Division of Behavioral Health and Recovery

Strategic Prevention Framework – State Prevention Enhancement (SPE)

Grant Proposal

June 2011

Special thanks to all of the state and local partners that assisted in developing and reviewing this grant proposal.

The following proposal was developed in respond to:

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Strategic Prevention Framework State Prevention Enhancement Grants
(Short Title: SPE Grants)
Request for Applications (RFA) No. SP-11-004
Catalog of Federal Domestic Assistance (CFDA) No.: 93.243

We anticipate a response prior to October 1, 2011.

Division of Behavioral Health and Recovery (DBHR)
Strategic Prevention Framework (SPF) – State Prevention Enhancement (SPE)
Grant Application

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Division of Behavioral Health and Recovery (DBHR)
Strategic Prevention Framework (SPF) – State Prevention Enhancement (SPE)
Grant Application

-- ABSTRACT --

The *Washington State Strategic Prevention Enhancement Project* will enhance our infrastructure by providing consistent professional training across our state agencies and community partners, providing a more accessible and responsive data collection system, and integrating primary care with substance abuse prevention, to create a contemporary and responsive prevention system infrastructure to meet the emerging demands of local needs and federal initiatives.

The Division of Behavioral Health and Recovery (DBHR) working with the Strategic Prevention Enhancement (SPE) Policy Consortium will develop and implement a Capacity Building/ Infrastructure Enhancement Plan and a Comprehensive Strategic Prevention 5-year Plan. The *SPE Project* will enhance our prevention infrastructure to better support local high need communities as they address substance abuse. DBHR, using the SPE grant, will build on current strengths in our systems to initiate and implement the following key enhancements:

1. Build a cohesive SPE Policy Consortium that capitalizes on system strengths and brings in new partners essential to the success of the state prevention plan.
2. Expand Training Plan to be a more extensive training, technical assistance and workforce development plan that includes: enhance website capabilities to host video trainings, webinars, and distance learning opportunities; expansion of trainings to include special topics areas and at risk populations and a feasibility study of certification requirements.
3. Expand and operationalize current data collection and reporting systems, capturing each step of the Strategic Prevention Framework and making data collection and reporting easily accessible and useable for both state and local communities.
4. Develop capacity in local communities to work with primary care through establishing a Primary Care Integration Demonstration project which will identify and/or develop innovative strategies by providing incentives to local communities to integrate substance abuse prevention with primary care, and expand our understanding of mental/emotional behavioral disorders and prescription/over the counter drug abuse prevention into current substance abuse prevention infrastructure.

The Washington State Strategic Prevention Enhancement project will provide infrastructure enhancement support to state agencies, local governments and our providers. We anticipate that as a result of this effort all of the citizens of Washington will share in its intended outcomes. This funding is for a one-year infrastructure and planning project and therefore, no specific direct service population is defined.

Division of Behavioral Health and Recovery (DBHR)
Strategic Prevention Framework (SPF) – State Prevention Enhancement (SPE)
Grant Application

-- PROJECT NARRATIVE --

SECTION A: Statement of Need

Summary Statement

Adequate resources to implement the SPE project to effect state-wide change: The Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) as the Single State Agency, is well positioned and equipped to meet the requirements and intent of the Strategic Prevention Enhancement Request for Applications. Our historical structure has demonstrated proven results in reducing risk and increasing protective factors associated with youth substance abuse while improving coordinated service delivery across multiple agencies.

With over 25 years of experience implementing the SAPT block grant and two separate State Incentive Grants, and even in the face of major budget challenges, DBHR has recently initiated the state *Prevention Redesign Initiative (PRI).* PRI is using the Strategic Prevention Framework (SPF) to create community level change by using the State Epidemiological Outcomes Workgroup's data analysis to focus our limited resources into the highest need communities in an intentional, collaborative, and community driven process. Through PRI we have redirected nearly all our current prevention resources, including federal, state, county and local educational authority personnel, funding, and data systems to focus on serving high need communities.

Functioning Epidemiological Workgroup, such as SEOW: The Washington State Epidemiological Outcomes Workgroup (SEOW), established in 2005, is currently supported through a SAMHSA/CSAP SEOW contract. The workgroup develops data analyses and reports to provide advice and direction to the leadership of DBHR and other agencies. Washington's SEOW formalized the collaboration between existing research and data committees and is comprised of epidemiologists and prevention researchers with thorough knowledge of the State's epidemiological data. The SEOW is central to Washington state's commitment to data-based decision making and meets regularly to review state data and related strategic plans.

Working Evidence-based Practices (EBP) Workgroup: DBHR is working with the state of Oregon to create a joint system for evidence-based practices review and listing. Beginning July 2011, DBHR will contractually require that 60 percent of implemented prevention practices are evidence based. We will draw initially from the National Registry of Evidence-based Programs and Practices. The list currently contains practices for substance abuse prevention, mental health promotion, and suicide prevention and specifically identifies practices appropriate for American Indians and tribal communities, which is essential to our state. Washington will also develop and maintain a web-based searchable database portal.

Strong state supported substance abuse prevention evaluation process and methodology: The state's prevention system is committed to gathering data that are necessary for evaluation. The three main sources of data are: school-based survey data which is collected every two years, that allows for measuring population level changes in consumption and outcomes; pre-post test and process data that are reported at the program level on a management information system; and archival and administrative data (social indicators) published bi-annually. These datasets are

used for both needs assessment and evaluation, and are incorporated into an evaluation plan that is modeled on the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) evaluation.

Logic model process at the state, tribal and community levels: DBHR's use of the SPF process to develop strong logic models has evolved in recent years to be a collaborative process between the state data experts, technical assistance managers, and local coalitions. In our previous system, counties and tribes were required to complete and submit strategic plans using the SPF process. Now, using the lessons we learned from the SPF-SIG to inform our Prevention Redesign Initiative (PRI), the state provides more technical assistance, guidelines, and data for counties to use in identifying high need communities. The PRI logic model forms the basis for the local PRI communities to use the SPF to develop and implement their required local logic models and strategic plans.

Functioning, state supported training and technical assistance system: DBHR's organizational structure includes the Prevention System Implementation and Integration Units that support a training and technical assistance (TA) system. Each county and tribe is assigned to a manager who monitors contractual requirements and provides necessary technical assistance to ensure success. The State Training Plan seeks to develop and standardize trainings that will enhance the knowledge and skills of the state and county prevention professionals who deliver TA to local communities. Our website (theAthenaForum.org) provides a forum for interactive learning and document sharing. DBHR designates funds that counties can use to support their local training needs to build capacity to effectively implement evidence-based programs.

Requirement that all State and Tribal prevention subrecipient communities must complete a comprehensive strategic plan based on a data-driven planning model: DBHR requires that all County and Tribal subrecipients submit a Strategic Plan with biennial updates. For the PRI, the SEOW provides community level data profiles in maps and tables that identify communities with elevated risks for substance abuse. Counties review this data, compare it with local contextual information and data, and with their partners select community(ies) on which to focus their efforts. The counties, local educational authority and the state provide technical assistance to support implementation in local communities of the SPF, including assessment, capacity building, planning, implementation and evaluation.

Ongoing planning process that includes key state/tribal leaders, including parents and youth: DBHR actively seeks input to ensure broad-based inclusion through a variety of formal and informal methods. Input is received from development of the State Interagency Prevention Plan, the Reducing Underage Drinking Coalition, TheAthenaForum.org, the PRI Learning Community, and the newly formed Behavioral Health Advisory committee. Representation on these groups includes substantial participation from key state/tribal leaders, and community members, parents, youth, providers, and advocates. DBHR will continue to use these established mechanisms to gain insight from the field and local families.

Ongoing process and support system for tribes and tribal organizations in the state: DBHR provides funding to each of the 29 tribes in Washington State; 80 percent of the tribes choose to focus this funding on prevention. In respect of the formally established state/tribal communication protocols, DBHR coordinates with the state's Indian Policy Advisory Committee to disseminate information to and gather input from the tribes. Additionally, each tribe has DBHR staff assigned for technical assistance and support.

Needs Assessment Profile and Gap Analysis

Proposed State Catchment Area and Related Demographic Information

According to the 2010 Census, Washington's 6.7 million people are nearly double its population from 40 years ago. Washington is divided into the largely rural east and densely populated west sides. This physical geography and her position on the Pacific Rim is reflected in a flourishing cultural diversity.

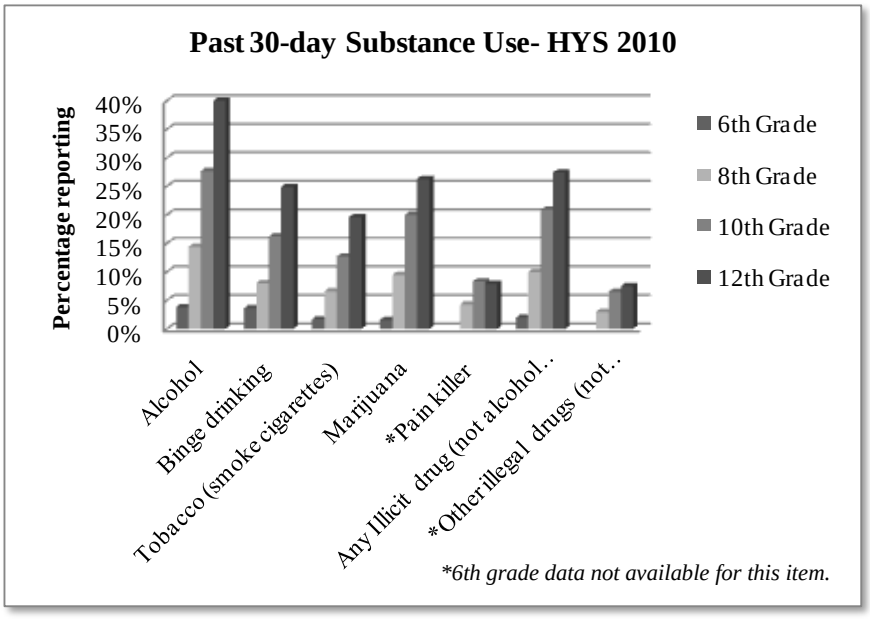
While the population remains mostly Caucasian (83.8 percent), the ethnic diversity of the state has increased dramatically (Office of Financial Management (OFM), 2010). More than 100 languages are spoken within Puget Sound school districts. Hispanics are the fastest growing group in the 2010 census, with 684,021 people, a growth of 54.9 percent since 2000 (OFM, 2010). Two counties in Washington are now majority Hispanic. The Native American population is 1.2 percent of the total. While small in number, this culturally complex group is made up of twenty-nine federally recognized tribes. African Americans, who make up 3.4 percent of the total state population, live primarily in the densely populated urban areas around the Puget Sound.

