State of Washington

Substance Abuse Prevention and Mental Health Promotion

Five-Year Strategic Plan

Washington State Prevention Enhancement Policy Consortium

November 2017

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

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Acknowledgements

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

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

We would like to give special thanks to all of the partnering state and tribal agencies and organizations and to those individuals who participate as representatives serving on the State Prevention Enhancement Policy Consortium. A complete list of representatives can be found in the *Appendix 2 - SPE Consortium Partner List.*

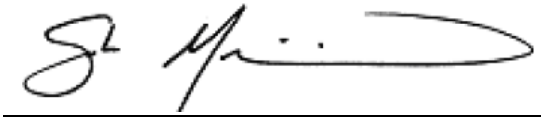
Additionally we would like to acknowledge Chris Imhoff, Director for the Division of Behavioral Health and Recovery, and Janna Bardi, Director from the Department of Health, for their support in this endeavor. Director Imhoff and Director Bardi are avid supporters of prevention efforts and we appreciate their continued encouragement for us to move our field forward to meet the demanding needs in the future of integrated continuum of care.

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

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

Sincerely,

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



Sarah Mariani, Co-Chair SPE Policy Consortium
Behavioral Health Administrator
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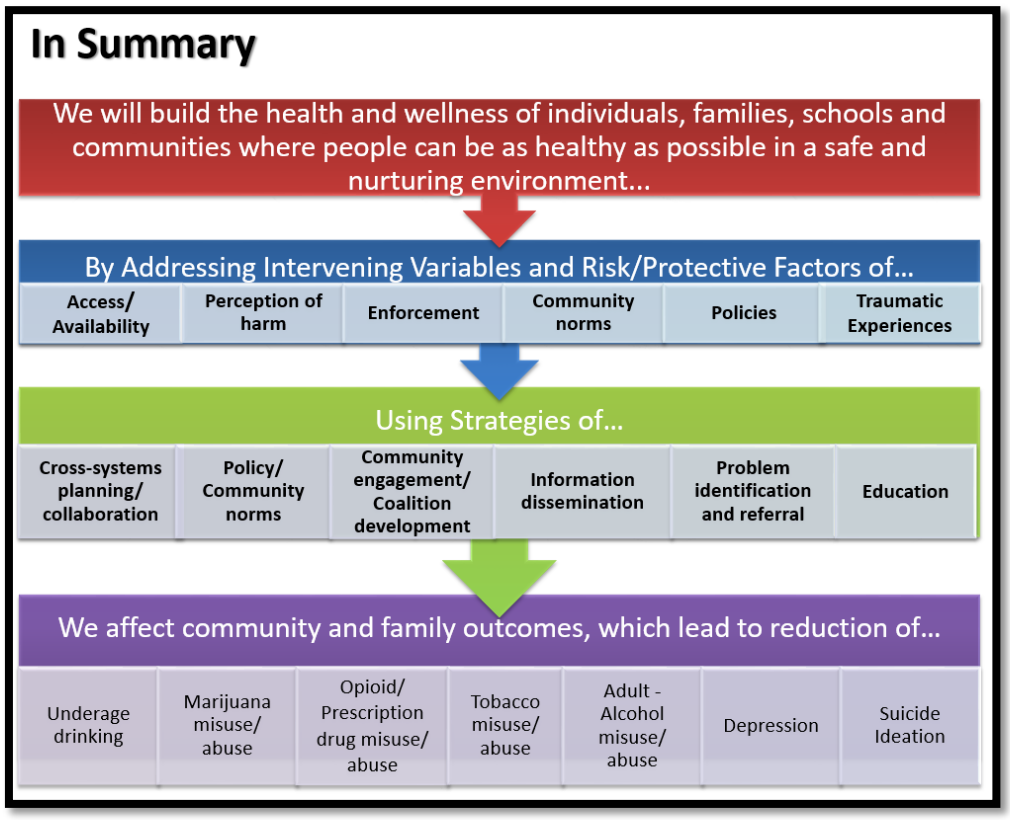
Integrating community substance abuse prevention and mental health promotion across Washington.

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

The Consortium held our first meeting in October 2011 and initiated our strategic planning process to develop our first five-year strategic plan for 2012-2017. Together our Consortium completed the strategic planning process in August 2017 and developed our second five-year comprehensive strategic plan through this well-established Consortium. We conducted an extensive review of state-level data and resources using our strategic planning process. Through our assessment, we were able to identify problem areas, as well as map current resources and partnerships that support substance abuse prevention and mental health promotion. We selected collaborative strategies from which to move forward in developing detailed Action Plans for each of our prioritized problem areas. In addition to supporting the current work of our partnering state and tribal agencies and organizations, and local communities, the Consortium is using strategies focused on cross-systems planning/collaboration, public campaigns, policies, and professional development to capitalize on the unique role of a state-level coalition to contribute to the overall collective impact.

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



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

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

We have made progress in many areas over the last five years and continue to look forward to further implementation and collaboration to sustain the substance abuse and mental health promotion efforts in Washington State. This is reflected in the data comparisons and prioritization data, and accomplishments section.

CHAPTER ONE: EXECUTIVE SUMMARY

Section 1: Overview of Prevention

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

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

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

Section 2: Risk and Protective Factors

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

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

Risk factor: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.

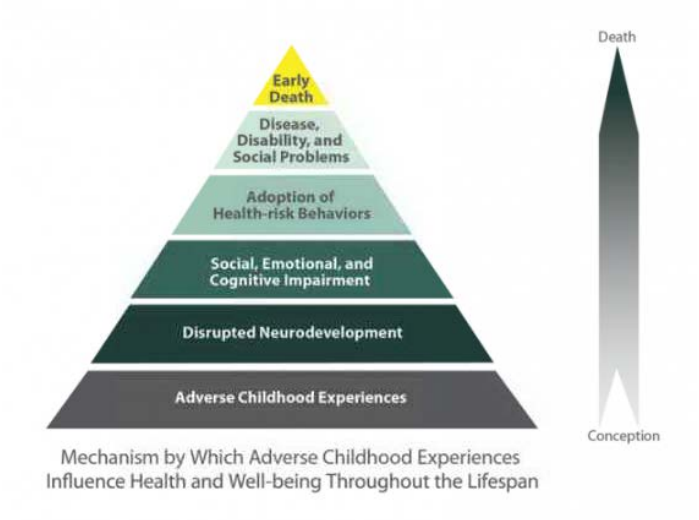
Risk and protective factors for substance abuse and mental health disorders are often categorized into four domains: individual, family, school, and community. Within each of these domains there are various factors that have been shown to either increase (risk factors) or decrease (protective factors)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

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

Section 3: Adverse Childhood Experiences

More recently within the prevention field, we have begun to recognize and integrate information provided regarding adverse childhood experiences (ACEs). The initial ACE study was conducted at Kaiser Permanente in collaboration with the Center for Disease Control and Prevention (CDC) from 1995 to 1997[1].

This diagram represents the conceptual framework of ACEs:



ACEs fall within two categories: abuse (physical, sexual, and verbal) and household dysfunction (substance abuse, parental separation/divorce, mental illness, battered mother, and criminal behavioral). Research has shown that there is a strong relationship between ACEs and a number of problem behaviors including age of first use and any alcohol use.[2] The ACE, along with science in the areas of brain development, complex trauma and resilience, provides information about experiences that increase risk for poor outcomes in physical, behavioral, and mental health. The ACE Study and Washington State Adverse Childhood Experiences data collected throughout the Behavioral Risk Factor Surveillance System (BRFSS) have shown that ACEs are common (majority of youth and adults experience one or more of the ACEs studied). Washington State is using this information to inform policy, systems, and practice at the state, tribes, and local levels. Further, by helping to identify more specifically the underlying causes related to adoption of certain behaviors by individuals, we can build on our knowledge of risk and protective factors to provide insight into the development of specific strategies in certain populations and increase the potential for successful outcomes.

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[1] *Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence*, 2006. Dube SR, Miller JW, Brown DW, Giles WH, Felitti VJ, Dong M, Anda RF. - http://www.ncbi.nlm.nih.gov/pubmed/16549308?dopt=Abstract. Accessed July 2012.
https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors

Section 4: Strengthening Families Protective Factors Framework

Some Washington State agencies use the Strengthening Families Protective Factors Framework. This framework was developed by the Center for Study of Social Policy and based on extensive research. This framework allows state systems, program, and community leaders to work across systems in building partnerships with families. This approach enhances support to increase five core protective factors[3]:

- Parental resilience: managing daily stressors and functioning well when challenges arise including trauma.
- Social connections: ability to develop relationships that are positive and provide emotional, informational, instrumental, and spiritual support
- Knowledge of parenting and child development: teaching parents about child development and strategies to facilitate physical, cognitive, language, social, and emotional development.
- Concrete support in times of need: Family access to resources as they are needed.
- Social and emotional competence of children: Positive family and child interactions that help children develop the ability to recognize and regulate their emotions.

The desired outcomes of using this framework is to strengthen families, optimize child development, and reduce the likelihood of child abuse and neglect. The research on the Protective Factor Framework shows that these factors help obtain the desired outcome of reduction of risk factors and increase of protective factors to create an impact on substance use disorder outcomes.

Section 5: Socio-ecological Model

The socio-ecological model is used within prevention frameworks to understand the multiple contexts in which risk and protective factors exist. The multiple contexts include individual, relationship (family), community, or societal. Individuals have biological and physical characteristics that can put them at greater risk or protect them from the effects of emotional, mental and behavioral health problems[4].

- Risk and protective factors also exist within relationships such as peers, partners, family members, and colleagues.
- Community factors can occur within schools, workplaces, and neighborhoods.
- Societal factors exist in cultural norms of communities that support problem behaviors.

Overall it is important to target risk factors and enhance protective factors at multiple levels. The SPE Consortium's overarching goals are to implement prevention strategies at these multiple levels through partnerships amongst our group state agencies, tribes, and local and state organizations.

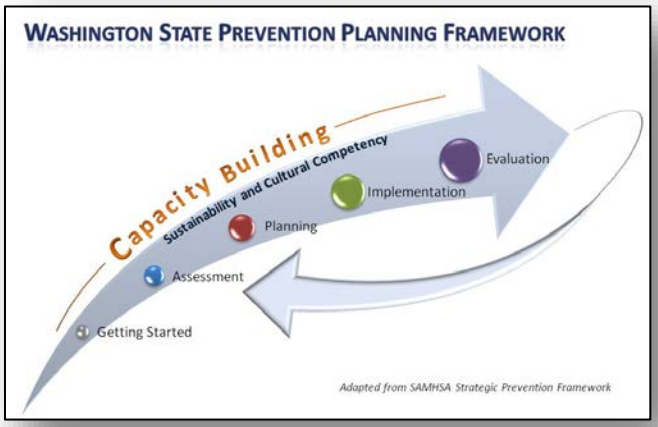
[3] Center for the Study of Social Policy.https://www.cssp.org/reform/strengtheningfamilies/2015/Core-Meanings-of-the-SF-Protective-Factors-2015.pdf Accessed June, 2017
Center for the Study of Social Policy. https://cssp.org/reform/strengtheningfamilies Accessed June 2017

[4] Center for Disease Control. https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html. Accessed June 2017.

Section 6: Strategic Prevention Framework (SPF)

The Consortium used the Prevention Planning Framework that is based on the Strategic Prevention Framework (SPF) as our overall planning framework for this process. The SPF was originally developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)[5]. SAMSHA's Strategic Prevention Framework is a comprehensive planning process designed to help states and communities build the infrastructure necessary for effective and sustainable prevention. Based on learning from the Strategic Prevention Framework State Incentive Grant process, we have slightly adapted this framework for the purposes of prevention planning in Washington State. The Prevention Planning Framework is comprised of the following key elements that contribute to more meaningful strategic plans:

- Getting Started: Initiate the process.
- Capacity: Mobilizing our state system and building capacity.
- Assessment: Assess our state's needs, resources, readiness, and gaps.
- Planning: Develop a strategic prevention plan.
- Implementation: Implement evidence-based prevention strategies.
- Reporting and Evaluation: Evaluate and monitor results, change as necessary.
- Cultural competence: Ensure that we operate in consideration of diverse communities.
- Sustainability: Identify new funding sources and resources and sustainable service delivery.



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

In addition to the frameworks above, some of our Consortium members follow Public Health Model in their work in prevention. This model implements services through a three-tiered approach that can have a great impact on both healthy development and school readiness. This approach includes identifying levels of prevention in which to devote resources. These levels include using a Universal (Primary), Selective (Secondary), and Indicated (Tertiary).

[5] Substance Abuse Mental Health Services Administration (SAMHSA), 2011 - https://www.samhsa.gov/capt/applying-strategic-prevention-framework. Accessed July 2017.

Universal/Primary prevention and promotion include targeting efforts to an entire general population that is not based on level of risk[6].

Selective/Secondary prevention includes targeting services and efforts to a group within the entire population who are at a higher level of risk due to characteristics of their subgroup. Examples of selective/secondary efforts would include providing resources to individuals with low incomes, immigrant families, or first-time pregnant mothers.

Indicated/Tertiary and early interventions to high-risk individuals and families. Examples of working with individuals at this level includes families involved in Child Protective Services, racial disparities, and individuals who have been caught using substances but are not diagnosed with having a substance use disorder.

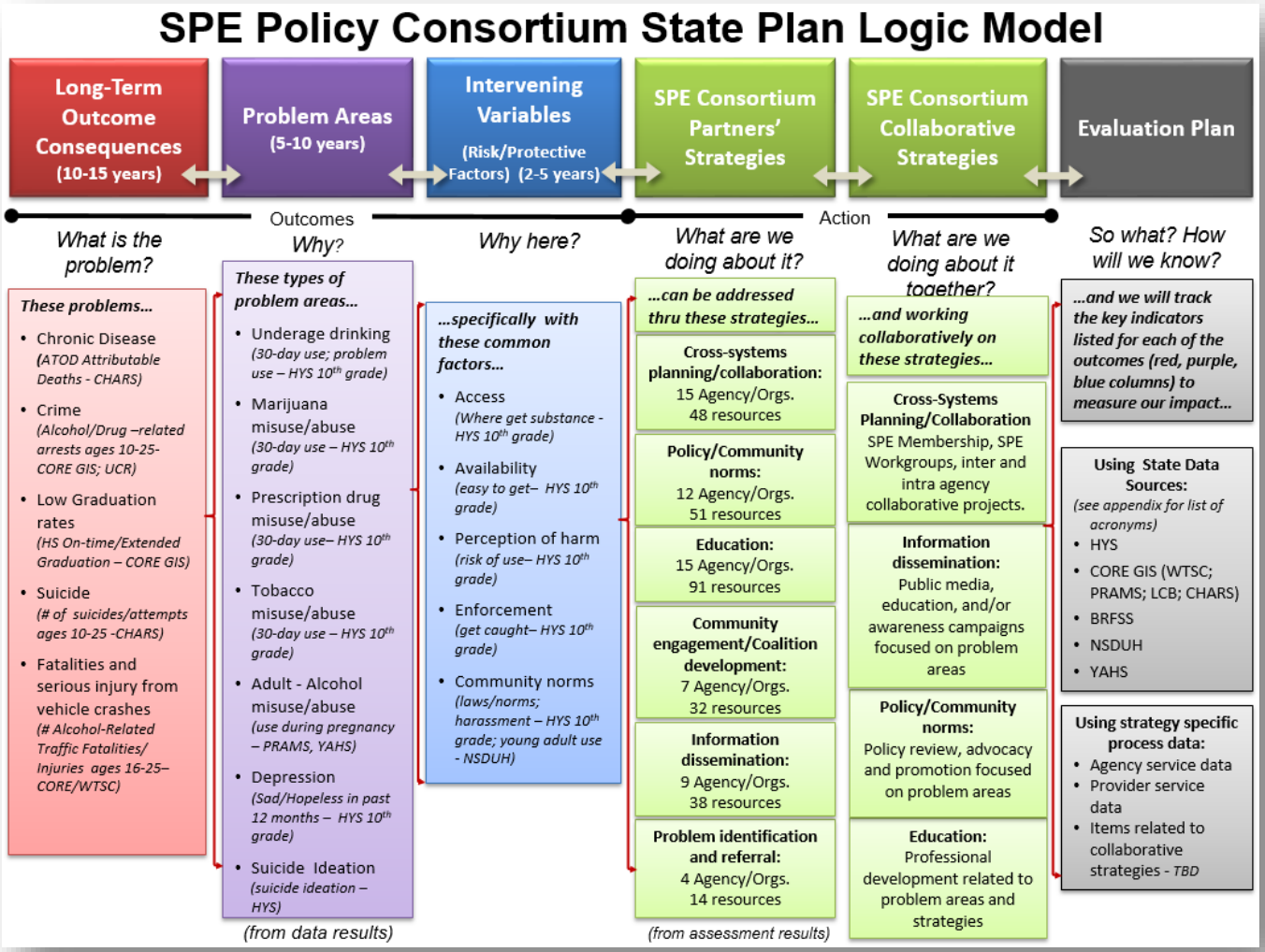
The remainder of this document will highlight the Consortium's key discussions and strategic decisions in relation to the components of the Prevention Planning Framework based on the Strategic Prevention Framework.

[6] Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention. https://www.samhsa.gov/capt/sites/default/files/resources/mapping-interventions-different-level-risks.pdf. Accessed June 2017.

CHAPTER TWO: STRATEGIC PLAN

As our five-year strategic plan came to a conclusion in 2017, the Consortium began going through the Strategic Prevention Framework process. The Consortium worked in collaboration with the State Epidemiological Outcomes Workgroup and state agency partners and organizations to review the Consortium structure, reestablish theoretical frameworks, review relevant data, examine state-level resources, develop new and continued priorities, and develop the following strategic plan update. While we made considerable effort to be inclusive and gather the best information available for our planning, we also recognize that this plan will be used as the foundation for ongoing planning as we move into the future. We plan to continue to follow the Strategic Prevention Framework process in our work to improve prevention efforts in Washington State through our Consortium.

Logic Model 2017



The logic model was developed to provide an overview of the central elements of our Strategic Plan. (For a full page view, see *Appendix 7- Logic Model page*.) This logic model overlays various logic model planning frameworks that are used by the Consortium partners. Furthermore, this logic model format

is being used to promote strategic planning in local community coalitions through the Community Prevention and Wellness Initiative (CPWI).

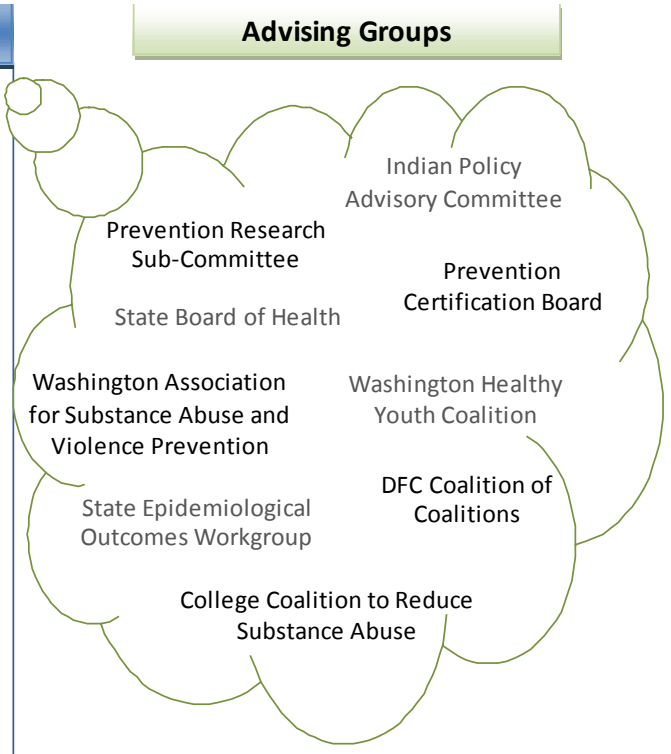
The first three columns of the logic model, ***Consequences***, ***Behavioral Health Problems,*** and ***Intervening Variables,*** pull together the prioritization from the data assessment. The fourth column, ***SPE Consortium Partners' Strategies,*** summarizes the information from the resources assessment.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

Section 1: Getting Started

As an established group since 2011 when the first consortium meeting convened, we have followed a developed structure for quite some time. Washington state agencies have a history of collaborating in a variety of venues for planning and implementing of prevention strategies. Over 25 years ago, the Washington Interagency Network (WIN) was established to include representatives from various agencies engaged in substance abuse prevention. The current Consortium was built from the original WIN group and integrates partnerships with mental health and primary care representatives. (A complete, current list of Consortium members can be found in the *Appendix 2 – SPE Consortium Members*)

Policy Consortium

- Department of Early Learning
- Department of Health, Prevention and Community Health
- Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery *(Chemical Dependency and Mental Health)*
- DSHS, Office of Indian Policy
- DSHS, Office of Juvenile Justice
- Health Care Authority
- Liquor Cannabis Board
- Office of Superintendent of Public Instruction
- Office of the Attorney General
- Office of the Lieutenant Governor
- Traffic Safety Commission
- Washington State Patrol
- Washington State University
- Commission on Hispanic Afairs
- Commission on Asian Pacific American Affairs



The Consortium is responsible for the state-level planning and implementation of collaborative strategies to address substance abuse prevention and mental health promotion. The Consortium has the unique role of a state-level coalition to implement strategies that contribute to an overall collective impact for our state. In a review of our capacity building and organizational development section of the strategic planning process, the Consortium decided to move forward with most of the processes and elements of the structure that were adopted from the first strategic planning process in 2011-2012.

