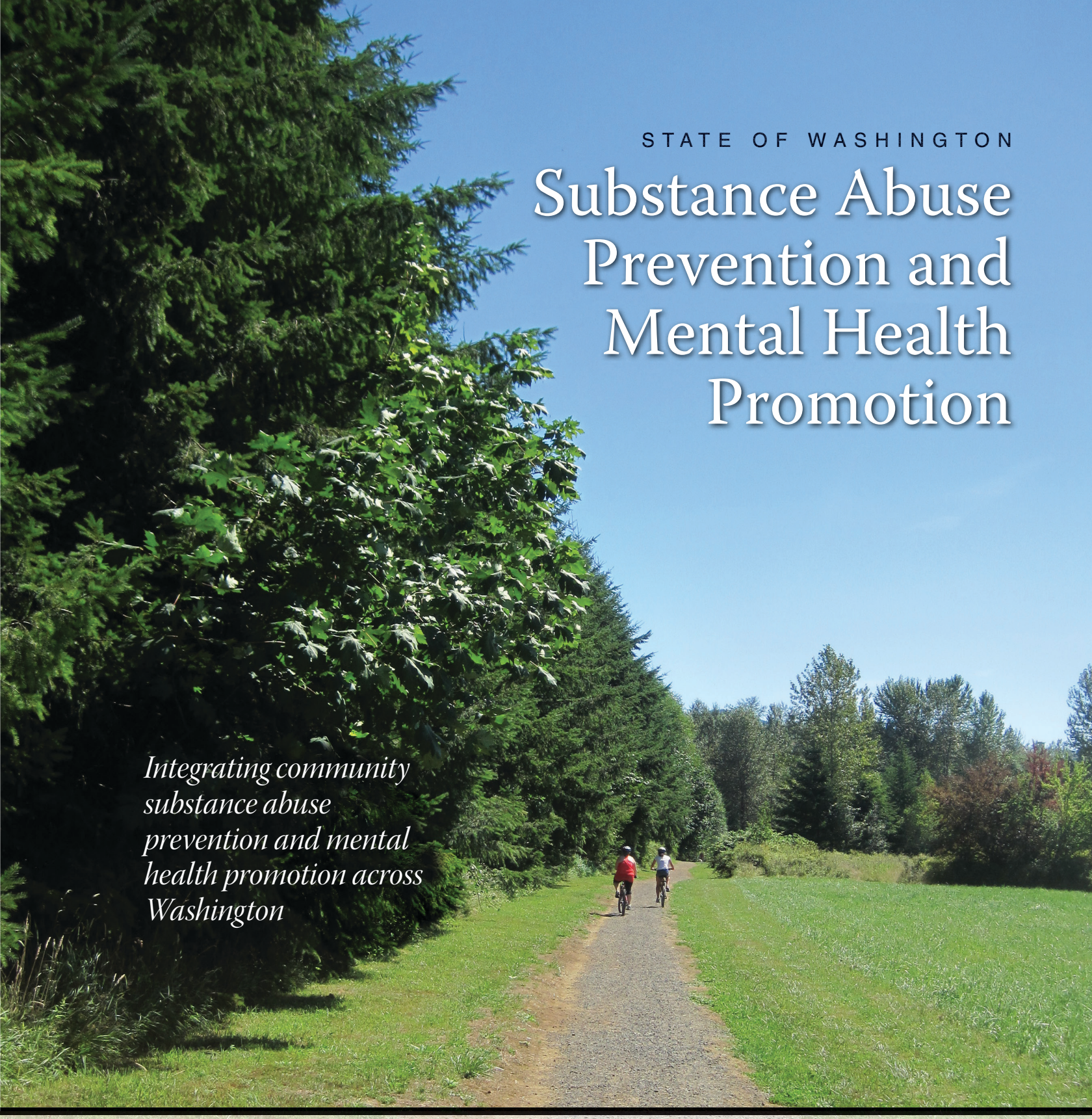

STATE OF WASHINGTON

Substance Abuse Prevention and Mental Health Promotion

Integrating community substance abuse prevention and mental health promotion across Washington

Five-Year Strategic Plan

Washington State Prevention Enhancement Policy Consortium

August 2012 *updated November 2015*

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ACKNOWLEDGEMENTS

It is with great pleasure that we have joined efforts to present this *Washington State Prevention Enhancement Policy Consortium Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan update*. We are committed to providing the best service to the children, individuals, families, and communities of our state.

We have updated this plan after conducting a scheduled need and resources assessment. Through implementation of this plan, we continue to build the health and wellness of individuals, families, schools, and communities where people can be as healthy as possible in a safe and nurturing environment.

We would like to give special thanks to all of the partnering state and tribal agencies and organizations and to those individuals who participate as representatives serving on the State Prevention Enhancement Policy Consortium. A complete list of representatives can be found in the Appendix -*SPE Consortium Partner List* page 54.

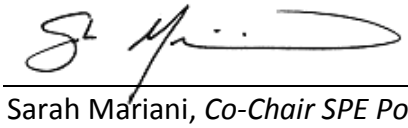
Additionally we would like to acknowledge Chris Imhoff, Director for the Division of Behavioral Health and Recovery, for her support in this endeavor. Director Imhoff is an avid supporter of prevention efforts and we appreciate her continued encouragement for us to move our field forward to meet the demanding needs in the future of integrated continuum of care.

Lastly, we would like to thank each of you who participated in the various information gathering opportunities through meetings, discussions, and review of documents for this plan originally and with the update.

We are honored to do this work on behalf of all of the citizens of Washington State.

Sincerely,

David Hudson, *Co-Chair SPE Policy Consortium*
Section Manager, Community-Based Prevention
Office of Healthy Communities
Division of Prevention and Community Health
Department of Health



Sarah Mariani, *Co-Chair SPE Policy Consortium*
Behavioral Health Administrator
Division of Behavioral Health and Recovery
Department of Social Health Services

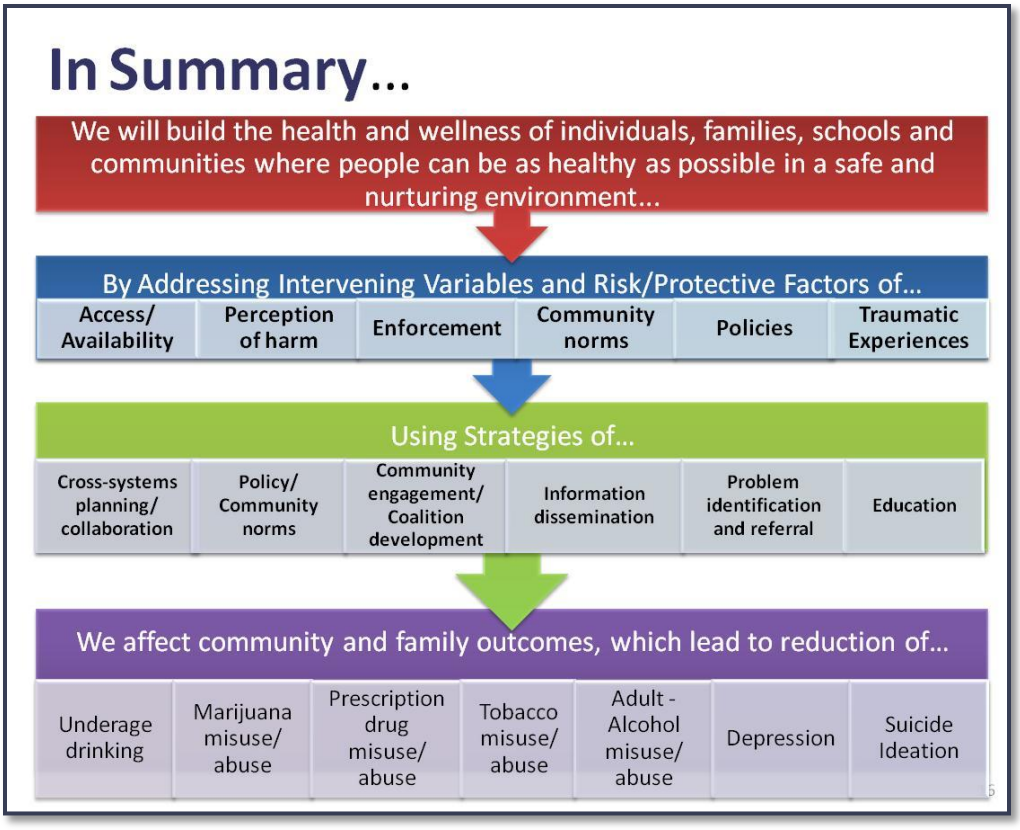
Chapter One: Executive Summary

Integrating community substance abuse prevention and mental health promotion across Washington.

The Washington State Prevention Enhancement Policy Consortium (hereafter referred to as the Consortium) is comprised of representatives from 26 state and tribal agencies and organizations. The goal of the Consortium is that through partnerships we will strengthen and support an integrated statewide system of community-driven substance abuse prevention, mental health promotion, and related issues.

The Consortium held our first meeting in October 2011 and initiated our strategic planning process in which we conducted an extensive review of state-level data and resources. Through this process, we were able to identify problem areas, as well as map current resources and partnerships that support substance abuse prevention and mental health promotion. Furthermore, we selected collaborative strategies from which to move forward in developing detailed Action Plans for each of our prioritized problem areas. In addition to supporting the current work of our partnering state and tribal agencies and organizations, as well as local communities, the Consortium is using strategies focused on public campaigns, policies, and professional development that will capitalize on the unique role of a state-level coalition to contribute to the overall collective impact.

The diagram to the right is a summary of the key elements of our plan. The top box captures our overall intended ***impact***; followed by the ***intervening variables*** we will focus on that lead us to the alignment of our ***strategies*** in order to create change in our identified ***problem areas***.



This plan includes a brief overview of the history and research that support our plan and documentation of the discussion along with conclusions and summation of decisions for each step of the strategic prevention framework planning process. We have included an extensive appendix for reference of the working products we used throughout this process.

The Consortium looks forward to the implementation of this plan as an opportunity to infuse energy into our system as we enhance our capacity to support community level strategic prevention planning and service.

In this 2015 edition of the plan we have updated the needs and resources assessment information and confirmed our priorities. We have updated the Team Action plans and made serval updates for context as noted throughout. We have made progress in many areas, as reflected in the accomplishments section, and will continue to look forward to further implementation and collaboration to sustain the substance abuse and mental health promotion efforts in Washington State.

This document is intended to summarize key discussions and decisions of the process and work of this plan. For more information about the State Prevention Enhancement projects and planning, go to www.TheAthenaForum.org/SPE.

Chapter Two: Prevention Background

Section 1: Overview of Prevention

The field of substance abuse prevention science has evolved quite significantly over the past twenty-five years and continues to progress as we consider the influence of current trends, including integration with mental health promotion. We have continued to build on our strong foundation of research-based practices focused on individual interventions as well as expand our focus to community-level interventions and outcomes.

According to the Preventing Mental, Emotional and Behavioral Disorders Among Young People Report[1] (also known as, *IOM Report*), prevention is specifically defined as, "Interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder." Mental health promotion is defined as, "Interventions that aim to enhance the ability to achieve developmentally appropriate tasks (developmental competencies) and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen the ability to cope with adversity."

The prevention field relies heavily on research and practice working in concert to inform our work to effectively create positive outcomes in building healthy families and communities. In Washington State, we follow the national guidance that encourages use of evidence-based practices. Within this framework, we also recognize the value of supporting efforts and programs that include adaptations and innovations that meet culturally relevant needs: for example, the twenty-nine federally recognized tribes in our state are using programs that are unique to their needs. While there are a number of conceptual frameworks included in substance abuse prevention, three key concepts of the current prevention work are: risk and protective factors, adverse childhood experiences, and the Strategic Prevention Framework.

Section 2: Risk and Protective Factors

Risk and protective factors provide the underlying framework upon which much of prevention research and practice is based. Although various research frameworks may be more general or specific depending on the research and intent of focus, the IOM Report[2] defines risk and protective factors broadly as follows:

> Protective factor: A characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.
>
> Risk factor: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

[1] National Research Council and Institute of Medicine of the National Academies, 2009. http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx. Accessed July 2012.

[2] National Research Council and Institute of Medicine of the National Academies, 2009. *(A list of risk factors can be found in the IOM Report Appendix E page 521.)*

Risk and protective factors for substance abuse and mental health disorders are often categorized into four domains: individual, family, school, and community. Within each of these domains there are various factors that have been shown to either increase (risk factors) or decrease (protective factors) the likelihood of an individual developing problem behaviors such as substance abuse. Generally speaking, a greater number of risks present compounded by fewer protective factors is associated with greater chance of problem behaviors developing. Conversely, less risk supported by greater presence of protection increases the likelihood of healthy development.

The essence of prevention practice is to decrease risk and increase protection through our efforts to create positive individual and community change.

Section 3: Adverse Childhood Experiences

More recently within the prevention field we have begun to recognize and integrate information provided regarding adverse childhood experiences (ACEs). The initial ACEs study was conducted at Kaiser Permanente in collaboration with the Center for Disease Control and Prevention (CDC) from 1995 to 1997[3]. Since the release of this study, over 50 scientific articles have been published which continue to inform our efforts.

This diagram represents the conceptual framework of ACEs[4]:

ACEs fall within two categories: abuse (physical, sexual, and verbal) and household dysfunction (substance abuse, parental separation/divorce, mental illness, battered mother, and criminal behavioral). Research has shown that there is a strong relationship between ACEs and a number of problem behaviors including age of first use and any alcohol use.[5] The ACEs study seeks to understand the frequency of problem behaviors present in our communities based on the underlying relationship of initiation of risky behavior by an individual. By helping to identify more specifically the underlying causes related to adoption of certain behaviors by individuals, we can build on our knowledge of risk

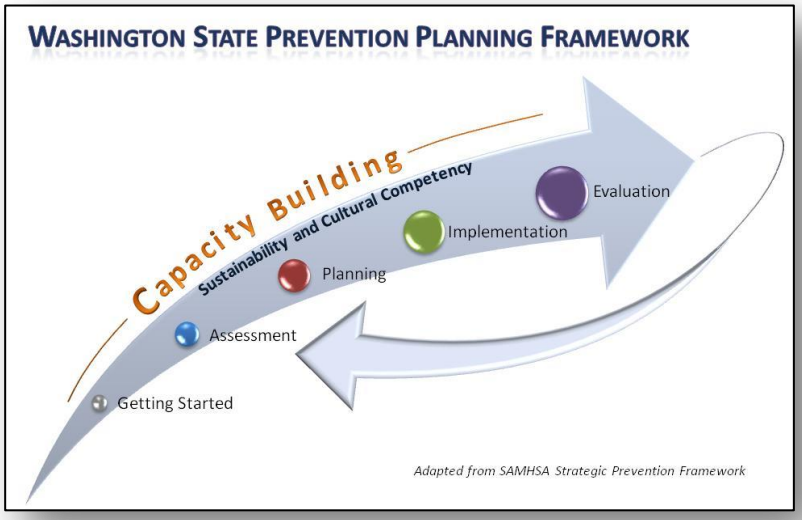
[3] Adverse Childhood Experiences, Center for Disease Control and Prevention, 2011 - http://www.cdc.gov/ace/index.htm. Accessed July 2012.
[4] Adverse Childhood Experiences, Center for Disease Control and Prevention, 2011
[5] *Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence*, 2006. Dube SR, Miller JW, Brown DW, Giles WH, Felitti VJ, Dong M, Anda RF. - http://www.ncbi.nlm.nih.gov/pubmed/16549308?dopt=Abstract. Accessed July 2012.

and protective factors to provide insight into the development of specific strategies in certain populations and increase the potential for successful outcomes.

Section 4: Strategic Prevention Framework (SPF)

The Consortium used the Prevention Planning Framework that is based on the Strategic Prevention Framework (SPF) as our overall planning framework for this process. The SPF was originally developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)[6]. SAMSHA's Strategic Prevention Framework is a comprehensive planning process designed to help states and communities build the infrastructure necessary for effective and sustainable prevention. Based on learning from the Strategic Prevention Framework State Incentive Grant process, we have slightly adapted this framework for the purposes of prevention planning in Washington State. The Prevention Planning Framework is comprised of the following key elements that contribute to more meaningful strategic plans:

- Getting Started: Initiate the process.
- Capacity: Mobilizing our state system and building capacity.
- Assessment: Assess our state's needs, resources, readiness, and gaps.
- Planning: Develop a strategic prevention plan.
- Implementation: Implement evidence-based prevention strategies.
- Reporting and Evaluation: Evaluate and monitor results, change as necessary.
- Cultural competence
- Sustainability



In using this framework, we are able to capitalize on the benefits of an outcome-based coordinated state plan. We have broad involvement and ownership in the process of this plan, leading to mutually agreed-upon focus and priorities. In 2011 we conducted a data-informed assessment of needs and resources to support our selection of strategies that are research-based programs, policies, and practices that build on existing resources and guide our evaluation strategy.

[6] Substance Abuse Mental Health Services Administration (SAMHSA), 2011 - http://www.samhsa.gov/prevention/spf.aspx. Accessed July 2012.

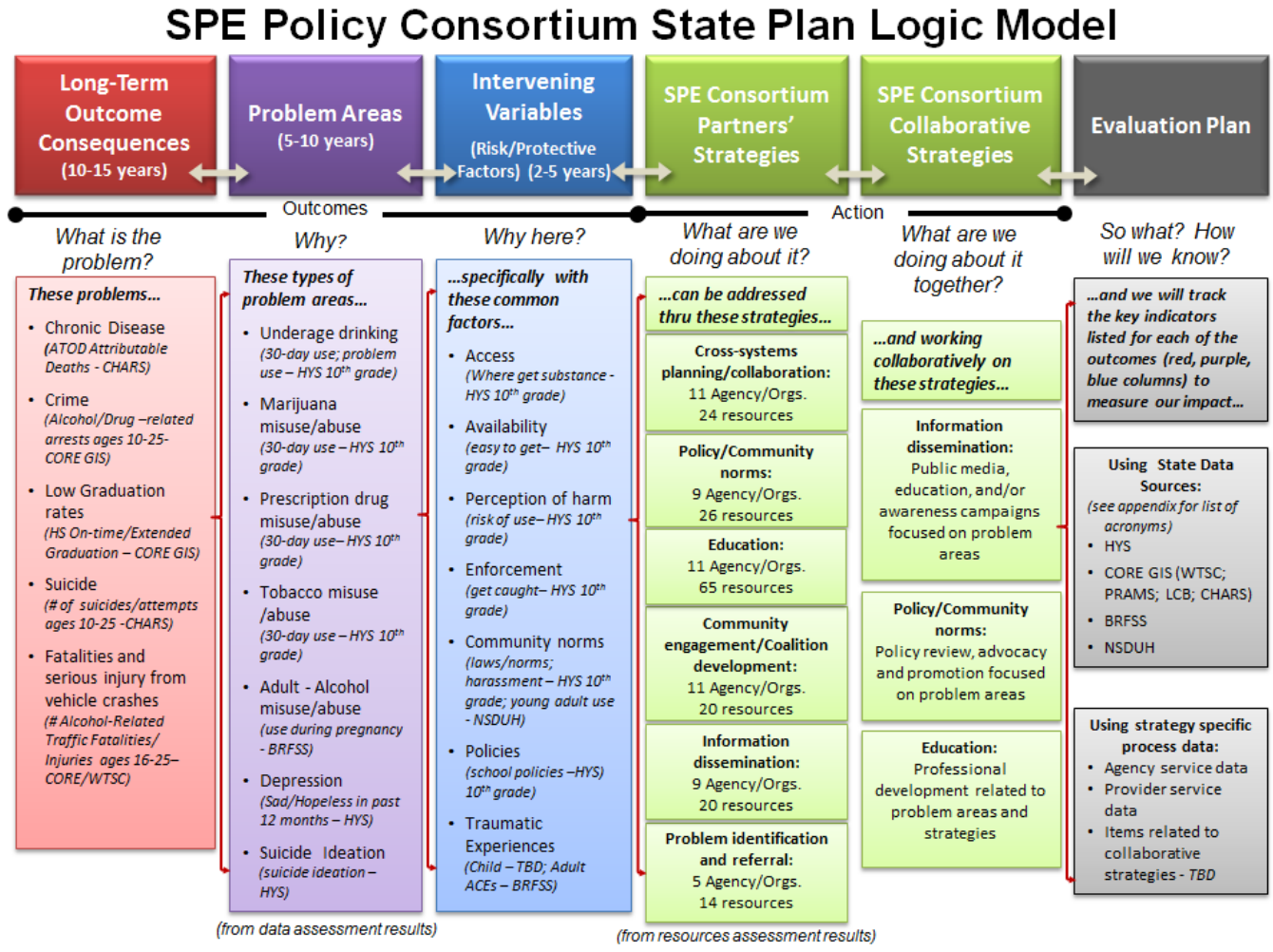
In 2013 we again examined the most current data available and made minor updates to this plan. In 2015 we updated this plan following a data-informed needs and resources assessment to examine and continue to support selected strategies. There are various places where the 2015 updated information or data is provided while we left the background and original information intact within the plan narrative.

The remainder of this document will highlight the Consortium's key discussions and strategic decisions in relation to the components of the Prevention Planning Framework based on the Strategic Prevention Framework.

Chapter Three: Strategic Plan

Beginning in October 2011, the Policy Consortium worked collaboratively to establish a structure, review data, examine state-level resources, and develop the following strategic plan. While we have made considerable effort to be inclusive and gather the best information available for our planning, we also recognize that this plan will be used as the foundation for ongoing planning as we move into the future. It is important that we continue to review, analyze, and update the strategies within this plan to meet the most relevant needs of our time.

Logic Model - Updated 2015



The logic model was developed to provide an overview of the central elements of our Strategic Plan. (For a full page view, see Appendix 8- Logic Model page 118.) This logic model overlays various logic model planning frameworks that are used by the Consortium partners. Furthermore, this logic model format is being used to promote strategic planning in local community coalitions through the Community Prevention and Wellness Initiative (CPWI).

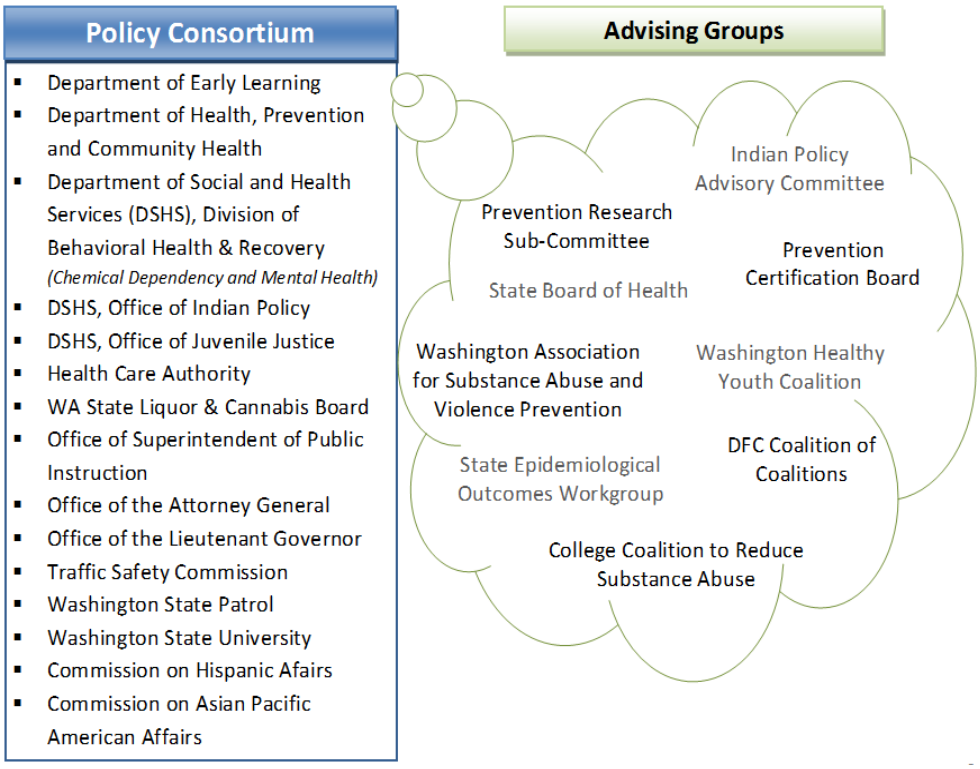
The first three columns of the logic model, ***Consequences***, ***Behavioral Health Problems,*** and ***Intervening Variables,*** pull together the prioritization from the data assessment. The fourth column,

SPE Consortium Partners' Strategies, summarizes the information from the resources assessment. The second green column, ***SPE Consortium Collaborative Strategies,*** lists the specific strategies that we are developing as collaborative projects for the Consortium to implement. The last column, ***Evaluation Plan***, records the sources for information we intend to collect and analyze as part of our continuous review of the plan. The process for decision-making and conclusions for each piece of this logic model are explained in the following sections.

Section 1: Getting Started

Policy Consortium Structure and Organization

In October 2011, we convened the first meeting of the Consortium. Washington state agencies have a history of collaborating in a variety of venues for planning and implementing projects. Over 20 years ago, we established the Washington Interagency Network (WIN) that included representatives from various agencies that are engaged in substance abuse prevention. The newly formed Consortium builds from the original WIN group and integrates new partnerships with mental health and primary care representatives.



(A complete, current, list of Consortium members can be found in the Appendix 2 - *SPE Consortium Partner* List, page 54.)

The Consortium is responsible for the state-level planning and implementation of collaborative strategies to address substance abuse prevention and mental health promotion. The Consortium has the unique role of a state-level coalition to implement strategies that contribute to an overall collective impact for our state. In December 2011, we completed our Capacity Building Plan followed by the competition of this Five-Year Strategic Plan in August 2012. The Consortium functions as a state-level inter-agency/organization, consensus-driven coalition. As needed, we use *Robert's Rules of Order* for formal decision making.

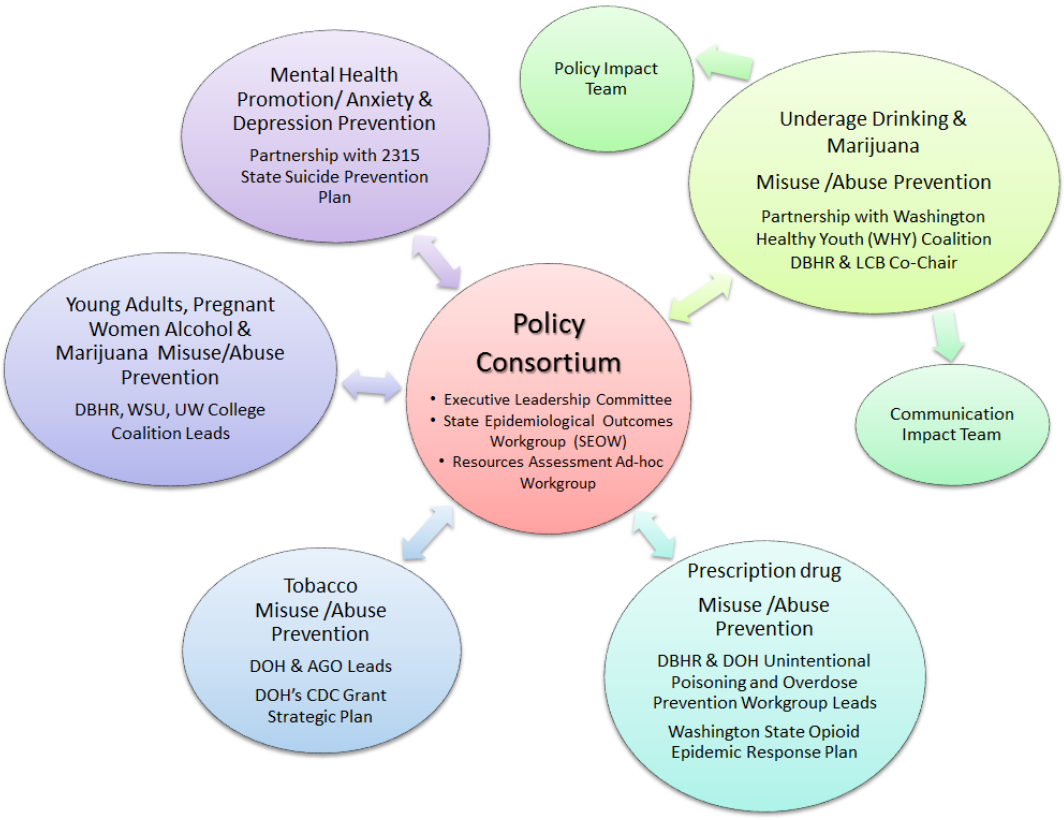
The Consortium meets most months of the year and is currently co-chaired by the Department of Health, Division of Prevention and Community Health, and the Department of Social and Health Services, Division of Behavioral Health and Recovery. The Consortium has a Leadership Committee, which provides direction and guidance to ensure that the goals and objectives of the Strategic Plan are met. Beginning with the next election cycle, the Consortium Leadership will consist of Co-chairs: one from a state public agency and one from a statewide organization. To increase continuity and focus, the co-chairs will serve staggered two-year terms, with annual elections to replace the outgoing co-chair. The Consortium also has an ad-hoc SPE Data, Resources Assessment and Evaluation Workgroup led by the State Epidemiological Outcomes Workgroup. This workgroup meets quarterly to conduct annual assessments and to consider and oversee evaluation.

The Consortium has also established the following Action Plan Teams to develop and implement plans for each strategy related to each problem area:

- Underage Drinking & Youth Marijuana Misuse/Abuse Prevention Team – Washington Healthy Youth (WHY) Coalition
- Prescription Drug Misuse/Abuse Prevention Team
- Tobacco Misuse/Abuse Prevention Team
- Young Adults & Pregnant Women Alcohol & Marijuana Misuse/Abuse Prevention Workgroup
- Mental Health Promotion/ Anxiety & Depression Prevention Team

This diagram shows our implementation structure- updated 2015.

Consortium Structure



The Consortium created Action Plan Teams to oversee the implementation of Action Plans focused on each of our identified problem areas in order to accomplish the goals and mission laid out in a strategic plan. Action Plan Teams are the principal vehicles through which Consortium members collaborate on a sustained and formal basis to realize the Consortium's strategic goals. Teams pursue an Action Plan that is revised annually and submitted to the Consortium for review and approval. Action Plans outline the goals to promote policies, projects, and partnerships for issues under jurisdiction of the working group. Action Plan Teams develop and implement plans for strategies related to each problem area. Because the partners and strategies are similar for both underage drinking and marijuana, the previously established Washington Healthy Youth (WHY) Coalition will serve as the Action Plan Team for both problem areas.

Membership Recruitment and Retention

Consortium members are expected to:

- Participate in a minimum of 2/3 of the meetings within a calendar year.
- Represent the Consortium at other meetings.
- Be aware of the state system of support and seek opportunities to actively support implementation and coordination of the Strategic Plan.
- Stay current – listen to 'what is going on' regarding substance abuse prevention and mental health promotion.
- Think about how projects/programs align with their agency interests, goals, programs, and projects, advise on possible state implications.
- Explore opportunities for collaboration and coordination.

Through active engagement and intentional recruitment, the Consortium is ensuring representation of key state agencies and organizations in our ongoing work.

To encourage active participation, we make a significant effort to provide accurate and timely communication with all of our members and the advisory groups. We keep them updated on the Consortium's efforts and help them to clearly understand their contributions to these efforts. Members and partners have opportunities to volunteer or be selected for leadership and committee positions.

The Consortium recruits new members as needed. In the event that an individual can no longer participate, we recruit a replacement from that agency/organization. As new state-level agencies or organizations are created or directed to work on these issues, we recruit their participation. We use existing partnerships and connections to invite participation of new members. As new members join the Consortium or a specific project, we meet with them to provide an orientation to our efforts. We also actively follow up with them after their initial meeting to answer their questions and provide additional information as needed.

Summary of the key decision-making processes and findings

The Consortium worked collaboratively for ten months to complete the Five-year Strategic Plan and continues to work to implement the goals and strategies outlined in the Plan. When we received the SPE grant in October 2011, we convened the first meeting of Consortium. Our focus for fall 2011 (November through January) was to cover the general framework of strategic prevention planning and

build readiness for the Consortium to conduct our assessments and planning. We conducted our Data Needs Assessment beginning in March 2012, and continuing through April 2012. Our Resources Assessment followed in April 2012, and concluded in May 2012. On June 11, 2012, we held an all-day planning session to review the findings from our assessments and develop the strategies and activities for our plan. Following the planning session, we began drafting this plan and seeking input. On June 12, 2012, we met with tribal leaders for a roundtable discussion meeting prior to a formal tribal consultation in July 2012. Additionally, we met with the community stakeholders which included representatives from counties, local health jurisdictions, treatment providers, healthcare plan providers, educational service districts, and coalitions to seek feedback into the proposed plan. In September 2012, the Consortium formed Learning Community Steering Committees to review in depth each problem area and prepare Action Plans for the Consortium to review and approve. In December 2012, the Consortium held a two-day planning meeting to conduct presentations on each problem area and propose and review Action Plans. Based on this review, the Consortium prioritized our 1-year Action Plans. Each year we update the 1-Year Action Plans to make sure we are meeting our goals.

In 2015, we began to update the strategic plan by conducting our Resources Assessment from February 2015 to June 2015. To update our needs assessment, we convened an ad-hoc work group in April 2015 to review statewide data presented by the State Epidemiological Outcomes Workgroup (SEOW). Nine Consortium members and staff participated and completed the review by June 2015. Following the process used in 2012, the Consortium held an extended planning session. During this session the group reviewed outcome measures, environmental changes and impacts, and youth consumption trends. From this session new target Intermediate Outcome goals were set for several Behavioral Health Problems, and each workgroup updated their annual Action Plan. See page 32.

Mission Statement and Key Values

Integrating community substance abuse prevention and mental health promotion across Washington.

Mission: The Consortium, through partnerships, is working to strengthen and support an integrated statewide system of community-driven substance abuse prevention, mental health promotion, and related issues.

The Consortium established and agreed to the following **key values** as critical components of all of our work:

- Build community wellness through substance abuse prevention and mental health promotion.
- Make data-informed decisions.
- Consider the entire lifespan of the individual.
- Support community-level initiatives.
- Ensure cultural competence, including honoring the Centennial Accord between the Federally Recognized Indian Tribes in Washington State and the State of Washington.
- Address health disparities.
- Work collaboratively to produce a collective impact.
- Consider impacts of Health Care Reform and Indian Health Care Improvement Act.
- Honor current state and tribal resources that support substance abuse prevention/mental health promotion.

Section 2: Capacity Building

Outreach and Sustainability

The Consortium partners have committed to attending bi-monthly meetings along with supporting the collaborative efforts and strategies identified in this plan. Additionally, each partner has identified the specific resources that it devotes to supporting substance abuse prevention and mental health promotion. *(*See Appendix - *Matrix of Resources Identified in Resource Assessment focused on* beginning on page 111.*)*

Furthermore, the Consortium is committed to working in concert with other state and tribal agencies, organizations, and advisory groups, to support our strategies and objectives. We recognize the value of staying informed of the efforts of other groups including the Behavioral Health Advisory Council; Community Transformation Grant Leadership Team; System of Care Family, Youth and System Partner Roundtables; Association of Counties Human Services Prevention Sub-committee; and Federally Recognized Tribes as well as other non-traditional groups such as youth prevention groups, local coalitions, and foundations. We will also consult with the community at large as we further develop our specific activities within each strategy to gather community input and create partnerships.

In addition to the commitments from each of the partnering agencies and organizations, the Division of Behavioral Health and Recovery (DBHR), as the "Single State Agency" responsible for substance abuse prevention and mental health promotion, is committed to supporting strategies and activities of the Consortium's plan with their Substance Abuse Prevention and Treatment (SAPT) Block Grant funding. The plan is in overall alignment with DBHR's goals and objectives and is seen as a guiding framework. Additionally, we intend to capitalize on opportunities to further integrate funding systems in the state, such as mental health block grant funding, to support integration of mental health promotion among substance abuse prevention providers.

An agreed-upon-formula for allocating state substance abuse prevention resources to identified communities of greatest need.

The Consortium agrees that substance abuse prevention and mental health promotion resources should be directed toward local programs and communities that demonstrate highest need and capacity to address need based on data-informed decisions. Furthermore, we support the continued use of evidence-based practices while honoring the value of adaptations and innovations that appropriately address culturally-specific prevention needs. Lastly, we recognize the importance of supporting local community coalitions in strategic planning to address these issues most effectively.

DBHR serves as the Washington State Single State Agency for the federal substance abuse prevention resources, also known as the state SAPT Block Grant.

This funding is allocated to communities of need through three main methods:

1) Funding is distributed to federally recognized tribes based on a formula, taking their enrolled membership into account.

2) Funding is distributed to county governments based on formula, which includes calculations for population and is allocated to the identified highest need community (Community Prevention and Wellness Initiative (CPWI) Communities). Highest need communities are identified based on a Risk Profile prepared by the State Epidemiological Outcomes Workgroup (SEOW) and provided to the counties and educational service districts. The Risk Profile includes rank listings of highest need communities based on the following indicators: consumption (alcohol), consequence (school performance, youth delinquency and mental health), economic deprivation, and troubled family.

3) Funding is distributed to the Office of Superintendent of Public Instruction (OPSI) to direct school-based prevention/intervention resources into the selected high-need communities.

Training/Technical Assistance

In Washington State, the prevention field is supported by an annual statewide prevention conference as well as a number of more local opportunities for training and technical assistance provided through tribes, government agencies, educational service districts, and local communities. While our workforce has a vast array of education and experience, we also recognize that there are always new developments in the science and practice.

The Consortium is committed to ongoing capacity building in our state to support a strong, relevant, and vital substance abuse prevention and mental health promotion workforce.

According to our baseline resources assessment, Consortium partners collectively have provided an additional 420 training/technical assistance activities in 2012. Over 50 hours of training was also conducted with SPE grant funds. We have developed the internal capacity to create, conduct, and record online trainings. We have established and added to an online e-learning environment, with content that is available at no-cost to our providers. This e-learning system not only provides online training and education opportunities, it tracks continuing education hours to provide documentation for professional certification and renewal. We plan to add a minimum of 20 hours of new content each year; this is congruent with the requirements for the bi-annual prevention professional certification renewal. Overall, we expect to increase our capacity for providing trainings/technical assistance activities by 20% by State Fiscal Year 2016. With the successful award of the Substance Abuse and Mental Health Services Administration's Partnerships for Success 2013 discretionary grant, we have achieved this goal.

In 2013, using the SPE grant we completed a number of valuable infrastructure enhancements to our systems to provide consistent professional training across our state agencies and community partners, provide a more accessible and responsive data collection system, and integrate primary care with substance abuse prevention. These enhancements build on our state infrastructure by increasing the capability of state staff to provide training and technical assistance to the field and support prevention professionals directly.

In 2013, we built new elements within our various data systems that are supported by online training/technical assistance modules. This will provide information and guidance to local community

providers to accurately and successfully use community-level data and service provision data in their planning efforts.

In 2013, we completed updates on two valuable training curriculums used in our state: the Office of Superintendent of Public Instruction's *Washington's Student Assistance Prevention and Intervention Services Program Manual* and the Department of Commerce Community Mobilization's *Art and Science of Community Organizing Training.* Both manuals now include updated information to address special populations, mental health promotion, primary care integration, and new areas of substance abuse including prescription drug abuse.

And finally, through our Primary Care Demonstration Project, we worked in partnership with nine local communities to discover and evaluate successful strategies to 1) include and encourage active participation of a primary health care provider in coalition meetings, activities, and representation of coalition goals in the community, and 2) integrate and collaborate between coalitions and primary health care providers. Communities provided documentation and presented their findings at our 2012 Prevention Summit so the state and local-level providers can learn from their efforts. The Department of Health will incorporate relevant information into its Community Health Care online worker training and patient-centered health home quality improvement worker trainings. In the coming years, we will also establish additional methods for disseminating the lessons learned through this process.

In addition to continuing to support the successful strategies, we already have in place for training and technical assistance, we will expand available training. The Consortium collaborative strategies include a significant focus on, "Professional development across all systems." This strategy includes training topics such as assisting new coalitions/providers to get 'up to speed' on state system and coalition frameworks ('new professional orientation'); education for broad networks of providers (prevention, mental health, and primary care) regarding mental health across the spectrum, including the connection to adverse childhood experiences; and education for state systems regarding the patient-centered health home training and the role of Health Care Authority.

As part of our Action Plans, we will develop methods to build readiness and capacity in additional high-need areas to be considered for funding in the future. Although there are current efforts to focus services in high-need areas, we are often faced with the challenge of high-need communities not being 'ready' for services, and thus not able to access the resources we make available. We have discussed how we can improve our ability to support these communities with services to get them 'ready' to receive resources to address these problem areas. Specifically, we will look to areas that have high needs but do not have the formal structures in place to respond to opportunities such as requests for proposals, or similar granting processes. We will continue to develop capacity within state staff and our local provider network to reach out to these areas and capitalize on the informal structures that can be grown to support more formal and organized planning and services for these communities.

The Consortium will ensure that education pieces are culturally specific and science-based while also supporting innovative development of evidence-based practices.

Workforce Development

In an effort to prepare for the opportunities that may become available through health care reform and to continue to advance our field, the Consortium reviewed three components of the current structure of our workforce. In 2011 we commissioned feasibility studies on individual prevention professional certification, agency licensure, and rate setting for prevention services. We asked each study to provide information about the current state system, what other states have done, the readiness of the field to meet requirements, the steps necessary for the state to consider for implementation, options for the state to consider, benefits and challenges to making the change, and how recommendations relate to the various potential impacts of health care reform. The following information provides an overview of each study's key findings and conclusions. For copies of the full reports go to www.TheAthenaForum.org/SPE.

Individual Prevention Professional Certification

In Washington, the Prevention Specialist Certification Board of Washington (PSCBW) is the certifying body for Certified Prevention Professionals (CPP). Some counties and local agencies require certification within the scope of their contracts and/or hiring practices; however, there is not a state requirement for certification of individuals. The Division of Behavioral Health and Recovery contracted with Spokane Falls Community College (SFCC) to conduct a professional certification feasibility study. SFCC reviewed other states with certification or agency requirements; interviewed national contacts, Washington State stakeholders, and coalition coordinators; and administered an online survey. The survey covered 120 contacts from eleven counties and six tribes with an 80 percent response rate.

In summary, SFCC found that while the PSCBW has a high-quality system set up for certifying individuals, as a voluntary board, without staff support, they may not have the capacity to respond if a requirement for certification were put into place. Furthermore, it is important to work with the other certifying bodies in the state so as to not unnecessarily duplicate processes. Additionally, it is important to consider the level of experience of the current prevention professionals in addition to their formal training and education. Based on the results of the online survey, there is a broad distribution of education and length of experience with the majority of current professionals having worked between 5-10 years (26.1%) followed by 10-15 years (15.2%).

Since the final report we have employed several of the report recommendations to elevate the level of education for prevention professionals. The report suggests that it is important to increase access to training for new providers by providing webinars, video training, and distance learning as well as working with higher education to develop prevention certificate or degree programs. We have provided several webinar series on strategic plan development, understanding community data and have provided annual Coalition Leadership Institute trainings since 2012. There are now a variety of training modules available as well as templates and slides for community education on prevention. There are quarterly Substance Abuse Prevention System Training available to providers as well. Washington State University now has a Interdisciplinary PhD Program in Prevention Science. The report recommended that in addition to the already established Certified Prevention Professional, the state consider providing opportunities for various levels of credentialing such as General Prevention Specialist or Associate Prevention Provider. Since 2011 we have worked with the PSCBW and there is now an APP available.

In July 2015, the Division of Behavioral Health and Recovery began to require that Community Coalition Coordinators participating in the Community and Wellness Prevention Initiative (CPWI) be Certified Prevention Professionals (CPP) by the PSCBW. The intent of this change is to advance the prevention professional workforce and increase the local capacity to provide effective prevention programming across the state.

Agency Licensure

SFCC conducted an agency licensure feasibility study in conjunction with the professional certification study. There are approximately 375 agencies in Washington that currently provide prevention-related services. Washington State does not currently require prevention agencies or organizations to have a license in order to provide substance abuse prevention services. Although a few states have tiered staffing requirements in prevention contracts, very few states have agency licensure for prevention. In review of our current systems and in consideration of developing a structure, new rules to establish administrative standards for licensing would need to be proposed. SFCC recommends partnering with the established behavioral health stakeholder workgroup that is reviewing the Washington Administrative Code (WAC) to propose including prevention in the code. It was also suggested that we consider using the tiered certification structure to support staffing requirements within agency licensure. In conclusion, while SFCC does recommend that we consider moving toward agency licensing, it is a process that will require careful examination before being implemented. As of 2015, no action has been taken regarding Agency Licensure.

Prevention Service Rate Setting

Washington State does not currently have set rates for substance abuse prevention services. Mercer Government Human Services Consulting (Mercer) was hired to conduct a study to examine the feasibility of establishing service rates for substance abuse prevention services. Their study included contact with fourteen states and interviews with representatives from five states (Illinois, Louisiana, New Jersey, South Dakota, and Tennessee) and three prevention experts.

Based on these interviews, Mercer was able to summarize key successes and challenges other states faced in establishing rates for substance abuse prevention services. While it was shown to noticeably increase accountability, improved reporting, efficiencies, and defined target audience, it was sometimes challenging for providers to bill and report using the technology required for tracking. Getting specific cost information and identifying the components of rates is critical for the success of the project. A few of the states' rates include a mixture of fee-for-service and cost reimbursement which allows for accounting on planning and reporting in addition to direct service. This study was helpful in providing the Consortium with a number of thoughtful points for consideration as we move forward in our deliberation of rate setting, including availability of state staffing resources, contracting regulations, capacity of current management information system to accept claims, steps needed to identify codes for prevention, timeline, involvement of stakeholders in the process, variance of rates by program or by category, and components the rates would include.

The information from all three studies was presented to the Consortium for review. The Consortium decided that based on the scope of work associated with these changes, that Individual Prevention Professional Certification would be the priority for Workforce Development.

Section 3: Assessments of State Substance Use and Mental Health Disorders Data and Resources

The Consortium conducted state-level assessments of both need and resources. We solicited the State Epidemiological Outcomes Workgroup (SEOW) to gather relevant data and provide information to the Consortium for review for our data assessment. Additionally, we formed a Resources Assessment Workgroup specifically to develop and prepare the resources assessment. Both workgroups gathered information and presented it to the full Consortium for review, discussion, and decisions for our strategic planning. We also collected and reviewed information about significant historical events, economic changes, policy/law changes, and major changes to funding resources/directives that may have impacted either our data indicator elements or explanation of resources. Results of each assessment follow.

As noted earlier, the Consortium conducted a state-level needs and resources assessment in 2015. As done for the previous assessment, we solicited the SEOW group to gather comparative data and the SEOW presented their findings to the entire Consortium. The Consortium formed a workgroup to review discuss key findings from the 2014 Healthy Youth Survey student survey data trends and Core GIS data, as available. The resources assessment update was conducted this year using an online survey. The survey was offered to all Consortium members, and was completed by 18 agencies. The assessment workgroup presented resource and needs assessment workgroup findings to the full Coalition for further discussion and decision making.

Data Assessment

To provide recommendations to the Consortium, the SEOW convened the SPE Data Workgroup to review the epidemiological data regarding substance use and mental health. The SPE Data Workgroup included partners from Department of Health, Division of Prevention and Community Health; Department of Health and Social Services, Division of Behavioral Health and Recovery; and Washington Traffic Safety Commission.

The workgroup examined data by age, race, ethnicity, and socioeconomic indicators based on prevalence rates, long-term trends, economic impact, and social impact including mortality, morbidity, traffic safety, effects on newborns, and school related consequences.

Key Findings:

The SPE Data Workgroup came to the following summary conclusions:

- Overall, based on the prevalence, social and economic indicators above, alcohol ranks highest of substance use problems, followed by marijuana (2nd), and tobacco (3rd), and lastly prescription drugs (4th). We also included a review of methamphetamine (meth) use, which has the least overall impact of these five substances, yet, remains a concern as it is perceived to have high prevalence in specific populations and areas. (For more information, see Appendix - *Data Assessment* page 60.)
- Based on the prevalence, trends, and impact of substance use, underage drinking remains the number one priority for prevention.
- Marijuana is ranked second due to high prevalence use among youth.

- Both substance use and mental health disorders are more prevalent among youth and young adults, and therefore our efforts should be focused on this age range.

Analysis and Prioritization of Data:
The data conclusions and recommendations related to substance misuse/abuse and mental health indicators were presented to the Consortium in three consecutive meetings *(see Appendix - Data Assessment page 60)*.

What is the problem?

In consideration of the recommendations and conclusions provided by the SPE Data Workgroup, we also looked to answer the broader question of "*What are the problems we are intending to address?*" After much discussion about the various implications that these substance use and mental health disorders have on society, we decided to focus on five ***long-term outcomes consequences***, 1) chronic diseases related to alcohol and tobacco; 2) crime; 3) low high school graduation rates; 4) teen and young adult suicide; and 5) fatalities and serious injury from traffic crashes.

Why?

After a thorough review and discussion of the data assessment, the Consortium decided to focus on the following intermediate outcomes also known as ***problem areas***:

Substance Abuse

The Consortium decided to focus on the top four ranked misused/abused substances: alcohol, marijuana, tobacco, and prescription drugs. Based on the prevalence by age, underage drinking remains the top priority. Additionally, the Consortium agreed that specific emphasis also be placed on strategies related to alcohol use prevention for the 18-25 year age range. It was noted that there are high rates of drinking during pregnancy, especially among white women over the age of 35. And lastly, the Consortium noted the importance of continuing to watch "trending" substances such as heroin, which has recently shown increased use, hypothesized to be related to the reformulation of prescription opiates.

It was decided to use the term 'misuse/abuse' to account for important distinctions related to each substance. Specifically, in regards to marijuana it is important to note that medical marijuana use is legal in this state; therefore not all marijuana use is considered abuse. Similarly prescription drugs when taken as prescribed, are not considered harmful or misuse/abuse. In regards to tobacco, it is important to recognize that in some cultures, tobacco is used for cultural traditions and ceremonies and would not be considered misuse or abuse.

Mental Health

The review of mental health indicators of serious mental illness, serious psychological distress, major depressive episodes, symptoms of depression, and suicidal ideation data suggest the importance of focusing on depression and suicidal ideation, specifically among those that are under 25 years of age.

Why here?

The Consortium reflected on, "*Why are these problems present in our state?*" and further identified key short-term outcomes, also known as ***intervening variables,*** *or risk/protective factors*. We focused on key state-level intervening variables, recognizing that each county, tribe, and community will need to further identify their own local conditions.

