuring that those with higher risks are served by interventions, the field of public health works toward achieving health equity (p. 10).

In order to reach our goals of health equity, prevention science demands a collaborative effort, comprised of the fields of education, healthcare, juvenile justice, social work, and others (p.10). This collaborative team will use current epidemiological data to respond to the population's most pressing health challenge. Driven by President Obama's Affordable Care Act (ACA), prevention is being integrated into the mainstream medical model. In addition, the White House and other public health leaders acknowledge the critical relationship between behavioral health and social and emotional health, advocating for an increased emphasis on the part of state and national initiatives, public health workers, and local educational systems (p. 11).

In order to achieve these outcomes, however, drastic changes will have to be made, beginning with a collaborative model that includes state prevention systems, community level coalitions, and public health workers, all working together in a new system of integrated care.

The authors of this report issued a number of desired outcomes and goals for the prevention field over the next decade. These included 1) developing public awareness about the effectiveness of prevention initiatives; 2) implementing community-driven capacity-building tools for local communities; 3) creating workforce development strategies to train healthcare practitioners; and 4) increasing infrastructure to create organizations that "provide coaching, technical assistance, and monitoring services to local community organizations" (p. 13).

In order to achieve these outcomes, however, drastic changes will have to be made, beginning with a collaborative model that includes state prevention systems, community level coalitions, and public health workers, all working together in a new system of integrated care (p. 15-16). State prevention systems have the scale to mobilize resources, provide organizational structures, generate public interest, and offer training and technical assistance to communities. Community coalitions, on the other hand, are made up of local organizations, community residents, prevention experts, and others who develop prevention systems to assess, identify, implement, and evaluate targeted prevention efforts. Finally, service providers such as doctors, nurses, and other health workers will provide assessment, screening, intervention and treatment. Directives for this collaboration come from the Affordable Care Act, providing an impetus for the improvement of behavioral health. Hawkins et al conclude with a profound statement about the urgent need for an integrated behavioral health system: "A new integrated system of primary care will provide health promotion and prevention services along with treatment or intervention for physical and mental health problems, including substance abuse" (2015, p. 16).

Primary Prevention in Behavioral Health (Shea & Shern, 2011)

In this working paper, Shea and Shern develop a vision for a "prevention-focused agenda for behavioral health" (p. 6). This agenda would utilize a public health approach, in which prevention priorities are assessed using epidemiological data, and evidence-based programs and policies are implemented and evaluated. This approach is based on a model of risk and protective factors, "whereby risks increase the likelihood of a problem and protective factors help to enhance resilience and/or mitigate such risks" (p. 7). Programs that enhance social, emotional, and psychological health can potentially mitigate risk factors like stress, trauma, racism, and poverty. Programs, policies, and practices that work to promote physical and behavioral health have been reported on by organizations such as the Institute of Medicine (IOM) for years, and researchers, practitioners, and policy-makers would do well to take advantage of this valuable research. An effective public health approach, the authors noted, would utilize culturally appropriate programs, policies, and practices, to make sure they respond to the unique cultural contexts of various cultural and linguistic groups. In addition, a public health approach recognizes that issues in education, housing, employment, justice, and the environment influence public health, and that prevention efforts should be integrated across these various sectors. Finally, Shea and Shern write, up-scaling prevention efforts to respond to the severity of the problem - such as the U.S.'s ranking as highest in the world in terms of rates of mental illness, and second highest in substance use, costing over $500 billion per year - remains a vital challenge (p. 4).

How do we get there? The authors issue a number of suggestions that the field of prevention can undertake, involving "coalitions and coordinated partnerships" who share data in order to tackle the community's most pressing behavioral health challenges. Shea and Shern suggest that prevention focus on children and youth, since half of all mental health diagnoses occur before the age of fourteen (p. 10).

Behavioral Health: Prevention, Early Identification, and Intervention (APHSA, 2013)

In 2013, the American Public Health Services Association (APHSA), a "bipartisan, non-profit organization representing state and local human service agencies," published a policy brief that proposed an integrated healthcare system that supports "prevention, early intervention, bridge supports, capacity building, and sustainable strategies" (p. 1). The authors note that trauma or stress early in a child's life can have a lasting impact on social, emotional, physical, mental, and behavioral health development. Left untreated, these early stressors can potentially lead to more serious mental health conditions, which affect roughly 20 percent of adults in the U.S. (p. 2). The authors report that, "half of all mental, emotional, or behavioral health disorders were diagnosed by age 14, and three-fourths were diagnosed by age 24" (p. 2). Unfortunately, youth in the child welfare system and the juvenile justice system have even *higher* rates of mental health problems-- 50% percent of youth in the child welfare system have mental health problems, and almost 70 percent in the juvenile justice system have a mental health disorder.