The Consortium functions as a state-level inter-agency/organization, consensus-driven coalition. As needed, we use *Robert's Rules of Order* for formal decision making.

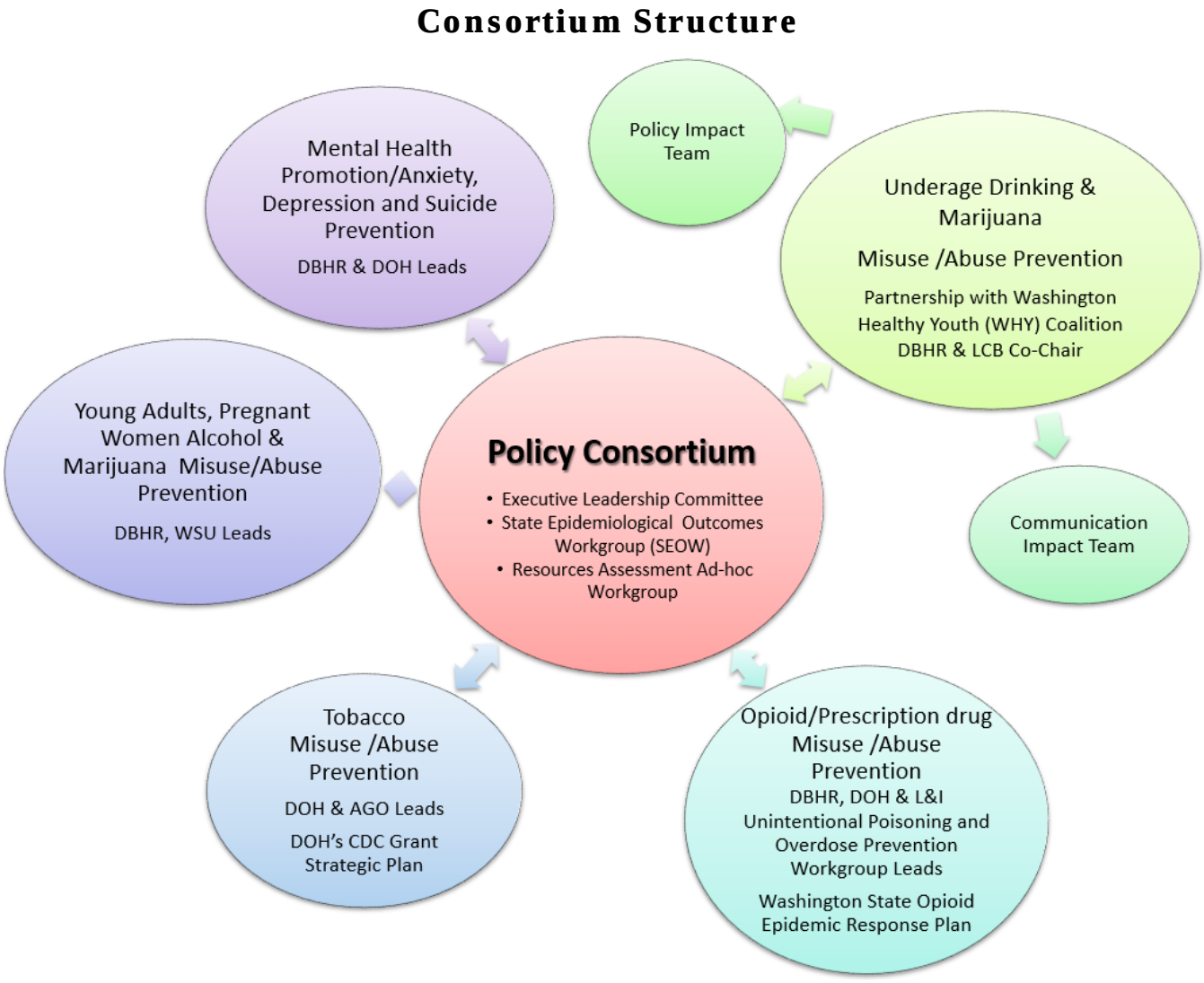
The Consortium meets most months of the year and is currently co-chaired by the Department of Health, Division of Prevention and Community Health, and the Department of Social and Health Services, Division of Behavioral Health and Recovery. The leadership team consists of the Consortium co-chairs and the leads for each workgroup. The Consortium also has an ad-hoc SPE Data, Resources Assessment and Evaluation Workgroup led by the State Epidemiological Outcomes Workgroup. This workgroup meets quarterly to conduct annual assessments and to consider and oversee evaluation.

The Consortium continued to support the following Action Plan Teams to develop and implement plans for each strategy related to each problem area:

- Opioid/Prescription Drug Misuse/Abuse Prevention Team

- Mental Health Promotion/Anxiety, Depression, and Suicide Prevention Team
- Tobacco Misuse/Abuse Prevention Team
- Underage Drinking & Youth Marijuana Misuse/Abuse Prevention Team – Washington Healthy Youth (WHY) Coalition
- Young Adults and Pregnant Women—Prevention of Alcohol and Marijuana Misuse Team

The diagram shows our implementation structure continuing in June 2017.



The Consortium created Action Plan Teams to oversee the implementation of Action Plans focused on each of our identified problem areas in order to accomplish the goals and mission laid out in a strategic plan. Action Plan Teams are the principal vehicles through which Consortium members collaborate on a sustained and formal basis to realize the Consortium's strategic goals. Teams pursue an Action Plan that is revised annually and submitted to the Consortium. Action Plans outline the goals to promote policies, projects, and partnerships for issues under jurisdiction of the working group. Action Plan Teams develop and implement plans for strategies related to each problem area.

Membership Recruitment and Retention

Consortium members are expected to:

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

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

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

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

Summary of the key decision-making processes and findings

As our first five-year strategic plan ended in August 2017, we began the process to develop a new five-year plan for the time period of 2017-23. We initiated the strategic planning process in October of 2016 and our goal was to have the plan ready for dissemination for the 2017 Prevention Summit in November 2017. Our timeline went as follows:

- Provided Consortium with introduction to the upcoming five-year strategic plan and provided a draft timeline of the plan. Consortium members and workgroup leads agreed to the timeline.
- Consortium leads began engaging their workgroups in the tasks for the strategic plan update.
- Consortium had an introduction to the needs assessment and resources assessment and engaged members to participate in strategic planning workgroups including ad-hoc needs and resources assessment workgroups.
- In December 2016, the State Epidemiological Outcomes Workgroup's quarterly meeting focused on the Consortium's needs assessment and the data recommendations that were provided.
- In January 2017, an epidemiologist from the State Epidemiological Outcomes Workgroup presented the recommendations from the SEOW on which data sources they would be gathering. The lead epidemiologist gathered additional recommendations from the SPE Consortium members and the workgroups and provided several presentations to the workgroups related to strategic planning and the needs assessment process.
- In January, the resources assessment workgroup revised previous resources assessment plan and process.

- The resources assessment was launched in February and the workgroup began gathering data on state prevention resources. During the Consortium meeting in February, the group discussed and made key decisions on changes to the overall organizational structure, mission statement and key values. Although some changes were made, many elements in the organizational development remained.
- The first data assessment presentation provided to the full Consortium took place in March 2017. A follow-up needs assessment presentation took place in April 2017.
- The resources assessment concluded in May 2017 and was presented to the data workgroup in June 2017.
- The data workgroup engaged in a prioritization of the needs assessment and drafted five-year targets in June 2017. Following the needs assessment prioritization workgroup meeting, the group presented the recommendations to the targets to the larger Consortium. Targets and prioritization recommendations were presented to each of the workgroup leads by workgroup members to finalize.
- From June-August 2017, workgroups initiated their internal planning activities to develop their annual strategic plan, finalize five-year targets, and discuss their previous year's accomplishments. These items were presented at the August 2017 meeting.
- Following the meeting, the Consortium compiled and completed the strategic plan elements as outlined in this document. A celebration took place at the November Consortium meeting.

Mission Statement and Key Values

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

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

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

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

Section 2: Capacity Building

Outreach and Sustainability

The Consortium partners have committed to attending bi-monthly meetings along with supporting the collaborative efforts and strategies identified in this plan. Additionally, each partner has identified the specific resources that it devotes to supporting substance abuse prevention and mental health promotion. *(See Appendix 2– SPE Consortium Members.)*

Furthermore, the Consortium is committed to working in concert with other state and tribal agencies, organizations, and advisory groups to support our strategies and objectives. We recognize the value of staying informed on the efforts of other groups including the Behavioral Health Advisory Council, Youth and System Partner Roundtables, Accountable Communities of Health (ACHs), and Federally Recognized Tribes, as well as other non-traditional groups such as youth prevention groups, community based organizations, local coalitions, and foundations. We will also consult with the community at large as we further develop our specific activities within each strategy to gather community input and create partnerships.

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

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

Key agencies have partnered with one another to engage work in high-need communities through the Community Prevention and Wellness Initiative coalitions by asking prevention providers to engage with CPWI coalitions when reasonable through request for application processes and in demonstrating collaboration. These agencies include the Department of Health, Office of Superintendent of Public Instruction, and the Department of Early Learning.

Training/Technical Assistance

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

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

From the 26 completed resources assessment surveys, Consortium members reported that they delivered 263 total prevention training for the years of 2016-2017 in which 2,683 people were trained. A majority of training is provided to prevention services providers and to prevention coalitions. There is also a fair amount of programs that provide training to communities, regional providers, and to other state agencies or organizations.

Trainings and prevention resources are delivered in a variety of formats by SPE Consortium members. There are key websites that have been developed that are dedicated to WA State Prevention resources.

Some of those include The Athena Forum website, Start Talking Now website, Ask HYS website, and Risk Profiles website.

Our Consortium partners provide guidance to local and regional partners to assist in accurately and effectively using community-level data and service provision data in their planning efforts. Guidance documents that have been developed by Consortium partners are included below.

1. Student Assistance Prevention and Intervention Services Program Manual
2. Art and Science of Community Organizing Training
3. CPWI Community Coalition Guide
4. Regional Marijuana Prevention Toolkit
5. Data Books
6. Risk Profiles
7. Prevention Best Practices Guide (Toolkit)
8. Risk Profiles
9. Excellence in Prevention Best Practices Page
10. Evidence Based, Research Based, and Promising Practices for Marijuana Prevention

In Washington State, we have a goal and a legislative mandate to integrate physical and behavioral health systems by 2020. We encourage our local programs to work with behavioral and physical health providers as well as other community partners. Accountable Communities of Health (ACHs) have been developed to implement health transformation regionally, including prevention and promotion. State and local partners are working to align their work with ACHs.

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

The Consortium state partners have a commitment to ensure that educational opportunities are culturally specific and science-based while also supporting innovative development of evidence-based practices. In the past years, Consortium partners have supported trainings and presentations for tribal prevention partners including a Prevention Summit, Spring Youth Forum, Tribal Prevention Gathering, Tribal Home Visiting Summit, Tribal Behavioral Health Conference, and had trainings for our providers on working with LGTBQ communities, support the Say It Out Loud Conference focus on LGTBQ Communities, increasing services to military veterans and families, training for pregnant and parenting women, and training focused on prevention efforts for the young adult population in colleges.

Workforce Development

In 2011, through support of the State Prevention Enhancement grant, the Consortium identified three components of the structure of workforce development, in an effort to prepare for the opportunities that may become available through health care reform and to continue to advance our field. The Consortium engaged in feasibility studies on individual prevention professional certification, agency licensure, and rate setting for prevention services. Although the Consortium still considers professionalizing the field through certification, agency licensure, and rate setting for prevention services important, these opportunities have not fully formed into the state status quo. The Consortium decided that based on the scope of work associated with these changes, that Individual Prevention Professional Certification would be the priority for Workforce Development. The

Consortium is currently taking a much more broad approach in enhancing prevention workforce development in the state. Below is a summary of the outcomes of each report in 2011 and our current efforts to advance the prevention workforce field. For copies of the full reports go to www.TheAthenaForum.org/SPE.

Individual Prevention Professional Certification

In Washington, the Prevention Specialist Certification Board of Washington (PSCBW) remains the certifying body for Certified Prevention Professionals (CPP). Some counties and local agencies require certification within the scope of their contracts and/or hiring practices; however, there is not a state requirement for certification of individuals. In 2011, the Division of Behavioral Health and Recovery contracted with Spokane Falls Community College (SFCC) to conduct a professional certification feasibility study. SFCC reviewed other states with certification or agency requirements; interviewed national contacts, Washington State stakeholders, and coalition coordinators; and administered an online survey. The survey covered 120 contacts from eleven counties and six tribes with an 80 percent response rate.

In summary, SFCC found that while the PSCBW has a high-quality system set up for certifying individuals, as a voluntary board, without staff support, they may not have the capacity to respond if a requirement for certification were put into place. The report offered several recommendations which included providing increased access to education for prevention professionals in a variety of formats. Since this study, there has been an increase in educational opportunities for prevention professionals through the various state agency partners on this Consortium.

In 2016, we followed up our workforce development efforts by conducting a workforce development survey targeted to Washington State prevention providers. There were 194 prevention providers who responded to at least part of the 2016 survey. Data was collected from seven different categories of prevention providers.

It has been 13 years since Washington State's prevention providers have been surveyed about their workforce development needs. In that period, there have been vast changes in the ways that prevention services are offered in the state, including the emphasis on use of evidence-based prevention practices. Predictably, the results of the 2016 Washington Prevention Providers Workforce Development survey show that the workforce has changed and that, in many cases, it is more attuned to meeting the challenges of the current prevention environment than its predecessors may have been. The results also show some significant challenges facing the current prevention workforce.

The 2016 results show that many of the prevention providers who responded to the survey are highly motivated, highly educated, and highly skilled. There is also a sizeable percentage of respondents who are just starting out in prevention and have very little knowledge and skills.

When comparing the 2003 and 2016 surveys, respondents to the 2016 survey report that salaries are higher and skills have increased almost across the board. There has been significant movement toward requiring baseline standards for workers in the field and the Division of Behavioral Health and Recovery (DBHR) now requires that community coalition coordinators and its own prevention staff earn Certified Prevention Professionals status.

Respondents to the 2016 survey showed significant improvement in confidence on 13 key prevention competencies as compared with results from the 2003 survey. Specifically, there were improvements in

the four of the seven categories including: planning and evaluation, education and skill development improved), community organization, and public and organizational policy.

Challenges demonstrated through the survey included a decrease in confidence among respondents to the 2016 survey in the area of professional growth and responsibility competency. Also the average age for prevention providers who took the survey increased to 46 years old from 2003's average age of 41 years old. The average years of education for prevention as well as the average years of experience in the field have both declined from the last time the survey was administered in 2003. In addition, there were serious gaps in knowledge and experience reported among prevention providers in several critical prevention planning and implementation competencies including developing a strategic plan, using a logic model to guide program evaluation, bullying prevention, and suicide prevention.

Washington State University has continued to develop the Interdisciplinary Ph.D. program in Prevention Science and in 2017, over 30 students entered into the program. The report recommended that in addition to the already established Certified Prevention Professional (CPP), the state consider providing opportunities for various levels of credentialing such as General Prevention Specialist or Associate Prevention Provider (APP). Since 2011, we worked with the PSCBW and there is now an APP available.

In response to these surveys and a discussion of workforce development with the Consortium, members established how their agencies each are implementing strategies across the state collectively to enhance the prevention workforce. The Consortium also broadly focuses on other than just working on the three prioritized areas of workforce development as in 2011, although items from the work in 2011 are still important for state prevention leaders to move towards. Below is a list of actions that have taken place to enhance the prevention professional workforce.

- State agency partners on the Consortium continue to provide educational opportunities throughout each year. The topics include substance abuse prevention, mental health promotion, suicide prevention, and Adverse Childhood Experiences.
- In 2015, the Division of Behavioral Health and Recovery began to require that its Coalition Coordinators obtain their Certified Prevention Professional (CPP) certification within 18 months of their hire date. The intent of this change is to advance the prevention professional workforce and increase the local capacity to provide effective prevention programming across the state.
- In 2017, the PSCBW reported that they have had an increase in applications for certification and now have 83 individuals in Washington State with a Certified Prevention Professional certification.
- Eastern Washington University offers courses provided by the Prevention Certification Board of Washington State.
- Washington State University has established a Doctor of Philosophy in Prevention Science. The program began in 2012 with 12 students in the Prevention Science Program, and by the fifth year, 38 students were enrolled. In 2016, the University had its first ever Ph.D. graduate in Prevention Science.
- State agency partners have increased requirements to engage in prevention science educational opportunities. In some instances, partners have supported funding scholarships to local and regional providers to attend the Communities that Care Facilitators and national prevention trainings.
- Partners also discussed the need to implement strategies to engage and keep millennials in the prevention workforce.

Partners are identifying opportunities to work with the Accountable Communities of Health and sharing information to ensure we all stay abreast of health transformation, including behavioral and physical health care integration.

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

In accordance with the former state Consortium strategic plan timeline, the five-year strategic plan needed a complete revision to develop a new five-year strategic plan for 2018-23. As mentioned previously, the Consortium followed the Strategic Prevention Framework and conducted an assessment of the needs, resources, and gaps of state substance use and mental health disorder using state level data. To conduct the needs assessment, the Consortium partnered with the State Epidemiological Outcomes Workgroup (SEOW) to gather relevant data. Additionally, to conduct the resources assessment, the Consortium developed an ad hock workgroup that prepared and implemented the resources assessment survey of Consortium members and prevention partners across the state. The Consortium began collecting information about significant historical events, economic changes, policy/law changes, and major changes to funding resources/directives that could have potential impacts on data indicators or on state prevention resources. The results of each of the assessments are included in this section of the strategic plan.

Data Assessment

In conducting the needs assessment, the SEOW and DBHR epidemiologist led the initial data gathering and presentation. The first task was to work with the SEOW to discuss and gather recommendations from the workgroup on which indicators were relevant in presenting to Consortium members. Following recommendations, the indicators were provided to the consortium for review and comment. The Consortium took the information back to their workgroups and made further recommendations to the epidemiologist on data indicators that they were interested in. This process took several weeks, as the epidemiologist presented and gathered requests from Consortium workgroups.

In April, the SEOW epidemiologist provided the data presentation on recommended indicators to the Consortium. The presentation covered trends and new data on consequence, consumption, and intervening variables related to substance use and mental health disorders. Also presented, was an overview on the data sources so that the group could identify additional data points of interest.

Following the presentation, the Consortium requested additional data elements and, in particular, data related to health disparities by race/ethnicity and gender. The epidemiologist provided a second training in the following month to accommodate requests. The Consortium also invited the Traffic Safety Commission to present on substance use traffic-related deaths.

Following the presentations mentioned above, the Needs Assessment Workgroup was formed to review the data and discuss prioritization of data and develop recommended targets for the upcoming five-year plan. The prioritization and target recommendations were provided to the larger Consortium and workgroup leads took the recommendations back to their workgroups for further review. Workgroup leads facilitated confirmation of targets around priorities to finalize for the plan.

Key Findings:

The SPE Data Workgroup came to the following summary conclusions:

- Overall based on prevalence, change over time, and some economic impact data, alcohol remains the most concerning substance abuse issue amongst both youth and adults.
- Marijuana ranks second for youth and third for adults. The change of marijuana use overtime remains flat.

- Tobacco ranks second highest amongst adults and the third highest amongst youth, with a decrease in use over time.
- The fourth highest concern is prescription pain reliever use. Misuse of prescription pain relievers among youth and young adults has decreased in recent years, but the potentially fatal implications of misuse warrants continued efforts toward further decreasing use rates. Opioid-related overdoses have been declared a crisis nationwide and in the state.
- Finally, the 5th ranked concern was changed from Meth to illicit drug use. We will continue to monitor meth and will also include other illicit drugs.
- Mental health concerns are also prioritized as there are an increase in prevalence of depression, suicide ideations, and suicide attempts for youth and adults.

Additional conclusions noted and discussed through the data assessment are listed below. They coincide with data collected. Please review the *Appendix – Data Assessment* for further details.