Below is the list of the identified intervening variables for each behavioral health problem area listed above:

Problem Areas (5-10 years)	Intervening Variables (Risk/Protective Factors) (2-5 years)
Adult Alcohol misuse/ abuse	▪ Community norms ▪ Sense of connectedness to community ▪ Favorable Attitudes: Perception of harm (e.g., perception of benefits of limited use/moderation) ▪ Promotion of alcohol ▪ Availability ▪ Enforcement ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Underage Drinking	▪ Access to alcohol ▪ Availability of alcohol ▪ Policies ▪ Promotion of alcohol ▪ Community norms ▪ Enforcement (e.g., lack of enforcement and perception of lack of enforcement) ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Marijuana misuse/ abuse	▪ Availability ▪ Favorable Attitudes: Perception of harm ▪ Enforcement (e.g., inconsistent application of laws in light of de-emphasis) ▪ Adults who use ▪ Laws (e.g., confusion about laws) ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)

Problem Areas (5-10 years)	Intervening Variables (Risk/Protective Factors) (2-5 years)
Prescription Drugs misuse/ abuse	▪ Availability (e.g., over prescribing, unused medication, and 'doctor shopping') ▪ Supply (e.g., abundant supply of prescription drugs) ▪ Favorable Attitudes: Perception of harm (e.g., misuse of prescribed and non-prescribed drugs and improper use of medications) ▪ Enforcement (e.g., unclear under the influence laws) ▪ Community norms Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Tobacco misuse/ abuse	▪ Policies (e.g., inconsistent policies and enforcement of policies in schools) ▪ Laws (e.g., preemption and local laws) ▪ Access (e.g., hookah lounges) ▪ Promotion of tobacco (e.g., targeted advertising to low-income/minority populations) ▪ Favorable Attitudes: Perception of harm ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Depression	▪ Community norms (e.g., stigma of MH screenings, MH screening not part of routine health screening, and community awareness and knowledge regarding treatability) ▪ Perception of stigma ▪ Connection to other mental health disorders (e.g., anxiety) ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Suicide Ideation	▪ Teens and young adults suicidal ideation ▪ Connection to other mental health disorders ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)

Following a review of each of these problem areas, we identified six common **intervening variables,** to address: 1) Access, 2) Availability, 3) Favorable Attitudes: Perception of harm, 4) Enforcement, 5) Community norms, and 6) Policies. These intervening variables were then used as the basis for our development of strategies later in our planning.

Resources Assessment

For our second assessment, we compiled information on state-level resources provided by the Consortium partners. The goal of the Resources Assessment Workgroup was *"to gather STATE-LEVEL resources that support substance abuse prevention and mental health promotion, in order to inform our strategic planning as well as identify where our resources are linked and where gaps are present."* We discussed the information to be collected and the level of analysis to be conducted on information gathered, in order to inform our strategic planning. Using this information, we created a map of state-level programs that illustrates where services from various state agencies are being delivered and a matrix that identifies the targeted problems addressed and the strategies being used.

The SPE Resources Assessment Workgroup included partners from Department of Commerce, Community Mobilizing Program; Department of Health, Division of Prevention and Community Health; Department of Health and Social Services, Division of Behavioral Health and Recovery; and the Office of the Attorney General.

Using the same **problem areas,** established in the data assessment, the workgroup established elements of the resources assessment within two categories to include, *Agency/Organization Information* (sources of funding received at the state-level, funding allocation from the state agencies to county/regional/local sites, training information, and data collection information); and *Resources Information* (name of resources, location of local allocation of resources for mapping, primary problem addressed, other areas of focus, target populations (age, race, and ethnicity), strategies used by resource and data related to their planning and monitoring).

For the purposes of this assessment, 'state-level' includes resources funded through state, federal and tribal sources within our state. 'Resource' is a strategy, program, policy, initiative, and/or service provided by the agency/organization.

Key Findings:

Resource information was collected via an online survey and through interviews. In 2015 eighteen (18) agencies/organizations participated in the survey and over sixty-five (65) resources were identified that directly or indirectly address substance abuse prevention/mental health promotion. Resource focuses in 2015 did not significantly change from resources in 2011. Detailed information from the resources assessment and comparison charts from 2011 to 2015 can be found in Appendix - beginning on page 100. Below is a summary of key information analyzed[7].

Most common focus areas being addressed (2015)

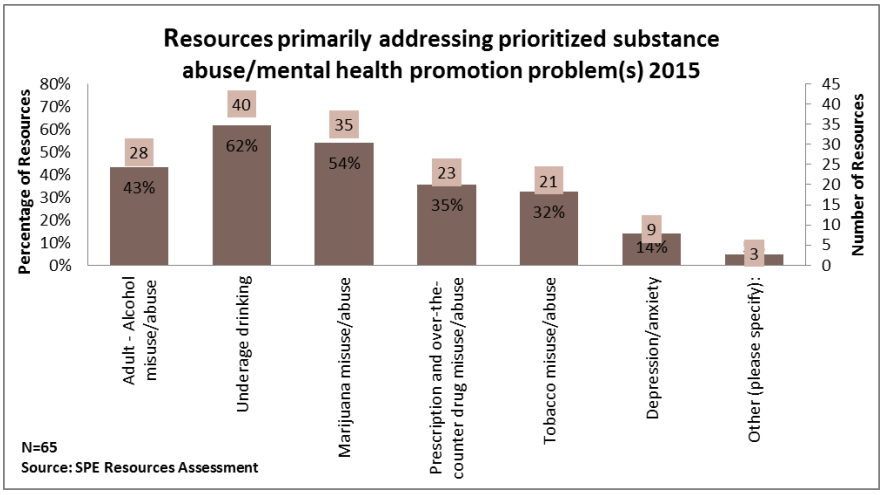
- General Substance Abuse (65%)
- Drinking and Driving (34%)
- Adverse Childhood Experiences (35%)
- General Mental Health (38%)
- Other Illicit Drugs (45%)
- Family relationships (40%)

[7] Resources may be duplicated as agencies were allowed to select more than one area, therefore category totals will equal more than 100 percent if combined.

Relative to addressing substance abuse, the chart to the right shows the percentage and the number of resources by substance.

<u>Most common strategies (2015):</u>

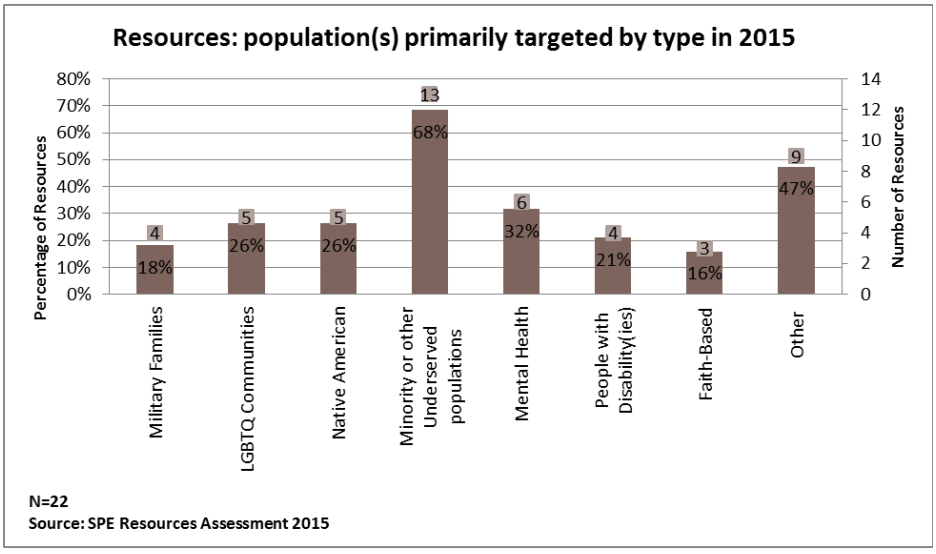
- Policy/Community Norms (42%)
- Cross-system Planning/ Collaboration (39%)
- Education (youth education/skill building; parent education/family support; other educational programs) (105%)*
- Community Engagement/Coalition Development (32%)
- Information Dissemination (32%)
- Problem Identification & Referral (23%)



<u>Target Populations (2015):</u>

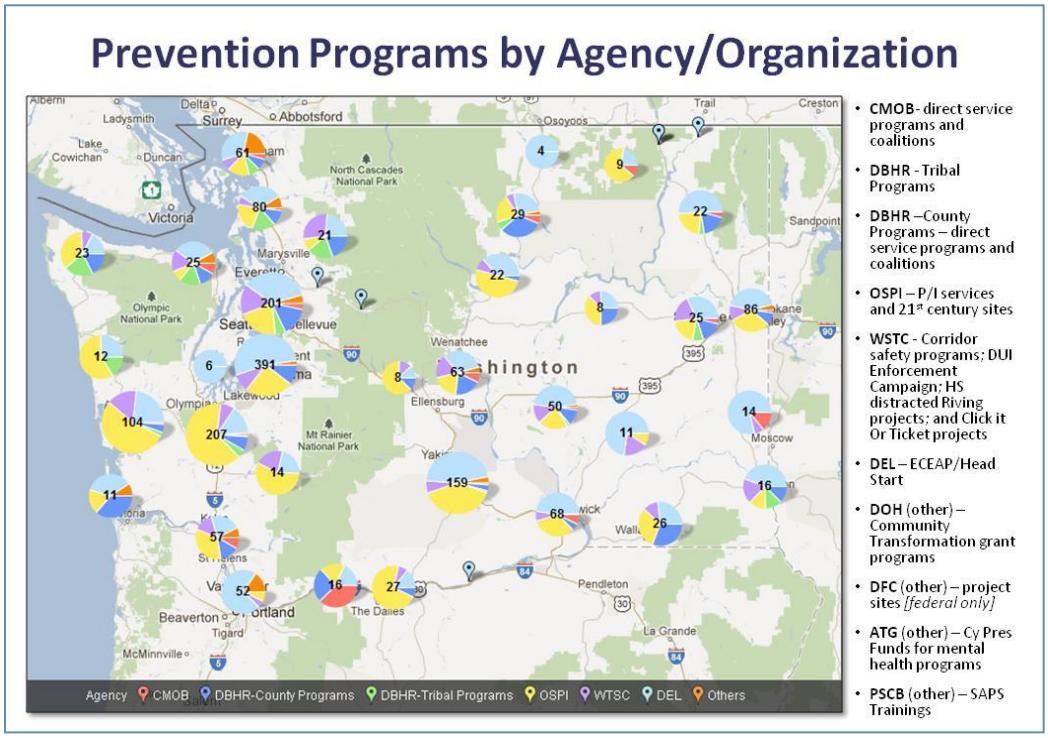
- While we have broad coverage on all ages, these resources most often focus on *adolescents*, *young adults and adults.*
- Minority or other underserved populations (68%) was the most common specific population targeted followed by Native American/Tribes (26%), LGBTQ (26%), and Mental Health (20%)

The chart to the right shows the percentage and number of 2015 resources targeting specific populations.

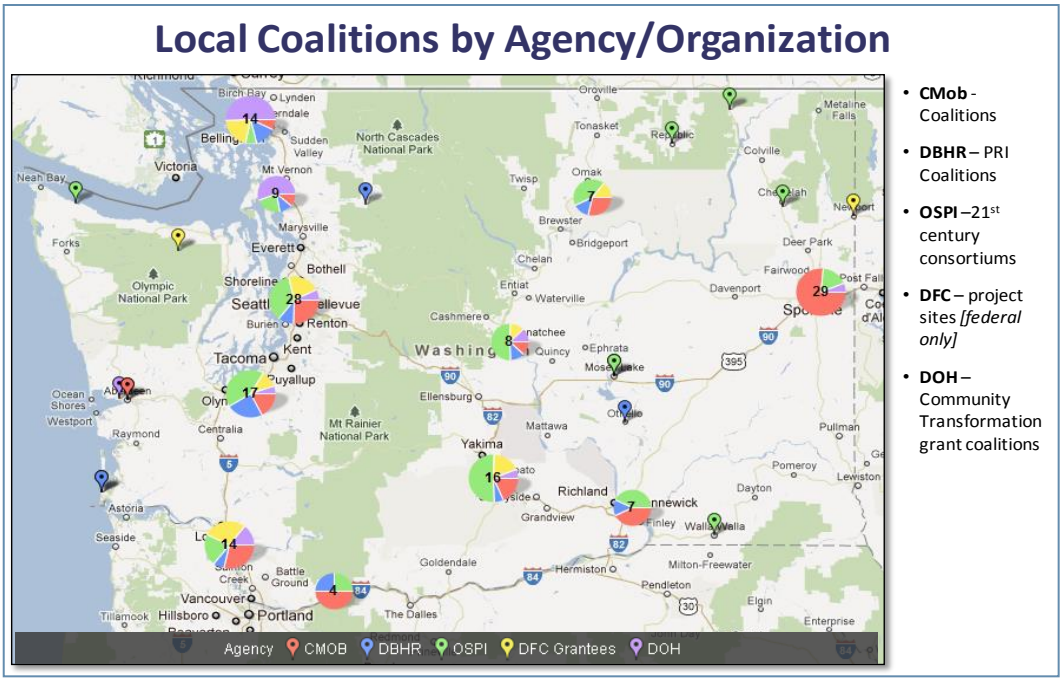


Services by Location *(Full size maps and acrnoym list are available in* Appendix – *Maps,* page 102.*)*

We have broad distribution of prevention services across the state. Below is a map illustrating the prevention programs by state agency/organization where local location was available in 2013. **This section was not updated in the 2015 Strategic Plan Update.**



- In 2013 there were over 169 coalitions working at the local level to support coordinated prevention and promotion efforts.



Prevention activities supported by coordinated funding streams

There are a number of prevention activities[8] that are supported by state-level coordinated funding streams both directly and indirectly. In 2012 had a total of 43 prevention activities supported by coordinated funding streams, and we anticipate that by 2017, we will have 65.

Beginning in October 2011, as part of this State Prevention Enhancement grant, the Consortium began working on four (4) specific prevention projects with coordinated funding. Prior to the start of this grant we had multiple projects supported by coordinated funding including the State Prevention Summit conference, Spring Youth Forum conference, four Reducing Underage Drinking strategies, Healthy Youth Survey, CORE GIS data collection and analysis, College Coalition, and Community Prevention and Wellness Initiative. As part of the state Community Prevention and Wellness Initiative, some of the Consortium partners have been involved in this process to support local coalitions. In 2012 we supported 34 local prevention activities (local coalitions) that include coordinated funds from Division of Behavioral Health and Recovery and Office of the Superintendent of Public Instruction, which were paired in many cases with Department of Health Community Transformation grant neighborhoods, Community Mobilization coalitions and Drug-Free Communities coalitions. Where possible, we looked to facilitate cross-agency communication to support aligning their local work in these areas when it fits the needs of the communities.

2015 Update:

Since October 2011 the prevention activities supported by state level coordinated funding has somewhat expanded. Continued state-wide prevention activities include the State Prevention Summit conference, Spring Youth Forum conference, Washington Healthy Youth Coalition (formally RUaD) communication and policy strategies, Healthy Youth Survey, CORE GIS data collection and analysis, College Coalition and CPWI (formerly PRI). In addition, other additional prevention activities have occurred such as, the expansion of SBIRT services, Washington State Prescription Drug Monitoring Program, youth marijuana use prevention campaigns, Alcohol & Drug Abuse Institute (ADAI) surveillance, and Evidence Based Practices development.

The CPWI efforts have expanded and now support 54 communities in local prevention coalitions and school partnerships. Additionally, five (5) new communities will join CPWI in 2015-2016 with the support of additional youth marijuana use prevention funding.

Analysis and Prioritization of Resources:

In conclusion, following a comprehensive review of this information, the Resources Assessment suggests continued support for what we have in place, that we build on current partnerships, and we look to establish new collaborative strategies and activities to work on together as the Consortium. As will be shown in the following section, this information was instrumental in informing our strategic planning, particularly in the development of strategies that address **intervening variables,** shown to impact our established outcomes.

[8] Note: "Prevention activity" in this instance is specifically defined by SAMHSA as any policies, programs, or practices implemented by the Consortium to address the [SPE grant] goals. When funds from multiple programs are used to finance an activity, that activity is said to be supported by coordinated funding streams.

Section 4: Plan for Action (Goals, Objectives, and Strategies)

Subsequent to the completion of our assessments of state substance use and mental health disorders data and resources we began to discuss and confirm our plan for working together to meet our common goals. This section details the discussions and decisions leading to the Consortium's commitment to support existing programs and partnerships and building collaborative strategies focused on public campaigns, policies and professional development to address our problem areas. The Consortium developed strategies that will make the most of the unique role of a state-level coalition to contribute to broad-based impact.

Common goals, objectives, and strategies for coordinating services

As the Consortium considered the recommendations and conclusions provided by the assessments, we also considered the question of, "*What are we trying to build*?" We agreed the goal of the Consortium is to build the health and wellness of individuals, families, schools, and communities where people can be as healthy as possible in a safe and nurturing environment.

SPE Consortium Partners' Strategies

What are we doing about it?

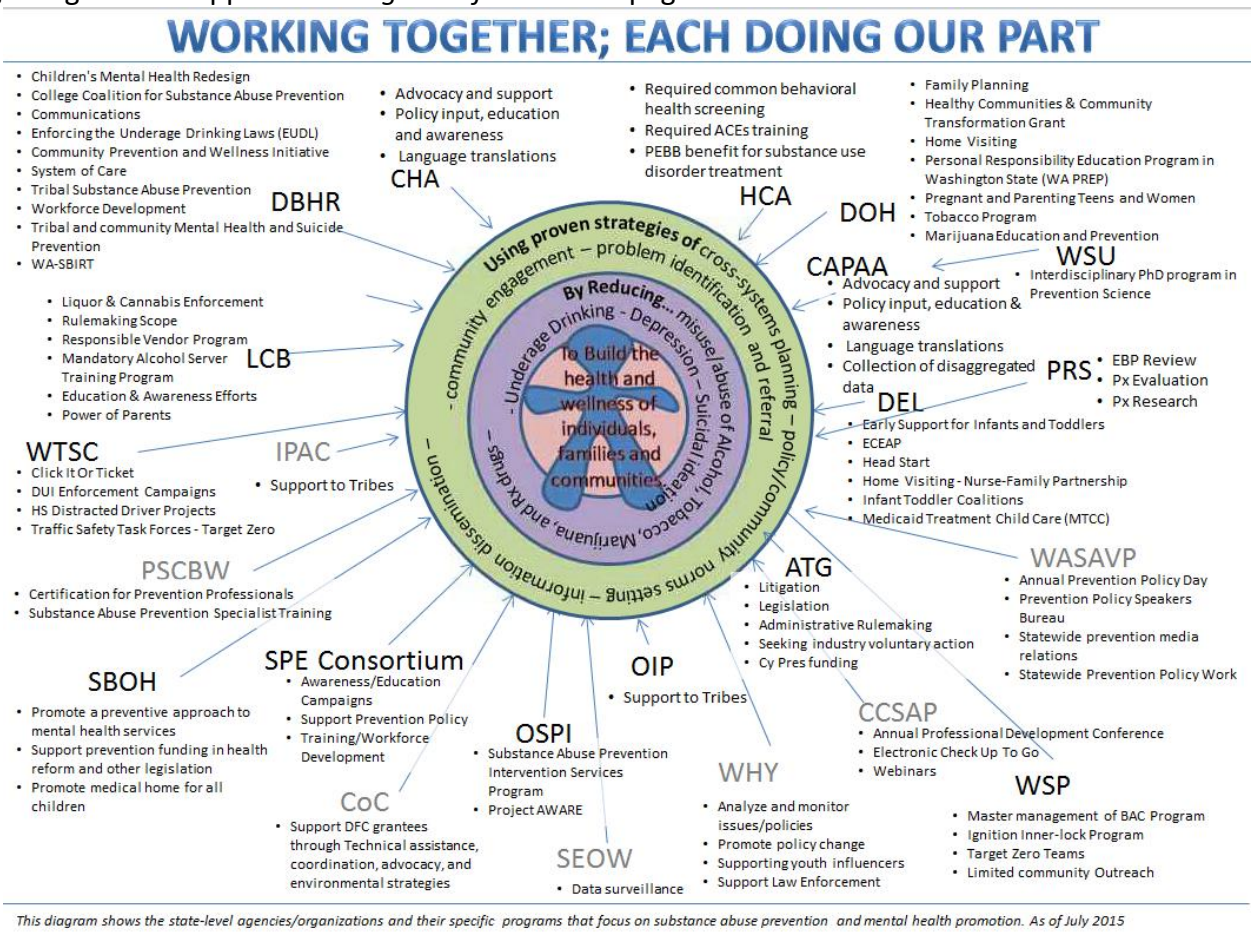
As mentioned previously, a key value of the Consortium is to honor and support the current efforts of each of the partners. Using the information from our Resources Assessment, we were able to review our current state-level supports for substance abuse prevention and mental health promotion, and to identify key opportunities to coordinate our services and efforts.

The following six primary strategies were identified as a result of the review of current work and as an opportunity for alignment to support our goal to build the health and wellness of individuals, families and communities in Washington State:

Strategy	Number of agencies/organizations providing a resource in this strategy	Number of resources directly or indirectly using this strategy
Cross-systems Planning/Collaboration:	11	24
Policy/Community norms:	9	26
Education:	11	65
Community Engagement/Coalition Development:	11	20
Information Dissemination:	9	20
Problem Identification and Referral:	5	14

Based on our Resources Assessment, we were able to identify a total of 1,935 local prevention activities[9] that are supported by the Consortium partners. An essential component of coordinated services is clear awareness and understanding of the various elements of state services and how they are delivered. The Consortium has agreed to refine and update this resource information annually to ensure that we are able to keep abreast of state-level resources and coordinate service where applicable and appropriate.

Below is an illustration of the state level agencies and organizations and their specific programs/initiatives that focus on substance abuse prevention and mental health promotion. For a full page diagram see Appendix - *Diagram of Resources* page 105.



This diagram shows the state-level agencies/organizations and their specific programs that focus on substance abuse prevention and mental health promotion. As of July 2015

In our assessment we reached beyond the traditional substance abuse prevention-focused agencies to include agencies and organizations that will assist in building connections for primary care and behavioral health integration efforts for example, the State Board of Health and the Health Care Authority. These two state entities play a fundamental role in partnering with the agencies that have primary care as their principal focus.

[9] *Note:* "Prevention activity" in this instance is specifically is defined by SAMHSA as any policies, programs, or practices implemented by the Consortium to address the [SPE grant] goals. When funds from multiple programs are used to finance an activity, that activity is said to be supported by coordinated funding streams.

Strategic direction for strategies, activities, and policy initiatives

Furthermore, in addition to identifying current resources directed to support these efforts, the Consortium also identified significant partnerships and opportunities for collaborative projects within these identified strategies.

Partnerships: Prevention activities and policies supported by partnerships among Consortium agencies

These opportunities were identified for specific partnership that will further our efforts:

- Supporting continued work by the Washington State Healthy Youth State (WHY) Coalition regarding policy and education campaigns focused on reducing underage drinking.
- Enabling cross-agency communication to support Washington State Patrol and Washington Association of Sheriffs and Police Chiefs (WASPC) in enforcement of the new law that states that during DUI enforcement, if someone under 16 years of age is in the vehicle and if there is a family relationship, law enforcement is required to immediately notify Child Protective Services.
- Facilitate and coordinate the multiple efforts to support local community coalitions, such as Drug Free Communities (DFC) grantees, Community Prevention and Wellness Initiative (CPWI) coalitions, Community Mobilization coalitions, and Community Transformation Grant (CTG) neighborhoods.
- Partner with groups that are working on prescription drug monitoring systems to coordinate efforts and monitor effectiveness.
- Continue the cross-agency collaboration supporting the implementation of the Healthy Youth Survey, as well as the effective use of the results.
- Partner with tribal programs and initiatives, such as the Northwest Tribes Task Force, which focuses on tribal laws and policies regarding prescription drug abuse.
- Continue partnership to support a searchable online resource for substance abuse prevention evidence-based list.
- Continued partnerships for data sharing and consideration for improvements to analysis and reporting of multiple data across multiple systems.
- Continue to provide opportunities for all partner agencies to participate in the organization and implementation of statewide training opportunities, including the Prevention Summit and the Youth Forum.

SPE Consortium Collaborative Strategies

What are we doing about it together?

Collaborative Strategies: Prevention activities and policies supported by coordinated resources

In addition to the direct services being offered by all of the partnering agencies and organizations as noted previously, and in order to capitalize on the unique role of the Consortium, we are focused on three main collaborative strategies:

- Policy review, advocacy, and promotion that is focused on the problem areas.
- Education/Workforce Development which includes professional development for providers across all healthcare and prevention systems.
- Information Dissemination/Public Awareness to include public media, education, and or awareness campaigns focused on policies and community norms that are specific to the problem area being addressed.

Beginning in September through December 2012, and annually thereafter, the Consortium engaged in rich discussions to further discern and elaborate on specific Action Plans related to the public campaigns, policy efforts, and professional development needed for each respective problem area (underage drinking; misuse/abuse of adult alcohol, marijuana, tobacco, and prescription drugs; depression; and suicide ideation). Annually we review and update the Action Plans as needed to make sure we are meeting our goals.

Action Plan Strategies by Behavioral Health Problem – updated 2015

Young Adults & Pregnant Women Alcohol and Marijuana Misuse/Abuse Prevention (updated 2015)
Workgroup Team: Work with existing College Coalition and Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to implement SPE strategies.
• ***Policy:*** Develop method for collecting statewide data on young adults for both those attending college and not attending college.
• ***Policy:*** Promote the use of SBIRT/BASICS among universities and colleges and 2) promote the use of SBIRT/BASICS for use with pregnant women.
• ***Policy:*** Improve care for young adults based on analysis of Young Adult Survey.
• ***Policy:*** Expand use of SBIRT program to be used to reach youth in public school settings.
• ***Education/Professional Development Strategy:*** Provide training and technical assistance to healthcare clinics to screen for tobacco use and refer to cessation resources.
• ***Information Dissemination/Public Awareness:*** Host or join a conference to teach about implementation of SBIRT.
Underage Drinking and Youth Marijuana Use Prevention (updated 2015)
Workgroup Team: Maintain integration with the state Washington Healthy Youth Coalition (WHY) to support the established priorities which include: Analyze and Monitor Issues/Policies; Promote Policy Change; Supporting Youth Influencers; and Support Law Enforcement.
• ***Policy:*** As appropriate, promote public or corporate policy changes with respect to emerging issues related to underage drinking and underage marijuana use.

- ***Policy:*** As appropriate, promote legislation, rule-making and other regulatory action related to prevention and reduction of underage drinking and underage marijuana use.
- ***Policy:*** Engage state agencies, community partners, and local providers to monitor impacts of marijuana legislation on state and communities.
- ***Policy:*** Advocate for prevention best practices with Liquor Cannabis Board in rule making for marijuana industry.
- ***Information Dissemination/Public Awareness:*** Analyze and disseminate information respect to emerging issues related to underage drinking and underage marijuana use.
- ***Information Dissemination/Public Awareness:*** Support community, regional, and statewide partners in distributing messaging for expanded underage drinking / youth marijuana use prevention toolkit.
- ***Information Dissemination/Public Awareness:*** Inform legislators and public officials of salient issues and developments relating to underage drinking and marijuana use through regular meetings with the Healthy Youth Coalition.
- ***Information Dissemination/Public Awareness:*** Use the Results Washington (A3) Process to inform public officials of salient issues and developments relating to underage drinking and marijuana use.
- ***Information Dissemination/Public Awareness:*** Support community, regional, and statewide partners in distributing messaging.
- ***Information Dissemination/Public Awareness:*** Communications campaign to educate the public regarding marijuana risks, resources, and understanding the new law pursuant to passage of Initiative 502 legalizing adult-use marijuana and disseminate via schools, community coalitions and networks, public health, and law enforcement.
- ***Information Dissemination/Public Awareness:*** Expand target audience for Website - Resources and FAQs.

Tobacco Misuse/Abuse Prevention (updated 2015)

Workgroup Team: Maintain State Inter-agency workgroup to focus on SPE strategies.

- ***Policy:*** Provide education and information on the creation of no-smoking policies to create smoke-free workplaces specifically targeting college and state agencies.
- ***Policy:*** Increase tobacco prevention funding by providing information to policy makers on the impacts of prevention.
- ***Policy:*** Reduce Youth Access to Tobacco by increasing the minimum legal sales age.
- ***Policy:*** Reduce depictions of tobacco use in youth-rated movies.
- ***Policy:*** Reduce youth access to vapor products.
- ***Education/Workforce development:*** Provide training and technical assistance to healthcare clinics to screen for tobacco use and refer to cessation resources in order to increase number of patients screened.
- ***Information Dissemination/Public Awareness:*** Establish and maintain public awareness of the causal link between smoking in movies and youth smoking.
- ***Information Dissemination/Public Awareness:*** Promote opportunities and resources that already exist with local community coalitions, law enforcement, health care providers, patients and patient advocates, Tribal entities, and public/individuals at risk.

- ***Information Dissemination/Public Awareness:*** Promote and update the website. Resources for questions about secondhand smoke to the website www.smokefreewashington.com and publicize the site in their respective organizations' materials.
- ***Information Dissemination/Public Awareness:*** Engaging existing coalitions to include tobacco prevention activities and mobilize the communities in the state against youth tobacco use.

Prescription Drug Misuse/Abuse and Overdose Prevention (updated 2015)

Workgroup Team: Maintain statewide workgroup to implement SPE strategies. Work collaboratively with existing statewide Unintentional Poisoning Workgroup and Information Dissemination committee.

- ***Policy:*** Identify funding sources for a broad scale social marketing campaign on prescription opiates and pain relief norms.
- ***Policy:*** Increase available funding by support funding requests and grant applications related to Rx Prevention projects and initiatives.
- ***Education/Workforce Development:*** Educate health care providers on revised Agency Medical Directors' Group (AMDG) *Interagency Guideline for Prescribing Opioids for Pain* to ensure appropriate opioid prescribing.
- ***Education/Workforce Development:*** Promote the use of the Prescription Drug Monitoring Program (PMP) among healthcare providers to help identify opioid use patterns, sedative co-prescribing, and indicators of poorly coordinated care/access.
- ***Education/Workforce Development:*** Promote accurate and consistent messaging about opioid safety and addiction by public health, law enforcement, community coalitions and others.
- ***Education/Workforce Development:*** Educate patients and the public on the importance and methods of proper storage and disposal of prescription pain medication.
- ***Information Dissemination/Public Awareness:*** Conduct an inventory of existing patient materials on medication safety for families and children. Develop new materials as needed as tools for medical providers and parents.
- ***Information Dissemination/Public Awareness:*** Develop materials to clarify best practices and correct misconceptions about disposal.

Mental Health Promotion, Depression & Suicide Ideation Prevention (updated 2015)

Workgroup Team: Re-establish a statewide workgroup involving Suicide Prevention Steering Committee and Project Aware Grant to implement SPE strategies. Identify strategies to implement from ESHB2315 State Suicide Prevention Plan.

- ***Education/Workforce Development:*** Enhance coordination, planning and activities between multiple child serving and intervention agencies and groups addressing suicide prevention.
- ***Education/Workforce Development:*** Provide/ support training to enhance workforce knowledge of Youth Mental Health First Aid response in high-need communities.
- ***Information Dissemination/Public Awareness:*** Collect data and resources to provide to communities including 1) Prevention and intervention material to reduce potential for youth suicide and depression and 2) Response (Post-intervention) to communities experiencing crisis of multiple suicides/contagion.
- ***Information Dissemination/Public Awareness:*** Increase Primary Care Provider's knowledge of role in suicide prevention. Support and disseminate information for PCP's in suicide prevention.

Section 5: Implementation

In order to accomplish our goals, the Consortium is committed to continuing support for the current resources directed to these efforts, as well as opportunities for partnerships and collaborative projects within identified strategies. We will continue to review and update our strategies as needed.

Prevention activities and policies supported by Consortium Partners

As shown in the matrix below, the Consortium partners each play a role in providing direct or indirect substance abuse prevention and mental health promotion services.

* Not updated in 2015 Update.

Agency – Resource (List of Acronyms is available in the Appendix - *List of Agencies Acronyms and Abbreviations*, page 53)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
AGO - Litigation, Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action	x					
CCSAP - Webinars	x	x				
CCSAP - Year End Professional Development Conference	x					
CCSAP - Electronic Check Up to Go	x	x				
DBHR - System of Care	x	x	x		x	
DBHR – Community Prevention and Wellness Initiative	x	x	x	x	x	x
DBHR - Children's Mental Health Redesign	x	x	x		x	x
DBHR - Tribal Substance Abuse Prevention	x	x	x	x	x	x
DBHR - Enforcing the Underage Drinking Laws (EUDL)	x					
DBHR - College Coalition For Substance Abuse Prevention	x	x	x	x	x	x
DBHR - Workforce Development	x	x	x			
DBHR - Communications	x	x	x	x	x	x
DBHR - Prevention Research Subcommittee	x		x	x	x	
DEL - Infant Toddler Regions		x	x			
DEL - Home Visiting Programs	x	x	x			x
DEL - Head Start	x	x	x			
DEL - Early Support for Infants And Toddlers	x	x	x			x
DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool		x				
DEL - Medicaid Treatment Child Care Program	x	x		x	x	x
DOH - Tobacco Program	x					
DOH - Project Launch Grant*		x	x			
DOH - Home Visiting*	x	x	x	x		x
DOH - Early Childhood Comprehensive Systems Grant*		x				
DOH - Children With Special Health Care Needs*		x				x

Agency – Resource (List of Acronyms is available in the Appendix - *List of Agencies Acronyms and Abbreviations*, page 53)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
DOH - Personal Responsibility Education Program in Washington State (WA PREP)			x			
DOH - Pregnant and Parenting Teens And Women*			x		x	
DOH - Coordinated School Health Program*	x	x			x	
DOH - Healthy Communities & Community Transformation Grant*	x	x	x			x
DOH - Family Planning*	x	x	x		x	x
OJJ - Juvenile Detention Alternatives Initiative*				x		
HCA - Service	x					x
HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.	x	x	x			x
HCA - Required Training on Adverse Childhood Experiences	x	x	x			x
HCA - PEBB Benefit for Substance Use Disorder Treatment	x					
IPAC - Support Tribes	x	x	x	x		x
LCB - Agency Initiatives	x					
LCB - Power of Parents	x					
LCB - Liquor Enforcement	x					
LCB - Rulemaking Scope	x					
LCB - Responsible Vendor Program	x					
LCB - Mandatory Alcohol Server Training Program	x					
LCB - Education and Awareness Efforts	x					
OIP - Support Tribes	x	x	x	x		x
OSPI - Substance Abuse Prevention Intervention Services Program	x	x	x			
OSPI – Project Aware		x	x			
PSCBW - Certification for Prevention Professionals	x	x	x	x	x	
PSCBW - Substance Abuse Prevention Systems Training	x					
WHY- Analyze and Monitor Issues/Policies	x					
WHY- Promote Policy Change	x					
WHY - Supporting Youth Influencers	x					
WHY - Support Law Enforcement	x					
SEOW - Data Surveillance	x	x	x	x		
CoC - Federal Drug Free Communities Support Program	x					
WASAVP - Annual Prevention Policy Day	x		x		x	
WASAVP - Statewide Prevention Policy Work	x		x	x	x	
WASAVP - Statewide Prevention Medial Relations	x		x	x	x	

Agency – Resource (List of Acronyms is available in the Appendix - *List of Agencies Acronyms and Abbreviations*, page 53)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
WASAVP - Prevention Policy Speakers Bureau	x				x	
SBOH - Health Disparities Council Behavioral Health Advisory Committee	x	x				
SBOH - Support Prevention Funding in Health Reform and Other Legislation	x					x
SBOH - Promote Medical Home for All Children	x	x				
SBOH - Promote A Preventive Approach to Mental Health Services						x
WSP - Master Management of BAC Program	x			x	x	
WSP - Limited Community Outreach	x			x	x	
WSP - Ignition Inner-Lock Program	x					
WSP - Target Zero Teams	x			x		
WSU - Interdisciplinary PhD Program in Prevention Science	x	x	x	x	x	
WTSC - Click It or Ticket	x					
WTSC - HS Distracted Driver Projects	x					
WTSC - DUI Enforcement Campaigns	x					
WTSC - Traffic Safety Task Forces - Target Zero	x					

The Consortium believes that by continuing support for services provided by each agency/organization, coupled with working collaboratively on state-level strategies, we will contribute to the overall collective impact.

Structural Support for Collaboration

The Consortium partners decided to retain the Consortium as a coalition of state agencies and organizations that will support the implementation of the agreed upon collaborative strategies. The Consortium will meet regularly every other month as a full Consortium with committees meeting in the interim. All of the partnering agencies of the current Consortium have agreed to continue to participate on the Consortium. DBHR has committed to provide ongoing staff support for the Consortium.

Our leadership structure and working committees focus on in-depth analysis of our problem areas and action steps related to each given collaborative strategy. Each partner agency and organization has committed through a Memoranda of Understanding to support specific commitments and reporting requirements on action step(s) agreed upon in this Five-Year Strategic Plan.

In accordance with our plan, the next year will be focused on specific action steps related to the identified strategies: public campaigns, policy efforts, and professional development needed for each of the seven specified problem areas. In order to more fully develop explicit action plans for each of

the problem areas (alcohol, marijuana, tobacco, prescription drugs, depression and suicide ideation), we established a learning community structure to provide guidance on presentations and information to be prepared. Each Steering Committee was required to create and provide presentations on information such as, additional data, literature reviews that emphasize leverage points for meaningful action, expert panels to discuss issues in-depth, and action plans. Upon agreement on each action plan, an Action Plan Team was established to carry out the tasks. Each year we will review and update the Action Plans as needed to make sure we are meeting our goals. See *Appendix 6*- for a summary of the specific partners committed to contributing to working on each Action Plan.

Additionally, the Consortium will look to involve new partners based on strategic direction and projects within this plan. For example, we are interested in inviting the Department of Labor and Industries to participate in the development of the activities of our action plans related to workplace and employment. Lastly, we will seek youth involvement in our planning through our established youth leadership network.

Implementation plan and a 5-year timeline

As stated above, in addition to the commitment from each of the Consortium partners to support and engage in the implementation of the identified strategies, we will also develop new partnerships when necessary to fully implement.

It is important to reiterate that, while we have made considerable effort to be inclusive and gather the best information available for our planning, we also recognize that this plan will be used as the foundation for ongoing planning as we move into the future. It is important that we continue to review, analyze, and update the strategies within this plan as needed to meet the most relevant needs of our time. Moreover, in the coming year we will spend considerable time to develop specific action plans for each of these strategies.

The table on the following pages is an overview of key tasks to be included in the Consortium Collaborative Strategies.

Implementation Plan Timeline

Task	Lead	2012	2013	2014	2015	2016
Policy Consortium						
Consortium bi-monthly meetings	DBHR	X	X	X	X	X
Renew leadership positions biennially	Consortium	X		X		X
Set evaluation targets for selected indicators	Consortium	X				
Steering Committee meetings		X				
Underage Drinking (WHY)	Steering Committee	X				
Alcohol	Steering Committee	X				

Task	Lead	2012	2013	2014	2015	2016
Marijuana	Steering Committee	X				
Tobacco	Steering Committee	X				
Prescription Drugs	Steering Committee	X				
Depression	Steering Committee	X				
Suicide Ideation	Steering Committee	X				
Establish Action Plan Teams	Each Team	X	X	X	X	X
Establish meeting schedules for Action Plan Teams	Each Team	X	X	X	X	X
Biennial review of resources assessment	Resources Assessment Workgroup/Consortium	X	X		X	
Biennial review of data assessment	SEOW/Consortium	X	X		X	
Public media, education, and or awareness campaigns						
Identify emerging opportunities	Consortium	X	X	X		X
Prioritize messages to be developed	Consortium	X				
Identify issues for 1st campaign	Consortium	X				
Develop detailed work plan for campaign	Action Plan Team	X				
Implement work plan for 1st campaign	Action Plan Team	X	X	X		
Develop message	Action Plan Team	X				
Test message	Action Plan Team	X				
Refine message	Action Plan Team	X				
Establish method to disseminate strategies	Action Plan Team		X			
Disseminate message via state partners	Consortium		X			
Disseminate message via local communities	Consortium		X			
Develop detailed work plan for 2nd campaign	Action Plan Team		X			
Implement work plan for 2nd campaign	Action Plan Team			X	X	
Develop detailed work plan for 3rd campaign	Action Plan Team			X		

Task	Lead	2012	2013	2014	2015	2016
Implement work plan for 3rd campaign	Action Plan Team			X	X	X
Policy review, advocacy and promotion						
Identify emerging opportunities	Consortium	X	X	X	X	X
Develop action initiative for local coalitions to use for 1st priority initiative	Action Plan Team	X		X		X
Develop message	Action Plan Team	X		X		X
Test message	Action Plan Team	X		X		X
Refine message	Action Plan Team	X		X		X
Establish method to Disseminate strategies	Action Plan Team		X		X	
Disseminate message via state partners	Consortium		X		X	
Disseminate message via local communities	Consortium		X		X	
Develop detailed work plan for 2nd initiative	Action Plan Team		X			
Implement work plan for 2nd initiative	Action Plan Team			X	X	
Develop detailed work plan for 3rd initiative	Action Plan Team			X		
Implement work plan for 3rd initiative	Action Plan Team			X	X	X
Review screening practices	Steering Committee	X		X		X
Determine effective methods to integrate prevention into screening	Action Plan Team		X		X	
Meet with primary care and behavioral health care providers	DOH, DBHR, HCA, SBOH		X		X	
Develop understanding of Medicaid among prevention providers	HCA	X		X		X
Professional development across all systems						
Identify emerging opportunities	Consortium	X	X	X	X	X

Task	Lead	2012	2013	2014	2015	2016
Develop work plan for 'new professional orientation'	Action Plan Team	X				
Identify resources	Action Plan Team	X				
Establish process	Action Plan Team	X				
Create bureau of mentors	Action Plan Team		X			
Provide mentorship	Action Plan Team		X	X	X	X
Determine training topics to be included in cross systems training	Consortium	X	X	X	X	X
Identify host agency for training	Action Plan Team	X	X	X	X	X
Determine method for delivering training	Action Plan Team	X	X	X	X	X
Arrange logistics	Action Plan Team	X	X	X	X	X
Conduct training	Action Plan Team	X	X	X	X	X
Follow-up from training	Action Plan Team	X	X	X	X	X
Follow up from results of feasibility studies						
Prioritize timeframe for each study	Consortium	X				
Establish Teams to thoroughly review all findings and develop next steps	Consortium	X				
Determine if new requirements will be put into place and timeframe for implementing	Consortium		X			
If needed, develop work plan	Consortium		X			
If needed, establish Team to implement work plan	Consortium		X			
Follow up from Primary Care Demonstration Projects						
Present at Consortium meeting	Demonstration Project sites	X				
Coordinate presentations to take place at state conference	DBHR	X				
Integrate related information into DOH trainings	DOH, DBHR	X				

Task	Lead	2012	2013	2014	2015	2016
Establish Team to thoroughly review all findings and develop next steps	Consortium	X				
Determine if additional projects should be supported	Consortium		X			
If so, develop work plan	Action Plan Team		X			
If so, establish Team to implement work plan	Consortium		X			
Continue to examine integrating data reporting systems with additional partners						
Presentation at Consortium meeting of various data systems	Consortium Partners	X				
Determine if additional systems would be combined/connected	Consortium Partners	X				
If so, develop work plan	Action Plan Team		X			
If so, establish Team to implement work plan	Consortium		X			

Plan for Cultural Competency

The Consortium recognizes cultural competency as a key value, and we must be diligent in attending to it throughout all of our efforts. In order to be culturally competent, it is essential to understand the elements that lead to more fully inclusive and thoughtful planning and implementation.

The U.S. Department of Health and Human Services defines cultural competence as "a set of behaviors, attitudes, and policies that come together in a system, agency, or program or among individuals, enabling them to function effectively in diverse cultural interactions and similarities within, among, and between groups." Culture and language play a significant role in the design, delivery, accessibility, acceptability, and effectiveness of prevention services and activities. We know that both the Consortium and the individual members need to build on these competencies.

As individuals, we are committed to increasing our understanding of cultural competency and moving through cultural knowledge, awareness, and sensitivity to competence.[10] We also understand that cultural competence extends the concept of self-determination to the community. Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g., neighborhood, civic, and advocacy associations;

[10] Community Anti-Drug Coalitions of America National Coalition Institute Cultural Competence Primer. 2007.

local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers). [11]

As we know from the work done at the National Center for Cultural Competence, Georgetown University, building a culturally competent effort requires that organizations[12]:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders, and communities.

The Consortium will use tools[13],[14] for ongoing assessment of our structure and support of membership, policies, structures, processes, and activities that include these critical components. We will conduct assessments regularly and make adjustments to effectively meet the needs of our state's population.

In 2015 we hosted a full day training opportunity focused on engaging communities to reduce health disparities in Washington State. Since 2013 we have hosted several presentations to inform and educate the Consortium membership. Such presentations include an overview of tobacco related health disparities report by the Department of Health, an overview of the services and needs addressed by the Commission on Hispanic Affairs, as well as sharing information and opportunities to participate in national webinars for priority populations including LGBTQ, Native Americans, Military Families and Veterans.

[11] Adapted from Cross, T. et al, 1989
[12] Adapted from - http://nccc.georgetown.edu/foundations/frameworks.html. Accessed June 2012.
[13] "Promoting Cultural Diversity and Cultural Competency- Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs Goode, T., 2002, NCCC, GUCDC.
Click on Resources and Tools for checklists that reflect these values and principles in policy and practice. Accessed June 2012.
[14] Taylor, T., & Brown, M., 1997, Georgetown University Child Development Center, (GUCDC) University Affiliated Program.

Section 6: Evaluation

Plan for tracking and reviewing evaluation information (baseline and outcomes data)

Based on our long-term commitment to collecting and reporting high quality data, Washington has an excellent data infrastructure, combining a management information system (MIS), a statewide youth survey, and a social indicator database that reports archival indicators at the school district level of geography. These systems are based on a theoretical framework that underpins substance abuse prevention.

The Consortium partners have a number of reporting systems that support our ability to compile data related to each level of analysis on our intended outcomes. A complete list of data sources used by Consortium partners is included in the *Appendix - Washington State Key Data Sources*, *page 58*. These data provide information on social impact indicators, as well as local community and service level data. Although, due to the complexities of the various funding allocation methods used by state agencies and the focus of services being delivered, we are not able to combine all service data collection systems, we currently have two state agencies committed to using a single system to collect service data from their respective providers. Furthermore, as one of our recent enhancements from the SPE grant projects, the Strategic Prevention Framework planning module has been added on the demo system of the prevention MIS. We will be able to begin testing and pre-loading data, and training staff and providers for full implementation of the new planning module with the start of the next fiscal year, July 2013. Regardless of which system is 'holding' the data, we have developed significant data-sharing agreements that allow for us to easily collect and compile valuable data not only for our assessments, but also to use in our evaluation.

The Consortium, under the guidance of the SEOW, selected the best measures available that provide points from which we can monitor our progress. This is not intended to be a finite list of all possible measures related to these issues. In January 2013, the Consortium finished an in-depth review of each of these indicators and set five-year targets for the **Intermediate Outcomes: Behavioral Health Problems**.

The tables on the following pages summarize the data indicators we will be monitoring over time related to our outcomes.

Long-Term Outcomes: Consequences	Source/ Year Baseline[15]
Chronic Disease	**DOH 2010**
▪ Alcohol related injury/accident (hospitalization)	Age 10-17: 12.8 per 100,000 Age 18-25: 83.8 per 100,000
▪ Other drugs related injury/accident (hospitalization) under	Age 10-17: 56.9 per 100,000 Age 18-25: 195.2 per 100,000
▪ Tobacco related deaths under age 10-17; 18-25 ▪ Tobacco related injury/accident (hospitalization) under age 10-17; 18-25	*N's are currently too small to validate. We will continue to monitor.*
▪ Alcohol related deaths	Age 10-17: 3.7 per 100,000 Age 18-25: 19.1 per 100,000
▪ Other drugs deaths	Age 10-17: 1.1 per 100,000 Age 18-25: 15.2 per 100,000
Crime	**UCR 2010**
▪ For Arrests, Alcohol Violation Age 10-17	Rate of 4.8 per 1000
▪ For Arrests, Drug Violation 10-17	Rate of 4.8 per 1000
▪ For Arrests, Alcohol Related Age 18-24	Rate of 25.8 per 1000
▪ For Arrests, Drug Related 18-24	Rate of 13.7 per 1000
Low Graduation Rates	**OSPI 2009**
▪ HS Extended Graduation Rate (Includes On-Time)	79%
Suicide	**CHARS 2010**
▪ For Suicide and Attempts Age 10-17:	Rate of 40.5 Per 100,000
▪ For Suicide and Attempts Age 18-25:	Rate of 116.0 Per 100,000
Fatalities and Serious Injury From Traffic Crashes	**WSDOT 2010**
▪ # Alcohol-Related Traffic Injuries (Age 16-25)	Rate of .6 per 10,000 (16-17) Rate of 1.8 per 10,000 (18-20) Rate of 1.1 per 10,000 (21-25)
▪ # Alcohol-Related Traffic Fatalities (Age 16-25)	Rate of .3 per 10,000 (16-17) Rate of .5 per 10,000 (18-20) Rate of .6 per 10,000 (21-25)

[15] Technical notes related to each baseline indicator are maintained within original data source.