As in most of the country, Washington's economy suffered during the recent recession, with unemployment approaching 10% in early 2010. In many rural counties unemployment was 14-15%. Historically the unemployment rate in Washington is higher than the U.S. average due primarily to a relatively high share of resource-based industries, which have more volatile seasonal employment patterns (OFM, 2011). The impact of the recession on the building industry is notable in this regard, not only for the loss of demand for forest products, but also because many Hispanic/Latino workers depend on temporary jobs in this sector.

Substance Abuse in Washington:

Overall, the state's rates of substance abuse are close to the national averages. However, notably, drug-induced death rates are more than double that seen ten years ago: in 2008 there were 992 drug-induced deaths (Department of Social and Health Services (DSHS), 2009).

This chart illustrates youth substance abuse data from the most recent youth survey.



Deaths involving the use of prescription-type opiates are of particular concern: in the Seattle area, for instance, deaths from prescription-type opiates rose from 29 in 1998 to 160 in 2009. An increase in pharmaceutical abuse has been seen across age groups. However, among

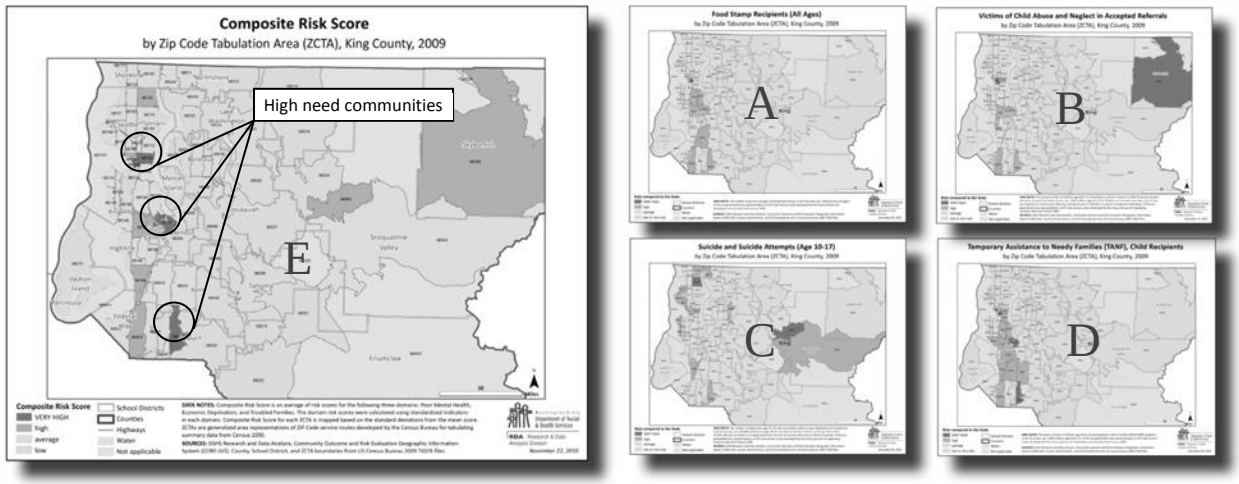
10th and 12th graders the use of pain killers "to get high" declined slightly from 2008 to 2010 (Healthy Youth Survey (HYS), 2010).

Alcohol and drug abuse costs Washington an estimated $5.2 billion dollars a year, a 105 percent increase over 1996 (Wickizer, 2007). Alcohol abuse accounted for 56 percent of that total, compared to 44 percent for illegal drugs.

Focus to high need communities

The state's Prevention Redesign Initiative (PRI) focuses on high need communities as identified by seven composite scores that include indicators of substance use, mental health (sample map C below), family problems (sample B), academic progress, crime or delinquency, and poverty (sample A and D). These composite indicators are then aggregated so that counties can target prevention services (sample E). The PRI requires that within a geographically designated community, a local needs assessment further clarifies the identification of subpopulations within the community, and the needs specific to those groups.

Below for demonstration purposes only is a visual snapshot sample of the PRI maps noted above: (Research and Data Analysis, 2010)



Gap Analysis

Need for Enhanced Infrastructure

DBHR is committed to a prevention system that is substantial and effective enough to achieve significant reduction in rates and impact of substance abuse statewide. Based on the work of the SEOW for the SPF-State Incentive Grant (SPF-SIG), DBHR has identified alcohol use as the single biggest problem based on prevalence and cost to the state. However, achieving population level changes in a high need community presents daunting challenges. Through SPF-SIG, we know that implementing a thorough needs assessment, developing a meaningful logic model and strategic plan, implementing evidence-based practices, and collecting evaluation and monitoring data required a level of training and technical assistance that the state's prevention system is challenged to sustain. Nevertheless, with our strong foundation in prevention science, and the long commitment to developing and maintaining data collection and reporting systems, we

believe that Washington's infrastructure can be enhanced in ways that will improve our capacity to provide needed support to communities.

Washington State's infrastructure for producing state/community profiles has been continuously improving since the early 1990s. There are two primary sources of data for these profiles.

1. The *Community Outcomes and Risk Evaluation Geographic Information System (CORE GIS)* was developed as a set of archival indicators (or social indicators) that were highly correlated with adolescent substance use, and the risk factors that predict substance use. There are currently forty-seven indicators, all maintained in the dataset at their lowest level of geography, down to address or latitude/longitude. Most indicators originate from the Department of Health, the Department of Social and Health Services, the Uniform Crime Report, and the Office of the Superintendent of Public Instruction. The data are published twice a year on a public website, and reported at the lowest feasible geography: state, county, school district/community, and locale (a geography that incorporates more than one school district when the base population of the school district is too low for reliable reporting). See http://www.dshs.wa.gov/rda/research/risk.shtm.

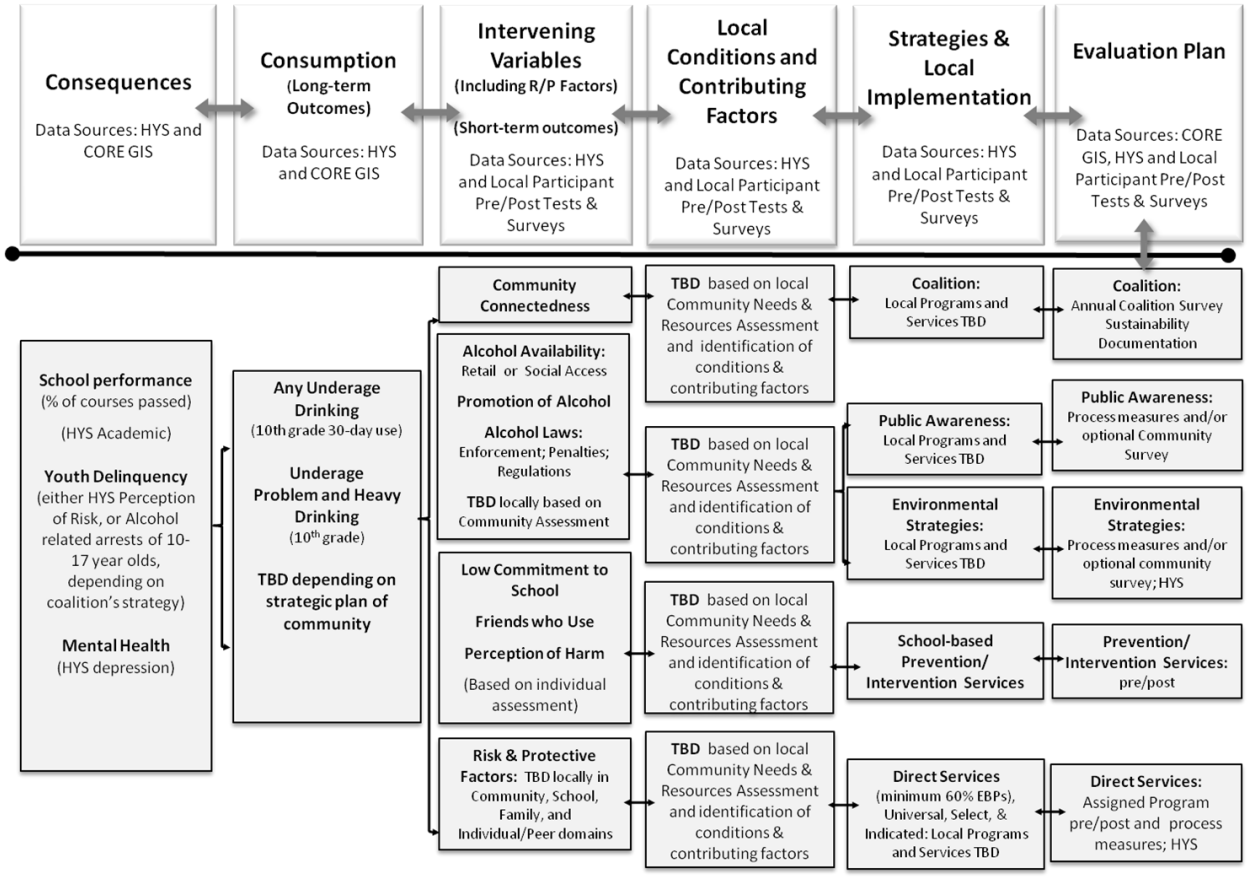
2. *Washington State Healthy Youth Survey (HYS)* is a bi-annual adolescent health behavior survey that is administered in school classrooms of 6th, 8th, 10th and 12th graders. In 2008 and 2010 more than eighty percent of school districts participated, which is sponsored by five state agencies. The HYS originated in 1988 and since 2002 has been a single survey that has incorporated questions from: the Youth Risk Behavioral Survey; alcohol, tobacco and other drug questions modeled on Monitoring the Future survey; risk and protective factor questions from the Communities That Care survey; and the Youth Tobacco Survey. The questions cover health and school success behaviors, from diet and nutrition to binge drinking to school skipping. State and county level reports are available publicly at AskHYS.net.