- Notable decrease in alcohol impaired fatal crashes from a high in 2009 (37%) to 2015 (8%).
- *Drug impaired driving has seen an increase from 28% in 2008 to 36% in 2015.*
- The 2016 Healthy Youth Survey shows that alcohol use continues to trend downward.
- In all surveyed grades, binge drinking is down. The tenth grade surveillance on the Healthy Youth Survey (HYS) is particularly important for the prevention field. As we can note, since 2006 there has been a steady decline. The trend shows a decrease of 17 percentage points since 1998.
- Between 2002 and 2016, marijuana use rates were flat (no significant change) for 8th, 10th, and 12th graders.
- Reported misuse of pain killers to get high in the HYS dropped by about half in the decade between 2006 and 2016. The 8th grade use was at 4% in 2006 and 2% in 2016. The 10th grade use was at 10% in 2006 and 4% in 2016. The 12th grade use was at 12% in 2006 and 5% in 2016. In addition to being a result of prevention efforts in local communities and statewide, these reductions are thought to be attributed in part to the greater expense in buying pain relief drugs on the street.
- All forms of tobacco use have declined across grades in the past decade. The rate of cigarette use decreased to 3 percent of 8th graders, 6 percent of 10th graders, and 11 percent of 12th graders in 2016. The use of e-cigarettes also decreased between 2014 and 2016, but remains a concern because of higher rates of use. In 2016, 6 percent of 8th graders, 13 percent of 10th graders, and 20 percent of 12th graders reported using e-cigarettes or vape pens in the past 30 days.
- For Grades 8 and 10, there were small decreases in skipping school from 2010 to 2016. For Grades 6 and 12, there were small increases in skipping school from 2010 to 2016.
- For Grades 8 and 12, there were substantial increases in suicidal ideations from 2006 to 2016. For Grade 10, there was *an increase* in suicidal ideation from 2006 to 2016: *Approximately one in five students* surveyed in 2016 indicated that they had serious thoughts of suicide in the past 12 months.
- Since 2002, the rate of students who answer that there is a "slight risk" or "no risk" to using alcohol among 12th graders has decreased from 41% to 26%. The trends among 8th graders and 10th graders show similar rates of decline (8th graders from 39% to 24%; 10th graders from 37% to 23%).

- Since 2006, the rate among 10th graders that answer that there is "slight risk" or "no risk" to using marijuana has grown from 18% to 33%. The trend among seniors is even steeper, from 21% to 45%.
- Health disparities remain apparent for youth among substance use and mental health indicators. For example, American Indian/Alaska Native 10th graders have more than double the smoking prevalence of white 10th graders (13% compared to 6%), and binge drinking is most prevalent among American Indian/Alaska Native (16%), Black or African American (15%), and Native Hawaiian or other Pacific Islander (15%) 10th graders. Please see Health Disparities Data chart in the *Appendix Section – Data Assessment*.

Analysis and Prioritization of Data:

As mentioned earlier, the data conclusions and recommendations related to substance misuse/abuse and mental health indicated over the period of four months and presented to the Consortium on four consecutive meetings. For details see *Appendix 4 – Data Assessment*.

What is the problem?

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

Why?

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

Substance Abuse

The Consortium decided to focus on the top four ranked misused/abused substances: alcohol, marijuana, tobacco, and prescription pain killers. Based on the prevalence by age, underage drinking remains the top priority. Additionally, the Consortium agreed that specific emphasis also be placed on strategies related to alcohol use prevention for the 18-25 year age range. It was noted that there is an increase in rates for drinking during pregnancy. And lastly, the Consortium noted the importance of continuing to watch "trending" substances, vapor product misuse, opioid misuse, and heroin use, which has shown increased use, hypothesized to be related to the reduced access of prescription opiates. Nationally, there has been an opioid crisis and Washington State also follows the national response in addressing this concern as opioid-related disease shows a significant burden including youth nonprescription misuse, opioid substance abuse treatment admissions, overdose hospitalizations, and deaths.

It was decided to use the term 'misuse/abuse' to account for important distinctions related to each substance. Specifically, in regards to marijuana it is important to note that the Consortium is cognizant that medical marijuana use remains legal in this state, recreational marijuana use is also legal for adults over the age of 21; therefore not all marijuana use is considered abuse. Similarly prescription drugs when taken as prescribed, are not considered harmful or

misuse/abuse. In regards to tobacco, it is important to recognize that in some cultures, tobacco is used for cultural traditions and ceremonies and would not be considered misuse or abuse.

Mental Health

The review of mental health indicators of serious mental illness, depression, anxiety, bullying, suicidal ideation, suicide attempts data suggest the importance of focusing on depression, anxiety, and suicidal ideation, specifically among those who are under 25 years of age.

Why here?

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

Below is the list of the identified intervening variables and behavioral health problem associated with each:

Intervening Variables
(Risk/Protective Factors) (2-5 years)

Adult Alcohol misuse/abuse	▪ Access to Alcohol ▪ Community norms ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Underage Drinking	▪ Access to alcohol ▪ Availability of alcohol ▪ Community norms ▪ Enforcement (e.g., lack of enforcement and perception of lack of enforcement) ▪ Promotion of alcohol ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Marijuana misuse abuse	▪ Access to marijuana ▪ Availability of marijuana ▪ Community Norms ▪ Enforcement (e.g., inconsistent application of laws in light of de-emphasis) ▪ Favorable Attitudes: Perception of harm ▪ Laws (e.g., confusion about laws) ▪ Promotion of marijuana (e.g. billboards and signage near retail outlets) ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)

Tobacco misuse/abuse	▪ Access (e.g., hookah lounges) ▪ Availability of tobacco ▪ Favorable Attitudes: Perception of harm ▪ Laws (e.g., preemption and local laws) ▪ Promotion of tobacco (e.g., targeted advertising to low-income/minority populations) ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Opioids/ Prescription Drugs misuse/abuse	▪ Access to prescription drugs (e.g. not prescribed to them and prescriptions provided) ▪ Availability (e.g., over prescribing, unused medication, and 'doctor shopping') ▪ Community norms ▪ Enforcement (e.g., unclear under the influence laws) ▪ Supply (e.g., abundant supply of prescription drugs) ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Depression & Anxiety	▪ Community norms (e.g., stigma of MH screenings, MH screening not part of routine health screening, and community awareness and knowledge regarding treatability) ▪ Connection to other mental health disorders (e.g., anxiety) ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Suicide Ideation	▪ Connection to other mental health disorders ▪ Teens and young adults suicidal ideation ▪ Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)

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

Resources Assessment

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

For the 2017 strategic plan update, the SPE Resources Assessment Workgroup included partners from Department of Health; Division of Prevention and Community Health; Office of Superintendent of

Public Instruction, Commission of Hispanic Affairs; and the Department of Health and Social Services, Division of Behavioral Health and Recovery.

The resources assessment workgroup decided to implement an online resources assessment survey that state agency partners were able to use to provide information on their state prevention resources. Resources were *defined* as a major program, policy, initiative and/or service with the purpose of preventing substance use disorders or enhancing mental health promotion activities. The resources assessment focused on four distinct categories that the workgroup determined to be important to collect for the strategic plan. Sections included:

- Agency contact information
- Prevention related trainings and technical assistance activities (number of trainings, names of trainings, and number of individuals trained)
- Resources and strategies (name of resources, primary problem addressed, other areas of focus, target populations (age, race, and ethnicity), and strategies used by resource)
- Funding resources and allocations (sources of funding received at the state-level, funding allocation from the state agencies to county/regional/local sites)
- Supported community coalitions and if so which coalitions (local support to coalition for mapping)

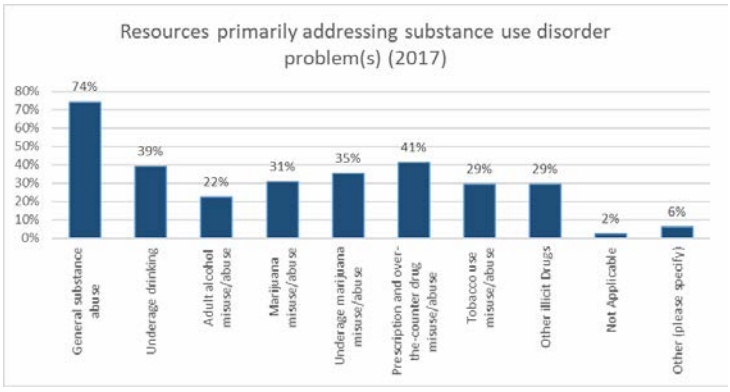
A total of 26 state agency programs completed the resources assessment. A total of 85 prevention resources were provided by those who completed the survey. Each survey collected additional details on the focus areas of resource by substance abuse/mental health problems, addressing other substance abuse and mental health promotion problems, populations targeted by age group, strategy type, and populations targeted by priority type.

Detailed information from the resources assessment and comparison charts from 2011 and 2017 can be found in *Appendix 5 – Resources Assessment*. Below is a summary of key information analyzed[7].

<u>Most common focus areas being addressed (2017)</u>

- General Substance Abuse (74%)
- Prescription and over-the-counter drug misuse/abuse (41%)
- Underage Drinking (39%)
- General Health Promotion (36%)
- Quality of Life (36%)
- Underage Marijuana Use (35%)
- Family Relationships (35%)

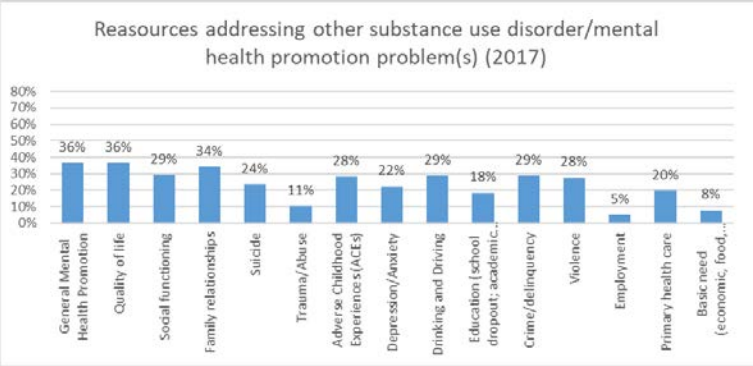
The chart to the right shows the percentage of resources focused on prevention by substance use problems.



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

Resources Addressed by Substance (2017)

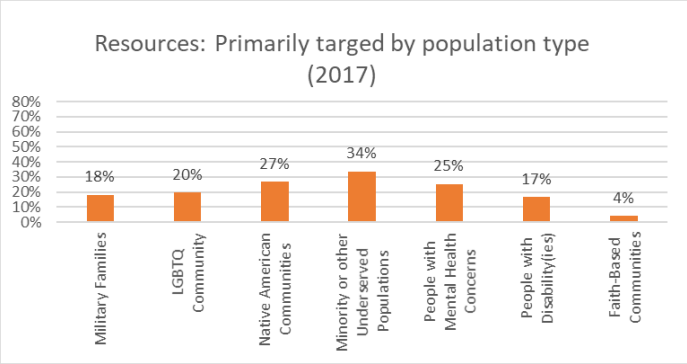
- Prescription and over the counter drug misuse/abuse (41%)
- Underage drinking (39%)
- Underage marijuana misuse/abuse (35%)
- Tobacco Use misuse/abuse (29%)
- Other illicit drug use (29%)



Most common strategies (2017):

- Policy/Community Norms (44%)
- Information Dissemination (34%)
- Cross Planning/Collaboration (32%)
- Community Based Youth education/skill building (32%)
- Community engagement/coalition development (29%)

Target Populations (2017):



- While we have broad coverage on all ages, these resources most often focus on *adolescents, young adults, and adults.*
- Minority or other underserved populations (34%) was the most common specific population targeted followed by Native American/Tribes (27%), People with Mental Health Concerns (25%), and LGTBQ Community (20%).

Beginning in October 2011, as part of this State Prevention Enhancement grant, the Consortium began working on four specific prevention projects with coordinated funding. We have maintained and added multiple projects supported by coordinated funding including the State Prevention Summit conference, Spring Youth Forum conference, Healthy Youth Survey, CORE GIS data collection and analysis, College Coalition, Suicide Prevention Plan, Opioid Executive Order plan (safe storage campaign), Prescriber Education Conferences, expansion of SBIRT services, Washington State Prescription Drug Monitoring Program, youth marijuana use prevention media campaigns, Alcohol & Drug Abuse Institute (ADAI) surveillance, Evidence Based Practices development, Marijuana I-502 surveillance, Home Visiting Programs and Community Prevention and Wellness Initiative (CPWI). As part of the state Community Prevention and Wellness Initiative, some of the Consortium partners have been involved in this process to support local coalitions.

As part of the CPWI, funds were coordinated to support local prevention activities (local coalitions) that include funds from Division of Behavioral Health and Recovery and Office of the Superintendent of Public Instruction, which were paired in many cases with Department of Health Community Transformation grant neighborhoods, Community Mobilization coalitions and Drug-Free Communities coalitions. Where possible, we looked to facilitate cross-agency communication to support aligning their local work in these areas when it fits the needs of the communities. Since the CPWI initiative began in 2011, there are now 64 coalitions in high-need communities across the state that are ready to collaborate with partners at the local level.

Where it aligns, many new request for applications require or provide an incentive if the RFP applicant works with a CPWI high-need community through other partnerships through the Youth Marijuana Prevention and Education Program, Home Visiting Programs through the Department of Early Learning, and the Life Skills Program through the Office of Superintendent of Public Instruction. Another connection that we are facilitating in the relationship between the high-need coalitions and the Health Care Authority's Accountable Communities of Health Entities (ACHs).

Analysis and Prioritization of Resources:

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

Section 4: Plan for Action

Following the data prioritization and target setting, the workgroup further recommended strategy types for the workgroups to consider to reach common goals. Following the recommendations provided by the data workgroup, the SPE Consortium workgroups began the development of their work plans. This section details the discussions and decisions leading to the Consortium's commitment to support existing programs and partnerships and build collaborative strategies.

Common goals, objectives, and strategies for coordinating services

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

SPE Consortium Partners' Strategies

What are we doing about it?

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

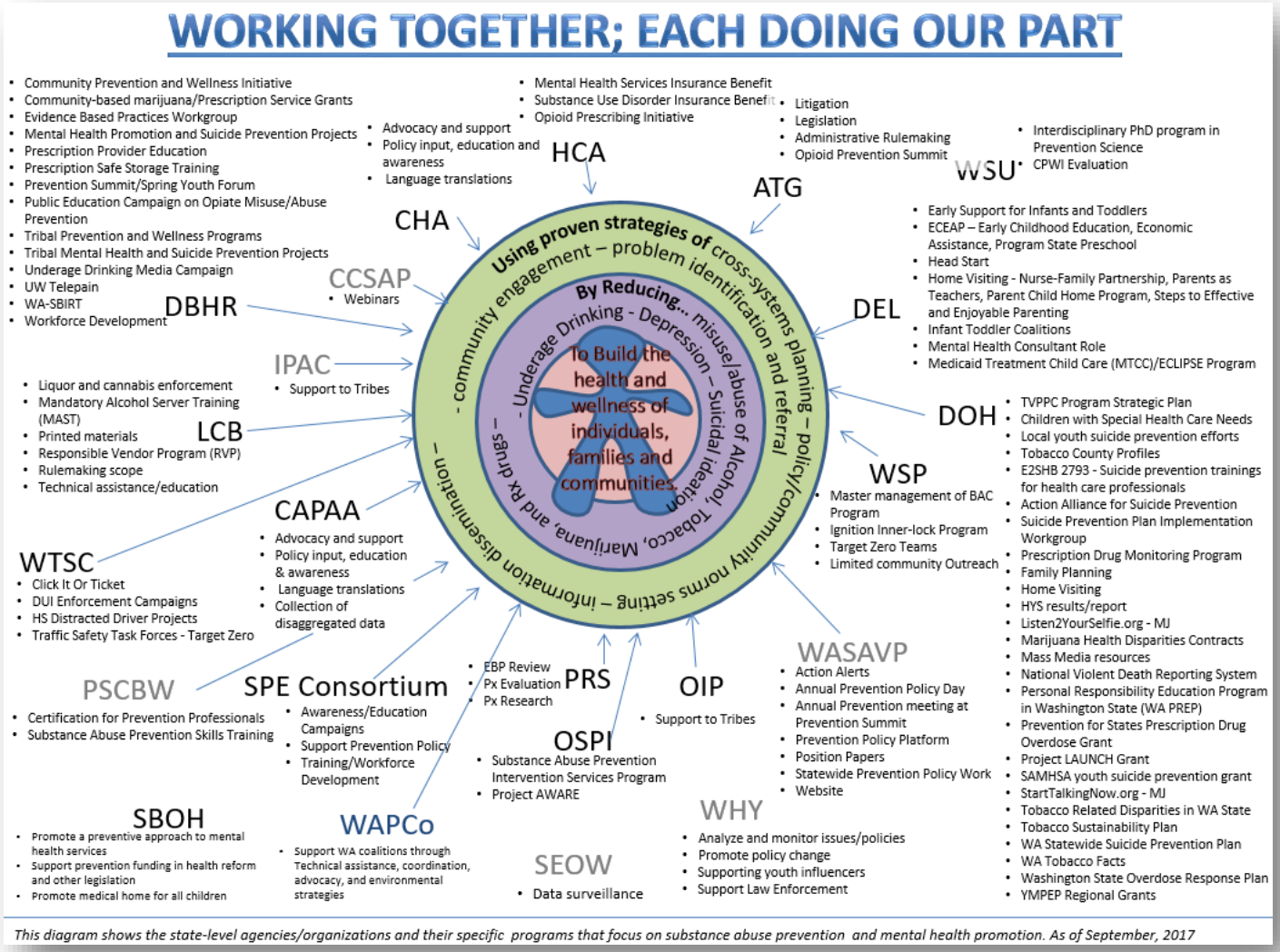
The following six primary strategies were identified as a result of the review of current work and as an opportunity for alignment to support our goal to build the health and wellness of individuals, families, and communities in Washington State:

Strategy	Number of resources directly or indirectly using this strategy
Education (School and Community Youth Education/Skill Building and Other Education):	60
Policy/Community norms:	36
Information Dissemination:	26
Community Engagement/Coalition Development:	24
Parent education/Family Support:	23
Cross-systems Planning/Collaboration:	21

An essential component of coordinated services is the clear awareness and understanding of the various elements of the state prevention services and how they are delivered. The Consortium has a history of revisiting resources information to ensure that they keep abreast of state-level resources and coordinated services where applicable and appropriate.

Below is an illustration of the state level agencies and organizations and their specific programs/initiatives that focus of substance abuse prevention and mental health promotion. The names listed in grey indicate collaborative groups such as committees and workgroups that inform the

SPE Consortium. The names listed in black are agencies/organizations. A full diagram is in the *Appendix section 6* of this plan – *Diagram of Resources.*



Strategic direction for strategies, activities, and policy initiatives:

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

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

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

- Supporting continued work by the Washington State Healthy Youth State (WHY) Coalition regarding policy and education campaigns focused on reducing underage drinking and underage marijuana use.

- Facilitate and coordinate the multiple efforts to support local community coalitions, such as Drug Free Communities (DFC) grantees and Community Prevention and Wellness Initiative (CPWI) coalitions.
- Partner with groups that are working on prescription drug monitoring systems to coordinate efforts and monitor effectiveness.
- Continue the cross-agency collaboration supporting the implementation of the Healthy Youth Survey, as well as the effective use of the results.
- Partner with tribal programs and initiatives, such as the Tribal Prevention gathering and tribal evidence based practices literature review.
- Continue partnership to support to the Evidence Based Practices Workgroup and to continue to support a searchable online resource for substance abuse prevention evidence-based list.
- Continued partnerships for data sharing and consideration for improvements to analysis and reporting of multiple data across multiple systems.
- Continue to provide opportunities for all partner agencies to participate in the organization and implementation of statewide training opportunities, including the Prevention Summit and the Youth Forum.

Collaborative Strategies: Prevention activities and policies supported by coordinated resources

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

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

In August 2017, the workgroup leads presented both their new action plans and their past year's accomplishments. This allowed Consortium members and workgroup leads to engage in a rich discussion of how they will work together to reach targeted outcomes. Further, workgroup leads were able to learn about each group's process and development through this discussion. Annually the workgroups will review and update their action plans to be sure that goals are being met. Through this process, workgroups will be tasked with collecting a record of how they are progressing throughout each year.