Intermediate Outcomes: Behavioral Health Problems	Source/ Year 2011 Plan Baseline[16]	2013 Plan Update	2015 Plan Update	Original 2017 Target *10% decrease from Baseline*	*Updated 2017 Target 10% decrease from HYS 2014*
Underage Drinking	**HYS 2010**	**HYS 2012**	**HYS 2014**		
▪ Drank Alcohol In Last 30 Days*	10th Grade: 27.7%	23.3%	**21.0%**	24.8%	*19%*
▪ Experimental Use of Alcohol	10th Grade: 10.9%	8.5%	**9.2%**	9.9%	*8%*
▪ Ever drank Alcohol			6th Grade: 21%		*19%*
▪ Heavy Use of Alcohol	10th Grade: 8.2%	7.1%	**5.8%**	7.2%	*5%*
▪ Problem Drinking	10th Grade: 10.4%	9.4%	**6.9%**	9.0%	*6%*
▪ Binge Drinking (any)	10th Grade: 16.2%	14.3%	**10.6%**	14.6%	*10%*
Marijuana Misuse/Abuse	**HYS 2010**	**HYS 2012**	**HYS 2014**		
▪ Used Marijuana In Last 30 Days*	10th Grade: 20.0%	19.3%	18.1%	18.0%	18%
▪ Used Marijuana In Last 30 Days*			6th Grade: 1%		*.99%*
▪ Used Marijuana 6+ Days	10th Grade: 8.4%	8.6%	7.9%	7.6%	7.6%
Prescription Misuse/Abuse	**HYS 2010**	**HYS 2012**	**HYS 2014**		
▪ Used Pain Killer In Last 30 Days*	10th Grade: 8.3%	6.0%	**4.6%**	7.5%	*4%*
▪ Used Ritalin-Type Drug In Last 30 Days	10th Grade: 3.5%	2.8%		3.2%	
Tobacco Misuse/Abuse	**HYS 2010**	**HYS 2012**	**HYS 2014**		
▪ Smoked Cigarettes In Last 30 Days*	10th Grade: 12.7%	9.5%	7.9%	11.4%	*7%*
▪ *E-cigarettes / Vapor pens*	10th Grade		18%		*16%*
▪ *Any tobacco use (cigarettes and smokeless tobacco)*			6th Grade: 2%		*1.8%*

*Signifies primary target.
[16] Technical notes related to each baseline indicator are maintained within original data source.

Intermediate Outcomes: Behavioral Health Problems	Source/ Year 2011 Plan Baseline[17]	2013 Plan Update	2015 Plan Update	Original 2017 Target *10% decrease from Baseline*	*Updated 2017 Target 10% decrease from HYS 2014*[18]
Adult - Alcohol Misuse/Abuse	**BRFSS 2010**				
▪ Women Report Alcohol Use any time During Pregnancy*	17.0%			15.3%	15%
Depression	**HYS 2010**	**HYS 2012**	**HYS 2014**		
▪ Sad/Hopeless In Past 12 Months*	10th Grade: 29.8%	30.9%	34.9%	26.8%	27%
Suicide Ideation	**HYS 2010**	**HYS 2012**	**HYS 2014**		
▪ Suicide Ideation*	10th Grade: 17.6%	18.8%	20.5%	15.8%	16%

*Signifies primary target.
[17] Technical notes related to each baseline indicator are maintained within original data source.
[18] Red text indicates a new lower target percentage fro the original 2017 target.

Short-term Outcomes: Intervening Variables	Source/ Year Baseline[19]
Access	**HYS 2010** ▪ 10th graders who got alcohol: – 7% bought it from a store – 18% gave money to someone to get it for them – 55% got it from friends or at a party – 27% home w/o permission ▪ 10th graders who ever used 'pain killers to get high': – 30% report using own prescription – 29% report getting it from a friend **LCB 2010** ▪ 14,425 state licenses (rate of 2.15/1000 persons) *[note: expect significant increase per I-1183]*
Availability	**HYS 2010** ▪ 10th graders: – 56% report sort of or very easy to get alcohol – 54.4% report sort of or very easy to get marijuana – 52.7% report sort of or very easy to get cigarettes
Community norms	**HYS 2010** ▪ 10th graders: – 75.5% report that 'adults in the community think it's wrong or very wrong' – 70% saw 'anti-alcohol ads' – 55% parents talked about it ▪ 34.5 % of 10th graders report laws and norms favorable toward drug use ▪ 8% of 10th graders report 'harassed due to health/disability' **NSDUH 2008/ 2009** ▪ 17% of young adults (18-25 years) report marijuana use in past 30 days
Enforcement	**HYS 2010** ▪ 10th graders: – 26% think the police would catch a kid drinking (response of 'yes' or 'YES!') – 31.2% think the police would catch smoking marijuana (response of 'yes' or 'YES!')
Perception of harm	**HYS 2010** ▪ 10th grade: – 27% think that there is no or slight risk to using marijuana regularly

[19] Technical notes related to each baseline indicator are maintained within original data source.

Short-term Outcomes: Intervening Variables	Source/ Year Baseline[19]
Policies	**HYS 2010** ▪ 10th graders: – 33.9% think school policies about alcohol and drugs are usually enforced (response of 'definitely yes') – 25.2% think 'no smoking policies' at school are usually enforced (response of 'definitely yes')
Traumatic Experiences	**BRFSS 2010** ▪ ACE: Family Alcohol Use For those that live w/ anyone who has a problem drinker/alcoholic: – 20% Report Binge Drinking – 25% Report Smoking Cigarettes ▪ ACE: Family Drug Use For those that live w/ anyone who used illegal street drugs or who abused prescription medications: – 28% Binge Drinking – 33% Cigarettes – 18% Marijuana – 2% Pain Killer ▪ ACE: Family Mental Illness For those that live w/ anyone who was depressed, mentally ill, or suicidal: – 20% Binge Drinking – 22% Cigarettes – 12% Marijuana ▪ ACE: Incarcerated Household Member For those that live w/ anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility: – 25% Binge Drinking – 38% Cigarettes – 21% Marijuana – 3% Pain Killer ▪ Childhood Trauma – Source: *RDA Report 11.178: Nov. 2012.* – 1.7 = Average number of ACES for Medicaid youth age 12-17 (SFY 2008 data) – 28.3% = Percentage of the identified DSHS youth clients during state fiscal year (SFY) 2008 that had experienced 3 or more ACES

The Consortium will continue to review these indicators regularly and update and revise as necessary to have the best measures in place. We will also monitor related indicators such as healthcare costs,

individual productivity, and employment outcomes; however, they are not included in the preceding tables due to the expected upcoming variance based on significant changes to overall healthcare systems. Furthermore, while we can gather data about college students biennially using the National College Health Association Health & Risk Behaviors Survey, there is a dearth of data about health/risk of young adults who are not attending college, except from police records. However, we are working to increase the data we have on young adults, including growing the number of young adults who complete the Behavioral Risk Factors Surveillance System to address this deficit. Consortium partners have also inquired with the national partners regarding the data collection on coalitions from the COMET and CADCA Survey to pull Washington State data. We will also continue examining ways for us to expand our ability to collect consistent state-level data on emerging issues, for example medical marijuana.

The State Epidemiological Outcomes Workgroup (SEOW) will continue to conduct surveillance on relevant outcome indicators and advise the Consortium of significant changes.

Additional measures will be determined to provide evaluation information as the action plans for specific problem area strategies are further developed.

Required reporting for Substance Abuse Mental Health Services Administration (SAMHSA)

In addition to the evaluation efforts that support the specific long-, intermediate-, and short-term outcomes related to our strategies as shown in the logic model, we have set the following goals in coordination with the national Government Performance and Results Act (GPRA).

Below is a table showing the reporting elements baseline from state fiscal year 2011 and the projected five-year target. **(Note: This was not assessed in the 2015 Update.)**

Measure	Baseline (State FY11)	Target (State FY16)
Percentage of communities[20] reporting data to the grantee system[21]	90.6%	100%
Percentage of communities submitting process data through grantee system. [22]	90.6%	100%
Percentage of direct service providers submitting process data through grantee system.[23]	9%	12%
Percentage of communities submitting outcome data through grantee system[23]	54.7%	66%
Percentage of direct service providers submitting outcome data through grantee system[24]	3%	3.5%

The Consortium will review outcome and process data annually to inform our evaluation and make adjustments as needed. Additionally, the Consortium will use this information to determine next steps for using this information including, how to inform partners, local organizations, and general public of pertinent data.

The Consortium continues to look forward to the implementation of this plan as an opportunity to infuse energy into our system as we enhance our capacity to support community level strategic prevention planning and service.

[20] For the purposes of the required SAMHSA reporting, 'community' is being defined as, "Counties and Federally Recognized Tribes." Many of the Consortium partners contract with county governments and Federally Recognized Indian Nations. In some cases, two counties have a joint contract. In some cases, counties have opted not to accept funding, in which case a non-governmental or quasi-governmental agency is contracted with for services. Tribes have the option of spending funding on Prevention, Treatment, or both Prevention and Treatment.

[21] *Method : Count of distinct DBHR counties and federally recognized tribes reporting in PBPS (the grantee system) in the specified state fiscal year 2011 (Excludes OSPI) Source: PBPS.*

[22] *Method : Count of distinct DBHR counties and federally recognized tribes reporting in PBPS (the grantee system) in the specified state fiscal year 2011 (Excludes OSPI) Source: PBPS.*

[23] *Method : Count of distinct DBHR counties and federally recognized tribes reporting in PBPS (the grantee system) in the specified state fiscal year 2011 (Excludes OSPI) Source: PBPS. Count of service providers identified in the SPE Resource Assessment by the partner agencies. Source: SPE Resource Assessment map – statewide count*

Appendix

APPENDIX

1. List of Agencies Acronyms and Abbreviations

- College Coalition for Substance Abuse Prevention (CCSAP)
- Department of Early Learning (DEL)
- Department of Health (DOH)
- Department of Social and Health Services (DSHS)
- Division of Behavioral Health and Recovery (DBHR)
- Frontiers of Innovation (FOI)
- Health Care Authority (HCA)
- Indian Policy Advisory Committee (IPAC)
- Liquor Control Board (LCB) *Changed in 2015 to Liquor and Cannabis Board(LCB)*
- Office of Indian Policy (OIP)
- Office of Juvenile Justice (OJJ)
- Office of Superintendent of Public Instruction (OSPI)
- Office of the Attorney General (AGO)
- Prevention Specialist Certification Board of Washington (PSCBW)
- State Board of Health (SBOH)
- State Epidemiological Outcome Workgroup (SEOW)
- Washington Association for Substance Abuse and Violence Prevention (WASAVP)
- Washington Drug Free Communities Coalition of Coalition
- Washington Healthy Youth Coalition (WHY)
- Washington National Guard (Nat'l Guard)
- Washington State Commission on Asian Pacific American Affairs (CAPAA)
- Washington State Commission on Hispanic Affairs (CHA)
- Washington State Institute for Public Policy (WSIPP)
- Washington State Patrol (WSP)
- Washington State Prevention Research Sub-Committee (Px Research Sub-Committee)
- Washington Traffic Safety Commission (WTSC)

2. SPE Consortium Partner List

Partner Agency/Organization	Policy Consortium Representative
Commission on Asian Pacific American Affairs (CAPAA)	Michael Itti, Executive Director Brianne Ramos, Project Coordinator
College Coalition for Substance Abuse Prevention (CCSAP)	Jason Kilmer, Research Assistant Professor and Asst. Director of Health/ Wellness, University of Washington
Department of Early Learning (DEL)	Veronica Santangelo, Medicaid Treatment Child Care Administrator
Department of Health (DOH), Division of Prevention and Community Wellness	***Consortium Co-chair*** David Hudson, Section Manager, Office of Healthy Communities Cristal Connelly, Marijuana Prevention Education Coordinator Frances Limtiaco, Tobacco Prevention Program Manager and Health Equity Consultant
Department of Social and Health Services (DSHS), Division of Behavioral Health & Recovery (DBHR)	***Consortium Co-chair*** Sarah Mariani, Behavioral Health Administrator
Department of Social and Health Services (DSHS), Frontiers of Innovation (FOI)	Anne Stone, State Director
Department of Social and Health Services (DSHS), Office of Indian Policy (OIP)	Tim Collins, Director
Department of Social and Health Services (DSHS), Office of Juvenile Justice (OJJ)	Currently Vacant
Health Care Authority (HCA)	Casey Zimmer, RN, Occupational Nurse Consultant
Indian Policy Advisory Committee (IPAC)	Currently Vacant
Liquor Cannabis Board (LCB)	Mary Segawa, Public Health Education Liaison
Office of Superintendent of Public Instruction (OSPI)	Krissy Johnson, Program Supervisor, Student Assistance / Dropout Prevention Bill Evans, Program Consultant, Student Support Programs Mandy Paradise, Project AWARE Program Supervisor
Office of the Attorney General (AGO)	Currently Vacant *(previously, Rusty Fallis, Assistant Attorney General)*
Prevention Specialist Certification Board of Washington (PSCBW)	Liz Wilhelm, Education and Ethics Committee Chair Gunthild Sondhi, President Stephanie Brooks, Committee member
State Board of Health (SBOH)	Michelle Davis, Executive Director
State Epidemiological Outcome Workgroup (SEOW)	Katie Weaver Randall, SEOW Co-chair; Evaluation and Quality Assurance Administrator, DBHR
Washington Association for Substance Abuse and Violence Prevention (WASAVP)	Derek Franklin, President
Washington Healthy Youth Coalition (WHY)	Beatriz Mendez, EUDL Grant Coordinator, DBHR
Washington State Commission on Hispanic Affairs (CHA)	Uriel Iñiguez, Executive Director
Washington State Drug Free Communities Coalition of Coalitions (CoC)	Lisa Stewart, Mercer Island Communities that Care Coalition
Washington State Institute for Public Policy (WSIPP)	Adam Darnell, Senior Research Associate
Washington State Patrol (WSP)	Lieutenant Dan L. Sharp
Washington State Prevention Research Sub-Committee	Elizabeth Weybright, Associate Professor Dept. of Human Development
Washington Traffic Safety Commission (WTSC)	Dick Doane, Research Investigator

Staff to Consortium provided by Division of Behavioral Health and Recovery (DBHR) 2014-present:

- Policy Consortium Lead Staff: Julia Havens, *Prevention System Development Manager*
- Policy Consortium Support Staff: Lucilla Mendoza, *Prevention System Manager*

3. Brief Overview of Strategic Prevention Framework (SPF)

The Strategic Prevention Framework (SPF) was originally developed by the federal Substance Abuse and Mental Health Services Administration.[24] SAMSHA's Strategic Prevention Framework is a comprehensive planning process designed to help states and communities build the infrastructure necessary for effective and sustainable prevention. The Strategic Prevention Framework (SPF) uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span. The SPF is built on a community-based risk and protective factors approach to prevention and a series of guiding principles that can be utilized at the federal, state/tribal and community levels.

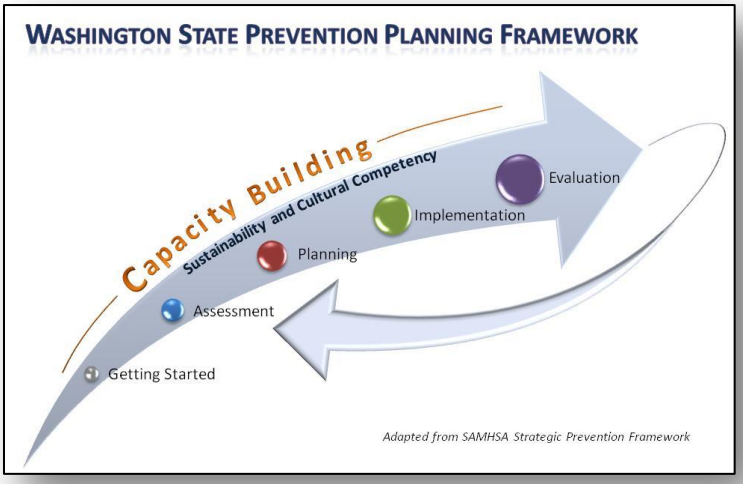
The idea behind SPF is to use the findings from public health research along with evidence-based prevention programs to build capacity within states/tribes/territories and the prevention field. This in turn will promote resilience and decrease risk factors in individuals, families, and communities.

The Strategic Prevention Framework Steps require states, territories, federally recognized tribes and tribal organizations, and communities to systematically:

- Assess their prevention needs based on epidemiological data.
- Build their prevention capacity.
- Develop a strategic plan.
- Implement effective community prevention programs, policies and practices.
- Evaluate their efforts for outcomes.

Throughout all five steps, implementers of the SPF must address issues of sustainability and cultural competence.

The State Prevention Enhancement Policy Consortium used this overall planning framework for our process. Based on our learning from the Strategic Prevention Framework State Incentive Grant (SPF-SIG) process, for the purposes of prevention planning in Washington State, we have added a "Getting Started" section and have included "Capacity" as an ongoing step throughout the process. It is expected that all tasks will be conducted in a culturally competent manner.



The following is a brief description of each part of this process.

Cultural competence

[24] SAMHSA, 2011 - http://www.samhsa.gov/prevention/spf.aspx. Accessed July 2012.

The U.S. Department of Health and Human Services defines cultural competence as "a set of behaviors, attitudes, and policies that come together in a system, agency, or program or among individuals, enabling them to function effectively in diverse cultural interactions and similarities within, among, and between groups." Culture and language play a significant role in the design, delivery, accessibility, acceptability, and effectiveness of prevention services and activities.

Cultural competence requires that organizations[25]:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders and communities.

Sustainability

Sustainability should include assets and resources that will promote and further the vision and mission of the coalition beyond the life of any given funding source. Examples of assets and resources include: policy changes, job descriptions, funding, use of facilities, and commitment from leadership, etc.

Getting Started

Purpose: Initiate the process.

- Establish working Consortium.
- Set up basic structure of Consortium.

Capacity: Mobilizing your state system and building capacity

Purpose: Developing and increasing state's capacity to support prevention and ability to address the problem(s).

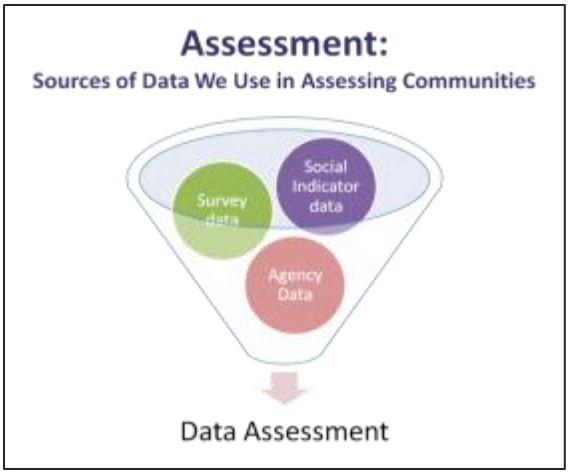
- Build effective Consortium.
- Clear roles and structure.
- Strategies for involvement of stakeholders and community.

Assessment: Our state's needs, resources, readiness, & gaps

Purpose: Identify needs, resources, and gaps.

- Collect and analyze data.
- Identify people, scope, readiness and resources.
- Identify gaps of services for needs.

[25] Adapted from - http://nccc.georgetown.edu/foundations/frameworks.html. Accessed July 2012.



Planning: Develop a strategic prevention plan

Purpose: Create a plan for implementing and evaluating tested, effective programs, policies, and practices.

- Selection of programs, policies, and practices to fill gaps.
- Implementation and evaluation plans.
- Measurable outcomes.

Implementation: Implement evidence-based prevention strategies

Purpose: Implement the plan.

- Confirm partnerships.
- Implement selected strategies, programs, policies, and practices.

Reporting and Evaluation: Evaluate and monitor results, change as necessary

Purpose: Evaluate the plan, and refine as needed.

- Evaluate the process and outcomes.
- Adjust the plan.

For more information about the Strategic Prevention Framework go to: http://www.samhsa.gov/prevention/spf.aspx.

4. Washington State Key Data Sources

In Washington State, we have a wealth of data from our key related collection systems including the following:

- Community Outcomes and Risk Evaluation Geographic Information System (CORE GIS) - A comprehensive time-series collection of data related to substance use and abuse, and the risk factors that predict substance use among youth.
  http://www.dshs.wa.gov/rda/research/risk.shtm

- Traffic Safety and Target Zero Teams Reports - These statistical mapping documents are generated on a 42-day rotational cycle and include information on collision, DUI arrests, other moving vehicle violations, and traffic fatalities.

- Washington Traffic Safety Commission/Fatality Analysis Reporting System (FARS) - Data on fatal crashes in Washington including traffic crash reports, state driver licensing and vehicle registration files, death certificates, toxicology reports, and emergency medical services. Data is available by age of driver, BAC level, and all drug findings.
  http://www.wtsc.wa.gov/statistics-reports/about-our-data/

- Healthy Youth Survey (HYS)/AskHYS.net - The information from the HYS can be used to identify trends in the patterns of behavior over time. In October 2002, 2004, 2006, 2008, 2010, 2014, students in grades 6, 8, 10, and 12 answered questions about safety and violence; physical activity and diet; alcohol, tobacco, and other drug use; and related risk and protective factors.
  http://www.askhys.net/

- Behavioral Risk Factor Surveillance System (BRFSS) – This on-going telephone health survey system tracks health conditions and risk behaviors in the United States yearly since 1984.
  http://www.cdc.gov/brfss/

- Performance Based Prevention System (PBPS) - A web-based MIS, PBPS, collects administrative and outcome data on all DBHR's Substance Abuse Block Grant funded substance abuse prevention services. https://waprev.onmosaix.com/waprevent2015/pEnter.aspx

- RMC Research's Student Assistance Prevention and Intervention Services Program (SAPISP) Database – This automated web-based reporting system is used to monitor service provision and student outcomes throughout the school year of participants in the local Student Assistance Prevention and Intervention Services Programs.

- Treatment and Assessment Reports Generation Tool (TARGET) - This system records outpatient demographic and service encounter data for substance abuse, and client and service encounter information for both Medicaid and non-Medicaid-funded services.

- ProviderOne - This system records and stores all Medicaid claims for outpatient and residential substance abuse treatment services and all encounter data for Medicaid-funded outpatient mental health managed care services and residential claims for mental health treatment.

- Catalyst –Web-based system utilized to collect and provide summary information pertaining to Department of Health's Tobacco Prevention and Control project and Community Transformation grant activities statewide.

- Office of the Superintendent of Public Instruction (OSPI) Report cards - The School Report Card is a parent-friendly resource for data on student demographics, student performance, and school staff in our state. http://reportcard.ospi.k12.wa.us/summary.aspx?year=2010-11

- Mental Health Consumer Information System (MHCIS) - Demographic information for all mental health consumers and non-Medicaid mental health service data are entered into MHCIS.

- Integrated Client Database (ICDB) - DSHS' longitudinal client database containing ten or more years of detailed service risks, history, costs, and outcomes.

- Comprehensive Hospital Abstract Reporting System (CHARS) – Includes coded hospital inpatient discharge information (derived from billing systems) available for 1987 to 2010. http://www.doh.wa.gov/ehsphl/hospdata/chars.htm

5. Data Assessment

The following is a compilation of the Data Assessment presentations provided at the March and April, 2015 Consortium meetings *is available online at: www.TheAthenaForum.org/SPE.*

The table below summarizes the findings from the review of substances:

2011 Baseline Ranking

Ranking	Alcohol	Tobacco	Marijuana	Meth	Prescription Drug
Prevalence Rates (youth/adult)	1st -youth 1st -adults	3rd -youth 2nd -adults	2nd -youth 3rd -adults	5th -youth NA- adults	4th -youth 4th -adults
Trends (youth/adult)	no trend change	no trend change	youth - increasing adult- increase in WA	no trend change	no trend change
Economic Impacts	1st	3rd	Illicit drugs: 2nd		
Social Impact	• Deaths: alcohol greater impact than illicit drugs • Drinking and driving: Age dependent • Traffic injuries and fatalities: Age dependent • School related consequences: Mixed				
OVERALL	**1st**	**3rd**	**2nd**	**5th**	**4th**

Notes: *Substances are ranked from the highest prevalence to the lowest. The first number indicates the ranking for youth and the second number indicates the ranking for adults (+18). **Substances are ranked based on trends. The first number indicates the ranking for youth and the second number indicates the ranking for adults (18+). With the exception of youth marijuana use, there has not been any discernible increasing or decreasing trends in these five substances. Youth marijuana use, therefore, was given the highest ranking.

2015 Update Ranking

Ranking	Alcohol	Tobacco	Marijuana	Meth	Prescription Drug
Prevalence Rates (youth/adult)	1st -youth 1st -adults	3rd -youth 2nd -adults	2nd -youth 3rd -adults	5th -youth NA- adults	4th -youth 4th -adults
Trends (youth/adult)	decrease	decrease	Slight increase for 12th Grade adult - no significant change in 2014 data	no trend change	decrease
Economic Impacts	1st	3rd	Illicit drugs: 2nd		
Social Impact	• Deaths: alcohol greater impact than illicit drugs • Drinking and driving: Age dependent • Traffic injuries and fatalities: Age dependent • School related consequences: Mixed				
OVERALL	**1st**	**3rd**	**2nd**	**5th**	**4th**

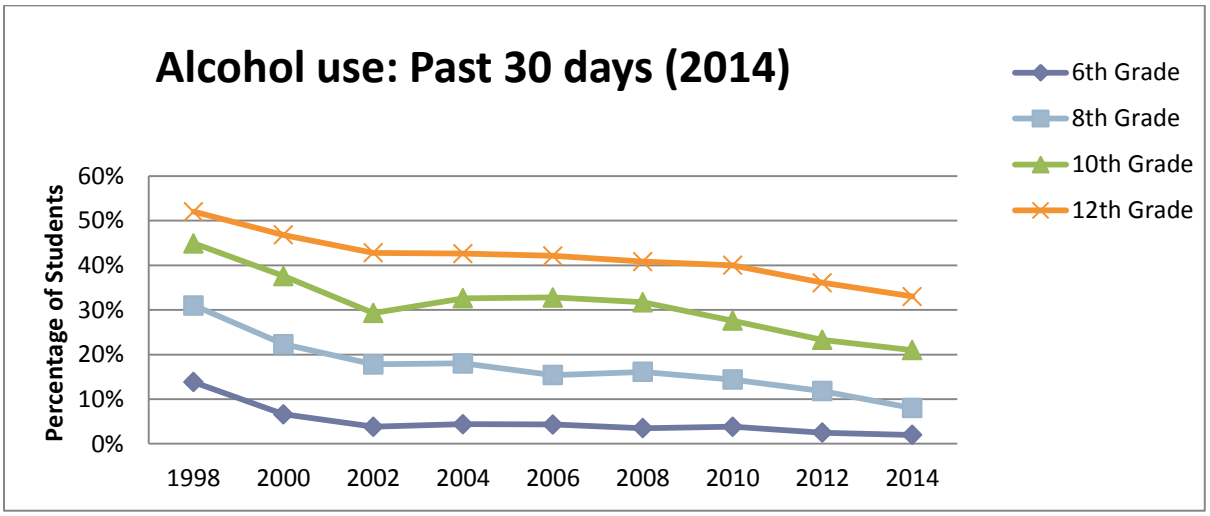
Following charts are the main data that were considered as part of our assessment:

Health Youth Survey (HYS): *Figures HYS 1-18*

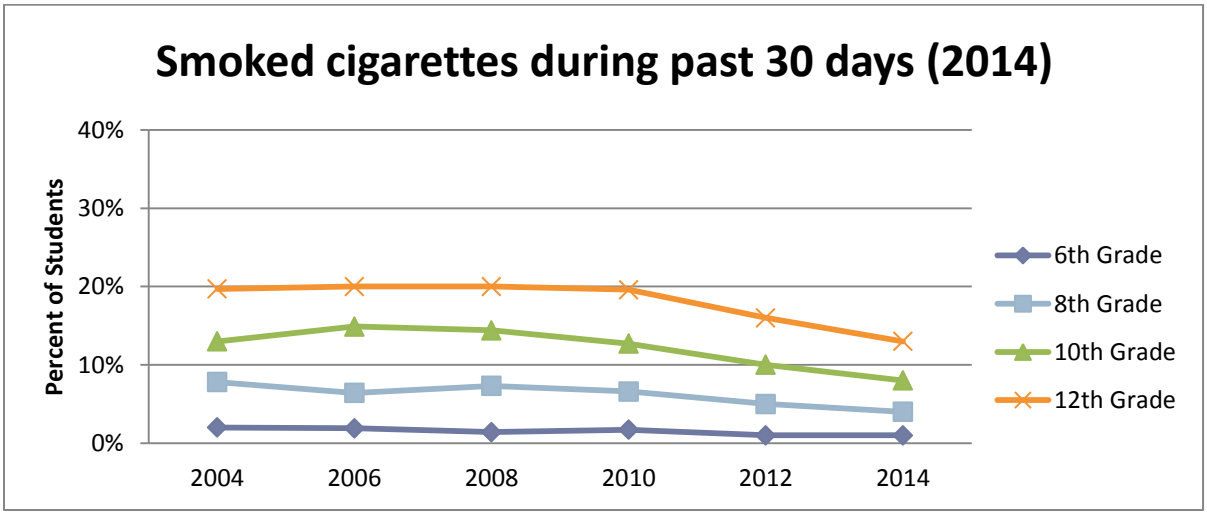
Notes:

- Statewide school survey conducted biannually.
- Collects data on health risk behaviors that contribute to morbidity, mortality, and social problems among youth.
- Respondents: students in the 6th, 8th, 10th, and 12th grades.
- Sample size (2010): 211,331 students from 1,145 schools.
- Sample size (2014): 223,202 students.
- In 2014, a pilot project included 7th, 9th, and 11th graders.