Taking into consideration a number of factors, including current budget limits, increasing expectations, federal funders seeking community-level change, emphasis in the proposed Governor's Prevention Plan on community-based prevention, research demonstrating success of coalition efforts, and system growth demands, we are moving to a community-focused approach to concentrate our efforts on high need communities using improved data-driven decision making. This move to a community-focused approach, with the expertise and commitment of our state and community partners, will help us leverage resources and demonstrate the efficacy of our efforts. The goal is to build on what works, deepen our impact, better measure those impacts, and therefore strengthen our ability to build support for additional investments in prevention.

In August 2009, DBHR began the Prevention Redesign Initiative (PRI) in discussions and meetings with key stakeholders. Currently we are contracting with county governments and the Office of the Superintendent of Public Instruction to provide effective community-based prevention services aligned with school-based prevention/intervention specialists to reduce alcohol, tobacco, and other drug use by our state's youth. Counties offer a variety of school and community-based prevention programs, while specialists placed in schools provide universal programs, early intervention and referral services to identified youth.

The Prevention Redesign Initiative (PRI) community selection process evolved from the process used for the SPF-SIG; however it was revised to accomplish additional goals. While both the SPF-SIG and the State's Interagency Strategic Plan prioritize underage drinking; DBHR chose to base the community selection process on a broader set of criteria in alignment with the block grant needs assessment. A set of indicators that include consumption, consequences associated with consumption (crime, truancy, lack of school success), and socio-economic data were identified based on data quality and availability, and input from stakeholders as to relevance and interpretability. Those indicators were grouped by domain, standardized, and then reported as composite scores. Every county received a Risk Profile that included the demographics and risk ranking for all the school districts in the county. They also received detailed data tables and a map with the composite scores by school district (see page 4). From these Risk Profiles a committee of key stakeholders within each county identified highest need communities for participation in PRI. PRI communities use the SPF to develop required local strategic plans and logic models.

The diagram below illustrates our integrated state/local logic model:



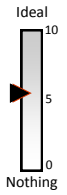
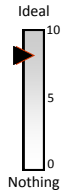
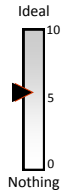
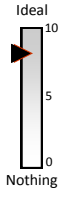
PRI demonstrates our infrastructure that uses archival and survey data to identify high need communities and to provide detailed state, county, zip code, and neighborhood level assessment data to drive decision making.

Based on our experience in the SPF-SIG, these data reports require professional assistance to incorporate into a community-level planning process. We need to simplify these reports, and embed them into a user-friendly planning template. Further, the existing data systems require additional development so that information on the availability of prevention resources and the penetration of those resources into high need communities will be collected.

Personnel, training, service gaps, and barriers related to need for infrastructure development/ enhancement

While we have many systems in place that support high need communities, our Preliminary Gap Analysis indicates that we also have areas in which enhancements, development and operationalization will bring us closer to the optimal state prevention infrastructure.

Preliminary Gap Analysis

Policy Consortium	
Key Infrastructure in place: ▪ Established collaborations and partnerships. ▪ Existing workgroups, councils, and related collaborative groups. **Infrastructure enhancements needed:** ▪ Build more structure and blend existing groups to reduce redundancy. ▪ More incorporation of primary care, mental health and prescription/over the counter drug (Rx/OTC) abuse partners.	
Prevention Infrastructure – data driven state and community profile	
Key Infrastructure in place: ▪ Recently completed a thorough assessment and data driven process through Prevention Redesign Initiative (PRI). **Infrastructure enhancements needed:** ▪ Create systems and operationalize the process developed. ▪ More incorporation of primary care, mental health and Rx/OTC abuse information. ▪ Develop and implement training to DBHR staff and community providers.	
Training and Technical Assistance System	
Key Infrastructure in place: ▪ Organizational staffing structure to support training and technical assistance. **Infrastructure enhancements needed:** ▪ Develop and implement training to DBHR staff and community providers. ▪ Use technology to increase access to available trainings. ▪ Develop capacity in high need areas that have low readiness.	
Ongoing processes for Assessments	
Key Infrastructure in place: ▪ Counties and tribes develop strategic plans and update them every two years. ▪ Through PRI we have recently integrated local ongoing assessments. **Infrastructure enhancements needed:** ▪ Develop and implement training to DBHR staff and community providers. ▪ More incorporation of primary care, mental health and Rx/OTC abuse information.	

Evidence-based Workgroup

Key Infrastructure in place:

- Contract requirement of 50% EBP; currently we have 67% implementation of EBP.
- Long standing history with WesternCAPT EBP listing.
- Oregon partnership to develop system for review and maintenance of EBP list.
- Have web platform to host the information.

Infrastructure enhancements needed:

- Develop inter-state review and approval process and train providers in process.
- Develop and integrate into website a searchable database for providers.
- More incorporation of primary care, mental health and Rx/OTC abuse information.

Data-driven Funding Allocation

Key Infrastructure in place:

- Structure in place that moves all counties and school based prevention funding to specific process to identify and fund high need communities over next 3 years.

Infrastructure enhancements needed:

- Develop and implement training to DBHR staff and community providers.
- Create systems and operationalize the process developed.
- More incorporation of primary care, mental health and Rx/OTC abuse information.

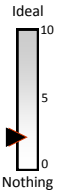
Expansion of Available Funds for High Need Communities

Key Infrastructure in place:

- Structure in place that moves all counties and school based prevention funding to specific process to identify and fund high need communities over next 3 years.
- Sustainability Workgroup focused on state and community resources development.
- Annual Drug Free Communities grantee application training is offered to the state.

Infrastructure enhancements needed:

- Develop and implement the Sustainability Plan.
- Develop capacity in high need areas that have low readiness.
- Develop and implement training to DBHR staff and community providers.



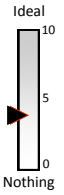
Multi-Agency Structure to Coordinate and Allocate Funding

Key Infrastructure in place:

- DBHR's mission is to service both substance abuse and mental health needs.
- Currently partner with educational system for funding of high need communities.
- Collaborative projects with multiple state agencies.

Infrastructure enhancements needed:

- Integration of funding systems in state, such as mental health block grant funding to support mental health promotion with substance abuse prevention providers.
- Support funding for additional PRI communities through other funding streams.



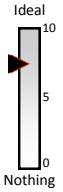
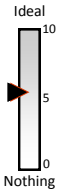
Data Collection Systems

Key Infrastructure in place:

- Current data collection systems collect archival, survey, and participant level data.

Infrastructure enhancements needed:

- Develop a system for analyzing all sets of data and providing real-time, ad-hoc reports to state and community level providers.
- Develop and implement training to DBHR staff and community providers.
- More incorporation of primary care, mental health, and Rx/OTC abuse information.

Ensuring Cultural Competence	
Key Infrastructure in place: ▪ Established trainings included in state sponsored conferences. ▪ Included as key part of required local level strategic plans. ▪ Organizational structure and policies that ensure cultural competency. ▪ Funding specifically dedicated to trainings which include cultural competency. ▪ Native American trainings provided by state Office of Indian Policy. **Infrastructure enhancements needed:** ▪ Enhance and implement training to DBHR staff and community providers. ▪ Enhance information available specific to LGBTQ, military and other special populations.	
Process and Outcome Evaluation Process	
Key Infrastructure in place: ▪ Current data collection systems collect archival, survey, and participant level data. **Infrastructure enhancements needed:** ▪ Develop a system for analyzing all sets of data and providing real-time, ad-hoc reports to state and community level providers. ▪ Enhance community development process modules. ▪ Develop and implement training to DBHR staff and community providers. ▪ Enhance our formative process to ensure data analysis is incorporated into next planning.	

Preliminary Gaps Analysis Summary: In a review of the infrastructure capacity within our current state prevention plan and the optimal infrastructure, we identified the following components that would most effectively support our mission:

1. Building more interagency collaborations that align existing state efforts and bring current key state and community partners together in the Policy Consortium to reduce duplication and encourage alignment and braiding of assessments, priorities, planning, reporting and evaluation.
2. Augmenting our state training and technical assistance plan to include web-based trainings, videos, templates, and samples. Expand content to ensure we specifically have resources for sustainability, and cultural competency, including areas focused on LGBTQ, Military, Native American and American Indian and other special populations. And, increase readiness in high need/low resource communities to receive support for local strategic prevention planning.
3. Enhancing data collection systems for assessment, evaluation and monitoring: improving the current resources assessment data collection instrument; incorporating improved reporting formats; and developing support for its use among state and local partners.
4. Supporting a Primary Care Integration Demonstration project for the development and documentation of connections and innovative strategies between local collaborative groups that support incorporated, data informed prevention strategies to actively integrate primary care services with substance abuse prevention and mental health promotion. For example, hosting parenting programs at primary care facility, identifying youth and parents that may benefit from receiving prevention information and referral to programs or when necessary creating rapid follow-up and referral to substance and mental health treatment agencies.