Action Plan Strategies by Behavioral Health Problem (Workgroup)

Underage Drinking and Youth Marijuana Use Prevention
Workgroup Team: Maintain integration with the state Washington Healthy Youth Coalition (WHY) to support the established priorities.
Cross-systems Planning/Collaboration: Increase statewide collaboration and partnerships with diverse partners.
Policy: Promote changes in industry policies and practices.
Policy: Educate policymakers on the following topics: Prevention funding levels, Advertising, Trends and health effects, Enforcement of laws, Disparities in enforcement, Salient Issues and best practices.
Policy: Monitor impacts of legislation.
Information Dissemination/Public Awareness: Analyze and disseminate information regarding current and emerging issues.
Information Dissemination/Public Awareness: Support community, regional, and statewide partners through development and distribution of educational materials and resources.
Education/Workforce development: Promote and expand use of evidence based prevention practices in the field.
Young Adult and Pregnant Women Alcohol and Marijuana Misuse/Abuse Prevention
Workgroup Team: Work with state agencies, universities, and College Coalition to implement SPE strategies focused on Young Adult and Pregnant Women.
Policy: Improve prenatal care practitioner's ability to effectively screen and identify pregnant women with substance use/abuse issues.
Policy: Promote the use of SBIRT/BASICS among universities, colleges, and health entities. Promote the use of SBIRT/BASICS for use with pregnant women.
Policy, Information Dissemination: Identify data collection indicators for ongoing monitoring of substance use among pregnant women.
Information Dissemination: Disseminate prevention resource for pregnant women and providers working with pregnant women.
Policy, Information Dissemination: Identify prevalence and predictors of cannabis and alcohol use among young adults.
Information Dissemination: Reduce marijuana use in young adults and pregnant women by supporting increase in communications, media outreach, and supporting help lines.
Information Dissemination, Education/Workforce development: Promote the use of prevention resources among those serving young adults and pregnant women.
Education/Workforce Development: Provide and/or promote training and education related to substance abuse in young adults and/or pregnant women.
Tobacco Misuse/Abuse Prevention
Workgroup Team: Consists of state, local, community and tribal-related organizations and other stakeholders with subcommittees focused on each of the listed policies and strategies.
Policy: Demonstrate the importance of restoring appropriate funding level for a comprehensive, evidence-based, statewide and local tobacco prevention and control program according to CDC Best Practices guidelines (CDC recommends for WA an annual investment of $44 to $63 million).

Policy: Reduce youth access to tobacco and vapor products by increasing the minimum legal age of purchase from 18 to 21 years statewide.
Policy: Educate policymakers and stakeholders on the value of local control to allow for local regulation of combustible and other tobacco and vapor products.
Information Dissemination: Reduce tobacco-related disparities and advance health equity by educating varied audiences on tobacco-related disparities among identified populations and potential policy solutions.
Education/Workforce development: Develop partnerships with health care providers to: • Enhance screening for tobacco use and referrals to cessation resources. • Address health insurance regulations so that all licensed health care providers can be reimbursed for providing tobacco cessation services.
Prescription Misuse/Abuse and Overdose Prevention
Workgroup Team: Maintain statewide workgroup to implement SPE Strategies. Work collaboratively with existing statewide Unintentional Poisoning Workgroup and Information Dissemination Committee.
Policy, Information Dissemination **and** ***Education/Workforce development:*** Promote use of best practices among health care providers for treating acute and chronic pain to reduce unnecessary and inappropriate use of opioids.
Information Dissemination **and** ***Education/Workforce development:*** Raise awareness and knowledge of the possible adverse effects of opioid use, including dependence and overdose, and focus on reducing the stigma of opiate use disorder
Information Dissemination **and** ***Education/Workforce development:*** Prevent opioid misuse in communities, particularly among youth
Information Dissemination **and** ***Education/Workforce development:*** Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse.
Policy, Information Dissemination **and** ***Education/Workforce development:*** Decrease the supply of illegal opioids.
Mental Health Promotion, Depression, Anxiety & Suicide Ideation Prevention
Workgroup Team: Statewide workgroup involving state and local organizations to focus on suicide prevention, Project Aware strategies and mental health promotion to implement SPE strategies.
Cross-systems Planning/Collaboration: Continue establishing a statewide workgroup including the Suicide Prevention Steering Committee to work towards implementing SPE strategies.
Cross-systems Planning/Collaboration: Identify and review measures of Mental Health in Washington communities other than the absence of disorders.
Cross-systems Planning/Collaboration: Work with DOH and DBHR to finalize the Mental Health Promotion/Suicide Prevention funding opportunity.
Information Dissemination/Public Awareness: Collect data and resources to provide to communities including 1) Prevention and intervention material to reduce potential for youth suicide and mental health and 2) Response (Post-intervention) to communities experiencing crisis of multiple suicides/contagion.
Education/Workforce development: Enhance coordination, planning, and activities between multiple child serving and intervention agencies and groups addressing suicide prevention.
Education/Workforce development: Support training to enhance workforce knowledge of Youth Mental Health First Aid response in high-need communities.

Section 5: Implementation

In order to accomplish our goal, the Consortium has a consistent history and commitment to continuing support for the current resources directed to these efforts, as well as opportunities for partnerships and collaborative projects within identified strategies. The Consortium will continue to review and update our strategies as needed and when resources become available or sunset.

The matrix below demonstrates the direct and indirect substance abuse prevention and mental health promotion services that the Consortium Partners collectively implement.

Agency – Resource (List of Acronyms is available in the *Appendix 1- List of Acronyms and* Abbreviations)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
AGO - Litigation, Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action	X					
AGO -Opioid Summit	X					
AGO -Tobacco 21	X					
CCSAP - Webinars	X	X				
CCSAP -Year End Young Adult Professional Development Conference		X				
DBHR - Community Prevention and Wellness Initiative (CPWI)	X	X		X		
DBHR - Community-based Marijuana Services Grants	X					
DBHR - Community-based Opioid/Prescription Services Grants	X					
DBHR - Healthy Youth Survey	X	X				
DBHR - Evidence Based Practice Workgroup	X	X		X		
DBHR - Mental Health Promotion and Suicide Prevention Projects		X				
DBHR - Prescription Provider Education	X					
DBHR - Prescription Safe Storage Training	X					
DBHR - Prevention Summit/SYF/Coalition Institute	X	X	X			
DBHR - Public Education Campaign On Opiate Misuse/Abuse Prevention	X					
DBHR - Start Talking Now - Website for Parents	X	X				
DBHR - The Athena Forum - Website for Prevention Professionals/Partners	X	X	X			
DBHR - Tribal Mental Health Promotion Mini Grant		X	X		X	
DBHR - Tribal Prevention and Wellness Programs	X	X		X		
DBHR - Underage Drinking Use Media Campaign	X					
DBHR - UW Tele Pain	X					
DBHR - WA-SBIRT Trainings	X					

Agency – Resource (List of Acronyms is available in the *Appendix 1- List of Acronyms and* Abbreviations)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
DBHR - Workforce Development, Trainings, and Technical Assistance	X	X				
DBHR - Young Adult Health Survey	X	X				
DEL - Early Support for Infants and Toddlers	X	X	X			
DEL - ECEAP Early Childhood Education Economic Assistance Program State Preschool		X				
DEL - Head Start	X	X	X			
DEL - Home Visiting Programs- 4 EBPs	X	X	X			
DEL - Infant Toddler Regions		X	X			
DEL - Mental Health Consultant Role			X			
DEL - MTCC/ECLIPSE Program			X			X
DOH - Contract for local youth suicide prevention efforts		X				
DOH - Mandatory (E2SHB 2793) Suicide Prevention Trainings for Health Care Professionals			X		X	X
DOH - Action Alliance for Suicide Prevention			X		X	X
DOH - Suicide Prevention Plan Implementation Workgroup		X	X		X	X
DOH - National Violent Death Reporting System				X	X	X
DOH - Prevention for States Prescription Drug Overdose Grant		X		X	X	
DOH - SAMHSA youth suicide prevention grant		X			X	
DOH - Statewide Suicide Prevention Plan		X	X		X	X
DOH - State Overdose Response Plan				X	X	X
DOH - Children with Special Health Care Needs						X
DOH - Family Planning	X		X		X	X
DOH - Home Visiting	X		X	X		X
DOH - Personal Responsibility Education Program in Washington State (WA PREP)			X			
DOH - Project LAUNCH Grant			X			
DOH - TVPPC Program Strategic Plan (2017-2021)		X				
DOH - Tobacco County Profiles		X				
DOH - Listen2YourSelfie.org	X					
DOH - Marijuana Health Disparities Contracts	X					
DOH - Tobacco Related Disparities in WA State (health equity)	X	X				
DOH - WA Tobacco Facts	X	X				
DOH - YMPEP Regional Grants	X					
DOH - Drug Prescription Monitoring Program	X					

Agency – Resource (List of Acronyms is available in the *Appendix 1- List of Acronyms and* Abbreviations)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
DOH - Mass Media resources	X					
DOH - Tobacco Sustainability Plan	X					
HCA - Mental Health Services Insurance Benefit for Medicaid Eligibles and Public Employee	X	X	X	X	X	X
HCA - New initiative on Opioid Prescribing						
HCA - Substance Use Disorder insurance benefit for Medicaid Eligibles and Public Employees	X	X	X	X	X	X
IPAC - Support Tribes	X	X	X			X
LCB - Liquor and Cannabis Enforcement	X			X		
LCB - Mandatory Alcohol Server Training (MAST)	X			X		
LCB - Printed materials	X					
LCB - Responsible Vendor Program (RVP)	X			X		
LCB - Rulemaking scope	X			X		
LCB - Technical Assistance/Education	X					
OIP - Support Tribes	X	X	X	X		X
OSPI - Life Skills	X					
OSPI - Project AWARE	X	X				
OSPI - Student Assistance	X					
OSPI - Suicide Prevention Program						
PSCBW - Certification for Prevention Professionals	X		X	X	X	
PSCBW - Substance Abuse Prevention Skills Training (WA-SAPST)	X	X				
WAPCo - Washington Association of Prevention Coalitions	X			X	X	
WASAVP - Action Alerts	X				X	
WASAVP - Annual meeting at Prevention Summit in Yakima	X					
WASAVP -Annual Policy Platform for prevention	X			X	X	
WASAVP -Monitoring and advocating for prevention with State Legislature	X				X	
WASAVP - Occasional position papers relevant to prevention	X			X	X	
WASAVP - Prevention Policy Day	X					
WASAVP - WASAVP Website	X				X	
WSU - Interdisciplinary Ph.D. Program in Prevention Science	X		X	X	X	X
WTSC - Click it or ticket	X					
WTSC - DUI enforcement campaigns	X					

Agency – Resource (List of Acronyms is available in the *Appendix 1- List of Acronyms and* Abbreviations)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
WTSC - HS distracted driver projects				X		
WTSC - Traffic Safety Task Forces - Target Zero	X			X		

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

Structural Support for Collaboration

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

The implementation of strategies includes workgroup implementation and maintenance of their action plans as written in the planning section of this plan. Each workgroup is responsible for completing action items and following up with the larger coalition to review if action items are accomplished. Leadership of each workgroup is responsible for providing bi-monthly updates on action plan progress to the Consortium staff.

The Consortium and the work groups continue to identify and engage new partners in implementation workgroup action items and the strategic prevention plan. Each year we will review and update the Action Plans as needed to make sure that we are meeting our goals. The appendix section provides a list of specific partners committed to contributing to the work of the Action Plans.

Implementation plan and Five-year Timeline

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

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

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

Implementation Plan Timeline

Task	Lead	2018	2019	2020	2021	2022
Consortium bi-monthly meetings	DBHR	X	X	X	X	X
Renew leadership positions	Consortium		X		X	
Set evaluation targets for selected indicators	Consortium		X		X	
Workgroup meetings	Workgroup Leads	X	X	X	X	X
Workgroup Action Plan implementation	Workgroups Workgroup Leads	X	X	X	X	X
Biennial review of resources	Resources Assessment Workgroup		X		X	
Biennial review of data assessment	SEOW/Data Assessment Workgroup		X		X	

Plan for Cultural Competency and Health Equity

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

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

As individuals, we are committed to increasing our understanding of cultural competency and moving through cultural knowledge, awareness, and sensitivity to competence.[8] We also understand that cultural competence extends the concept of self-determination to the community. Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g., neighborhood, civic, and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers).[9]

As we know from the work done at the National Center for Cultural Competence, Georgetown University, building a culturally competent effort requires that organizations:[10]

[8] Community Anti-Drug Coalitions of America National Coalition Institute Cultural Competence Primer. 2007.
[9] Adapted from Cross, T. et al, 1989
[10] Adapted from - http://nccc.georgetown.edu/foundations/frameworks.html. Accessed June 2012.

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

The Consortium will use tools,[11] [12] for ongoing assessment of our structure and support of membership, policies, structures, processes, and activities that include these critical components. We will conduct assessments regularly and make adjustments to effectively meet the needs of our state's population.

In 2015, our consortium began to follow specific tasks to ensure that our state agency partners were following federal guidance in addressing health disparities through our work in Washington State. Substance Abuse and Mental Health Services Administration (SAMSHA) and the Center for Disease Control (CDC) and Prevention provided guidance for the definition of "health disparities" to mean that it is a "health difference that is linked with social, economic, and/or environmental disadvantage."[13] [14] There are many example in which our state agency partners have worked on the reduction of health disparities in many aspects of our work including in assessment, data collection, workforce development, training and technical assistance, planning, program implementation, and evaluation. Please see a few of the examples below on how our partners have focused our work on the reduction of health disparities.

Workforce Development Training and Technical Assistance

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

Data Collection and Evaluation

- To address data gaps, partners who work on the Healthy Youth Survey have included additional categories in the race and ethnicity survey questions to include additional options in the Asian/Asian American category to include subpopulation demographics as options.

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[11] "Promoting Cultural Diversity and Cultural Competency- Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs Goode, T., 2002, NCCC, GUCDC.
Click on Resources and Tools for checklists that reflect these values and principles in policy and practice. Accessed June 2012.
[12] Taylor, T., & Brown, M., 1997, Georgetown University Child Development Center, (GUCDC) University Affiliated Program.
[13] Healthy People 2020. https://www.healthypeople.gov/2020/leading-health-indicators/Leading-Health-Indicators-Development-and-Framework. Accessed October, 2017.
[14] Centers for Disease Control and Prevention. Strategies for Reducing Health Disparities. 2016. https://www.cdc.gov/minorityhealth/strategies2016/index.html Accessed October, 2017.

- The Division of Behavioral Health and Recovery significantly increased efforts to collect health disparity data with the development of their new data collection system including collection of military status, veteran's status, LGBTQ, and additional racial subcategories for Latino and Asian populations. Additional details were added to the data collection site to identify tribal governments and their partners.
    - These changes took place as a result of our continuous improvement of evaluation, guidance from federal partners, and advisory groups in the Consortium including the Commission on Hispanic Affairs and the Commission on Asian Pacific American Affairs.
- Health Youth Survey planning committee committed to adding a question on the 2018 questionnaire on gender identity.
- The most recent strategic plan renewal (2018-2023) the Needs Assessment included a review of the data in terms of health disparities. For further details, please see the *Appendix 4 – Needs Assessment.*

Program Planning and Implementation

- Increased prevention services to tribes were provided in the last biennium including providing culturally adapted evidence based program trainings including the Incredible Years, Mentoring, and Family Spirit Home Visiting program, Native American - Substance Abuse Prevention Skills Training, Tribal Behavioral Health Summit, Tribal Home Visiting Summit, and a Tribal Prevention Gathering. Partnerships in working with tribes exist with all state agencies including consultation policies in working with prevention programs. Advisory groups are used in planning and preparation around prevention programs including the American Indian Health Commission and the Indian Policy Advisory Committee (IPAC).
- Partners have specific projects and programs that address health disparities as they exist in Washington State. The Department of Health has a Tobacco Disparities Program and a Marijuana Prevention Disparities Program embedded in their overall prevention programs.
- The Division of Behavioral Health and Recovery's received specific funding through the Dedicated Marijuana Account to support tribal prevention/treatment activities for youth middle school and high school aged.
- State agency partners continue to fund the highest need communities in the state through the Community Prevention and Wellness Initiative sites, regional sites through the Tobacco Health Disparities contracts, the Youth Marijuana Prevention and Education Programs (YMPEP) health disparities contracts, suicide prevention efforts, tribal home-visiting allocations, and many more.
- As state agency partners develop requests for applications for funding and contracting, they have asked potential applicants to include a plan to address health disparities in their work at the community/regional level.

These examples show our Consortium's and state agency partner's commitment and dedication to reducing health disparities through their continued efforts. There are plans to also enhance this work through the efforts of the Consortium and the Consortium workgroups.

Section 6: Evaluation

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

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

The Consortium partners have a number of reporting systems that support our ability to compile data related to each level of analysis on our intended outcomes. A complete list of data sources used by Consortium partners is included in the *Appendix 3 – Washington Key Data Sources.*

These data sets provide information on social impact indicators, as well as local community and service level data. Although, due to the complexities of the various funding allocation methods used by state agencies and the focus of services being delivered, we are not able to combine all service data collection systems, we currently have two state agencies committed to using a single system to collect service data from their respective providers. Regardless of which system is 'holding' the data, we have developed significant data-sharing agreements that allow for us to easily collect and compile valuable data not only for our assessments, but also to use in our evaluation.

So what? How will we know?

The Consortium, under the guidance of the SEOW, selected the best measures available that provide points from which we can monitor our progress. This is not intended to be a finite list of all possible measures related to these issues. In June 2017, the Consortium finished an in-depth review of each of these indicators and set five-year targets for the **Intermediate Outcomes: Behavioral Health Problems**.

In 2015 during our plan update from the original Strategic Plan 2012-2017, the data revealed that the original targets were mostly met or exceeded well before the end of the strategic planning period. In 2015, new targets were set and the numbers continue to show progress of our prevention efforts. Overall, our Consortium goals are to have 5% reductions by 2019 and 10% reductions by 2023. However, in the case of young adult marijuana and alcohol use, the targets are more aggressive.

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

Long Term Outcomes: Consequences	Source/Year Baseline		
Chronic Disease/Injury/Death	**Ages/Category**	**DOH 2010**	**RDA 2015**
Alcohol related injury/accident (hospitalization)	Age 10-17: Age 18-25:	12.8 per 100,000 83.8 per 100,000	9.73 per 100,000 63.5 per 100,000
Other Drug related injury/accident (hospitalization)	Age 10-17: Age 18-25:	56.9 per 100,000 195.2 per 100,000	31.4 per 100,000 142.9 per 100,000
Tobacco related deaths	All Ages Tobacco-attributable deaths	Average annual 2005-2009: 8,700	NA
Alcohol related deaths	Age 10-17: Age 18-25:	3.7 per 100,000 19.1 per 100,000	4.1 per 100,000 17. 2 per 100,000
Other Drug related deaths	Age 10-17: Age 18-25:	1.1 per 100,000 15.2 per 100,000	0.07 per 100,000 13.5 per 100,000
Opioid related deaths	All ages:	NA	All Opioids: 9.7 Rx Drugs: 5.5 Heroin: 4.4
Crime	**Ages/Category**	**UCR 2010**	**UCR 2016**
For Arrests, Alcohol Violation **For Arrests, Alcohol Related**	Age 10-17: Age 18-24:	4.8 per 1,000 25.8 per 1,000	1.8 per 1,000 12.9 per 1,000
For Arrests, Drug Violation **For Arrests, Drug Related**	Age 10-17: Age 18-24:	4.8 per 1,000 13.7 per 1,000	2.3 per 1,000 4.8 per 1,000
Low Graduation Rates	**Ages/Category**	**OPSI 2009**	**OSPI 2016**
HS Extended Graduation Rate (include on-time graduation)		79%	81%
Suicide	**Ages/Category**	**CHARS 2010**	**CHARS 2015**
For Suicide and Attempts	Age 10-17: Age 18-25: All Ages:	40.5 Per 100,000 116.0 Per 100,000 13.8 per 100,000	75.72 per 100,000 Not Available 15.6 per 100,000
Fatalities and Serious Injury From Traffic Crashes (Number of young drivers in serious or fatal crash)	**Ages/Category**	**WSDOT 2010**	**WSTSC 2015, WA-FARS 2015***
Alcohol-Related Traffic Injuries (Age 16-25)	Age 16-17: Age 18-20: Age 21-25:	0.6 per 10,000 1.8 per 10,000 1.1 per 10,000	2.3 per 10,000 1.5 per 10,000 1.9 per 10,000
Alcohol-Related Traffic Fatalities (Age 16-25)	Age 16-17: Age 18-20: Age 21-25:	0.3 per 10,000 0.5 per 10,000 0.6 per 10,000	0.9 per 10,000 0.3 per 10,000 0.6 per 10,000

Long Term Outcomes: Consequences	Source/Year Baseline		
Fatalities and Serious Injury From Traffic Crashes	**Ages/Category**	**WSDOT 2010**	**WSTSC 2015, WA-FARS 2015***
Marijuana-Related Traffic Fatalities (Age 16-25) Number of young drivers in serious or fatal crash	Age 16-25: Age 16-25:	21.4%% (Any THC Tested Drivers) 13.1% (Any THC Total Drivers) 44.4% (Delta-9 THC Positive)	23.2% (Any THC Tested Drivers) 12.0% (Any THC Total Drivers) 89.1% (Delta-9 THC Positive)

Table Note: Green and red arrows indicate increases and decreases in data from the previous year data set.
* Cannot determine if rates are higher or lower than 2010 rates as the data sources are different.