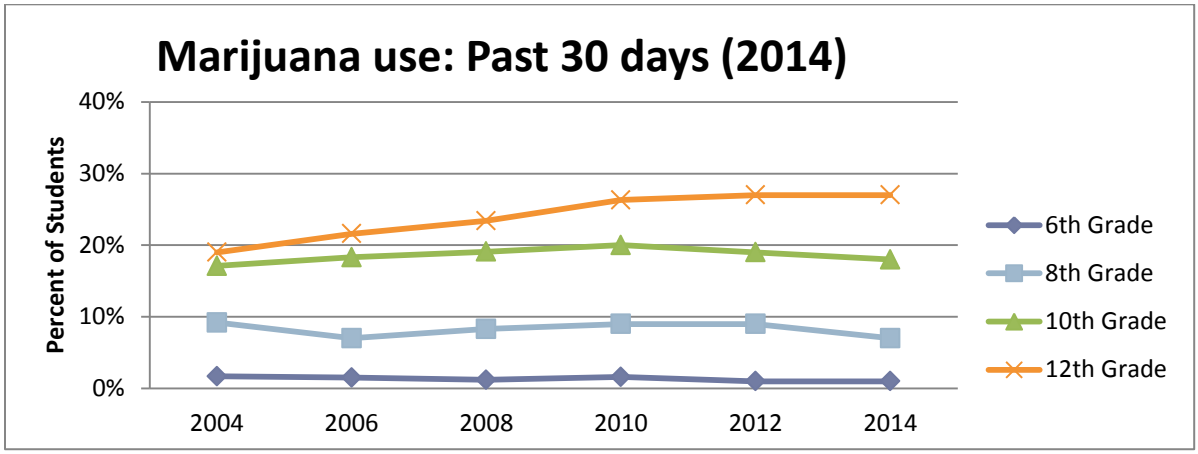
HYS - Figure 1



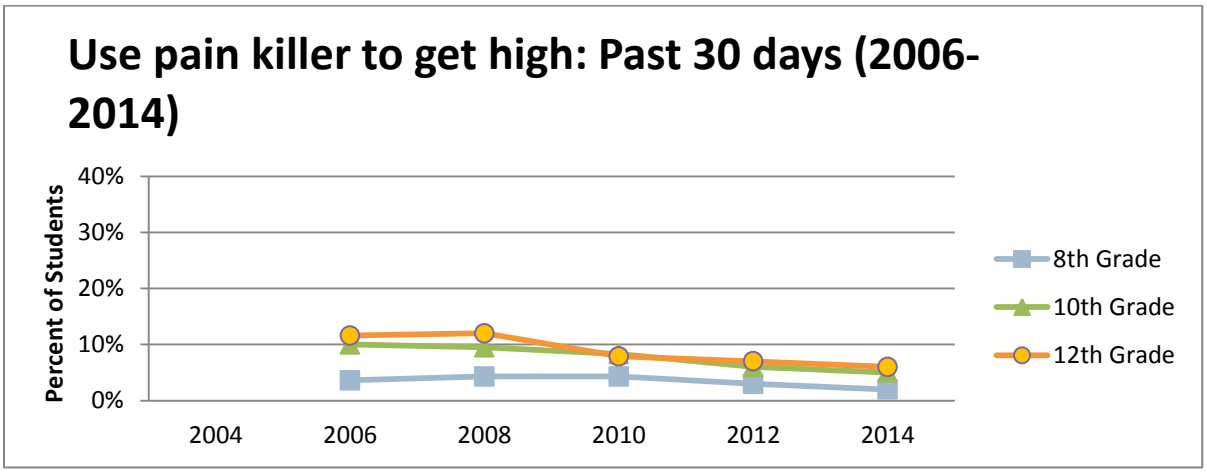
HYS - Figure 2



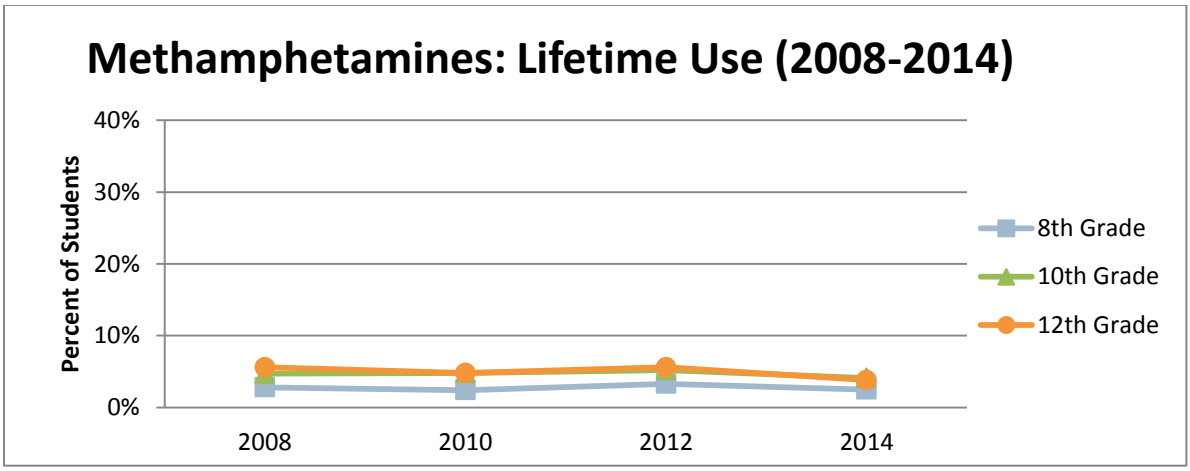
HYS - Figure 3



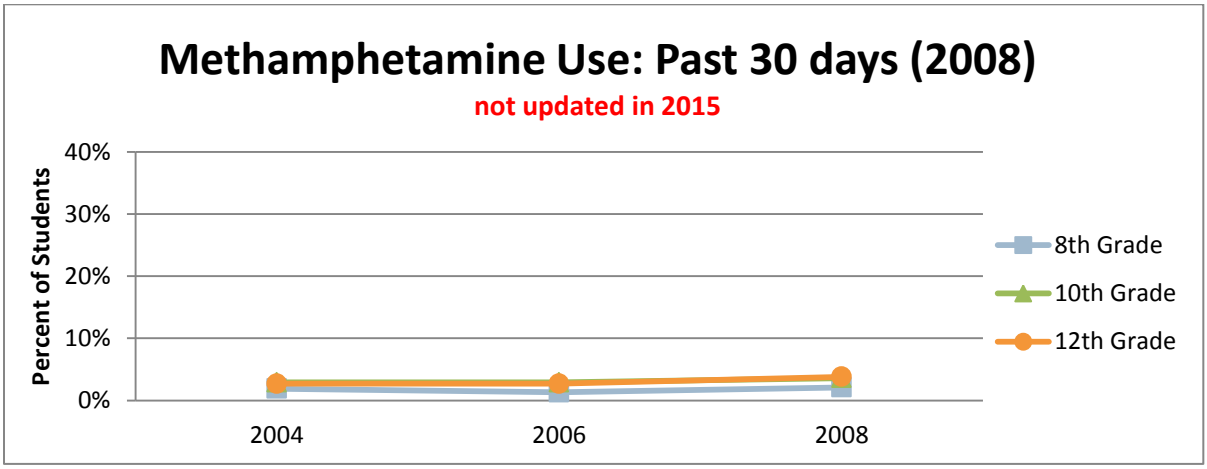
HYS - Figure 4



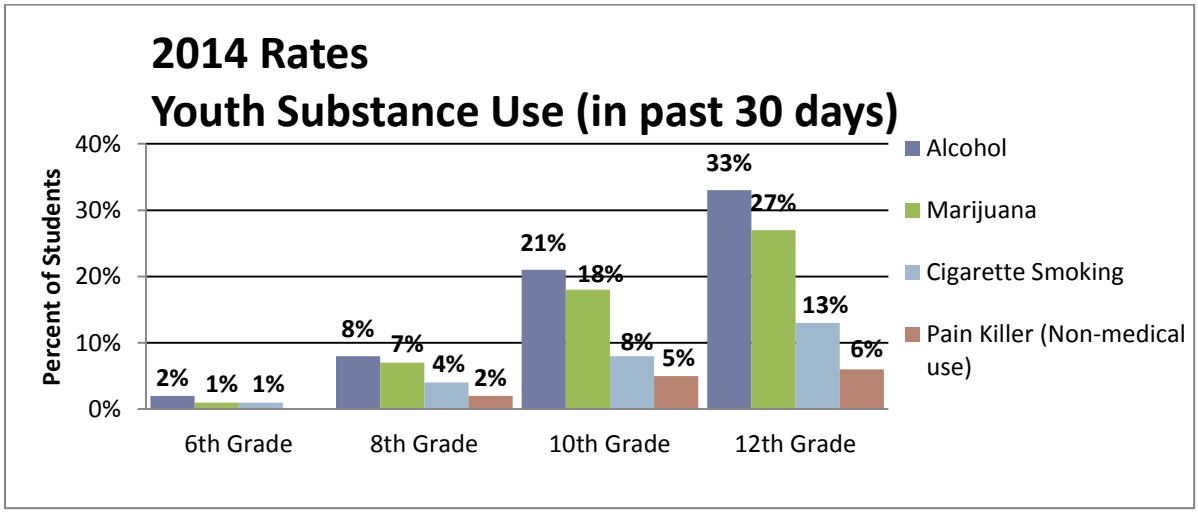
HYS - Figure 5



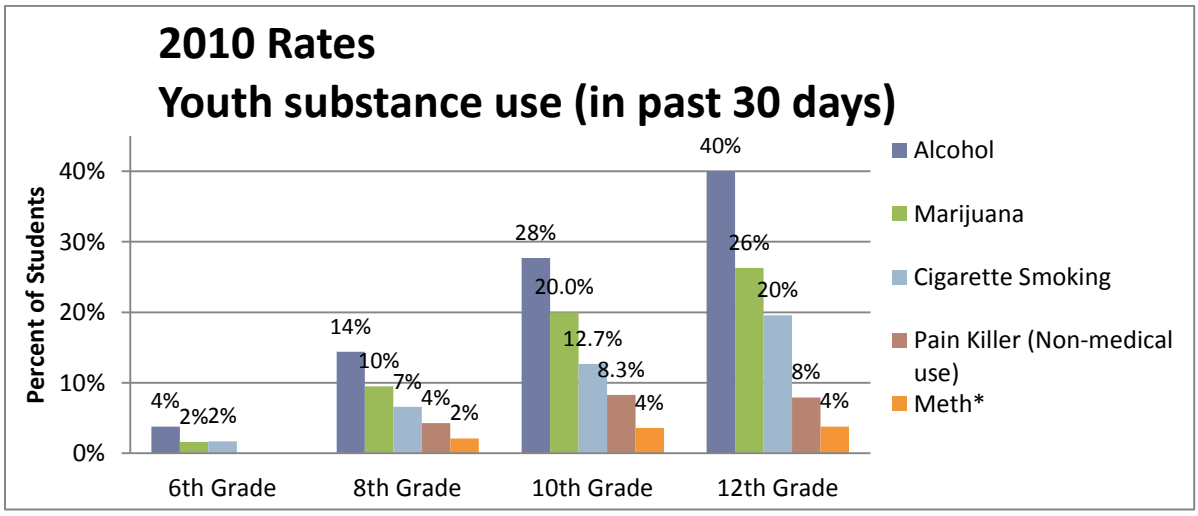
HYS - Figure 6



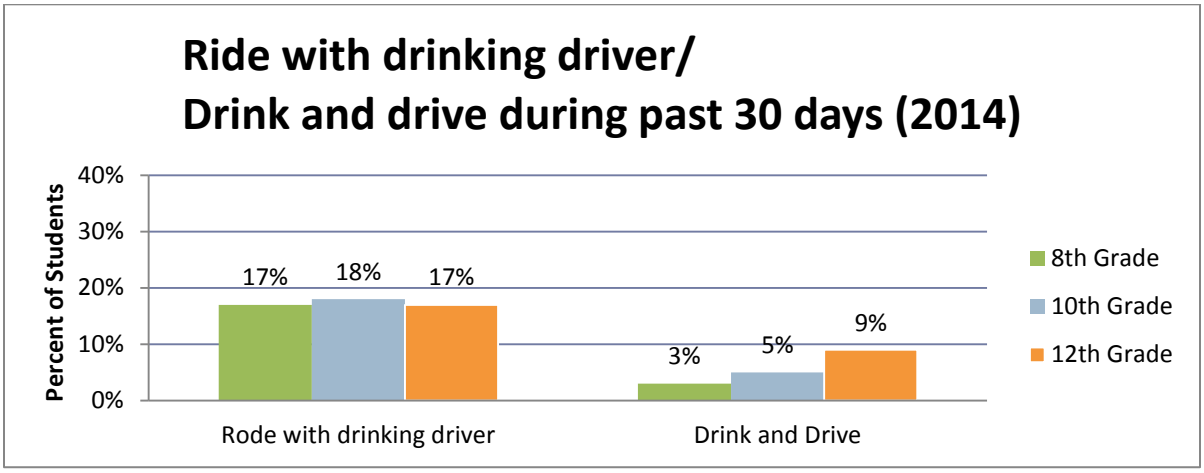
HYS - Figure 7



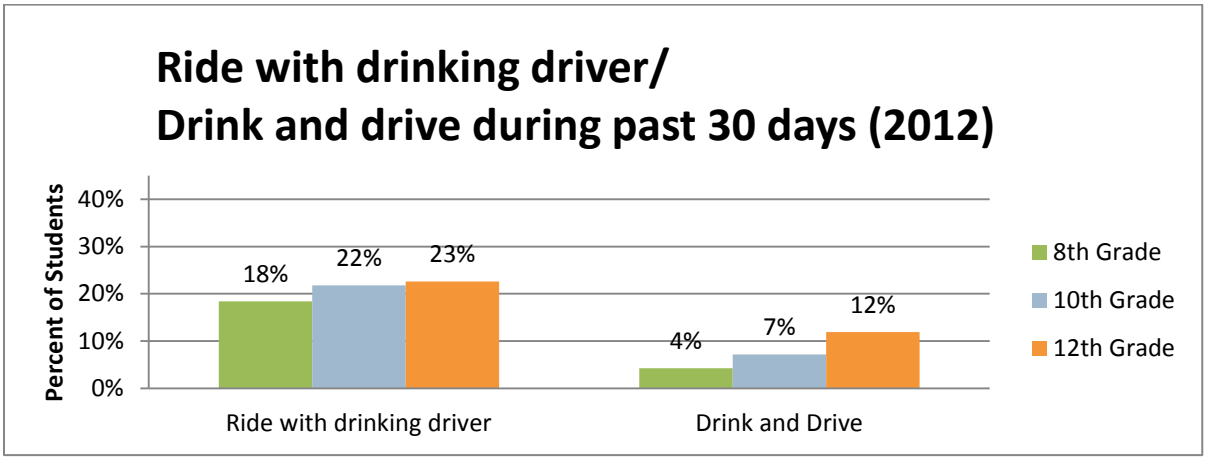
HYS - Figure 8



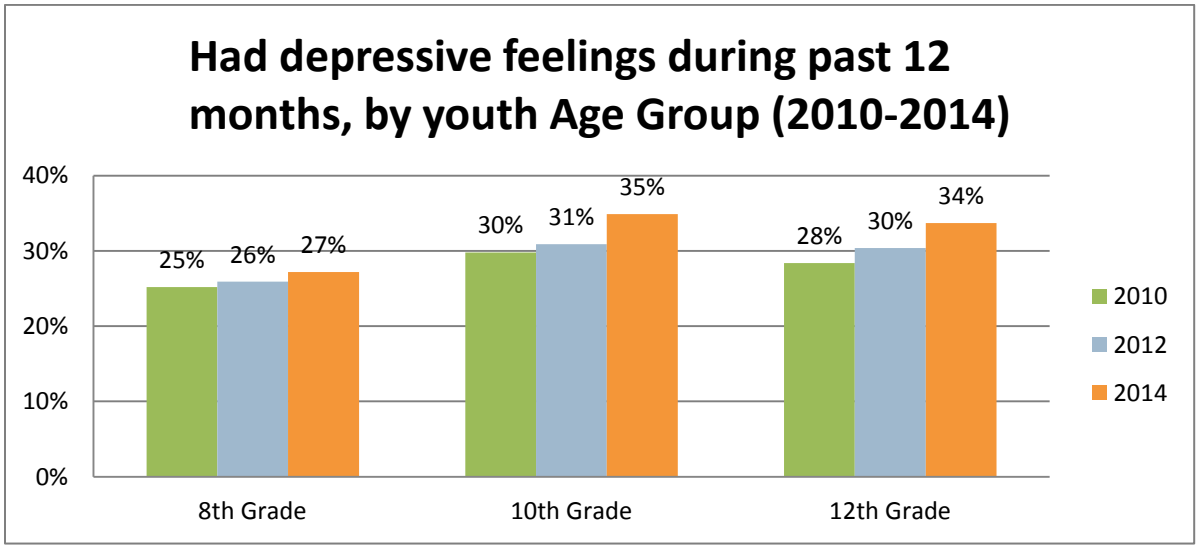
HYS - Figure 9



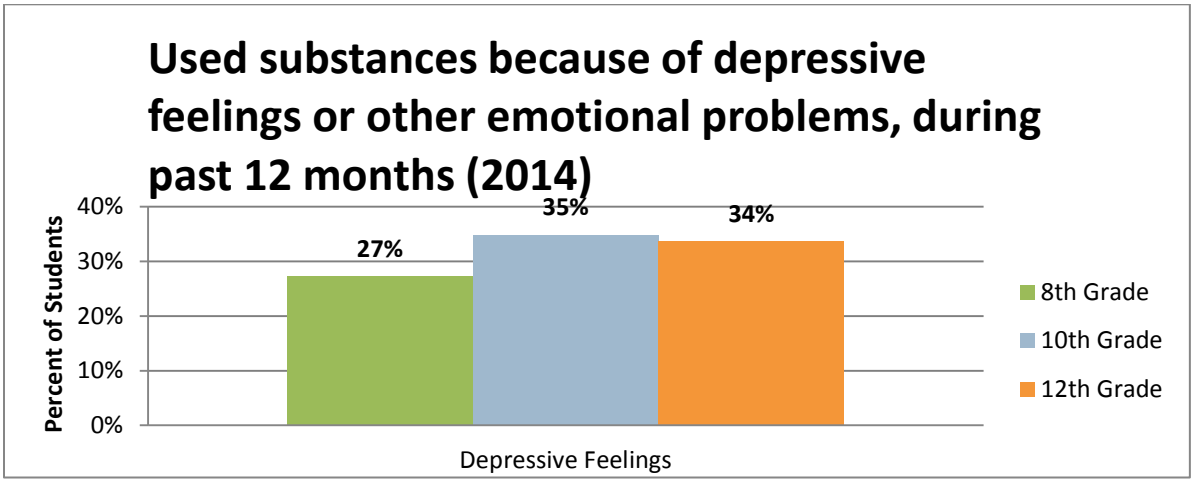
HYS - Figure 10



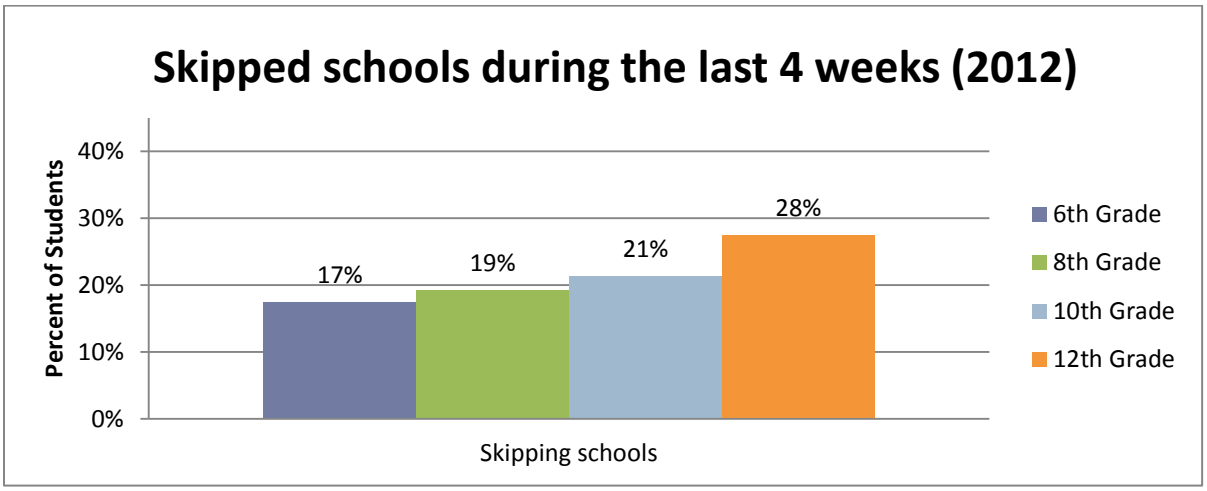
HYS - Figure 11



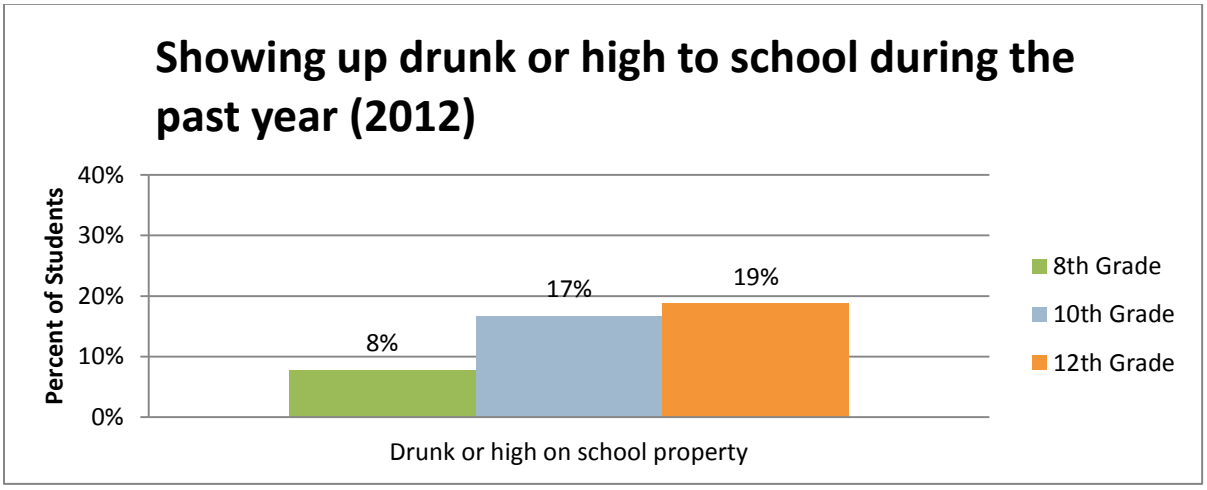
HYS - Figure 12



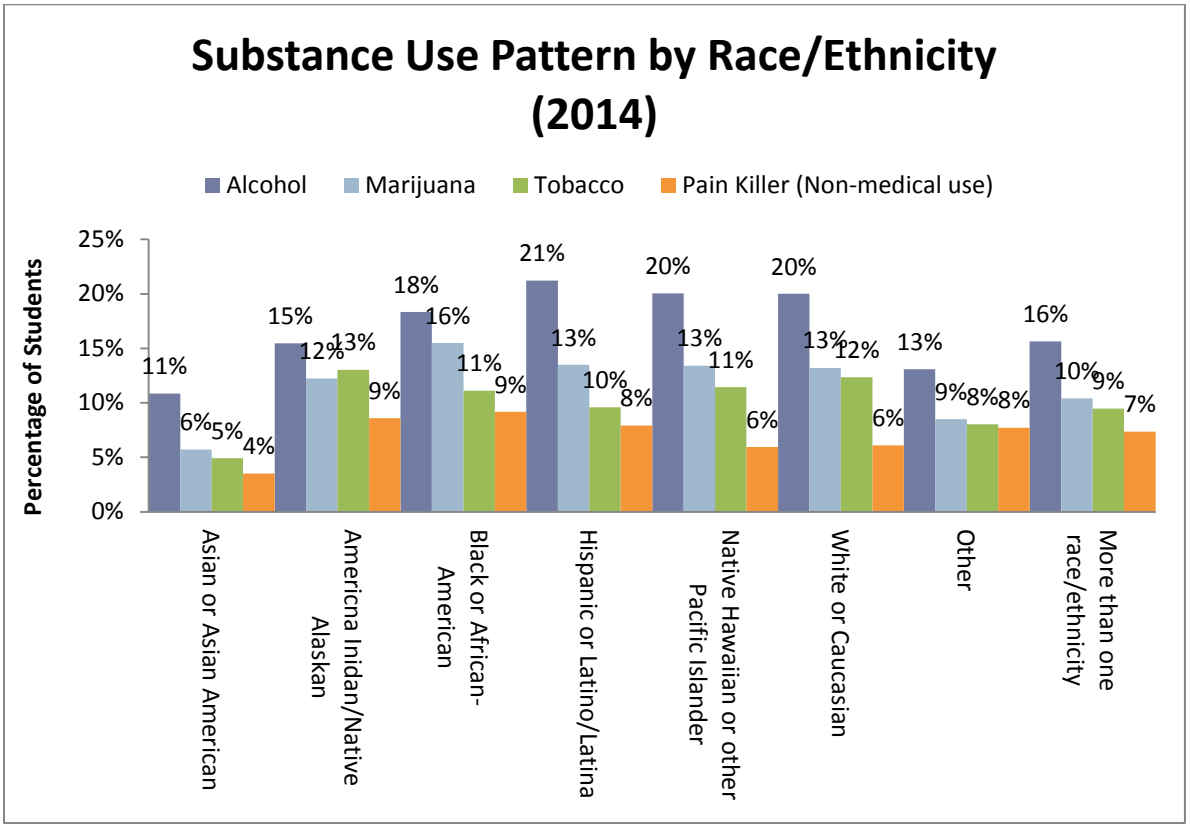
HYS - Figure 13



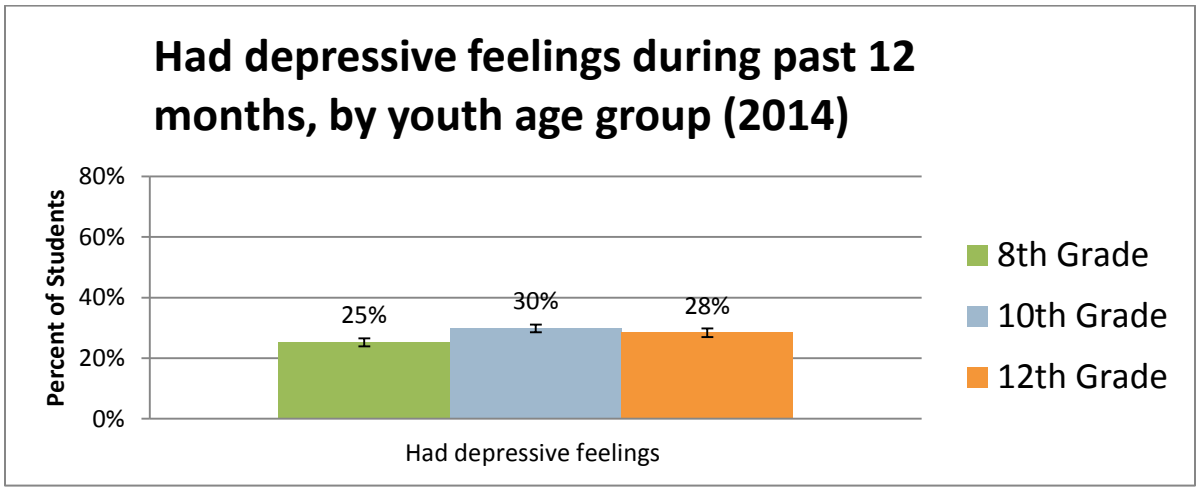
HYS - Figure 14



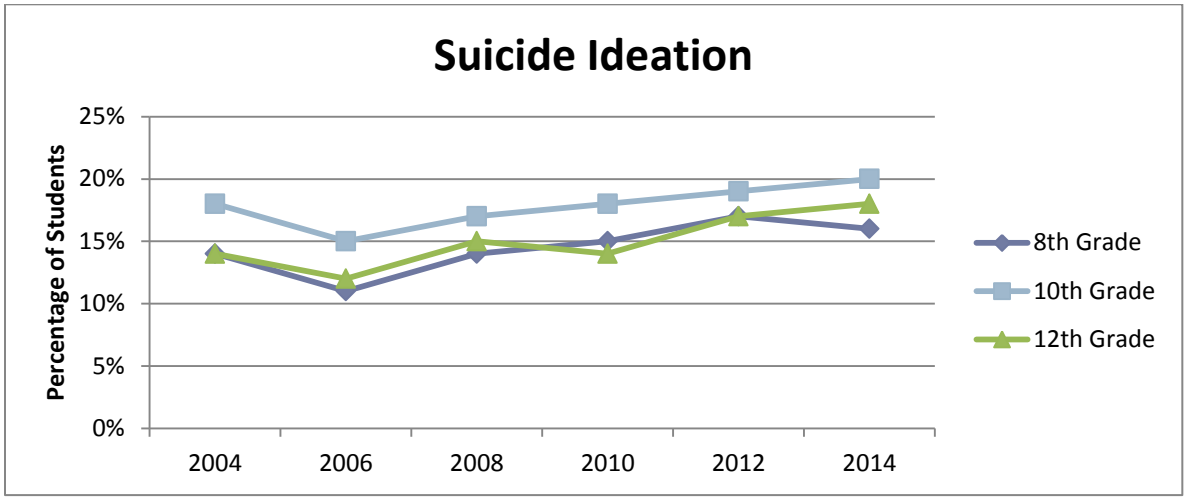
HYS - Figure 15



HYS - Figure 16



HYS - Figure 17



HYS - Figure 18

Correlation between substance use and negative consequences (Odds Ratio)

	Alcohol	Marijuana	Pain Killer*	Tobacco
Depressive Feelings	2.3	2.0	3.1	2.3
Drunk or high at school	12.6	24.7	22.3	14.0
Riding with driver who had alcohol	6.0	4.8	7.3	4.9
Skipping school	3.5	4.1	5.0	4.1

Source: 2010 HYS. *This data not updated in 2015.*

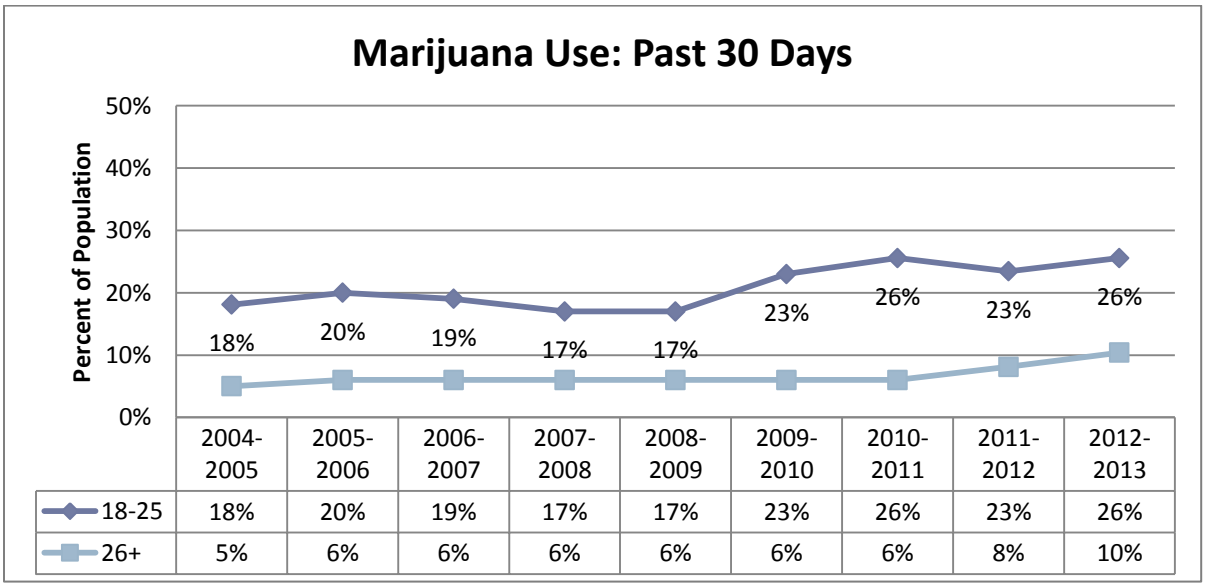
* Used pain killers to get high

National Survey on Drug Use and Health (NSDUH): *Figures NSDUH 1-13*

Notes:

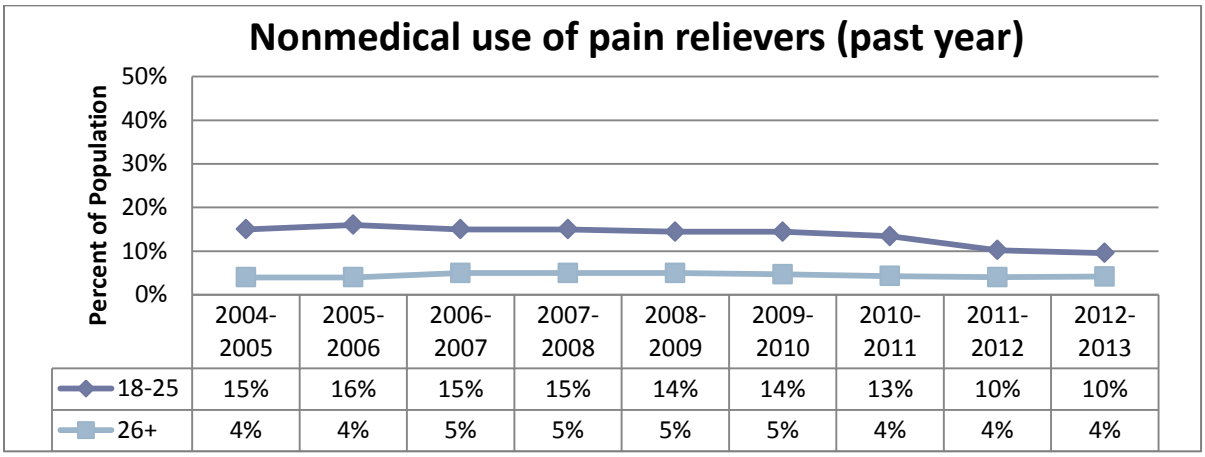
- Nationwide annual survey conducted through computerized interviews.
- Collects data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health indicators.
- Respondents: individuals 12 years and older.
- Sample size: approximately 70,000 nationally.
- Estimating Rates of Mental Illness
  - Psychological distress measured by Kesseler-6 distress scale.
  - Functional impairment measured by the World Health Organization Disability Assessment Schedule (WHODAS) and the Sheehan Disability Scale (SDS).
  - Conducted clinical interviews with a subsample to determine mental illnesses.
  - Rates of mental illness estimated using statistical models based on K-6, WHODAS/SDS, and parameters determined by the clinical interviews.
- Estimating Rates of Depression
  - Major depressive episode: defined as in DSM-IV - a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.
  - Adult questions adapted from the National Comorbidity Survey Replication (NCS-R).
  - Youth (12 to 17) questions adapted from the National Comorbidity Survey Adolescent (NCS-A).

NSDUH - Figure 1



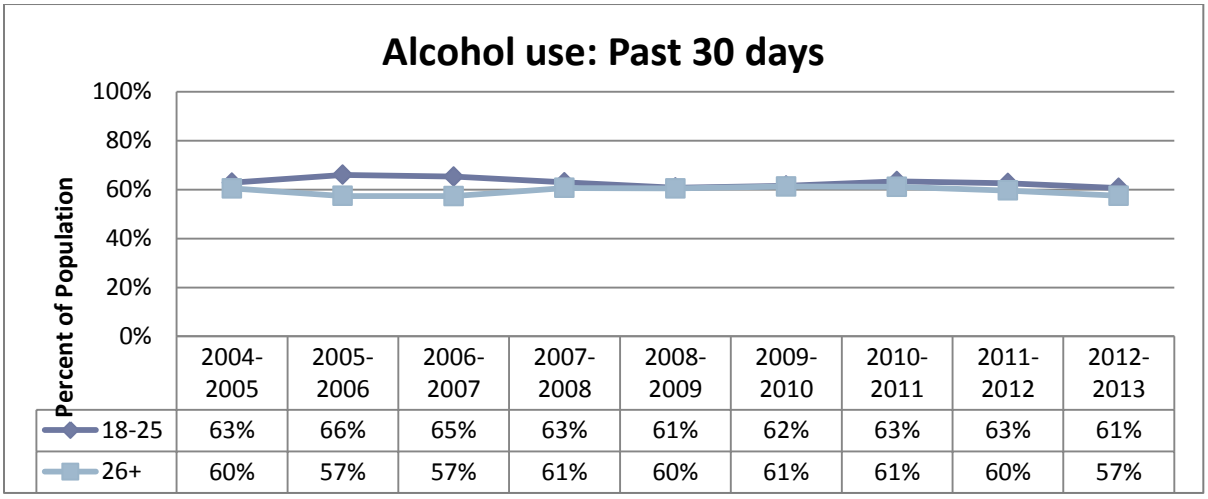
	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
18-25	18%	20%	19%	17%	17%	23%	26%	23%	26%
26+	5%	6%	6%	6%	6%	6%	6%	8%	10%

NSDUH - Figure 2



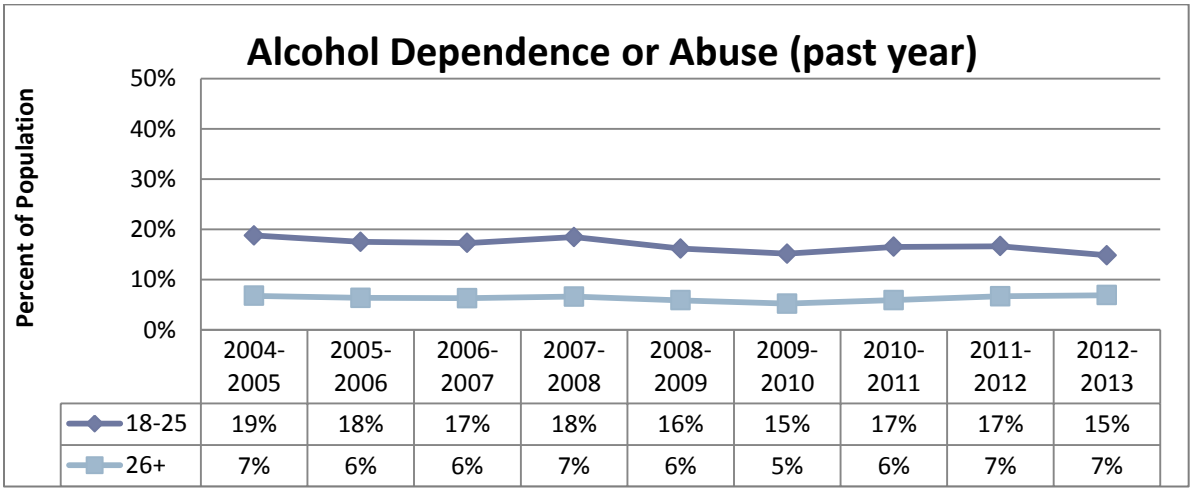
	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
18-25	15%	16%	15%	15%	14%	14%	13%	10%	10%
26+	4%	4%	5%	5%	5%	5%	4%	4%	4%

NSDUH - Figure 3



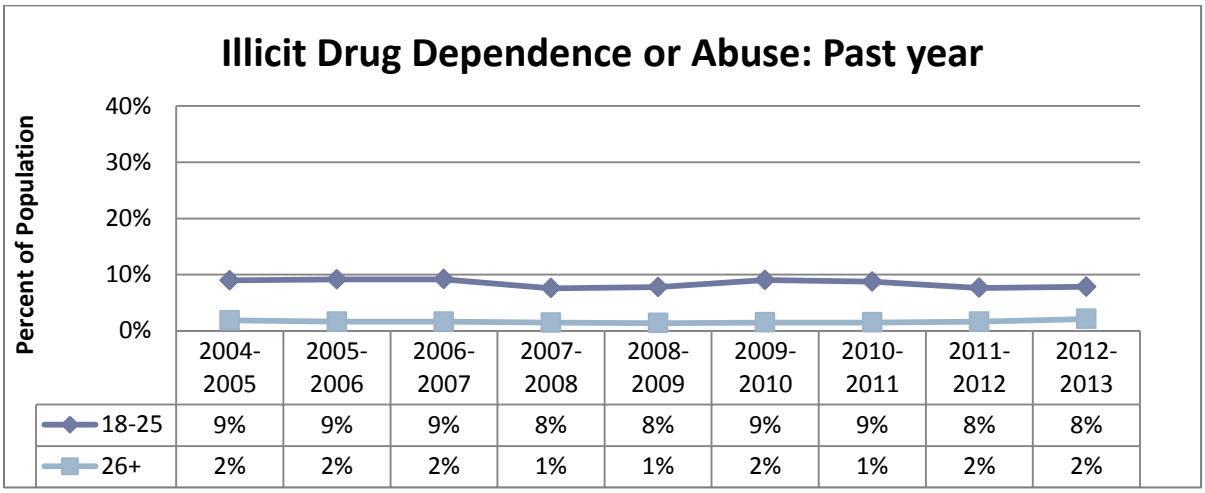
	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
18-25	63%	66%	65%	63%	61%	62%	63%	63%	61%
26+	60%	57%	57%	61%	60%	61%	61%	60%	57%

NSDUH - Figure 4

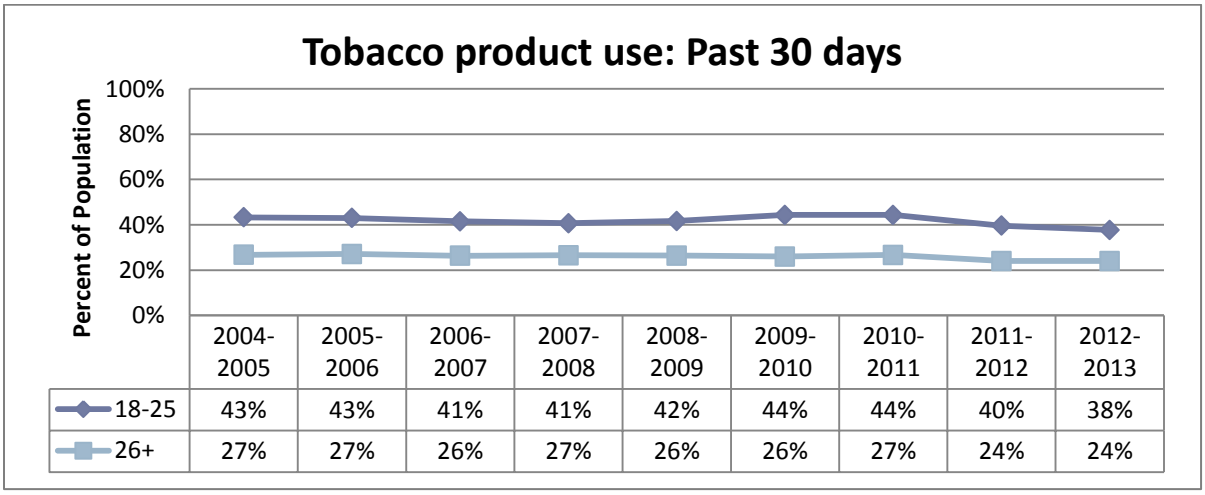


	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
18-25	19%	18%	17%	18%	16%	15%	17%	17%	15%
26+	7%	6%	6%	7%	6%	5%	6%	7%	7%

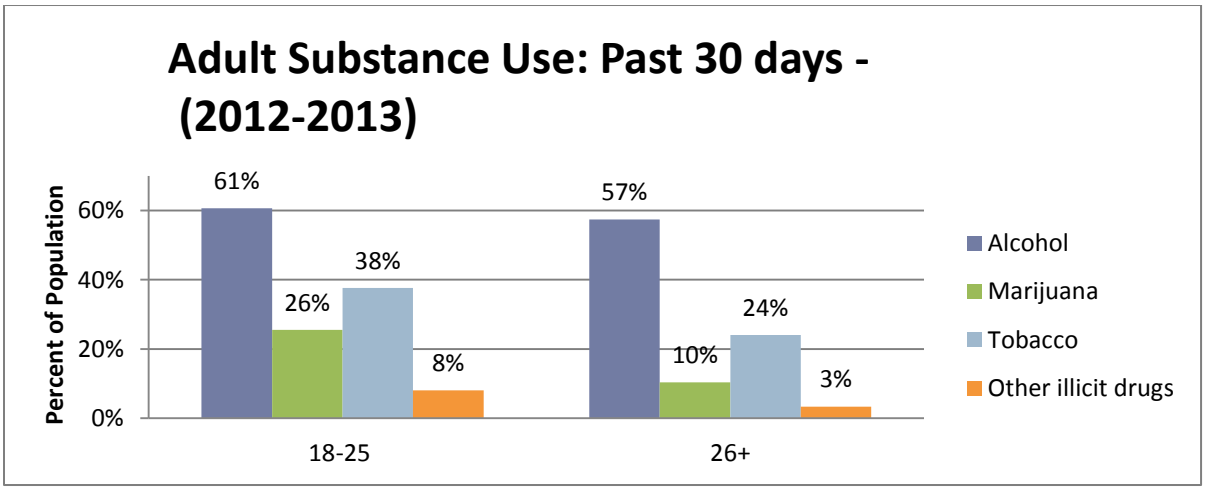
NSDUH - Figure 5



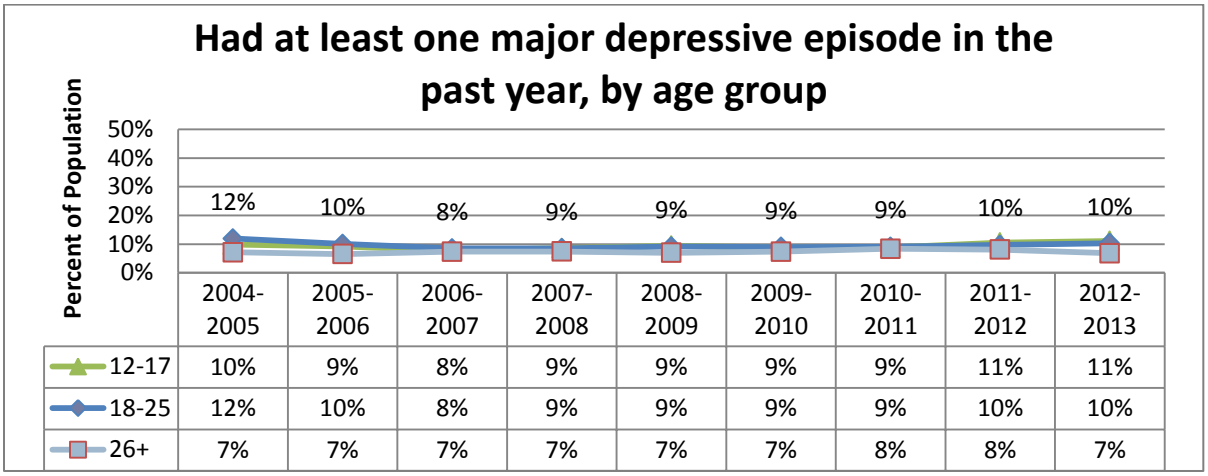
NSDUH - Figure 6



NSDUH - Figure 7

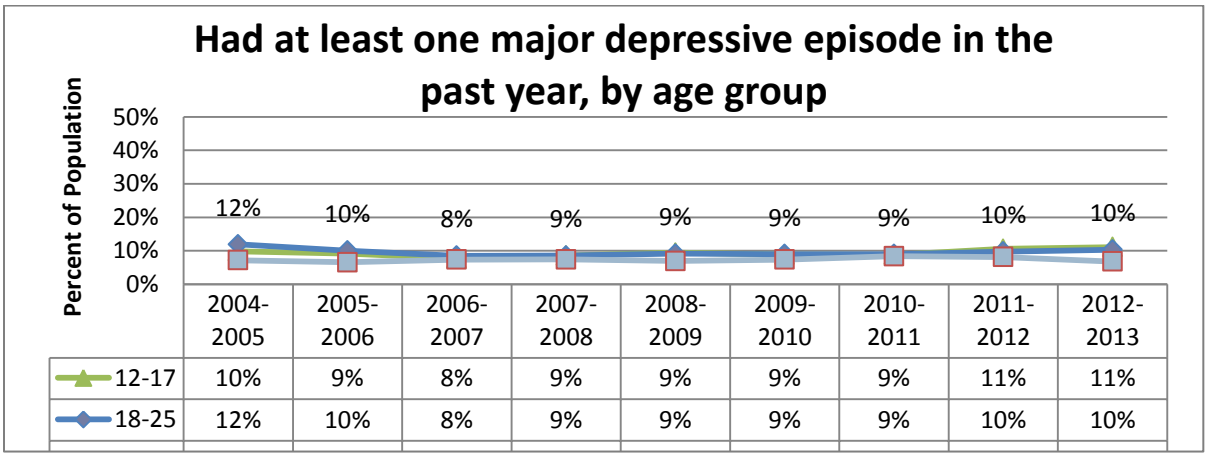


NSDUH - Figure 8



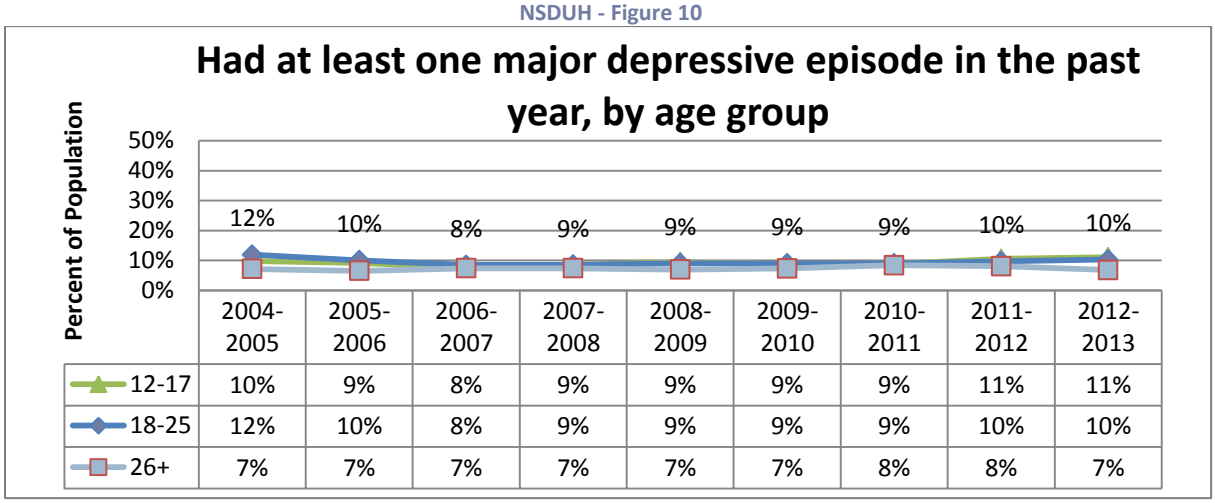
	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
12-17	10%	9%	8%	9%	9%	9%	9%	11%	11%
18-25	12%	10%	8%	9%	9%	9%	9%	10%	10%
26+	7%	7%	7%	7%	7%	7%	8%	8%	7%

NSDUH - Figure 9



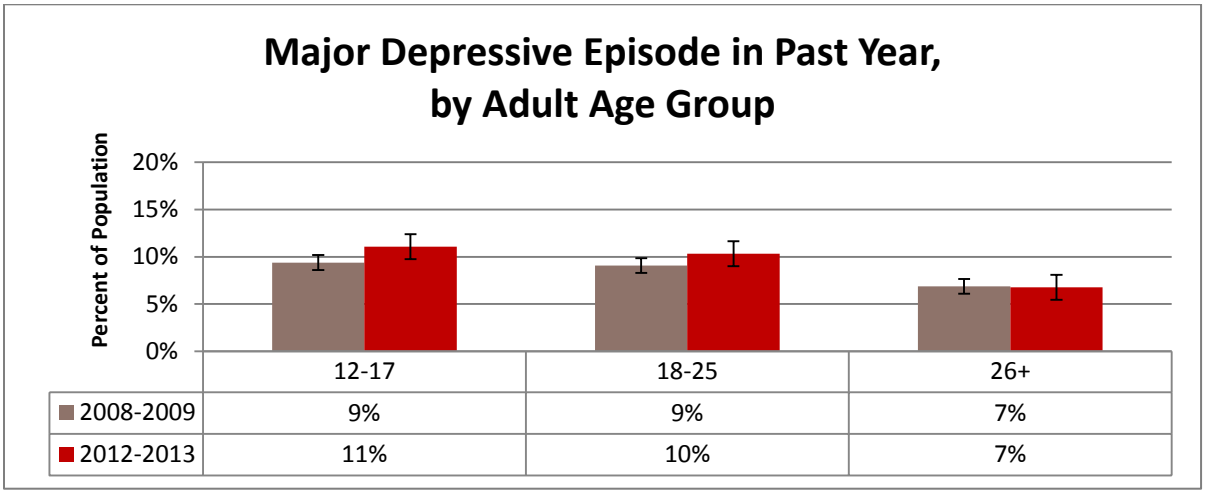
	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
12-17	10%	9%	8%	9%	9%	9%	9%	11%	11%
18-25	12%	10%	8%	9%	9%	9%	9%	10%	10%

NSDUH - Figure 10

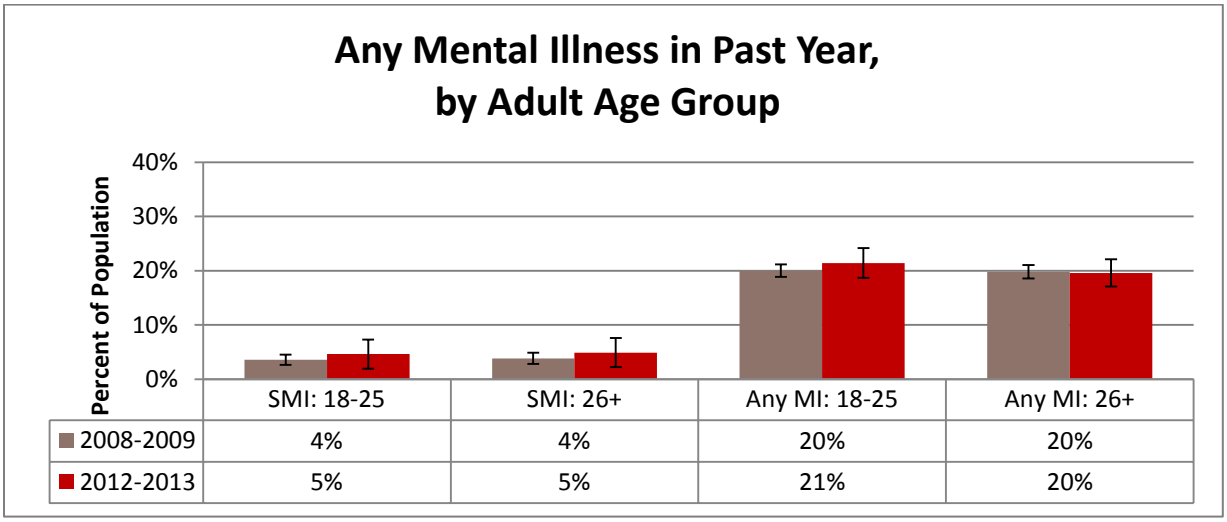


	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
12-17	10%	9%	8%	9%	9%	9%	9%	11%	11%
18-25	12%	10%	8%	9%	9%	9%	9%	10%	10%
26+	7%	7%	7%	7%	7%	7%	8%	8%	7%

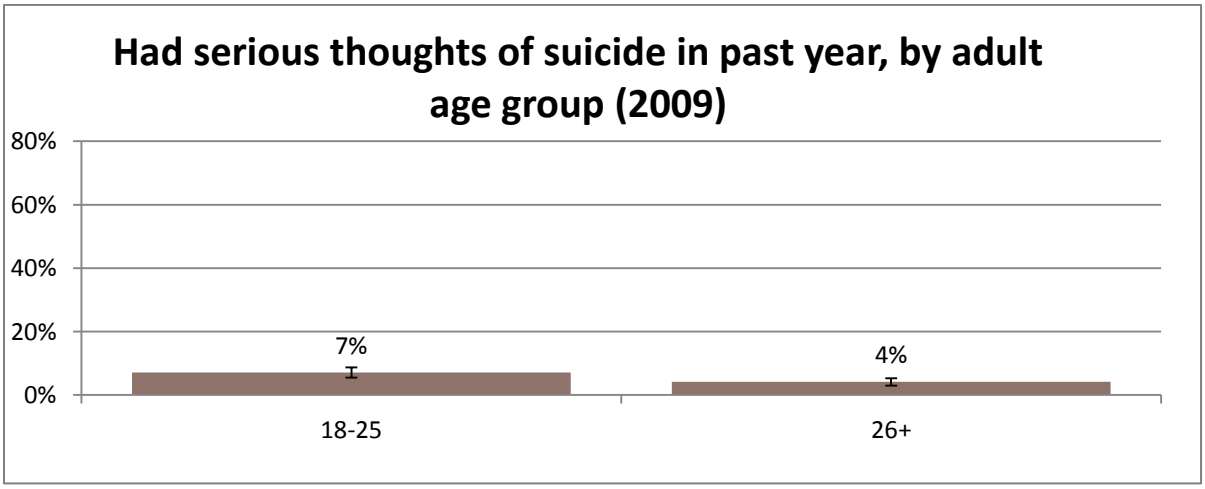
NSDUH - Figure 11



NSDUH - Figure 12



NSDUH - Figure 13

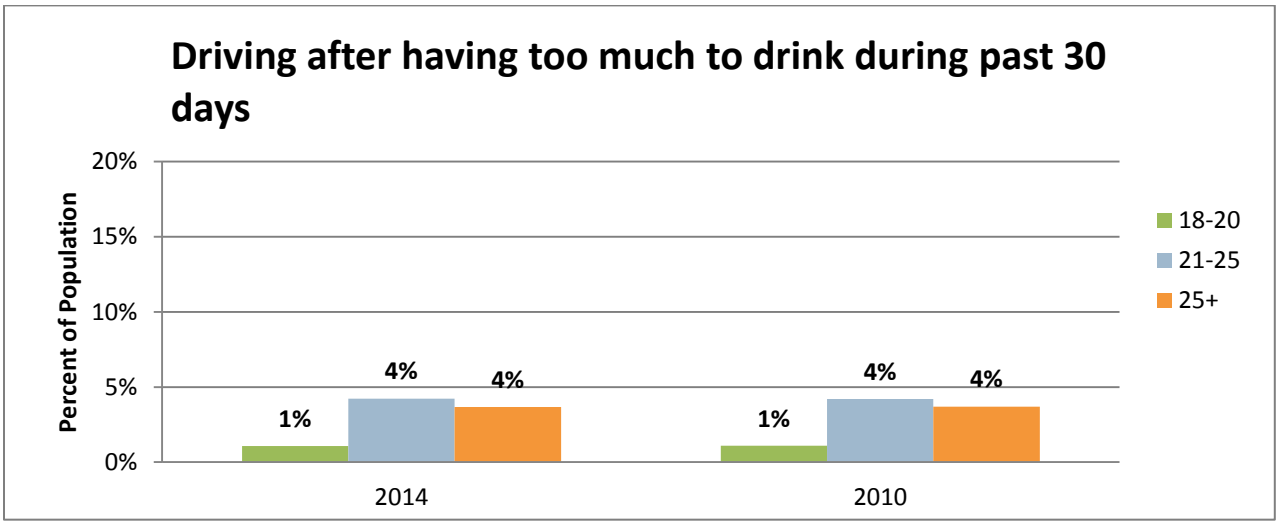


Behavioral Risk Factors Surveillance System (BRFSS): *Figures BRFSS 1-28*

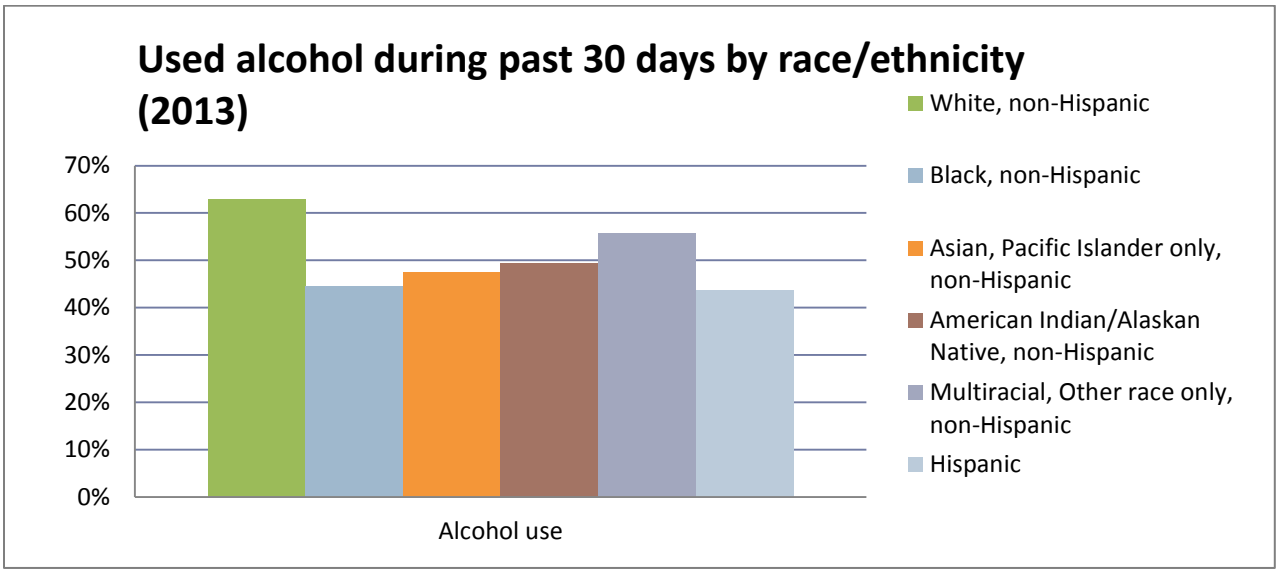
Notes:

- National and statewide annual telephone survey.
- Collects information on health behaviors and preventive practices.
- Respondents: adults 18 years and older.
- Sample size (2010): approximately 20,000 in Washington State.
- Annual Survey in 2013 was provided for the Strategic Plan Update 2015.
- Sample size (2013): approximately 10,000 in Washington State.
- Measuring Serious Psychological Distress (BRFSS)
  - Measured by Kessler-6 distress scale.
  - Serious psychological distress – defined as a score of 13 or more on K-6.