Stakeholders and resources in state that can help implement the enhancements
DBHR will strengthen current partnerships with the Washington Interagency Network (WIN) and invite additional agencies to join to form the Policy Consortium. Each member agency of the Policy Consortium will agree to at least one action step that their agency/organization will implement in each plan. We will also recruit existing workgroups to serve as consulting/advising groups to the Policy Consortium. DBHR will use SPF capacity development strategies as we engage partners in our state level strategic prevention planning.

Consistency of Priorities

This proposal demonstrates our intent to continue our commitment and enhance our effectiveness in implementing our current priorities as the Single State Agency to address substance abuse prevention. We are directing our resources to high need communities through data driven decisions and engaging local communities in strategic prevention planning to implement environmental strategies and evidence-based practices.

SECTION B: Proposed Approach

Purpose of the Proposed SPE grant Project

Goals and Objectives General

The overall purpose of our SPE proposal is to enhance our prevention infrastructure so that we can more effectively and efficiently support high need communities as they address substance abuse. We plan to build on current strengths in our systems and to address identified gaps as we work to meet the goals of SAMHSA and this SPE grant.

The SPE will also support our ability to meet the emerging demands for prevention efforts in consideration of federal initiatives and health care reform. We will ensure a contemporary and responsive prevention system infrastructure is in place to develop and implement both the Capacity Building Plan and the 5-Year Plan. The SPE will provide us with the opportunity to develop long term plans and implement needed enhancements to meet the goals as outlined in the four key objectives: 1) build a cohesive SPE Policy Consortium; 2) expand our training plan; 3) expand and operationalize current data collection and reporting system; and 4) support a Primary Care Integration Demonstration project to integrate primary care services with substance abuse prevention efforts (see detailed description on page 14). Additionally, we will use the SPE grant to examine the feasibility of the system reforms included in the four objectives and to the extent it is possible we will begin implementation

Proposed Project Activities

SAMHSA Initiative #1 Goals

SAMHSA Goal 1.1: *With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.*

The State's prevention system has a well established framework that can identify high need communities and support local coalitions as they develop comprehensive strategic plans,

collaborate to implement environmental strategies and evidence-based practices (EBP), and provide prevention/intervention services to address substance abuse prevention needs. We have included primary care, mental health promotion and substance abuse treatment providers in the intended coalition membership; however more training and technical assistance are necessary for communities to be able to fully integrate this component. We will look to infrastructure enhancements that create efficiencies and enhance user experience and competency in our data collection and reporting.

We will use the SPE Capacity Building Plan to include training as an opportunity to build our infrastructure to more adequately support local communities in developing partnerships with primary care, LGBTQ, military, Native American, mental health promotion and treatment providers. Specifically we will seek to incorporate the work of our state Children's Mental Health Redesign to identify more cross fertilization of services between health home models, which integrate behavioral health and primary care, with prevention coalition models. The Children's Mental Health Redesign cites the Adverse Childhood Experiences study (Felitti, 1998) which demonstrates a relationship between mental and emotional disorders and substance abuse to support the strategy of strengthening screening for, and education about, mental health and substance abuse risk patterns at the primary care office level. It also supports an increase in prevention and early intervention strategies. We will further develop the EBP workgroup with Oregon to identify those strategies that have a mental health component and train the staff and prevention field on mental health promotion. Lastly, we will create a Primary Care Integration Demonstration project, which will provide support for local communities to work creatively to generate and document successful strategies for prevention and primary care provider partnerships.

SAMHSA Goal 1.2: *Prevent or reduce consequences of underage drinking and adult problem drinking.*

Washington has directed block grant and other funding and staff resources to support our long time commitment and prioritization of underage drinking through the Prevention Redesign Initiative (PRI) and the statewide Reducing Underage Drinking Coalition (RUaD). DBHR leads this statewide coalition consisting of state education, health, liquor control, law enforcement, traffic safety, attorney general, commerce, and higher education agencies with a comprehensive plan to address underage drinking through policy, enforcement, and communication. The RUAD's current policy action items include work on social host ordinances, indoor advertising, and high alcohol content drinks. The coalition also monitors legislation, and supports the website based on the *Start Talking Now* campaign.

One of the most intractable problems in the development of community-level prevention is the lack of data on groups other than those students participating in the Healthy Youth Survey. Other age groups are represented in national surveys, for instance the National Survey on Drug Use and Health, and the Behavioral Risk Factor Surveillance System, but those data are not sufficient for needs assessment at the local level. The SPE proposal specifically focuses on efforts to improve our ability to collect data for additional indicators of the drinking consequences at the community level and to develop measurements on a broader age range.

SAMHSA Goal 1.3: *Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, or American Indians and Alaska Natives.*

DBHR has relied heavily on our partnership with Department of Health (DOH) to address suicide prevention. DBHR serves on the DOH Advisory Committee which developed the state Suicide Prevention Plan implemented by the State Youth Suicide Prevention Program.

DBHR will use the SPE to enhance our infrastructure to more directly impact suicide prevention through further developing our partnership with DOH and expanding our partnerships to identify and include experienced providers who work on suicide prevention and/or focus on populations at high risk.

We will enhance our Prevention Redesign Initiative (PRI) system by providing support and developing training that educates communities on successful strategies to build the relationships to address the needs of these populations. We will work with coalitions and established organizations committed to serving military families, LGBTQ, American Indians and Alaska Natives, and with mental health and primary care providers to build the interconnected structures and resources for substance abuse providers. Mental health crisis and treatment providers will be integrated into a community linked service array with community coalitions. Additionally, we will develop capacity for local communities to incorporate primary care into the system of providers that actively intervene to prevent substance abuse, suicides and suicide attempts.

DBHR will work with two state agencies, the Office of Superintendent of Public Instruction and Department of Commerce, to update key training materials and curricula to include mental health promotion, as well as sections on military family stresses, and LGBTQ issues.

SAMHSA Goal 1.4: *Goal 1.4: Reduce prescription drug misuse and abuse.*

To understand prescription drug abuse, DBHR has worked with the Department of Health (DOH), the Attorney General's Office, and the University of Washington. We collaborate with a number of agencies in addressing prescription/over the counter drug (Rx/OTC) abuse.

Washington's Healthy Youth Survey (HYS) has collected data on prescription drug use for many years. In 2008 and 2010 questions specific to opioid-type drugs were inserted. In addition to the alarming increase in youth prescription drug use, poisoning deaths have increased dramatically across all age groups, overtaking impaired driving fatalities as the leading cause of unintentional death in the state. Data show that a high percentage of heroin users began with using prescription opiates. Efforts to combat these trends are occurring in a variety of settings.

DBHR will continue to support coalitions across the state to work with local law enforcement to host "take back" days. Another avenue the state has explored is public health education for parents, encouraging the correct handling of prescriptions in the home. We are currently supporting the Partnership for a Drug Free America's 360 degrees presentations which engage local parents in Rx/OTC abuse prevention activities. In our statewide conferences, Spring Youth Forum and Prevention Summit, we include education and skill development for youth and adults on substance abuse prevention and include specific sessions on Rx/OTC abuse prevention.

DBHR will partner with DOH, guided by the SEOW, to build a cohesive plan to include the new Prescription Drug Monitoring Program data to support our prevention system by integrating with

other outreach efforts to primary care settings, such as drug monitoring reports pushed out to physicians.

Additional SPE-specific Goals:
SPE Goal 1. *Enhance State/Tribal workforce development*

DBHR has allocated and distributed community prevention training funds to each county to be used to train on substance abuse prevention evidence-based practices.

Further, DBHR has developed a workforce development plan to train staff and stakeholders on the SPF and the critical components needed to successfully implement local strategic planning. We are using the SPF as the foundation of our Training Plan which includes the following:

- **Getting Started**, which includes assessing community readiness, and building initial support;
- **Capacity,** which includes decision making models, SPF overview, key leader/board orientation, coalition and membership development;
- **Assessment,** which include community assessment training/clinic (plus contributing factors), community resources assessment training/clinic, and using local data updates to re-energize your coalition;
- **Planning,** which contains community planning training/clinic (develop proposed local strategic plan), getting your message out, and planning and tracking the penetration of messages;
- **Implementation,** which consists of community plan implementation and evaluation training (plus community buy-in) and environmental strategies workshop; and
- **Reporting and Evaluation,** which will focus on how to use evaluation information to build coalition support.

DBHR will be using the SPE grant to initiate a more enhanced training system through the development and implementation of the Capacity Building Plan and as part of the development of the 5-Year Plan to comprise the following four main areas of development 1) enhance website capabilities to host video trainings, webinars, and distance learning opportunities; 2) update the Student Assistance Manual and Community Mobilizing training curriculum to include mental health promotion, a section on how to work with military family stresses, and guidelines for working in the LGBTQ community; 3) host Communities That Care training of trainers; and 4) support Communities Anti-Drug Coalitions of America's coalition coaching.

We will use lessons learned from the newly developed Primary Care Integration Demonstration projects to expand our knowledge and provide additional training on primary care integration, mental health promotion education and working with high risk populations.

Washington currently has the Associate Prevention Professional (APP) credential and the Certified Prevention Professional (CPP) available. As part of the SPE we will explore the feasibility of requiring the CPP. If this becomes required, we will need to support the increased capacity for individuals to seek and complete their certification. We will work with the Prevention Specialist Certification Board of Washington to deliver the Substance Abuse Prevention Specialist Trainings, a comprehensive training that supports professionals' ability to attain certification.