These figures point to the relationship between behavioral health - including physical and social environment, socioeconomic status, physical health, and education - and behavior. In addition, low

socioeconomic status "also affects cognitive, emotional, behavioral, and physical development through its frequent association with substandard housing, frequent moves, changes of school, limited access to healthcare, unsafe or stressful environments, and lack of enough food or adequate nutritional intake" (p. 2).

With the development of new approaches to tackling public health in this country, the authors describe a shift that is currently underway toward a model of integrated healthcare. However, there are still significant challenges before success can be declared.

First, the authors recommend that access to healthcare services be available in *schools* and *child-care facilities*, since youth spend much of their time here. The School-Based Health Center (SBHC) model provides community-based health centers on (or near) school grounds, with the aim of providing physical and behavioral healthcare to under-resourced communities. Demand for these services is high, especially in urban settings, but increasingly in rural settings as well. In addition, access to appropriate healthcare is needed for adults with *co-occurring disorders* (i.e., both a mental health and substance use disorder). In the U.S., almost 9 million people suffered a co-occurring disorder, but over half received no treatment. Access to appropriate healthcare remains imperative for this group.

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Second, the authors note that particular organizational and technical barriers exist, preventing the behavioral health system from seeing full success. One of these barriers lies in a shortage of trained prevention providers and behavioral health professionals, notably those serving *uninsured clients,* in rural and urban centers. Another barrier comes from a technology infrastructure that does not permit information or data sharing, because they are not interoperable with other systems (p. 3).

Third, the report documents the challenges around financing an integrated public health system that supports both behavioral health and substance abuse prevention. Funding for states and local agencies is decreasing, which the authors call a "perfect storm of factors, including outdated information technology, funding cuts, lack of providers, and professionals untrained in behavioral health and use of available information technology" (p. 4).

There are, however, promising practices and tools that allow states and communities to support its goals of behavioral health. For example, the authors list the SAMHSA developmental framework and system of care as promising ways to support public health. These tools and systems can work as levers to provide significant environmental level change. In Washington state, for example, it was found that "evidence-based pre-school-based programs supporting healthy development and cognitive abilities led to net savings of $10,000 per child" (APHSA, p. 5).

TAKE-AWAYS FROM BLUE RIBBON PAPERS

1. One particularly effective way to reach substance abuse prevention goals is by taking a **public health approach that integrates behavioral health and physical health.** A public health

approach, based on an accurate assessment and using evidence-based practices, programs and policies, would also use culturally appropriate materials and interventions to reach their goals. In addition, a public health approach would use a system of risk and protective factors, suggesting that programs that enhance social, emotional, and psychological health can mitigate risk factors like stress, trauma, and poverty.

2. In order to reach our national goals of health equity and to address multiple-risk factors, the field of prevention must align itself with behavioral health. At the same time, **prevention must scale up and team up with efforts in education, housing, employment, justice, and healthcare** to address pressing public health concerns.
3. An integrated public health approach (e.g., integrating behavioral health and physical health) acknowledges that large-scale change needs to happen. For example, since early trauma or stress can have lasting impact (e.g., 50 percent of all mental or behavioral health disorders are diagnosed by age 14), **it is important that state prevention systems, community coalitions, and public health workers collaborate to serve the public's health needs.**

AN INTEGRATED MODEL

Public Health Programs That Integrate Behavioral Health & Substance Abuse Prevention Programming

As suggested by the aforementioned blue ribbon papers, there is a serious need within public health for evidence-based interventions, initiatives, policies, and programs that integrate substance abuse prevention within behavioral health outcomes. Programs that align behavioral health and substance use/abuse prevention, it is theorized, are in a strong position to reach the goals of their prevention initiative. The following section presents four studies – (Andreas, Ja, & and Wilson, 2010) (J. David Hawkins P. E., 2008) (Castro & Hernández-Alarcón, 2002) (Hodge, 2010)Andreas, 2010; Hawkins, 2008; Castro, 2002; and Hodge, 2010 – that suggest how behavioral health can be successfully integrated into substance use/abuse prevention programming.