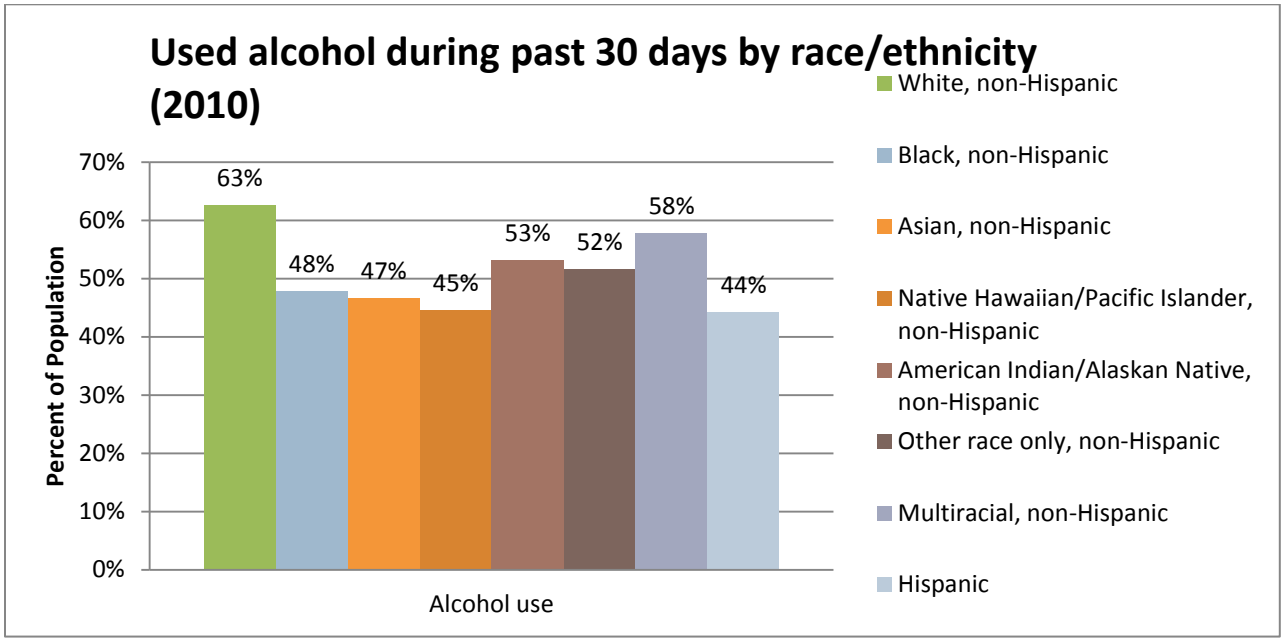
BRFSS - Figure 1



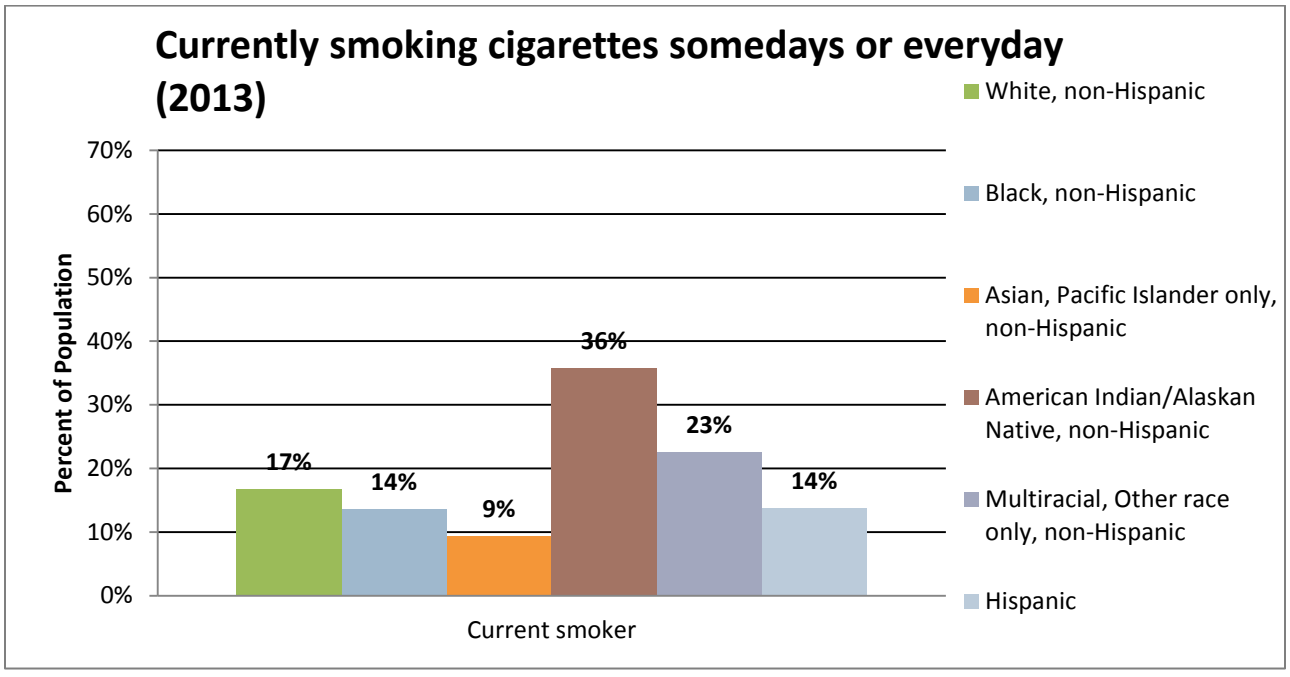
BRFSS - Figure 2



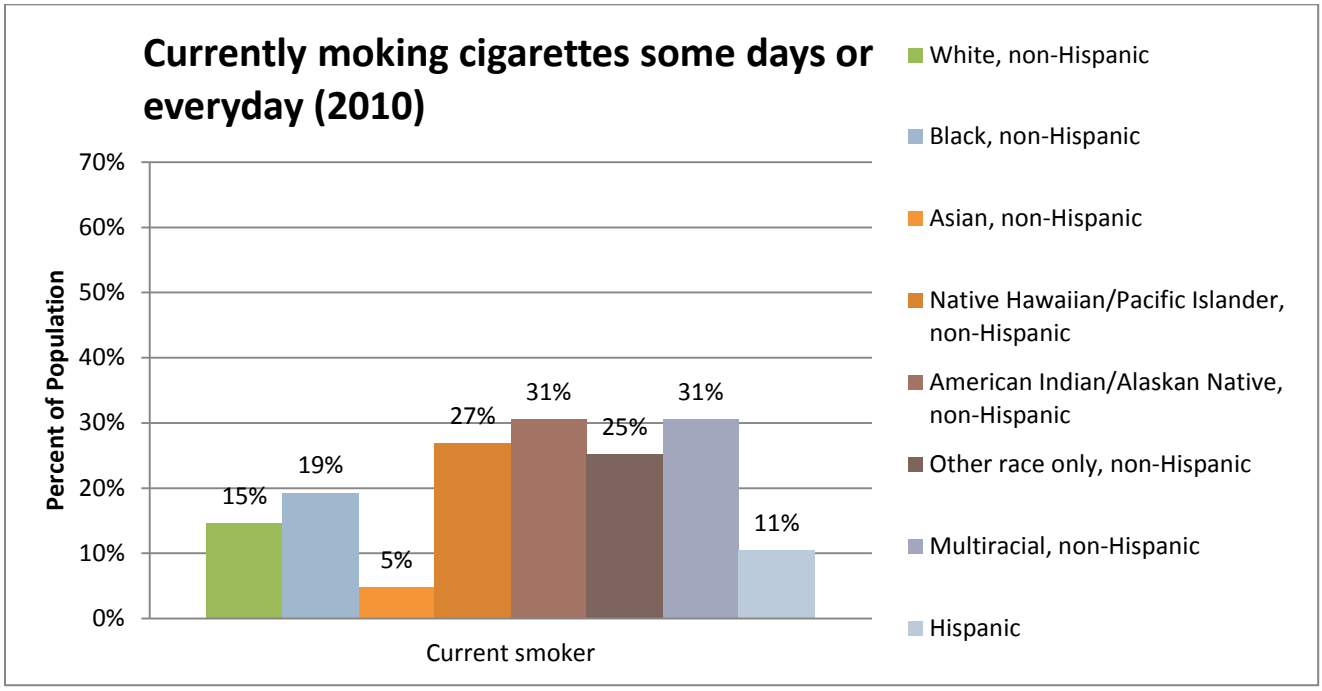
BRFSS - Figure 3



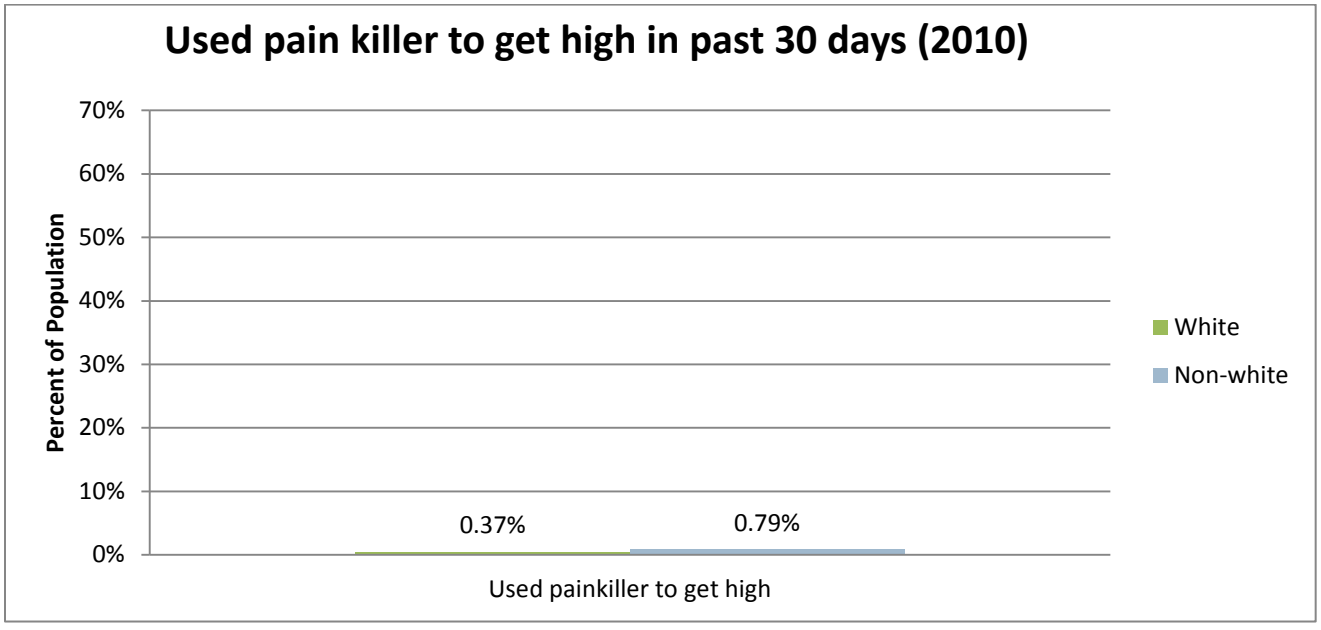
BRFSS - Figure 4



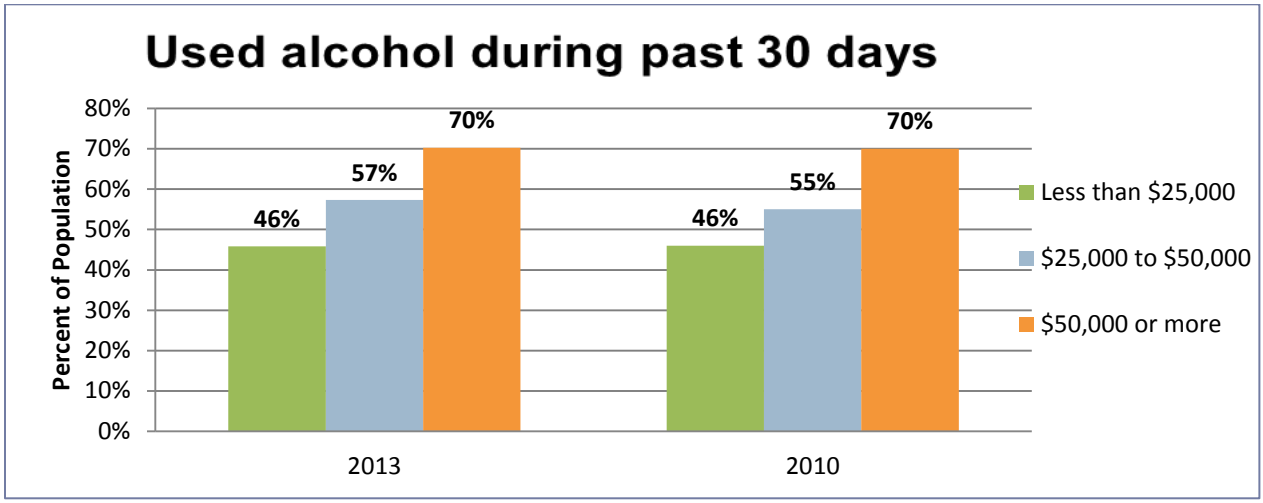
BRFSS - Figure 5



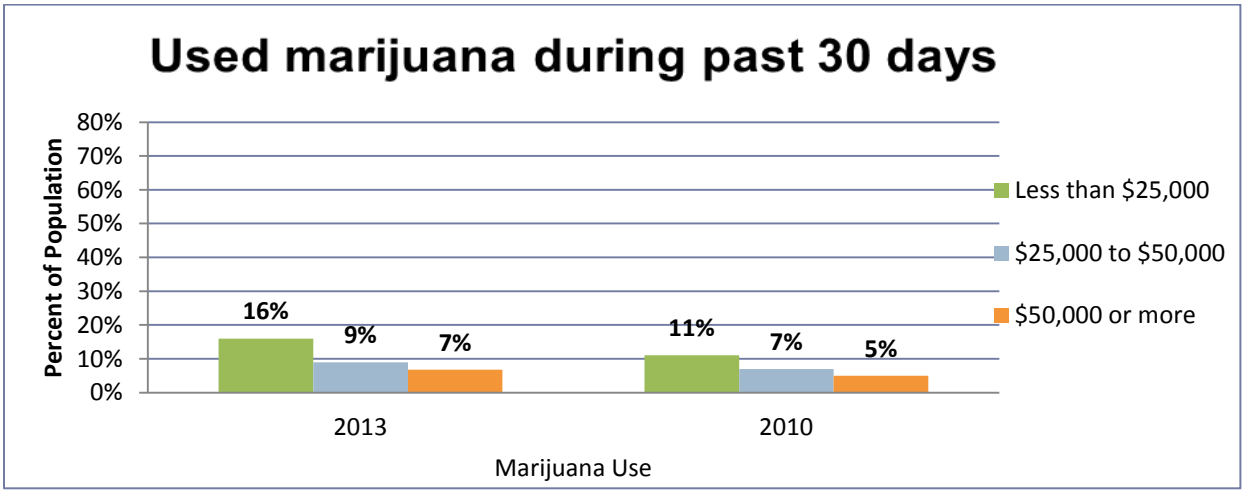
BRFSS - Figure 6



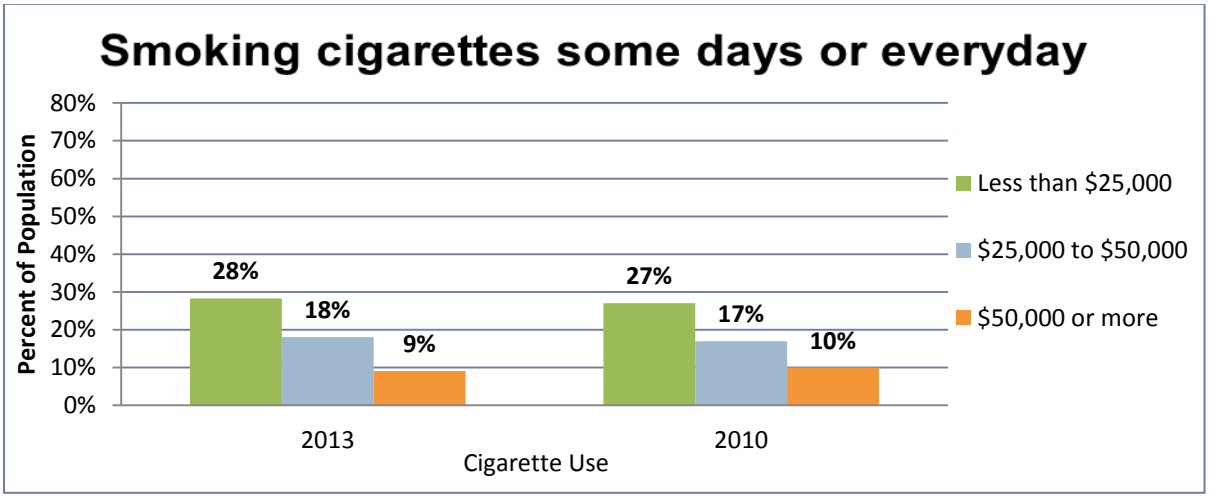
BRFSS - Figure 7



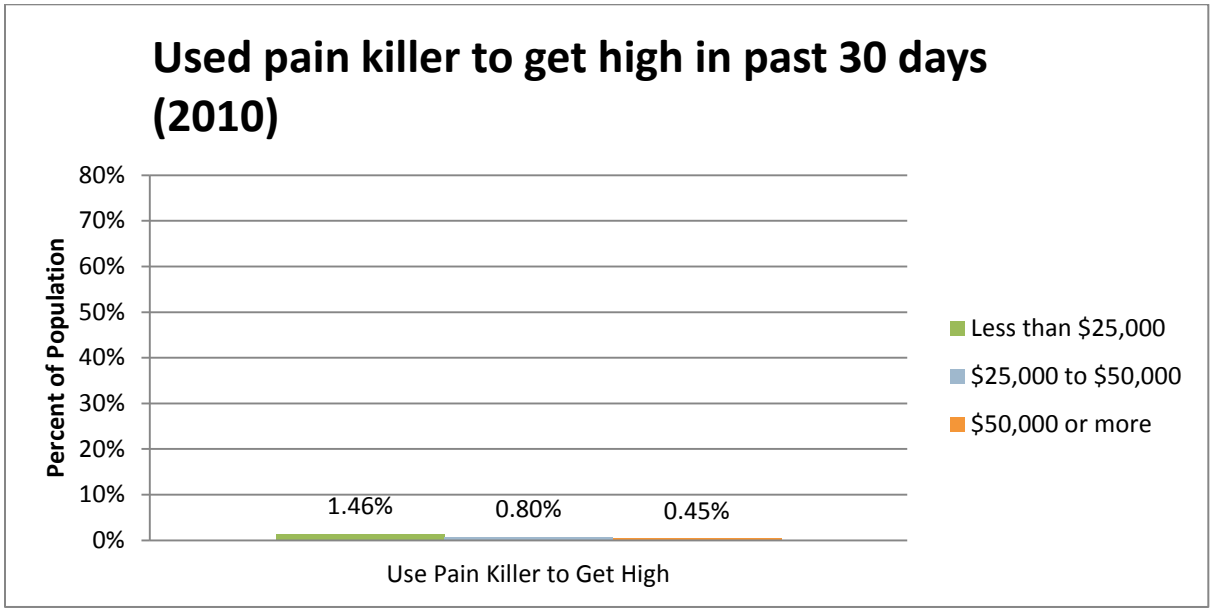
BRFSS - Figure 8



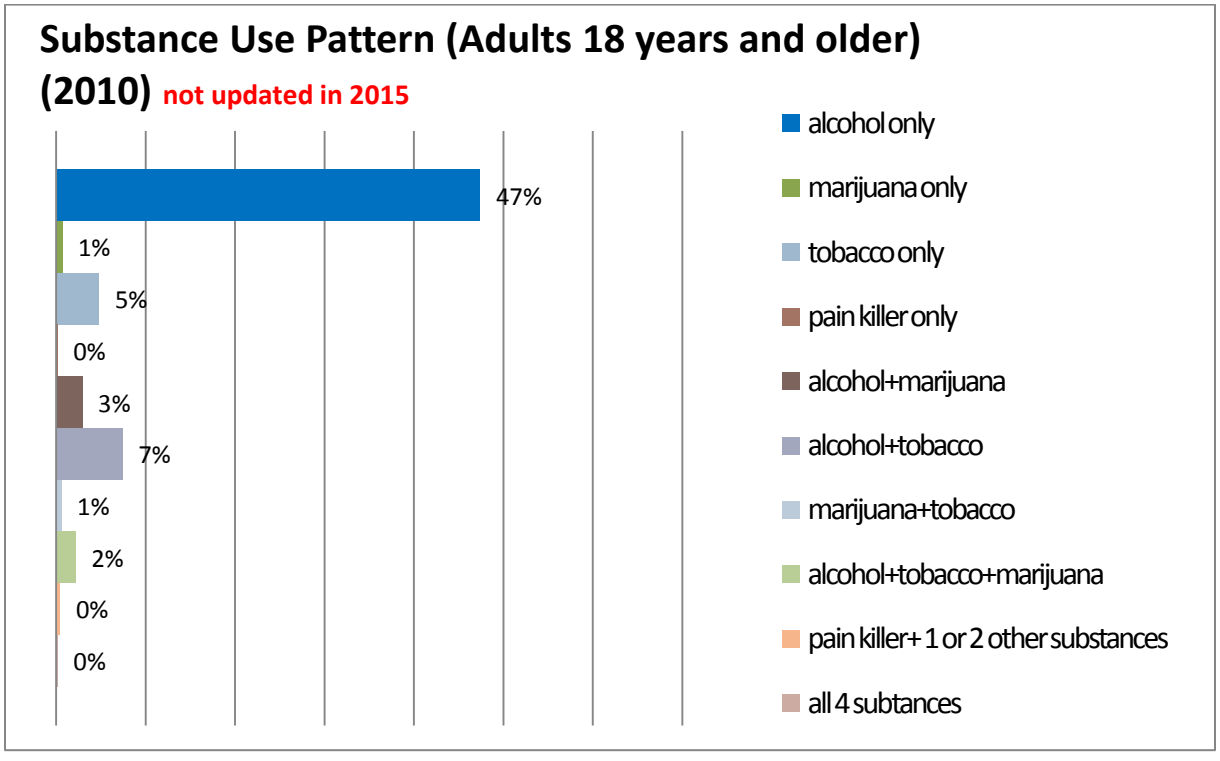
BRFSS - Figure 9



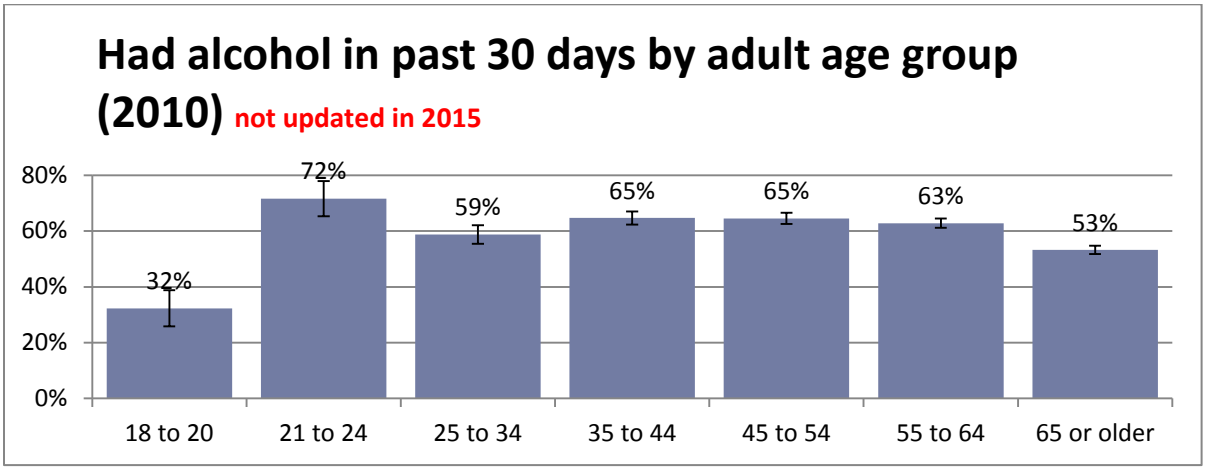
BRFSS - Figure 10



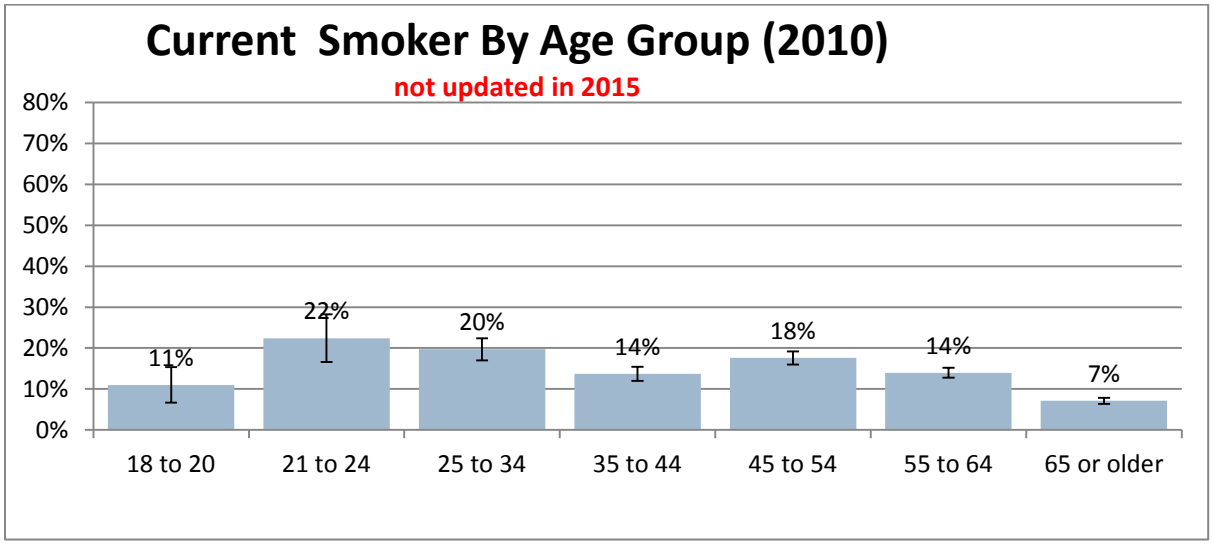
BRFSS - Figure 11



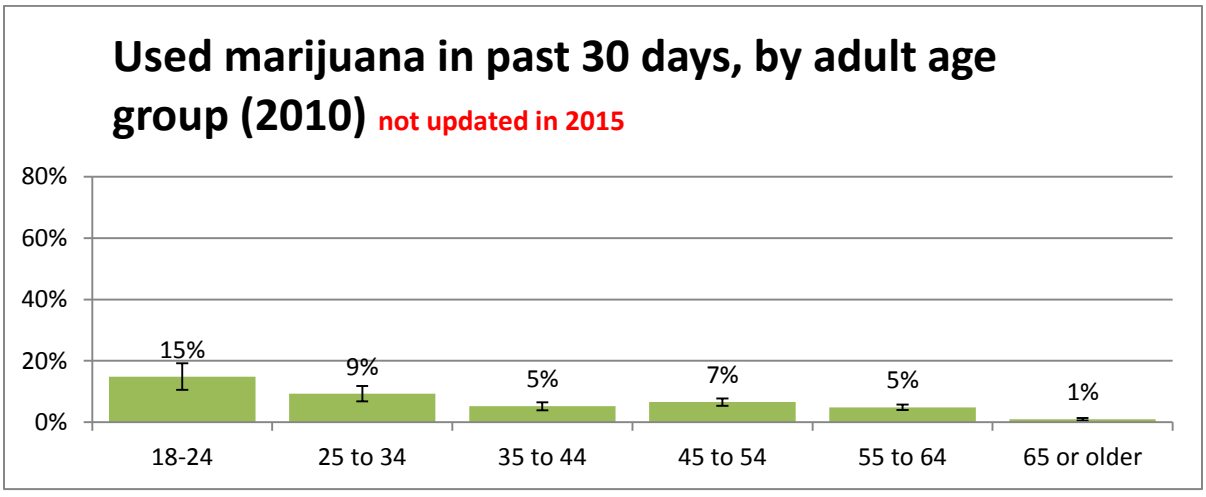
BRFSS - Figure 12



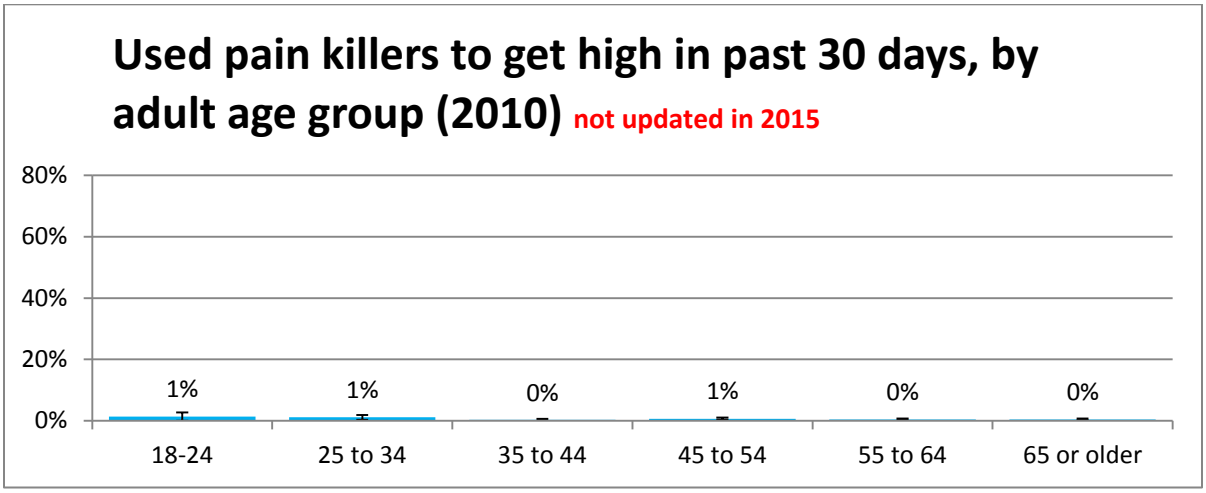
BRFSS - Figure 13



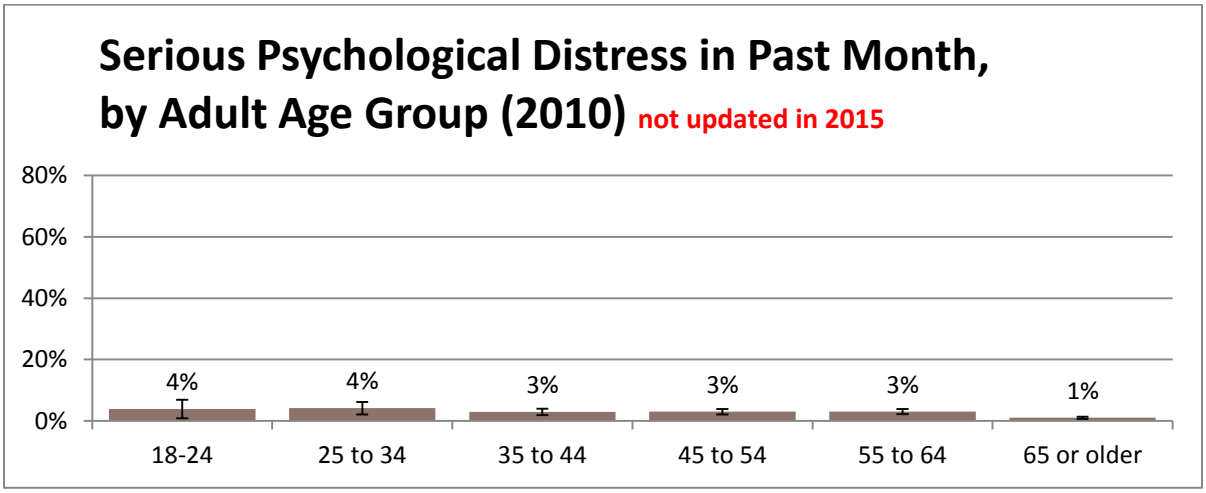
BRFSS - Figure 14



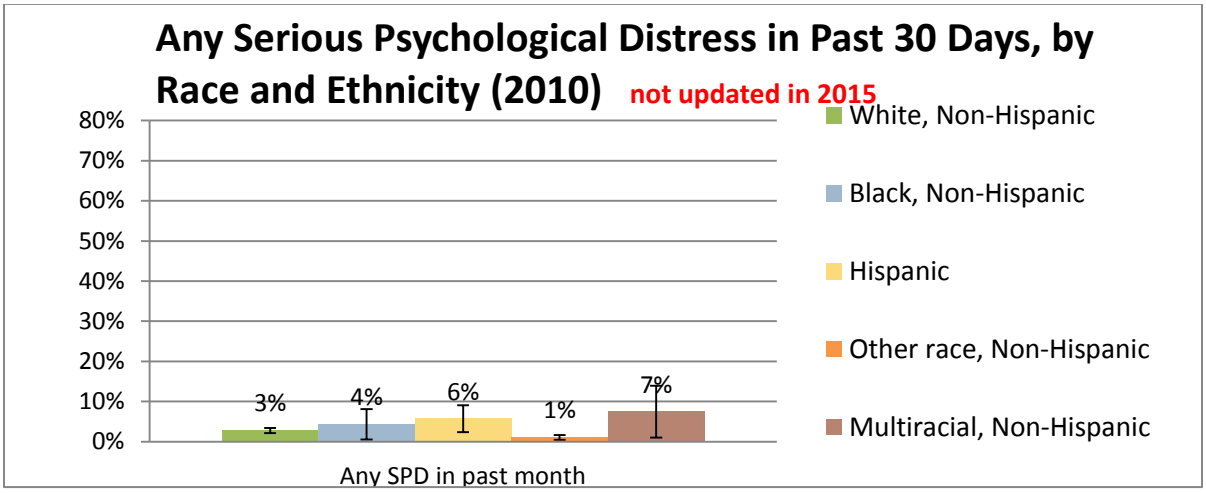
BRFSS - Figure 15



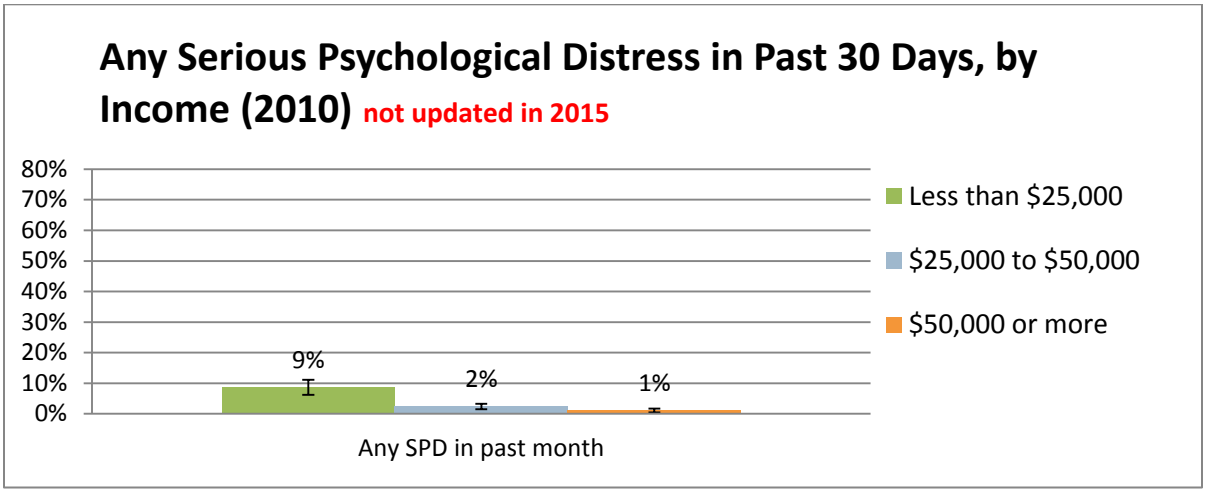
BRFSS - Figure 16



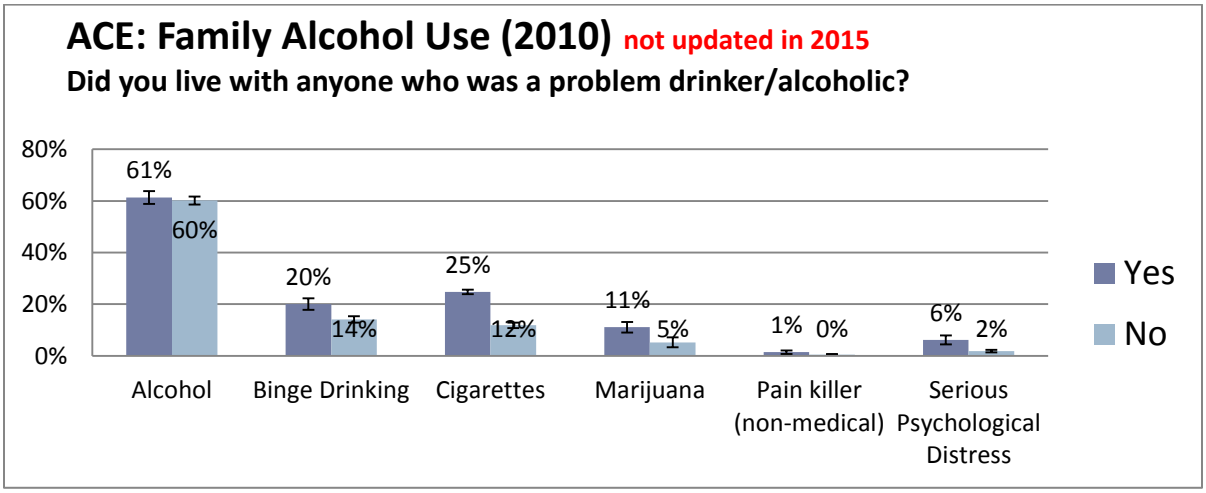
BRFSS - Figure 17



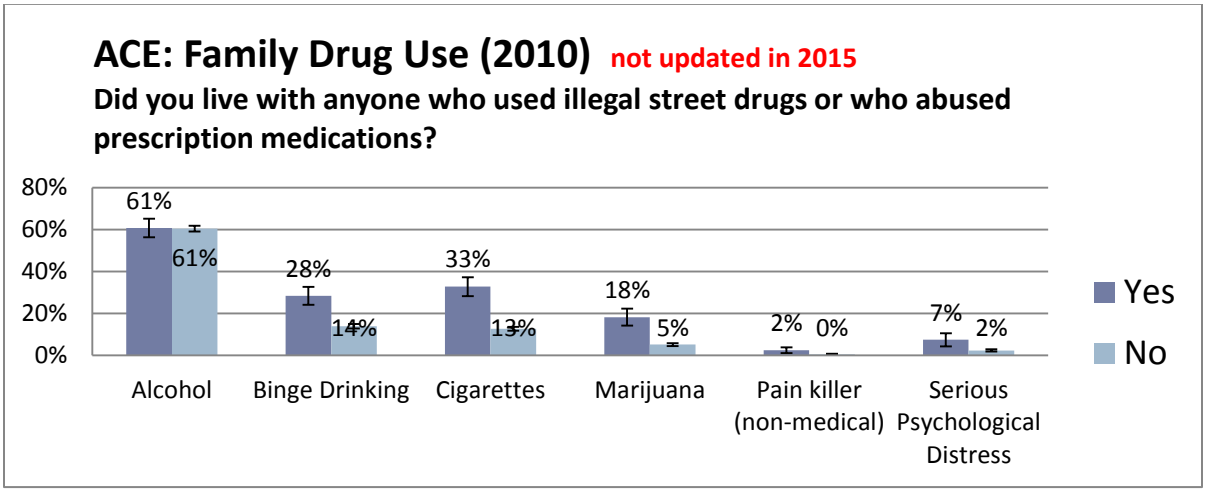
BRFSS - Figure 18



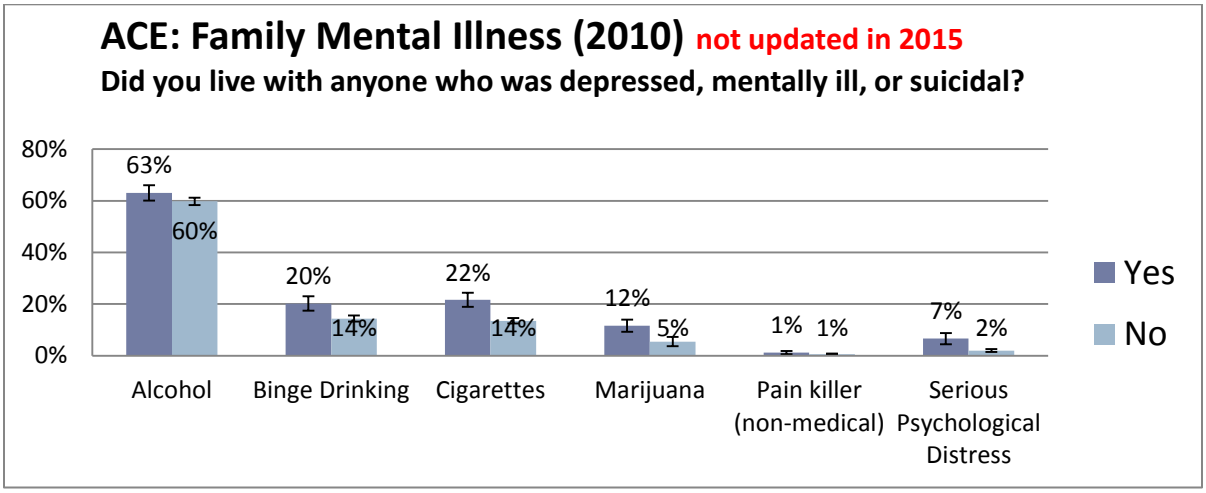
BRFSS - Figure 19



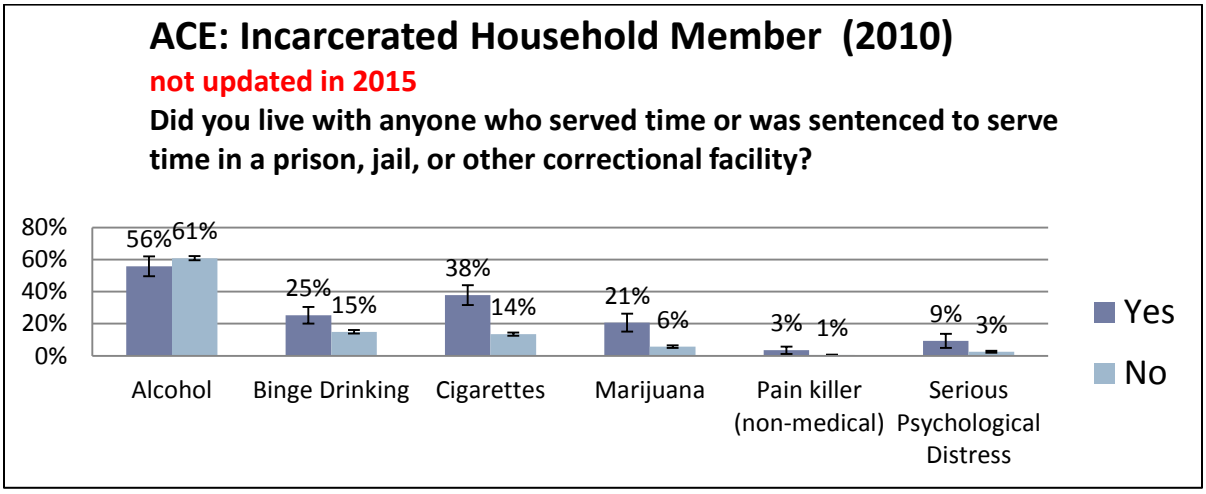
BRFSS - Figure 20



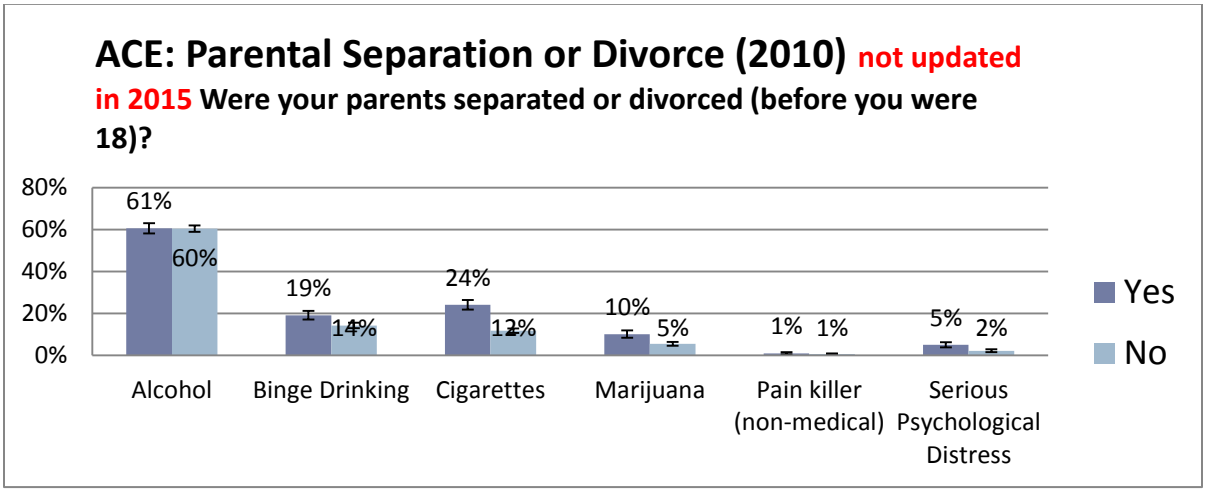
BRFSS - Figure 21



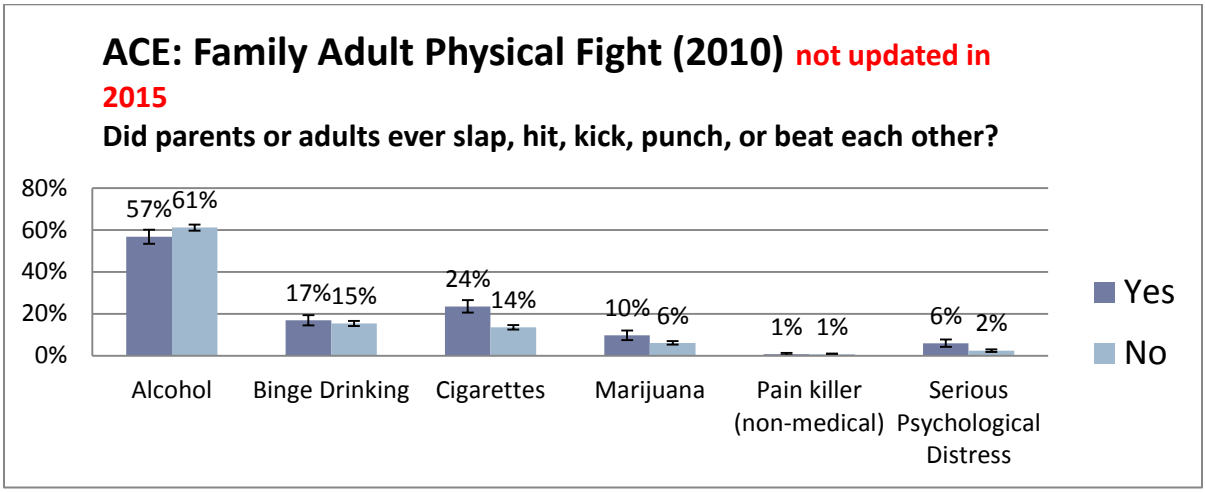
BRFSS - Figure 22



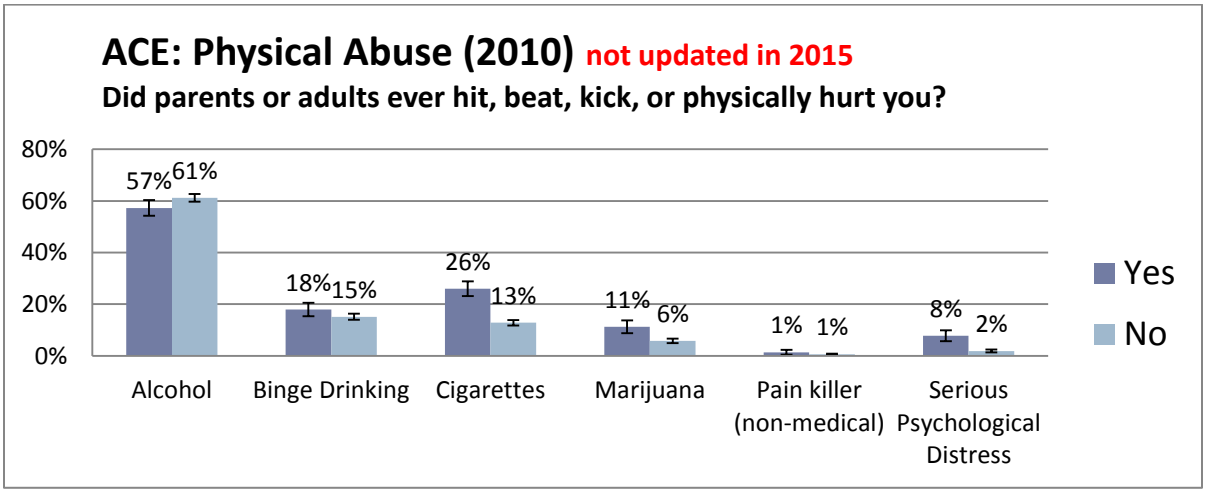
BRFSS - Figure 23



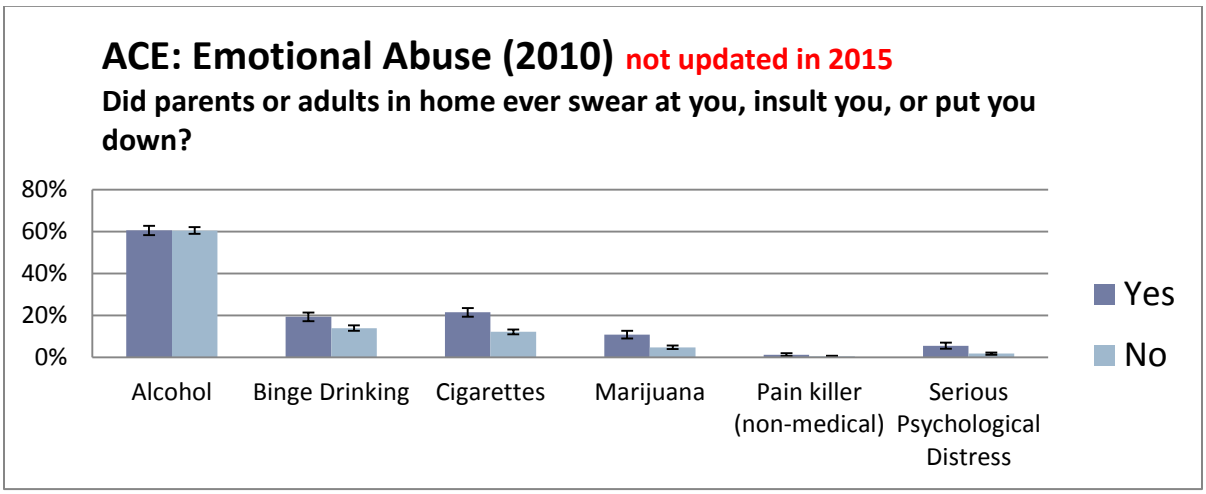
BRFSS - Figure 24



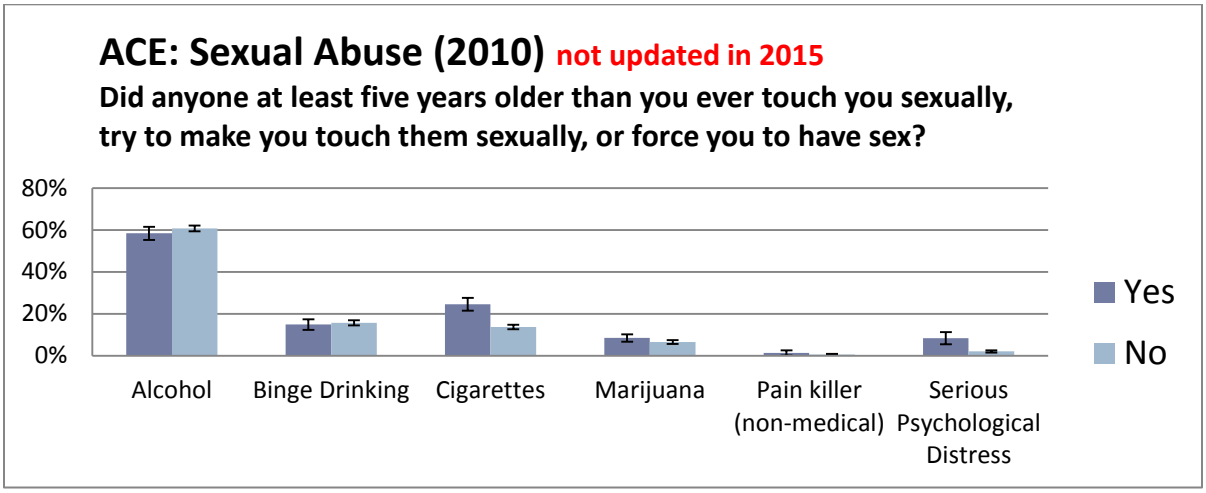
BRFSS - Figure 25



BRFSS - Figure 26



BRFSS - Figure 27



BRFSS - Figure 28

ACEs:	Drinking Alcohol	Binge Drinking	Smoking Cigarettes	Using Marijuana	Using Pain Killers to Get High	Serious Psychological Distress
Family Drinking	1.05	1.54	2.46	2.28	2.92	3.53
Family Drug Use	1.01	2.47	3.36	4.15	5.18	3.40
Family Mental Illness	1.15	1.51	1.77	2.28	1.96	3.45
Household Members Incarcerated	0.81	1.93	3.90	4.31	6.92	4.01
Parents Divorced or Separated	1.01	1.43	2.39	1.95	1.49	2.41
Family Adult Physical Fight	0.84	1.12	1.96	1.66	1.08	2.60
Physical Abuse	0.85	1.22	2.39	2.06	2.40	4.44
Emotional Abuse	1.00	1.48	1.97	2.43	2.66	3.34
Sexual Abuse	0.91	0.94	2.05	1.33	2.26	4.30

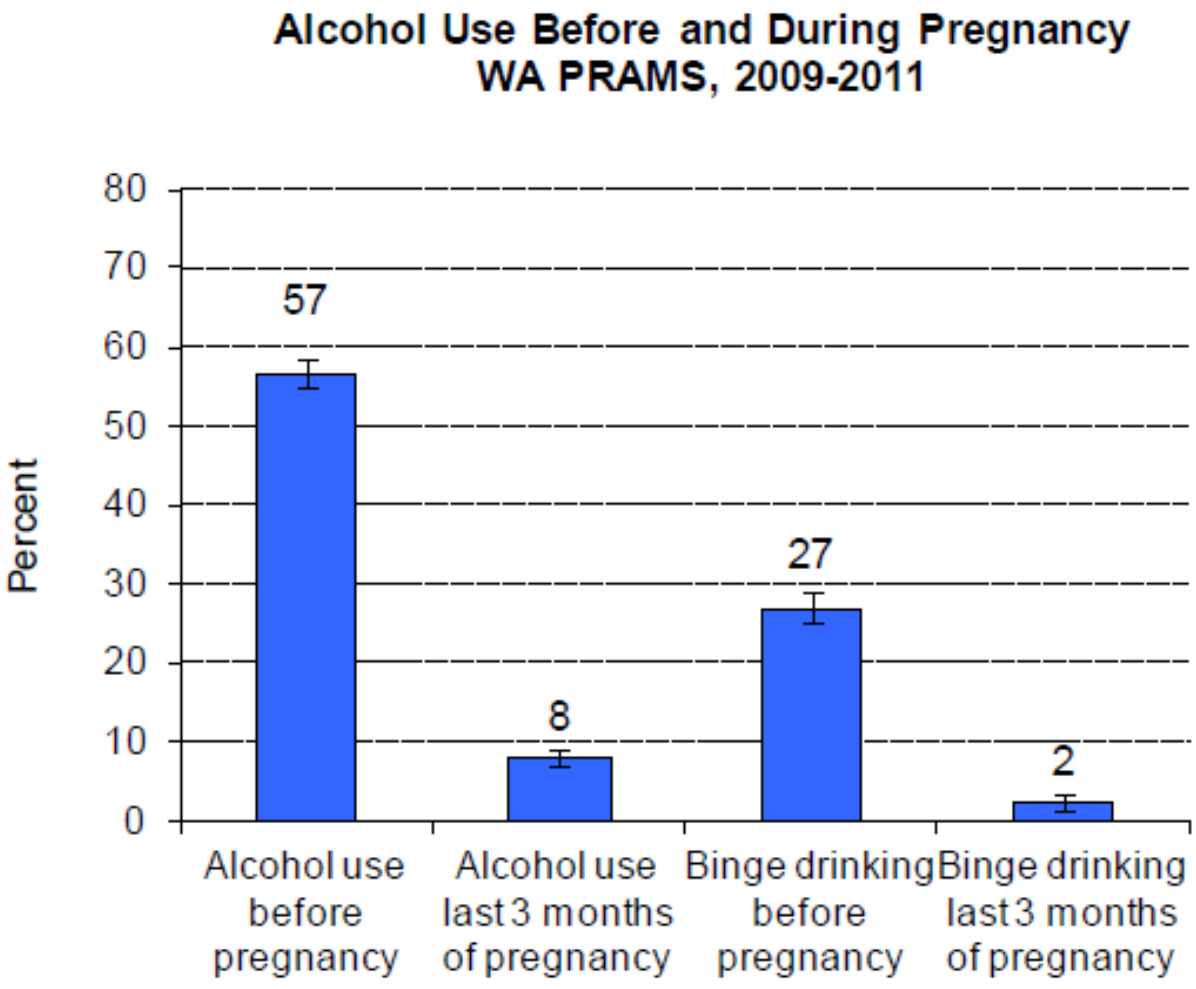
* This diagram was not updated in the 2015 Strategic Plan Update. ACEs questions not asked on latest version of BRFSS.