DBHR currently serves on the Advisory Committee of the National Guard Western Regional Counterdrug Training Center (WRCTC). We will enhance our partnership so that we can include more military family-focused information in the implementation of our workforce development plan. The WRCTC's mission is to provide high quality training to those people we list as natural allies - law enforcement officers, military personnel, treatment and prevention professionals, and community coalition members. WRCTC can facilitate and subsidize training across the state.

SPE Goal 2. *Enhance State/Tribal Policy development to support needed service system improvements*

DBHR has a strong commitment to policies and infrastructure that support our work in the most effective and efficient manner. We will use the SPE to capitalize on the knowledge of the Policy Consortium to consider the following system improvements in our 5-Year Plan: 1) a feasibility study regarding CPP requirement and agency licensure; 2) rate setting for prevention programs and seeking opportunities to tie those to Medicaid billing codes; 3) a web-based system that uses service monitoring and evaluation outcome data to automatically produce reports for state and local communities; and 4) integration of TheAthenaForum.org, our professional development online system with the Performance-Based Prevention System, our online monitoring and evaluation system, to include a newly added fiscal reporting component.

The Key Objectives: The following key objectives summarize the enhancement strategies needed to meet the optimal system across the six combined goals.

1. Build a cohesive SPE Policy Consortium that capitalizes on system strengths and brings in new partners essential to the success of the state prevention plan. The Policy Consortium will guide the creation of the Capacity Building/Infrastructure Enhancement Plan (month 3) and Comprehensive 5-Year Strategic Prevention Plan (month 11). When needed, DBHR will use consultants to assist with these planning processes. The Policy Consortium will ensure that these Plans include thorough analysis of the following strategies needed for long term infrastructure:
   - General strategic direction to support high need communities to implement SPF.
   - Support for developing readiness in other high need communities to implement SPF.
   - Development of a fee structure/rate setting for prevention services and integrate fee structure into current reporting system.
   - Update theAthenaForum.org to host a seamless transition to reporting system.
   - Integration of prevention system websites and develop compatible Smartphone applications.
   - Examine feasibility of developing a comprehensive prevention application to be used in health homes and other primary care settings.
   - Work with the SEOW for identification of additional indicators of risk.

2. Expand Training Plan to be a more extensive training, technical assistance and workforce development plan that includes:
   - Extensive capacity training information and resources and an online learning community. Through use of SPE, we will focus on developing sustainable capacity by using technology, i.e. video training posted online;
   - Development of curricula with independent modules on SPF and related strategies, evidence-based practices, sustainability, and special topic areas, i.e.:

  - primary care; mental health promotion; suicide prevention curricula expansion and suicide prevention for LGBTQ, Native American, Military, and other underserved populations;
  - Adverse Childhood Experiences, and its relationship with the development of problem behaviors;
  - Institute of Medicine explanation of the relationship between mental, physical, and emotional health and youth behavior;
  - developing readiness, systems theory as it relates to enhanced community building;
  - alcohol and prescription/over-the-counter drugs;
  - prevention professional certification; and
  - strategies for effectively supporting underserved populations including military families, LGBTQ, and Native Americans.
- Review of methods to build a more professionally recognizable workforce and provider network by developing a Certification and Licensure Feasibility Plan that will move us toward requiring key professional prevention staff to be certified prevention professionals and contracted agencies to obtain licensure to provide prevention services; and
- Incorporation into our 5-Year Plan a method to build capacity readiness in additional high need areas to be considered for funding in the future.

DBHR will partner with other state agencies on the Policy Consortium for the planning, execution and involvement in training and workforce development opportunities.

3. Expand and operationalize current data collection and reporting systems, capturing each step of the SPF and making data collection and reporting easily accessible and useable for both state and local communities by:

   - Building on the current Healthy Youth Survey on-line query and reporting system to enhance community level profiles to make them more accessible and usable for community needs assessment.

   - Creating efficiencies with the Performance Based Prevention System by streamlining and automating contract monitoring process, for example:
     - a more intuitive front end for data analysis and report building;
     - closer alignment with the SPF planning model;
     - enhancements on data assessment profiles, strategic planning reports, collection of process and outcome service implementation data, and service and outcome evaluation reports;
     - a user-friendly resource assessment module, workable with all types of services and available to other systems;
     - an updated interface, more useful reports, and a query system;
     - As part of our 5-Year Plan, we will consider a “front end” to interweave our current online systems into a seamless interface; and
     - An exploration of ways to support primary care providers to direct individuals and families to community prevention and mental health promotion services, as well as referral to treatment if needed.

4. Develop capacity in local communities to work with primary care through establishing a Primary Care Integration Demonstration project which will identify and/or develop innovative strategies by providing incentives to local communities to integrate substance abuse prevention with primary care, and expand our understanding of mental/emotional behavioral disorders and prescription/over the counter drug abuse prevention into current substance abuse prevention infrastructure through:

    - Support of local Prevention Redesign Initiative community coalitions to develop exemplarily strategies for involving and integrating primary care with substance abuse prevention by:
        - providing an incentive to each coalition that can demonstrate active participation of a primary care provider in coalition; and
        - providing an extra incentive for coalitions to develop innovative collaborative substance abuse prevention efforts with primary health care providers. For example hosting parenting classes in a primary care facility.

    - Documentation requirement that coalitions report on process and outcomes from active involvement and collaborative projects. DBHR will disseminate the lessons learned and highlight successful strategies to coalitions statewide.

Increase System Capacity to support effective substance abuse prevention services

The SPE goals and objectives described above will help Washington State DBHR build partnerships, capacity and develop a 5-Year Plan that builds on current infrastructure to bring our system to the next level of achievement that will have a lasting impact. Using technology enhancements will increase our systems' ability to effectively assess data, plan, implement and evaluate from the local level up to the state level. Furthermore by using the SPE grant to provide essential professional development to our staff we will be able to better support the local high need communities as they use the SPF to develop and implement strategic plans.

The employees in the Prevention System Implementation and Prevention System Integration Units to be trained are the key staff in the overall organizational structure to provide support for local communities to implement SPF with the integration of primary care and behavioral health. Additionally the SPE grant will be used to extend our use of technology as a means to make the training that is developed and provided sustainable over time. For example, by developing and recording trainings that are posted on state's TheAthenaForum.org, staff from both the state and local levels can continue to access these trainings for years to come. All of the proposed goals and objectives will build the state's infrastructure to be responsive to local needs to support effective delivery of service that will impact substance abuse and mental health outcomes.

Project Timeline

Overall the two primary activities will be to develop and implement a Capacity Building/Infrastructure Enhancement Plan and a Comprehensive Strategic Prevention 5-year Plan. Those plans will be supported by the four key objectives.

Key: **S** = Start working on this task during this quarter; **C** = Completed during this quarter; **S/C** = Start and completed during this quarter; **O** = ongoing task; **Quarters** are based on start date of October 1, 2011.

SPE Grant Management Key Activities:	Key Staff/Lead	Q1	Q2	Q3	Q4
▪ Hire Project Manager to coordinate process and document plans and reports	Project Director	S/C			
▪ Host meetings with partners	Project Director	S	O	O	O
▪ Develop plan in conjunction with activities below	Policy Consortium	S	O	O	O
▪ Seek community stakeholder feedback for plan	Policy Consortium	S	O	O	O
SPE Key Objectives:	**Key Staff/Lead**	**Q1**	**Q2**	**Q3**	**Q4**
1. Build a cohesive SPE Policy Consortium					
▪ Recruit Policy Consortium (PC) members	Project Director	S	O	O	O
▪ Establish relationships with PC Advising Groups	Project Director	S	O	O	O
▪ Conduct monthly PC meetings	Project Manager	S	O	O	O
▪ Develop Capacity Building and 5-Year Plans	Policy Consortium	S	O	O	O
▪ Solicit stakeholder and community feedback for development of Plans	Project Director		S/C		S/C
▪ Ongoing review of grant reporting and adherence to SPE goals and objectives	Policy Consortium	S	O	O	O
▪ As needed, contract consultant(s) to assist with Plans	Policy Consortium	S	O	O	O
▪ Develop primary care and mental health partnerships for increased integration	Policy Consortium		S	O	O
▪ Develop partnership with Washington Health Foundation to explore health home prevention Smartphone app for 5-Year Plan	Integration Unit				S
2. Expanded Training Plan and Workforce Development		**Q1**	**Q2**	**Q3**	**Q4**
▪ Determine gaps in available trainings to build knowledge and skills among prevention providers. Particular emphasis placed on trainings about working with high-risk populations.	Integration Unit	S/C			
▪ Prioritize identified training topics and set timeline for development and implementation.	Policy Consortium		S/C		
▪ Develop Statewide Sustainability Plan and capacity to provide technical assistance and grant writing training to local communities	Implementation Unit		S/C		
▪ Conduct in person trainings on prioritized topics	Integration Unit		S	O	O
▪ Produce training videos on prioritized topics	Integration Unit			S	O