Intermediate Outcomes: Behavioral Health Problem Targets			
Underage Drinking (10th Grade)	**HYS 2016**	**Target 2019: from HYS 2016**	**Target 2023: from HYS 2016**
Drank Alcohol in Last 30 Days	20.4%	17.0%	15.0%
Experimental Use of Alcohol	8.7%	8.0%	7.0%
Heavy Use of Alcohol	6.2%	5.0%	4.0%
Problem Drinking	6.8%	6.0%	5.0%
Binge Drinking	10.9%	10.0%	9.0%
Marijuana Misuse/Abuse (10th Grade)	**HYS 2016**	**Target 2019: from HYS 2016**	**Target 2023: from HYS 2016**
Used Marijuana in Last 30 Days	17.2%	15.0%	12.0%
Used Marijuana 6+ Days	7.8%	7.0%	6.0%
Young Adult Marijuana Use	**YAHS 2016**	**Target 2019: 5% decrease from YAHS 2016**	**Target 2023: 10% decrease from YAHS 2016**
Age 18-20 Past Year Use	41.0%	39.0%	36.9%
Age 21-25 Past Year Use	47.0%	44.7%	42.3%
All Ages Past Year Use	44.7%	42.5%	40.2%

Prescription Drug Misuse/Abuse (10th Grade)	**HYS 2016**	**Target 2019: 5% decrease from HYS 2016**	**Target 2023: 10% decrease from HYS 2016**
Misused Painkiller in Past 30 Days	4.4%	4.2%	4.0%
Tobacco Misuse/Abuse (10th Grade)	**HYS 2016**	**Target 2019: 5% decrease from HYS 2016**	**Target 2023: 10% decrease from HYS 2016**
All Tobacco 30 Day Use (excluding e-cigarettes)*	10.2%	9.7%	9.2%
E-Cigarettes and Vapor Products (10th Grade)	**HYS 2016**	**Target 2019: 5% decrease from HYS 2016**	**Target 2023: 10% decrease from HYS 2016**
Marijuana vaping (percentage of students who use marijuana who vape it)	5.1%	4.8%	4.6%
E-cigarettes and/or vape products	12.7%	12.1%	11.4%
Polysubstance Use (10th Grade)	**HYS 2016**	**Target 2019: 5% decrease from HYS 2016**	**Target 2023: 10% decrease from HYS 2016**
Current (Past 30 Day) Polysubstance Use	13.6%	12.9%	12.2%
Current Alcohol Users Also Use Marijuana	55.4%	52.6%	49.9%
Current Marijuana Users Also Use Alcohol	65.5%	62.2%	58.9%
Current Cigarette Users Also Use Marijuana	75.3%	71.5%	67.8%
Pregnant Woman Alcohol Misuse/Abuse	**PRAMS 2014**	**Target 2019: 5% decrease from PRAMS 2014**	**Target 2023: 10% decrease from PRAMS 2014**
Women Report Alcohol Use Any Time During Pregnancy	11.0%	10.5%	9.9%
Young Adult Alcohol Use	**YAHS 2015**	**Target 2019: 5% decrease from YAHS 2015**	**Target 2023: 10% decrease from YAHS 2015**
Age 18-20	52.8%	50.2%	47.5%
Age 21-25	79.7%	75.7%	71.7%
All ages	70.3%	66.8%	63.3%

Depression (10th Grade)	HYS 2016	Target 2019: 5% decrease from HYS 2016	Target 2023: 10% decrease from HYS 2016
Sad/Hopeless in Past 12 Months	34.5%	32.8%	31.1%
Suicide (10th Grade)	**HYS 2016**	**Target 2019: 5% decrease from HYS 2016**	**Target 2023: 10% decrease from HYS 2016**
Suicide Ideation	20.6%	19.6%	18.5%
Suicide Plan	17.0%	16.2%	15.3%
Suicide Attempt	10.1%	9.7%	9.2%

Table Note: * Includes cigarettes, chewing tobacco, snuff, or dip, and cigars, cigarillos, or little cigars

Short-term Outcomes: Intervening Variables	Source/Year Baseline		
Access		**Source/Year**	**Source/Year**
	10th Graders who got alcohol	**HYS 2010**	**HYS 2016**
	Bought it from a store	7%	7%
	Gave money to someone else to get it for them	18%	15%
	Got it from friends or at a party	55%	53%
	From home without permission	15%	22%
	From home with permission	14%	16%
	10th Graders who used "pain killers to get high"	**HYS 2010**	**HYS 2016**
	Reporting using own prescription	30%	30%
	Report getting it from a friend	29%	29%
	10th Graders who got marijuana	**HYS 2014**	**HYS 2016**
	Report getting it from a friend	61%	50%
	Report gave someone money	19%	25%
	10th Graders who used electronic vapor products	**NA**	**HYS 2016**
	Bummed from someone	NA	27%
	Paid someone	NA	16%
	Bought it from a store	NA	10%
	Young Adults who got marijuana	**YAHS 2015 (Cohort 2,Year1)**	**YAHS 2016 (Cohort 3,Year 1)**
	Report getting it from a friend (Age 18-20)	76%	70%
	Report getting it from a friend (Age 21-25)	55%	43%

Short-term Outcomes: Intervening Variables	Source/Year Baseline		
	Report getting it from a store (Age 21-25)	52%	73%
	State Licensing Of Liquor Licenses	**LCB 2010**	**LCB 2016**[11]
	Number of state licenses	14,425	17,626
	Rate per 1,000 persons	2.15 per 1,000	NA
	Synar Report 2015 – 2016 Comparison	**2015**	**2016**
		17%	11%
	State Licensing Of Marijuana Store Licenses	**NA**	**LCCB 2016**
	Retail & Producer/Processors	NA	1,415
Availability		**Source/Year**	**Source/Year**
	10th Graders	**HYS 2010**	**HYS 2016**
	Report "sort of" or "very easy" to get **alcohol**	56%	47%
	Report "sort of" or "very easy to get **marijuana**	54%	48%
	Report "sort of" or "very easy" to get **cigarettes**	53%	35%
	Opioid Access	**NA**	**PMP 2014**
	All Opioids	NA	231.8 per 1,000
Community Norms		**Source/Year**	**Source/Year**
	Alcohol - 10th Graders	**HYS 2010**	**HYS 2016**
	Report "adults in the community think it's wrong or very wrong"	76%	80%
	Report having seen "anti-alcohol" ad	70%	NA
	Report "parents talked about it"	55%	61%
	Marijuana – 10th Graders	**HYS 2010**	**HYS 2016**
	Report "parents think it's wrong" or "very wrong"	89%	90%
	Report "adults think it's wrong to use marijuana"	82%	81%
	Report "parents talked about not using marijuana	55%	62%
	Laws – 10th Graders	**HYS 2010**	**HYS 2016**
	Report laws and norms are favorable towards drug use	35%	28%
	Harassment due to health/disability – 10th Graders	**HYS 2010**	**HYS 2016**
	Report harassment due to health/disability	8%	NA
	Young Adult Marijuana Use (Age 18-25)	**NSDUH 2008/2009**	**NSDUH 2013-2014**
	Report marijuana use in past 30 days	17%	24%

Enforcement		HYS 2010	HYS 2016
	Think police would catch a kid drinking (response of ”yes” or “YES!”	26%	28%
	Think police would catch a kid smoking marijuana (response of ”yes” or “YES!”	31%	32%
Perception of Harm		**Source/Year**	**Source/Year**
	10th Graders	**HYS 2010**	**HYS 2016**
	Drinking once or twice a day has no risk or slight risk		23%
	Regular marijuana use has no risk or slight risk	27%	33%
Policies		**Source/Year**	**Source/Year**
	School policies – 10th Graders	**HYS 2010**	**HYS 2016**
	Think school policies about alcohol and drugs are usually enforced (response of “definitely yes”	34%	NA
	Think “no smoking policies” at school are usually enforced (response of “definitely yes”	25%	NA
Traumatic Experiences		**Source/Year**	**Source/Year**
	ACE: Family Alcohol Use - For those that live with anyone who has a problem drinking/alcoholic	**BRFSS 2010**	**DATA NO LONGER AVAILABLE**
	Report binge drinking	20%	
	Report smoking cigarettes	25%	
	ACE: Family Drug Use - For those that live with anyone who used illegal street drugs or who abused prescription medications	**BRFSS 2010**	**DATA NO LONGER AVAILABLE**
	Report binge drinking	28%	
	Report smoking cigarettes	33%	
	Report using marijuana	18%	
	Report using pain killers	2%	
	ACE: Family Mental Illness – For those that live with anyone who was depressed, mentally ill, or suicidal	**BRFSS 2010**	**DATA NO LONGER AVAILABLE**
	Report binge drinking	20%	
	Report smoking cigarettes	22%	
	Report using marijuana	12%	
	ACE: Incarcerated Household Member – For those that live with anyone who served time or was	**BRFSS 2010**	**DATA NO LONGER AVAILABLE**

	sentenced to serve time in prison, jail, or other correctional facility		
	Binge drinking	25%	
	Cigarettes	38%	
	Marijuana	21%	
	Pain killer	3%	

The Consortium will continue to review these indicators regularly and update and revise as necessary to have the best measures in place. We will also monitor related indicators such as health care costs, individual productivity, and employment outcomes; however, they are not included in the preceding tables due to the expected upcoming variance based on significant changes to overall health care systems. For young adults, we continue to enhance our efforts to collect data from those individuals who do not attend college. Other efforts to enhance evaluation and data gathering efforts is to identity additional measure for both pregnant women and substance use during and post pregnancy and data measures to measure mental health in addition to what is currently being measured.

The State Epidemiological Outcomes Workgroup (SEOW) will continue to conduct surveillance on relevant outcome indicators and advise the Consortium of significant changes. At least, every two years, the Consortium will review outcomes in accordance with the release of the Healthy Youth Survey.

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

CHAPTER THREE: APPENDIX

1. List of Acronyms and Abbreviations

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

2. SPE Consortium Partner List

Partner Agency/Organization	Policy Consortium Representative
American Indian Health Commission (AIHC)	Jan Olmstead, Public Health Policy and Project Consultant
Commission on Asian Pacific American Affairs (CAPAA)	Michael Itti, Executive Director
College Coalition for Substance Abuse Prevention (CCSAP)	Jason Kilmer, Research Assistant Professor and Asst. Director of Health/ Wellness, University of Washington
Department of Early Learning (DEL)	Veronica Santangelo, Medicaid Treatment Child Care Administrator
Department of Health (DOH), Division of Prevention and Community Wellness	***Consortium Co-chair*** David Hudson, Section Manager, Office of Healthy and Safe Communities Cristal Connelly, Marijuana Prevention Education Coordinator Frances Limtiaco, Tobacco Prevention Program Manager and Health Equity Consultant Tory Henderson, Adverse Childhood Experiences (ACEs) Consultant Gary Garrety, Health Services Consultant, Prescription Drug Monitoring Program
Department of Social and Health Services (DSHS), Division of Behavioral Health & Recovery (DBHR)	***Consortium Co-chair*** Sarah Mariani, Behavioral Health Administrator Billy Reamer, Prevention System Integration Manager Gabby Richard, Prevention System Manager Seth Greenfest, Prevention System Project Manager
Department of Social and Health Services (DSHS), Frontiers of Innovation (FIO)	Anne Stone, State Director
Department of Social and Health Services (DSHS), Office of Indian Policy (OIP)	Tim Collins, Director
Department of Social and Health Services (DSHS), Office of Juvenile Justice (OJJ)	Currently Vacant
Health Care Authority (HCA)	Misty Wood, Program Specialist for CQCT/Managed CARE
Indian Policy Advisory Committee (IPAC)	Currently Vacant
Liquor and Cannabis Board (LCB)	Mary Segawa, Public Health Education Liaison
Office of Superintendent of Public Instruction (OSPI)	Krissy Johnson, Program Supervisor, Student Assistance / Dropout Prevention Mandy Paradise, Project AWARE Program Supervisor
Office of the Attorney General (AGO)	Kelly Richburg, Senior Policy Analyst
Prevention Specialist Certification Board of Washington (PSCBW)	Liz Wilhelm, Education and Ethics Committee Chair Gunthild Sondhi, President
State Board of Health (SBOH)	Michelle Davis, Executive Director
State Epidemiological Outcome Workgroup (SEOW)	Can Du, SEOW Co-chair; Office Chief of the Decision of Evaluation and Support, DBHR
Washington Association for Substance Abuse and Violence Prevention (WASAVP)	Derek Franklin, President
Washington Healthy Youth Coalition (WHY)	Julee Christianson, Prevention System Project Manager, DBHR
Washington Poison Center	Arti Patel, Health Education and Outreach Specialist
Washington State Commission on Hispanic Affairs (CHA)	Currently Vacant
Washington Association of Prevention Coalitions (WAPCo)	Liz Wilhelm, Chair
Washington State Institute for Public Policy (WSIPP)	Adam Darnell, Senior Research Associate
Washington State Patrol (WSP)	Vacant
Washington State Prevention Research Sub-Committee	Elizabeth Weybright, Associate Professor Dept. of Human Development
Washington Traffic Safety Commission (WTSC)	Dick Doane, Research Investigator

3. Washington State Key Data Sources

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

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

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

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

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

- Healthy Youth Survey (HYS)/AskHYS.net - The information from the HYS can be used to identify trends in the patterns of behavior over time. In October 2002, 2004, 2006, 2008, 2010, 2014, 2016 students in grades 6, 8, 10, and 12 answered questions about safety and violence; physical activity and diet; alcohol, tobacco, and other drug use; and related risk and protective factors. http://www.askhys.net/

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

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

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

- Substance Abuse Prevention and Mental Health Promotion Online Data Reporting System (Minerva) - A web-based Management Information System, collects administrative and outcome data on all DBHR's Substance Abuse Block Grant funded substance abuse and mental health promotion community services.

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

- RMC Research's Student Assistance Prevention and Intervention Services Program (SAPISP) Database – This automated web-based reporting system is used to monitor service provision

and student outcomes throughout the school year of participants in the local Student Assistance Prevention and Intervention Services Programs.

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

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

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

4. Data Assessment

The following is a compilation of the Data Assessment presentations provided at the March and April 2017 Consortium meetings *and available online at: www.TheAthenaForum.org/SPE*.

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

Baseline Ranking 2011

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

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

New Plan Ranking 2017

Prevalence Rank	Alcohol	Tobacco[2]	Marijuana	Meth	Prescription Pain Relievers
Youth	1st	3rd	2nd	5th	4th
Adults	1st	2nd	3rd	-	4th
Change over time[1]	**Alcohol**	**Tobacco[2]**	**Marijuana**	**Meth**	**Prescription Pain Relievers**
Youth	Decrease	Decrease	Flat	Flat	Decrease
Adults	Flat	Decrease for 18-25; Flat for 26+	Flat for 18-25 flat; Increase for 26+	-	Decrease for 18-25; Flat for 26+

1. The change over time is the difference between 2010-2011 and 2013-2014 for adults (NSDUH) and between 2010 and 2016 for youth (HYS).
2. Tobacco indicator used for youth is cigarettes for youth and tobacco products for adults.

Economic Impact

Total cost of excessive alcohol consumption in Washington State, 2010: $5.8 billion (this includes lost productivity, health care, criminal justice, and a variety of other types of costs).[15]

ROI for Alcohol Prevention: Strategies like SBIRT typically take place in a clinical setting after alcohol use has caused harm. An evidence-based strategy for reducing alcohol use and associated harms of excessive use is to increase the price of alcohol. For every 10% increase in the price of alcohol, alcohol consumption should fall by 7.7%. Levying a tax on alcohol to increase the price doesn't technically cost anything, so you can't really talk about it in terms of ROI.[16]

Tobacco Annual health care costs: $2.8 billion (lost productivity would be another $2.2 billion). [17]

[15] Source: Sacks JJ, Gonzales KR, Bouchery EE, Tomedi LE, Brewer RD. 2010 National and State Costs of Excessive Alcohol Consumption. Am J Prev Med. 2015 Nov;49(5):e73-9. doi: 10.1016/j.amepre.2015.05.031. Epub 2015 Oct 1. PubMed PMID: 26477807.

[16] Source: https://www.thecommunityguide.org/content/increased-alcohol-taxes-can-prevent-excessive-alcohol-use-and-other-harms

[17] Source: Centers for Disease Control and Prevention. (2014). Best practices for comprehensive tobacco control programs—2014. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. See also - https://www.tobaccofreekids.org/facts_issues/toll_us/washington

ROI for modestly funded comprehensive state tobacco control program: $5 saved in hospitalization costs for tobacco-attributable disease for every $1 spent.[18]

State agency partners utilize the work of the Washington State Institute for Public Policy cost benefit analysis for planning and program implementation. The WSIPP mission is conduct non-partisan research as requested by the WA State Legislature. WSIPP regularly researches and reports cost - benefit analysis of programs that have positive outcomes with the prevention and reduction of youth marijuana use that is used in practice with our state agency partners.[19]

[18]Source: Dilley JA, Harris JR, Boysun MJ, Reid TR. Program, policy, and price interventions for tobacco control: quantifying the return on investment of a state tobacco control program. Am J Public Health. 2012 Feb;102(2):e22-8. doi: 10.2105/AJPH.2011.300506. Epub 2011 Dec 15. PubMed PMID: 22390458; PubMed Central PMCID: PMC3484005.

[19] Washington State Institute for Public Policy. http://www.wsipp.wa.gov/Reports. Accessed October, 2017

Intermediate Outcomes Summary Data 2017

Intermediate Outcomes: Behavioral Health Problem	Source/Year 2011 Plan Baseline	2013 Plan Update	2015 Plan Update	2017 Plan Update
Underage Drinking 10th Grade	**HYS 2010**	**HYS 2012**	**HYS 2014**	**HYS 2016**
Drank Alcohol in Last 30 Days	27.7%	23.3%	21.0%	20.4% ↓
Experimental Use of Alcohol	10.9%	8.5%	9.2%	8.7% ↓
Heavy Use of Alcohol	8.2%	7.1%	5.8%	6.2% ↑
Problem Drinking	10.4%	9.4%	6.9%	6.8% ↑
Binge Drinking	16.2%	14.3%	10.6%	10.9% ↑
Marijuana Misuse/Abuse 10th Grade	**HYS 2010**	**HYS 2012**	**HYS 2014**	**HYS 2016**
Used Marijuana in Last 30 Days	20.0%	19.3%	18.1%	17.2% ↓
Used Marijuana 6+ Days	8.4%	8.6%	7.9%	7.8% ↓
Young Adult Marijuana Use		**YAHS 2014**	**YAHS 2015**	**YAHS 2016**
Used Marijuana in the Past 30 Days, By Age Group		18-20: 27.3% 21-25: 26.4% All Ages: 26.7%	18-20: 30.1% 21-25: 31.0% All Ages: 30.7%	18-20: 25.1% ↓ 21-25: 30.0% ↓ All Ages: 28.4% ↓
Prescription Misuse/Abuse 10th Grade	**HYS 2010**	**HYS 2012**	**HYS 2014**	**HYS 2016**
Misused Painkillers in Last 30 Days	8.3%	6.0%	4.6%	4.4% ↓
Tobacco Misuse/Abuse 10th Grade	**HYS 2010**	**HYS 2012**	**HYS 2014**	**HYS 2016**
Current (Past 30 day) Tobacco Use (All Tobacco, excluding vape)*	N/A	15.9%	15.2%	10.2% ↓
Smoked Cigarettes in Last 30 Days	12.7%	9.5%	7.9%	6.3% ↓
E-Cigarettes/Vapor Products Misuse/Abuse 10th Grade	**HYS 2010**	**HYS 2012**	**HYS 2014**	**HYS 2016**
E-cigarettes/Vapor Pens	N/A	3.9%	18.0%	12.7% ↓
Marijuana vaping (percentage of students who use marijuana who usually vape it)	N/A	N/A	5.4%	5.1% ↓

Polysubstance Misuse/Abuse 10th Grade	**HYS 2010**	**HYS 2012**	**HYS 2014**	**HYS 2016**
Current (Past 30 day) Polysubstance Use	18.9%	16.9%	14.7%	13.6% ↓
Current Alcohol Users Also Use Marijuana	52.7%	57.6%	56.6%	55.4% ↓
Current Marijuana Users Also Use Alcohol	72.8%	69.5%	64.3%	65.5% ↑
Current Cigarette Users Also Use Marijuana	73.9%	74.5%	70.7%	75.3% ↑
Pregnant Women Misuse/Abuse	**PRAMS 2010**	**PRAMS 2012**	**PRAMS 2014**	**PRAMS 2016**
Pregnant Women Report Alcohol Use Any Time During Pregnancy	8.0%	12.0%	11.0%	Not Available
Young Adult Alcohol 30 Day Use		**YAHS 2014**	**YAHS 2015**	**YAHS 2016**
Alcohol Use, by Age Group		18-20: 50.3% 21-25: 77.9% All ages: 67.1%	18-20: 52.8% 21-25: 79.7% All ages: 70.3%	18-20: 47.8% ↑ 21-25: 76.5% ↓ All ages: 67.3% ↓
Depression (10th Grade)	**HYS 2010**	**HYS 2012**	**HYS 2014**	**HYS 2016**
Sad/Hopeless in Past 12 Months	29.8%	30.9%	34.9%	34.5% ↓
Suicide (10th Grade)	**HYS 2010**	**HYS 2012**	**HYS 2014**	**HYS 2016**
Suicide Ideation	17.6%	18.8%	20.5%	20.6% ↑
Suicide Plan	12.4%	14.3%	16.4%	17.0% ↑
Suicide Attempt	7.2%	7.8%	10.2%	10.1% ↑
Bullied/Harassed/Intimidated (10th Grade)	**HYS 2010**	**HYS 2012**	**HYS 2014**	**HYS 2016**
Bullied in the past 30 days	24.3%	17.0%	22.6%	20.7% ↑

Table Note: * Includes cigarettes, chewing tobacco, snuff, or dip, and cigars, cigarillos, or little cigars.
Table Note 2: Green and red arrows indicate increases and decreases in data from the previous year data set.