Pregnancy Risk Assessment Monitoring System (PRAMS): *Figures PRAMS 1-9*

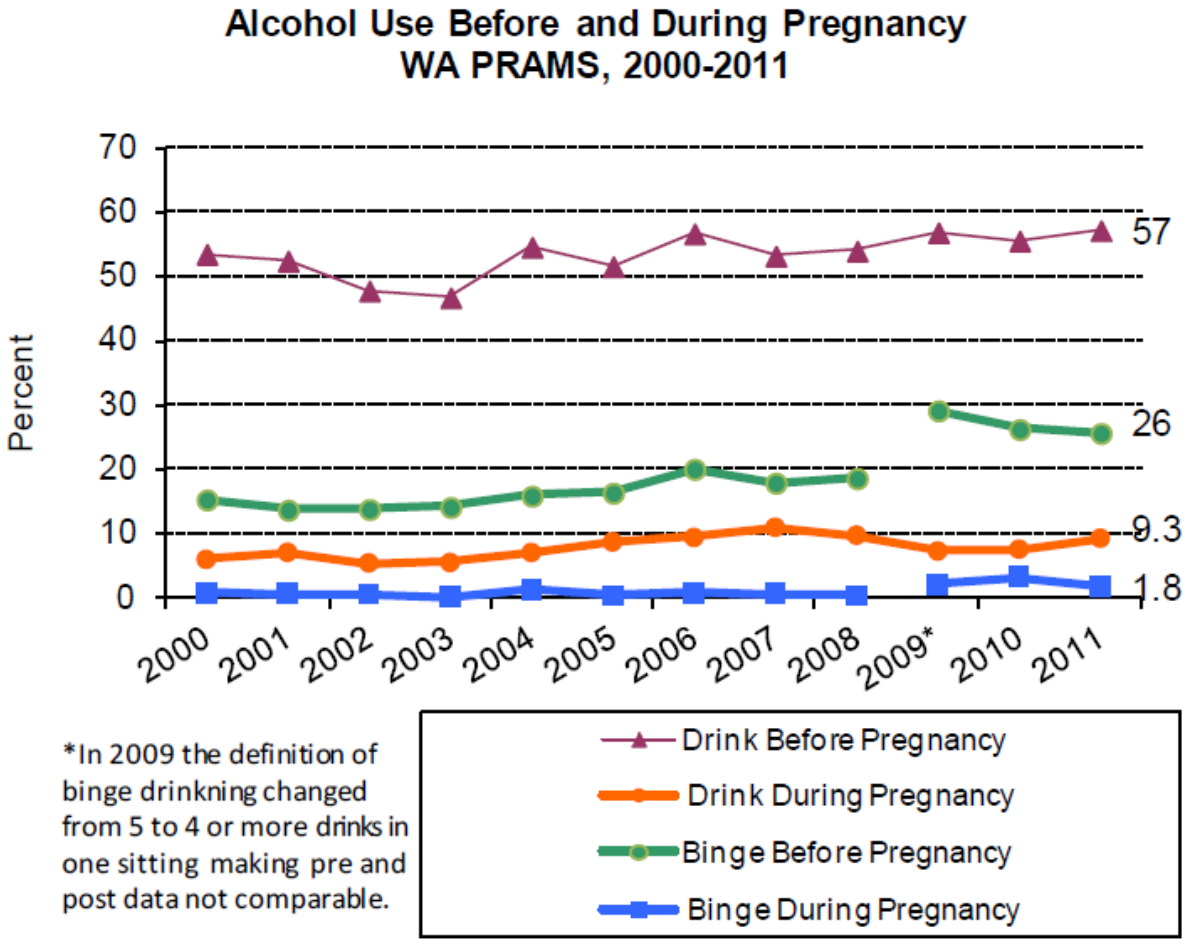
Notes:

- National and statewide mail and telephone survey.
- Collects data on new mothers' behaviors and experiences before, during, and shortly after pregnancy.
- Respondents: new mothers 2 to 6 months after delivering a baby.
- Sample size: approximately 1,800 surveys mailed each year in Washington with about a 76% response rate.
- PRAMS information was included in the 2015 update to include 2009-2011 data.

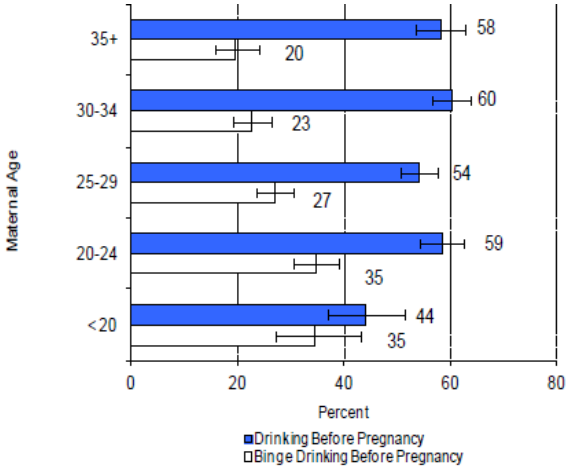
PRAMS - Figure 1



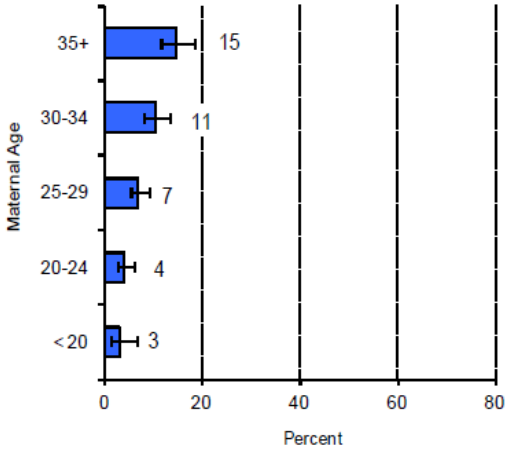
PRAMS - Figure 2



PRAMS - Figure 3

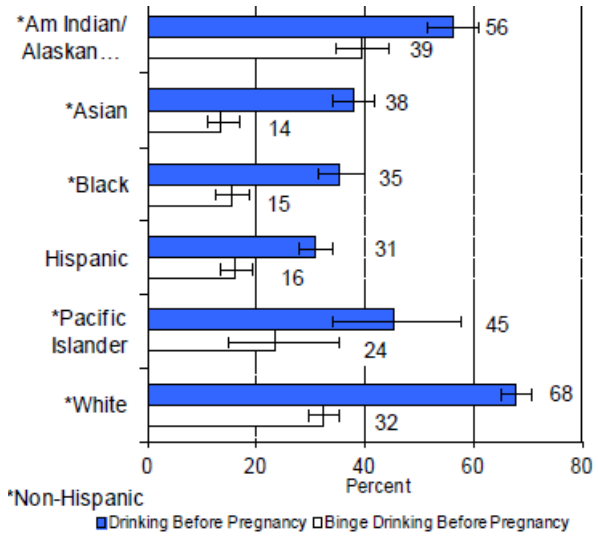


Drinking and Binge Drinking Before Pregnancy by Maternal Age, 2009-2011

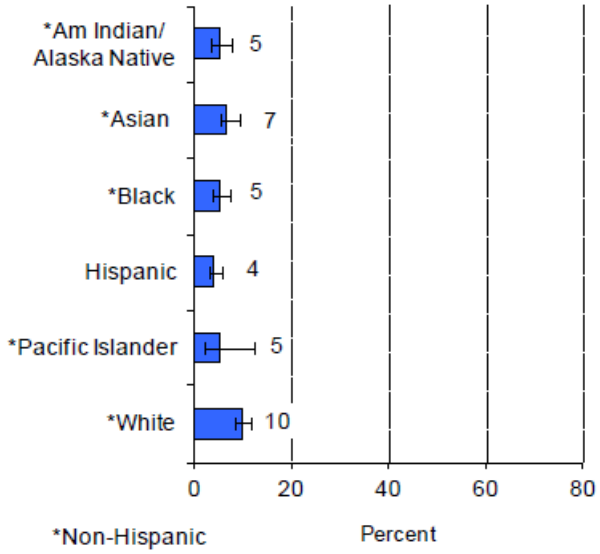


Drinking In Third Trimester by Maternal Age, 2009-2011

PRAMS - Figure 4



Drinking and Binge Drinking Before Pregnancy by Maternal Race/Ethnicity, 2009-2011

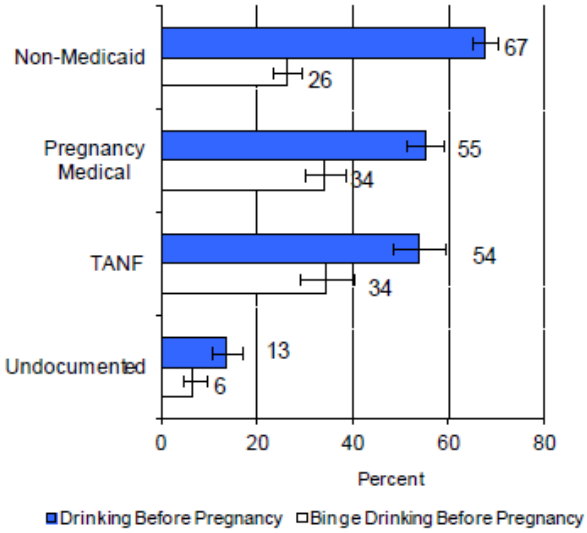


Drinking In Third Trimester by Maternal Race/Ethnicity, 2009-2011

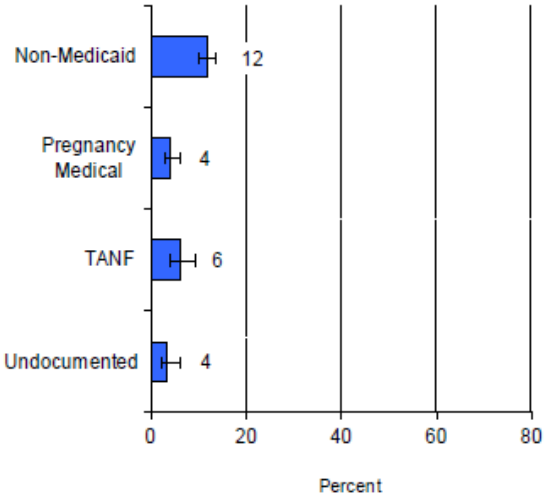
Notes: S-women, in the table below, are citizens who are eligible to receive Medicaid because they are pregnant and have income at or below 185% federal poverty line.

PRAMS - Figure 5

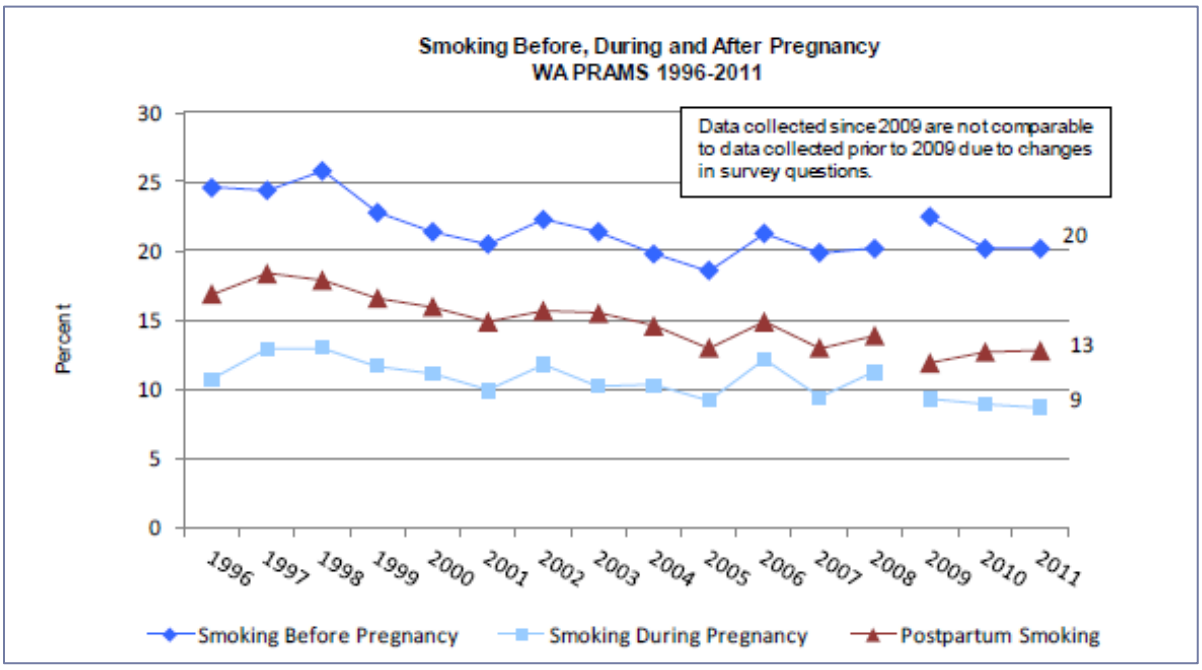
Drinking and Binge Drinking Before Pregnancy by Medicaid Program, 2009-2011



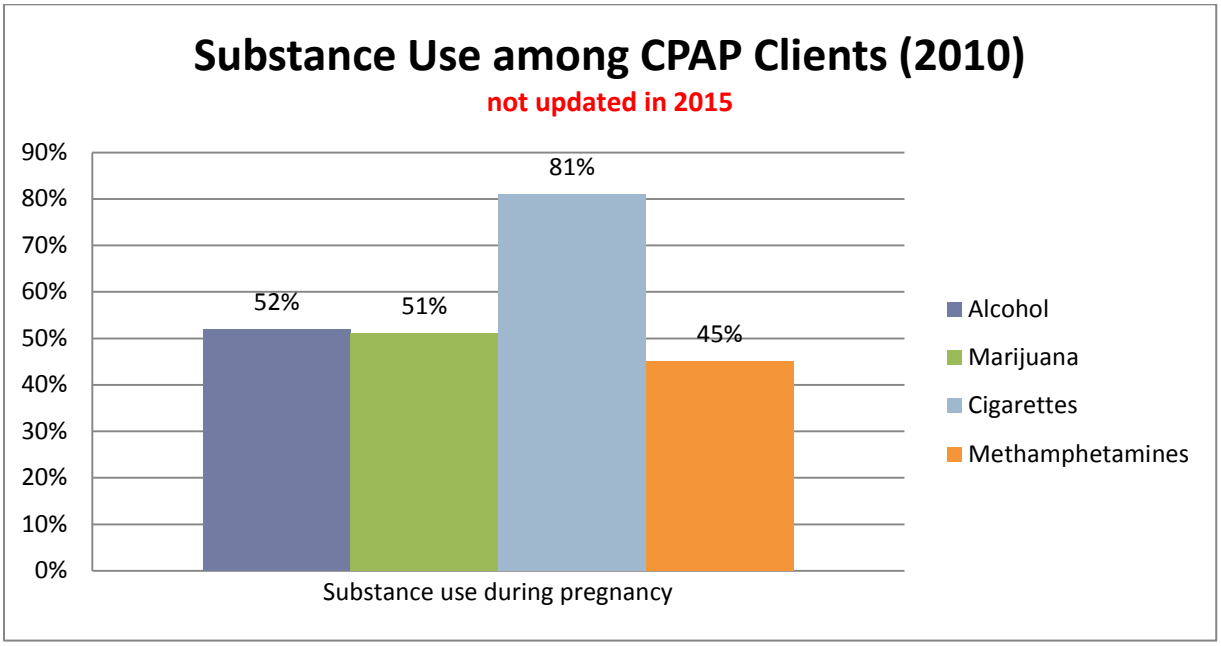
Drinking In Third Trimester by Medicaid Program, 2009-2011



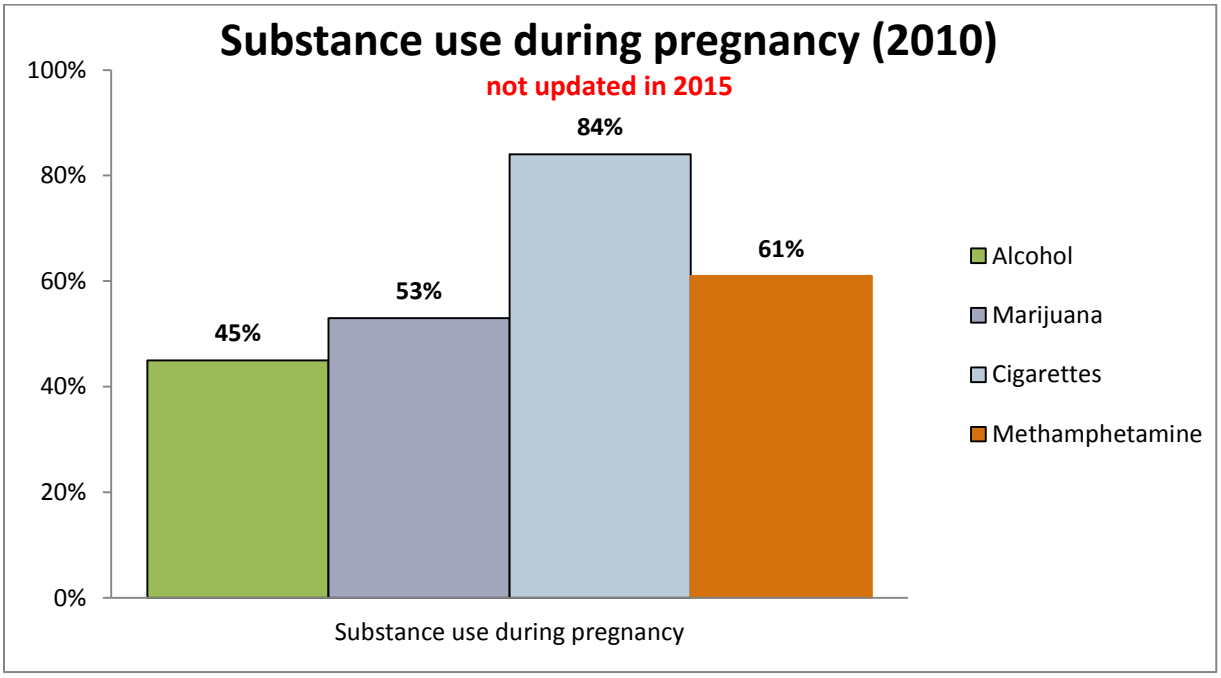
PRAMS - Figure 6



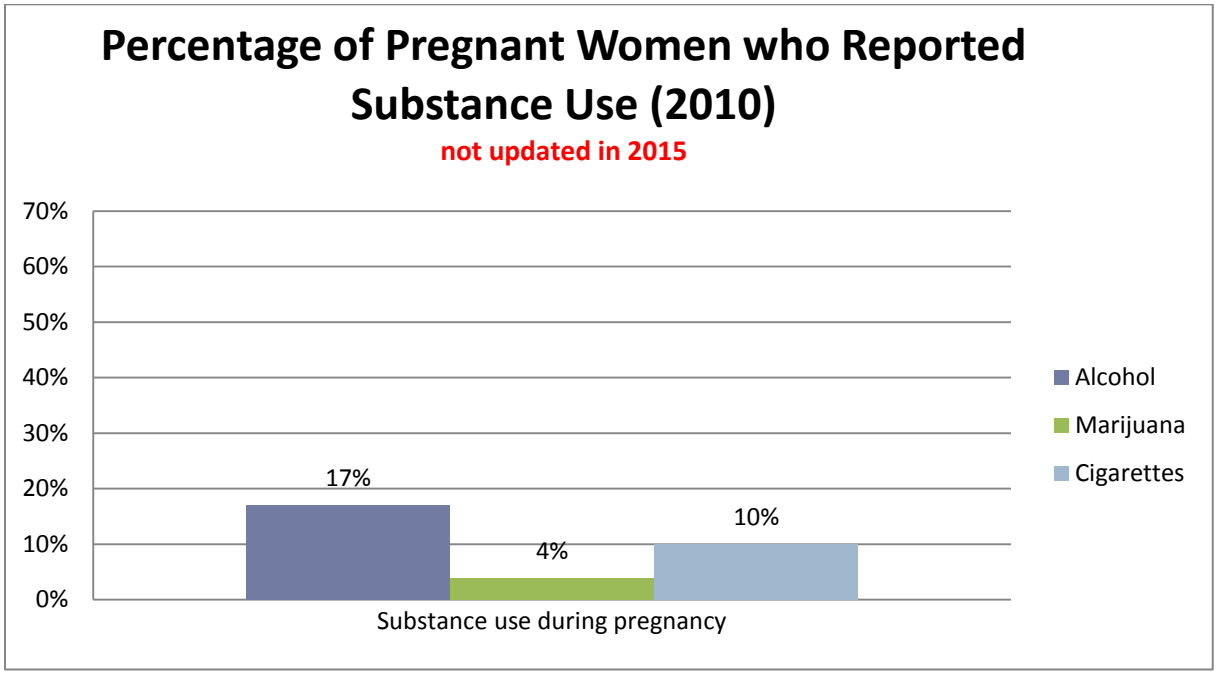
PRAMS - Figure 7



PRAMS - Figure 8



PRAMS - Figure 9

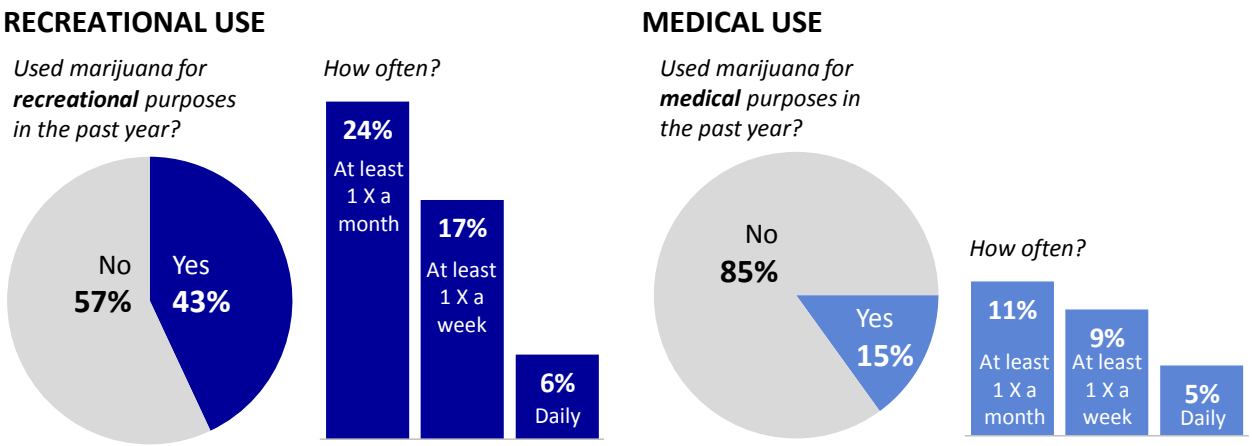


Young Adult Survey 2014: *Figures 1-2*
Center for the Study of Health and Risk Behaviors at the University of Washington and the Department of Social and Health Services and the Washington State Epidemiological Outcomes Workgroup

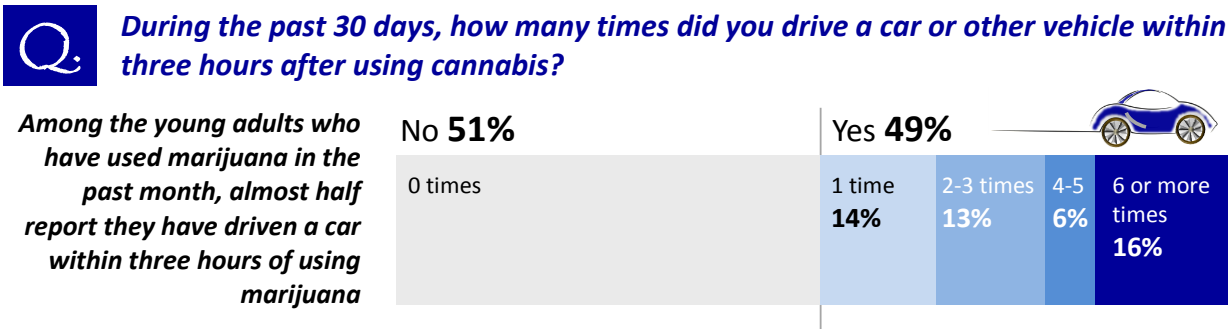
Notes:

- First Statewide Young Adult Survey in Washington State.
- Internet based survey conducted from May through early July of 2014.
- Survey Participation 2,101 Washington residents aged 18-25.
    - County level participation: 39 counties participated

YAHS - Figure 1



YAHS - Figure 2

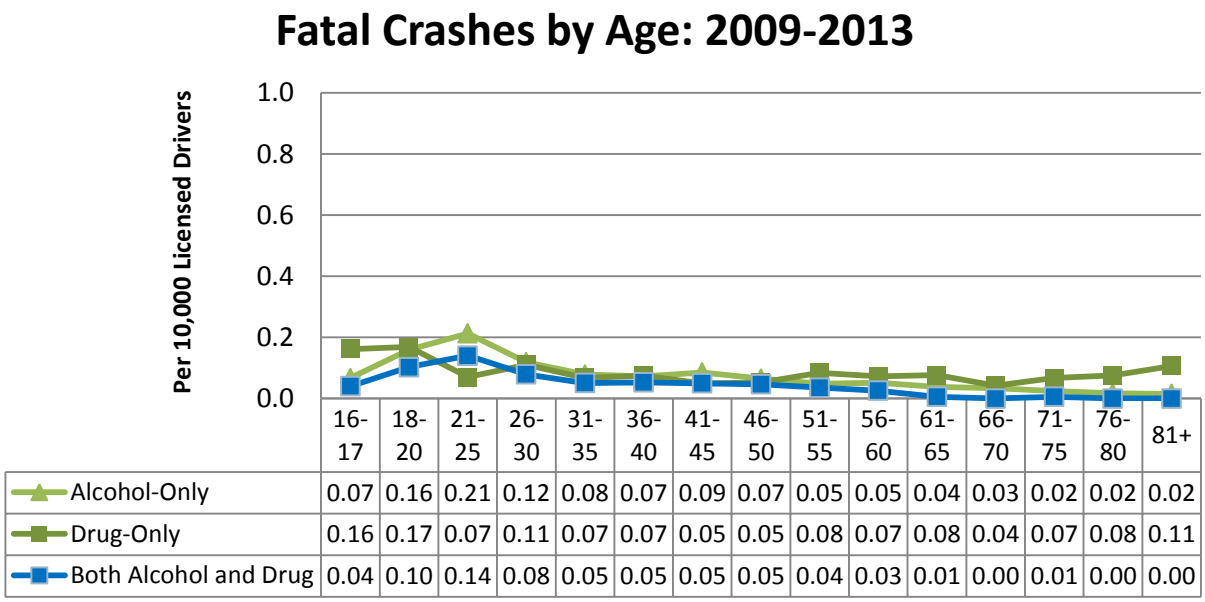


Traffic Data: *Figures Traffic Data 1-3*
Fatality Analysis Reporting System (FARS)

Notes:

- Nationwide census with data regarding fatal injuries suffered in motor vehicle traffic crashes.
- Maintained by National Highway Traffic Safety Administration (NHTSA).
- Data available yearly from 1975.
- Collects data on crashes involving a motor vehicle traveling on a traffic way customarily open to the public and resulting in the death of a person within 30 days of the crash.
- Counts of DUI arrests and Fatal Crashes declining (2009-2013 data) – similar to historical and national trends
- Increased use of "ignition interlock devices"
- Conclusion: **DUI/crash impacts inconclusive (for now)**

Traffic Data - Figure 1

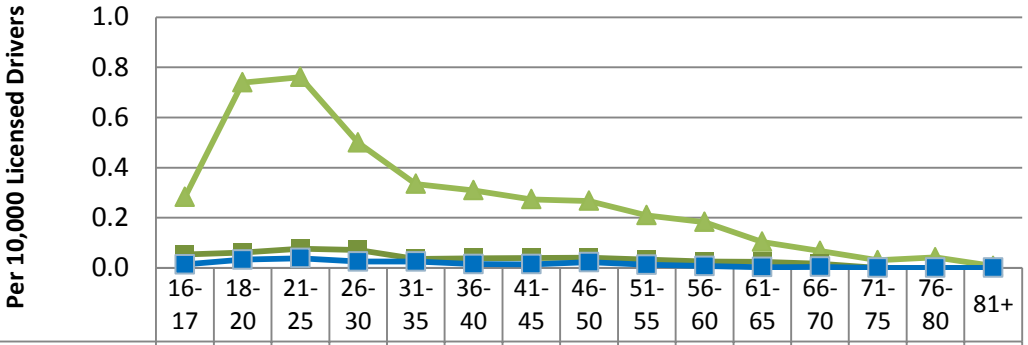


	16-17	18-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81+
Alcohol-Only	0.07	0.16	0.21	0.12	0.08	0.07	0.09	0.07	0.05	0.05	0.04	0.03	0.02	0.02	0.02
Drug-Only	0.16	0.17	0.07	0.11	0.07	0.07	0.05	0.05	0.08	0.07	0.08	0.04	0.07	0.08	0.11
Both Alcohol and Drug	0.04	0.10	0.14	0.08	0.05	0.05	0.05	0.05	0.04	0.03	0.01	0.00	0.01	0.00	0.00

Sources: Data provided by the Washington Traffic Safety Commission. Fatality Analysis Reporting System (FARS), March 2015. Department of Licensing (data on licensed drivers by age/year), March 2015.

Traffic Data - Figure 2

Serious Injurys by Age: 2009-2013



	16-17	18-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81+
Alcohol-Only	0.28	0.74	0.76	0.50	0.34	0.31	0.27	0.27	0.21	0.18	0.10	0.07	0.03	0.04	0.01
Drug-Only	0.05	0.06	0.08	0.07	0.04	0.04	0.04	0.04	0.03	0.03	0.02	0.02	0.00	0.00	0.00
Both Alcohol and Drug	0.01	0.03	0.04	0.03	0.03	0.01	0.01	0.02	0.01	0.01	0.00	0.00	0.00	0.00	0.00

Sources: Data provided by the Washington Traffic Safety Commission. Fatality Analysis Reporting System (FARS), March 2015. Department of Licensing (data on licensed drivers by age/year).

Traffic Data - Figure 3

Traffic Fatalities - WSDOT, Target Zero Priority One

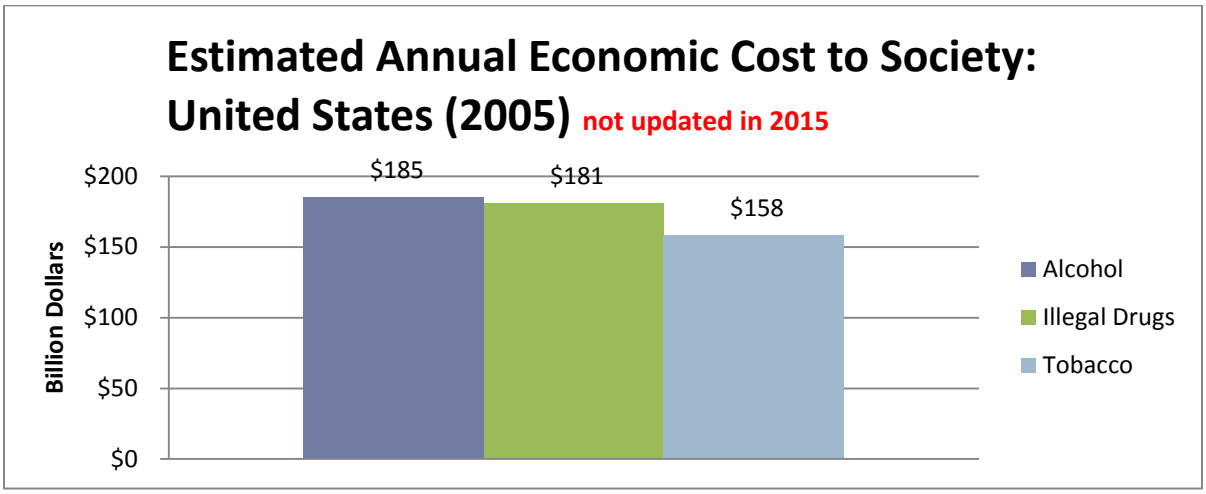
Target Zero Years	2003-2005		2006-2008		2009-2011		2012-2014*		2012-2014* v. 2009-2011
	Deaths	*% of Total Deaths*	*Deaths*	*% of Total Deaths*	*Deaths*	*% of Total Deaths*	*Deaths*	*% of Total Deaths*	*Percent Change in Number of Deaths*
Total Fatalities	**1,816**	***100.0%***	**1,725**	***100.0%***	**1,406**	***100.0%***	**1,333**	***100.0%***	***-5.2%***
Priority One									
Alcohol/Drug Impaired Driver-Involved	794	*43.7%*	827	*47.9%*	704	*50.1%*	647	*48.5%*	***-8.1%***
Drinking Driver-Involved	706	*38.9%*	712	*41.3%*	610	*43.4%*	478	*35.9%*	***-21.6%***
Alcohol Impaired Driver-Involved	557	*30.7%*	544	*31.5%*	476	*33.9%*	364	*27.3%*	***-23.5%***
Drug Impaired Driver-Involved	412	*22.7%*	473	*27.4%*	416	*29.6%*	448	*33.6%*	***7.7%***
Run Off the Road	765	*42.1%*	720	*41.7%*	615	*43.7%*	516	*38.7%*	***-16.1%***
Speeding Driver-Involved	707	*38.9%*	693	*40.2%*	555	*39.5%*	504	*37.8%*	***-9.2%***

Source: Data provided by the Washington Traffic Safety Commission, Washington Department of Transportation, Target Zero, April 2015.

Note: * 2014 figures are based on preliminary data, and are subject to change up until 11:59 PM on December 31, 2015.

Economic Data: *Figures Economic Data 1-2*

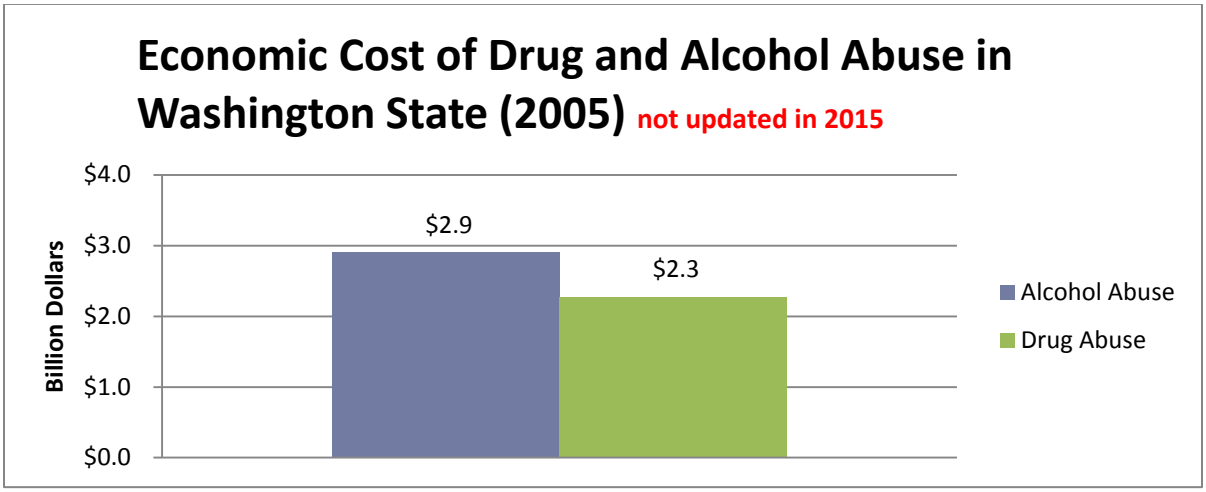
Economic Data - Figure 1



Source: Surgeon General's Report, 2004; ONDCP, 2004; Harwood, 2000, quoted in NIDA (2008). Addition Science: From Molecules to Managed Care.
http://www.drugabuse.gov/publications/addiction-science

Note: Economic costs include specialty treatment, medical consequences, lost earnings, and other costs such as accidents and criminal justice.

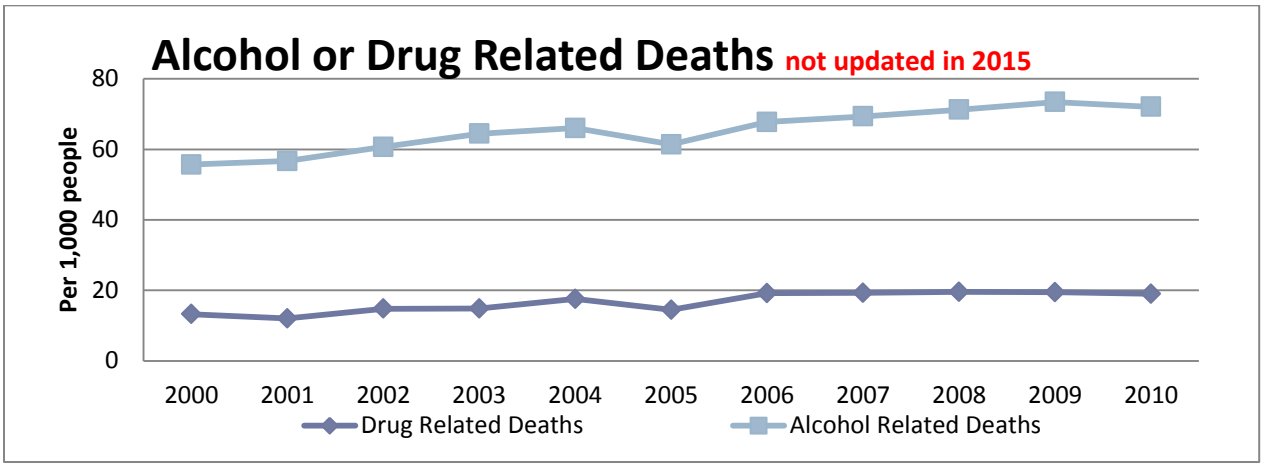
Economic Data - Figure 2



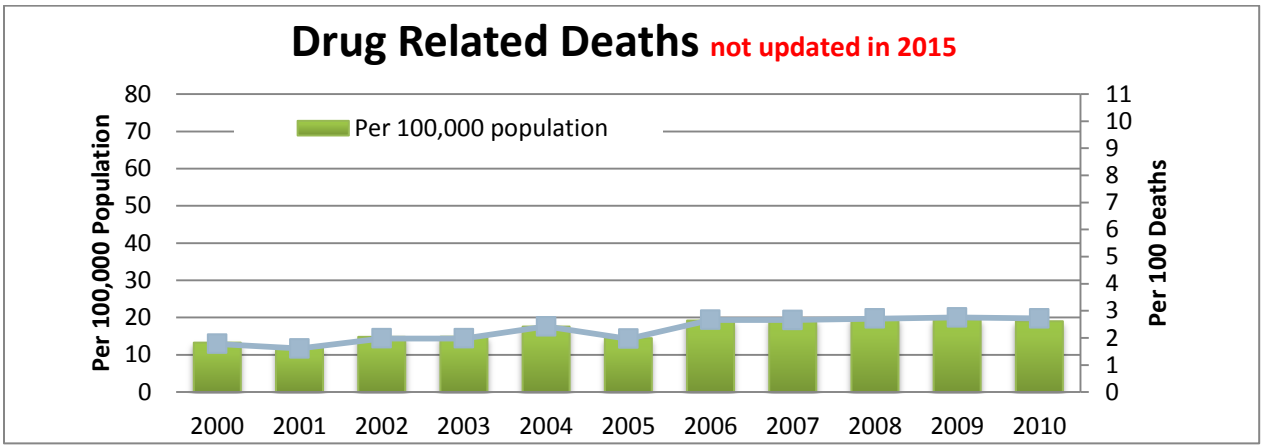
Source: Computed from Wickizer, T. The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

Death Data: *Figures Death Data 1-3*

Death Data - Figure 1

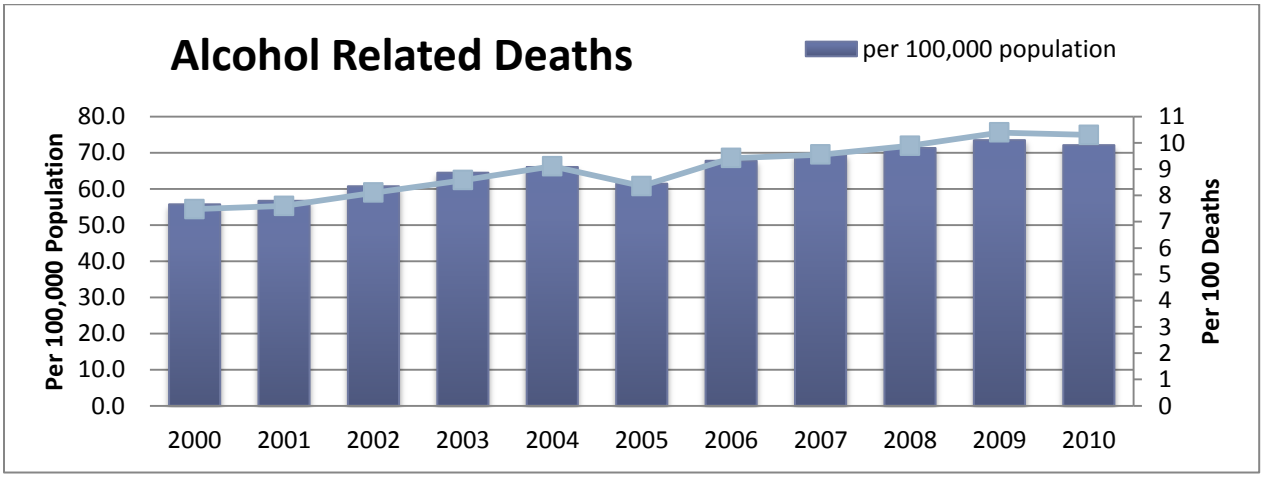


Death Data - Figure 2



*Source: Department of Health, Center for Health Statistics, Death Certificate Data File

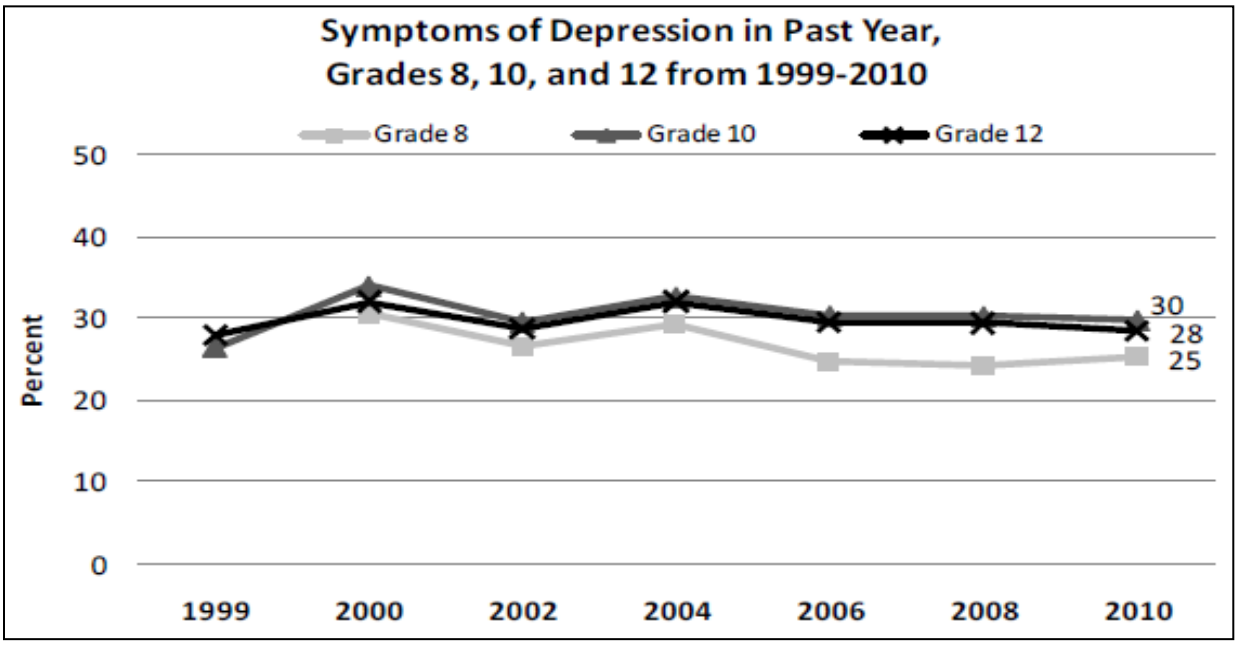
Death Data - Figure 3



*Source: Department of Health, Center for Health Statistics, Death Certificate Data File

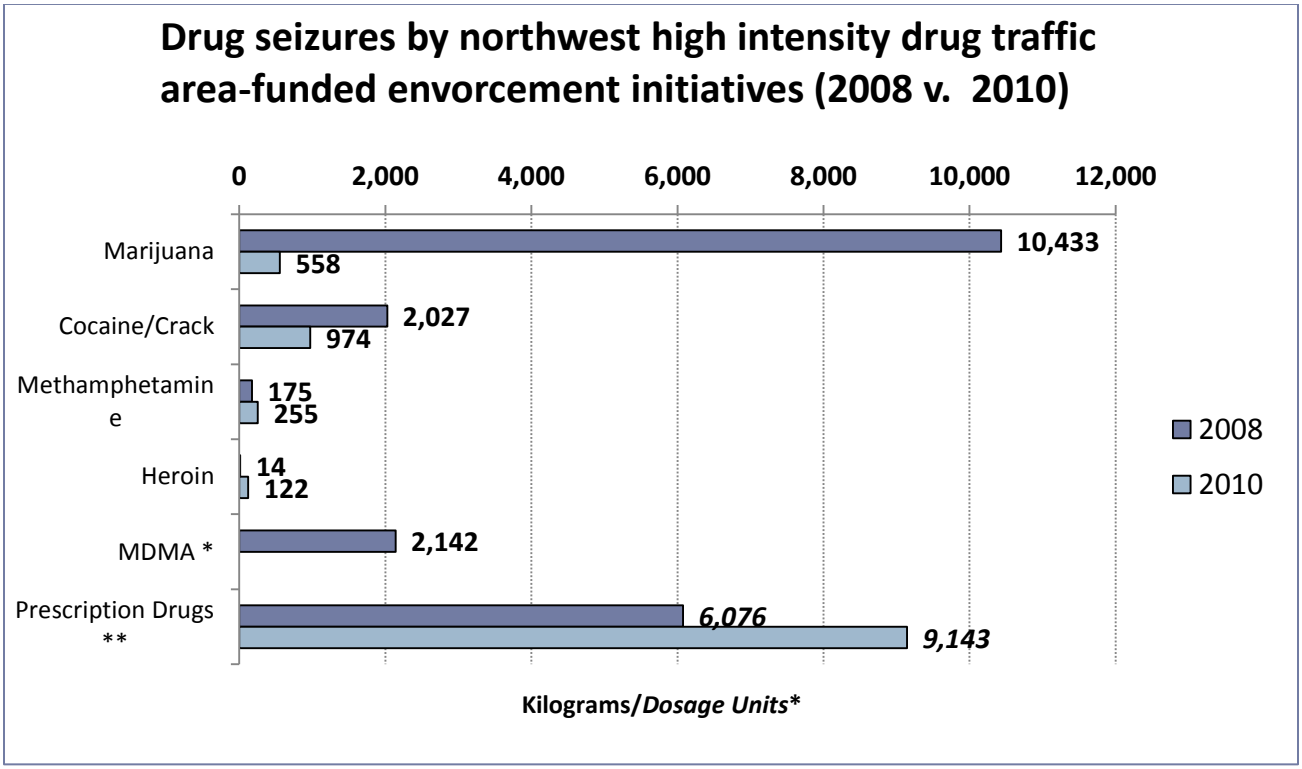
Other Data: *Figures Other data 1-2*

Other Data - Figure 1



Source: YRBS, 1999, WASSAHB, 2000, HYS, 2002, 2004, 2006, 2008, 2010

Other Data - Figure 2

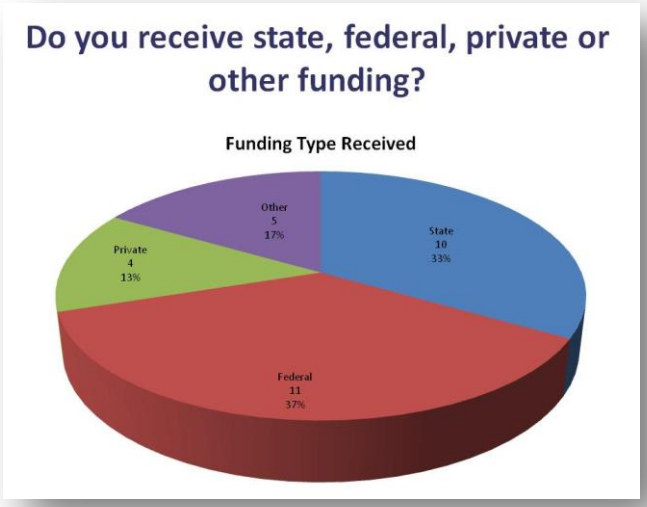


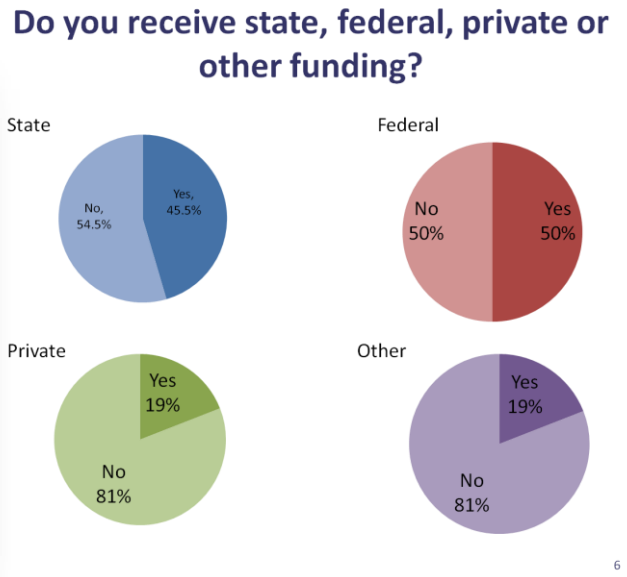
Source: U.S. Department of Justice, National Drug Intelligence Center. Northwest High Intensity Drug Trafficking Area Drug Market Analysis, 2011-R0813-023, September 2011.

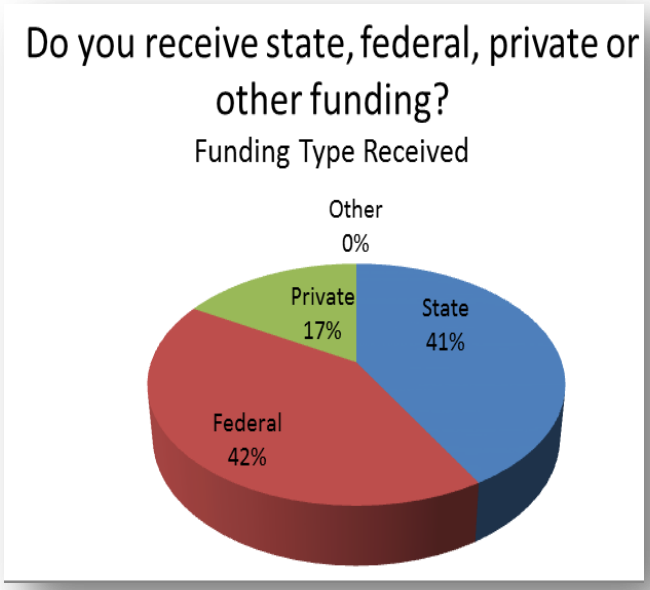
6. Resource Assessment

The information that follows is a summary of the survey results of the Resources Assessment. Consortium partners responded to a series of questions regarding funding and resources they provide. A compilation of the Resources Assessment presentation provided *is available online at: www.TheAthenaForum.org/SPE*.