▪ Expand capabilities on TheAthenaForum.org to host videos, webinars, and distance learning	Integration Unit		S/C		
▪ Training of Trainers to all DBHR staff on Communities That Care and other community-system organization frameworks	Integration Unit		S/C		
▪ Post all training materials and resources on TheAthenaForum.org	Integration Unit		S	O	O
▪ Community Anti-Drug Coalitions of America to provide *Coaching & Technical Assistance* training for state agencies with staff who provide training and technical assistance to local communities.	Integration Unit		S/C		
▪ Develop and present trainings on the use of prevention MIS reports and service entry enhancements.	Integration Unit/ Grants Manager	S	C		
▪ Enhance partnerships with the National Guard and State Certification Board for training and certification planning support	Project Manager	S	O	O	O
▪ Office of Superintendent of Public Instruction (OSPI) *Student Assistance Manual* and Community Mobilization's (CM) *Arts and Science of Community Organizing* curriculum updated.	OSPI/CM contractors	S	C		
▪ Conduct a Certification and Licensing Feasibility Study.	Project Manager		S	C	
3. Expand current data collection and reporting systems		**Q1**	**Q2**	**Q3**	**Q4**
▪ Write process and outcome evaluation reports and submit coding for addition to PBPS	Grants Manager	S	C		
▪ Add a resources assessment model that can track local community level resources and coalitions	Systems Coordinator			S	C
▪ Enhance askHYS.net to offer multiple-variable queries	Research Manager				S/C
▪ Develop with OSPI a standardized system for authorizing the local level review of school building level data reports on askHYS.net.	Research Manager				S/C
4. Primary Care Integration Demonstration project		**Q1**	**Q2**	**Q3**	**Q4**
▪ Develop and distribute guidelines and requirements for Prevention Redesign Initiative communities' participation.	Project Manager	S			
▪ Review and select communities.	Policy Consortium/ Project Manager	S	C		
▪ Review community reports semi-annually and distribute incentives.	Project Manager		S	O	O
▪ Document process and outcomes of the Primary Care Integration Demonstration projects.	Research Manager			S	O
▪ Disseminate lessons learned statewide and post information on TheAthenaForum.org.	Project Manager/ Integration Unit			S	O

Policy Consortium Plan

The DBHR is committed to building upon the successes of existing and previous policy and program boards to establish the State Prevention Enhancement (SPE) Grant Policy Consortium, (Policy Consortium). The Policy Consortium will include decision makers and stakeholders from those entities required in the SPE Grant, as well as representatives from key partners who currently serve as leaders on several statewide substance abuse prevention and mental health promotion planning and oversight bodies.

The Policy Consortium will serve as oversight to the SPE Grant, giving specific input in the development and implementation of the Capacity Building/Infrastructure Enhancement Plan and 5 year State Strategic Plan. DBHR will convene the initial meeting of the Consortium within the first 30 days of SPE Grant Award notice. Given the quick pace of the grant, several members of the Policy Consortium have committed to contributing to and reviewing drafts of the SPE Grant Application. Achieving this intimate knowledge of the project will enable the required plans to be developed in an efficient and timely manner. We will also recruit existing workgroups to serve as consulting groups to the Policy Consortium. DBHR will use SPF capacity development strategies as we engage partners in our state level strategic prevention planning.

Policy Consortium (WIN)

*DBHR: Chemical Dependency
*DBHR: Mental Health
*Washington State Patrol
*Department of Health
*Superintendent of Public Instruction
*Traffic Safety Commission
*Juvenile Justice Advisory Committee
*Medicaid Purchasing Authority
Liquor Control Board
Office of the Lieutenant Governor
National Guard
Department of Early Learning
Department of Commerce
Family Policy Council
Office of the Attorney General

** SPE Grant Requirement*

Consulting Groups

Policy Consortium primary responsibilities will be to:

- Advise DBHR and the SSA Director, as well as the Washington Interagency Network (WIN) Agencies, on the:
    - Integration of substance abuse prevention with primary health care and mental health promotion in a health care reform environment;

  - State system changes that will best support local community efforts to achieve community level change;
  - How to best meet the needs of high risk populations, including youth, young adults, military families and LGBQT youth; and
  - How best address the challenges presented by those drugs with high prevalence rates in our state, such as alcohol, marijuana, tobacco and prescription drugs.
- Commit to established meeting schedule which will include: grant application reading within 60 days of submitting the application; initial meeting convened within 4 weeks of receiving grant notice; monthly meetings convened throughout the year of the grant; and quarterly meetings convened as a sustainability step to guide the implementation of the 5 year strategic plan.
- Contribute to the development of the Capacity Building/Infrastructure Enhancement Plan and 5 year State Strategic Plan, this development includes reviewing and providing critical feedback to draft plans.
- Secure agency/organizational support for the planning documents and identify at least one action step that their agency/organization will implement in each of the plans.

<u>The Policy Consortium leadership will consist of the following roles and expectations:</u>

- Co-chairs
  - Facilitate meetings
  - Liaison with DBHR staff to establish meeting agendas
  - Serve on the new Division of Behavioral Health and Recovery Advisory Council

- Secretary
  - Report on Plan progress
  - Review meeting notes with the Policy Consortium

- Sustainability Advisor
  - Work with SPE Project Director to identify strategies to sustain key plan elements such as training, workforce development, reporting systems, resource assessment reports

- Technical Advisors
  - Provide data reports to the Policy Consortium
  - Advise Policy Consortium on addressing data gaps and workforce development needs

Partner Organizations

DBHR has secured Letters of Commitment (see Attachment 1) that show support for the Grant Direction and agreement to serve on the Policy Consortium. These commitments to meet the expectations listed above from substantial partners include: Lieutenant Governor, Prevention Certification Board, Coalition of Coalitions, Reducing Underage Drinking Coalition, Social Development Research Group, College Coalition, Prevention Research Committee, Office of Superintendant of Public Instruction, Liquor Control Board, Traffic Safety Commission, State Patrol, SEOW, Indian Policy Advisory Committee, Department of Commerce, Board of Health, Early Learning, Justice, Primary Health Care, Department of Health, Washington Association

Substance Abuse and Violence Prevention, Washington State National Guard, and Office of the Attorneys General.

DBHR also will secure Memorandums of Understanding with these partners and any additional partners identified, with specific commitments and reporting requirements on action step(s) agreed upon from the Capacity Building Plan and 5-Year Strategic Plan.

Proposed Project Addresses Demographics, Language Literacy, Sexual Identity and Disability

DBHR has a successful history of providing services to a wide range of individuals. We will continue to build on our success and implement culturally inclusive strategies.

For example, DBHR has made considerable efforts to provide resources that are at appropriate reading levels and program tools that are accessible in multiple languages. A set of survey instruments which have been validated with elementary school participants were adopted for use. All other instruments are expected to be at the 8th grade reading level. We have translated 20 survey instruments into Spanish, Russian, Cambodian, Vietnamese, and Samoan. Additionally, we work to fulfill other requests for translations as needed. Translated instruments are available for use by all providers. As an example of our intentional programming, we currently support the adaptation of evidence based practices for implementation in additional languages as well as with tribal communities. Additionally, we have specifically modified our service data collection system to include a LGBTQ-identified gender field for individual client demographics.

DBHR also provides training allocations to each county to meet the locally identified population needs. The chart below illustrates the DBHR service populations as compared to the 2010 state population (Washington DSHS PBPS, 2011; Washington OFM, 2011).

Race/Ethnicity	Ethnic Distribution (Percentage) of those **Receiving Recurring Prevention Services 2010**	Ethnic Distribution (Percentage) of **Washington State 2010 Population**
Asian/Pacific Islander	4.4	7.5
Black/African American	3.6	3.7
Multiracial	3.6	3.2
Native American/Alaska Indian	7.9	1.8
Other	9.4	NA
White/Caucasian	71.0	83.8
*Hispanic**	*18.4*	*12.1*

**The total is greater than 100% because any race may report Hispanic ethnicity.*

DBHR will continue our efforts to ensure broad inclusion with further outreach as we develop the 5-Year Plan.

Community Involvement

The DBHR has a long history of including key stakeholders and community partners in our planning processes, including most significantly the State Interagency Prevention Plan, the Mental Health Transformation Project, the Reducing Underage Drinking Coalition, and the Prevention Redesign Initiative. In preparation of this SPE proposal, DBHR used established collaborative groups including the Washington Interagency Network and the Prevention Redesign Initiative Learning Community to develop general concepts and review the proposal and written application. These individuals represent contributions from essential state partners and local subrecipient providers into the development of our SPE Proposed Plan. The involvement of the Policy Consortium, as well as other established workgroups, will be essential in the execution of the SPE proposal to ensure integrity and sustainability of implementation.

Potential Barriers and Strategies to Overcome

Although DBHR has many systems in place to successfully accomplish the SPE, we will encounter challenges regarding the recently reduced staffing, limited budget, and historical protection of funding silos among state agencies. Despite these challenges, we intend to sufficiently prioritize our resources and direct them to be used in the most compelling manner to serve our communities and impact substance abuse statewide. We will continue to use the established partnerships and to develop necessary new partnerships. We will offer our resources and leadership to host a collaborative process that honors each partner's unique interests and motivations while also capitalizing on their strengths. We will use the time-limited infusion of SPE funds to develop system efficiencies that can be sustained long term.

Proposed Activities to Improve Substance Abuse Prevention Services

DBHR is committed to a statewide prevention system that is substantial and targeted enough to achieve significant reduction in rates and impacts of substance abuse statewide. We believe the newly initiated Prevention Redesign Initiative (PRI) model for our state prevention system will demonstrate the efficacy of our efforts so that we can develop additional investment in our prevention system. This grant will provide DBHR with necessary resources to build and enhance our infrastructure, directly impacting our ability to support this initiative more fully. We expect the SPE project to provide more effective training and technical assistance for strategic prevention planning in high need communities. This will help Washington's prevention field enhance what works, have a deeper impact, better measure those impacts, and build support for additional investments in prevention.

Sustainability and Program Continuity – Plan to implement the project after the funding period ends; maintain when there is change in operational environment

DBHR is committed to continuing to expand the PRI model throughout the state over three years. We will direct nearly all prevention resources including the SAPT block grant and any future iterations of the block grant to the successful implementation of this model and plan.