Health Disparities Data

Substance Use/Misuse/Abuse Depression and Suicide by Race, Ethnicity, and Gender HYS 2016	State Rate	AI/AN	Asian	Black	Hispanic	Multi-Race	Native Hawaiian or Other Pacific Islander	Other	White	Female	Male
Alcohol 30 Day Use	20.0%	**25.0%**	10.0%	18.0%	23.0%	19.0%	22.0%	19.0%	20.0%		
Marijuana 30 Day Use	17.0%	**26.0%**	7.0%	**21.0%**	**20.0%**	18.0%	21.0%	17.0%	15.0%		
E-Cigs 30 Day Use	12.7%	**21.3%**	5.1%	12.9%	12.4%	12.6%	15.8%	13.6%	12.7%	11.8%	13.6%
Pain Killer 30 Day Use	4.0%	**7.5%**	2.0%	**7.0%**	5.0%	4.0%	**6.0%**	6.0%	4.0%		
Tobacco 30 Day Use (2012-2014 State Tobacco Facts)		**36.6%**	9.7%	**16.7%**	13.5%	**25.4%**	**24.4%**	20.9%	16.6%		
Rx Misuse 30 Day Use	7.6%	9.1%	4.5%	**10.9%**	9.1%	7.9%	9.9%	9.4%	6.6%		
Sad/Hopeless in Past 12 Months	35.0%	**42.0%**	29.0%	32.0%	**37.0%**	**41.0%**	38.0%	**40.0%**	33.0%	**44.0%**	24.0%
Suicide Ideation	21.0%	**27.0%**	17.0%	20.0%	19.0%	**27.0%**	22.0%	**23.0%**	20.0%	**26.0%**	14.0%
Suicide Plan	10.0%	21.0%	15.0%	15.0%	16.0%	**22.0%**	17.0%	19.0%	16.0%	22.0%	12.0%
Suicide Attempt	10.0%	**17.0%**	8.0%	11.0%	11.0%	12.0%	13.0%	12.0%	9.0%	13.0%	7.0%
Bullied/Harassed/Intimidated Because of Real or Perceived Race/Ethnicity/National Origin	11.7%	**15.5%**	16.0%	**20.0%**	14.0%	9.1%	16.0%	19.3%	7.0%	22.0%	

Table Note: Highlighted data indicates health disparities.

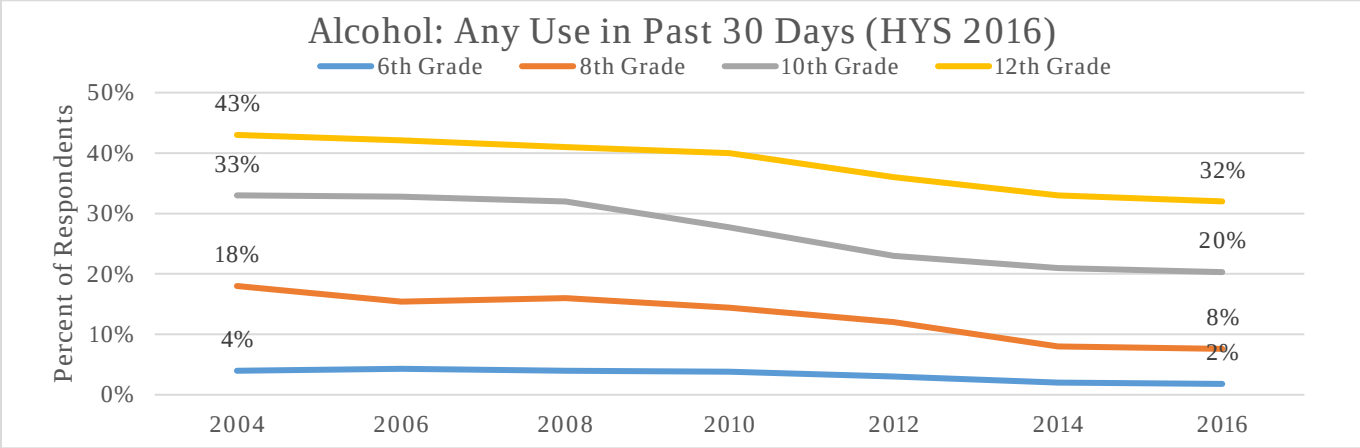
Following charts are the main data that were considered as part of our assessment:

Health Youth Survey (HYS): Figures HYS 1-21

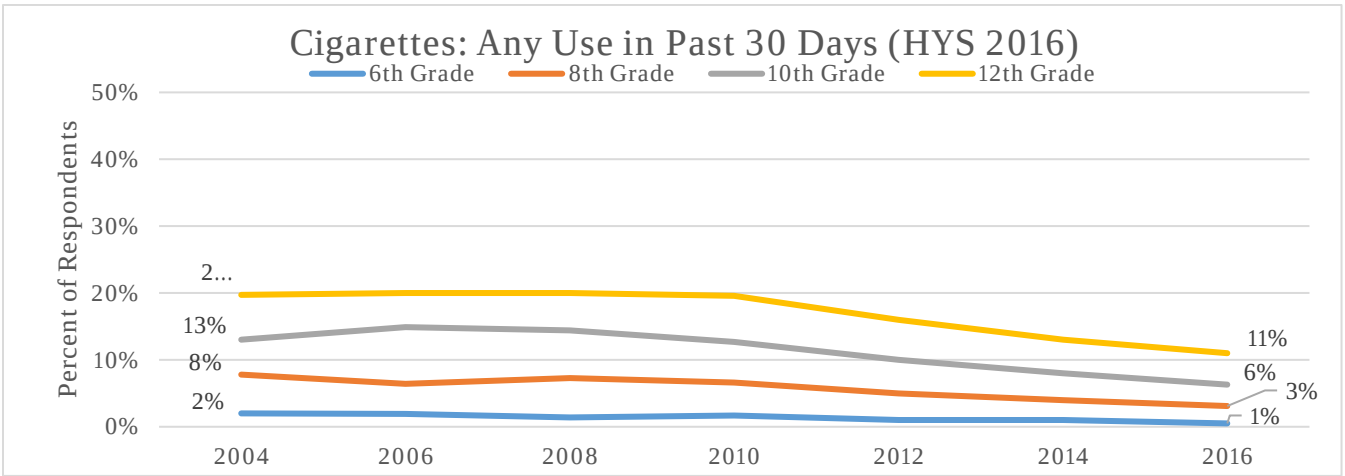
Notes:

- Statewide school survey conducted biannually.
- Collects data on health risk behaviors that contribute to morbidity, mortality, and social problems among youth.
- Respondents: students in the 6th, 8th, 10th, and 12th grades.
- Sample size (2010): 211,331 students from 1,145 schools.
- Sample size (2016): More than 230,000 students.
  - Schools: 1,000 public schools
  - State Sample: 38,000 students
  - State Sample 10th Grade: 11,000 students
- Beginning in 2014, a pilot project included 7th, 9th, and 11th graders.
- Participants: 230,00 students

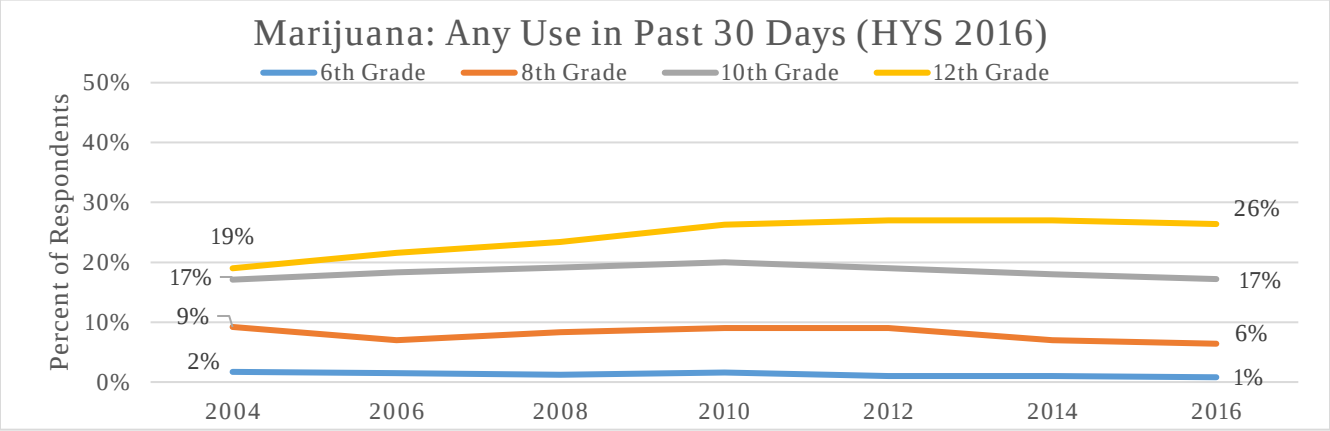
HYS - FIGURE 1



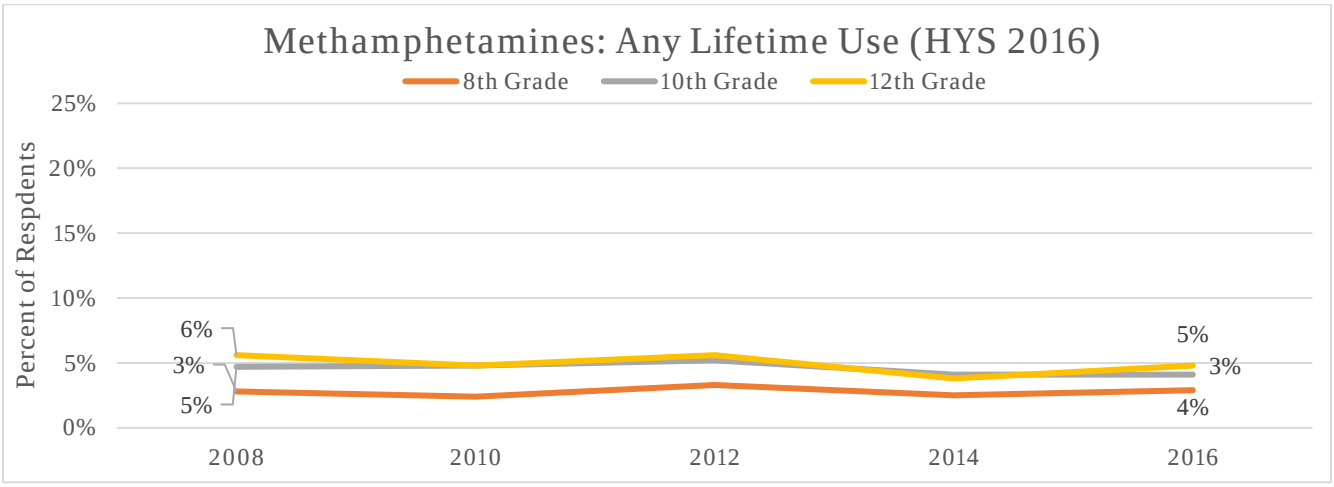
HYS - FIGURE 2



HYS - FIGURE 3

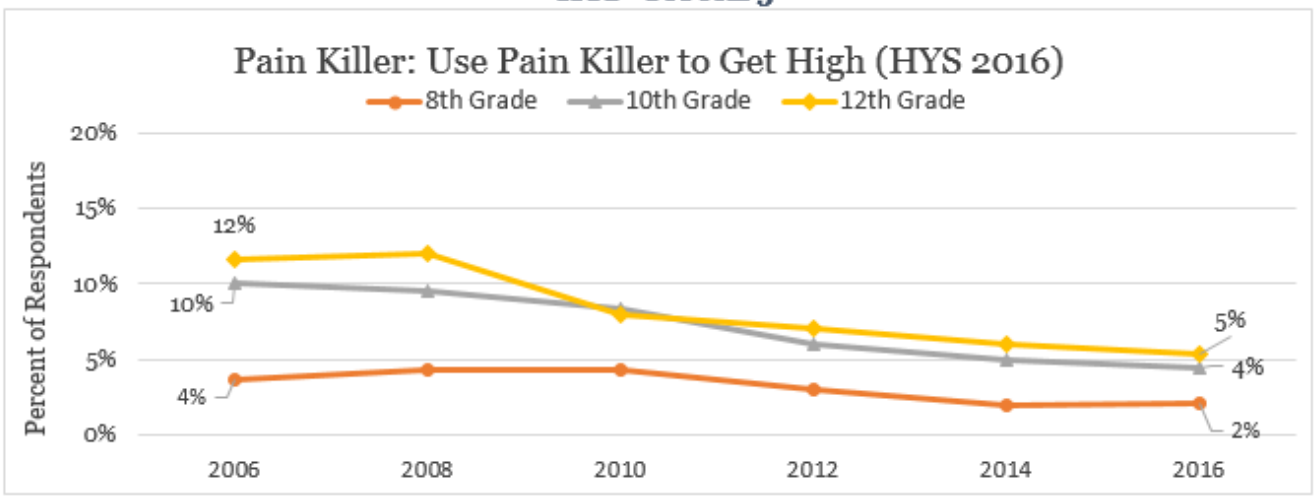


HYS - FIGURE 4

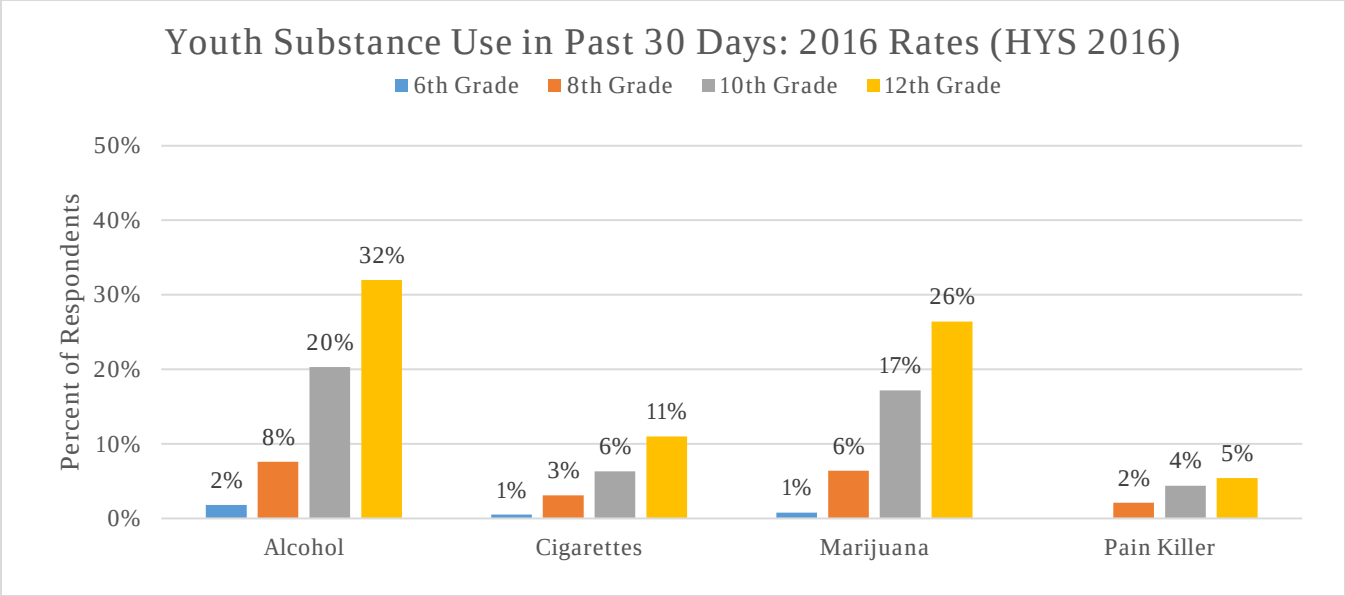


Note: Question not asked in 2004 and 2006. Question not asked of 6th graders.

HYS - FIGURE 5

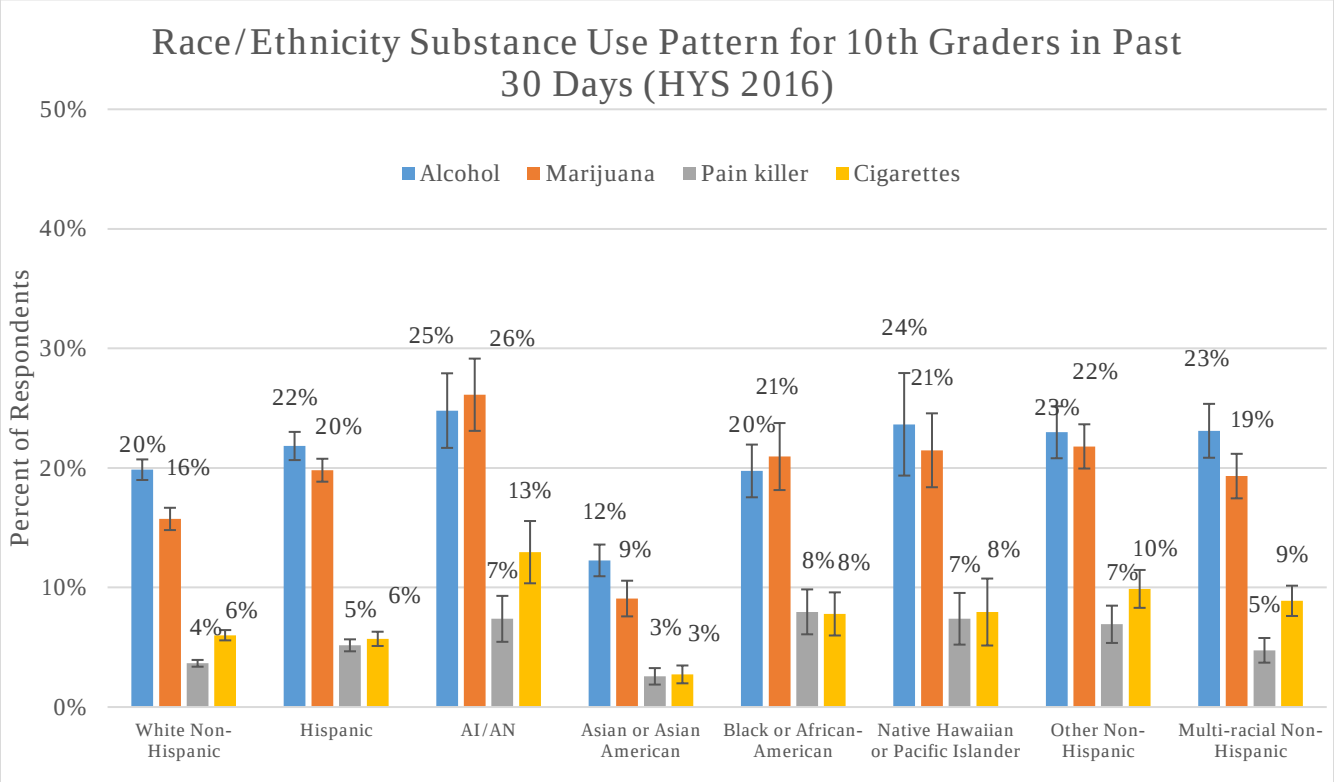


Note: Question not asked in 2004. Question not asked of 6th Graders.

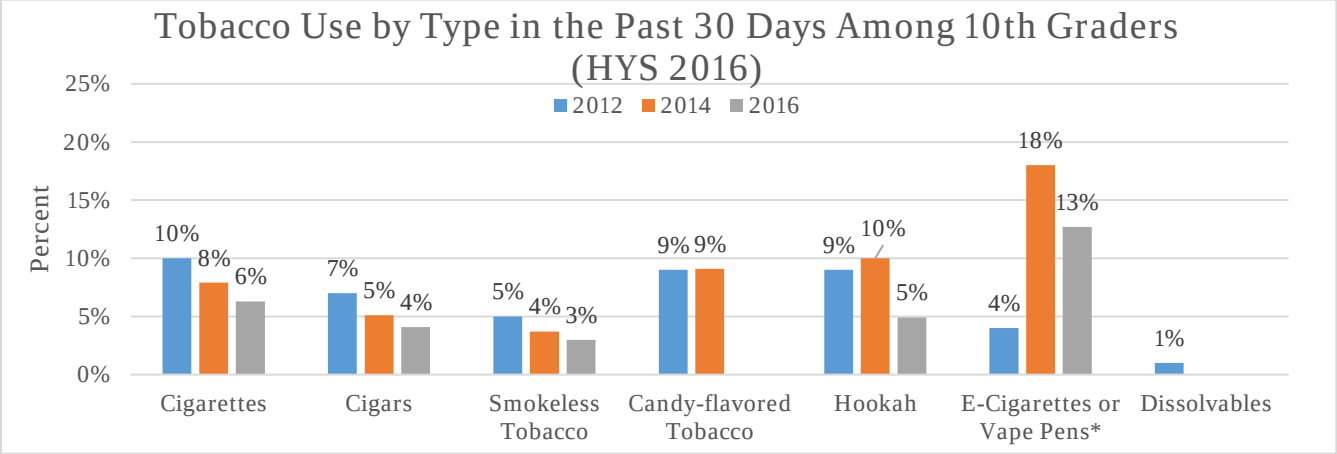


Note: Question on Pain Killer Use not asked of 6th graders.