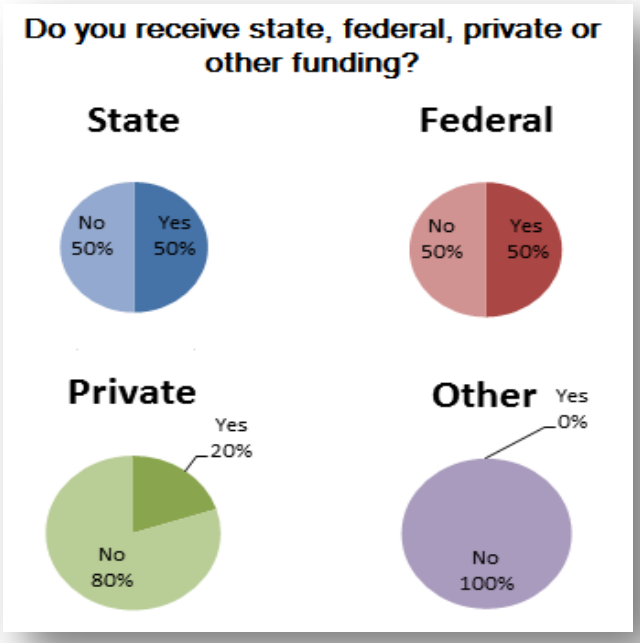
Funding Information





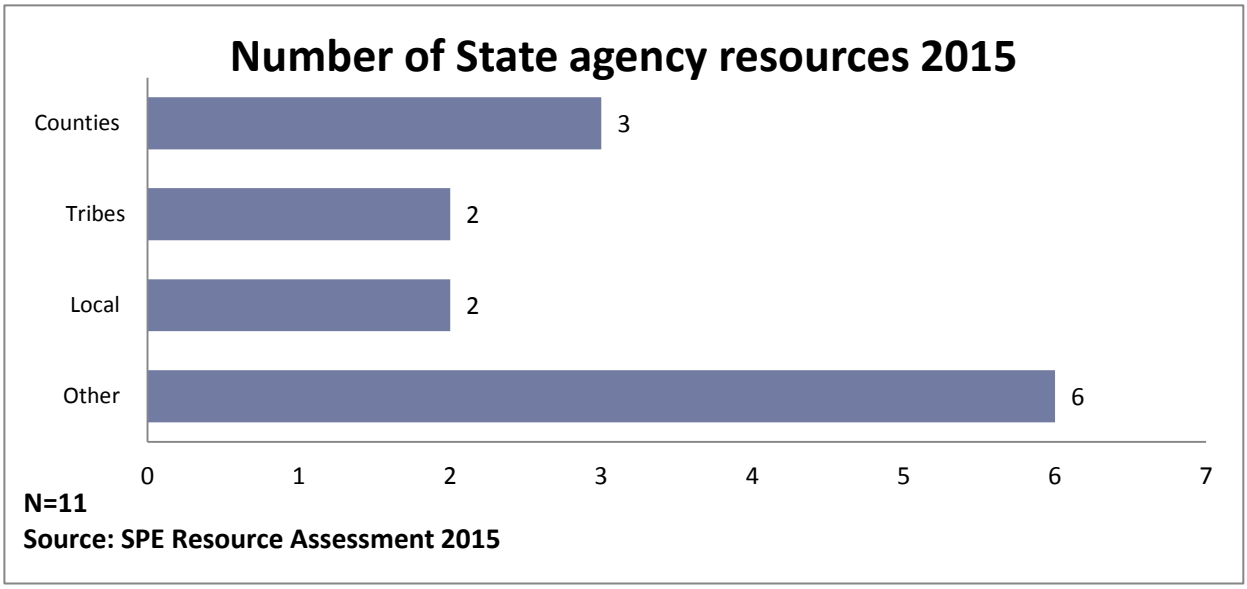


N=10
Source: SPE Resource Assessment 2015



N=10
Source: SPE Resource Assessment 2015

Resources - Figure 1



N=11

Source: SPE Resource Assessment 2015

7. Resources Assessment

Below is a quick reference of which counties have funds allocated to them from the listed agency. The arrow indicates comparison to median for number of resources per county.

2012

State Agency Resources allocated to Counties

County	CMOB	DBHR	DEL	DOH	WSP	WTSC	NWHIDTA	Subtotal
Adams	x	x	x	x				4
Asotin	x	x		x				3
Benton	x	x		x		x	x	5
Chelan	x	x		x		x		4
Clallam	x	x		x		x		4
Clark	x	x		x		x	x	5
Cowlitz	x	x	x	x		x	x	6
Columbia	x	x		x				3
Douglas	x	x		x		x		4
Ferry	x	x		x		x		4
Franklin	x	x	x	x		x	x	6
Garfield	x	x		x				3
Grant	x	x		x		x		4
Grays Harbor	x	x	x	x		x		5
Island	x	x		x				3
Jefferson	x	x		x		x		4
Klickitat	x	x		x				3
Kitsap	x	x		x		x	x	5
Kittitas	x	x		x		x		4
King	x	x	x	x	x	x	x	7
Lewis	x	x		x		x	x	5
Lincoln	x	x		x		x		4
Mason	x	x	x	x		x		5
Okanogan	x	x	x	x				4
Pacific	x	x	x	x		x		5
Pend Oreille	x	x	x	x				4
Pierce	x	x		x	x	x	x	6
San Juan	x	x		x				3
Skagit	x	x	x	x		x	x	6
Skamania	x	x		x				3
Snohomish	x	x	x	x	x	x	x	7
Spokane	x	x	x	x		x	x	6
Stevens	x	x		x				3
Thurston	x	x		x		x	x	5
Wahkiakum	x	x		x				3
Walla Walla	x	x		x		x		4
Whatcom	x	x		x			x	4
Whitman	x	x		x				3
Yakima	x	x	x	x		x	x	6

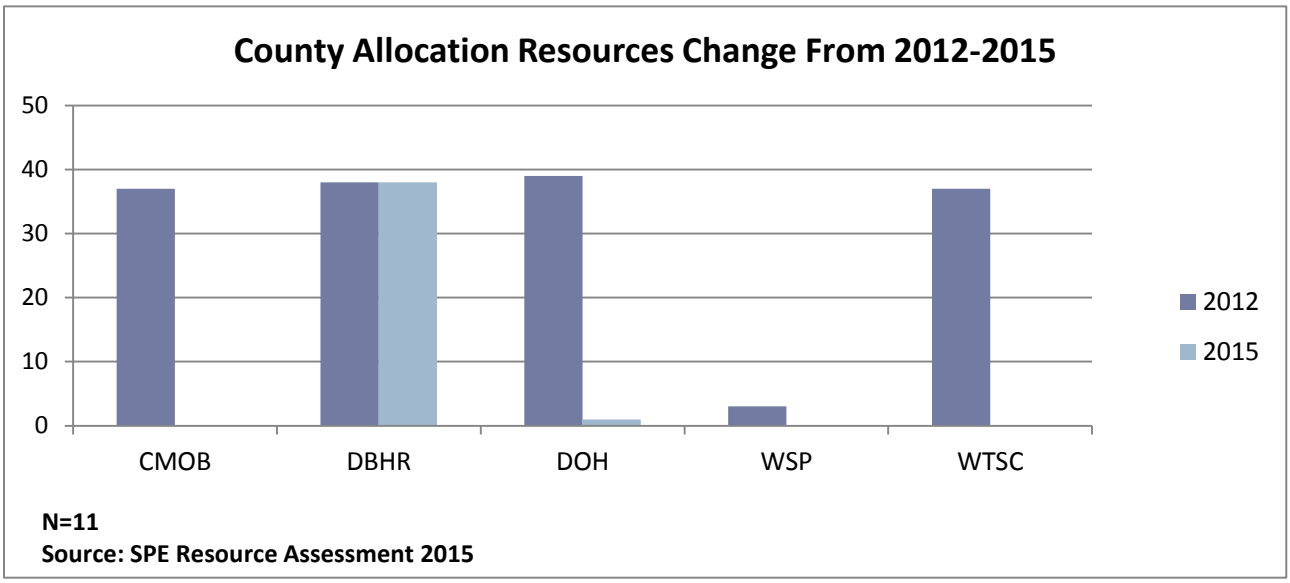
State Agency Resources Allocated to Counties 2015

County	Cmob	DBHR	DEL	DOH	WSP	WTSC	NWHIDTA	Subtotal
Adams		x	x					2
Asotin		x						1
Benton		x				x	x	2
Chelan		x				x		2
Clallam		x				x		2
Clark		x				x	x	2
Cowlitz		x	x			x	x	3
Columbia		x						1
Douglas		x				x		2
Ferry		x				x		2
Franklin		x	x			x	x	3
Garfield		x						1
Grant		x				x		2
Grays Harbor		x	x			x		3
Island		x						1
Jefferson		x						1
Klickitat		x						1
Kitsap		x				x	x	2
Kittitas		x				x		2
King		x	x		x	x	x	4
Lewis		x				x	x	2
Lincoln		x				x		2
Mason		x	x			x		3
Okanogan		x	x					2
Pacific		x	x			x		3
Pend Oreille		x	x					2
Pierce		x			x	x	x	3
San Juan		x						1
Skagit		x	x			x	x	3
Skamania		x						1
Snohomish		x	x		x	x	x	4
Spokane		x	x			x	x	3
Stevens		x						1
Thurston		x				x	x	2
Wahkiakum		x						1
Walla Walla		x				x		2
Whatcom		x					x	1
Whitman		x						1
Yakima		x	x				x	2

Notes: (a list of acronyms can be found in Appendix - *List of Agencies Acronyms and Abbreviations* on page 53)

- CMOB - county allocations
- DBHR - county allocations for prevention services/CPWI (not WHY or other special grants)
- DEL - county allocations for ESIT (special programs not indicated - NFP/Home visiting)
- DOH - Local Health Jurisdictions
- WSP - target zero
- WTSC - task forces
- NW HIDTA - federal funding allocated to counties

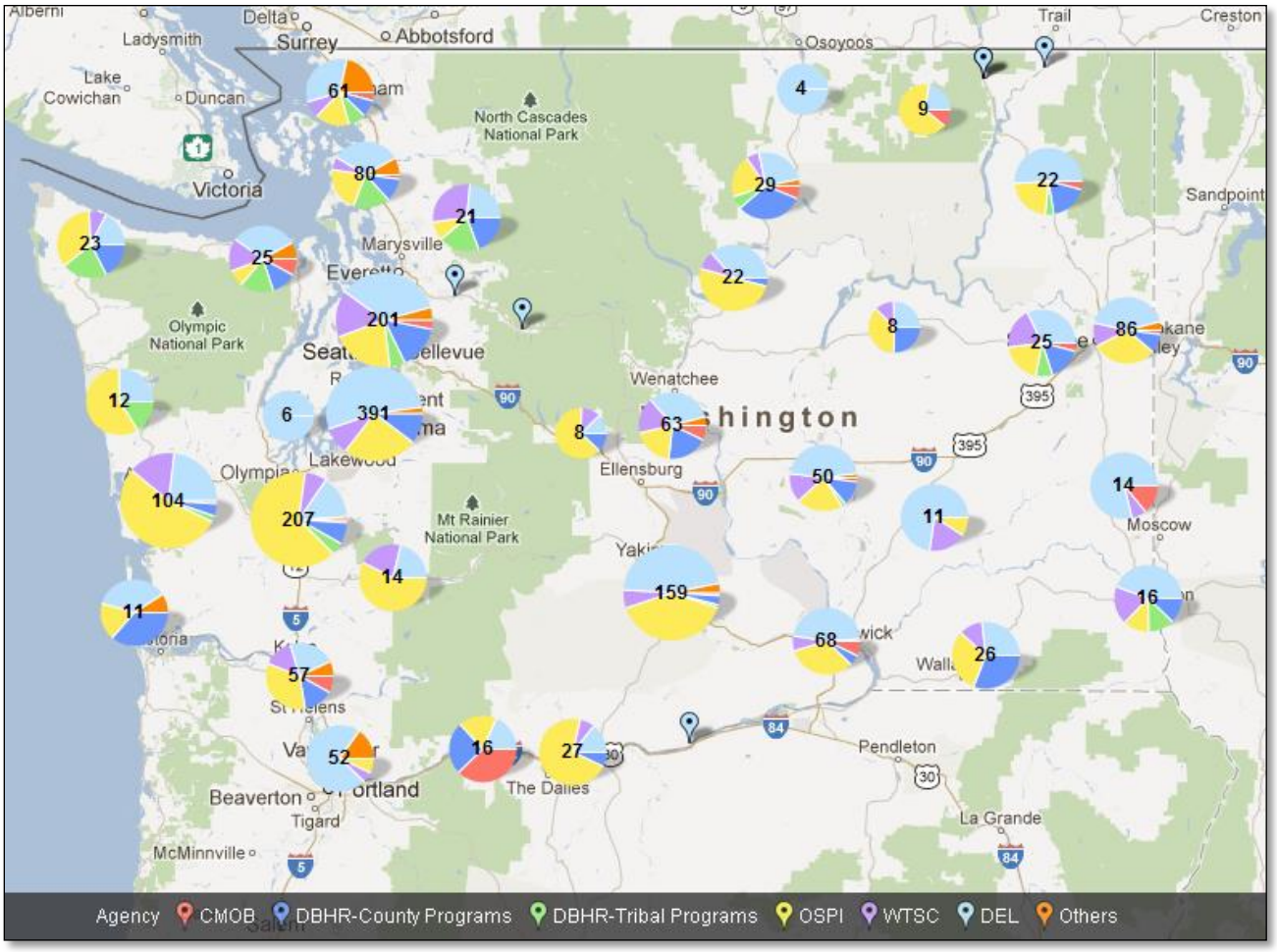
Resources - Figure 3



N=11
Source: SPE Resource Assessment 2015

Prevention Programs by Agency/Organization

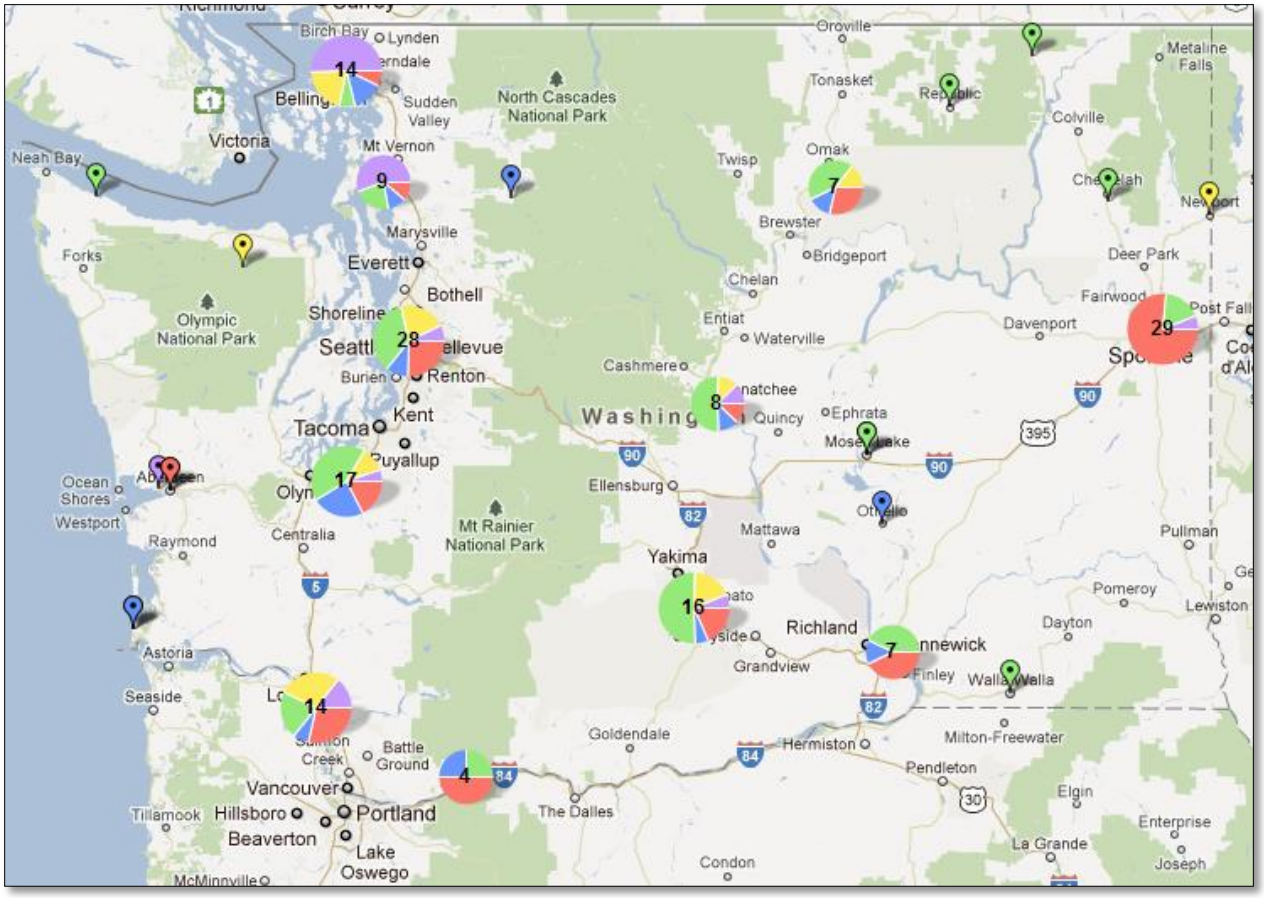
*This section was not updated in the Strategic Plan Update for 2015



- **CMOB** - direct service programs and coalitions
- **DBHR** - Tribal Programs
- **DBHR** –County Programs – direct service programs and coalitions
- **OSPI** – P/I Services and 21st Century sites
- **WSTC** - Corridor safety programs; DUI Enforcement Campaign; HS Distracted Driving projects; and Click It or Ticket projects
- **DEL** – ECEAP/Head Start
- **DOH** (other) – Community Transformation grant programs
- **DFC** (other) – project sites *[federal only]*
- **AGO**(other) – Cy Pres Funds for mental health programs
- **PSCB** (other) – SAPS Trainings

Coalitions by Agency/Organization

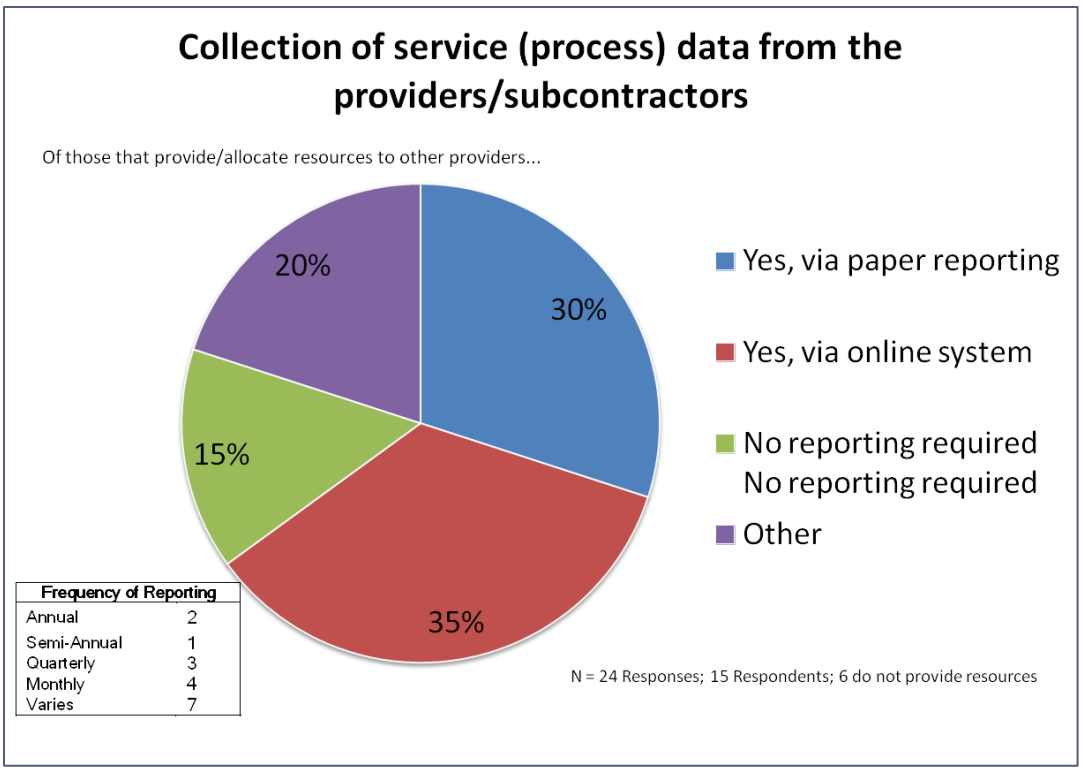
*This section was not updated in the Strategic Plan Update for 2015



- **CMOB** - Coalitions
- **DBHR** – PRI Coalitions
- **OSPI** –21st Century consortiums
- **DFC** – Project sites *[federal only]*
- **DOH** – Community Transformation grant coalitions

Collection of Evaluation Data

*This section not completed for the Strategic Plan Update 2015



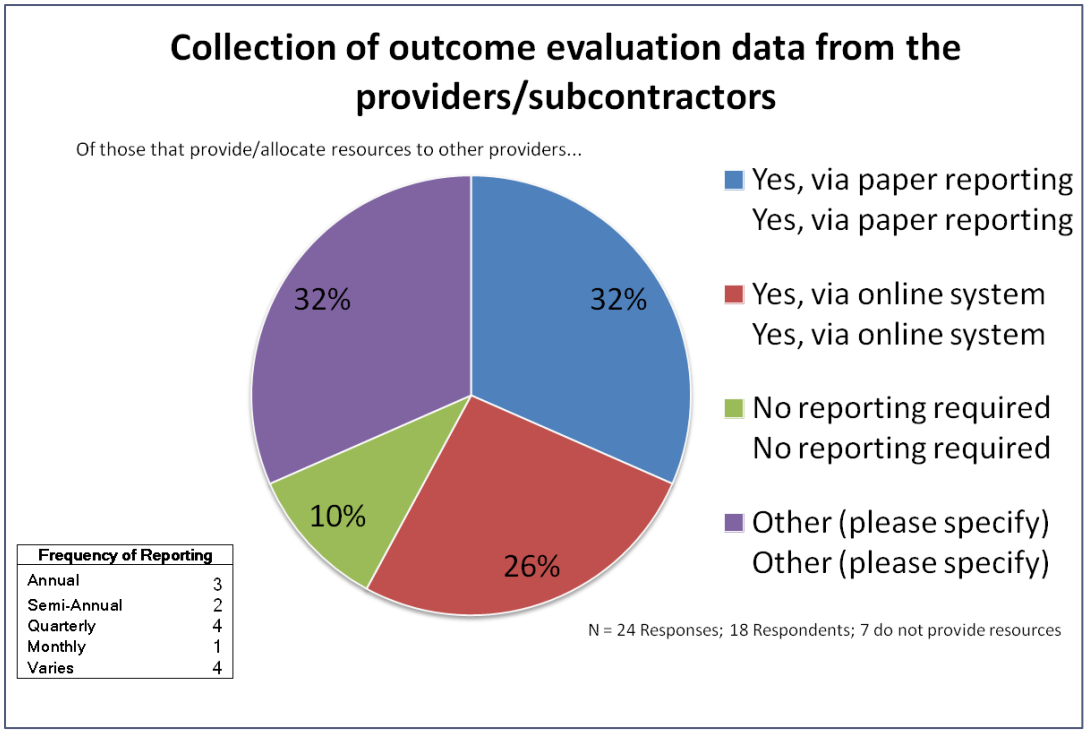
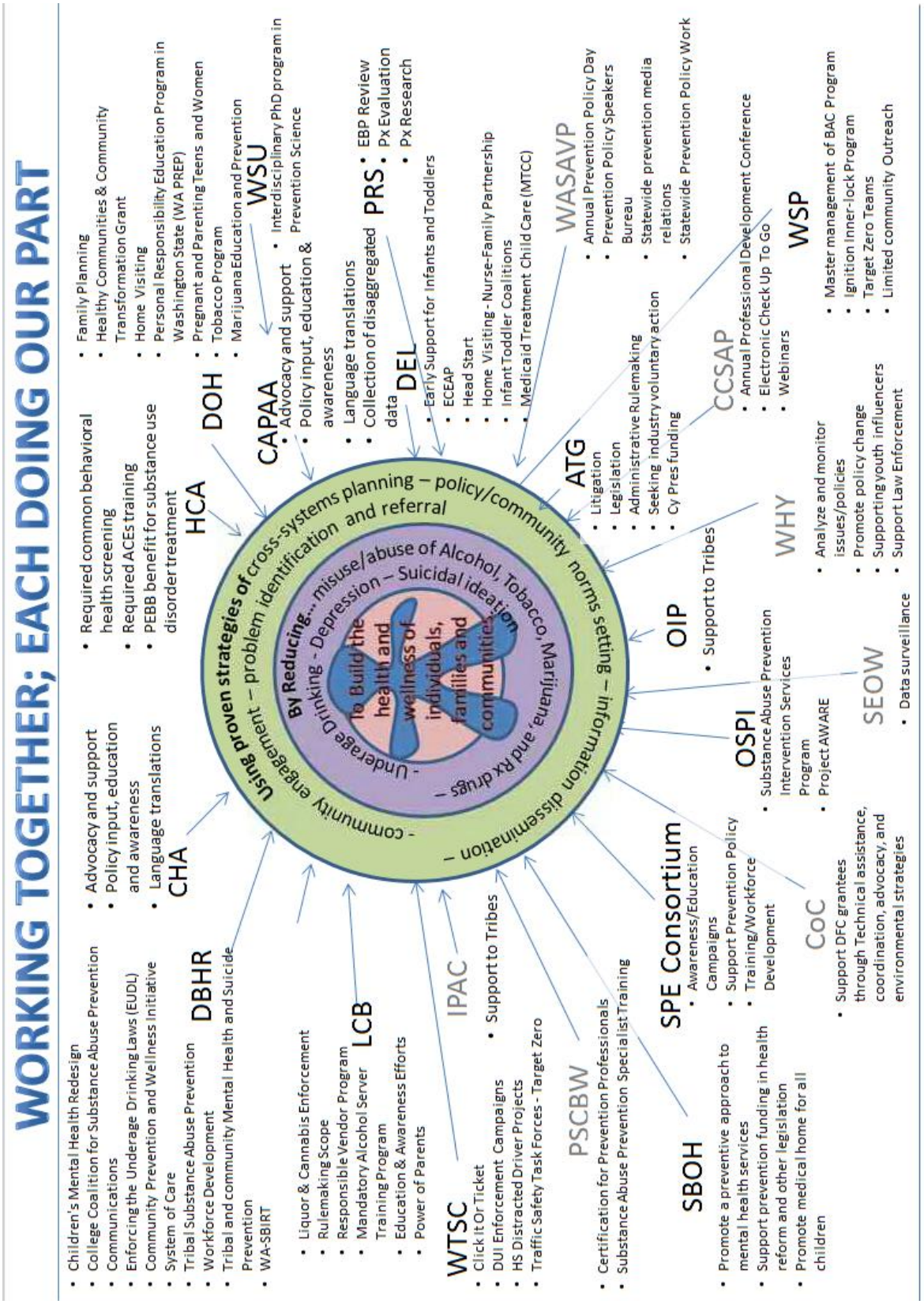
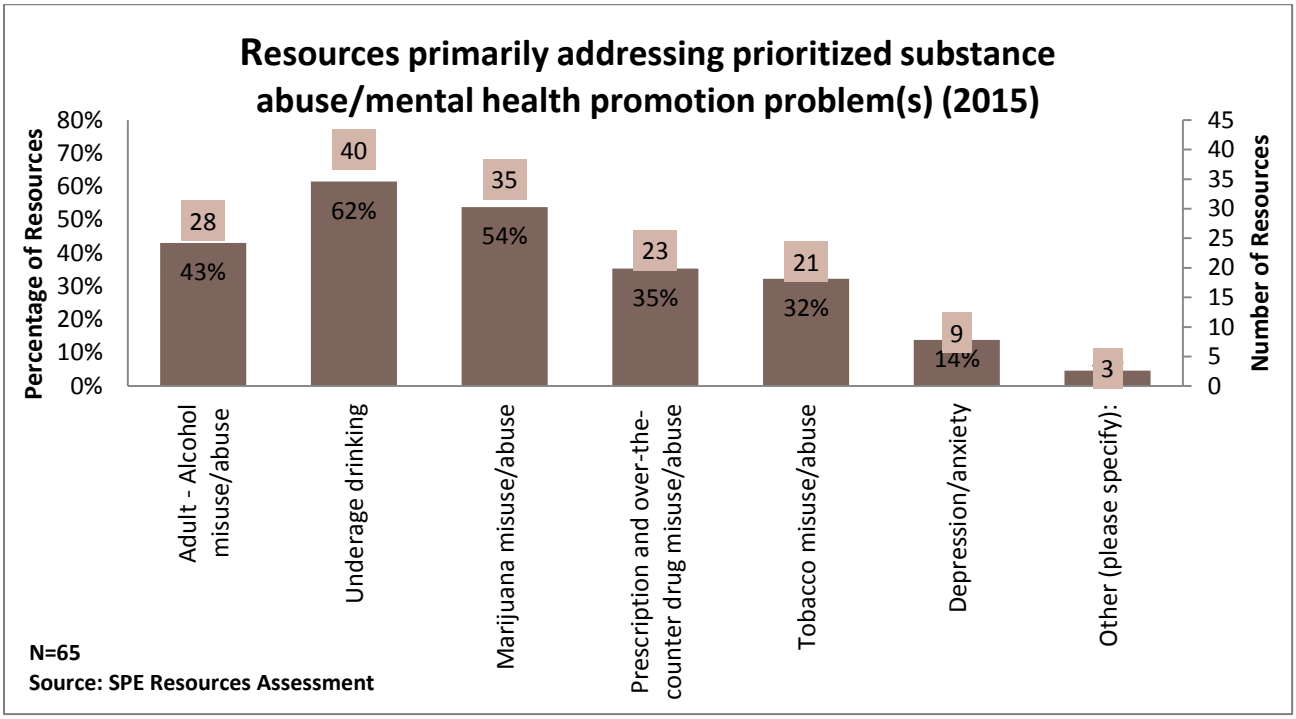
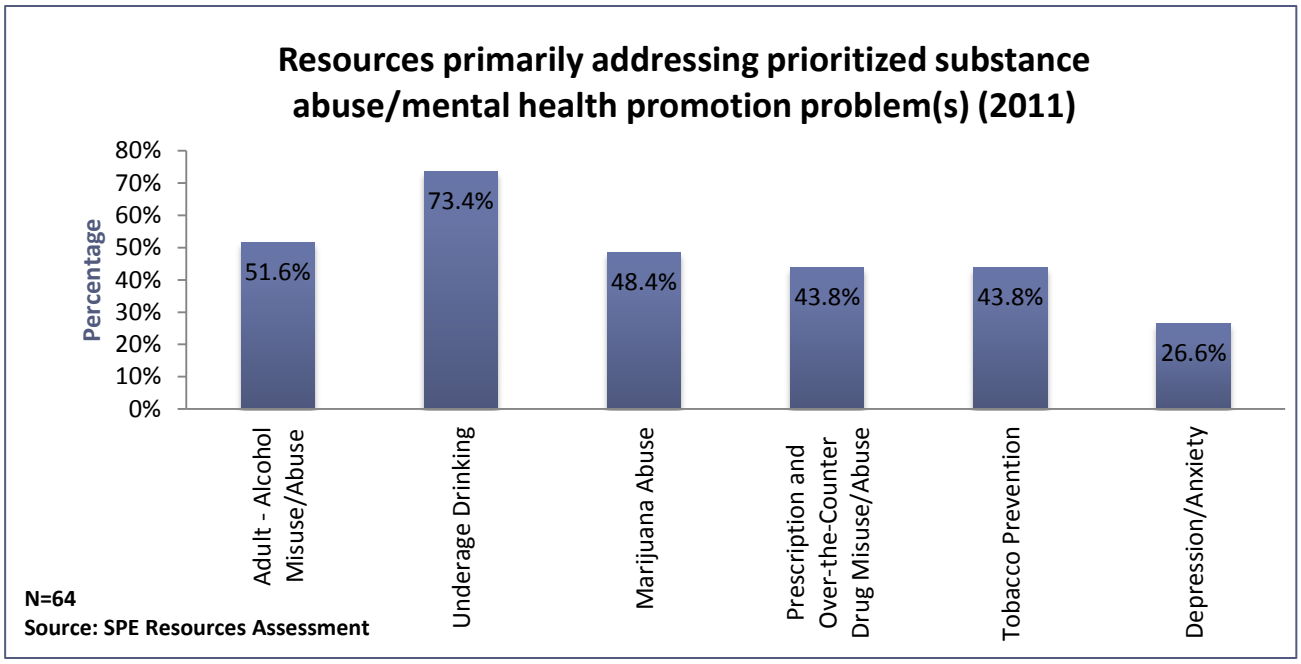


Diagram of Resources

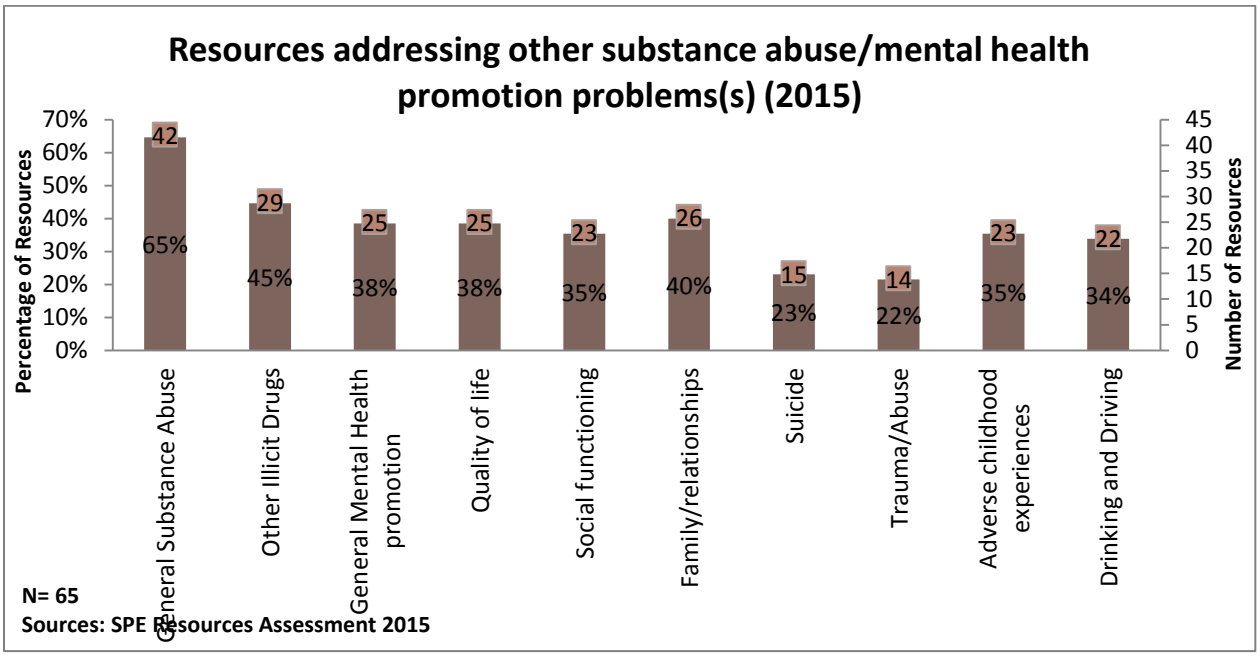


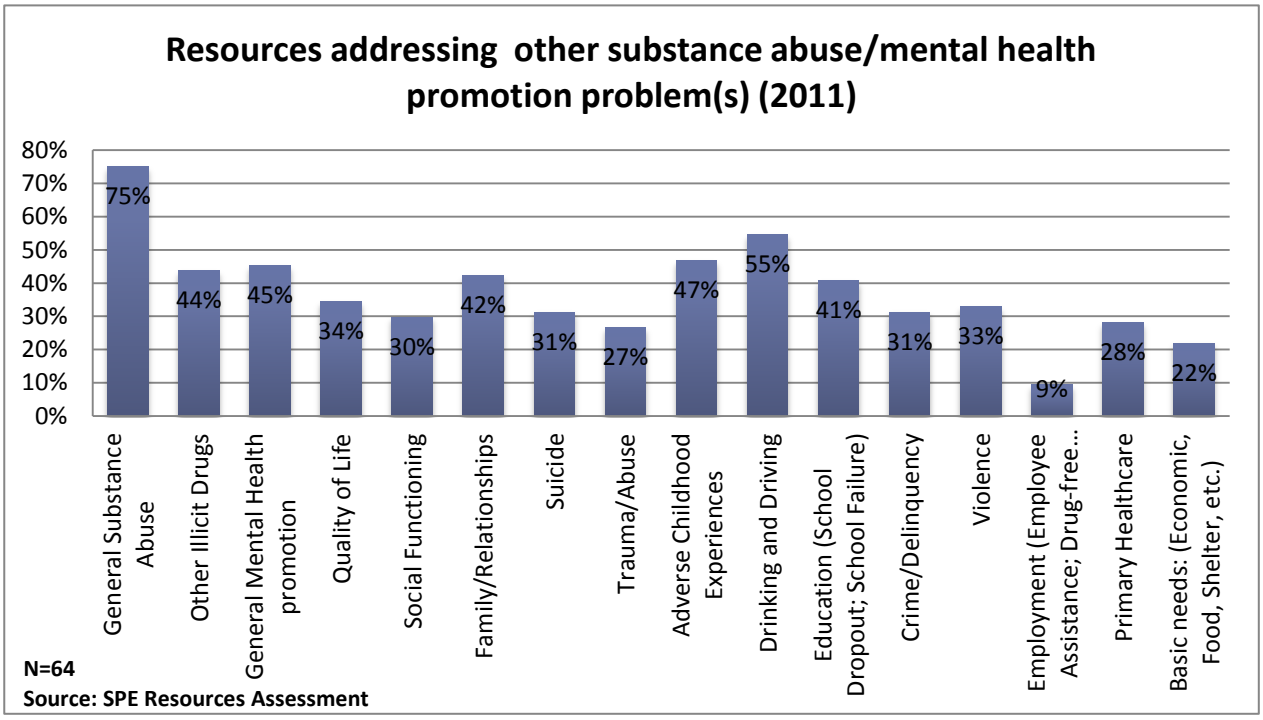
Summary of Resource Information[26]

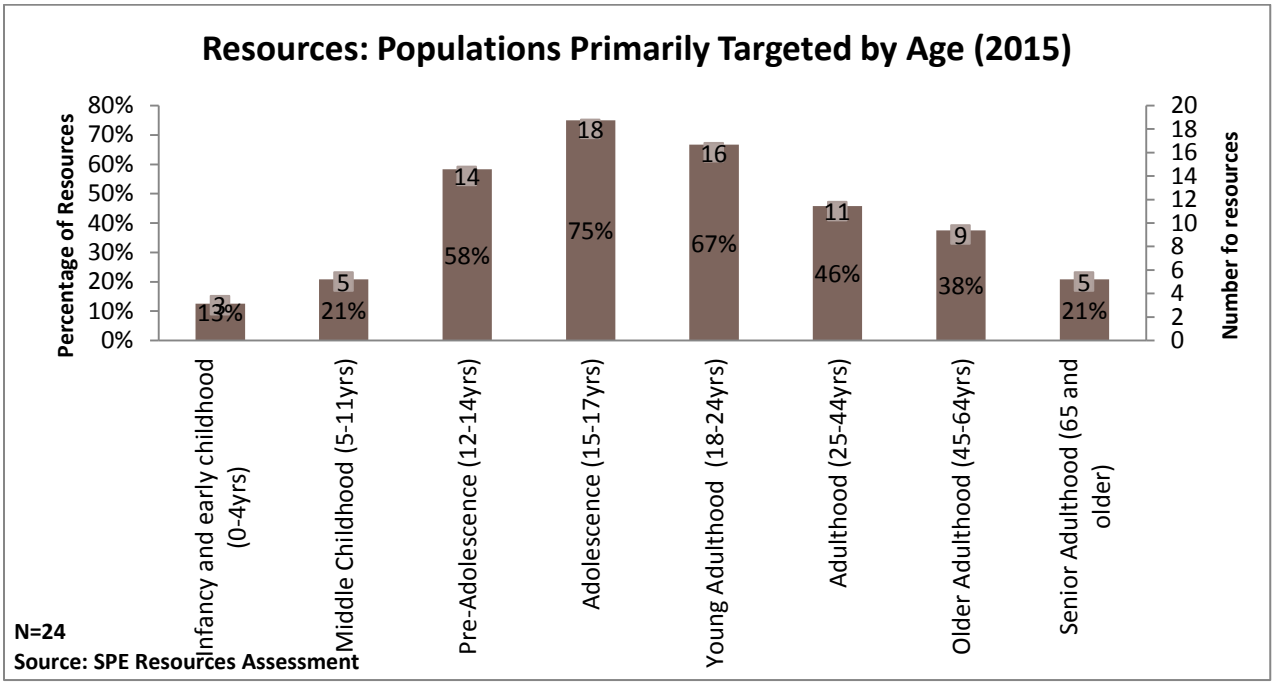


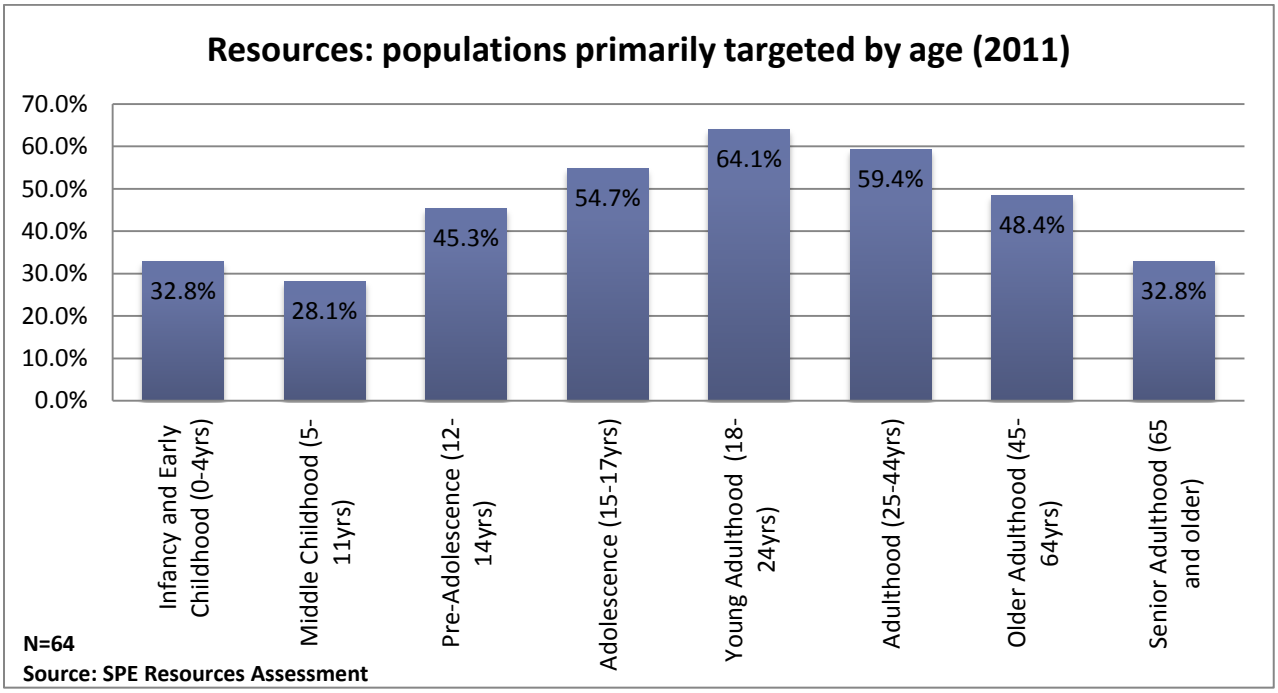


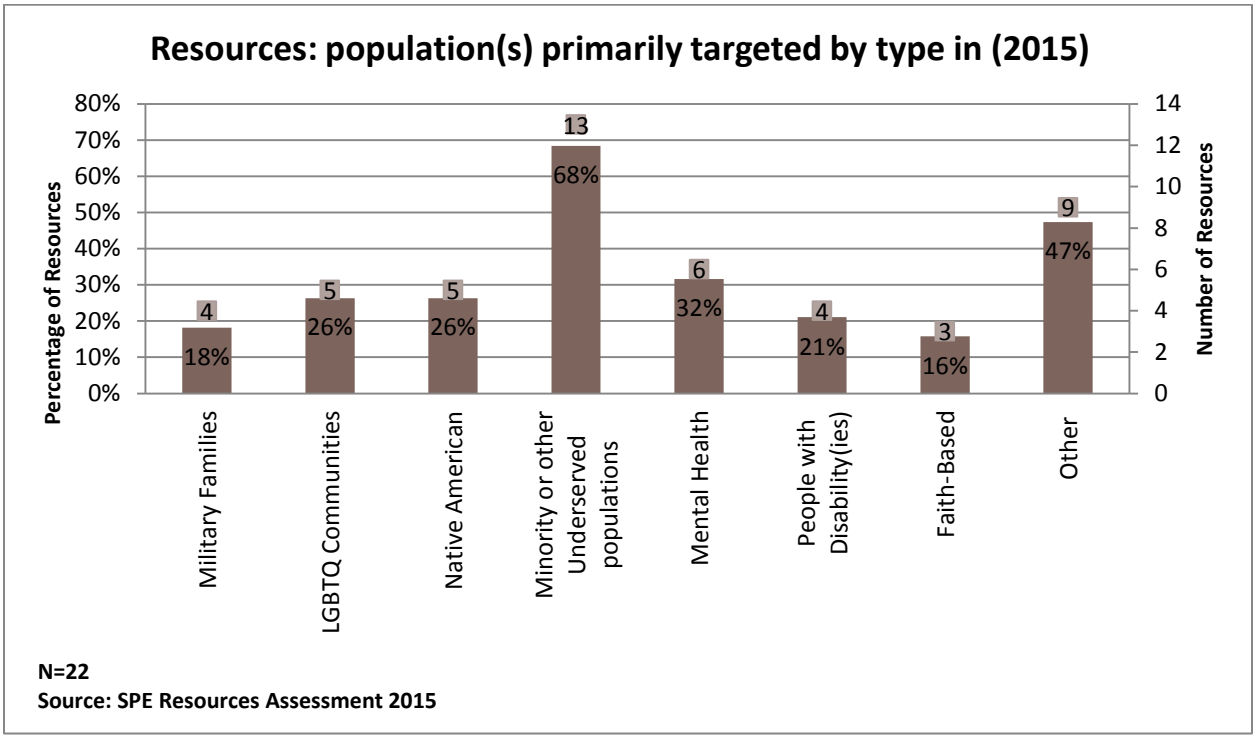
[26] Resources may be duplicated as agencies were allowed to select more than one area, therefore category totals will equal more than 100 percent if combined.