Furthermore, DBHR has currently engaged partners from the PRI Learning Community in a sustainability workgroup to establish a statewide sustainability plan that will incorporate support for local sustainability plans. The sustainability plan will include key elements, including: a connection to annual resource assessment; examples of sustainability strategies; target

fundraising goals for each year; consideration of applying for 501(c) 3 status; and identification of potential external funding. The key goal of local sustainability plans is to grow services over time and to be able to show what the coalition plans to do relevant to specific community needs.

DBHR currently provides annual technical assistance and training to local community coalitions on strategies for applying to Drug Free Communities Support Program (DFC) grants and will look to expand grant writing training support. Washington did very well, with a 75 percent success rate of DFC applicants of the 12 coalitions who participated in the training series and completed an application compared to the 2010 national application success rate of approximately 34 percent. Two of the ten new grants in Washington were received by tribes reflecting a similarity to the national average of 10 percent tribal grantees. Washington currently supports ongoing inter-collaboration between our 34 DFC grantees.

SECTION C: Staff Management, and Relevant Experience

Capability and Experience:

The Division of Behavioral Health and Recovery (DBHR) was created in May 2009 with the integration of two Single State Agencies, the Division of Alcohol and Substance Abuse and the Mental Health Division, both within the Department of Social and Health Services in the State of Washington. The combined division provides prevention, early intervention, treatment and recovery support services for substance abuse and serious mental illness with a combined budget of over $766 million.

DBHR is the Single State Agency designated by the governor to administer federal Substance Abuse Prevention and Treatment (SAPT) block grant funding. Slightly over half (5.5 million) of the prevention set-aside dedicated to prevention is distributed to the state's twenty-nine federally recognized tribes and thirty-nine counties. Funding to tribes is used to provide prevention services to their respective members and community through government-to-government agreements. Counties use the funds to hire or contract a Prevention Specialist whose job it is to perform periodic assessments and planning processes in collaboration with other prevention service providers, and to either implement or contract with providers to deliver prevention services. Counties identify the targeted populations and prevention services according to a data-based needs assessment and must select at least 60 percent of their services from a list of recognized and approved best practices.

DBHR also directs approximate 40 percent (4.1 million) of the SAPT dollars to support a school-based effort modeled on Project Success. This program places chemical dependency professionals and counselors in many public schools to provide prevention, early intervention, screening, and referral services. The remaining 7% ($692,000) is used for special projects, communication, training, program development, reports, stakeholder meetings, and MIS.

<u>History of collaboration across agencies to address public health issues in Washington:</u>
In addition to DBHR, six state agencies have responsibilities for specific sectors of the population for substance abuse prevention in our state. The *Office of the Superintendent of Public Instruction* supports a variety of school-based prevention efforts, addressing a range of risk and protective factors associated with substance use and related problem behaviors. Tobacco

prevention efforts are directed by the *Department of Health*, with school programs implemented in collaboration with the regional educational service districts. In addition to a very successful campaign to change tobacco-related policies, the tobacco control program dedicated a significant proportion of its tobacco industry's settlement dollars to developing skills trainings that were available to all prevention workers. Suicide prevention programs are supported by both the health and the education departments, as are other school health related programs. The *Department of Commerce* administers the Community Mobilization Against Substance Abuse and Violence program. The *Family Policy Council* is an interagency council that focuses on a wide range of family-based issues and trains coalitions across the state, some of which include substance abuse prevention in their priorities. The *Traffic Safety Commission* Target Zero Task Forces use a data-based planning model to reduce DUIs and encourage safety restraint usage. The *Liquor Control Board* supports an Alcohol Awareness Program.

For years Washington state agencies have collaborated in a variety of venues for planning and projects. For instance, along with the State's Attorney General, National Guard and state-level law enforcement, all of the above agencies participate in the statewide Reducing Underage Drinking Coalition. There is also broad collaboration on the state's adolescent Healthy Youth Survey (HYS). The data HYS generates form the foundation for much of the state's prevention work across all of these agencies/councils. The SPF-SIG, achieved broad interagency collaboration that has continued beyond the grant. In addition, the prevention system has a close partnership with the University of Washington and Washington State University through our statewide prevention research committee in which these colleagues plan, consult, and advise on various workgroups or as ad-hoc advisers. We also regularly collaborate on grant funded research projects, sometimes as co-principal investigators on major studies.

DBHR through our hiring, training and contractual requirements ensures that our staff, sub-contractors, and providers are culturally competent. In Washington State, DBHR and its partners have committed in policy and practice to build and support a system that integrates cultural competency throughout all elements of strategic prevention planning and implementation. DBHR and our partners, as stated in the State Interagency Prevention Plan, strongly believe that cultural competence is beyond simply understanding, appreciating and responding to cultural values and differences; cultural inclusion involves embracing and incorporating each culture's strengths and values into prevention strategy identification, implementation, and evaluation.

List of Staff

The goals and objectives of this SPE proposal are directly aligned with the overall direction of prevention in Washington State; therefore while the entire DBHR prevention section staff will be involved in various aspects of the SPE. The Project Director and Project Manager will be the primary leads for the implementation of the SPE. The secondary support staff will assist in specific key activities in their areas of expertise and focus related to the SPE efforts.

Key Staff - The SPE project will be primarily supported by the following significant positions:

> Project Director - Michael Langer, Behavioral Health Administrator, manages the entire Prevention Section including Budget, Policy Development, Program Direction, Supervision, State/National Interagency Collaborations and National Prevention Network designee.

SPE Project Manager - DBHR will hire/designate a SPE Project Manager to provide coordination, consulting, reporting and training to ensure that the full execution of the SPE goals, objectives and related activities are completed in the most successful manner. DBHR will seek a manager that has a proven record of success and can complete the following deliverables:

- Assist with the inclusion of multiple sectors in the development of the Capacity Building and 5-Year Strategic Plans.
- Facilitate the development of new partnerships that will promote the goals and objectives of the SPE and State Prevention Strategic Plan.
- Assist with the coordination of the Policy Consortium to carry out the activities of the grant including the development of the Capacity Building and 5-Year Strategic Plans.
- Develop and write grant reports.
- Assist with the development of content, structure, logistics and facilitation of trainings.
- Coordinate efforts to enhance technology components including enhancements to theAthenaForum.org, the PBPS data/reporting system, and the development of Smartphone applications.
- Coordinate the workgroup to develop a plan for prevention fee structure/rate setting for prevention services.
- Conduct study and write Feasibility Plan for Certification and Licensing.

SPE Project Systems Coordinator - DBHR will hire/designate a SPE Project Systems Coordinator to assist the Prevention System Grant Manager with development and design reporting elements to ensure that SPE related activities and enhancements are completed and that all monitoring is tracked and documented in the most successful manner. DBHR will seek a coordinator that has a proven record of technical success and practical knowledge. It is expected that the position will:

- Collect and analyze information for SPE grant reports.
- Coordinate efforts to enhance the current technology infrastructure, including our current reporting database and to TheAthenaForum.org web site.
- Assist with development of SQL Server report templates used to analyze and present outcome and administrative data on community-level change, individual outcomes, and statewide process measures.

Secondary Support - Secondary support will come from DBHR Prevention Section which is comprised of four distinct units within the Prevention Section and from the Evaluation and Quality Assurance Section:

Prevention System Implementation Unit: (Steve Smothers, Prevention System Lead; Julie Bartlett, Julia Greeson, Stephanie Atherton, and Ivon Urquilla, Prevention System Managers): The System Implementation Unit is core to the Prevention Redesign Initiative (PRI) implementation. They provide technical assistance and training, county and tribal

contract development and management and work as state leads for the following projects: Drug Free Communities, State Awards, the Office of Superintendent of Public Instruction (OSPI) contract supporting the statewide student assistance program and Statewide Parenting Initiative Network.

Prevention System Grants Unit: (Aaron Starks, Prevention System Grant Manager; to be hired, SPE Project Systems Coordinator): The Prevention Systems Grants Unit focuses on prevention SAPT grant writing, monitoring, reporting, prevention performance-based contract language development, prevention cost-benefit reports, PBPS development and report writing, prevention NOMS, intra-divisional work with internal data committee and Healthy Youth Survey.

Prevention System Integration Unit: (Scott Waller, Prevention Integration Lead; Sarah Mariani, Prevention Systems Integration Manager; Earlyse Swift, Reducing Underage Drinking Coalition Manager): The System Integration Unit is responsible for the statewide training and technical assistance, (conferences, Substance Abuse Prevention Specialist Training, certification), staff development for PRI, substance abuse prevention/mental health promotion/physical health integration, Medicaid opportunities, Enforcing Underage Drinking Laws workgroup, development/adoption of Washington State EBP identification process, College Coalition, and TheAthenaForum.org.

Communications Unit: (Deborah Schnellman, Communications Manager; Adam Halverson, CSAP Fellow): Communications Unit is charged with communicating messages to the key stakeholders, partners and local communities including dissemination of public information, social marketing campaigns, counter advertising, Director's communications and DBHR website.

Evaluation and Quality Assurance (EQA): (Linda Becker, Prevention Research Manager): The EQA Section will work with all of the staff listed above to coordinate data collection, interpretation, and reporting. EQA will also participate actively in Learning Community efforts to transform process experience and evaluation outcomes into an on-going learning opportunity.

Cultural Competency of Key Staff

DBHR staff are required to participate in an annual diversity training provided by Washington State Department of Social and Health Services and each of the key training and technical assistance staff has completed a one-day training on Native American culture, policies and protocol provided by the State Office of Indian Policy. Furthermore, all staff are encouraged to seek additional opportunities to gain knowledge and skills that enable us to better service the broad range of individuals in our state.

Key staff have been involved in planning and execution of statewide conferences, such as State Prevention Summit and Say It Out Loud (state LGBTQ conference) that include diversity and cultural competency as critical components in overall program planning and especially the selection of speakers and presentations. Additionally staff are skilled in providing technical

assistance to sub-contracted counties and tribes in developing planning processes and programs that incorporate critical cultural considerations for the local community.