I. Peer-Led Recovery Integrates Substance Abuse Prevention with Wrap-Around Services

In an article that explores how a major metropolitan area responds to public health and behavioral health challenges, Andreas describes the benefits of a peer-led recovery program in Los Angeles, a city in the United States that has one of the highest numbers of people on parole, probation, or who are about to be released from prison. Many of these people suffer from the crippling effects of substance abuse *and* incarceration. The PROSPER program was designed to provide peer support to address the twin challenges of recovery and re-entry. Andreas reports that the program includes "an array of peer-run groups, coaching, workshops/seminars, social and recreational activities, and community events" (p. 327). Informed by a public health model

that links behavioral health and substance abuse programming, PROSPER provides wrap-around services to address long-term, challenging issues, such as low educational levels; unemployment; trauma; intergenerational substance abuse; and homelessness.

One of the major goals of the PROSPER program is to provide *culturally appropriate services* for those in recovery and their families, so that clients avoid relapse and recidivism. Services provided include support groups and monthly recreational activities, health and wellness services (including stress and pain management), and workforce training (p. 329-330). Program evaluation found a number of positive and significant outcomes, including increases in a number of important areas. For example, clients felt that their access to social support increased, and their quality of life increased, while stress decreased. Andreas notes, "Given the extreme risk levels of this population, the utilization of a peer-driven program designed to facilitate recovery around the shared experiences of addiction and incarceration seems to represent a positive intervention" (p. 337).

II. *Communities that Care* Reduces Risk Factors Common to Substance Abuse & Behavioral Health Domains

In an article that explores the effects of the *Communities that Care* (CTC) grant on select risks and behavioral health outcomes, the authors present a number of fascinating findings. Communities that Care is a "prevention system that empowers communities to address adolescent health and behavior problems through a focus on empirically identified risk and protective factors" (p. 15). Informed by a public health model in which substance abuse prevention goals (such as preventing alcohol, tobacco, and other drug use) are linked with behavioral health goals (such as the promotion of mental and physical health), CTC works to mobilize community stakeholders to form a community coalition. This coalition, in turn, is trained in the public health approach and, using community-level data, identifies risk and protective factors in the community, as well as selecting an appropriate and effective strategy to reduce substance use/abuse.

Hawkins et al describe the theory of change that undergirds CTC. First, CTC is supposed to improve collaboration between service providers while increasing the use, adoption, implementation, and evaluation of evidence-based prevention interventions that "address risk and protective factors identified by the community" (p. 16). Second, these coalition-level changes are designed to produce changes in the risk factors (i.e. a, decrease in risk factors) targeted for change. Third, this decrease in risk factors should, it is theorized, reduce *problem behaviors* (e.g., delinquent behavior and substance use) among youth. The proposed reduction in risk factors should happen within two years of implementing CTC, and the proposed decrease in substance use and problem behavior should begin within five to ten years.

Following the theory of change, the authors found that community coalitions that implemented evidence-based programs with fidelity (including *school-based* programs like Life Skills Training; *community-based youth programs* such as Big Brothers/Big Sisters; and *family-based* programs like Guiding Good Choices) saw modest but significant decreases in the levels of risk factors (p. 21). The authors found that these decreases in levels of risk factors (i.e., problem and/or delinquent behavior) took roughly 1.67 years to achieve. This decrease in risk factors is significant, because a decrease in delinquent behavior suggests a similar decrease in substance use and/or abuse (p. 21).

III. Cultural Variables May Be An Important Link Between Behavioral Health and Substance Use/Abuse, but…"It's Complicated"

In an article that explores the relationship between cultural variables (e.g. *machismo*) and the onset of substance use and abuse, Castro found that some cultural variables could serve as a cultural protective factor against substance use and other behavioral health challenges. Castro and other public health researchers are interested in investigating the relationship between cultural practices and behavioral health; this work provides an alternative to the *culturally blind* approach in which prevention programming is assumed to be universally applicable, without differentiation by culture.

This study set out to learn more about how cultural norms (e.g., familism, ethnic pride, traditionalism, modernity, etc.) can serve to moderate (or not) substance use within particular communities. Put simply, what cultural norms exist to limit (or not) substance use? However, Castro and colleagues find that, as expected, the model is more complex than one interaction between cultural variables and substance use; often times, interactions are linked, as chains of behavior, to other activities and experiences. That is, interactions often lead to responses that can provide support and guidance. For example, let's assume that a young woman faces a very stressful event, such as receiving a low grade in school. Typically, a stressful event like this can act to increase the probability (or severity) of an unhealthy outcome, such as depression. However, Castro noted, "the presence of a cultural variable like familism (family cohesion and support) might buffer the otherwise adverse effects of Stressors on the development of depression" (p. 795).