HYS - FIGURE 6

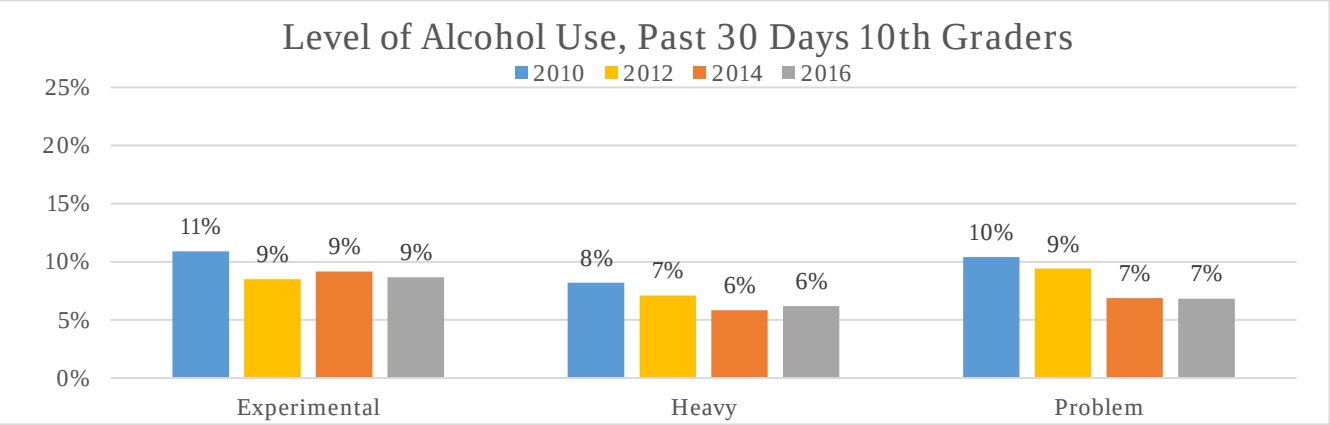


HYS - FIGURE 7



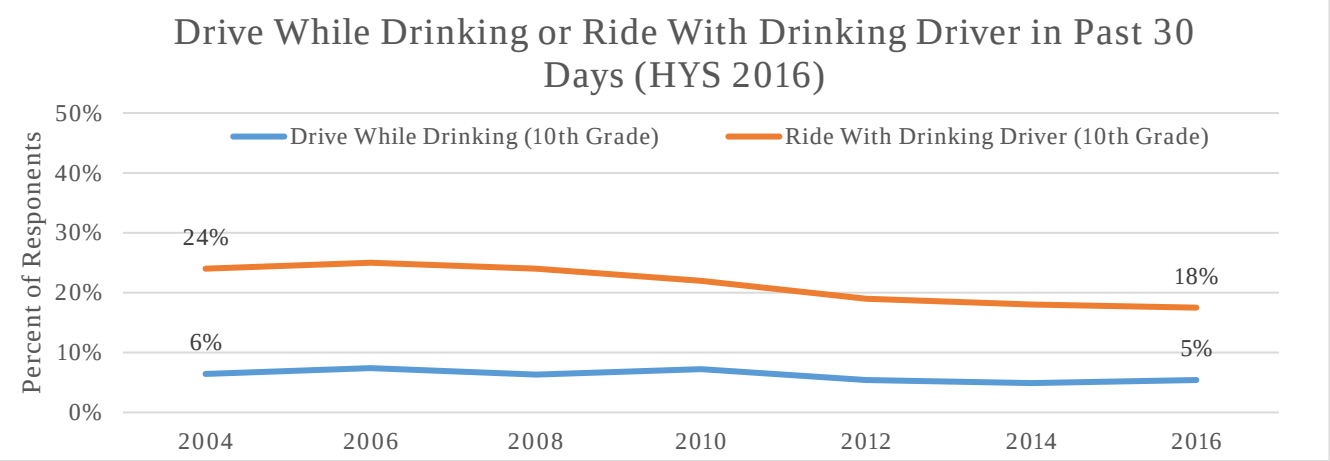
Note: E-Cigarettes and Vape Pens combined into one question in 2014. Question on dissolvables discontinued in 2014 and on candy-flavored tobacco discontinued in 2016.

HYS - FIGURE 8

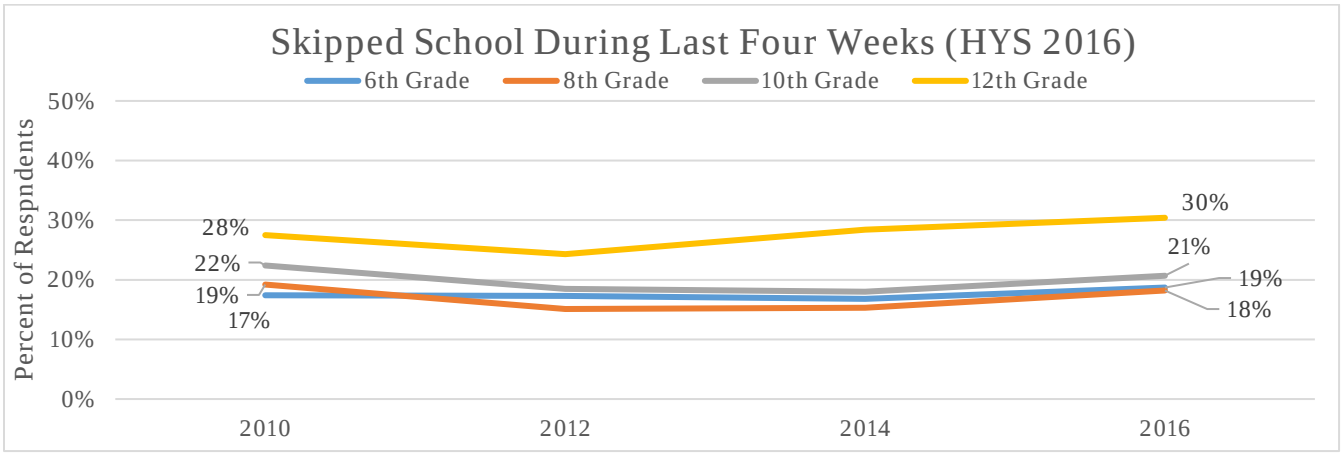


Note: Among 10th graders who drank alcohol in the past 30 days, nearly 1 in 3 are problem drinkers

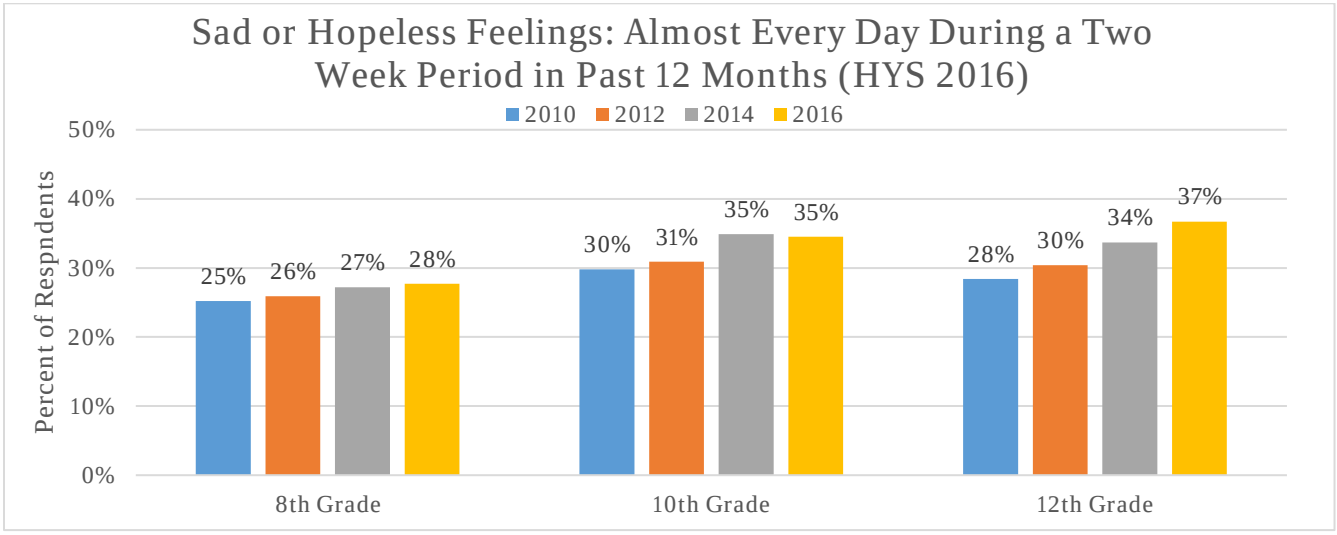
HYS - FIGURE 9



HYS - FIGURE 10

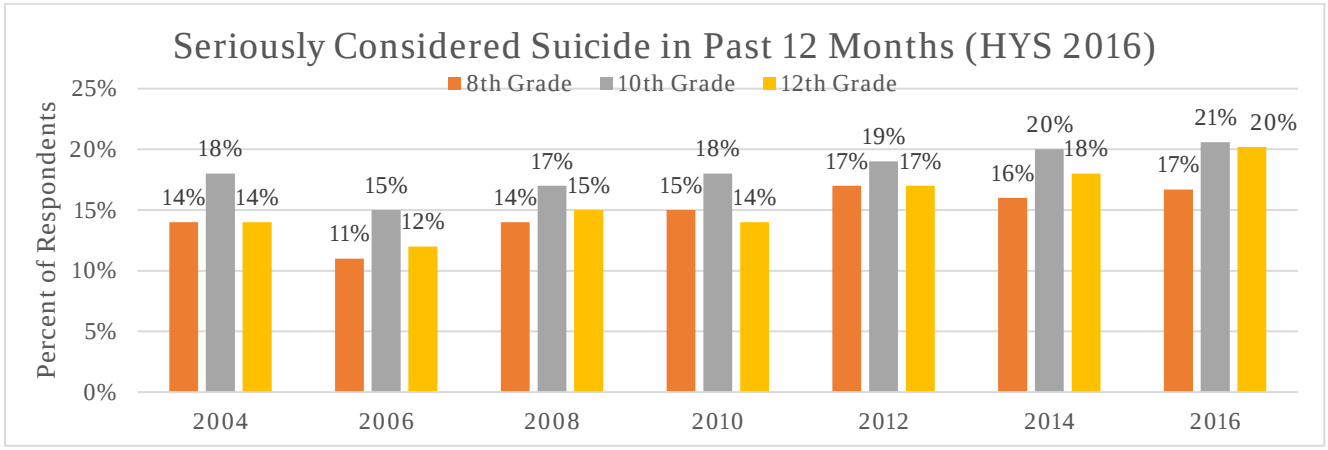


HYS - FIGURE 11



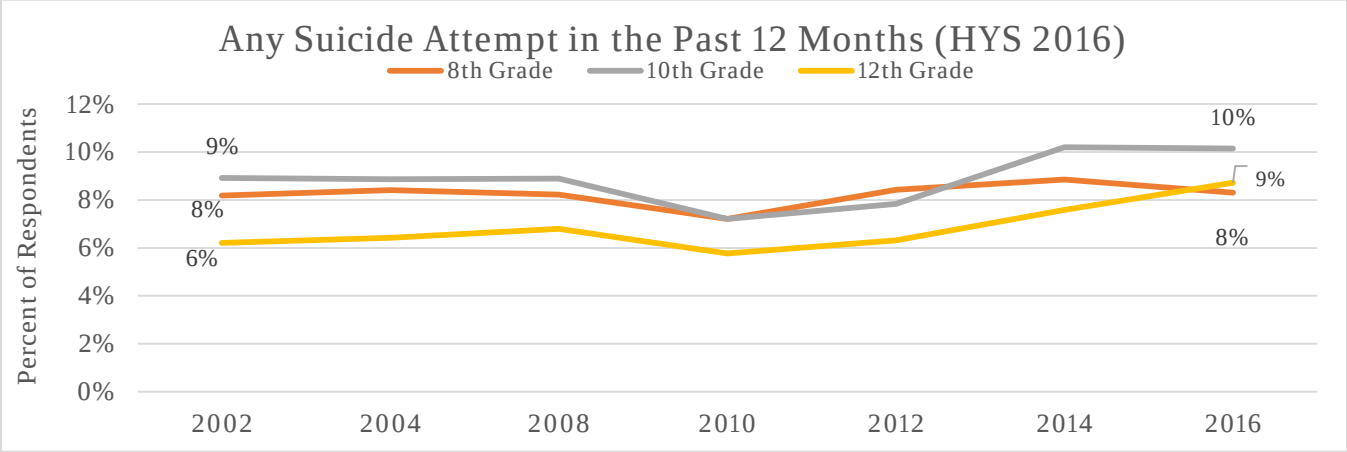
Note: Question not asked of 6th Graders.

HYS - FIGURE 12

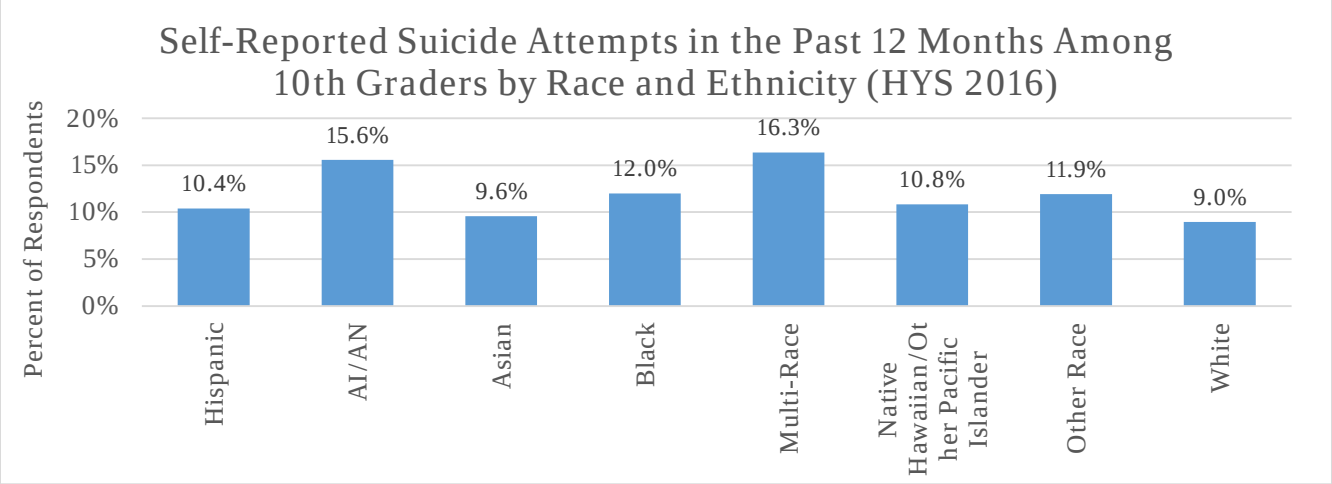


Note: Question not asked of 6th Graders.

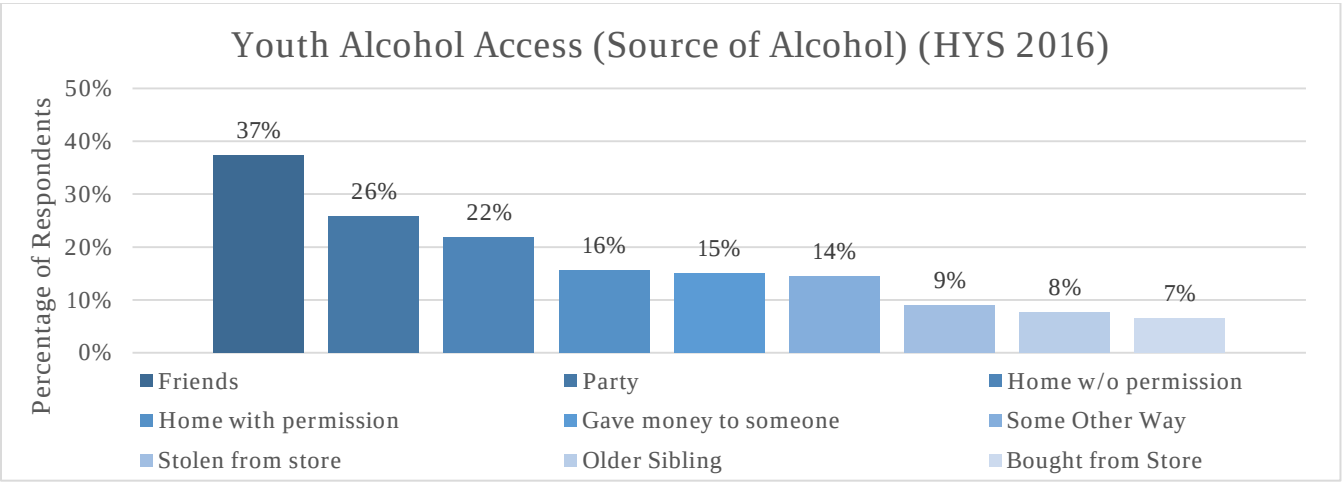
HYS - FIGURE 13



HYS - FIGURE 14

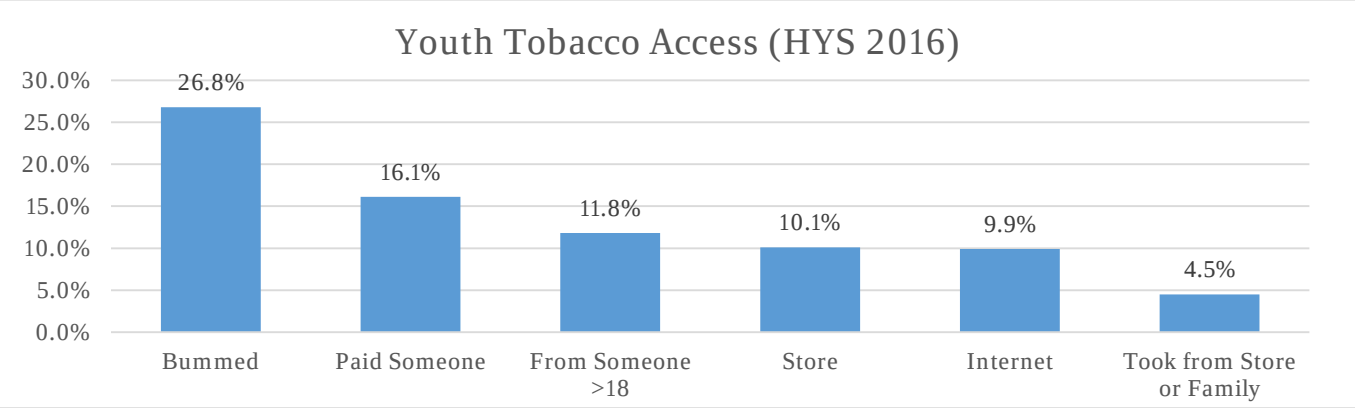


HYS - FIGURE 15



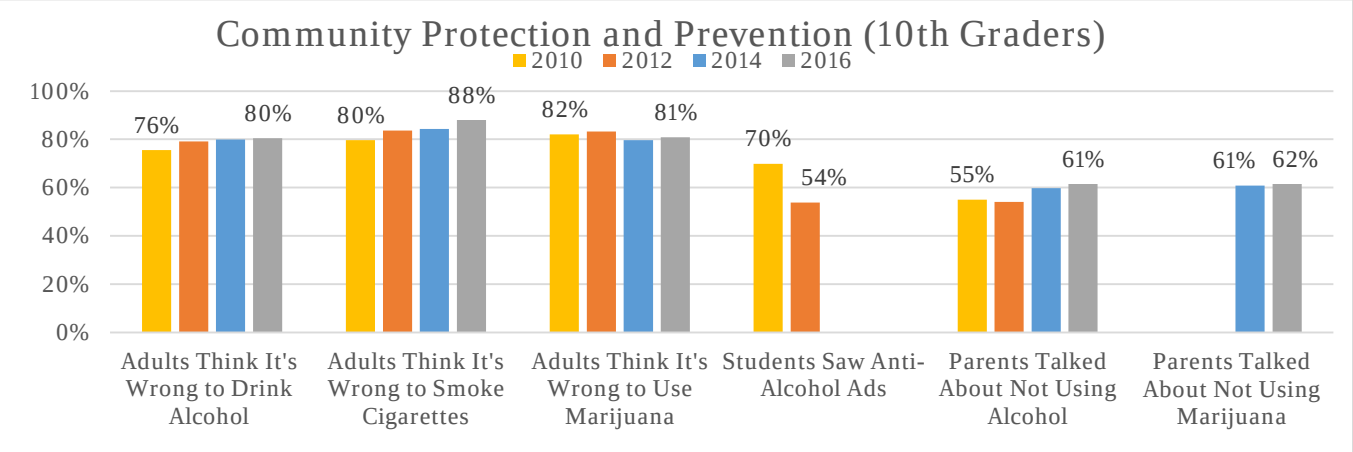
Note: (Percent of 10th graders who reported getting alcohol during the past 30 days)