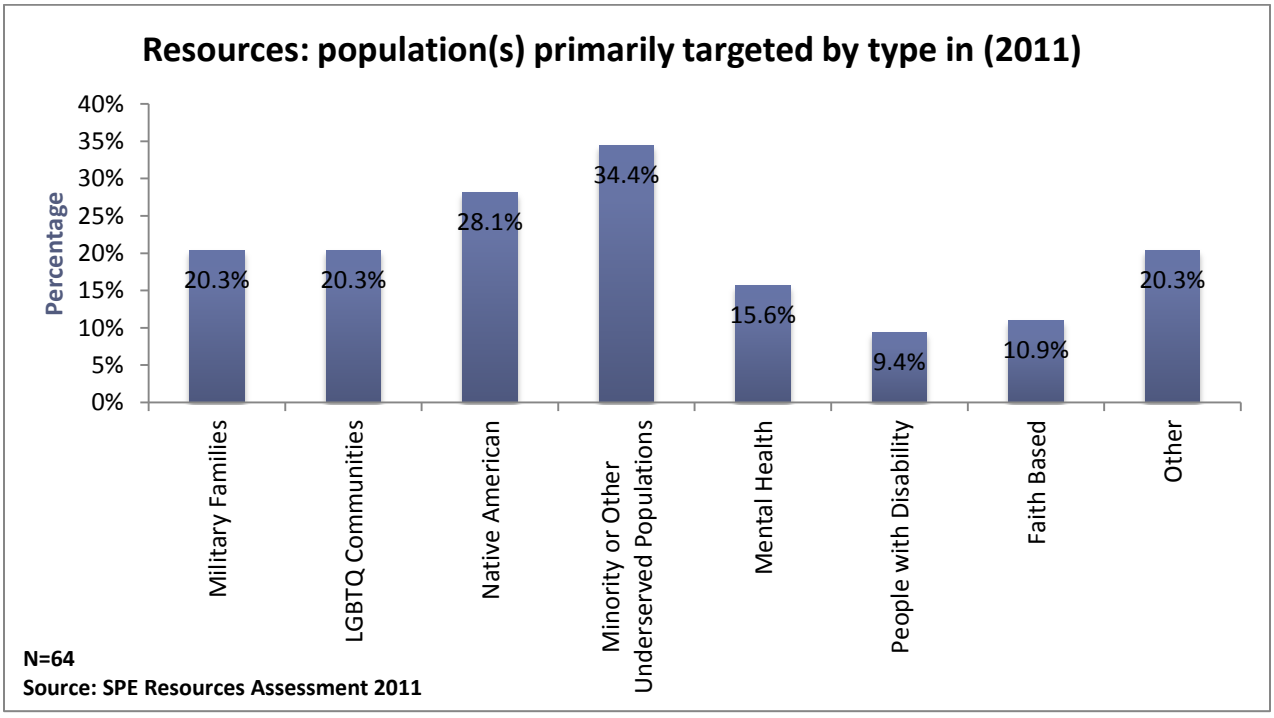

Resources addressing other substance abuse/mental health promotion problems(s) (2015)
Percentage of Resources
Number of Resources
70%
60%
50%
40%
30%
20%
10%
0%
45
40
35
30
25
20
15
10
5
0
42
65%
29
45%
25
38%
25
38%
23
35%
26
40%
15
23%
14
22%
23
35%
22
34%
General Substance Abuse
Other Illicit Drugs
General Mental Health promotion
Quality of life
Social functioning
Family/relationships
Suicide
Trauma/Abuse
Adverse childhood experiences
Drinking and Driving
N= 65
Sources: SPE Resources Assessment 2015

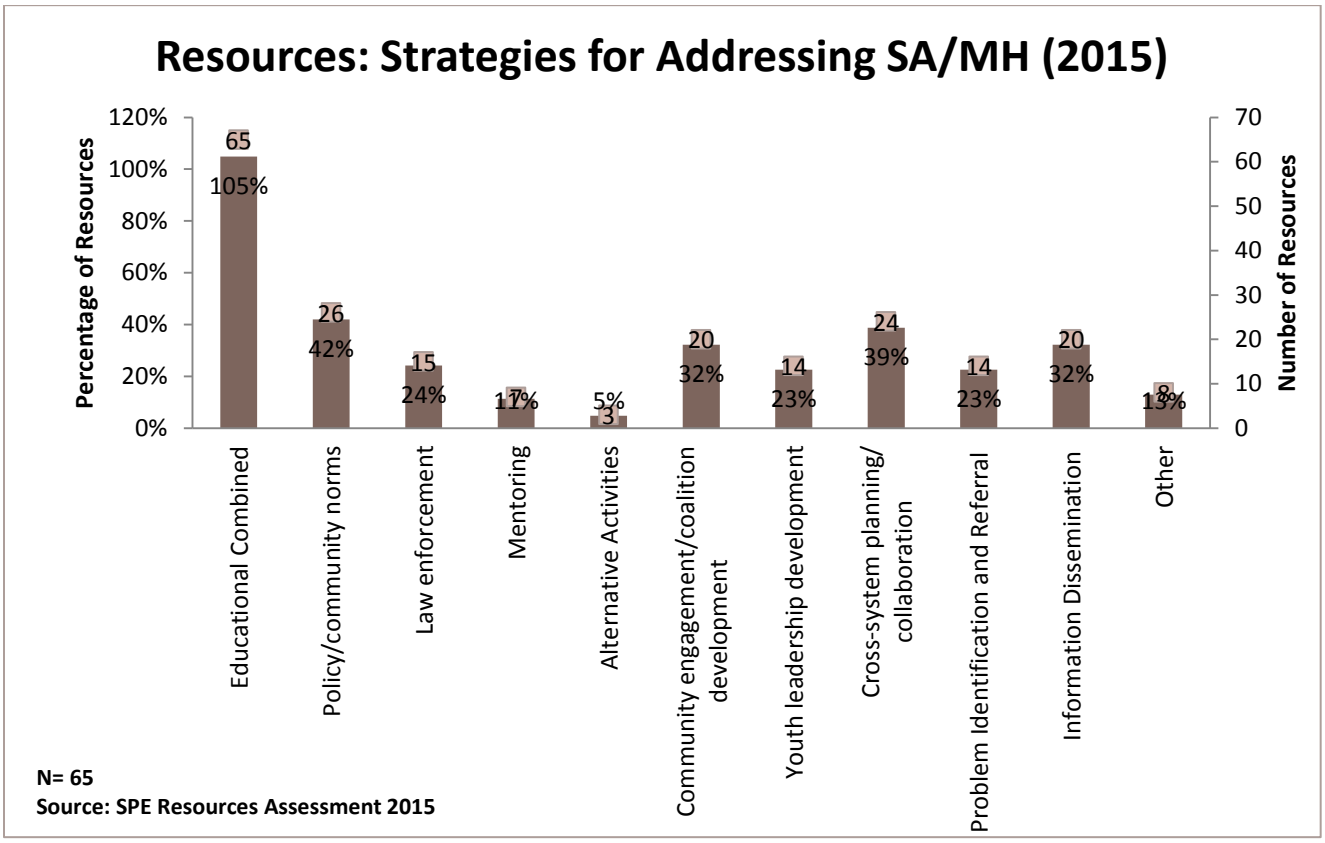

Resources addressing other substance abuse/mental health promotion problem(s) (2011)
80%
70%
60%
50%
40%
30%
20%
10%
0%
75%
44%
45%
34%
30%
42%
31%
27%
47%
55%
41%
31%
33%
9%
28%
22%
General Substance Abuse
Other Illicit Drugs
General Mental Health promotion
Quality of Life
Social Functioning
Family/Relationships
Suicide
Trauma/Abuse
Adverse Childhood Experiences
Drinking and Driving
Education (School Dropout; School Failure)
Crime/Delinquency
Violence
Employment (Employee Assistance; Drug-free…
Primary Healthcare
Basic needs: (Economic, Food, Shelter, etc.)
N=64
Source: SPE Resources Assessment

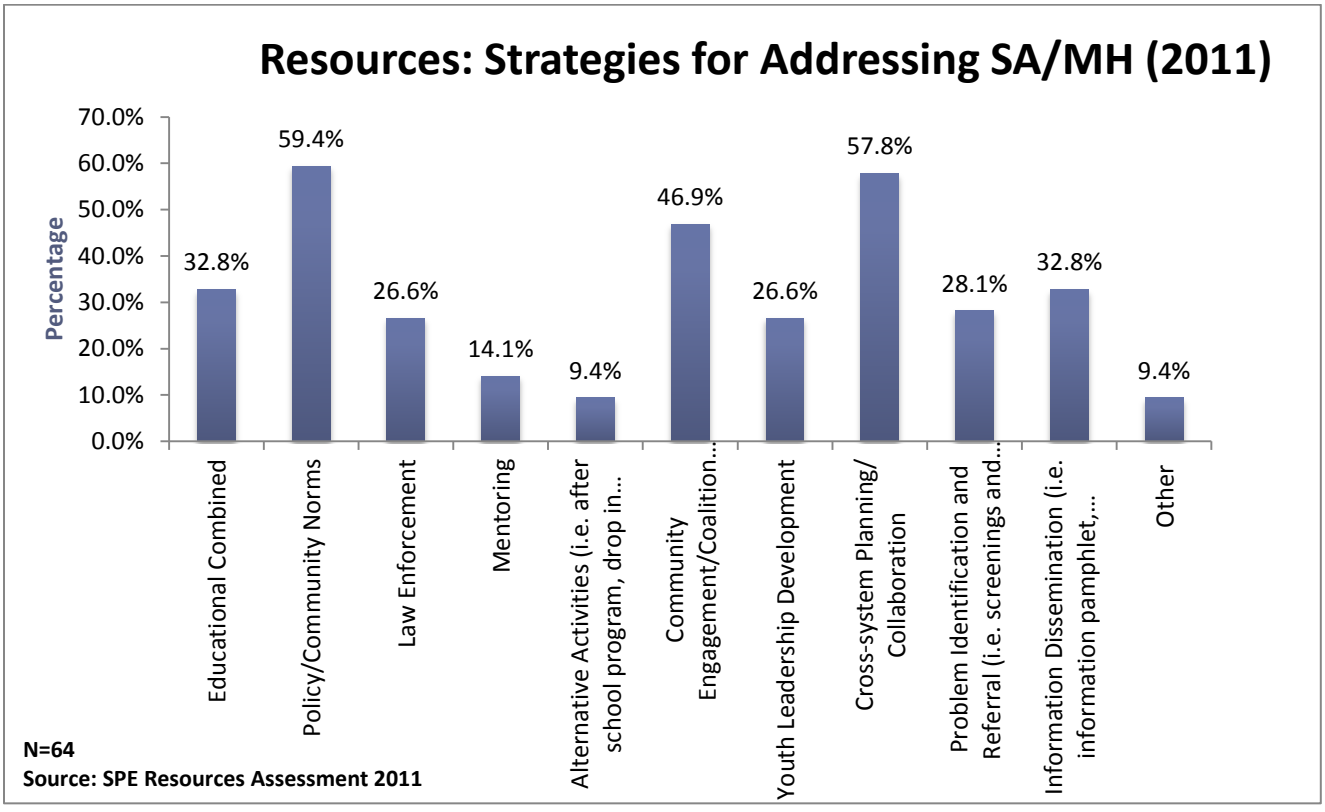

Resources: Populations Primarily Targeted by Age (2015)
Percentage of Resources
Number fo resources
80%
70%
60%
50%
40%
30%
20%
10%
0%
20
18
16
14
12
10
8
6
4
2
0
2
13%
5
21%
14
58%
18
75%
16
67%
11
46%
9
38%
5
21%
Infancy and early childhood (0-4yrs)
Middle Childhood (5-11yrs)
Pre-Adolescence (12-14yrs)
Adolescence (15-17yrs)
Young Adulthood (18-24yrs)
Adulthood (25-44yrs)
Older Adulthood (45-64yrs)
Senior Adulthood (65 and older)
N=24
Source: SPE Resources Assessment


Resources: populations primarily targeted by age (2011)
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
32.8%
28.1%
45.3%
54.7%
64.1%
59.4%
48.4%
32.8%
Infancy and Early Childhood (0-4yrs)
Middle Childhood (5-11yrs)
Pre-Adolescence (12-14yrs)
Adolescence (15-17yrs)
Young Adulthood (18-24yrs)
Adulthood (25-44yrs)
Older Adulthood (45-64yrs)
Senior Adulthood (65 and older)
N=64
Source: SPE Resources Assessment


Resources: population(s) primarily targeted by type in (2015)
Percentage of Resources
Number of Resources
80%
70%
60%
50%
40%
30%
20%
10%
0%
14
12
10
8
6
4
2
0
4
18%
5
26%
5
26%
13
68%
6
32%
4
21%
3
16%
9
47%
Military Families
LGBTQ Communities
Native American
Minority or other Underserved populations
Mental Health
People with Disability(ies)
Faith-Based
Other
N=22
Source: SPE Resources Assessment 2015


Resources: population(s) primarily targeted by type in (2011)
Percentage
40%
35%
30%
25%
20%
15%
10%
5%
0%
20.3%
20.3%
28.1%
34.4%
15.6%
9.4%
10.9%
20.3%
Military Families
LGBTQ Communities
Native American
Minority or Other Underserved Populations
Mental Health
People with Disability
Faith Based
Other
N=64
Source: SPE Resources Assessment 2011


Resources: Strategies for Addressing SA/MH (2015)
Percentage of Resources
Number of Resources
120%
100%
80%
60%
40%
20%
0%
70
60
50
40
30
20
10
0
65
105%
26
42%
15
24%
11
17%
3
5%
20
32%
14
23%
24
39%
14
23%
20
32%
8
13%
Educational Combined
Policy/community norms
Law enforcement
Mentoring
Alternative Activities
Community engagement/coalition development
Youth leadership development
Cross-system planning/ collaboration
Problem Identification and Referral
Information Dissemination
Other
N= 65
Source: SPE Resources Assessment 2015


Resources: Strategies for Addressing SA/MH (2011)
Percentage
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
32.8%
59.4%
26.6%
14.1%
9.4%
46.9%
26.6%
57.8%
28.1%
32.8%
9.4%
Educational Combined
Policy/Community Norms
Law Enforcement
Mentoring
Alternative Activities (i.e. after school program, drop in...
Community Engagement/Coalition...
Youth Leadership Development
Cross-system Planning/ Collaboration
Problem Identification and Referral (i.e. screenings and...
Information Dissemination (i.e. information pamphlet,...
Other
N=64
Source: SPE Resources Assessment 2011

Matrix of Resources Identified in Resource Assessment focused on Substance Abuse

(*) Represents no new data in 2015.

Resources Focused on Substance Abuse	General Substance Abuse	Adult - Alcohol misuse/abuse	Underage drinking	Marijuana abuse	Prescription and over-the-counter drug misuse/abuse	Tobacco prevention	Other Illicit Drugs	Drinking and Driving
AGO - Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action			x			x		
CCSAP - Webinars	x	x	x	x	x	x	x	x
CCSAP - Year End Professional Development Conference	x	x	x	x	x		x	x
CCSAP - Electronic Check Up To Go	x	x	x			x		x
CoC - Federal Drug Free Communities Support Program	x	x	x	x	x	x	x	x
DBHR – Community Prevention and Wellness Initiative	x	x	x	x	x	x	x	x
DBHR - Children's Mental Health Redesign	x		x	x	x			
DBHR - Tribal Substance Abuse Prevention	x	x	x	x	x	x	x	x
DBHR - Enforcing The Underage Drinking Laws (EUDL)		x	x					x
DBHR - College Coalition For Substance Abuse Prevention	x	x	x	x	x	x	x	x
DBHR – WASBIRT-PCI	x	x		x	x	x	x	x
DBHR – Washington Healthy Youth Coalition	x	x	x	x			x	x
DBHR - Workforce Development	x	x	x	x	x	x	x	x
DBHR - Communications	x	x	x	x	x	x	x	x
DBHR - Prevention Research Subcommittee	x	x	x	x	x	x	x	x
DEL - Home Visiting Programs	x							
DEL - Head Start	x							
DEL - Early Support For Infants And Toddlers	x							
DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool								
DEL - Medicaid Treatment Child Care Program	x						x	
DOH – Youth Tobacco Program				x		x		
DOH - Youth Suicide Prevention Program			x	x	x			
DOH - Home Visiting*	x							
DOH - Coordinated School Health Program*	x							
DOH - Healthy Communities & Community Transformation Grant*						x		
DOH - Family Planning*	x							x
HCA - Service					x			
HCA – Smoking Cessation								
HCA-SBIRT Screening								
HCA – Triple PPP								
HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.	x	x		x	x		x	
HCA - Required Training On Adverse Childhood Experiences For The Primary Care Provider Community In The State Of Washington.	x	x	x	x	x	x	x	
HCA - PEBB Benefit For Substance Use Disorder Treatment	x	x		x	x		x	
IPAC - Support Tribes	x	x	x	x	x	x	x	
LCB – Technical Assistance and Education	x	x	x					
LCB - Power Of Parents			x					
LCB - Liquor Enforcement	x	x	x					x

Resources Focused on Substance Abuse	General Substance Abuse	Adult - Alcohol misuse/abuse	Underage drinking	Marijuana abuse	Prescription and over-the-counter drug misuse/abuse	Tobacco prevention	Other Illicit Drugs	Drinking and Driving
LCB - Rulemaking Scope	x	x						
LCB - Responsible Vendor Program	x	x	x				x	x
LCB - Mandatory Alcohol Server Training Program	x	x	x					
LCB - Education And Awareness Efforts – Printed Materials	x		x	x				
OIP - Support Tribes	x	x	x	x	x	x	x	
OSPI - Substance Abuse Prevention Intervention Services Program	x		x	x	x	x	x	
OSPI – Project Aware								
PSCBW - Certification For Prevention Professionals	x	x	x	x	x	x	x	x
PSCBW - Substance Abuse Prevention Specialist Training	x	x	x	x	x	x	x	x
SEOW - Data Surveillance	*x*	*x*	*x*	*x*	*x*	*x*	*x*	
WASAVP - Annual Prevention Policy Day	x		x	x	x	x		
WASAVP - Statewide Prevention Policy Work	x		x	x	x	x		x
WASAVP - Statewide Prevention Medial Relations	x		x	x	x	x	x	x
WASAVP - Prevention Policy Speakers Bureau	x		x	x	x	x	x	
WHY – Law Enforcement Partnerships	x	x	x					
WHY – Let's Draw the Line Between Youth and Alcohol	x	x	x	x			x	x
WHY – Media Awareness Presentations with Miss Washington	x		x	x			x	x
WHY - Analyze And Monitor Issues/Policies	x		x					x
WHY - Promote Policy Change	x		x					x
WHY - Supporting Youth Influencers	x		x					x
WHY - Support Law Enforcement	x		x					x
WSP - Ignition Inner-Lock Program	x	x						x
WSP - Target Zero Teams	x	x	x	x	x		x	x
WSU - Interdisciplinary PhD Program In Prevention Science	x	x	x	x	x	x	x	x
WTSC - Click It or Ticket	x	x	x					x
WTSC - HS Distracted Driver Projects			x					x
WTSC - DUI Enforcement Campaigns		x	x					x
WTSC - Traffic Safety Task Forces - Target Zero			x					x

Matrix of Resources Identified in Resource Assessment focused on Mental Health

Resources focused on Mental Health	General Mental Health promotion	Quality of life	Social functioning	Family/ Relationships	Suicide	Trauma/Abuse	Adverse Childhood Experiences
CCSAP - Electronic Check Up To Go		x					
DBHR – Community Prevention and Wellness Initiative	x			x			x
DBHR - Children's Mental Health Redesign	x	x	x	x	x	x	x
DBHR - Tribal Substance Abuse Prevention	x	x	x	x	x	x	x
DBHR - College Coalition For Substance Abuse Prevention	x	x	x	x	x	x	x
DBHR – WASBIRT - PCI	x	x	x	x	x	x	
DBHR – Washington Healthy Youth Coalition		x	x	x		x	x
DBHR - Workforce Development	x						x
DBHR - Communications	x	x	x	x	x	x	x
DBHR - Prevention Research Subcommittee		x	x	x	x	x	x
DEL - Infant Toddler Regions	x	x	x	x		x	x
DEL - Home Visiting Programs	x	x	x	x			x
DEL - Head Start	x	x	x	x		x	x
DEL - Early Support For Infants And Toddlers	x	x	x	x			x
DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool	x	x	x	x			
DEL - Medicaid Treatment Child Care Program	x	x	x	x		x	
DOH – Tobacco Youth Prevention Program							
DOH - Youth Suicide Prevention Program	x	x	x	x	x	x	x
DOH – SUICIDE PREVENTION WORKS!	x	x	x	x	x	x	x
DOH - Project Launch Grant*	x	x	x	x			x
DOH - Home Visiting*	x	x	x	x		x	x
DOH - Early Childhood Comprehensive Systems Grant*	x			x			
DOH - Children With Special Health Care Needs*	x			x			
DOH - Personal Responsibility Education Program In Washington State (WA PREP)		x	x	x			x
DOH - Pregnant And Parenting Teens And Women				x		x	x
DOH - Coordinated School Health Program	x			x			
DOH - Healthy Communities & Community Transformation Grant	x	x					x
DOH - Family Planning	x	x	x	x	x	x	x
HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.	x	x	x	x	x	x	x
HCA - Required Training On Adverse Childhood Experiences	x	x	x	x	x	x	x
IPAC - Support Tribes	x	x			x		x
LCB - Power Of Parents				x			
OIP - Support Tribes	x	x			x		x
OSPI - Substance Abuse Prevention Intervention Services Program		x	x	x		x	x
OSPI – Project Aware	x	x	x	x	x	x	x
PSCBW - Certification for Prevention Professionals	x		x	x	x		x
SEOW - Data Surveillance	x				x		x
WASAVP - Annual Prevention Policy Day				x	x		x
WASAVP - Statewide Prevention Policy Work		x			x		x
WASAVP - Statewide Prevention Medial Relations					x		x

Resources focused on Mental Health	General Mental Health promotion	Quality of life	Social functioning	Family/ Relationships	Suicide	Trauma/Abuse	Adverse Childhood Experiences
WHY – Law Enforcement Partnerships		x	x	x			
WHY – Let's Draw the Line Between Youth and Alcohol	x	x	x	x			
WHY – Media Awareness Presentations with Miss Washington		x	x				
SBOH - Health Disparities Council Behavioral Health Advisory Committee	x						
WSU - Interdisciplinary PhD Program In Prevention Science	x	x	x	x	x	x	x

Matrix of Resources Identified in Resource Assessment by Strategy

Resources by Strategy	Youth Education/Skill building - School based	Youth Education/Skill building - Community	Parent education/family	Other Educational	Policy/community norms	Law enforcement	Mentoring	Alternative Activities	Community engagement/ coalition development	Youth leadership development	Problem Identification and Referral	Information Dissemination	Cross-system planning/ collaboration
AGO - Litigation, Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action					x								
CCSAP - Webinars				x									
CCSAP - Year End Professional Development Conference				x					x			x	
CoC - Federal Drug Free Communities Support Program	x	x	x	x	x		x		x	x		x	x
DBHR - System of Care			x		x				x	x		x	x
DBHR - Community Prevention and Wellness Initiative	x	x	x	x	x	x	x	x	x	x	x	x	x
DBHR - Children's Mental Health Redesign					x				x		x		x
DBHR - Tribal Substance Abuse Prevention	x	x	x	x	x	x	x	x	x	x	x	x	x
DBHR - College Coalition For Substance Abuse Prevention			x	x	x	x	x				x	x	x
DBHR – WASBIRT-PCI											x	x	
DBHR – Washington Healthy Youth Coalition	x	x			x	x			x	x			x
DBHR - Workforce Development					x							x	x
DBHR - Communications												x	
DBHR - Prevention Research Subcommittee											x	x	x
DEL - Infant Toddler Regions					x		x		x		x		x
DEL - Home Visiting Programs		x	x										
DEL - Early Support For Infants And Toddlers			x	x							x		
DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool				x							x		
DEL - Medicaid Treatment Child Care Program		x	x	x		x	x				x		x
DOH – Youth Tobacco Program					x				x	x			
DOH – Youth Suicide Prevention Program*					x				x		x	x	x
DOH – SUICIDE PREVENTION WORKS!*	x		x	x	x	x			x		x	x	x
DOH - Project Launch Grant*			x	x	x				x		x	x	x
DOH - Home Visiting*			x		x				x				x

Resources by Strategy	Youth Education/Skill building - School based	Youth Education/Skill building - Community	Parent education/family	Other Educational	Policy/community norms	Law enforcement	Mentoring	Alternative Activities	Community engagement/ coalition development	Youth leadership development	Problem Identification and Referral	Information Dissemination	Cross-system planning/ collaboration
DOH - Early Childhood Comprehensive Systems Grant*												x	x
DOH - Children With Special Healthcare Needs*			x								x	x	x
DOH - Personal Responsibility Education Program In Washington State (WA PREP)	x	x	x	x					x	x	x		x
DOH - Pregnant And Parenting Teens And Women*	x	x	x		x		x		x		x	x	x
DOH - Coordinated School Health Program*			x	x	x				x				x
DOH - Healthy Communities & Community Transformation Grant*				x	x		x	x	x	x	x	x	x
DOH - Family Planning	x	x	x	x		x				x	x	x	x
OJJ - Juvenile Detention Alternatives Initiative*					x	x		x	x		x		x
HCA - Service											x		
HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.											x		
HCA – Smoking Cessation													
HCA – SBIRT Screening													
HCA – Triple PPP													
HCA - Required Training On Adverse Childhood Experiences				x									
HCA - PEBB Benefit For Substance Use Disorder Treatment					x								
IPAC - Support Tribes									x				x
LCB - Agency Initiatives			x	x	x							x	
LCB - Power Of Parents			x										
LCB - Liquor Enforcement					x	x							
LCB - Rulemaking Scope					x								
LCB - Responsible Vendor Program				x	x	x							
LCB - Mandatory Alcohol Server Training Program				x	x	x							
LCB - Education And Awareness Efforts Printed Materials			x									x	
LCB – Technical Assistance and Education			x		x				x				x
OIP - Support Tribes									x				x
OSPI - Substance Abuse Prevention Intervention Services Program	x		x		x				x	x	x		
OSPI – Project Aware	x	x	x										
PSCBW - Certification For Prevention Professionals				x									
PSCBW - Substance Abuse Prevention Specialist Training				x									x
WASAVP - Annual Prevention Policy Day		x			x			x	x	x			x
WASAVP - Statewide Prevention Policy Work					x							x	
WASAVP - Statewide Prevention Medial Relations					x				x	x			
WASAVP - Prevention Policy Speakers Bureau					x				x	x			x
WHY – Law Enforcement Partnerships	x	x			x	x				x		x	x
WHY – Let's Draw the Line Between Youth and Alcohol	x	x	x	x	x	x	x	x	x	x		x	x
WHY – Media Awareness Presentations with Miss Washington	x	x	x	x	x				x	x			x

Resources by Strategy	Youth Education/Skill building - School based	Youth Education/Skill building - Community	Parent education/family	Other Educational	Policy/community norms	Law enforcement	Mentoring	Alternative Activities	Community engagement/ coalition development	Youth leadership development	Problem Identification and Referral	Information Dissemination	Cross-system planning/ collaboration
WHY - Analyze And Monitor Issues/Policies					x				x	x			x
WHY - Promote Policy Change			x		x				x	x		x	x
WHY - Supporting Youth Influencers		x			x				x	x		x	x
WHY - Support Law Enforcement					x	x			x	x			x
WSP - Master Management Of BAC Program						x							
WSP - Limited Community Outreach	x												
WSP - Ignition Inner-Lock Program				x		x					x		
WSP - Target Zero Teams				x	x	x						x	x
WSU - Interdisciplinary PhD Program In Prevention Science		x	x	x	x				x	x			
WTSC - Click It or Ticket					x	x							
WTSC - HS Distracted Driver Projects						x				x			
WTSC - DUI Enforcement Campaigns					x	x							
WTSC - Traffic Safety Task Forces - Target Zero						x							x

8. Learning Community Steering Committees

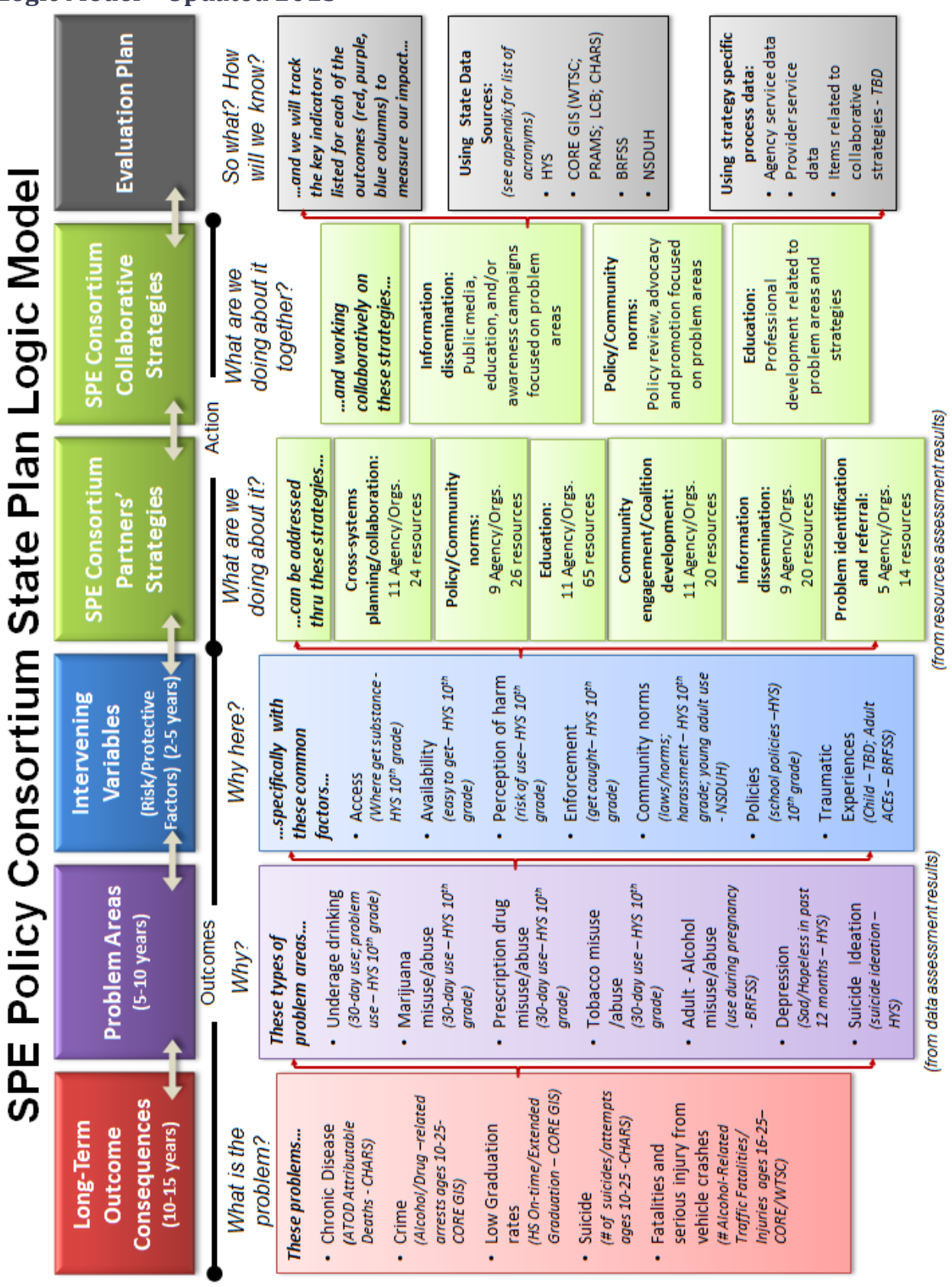
The table below summarizes the specific partners committed to contributing to working on each Learning Community Steering Committee.

The SPE Prevention Consortium no longer has learning or steering committees for SPE. SPE members participate on one of five (5) SPE workgroups. A list of workgroups is below.

- Underage Drinking & Youth Marijuana Misuse/Abuse Prevention Team – Washington Healthy Youth (WHY) Coalition
- Prescription Drug Misuse/Abuse Prevention Team
- Tobacco Misuse/Abuse Prevention Team
- Young Adults & Pregnant Women Alcohol & Marijuana Misuse/Abuse Prevention Workgroup
- Mental Health Promotion Team

Partner Agency/Organization (2015)	Alcohol	Underage Drinking & Marijuana	Tobacco	Prescription Drugs	Mental Health
College Coalition for Substance Abuse Prevention (CCSAP)	X	X			
Department of Early Learning (DEL)					X
Department of Health (DOH)	X	X	X	X	X
Division of Behavioral Health & Recovery (DBHR)	X	X	X	X	X
Health Care Authority (HCA)				X	X
Liquor Control Board (LCB)	X	X			
Office of Indian Policy (OIP)					X
Office of Superintendent of Public Instruction (OSPI)		X			X
Office of the Attorney General (AGO)		X	X		
Prevention Specialist Certification Board of Washington (PSCBW)	X	X			
State Board of Health (SBOH)			X	X	
State Epidemiological Outcome Workgroup (SEOW)	X	X	X	X	X
Washington Association for Substance Abuse and Violence Prevention (WASAVP)	X	X	X		
Washington Healthy Youth Coalition (WHY)	X	X			
Washington State Commission on Asian Pacific American Affairs (CAPAA)	X				X
Washington State Drug Free Communities Coalition of Coalitions (CoC)	X	X	X	X	
Washington State Patrol (WSP)	X	X			
Washington State Prevention Research Sub-Committee	X	X	X	X	X
Washington Traffic Safety Commission (WTSC)	X	X			

9. Logic Model – Updated 2015



10. Prevention Consortium Team Accomplishments 2013-2014

Washington Healthy Youth Coalition (WHY Coalition) Underage Alcohol Use Prevention Team Accomplishments

WHY Coalition

- Leaders met with Attorney General Bob Ferguson to affirm continued commitment to underage drinking prevention.
- The new name for the coalition is Washington Healthy Youth coalition. The name change was necessary to reflect an emphasis on underage alcohol AND marijuana use.
- Coalition established a youth marijuana misuse/abuse prevention sub-group.
- Completed A3 Results Washington Planning Process.

Let's Draw the Line between Youth and Alcohol

- Reaching 5,000 people in 42 communities.
- 2014 – 34 Washington community groups participated in the project this spring. Each community received up to $1,000 for completion of a Community Assessment of Neighborhood Stores (CANS) surveys and their choice of two other projects from a menu of 10 possible projects. The project concluded June 30.

Law Enforcement Partnerships

- Four communities participated in Spring 2013 with only 5% violation rate on sales to minors.
    - Communities were offered $6,500 in funding to implement additional compliance, alcohol purchase surveys and community awareness work from spring break through graduation season.
        - Each coalition received training in working with law enforcement and media.
        - Law enforcement received training on Conducting Alcohol Compliance Checks.
    - There is funding for up to six communities to test new fidelity of implementation guidance for alcohol compliance checks and purchase surveys.
    - Seven Community Prevention and Wellness Initiative (CPWI) coalitions and one former Enforcing Underage Drinking Law (EUDL) Discretionary Grant recipient received up to $3,000 to implement a combination of alcohol compliance checks, alcohol purchase surveys and community awareness about law enforcement. Many of the participating coalitions enjoyed being involved in implementing alcohol purchase surveys and reinforcing communication to stores and staff who asked for identification.
        - The eight coalitions are: Oak Harbor (Island County), Concrete (Skagit County), Castle Rock (Cowlitz County), West Central Spokane (Spokane County), Moses Lake (Grant County), Quincy (Grant County) and Omak (Okanogan County).
    - A no-cost extension has been submitted to the office of Juvenile Justice Delinquency Prevention for EUDL Block Grant and a budget revision of the EUDL Discretionally Grant.

I-1183 Advisory Committee

- Linda Becker, Ph.D., DBHR and Julia Dilley, Ph.D., Multnomah County, OR, presented preliminary findings regarding increases in use by youth and changes in attitudes toward use by youth in our state.

Young Adults & Pregnant Women Alcohol & Marijuana Misuse/Abuse Action Team Accomplishments

- Developed an action plan to provided outreach to colleges and universities and used training funds from Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant to support non-grantee sites with training.
- Coordinating conference in October 2014 to provide SBIRT Training to healthcare community.
- Department of Health (DOH) is now creating online training for physicians, nurses and other healthcare workers through the WHIN institute.

Marijuana Misuse/Abuse Prevention Action Team Accomplishments

Engage Liquor Control Board in Rule Making

- LCB provided recommendations to legislature on Medical Marijuana (MMJ) and included several protective factors to support and several risk factors MMJ to youth and 18-21 year old segments (home grows allowed, tax breaks, and increased purchase amounts). The team continues to educate rule makers about these issues and to also communicate to prevention field (Washington Association of Substance Abuse and Violence (WASAVP) and Coalition of Coalitions (CoC)).

Website and Resources & FAQ's

- FAQ's completed. Info now available statewide at www.learnaboutmarijuanawa.com.
- Built page on Athena for Marijuana Misuse/Abuse Prevention http://www.theathenaforum.org/marijuana.
- Marijuana Education Movie completed and available online and in hard copy—dissemination taking place with CPWI, DFC, and WASAVP— exploring dissemination via Office of Superintendent of Public Instruction (OSPI). Consider updating movie for 2014.
- Map created of Marijuana Stakeholders and state agency roles to help guide workgroup mission and analyze gaps.
- Parent Tool Kit collaboratively developed with DOH, LCB, DBHR and Inga Manskopf and Dr. Leslie Walker of Seattle Children's Hospital for parents of middle school youth. Inga Manskopf, Dr. Walker and Kevin Haggerty, Ph.D. and Rico Catalano, Ph.D. (UW-SDRG) developed original guide. Toolkit available on the Athena Forum http://www.theathenaforum.org/parenttoolkit.
- Parent Guide to MJ article in *Parent Map* agrees that parents should use zero tolerance messages with youth.

Conference to gather state leaders and key stakeholders

- Youth Marijuana Use Prevention symposium, completed July 2013.

Tobacco Misuse/Abuse Prevention Team Accomplishments

Participated in and Presented at TAP Summit

- December 2013, Attended by 117 people.
    - Included a call for advocates to join efforts with Heart, Lung, & American Cancer Society.
    - Held a health meeting to address the creation of a community driven, statewide tobacco coalition that will provide advocacy prevention funding.

Washington Health Improvement Network (WHIN)

- Webinar for healthcare providers on screening and referring patients to cessation services.

The Fresh Air Campus Challenge

- November 2013, Great American Smoke Out day campuses: Tacoma Community College, University of Washington, Tacoma, Edmonds Community College and Walla Walla Community College promoted a one day smoke free policy.

Other Tobacco Abuse Prevention Accomplishments

- Attorney General Ferguson, along with other state attorneys general will sign a letter to the FDA urging the FDA to ban menthol cigarettes.
- Staff from the Attorney General's office (AGO) sent a letter to R.J. Reynolds asking for information about recent magazine advertising campaigns, which raise concerns about youth exposure to cigarette advertising.
- Several public health organizations and six state attorneys general sent a letter to the CEO of Comcast (which owns Universal Studios) requesting that marketing materials for the upcoming feature film *Rush* be scrubbed of smoking and cigarette brand imagery.
- Meeting with Parent Teacher Association (PTA) Executive Director and provided information on movie smoking to help inform membership about the issue.
    - Resulted in a basis for making contact with the national PTA office.
    - Working with staff at Legacy to arrange a meeting between federal Health and Human Service officials and the national PTA Executive Director to discuss grass roots involvement in the movie smoking issue.
- Washington is chairing a recently-formed working group of state AGOs to review and update priorities for AGOs' public health-related work under the Master Settlement Agreement (MSA) (there are other MSA issues, such as enforcing payment requirements, dealing with bankrupt tobacco companies, etc., that do not directly involve advancing public health).
- Washington participated in a working group which submitted comments to the (FDA) on its proposed rule regarding the deeming of certain products to be "tobacco products."
- Washington continues to chair a workgroup on smoking in the movies, which is actively working with other stakeholders to develop policy advocacy and media strategies. The ultimate goal is to eliminate smoking in youth-rated movies (a goal that is also included in the SPE Strategic Plan).
- Washington continues to co-chair a working group that encourages and supports collaboration between state health departments and state AGOs.

- Washington State University adopted tobacco-free campus policy.
- Built Athena page for Tobacco Abuse Prevention http://www.theathenaforum.org/tobacco.

Prescription Drug Misuse/Abuse Prevention Action Team Accomplishments

Information Dissemination to Communities

- Built Athena page for Prescription Drug Abuse Prevention http://www.theathenaforum.org/rx.
- Reached out to Higher Education to promote this information (college coalition, and doctors in training).
- Conducted several presentations including;
    - State Board of Health @ SeaTac from King County Take Back Program – November 2013.
    - Joint Conference on Health (annual) presentation/exhibit table for Take Back Your Meds– October 2013 to October 2015. www.wspha.org.
    - Board of Health presentation November 2013.
    - Prescription Statistics represented at Prescription Monitoring Program (PMP) National Meeting.
    - June 2014 group presentation to College Coalition – available online.
    - Provided 10,000 Good Samaritan Law / 911 Overdose Prevention Cards to 52 Washington State community coalitions for local distribution.

Promote Value of Prescription Monitoring Program (PMP) to get continued advocacy

- PMP article sent to HCA.
- HB 1565 passed – Funding for Prescription Drug Monitoring.
    - In budget little over $500,000/year for 2.0 FTE; Vendor system costs (~200,000/year) and Education/outreach.
- Drug take-back law passed by King County Board of Health.
- Received funding as part of PFS grant to incorporate PMP data into our data books for local communities.

Mental Health Promotion Action Team Accomplishments

- Suicide prevention training to coalitions in Battleground, North Kitsap, Gig Harbor, King County, Bellingham, Forks, Spokane, Wenatchee, and Grays Harbor. Information, strengths and challenges collected.
- Statewide Suicide Prevention Day launched on September 2013 with Governor's Proclamation. Multiple agencies held activities statewide.
- Collaboration with DOH on training health care professionals in suicide prevention, youth suicide prevention activity.
- NW Indian College partnered with Colville Confederated Tribes last year on Suicide Prevention project.
- University of Washington (UW) has Substance Abuse and Mental Health Services Administration (SAMHSA) funded suicide prevention project for students at Seattle campus.
- Met with DSHS Secretary Quigley re: suicide prevention with Native American focus.

- Group created a website page on the Athena Website: http://theathenaforum.org/mentalhealth.
- Training Educational Service Districts (ESD) how to use plan. Material should be up on the OSPI school safety website.
- Forefront has training curricula for nurses' schools and others in suicide prevention.
- DOH submitted 2014 suicide prevention SAMHSA grant, put together by MH Promotion Team Committee members.
- Juvenile Justice and Rehabilitation Administration (JJRA) and Suicide Prevention Conference September 2014 at Great Wolf Lodge.
- Department of Health (DOH) will be convening a steering committee to develop a statewide plan for suicide prevention across the lifespan August 2014.
- Promoted establishment of permanent cross agency statewide suicide prevention and mental health promotion group.
- Supported *Mental Health First Aid Training* implementation in collaboration with OSPI.
- Supported Department of Health (DOH)/Division of Behavioral Health and Recovery's (DBHR) effort to expand Washington's data on suicide and violent death reporting statistics.

11. Prevention Consortium Team Accomplishments 2014-2015

Washington Healthy Youth Coalition (WHY Coalition) Underage Drinking and Marijuana Team Accomplishments

Let's Draw the Line between Youth and Alcohol

- The Let's Draw the Line mini-grants applications were released February 2015 38 groups completed the 2015 LDTL. The groups were awarded $1,000 for their completion of Community Assessment of Neighborhood Stores (CANS) surveys, implementation of one of the Above the Influence projects, and their choice of another projects from a menu 6 possible projects.

Law Enforcement Partnership

- Three communities participated in the Law Enforcement Partnership mini-grants. Communities included Tenino/Bucoda, Castle Rock, Klickitat-Lyle
    - Awarded communities implemented a mix of underage drinking prevention strategies, with a major focus on working with their local and county law enforcement agencies and local media. The communities conducted alcohol purchase surveys, compliance checks, and a media awareness plan.

Policy Impact Team

- Clarified process for reporting violations and it was determined that violations should be reported to Liquor Control Board (LCB). LCB's role is primary enforcer of marijuana law and rules.
- Literature Review is available for stakeholders to utilize to advocate for the regulation and inherent dangers of certain edibles.
    - Policy paper is available for utilization and provided to LCB for reference.
- LCB enacted emergency rules to address MJ edibles.
- Stakeholders and policy makers become better informed about powdered alcohol and its potential implications for underage drinking. The paper was read and/or discussed by agency officials, stakeholders and legislators.
    - House Bill 5292 was passed and signed by the governor. The bill prohibits the possession, use and sale of powered alcohol.
- Expansion of RVP to beer/wine retailers approved by the LCB. Beer/wine retailers are joining RVP, 15 coalitions are working with LCB to promote the RVP to order to increase compliance rates for no sales to minors.

Communications Impact Team

- Completed talking points for communities: June 2014. Info card for parents translated into 8 languages. Distributed online and by WA Commission on Asian Pacific American Affairs.
    - DBHR funded an updated translation of the Cambodian card, and a new translation in Mien. They are now uploaded to the UW site. The plan is to print copies of the Asian language cards and make them available for ordering through the DES webpage for publications. When this is set up, will post on Athena.
    - Communications staff updated the Marijuana Prevention Toolkit page on Athena with links to all of the translated cards.
- Printed 50,000 parent guides and fact cards Toolkit is online and Distributed to Schools through ESDs.
- DOH launched one-month radio and online marijuana educational campaign targeting parents. Announced by Governor Inslee on June 2014 with 34.8 million impressions. 38,888 visits to campaign website.
- Dr. Walker radio ad airing statewide beginning May 2015 to educate the State's parents about State's law regarding recreational marijuana use (I-502).
    - Parents will be directed to StartTalkingNow website for more information, and tips on talking with their kids about the risks of marijuana.
- In March, fact sheets and talking points were updated with the 2014 Healthy Youth Survey results. Updated tools are being added online regularly.
- A new video for parents with prevention tips from a pediatrician was posted to the Starttaklingnow.org webpage on January 2015.
- The Start Talking Now (STN) homepage is currently under redesign. New pages are being created for parents in multiple languages. Spanish language page for parents was completed June 2015.
- Interview with Bea Mendez with Univision, Spanish language station.

Young Adults & Pregnant Women Alcohol & Marijuana Misuse/Abuse Action Team Accomplishments

- Hosted a 1-day SBIRT training/conference to teach medical provides about SBIRT services. Provided a platform for Dr. Jason Kilmer, Dr. Paul Grossberg and Dr. Jim Schaus.
- Disseminated the *Substance Abuse During Pregnancy: Guidelines for Screening and Management* best practice guide, via email and list serves.
    - http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy
- Completed WSHA Safe Deliveries Roadmap standards/QI project. Purpose of standards is to improve care and insure comprehensive care including screening and referring for substance use/abuse. Standards finalized and vetted with all the sub advisory committees who developed

them; released spring 2015. Project included recommended evidence-based standards for primary care for child-bearing age and pregnancy care. SBIRT is included in these standards.

- Women's Healthy messages portal page and factsheet on the DOH webpage.
- DOH webpage health information for pregnant women.
    - http://www.doh.wa.gov/YouandYourFamily/WomensHealth
    - http://www.doh.wa.gov/YouandYourFamily/WomensHealth/Pregnancy
- College Coalition for Substance Abuse Prevention hosted a year end conference.

Prescription Drug Prevention Action Team Accomplishments

Information Dissemination to Communities

- Jennifer Sable presented the background (history and purpose) of the UPWG and PMP. Also presented on Opioid Guidelines revision. Some of the major changes/updates we can expect to see in the release of these new guidelines are centered on the procedures and guidelines for Emergency Room Departments.
- ER departments and Safeway pharmacies are using the DOH "Take as Directed" brochures. The update released on June 2015.
- Alex Schwartz presented to the Pain Medicine Department at Harborview medical Center on March 2015 and educated the physicians and health care team on the PMP.
- Presented to providers at Co-Occurring Conference and to the College Coalition

Promote Value of Prescription Monitoring Program (PMP) to get continued advocacy

- Analyzed new DEA regulation on take-back of controlled substances.
- Outreach provided to stakeholders, including pharmacies, law enforcement, and local governments on impacts to existing medicine take-back programs and establishment of any new take-backs.
- Promoted DEA Take-Back event Sept. 2014 to CPWI sites during monthly meeting and on The Athena Forum.
- Distributed a total of 10,000, "911/Good Samaritan Law Cards" to 52 CPWI coalitions for local distribution.
- Developed messaging to share with prescribers to encourage use of PMP.
- Supported announcement distribution of Opioid Summits to constituents.
- Successfully supported five (5) Community Prevention and Wellness Initiative Communities in Prescription Drug Take Back Projects.
- Completed comparison of toxicology results from King County to codes on death certificate.
- Met with King County Medical Examiner (ME) to discuss results and ideas to reaching out to other MEs and coroners.
- Met with state toxicologist to request toxicology data on drug overdose cases.
    - Scheduled to receive regular data to analyze.

Mental Health Promotion Action Team Accomplishments

HB 2315 Implementation

- Completed Statewide Suicide Prevention plan with statewide partners. Plan is currently under review.

Tobacco Abuse Prevention Team Accomplishments

- Landlord survey implemented to determine the percentage of apartments with a no-smoking policy. Results were available spring 2015.
- Kick Butts Day included outreach to college campuses.
- 3 relevant bill considered by legislature with significant impact including raising smoking age to 21, raising fines and fees for tobacco and regulating e-cigarettes, and allowing cigar bars as an exception to smoking in public places.
- CANS results for 2014 tabulated and distributed to partners.
- We are continuing to promote cessation and especially promoting our smart phone cessation app that we encourage everyone to add to their web site and promote any other way possible.
    - DOH pays for the fee to use the full version of the app for anyone living in Washington State. Get details at www.quitline.com
- WHIN program has experience almost complete turn-over in staff and now has a new section manager with pans to re-staff program.
- Smoking in Movies: On June 29 Disney adopted a broadened tobacco policy, extending to its Lucasfilm, Marvel and Pixar labels its policy that was previously applied only to Disney-branded films. Individual studio policies are a less-effective means than a change in the movie rating system for protecting kids against tobacco impressions in youth-rated movies, because they contain loopholes and are not consistently enforced (one outstanding question regarding Disney's policy is whether it will apply to Touchstone films, which in the past have been a pipeline for smoking in youth-rated movies). Nevertheless, given the dose-response relationship between tobacco exposures from movies and youth smoking initiation, Disney's move may result in some amount of reduced youth-smoking initiation.
- Age 21/e-cigarettes: Although neither bill was enacted, we began to build support in the legislature and elsewhere for major policy changes.
- *Youth smoking rate: Continued decline, as reported in the HYS results.

12. Significant Events Influencing the Field of Prevention from 2010-2015

Significant Events in WA 2010-2015	Year	Economic Event	Policy/ Law Change	Change in Funding
Passing of the Good Samaritan Laws / SB 1671 - Opioid overdose prevention	2010/2015		X	
Tobacco sales tax structure changes	2010	X	X	
Passage of Initiative 1183 Liquor privatization	2011			
Strengthened managed care monitoring	2011		X	
Contract Language re: Mental Health Services	2012		X	
Elimination of Family Policy Council funding	2012			X
Passing of I-502 Non-medical Marijuana Legalization	2012		X	
Elimination of Community Mobilization funding	2013			X
SIM Grant Awarded to Health Care Authority & Accountable Communities of Health	2013			X
Vast expansion of electronic cigarette industry/marketplace	~ 2013		X	
Added SBIRT to Medical Benefit	2014		X	
Garret Lee Smith Grant awarded DOH	2014			X
House Bill 2315 passed (suicide prevention)	2014		X	
WA Prescription Drug Monitoring Program (PMP) State funded	2014		X	X
Significant decrease in youth perception of harm (marijuana use)	2014			
DEA Rules on Rx Drugs and Drug Take-back Program ended	2015		X	
Youth Mental Health First Aid Pilot Efforts	2015			X
Oregon/ Alaska retail marijuana legalization	2015		X	
Potential developmental Screening for young children	2015		X	
Expansion of home visiting (2 million)	2015			X
SB 5052 passed: legalized medical marijuana/ home grows	2015	X	X	
Strengthened language in contract re: Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	2015		X	
Tax funding from I-502 for prevention and treatment programs allocated	2015		X	X
Tribes able sell and produce marijuana legally	2015	X	X	
DBHR requires CPP credential for community coalition coordinators.	2015		X	
Health Care Reform - Behavioral Health Organizations (BHO)	2015/2016		X	

This report was originally prepared in 2011, and updated in 2013 on behalf of all of the partners of the State Prevention Enhancement Policy Consortium by Sarah Mariani, State Prevention Enhancement Project Manager, DBHR, with support from Chris Imhoff, Director, DBHR; and guidance from Michael Langer, Behavioral Health Administrator, DBHR; Sue Grinnell, Division of Prevention and Community Wellness Director, Department of Health; and Rusty Fallis, Assistant Attorney General, Office of the Attorney General.

2015 update prepared on behalf of all of the partners of the State Prevention Enhancement Policy Consortium by Julia Havens, Prevention System Development Manager and Lucilla Mendoza, Prevention System Manager, DBHR, with support from Chris Imhoff, Director, DBHR, and guidance from Sarah Mariani, Behavioral Health Administrator, DBHR; David Hudson, Section Manager, Community-Based Prevention Office of Healthy Communities Department of Health; and Robert (Rusty) J. Fallis, Assistant Attorney General, Office of the Attorney General.

Funding for the development of this Washington State Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan was provided by Washington State Department of Social and Health Services Aging and Disabilities Services Administration Division of Behavioral Health and Recovery with support of the State Prevention Enhancement grant #1U79SP018669-01 from SAMHSA. The views expressed within these materials and plan do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices or organizations imply endorsement by the U.S. Government.

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For more information about the State Prevention Enhancement projects and planning, go to www.TheAthenaForum.org/SPE.

State Prevention Enhancement Policy Consortium Partners