The results were complex, and contradictory. In some cases, having high levels of ethnic pride was a risk factor for youth alcohol use, especially in a home environment that is considered permissive. In other cases, ethnic pride acts a protective factor, especially when young people live in a conservative home environment (p. 796). Castro and colleagues noted that ethnic pride could serve as a protective factor, but only when young people live in a conservative home environment. Thus, this research suggests that existing familial or cultural norms also interact with wider cultural norms, such as ethnic pride. Parents, elders, and others need to be

incorporated into the design of substance abuse prevention programming in order to reach appropriate results.

IV. Leading Evidence-Based Program Parent Management Training (PMT) Provides Culturally Sensitive Interventions

In a study that aimed to explore the effectiveness of a leading program aimed at teaching children appropriate behavior management, Hodge found that Parent Management Training was effectively integrating culturally sensitive interventions as part of its theory of change. PMT is designed, in part, to respond to a number of related risk factors for problem behavior, including "academic difficulties, delinquency, early substance use, and early sexual behavior" (p. 841). While PMT is a promising program (i.e., one study of PMT found that a child who trained in the program had 80 percent fewer behavioral problems than a child who did not receive PMT), it has not been adapted for different cultural groups. This study aimed to find out the effectiveness of adapting a popular program for a Spanish-speaking community, particularly whether or not it was able to improve parenting practices (e.g., communication, monitoring, engagement), and whether or not this improvement in parenting practices will lead to a decrease in substance use, an increase in academic achievement, and an improvement in problem behaviors, including aggression and depression (p. 843).

Key components of the culturally sensitive intervention program included weekly group sessions based on relevant topics (e.g., strong Latino roots; bridging cultures; and dealing with obstacles on the road to success). These group sessions included didactic training, as well as opportunities to discuss, problem-solve, and role-play with peers and trained *entrenadores*, or coaches. Parents, which included equal numbers of mothers and fathers, "reported high levels of satisfaction with the intervention," noting that they liked both the weekly sessions and the overall program (p. 848). While able to report that the intervention improved parenting practices, meeting the goal of the program, the authors found that nativity status (e.g., native versus immigrant) played a more complicated role. For example, the authors note that the intervention was more effective for those born in the U.S. than for immigrants to the U.S., citing research that discusses the differential process of socialization for both groups of youth.

TAKE-AWAYS FROM PREVENTION PROGRAMS IN THE INTEGRATED MODEL

I. Informed by a public health approach, Communities that Care and other programs suggest that **substance abuse prevention goals (such as preventing alcohol, tobacco, and other drug use) be linked with behavioral health goals (such as the promotion of mental and physical health)**

(Hawkins, 2008). CTC and others use a theory of change that empowers community coalitions to address adolescent health and behavior problems through a focus on evidence-based risk and protective factors.

II. Culturally sensitive interventions, such as PROSPER, PMT for Spanish speakers, and other programs utilizing cultural variables can be effective tools to support substance abuse prevention and recovery. **For example, Hodge (2010) found that cultural variables, such as familism, might provide a buffer from the otherwise adverse effects of stressors on the development of behavioral health problems, such as depression.** Similarly, Andreas (2010) used culturally responsive services, including groups, coaching workshops, social and recreational activities, and wrap-around services, to address and prevent recidivism in southern California.

III. **Hodge and others found that promising programs such as Parent Management Training could be adapted in culturally sensitive ways.** In adapting PMT for Spanish speakers, Hodge aimed to support behavior change in parents while addressing cultural issues, such as communication, parental monitoring, and engagement. The authors found that weekly group sessions, dealing with issues such as cultural roots, bridging culture, and dealing with obstacles, coupled with didactic training and coaches, proved satisfactory to parents.

CONCLUSION

It seems clear from the research presented above that there is a strong need for a public health approach to substance abuse prevention that is aligned with behavioral health. By aligning prevention with behavioral health, the field of substance abuse prevention can continue to provide effective evidence-based programs, policies, and practices to those who need it most. As the research suggested, substance abuse prevention and behavioral health share common aims: total physical, mental, social, and emotional wellbeing. In order to reach these goals, however, prevention should look to collaborate with others committed to public health, including the fields of education, juvenile justice, housing, employment, and others. Only by addressing the systemic roots of substance use can the field begin to see meaningful change.

AUTHOR INFORMATION

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