Examples of technical assistance provided:

- Guidance materials and resources that clarify for prevention planners how to adapt evidence-based programs, policies, and practices to different cultural community contexts;
- A system for soliciting feedback from program facilitators about how they have successfully adapted evidence-based programs for cultural appropriateness;
- A policy that ties funding to the completion of training in the "Ethics of Prevention Practice" and cultural competency and inclusion; and
- Training in the cultural and community-based approaches that form the foundation of effective prevention programming---that prevention programs should be culturally and linguistically appropriate, open, inclusive and affirming at each point in the process with no barriers to participation.

The Prevention System Implementation and Prevention System Integration Unit Managers are required to be Certified Prevention Professionals which includes a proven adequacy in cultural competence. DBHR is committed to ensure cultural competence among all staff.

Resources available for Proposed Project

DBHR is committed to the successful implementation of the SPE and the implementation of the 5-Year Plan. DBHR will dedicate the thirteen Prevention Section staff and one staff member from the Evaluation and Quality Assurance Section to contribute to these efforts. DBHR will provide office space, workspace equipment (computer, phone, fax) and meeting facilities. Because of the congruence of the SPE with DBHR's current direction, additional SAPT block grant resources will be used to support common goals and objectives. DBHR partner agencies will provide staff time in-kind to the Policy Consortium and related activities. We anticipate having adequate resources to accomplish the intended goals and objectives.

SECTION D: Performance Assessment and Data

Collect and Report on GPRA

The Division of Behavioral Health and Recovery (DBHR) has a number of reporting systems that will support our ability to complete all required reporting. Specific strategies have been identified in the Capacity Building Plan that will further our ability to collect, analyze and have meaningful dialogue about the data and thus incorporate it into our future strategic planning.

<u>Plan to Align and Braid Current Infrastructures</u>
DBHR uses the following data collection systems for prevention:

Performance Based Prevention System (PBPS): PBPS is a web-based system that collects information from both DBHR and the Office of Superintendent of Public Instruction (OSPI) regarding the direct services, community coordination, and environmental strategies that counties, tribes and local communities provide. Each county and tribe is required to report these service and evaluation data into the PBPS monthly. This enables DBHR to have real-time data on 30,000 individuals annually. The data system provides Block Grant reports as well as contract

compliance measures for state staff. PBPS was built to align the data fields of the county, tribe and education service delivery which allows for comparison reports to be developed.

Healthy Youth Survey (HYS): this interagency youth survey is administered every other year, most recently Fall 2010 in more than 80% of Washington's school districts. Data are collected on substance abuse as well as mental and physical health. Since 2002 the HYS has incorporated questions from the Youth Risk Behavior Survey; alcohol, tobacco and other drug questions modeled on Monitoring the Future survey; risk and protective factor questions from Communities That Care; and the Youth Tobacco Survey. As an improvement over multiple surveys previously administered, this collaborative effort reduces the burden on schools and students, meets the needs of multiple state agencies, and better serves the people of Washington.

Community Outcomes and Risk Evaluation Geographic Information System (CORE GIS): the CORE GIS includes administrative and archival data related to the risk and protective factors for adolescent substance use. The CORE-GIS is a major source of data for public health planning across the state, as it reports a ten-year span of a wide variety of indicators at state, county, and community levels in risk factor profiles organized by domain (community, school, family, and individual).

In addition, DBHR uses data from the National Survey on Drug Use and Health, and the Behavioral Risk Factor Surveillance System. Because neither of these systems is able to produce reliable community-level estimates, DBHR uses client service utilization data combined with census data to extrapolate needs for sub-populations.

As we build our 5-Year Plan, we will use the SPE as a catalyst for innovation on DBHR's well functioning systems, such as the integrating a fee schedule and financial information in the PBPS, connecting CORE GIS information with the PBPS data, adding a resources assessment module, and building a Smartphone application that will create efficiencies and accuracy of reporting. Additionally, we will seek opportunities to integrate additional state agencies data collection systems with these systems. DBHR will examine the feasibility of building a module that will integrate common fields of interest and capture additional Department of Commerce Community Mobilization data into the PBPS, thus combining one more service data collection system into PBPS.

<u>Strategies to Determine Cost Savings and Additional Initiatives</u>
DBHR will employ strategies that capture the cost savings resulting from the alignment and braiding of infrastructures in close partnership with our collaborating agencies. We will ensure that records are retained that demonstrate the full cost of projects and illustrate the savings that are captured as a result of the collaborative nature of completing the project or initiative together. DBHR Prevention System Grant Manager will develop a strong quarterly review process that aligns with the SPE reporting timeline so that we can gather and analyze the data efficiently. The DBHR SPE Project Manager will coordinate the compilation of information for reporting.

The cost savings identified will enable the limited resources to be directed efficiently to the local communities to support substance abuse prevention. Any resulting net cost savings will be allocated to enhance the infrastructure in support of the SPE (e.g., fund integration of advanced mapping data with service and resource assessment system) or to provide additional services (e.g., increase the number of PRI sites; expand prevention/intervention school-based services,

and suicide prevention screening, information and referral; and/or develop curriculum implementation in education and primary care settings).

Successful Data Infrastructure Integration

Based on our long-term commitment to collecting and reporting high quality data, Washington has an excellent data infrastructure, combining a management information system, 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. We face several challenges as we move forward with Health Reform. The existing systems include little mental health data. The SEOW is investigating ways to reduce this data gap, which will build on the current Mental Health System Redesign efforts. Specific examples that are in progress include evaluating the opportunity to include Adverse Childhood Experiences screening and other rapid screening into state-funded primary care offices, clinics, and managed care networks, and collecting data on the prevalence of risk factors for mental/emotional issues and the effectiveness of referral to targeted prevention programs.

A second need is to develop reporting functions that allow stakeholders and community members to review more readily interpretable data. Because potential users have a wide range of skills, interests, and needs for data, the data infrastructure needs to be more flexible, one with a user interface that allows users to pull data in a variety of "ad-hoc" filtered reports. An exciting area for further development takes advantage of the increasing use of data with geographic "point" data. Mapping technology allows for the layering different data into a map format that is far more intuitive than a table or graph.

Another hurdle for DBHR to face will be the effective alignment of objectives to evaluation survey tools. This last year as we reviewed our PBPS data, we discovered that while programs were consistently completing the reporting requirement and submitting their pre-post test results into our system, we were not able to show much program level impact. This was partly due to the lack of sensitivity of the instruments, and partly due to inefficient pairing of interventions and measures. DBHR provided significant technical assistance resulting in a more proper alignment of pre-post tests to objectives, and more precise indicators of target population. We will re-address these challenges as we move forward.

As we continue to enhance our data collection methods we will ensure input is gathered and considered from a diverse range of users, stakeholders, providers and service participants to make sure that all data collection is culturally appropriate and meaningful. For example, in addition to standard classifications, DBHR has been responsive to a request from the field to provide a method for collecting client demographics for the LGBTQ population. An optional field was added to the Prevention MIS (PBPS) to that end. We need to ensure that as these type of modifications are made that they are completed in a manner that make them usable data sets.

While the scope and depth of our overall data collection systems are clear, there are significant gaps. First, the only populations about which we have complete data are adolescents in school. Data for young adults and other age groups are based on the national surveys. Neither of these surveys report data at the sub-county level, and their county estimates have wide confidence intervals. Many of the social indicators that reflect substance use and its consequences are

reported at the community level, but some of the most important consequences have small number problems. We will examine methods to address this in our 5-Year Plan.

Plan for Conducting the Performance Assessment

The Strategic Prevention Enhancement (SPE) Project Manager will be the lead coordinator for the collection, analysis and compilation of all required SPE reports, supporting documents and Plans. The SPE Project Manager will work closely with the Prevention Systems Grant Manager and the Prevention Research Manager to ensure that all data components are incorporated into current reporting systems and collected in a timely manner. We will add sections into all current systems and look to create efficiencies in reporting from the state to local level.

Tracking/monitoring
DBHR will closely track information and maintain records on the integration of infrastructures, braiding funding, overcoming barriers, and consensus building. We will create detailed records of the Policy Consortium meetings and workgroups, and will map key decisions that are intended to create lasting impacts.

Methods for Assessing Process Questions
DBHR will also develop an effective system for collection of both quantitative and qualitative data that can be used to complete the quarterly performance assessment progress reports and enable the proper reporting on semi-annual GPRA measures. DBHR will collect information on the following process measures:

1) improvements in the ability to identify prevention resources of braided funding, shared training opportunities and cross-agency participation in trainings offered through this funding.
2) consensus on the methods to be used to identify emerging issues and needs and the methods to redistribute and reallocate resources to the community based on those needs;
3) the infrastructure needed to monitor, evaluate, and maintain the key elements of the State/Tribal-wide system;
4) coalition survey administered at project start and again following the completion of the 3-month and 11-month plans. Provides baseline measure, interim analysis to address problems, and outcome results;
5) key program elements as detailed in the timeline will be operationalized into performance measures and tracked by the System Managers. Project Director will receive monthly updates on progress towards action items; and
6) data collection and reporting infrastructure improvements. As measured by, timely development and implementation of technology changes, increased use of Prevention MIS reporting features, decreased late data entry.

DBHR will diligently develop reports for the Policy Consortium to review and consider as each report is compiled. Additionally this information will be used by the Policy Consortium to inform the strategies in the Capacity Building/Infrastructure Enhancement Plan and Comprehensive 5-Year Strategic Prevention Plan.

DBHR looks forward to using the SPE as an opportunity to infuse energy to establish needed enhancements into our system as we enhance our capacity to support community level strategic prevention planning and service.

SECTION E: LITERATURE CITATIONS

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