HYS - FIGURE 16

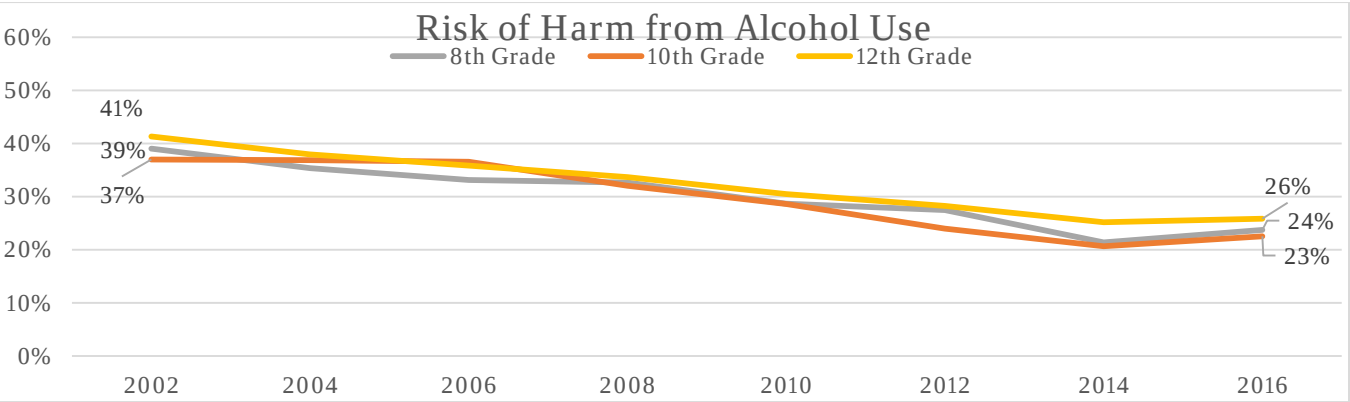


Note: (Percent of 10th graders who reported getting tobacco during the past 30 days)

HYS - FIGURE 17

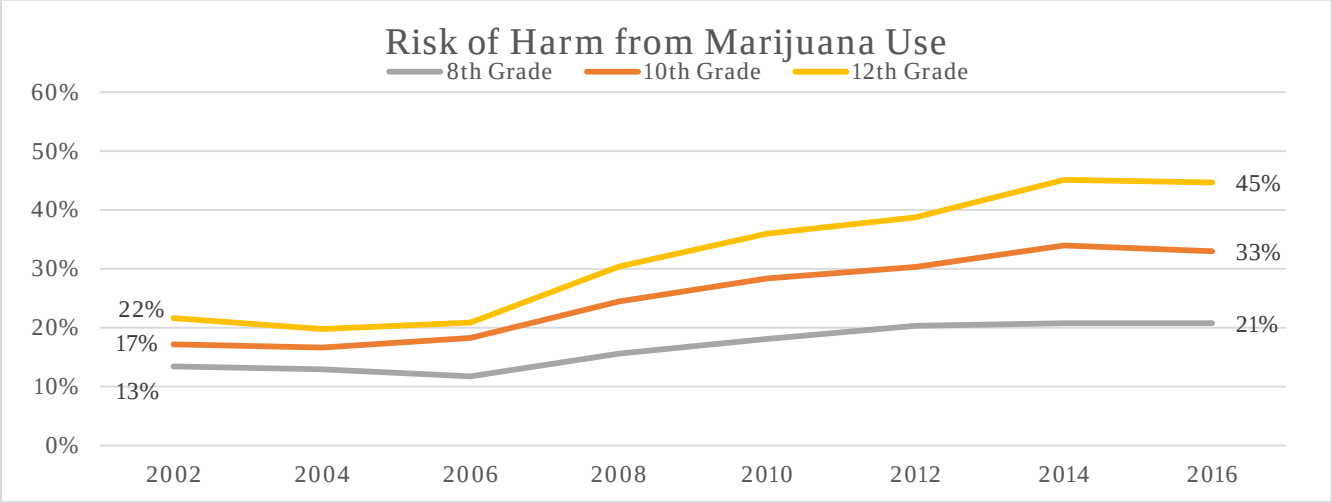


HYS - FIGURE 18

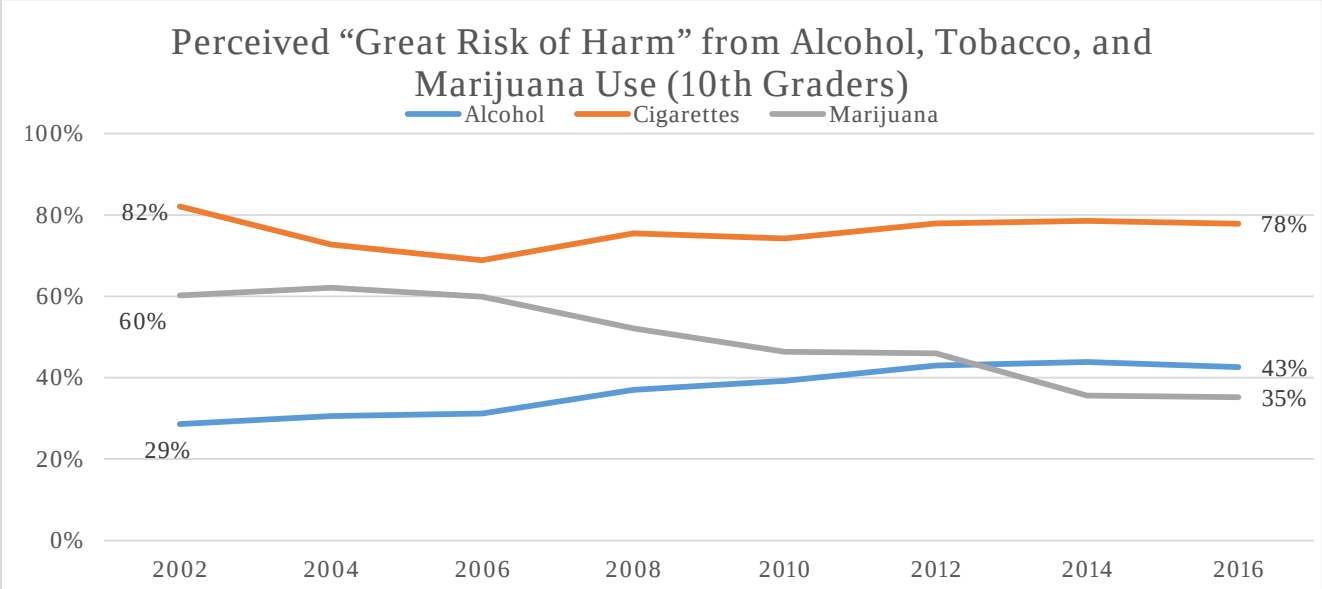


Note: Example Question - "How much do you think people risk harming themselves if they---Smoke marijuana regularly (at least once or twice a week

HYS - FIGURE 19



HYS - FIGURE 20



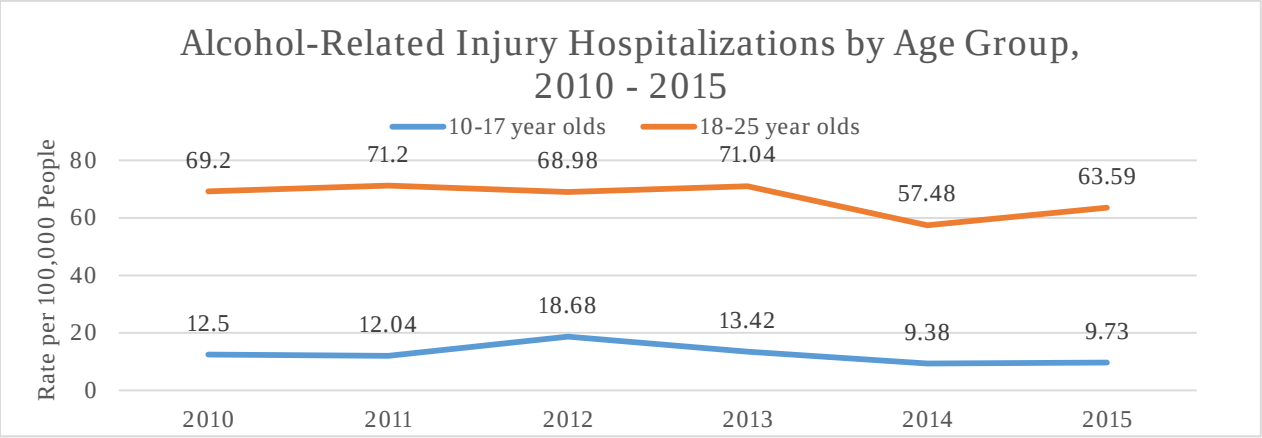
Community Outcomes and Risk Evaluation (CORE) **Figures 1-11**

The Community Outcomes and Risk Evaluation Information System (CORE), was developed as a set of archival indicators (or social indicators) that are highly correlated with adolescent substance use, and the risk factors that predict substance use. Currently there are roughly 50 indicators maintained in the dataset at their lowest possible level of geography, down to address or latitude/longitude in some cases (other indicators are only available at a county level). The standard reports 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).

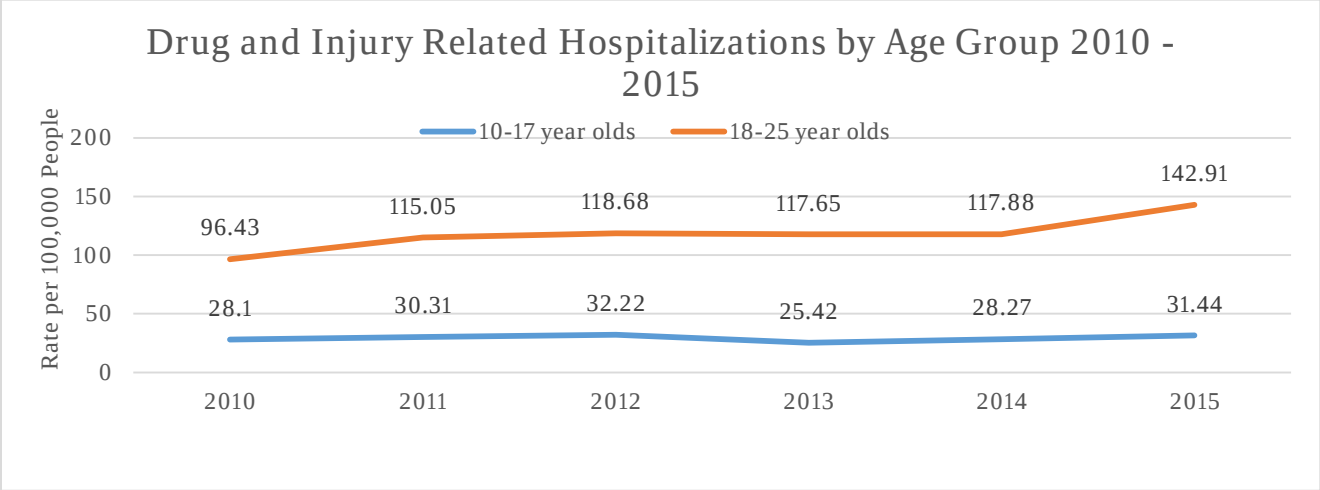
Data within CORE includes:

- Comprehensive Hospital Abstract Reporting System (CHARS) provides non-fatal injury data.
- The Department of Health receives tobacco retailer data from the Department of Licensing (DOL). Licensing maintains the Master License Service to track licenses issued by Washington State.
- The UCR Program collects statistics on violent crime (murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault) and property crime (burglary, larceny-theft, and motor vehicle theft).
- The National Incident-Based Reporting System (NIBRS) presents quantitative and qualitative data that describes each incident and arrest.
- The Department of Health collects information on deaths in Washington State from death certificates.
- Washington Association of Sheriffs and Police Chiefs (WASPC) receives UCR/NIBRS data from local law enforcement agencies for domestic violence related offences, then forwards the data to the FBI. Washington Association of Sheriffs and Police Chiefs (WASPC) data are part of NIBRS.

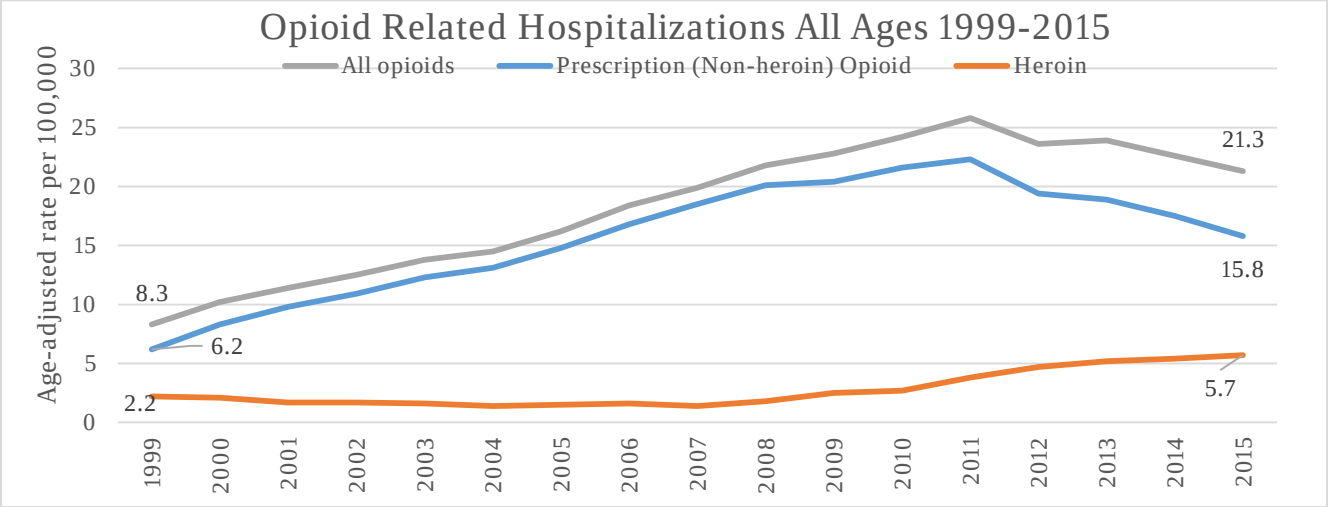
CORE FIGURE 1



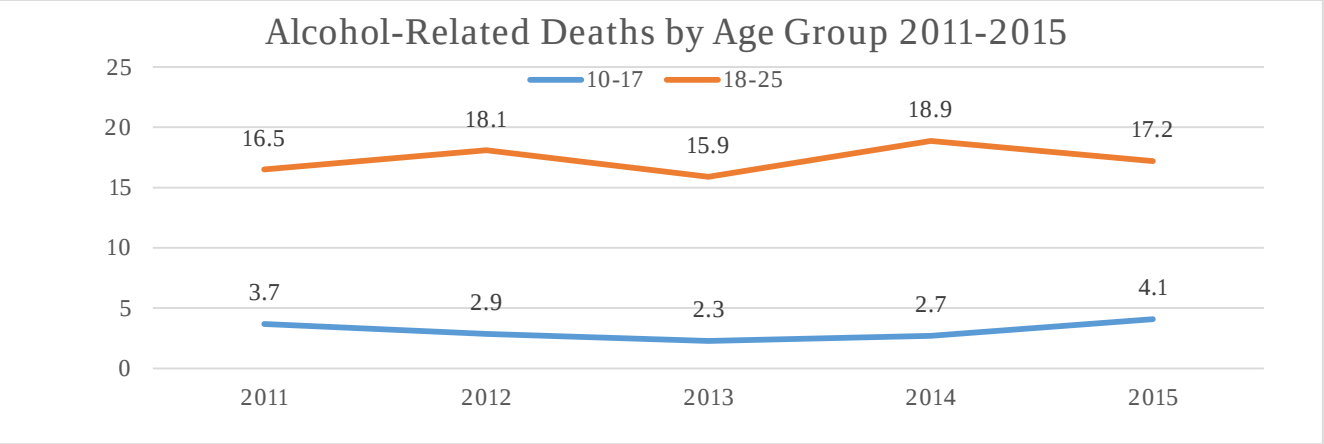
CORE FIGURE 2



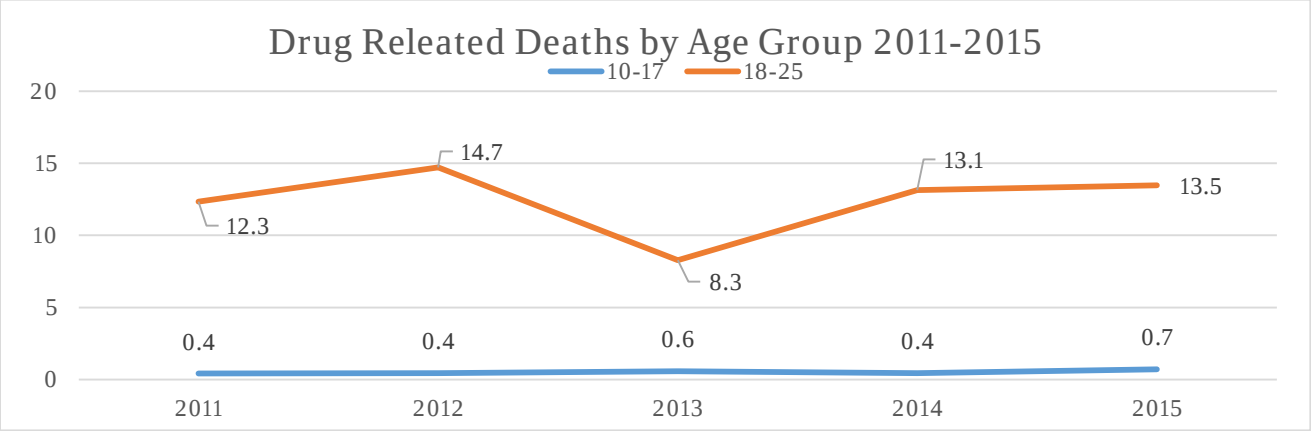
CORE FIGURE 3



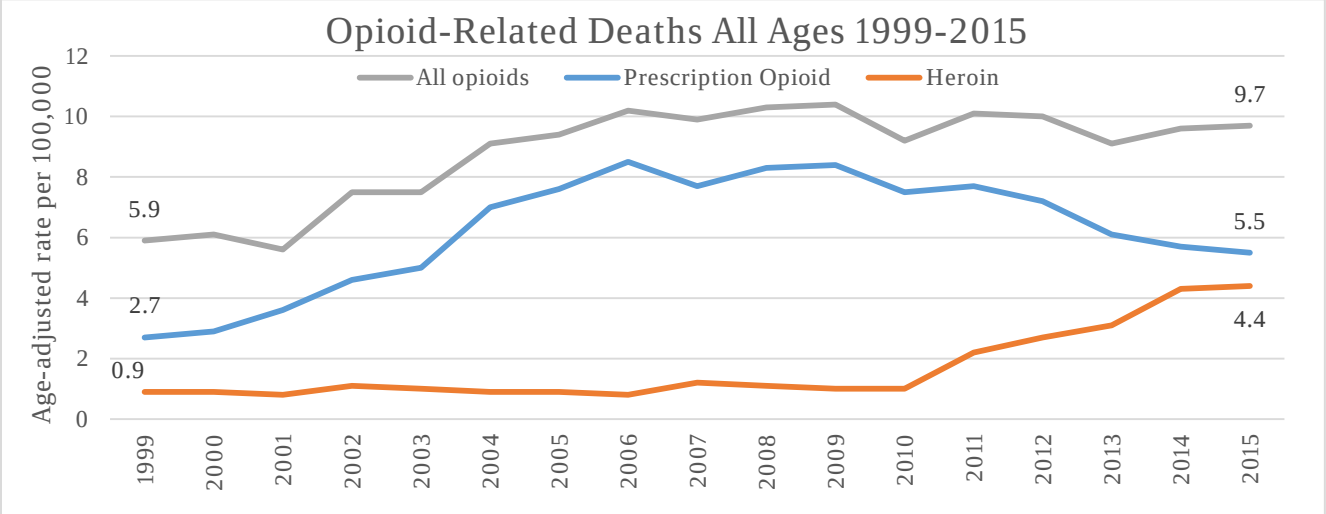
CORE FIGURE 4



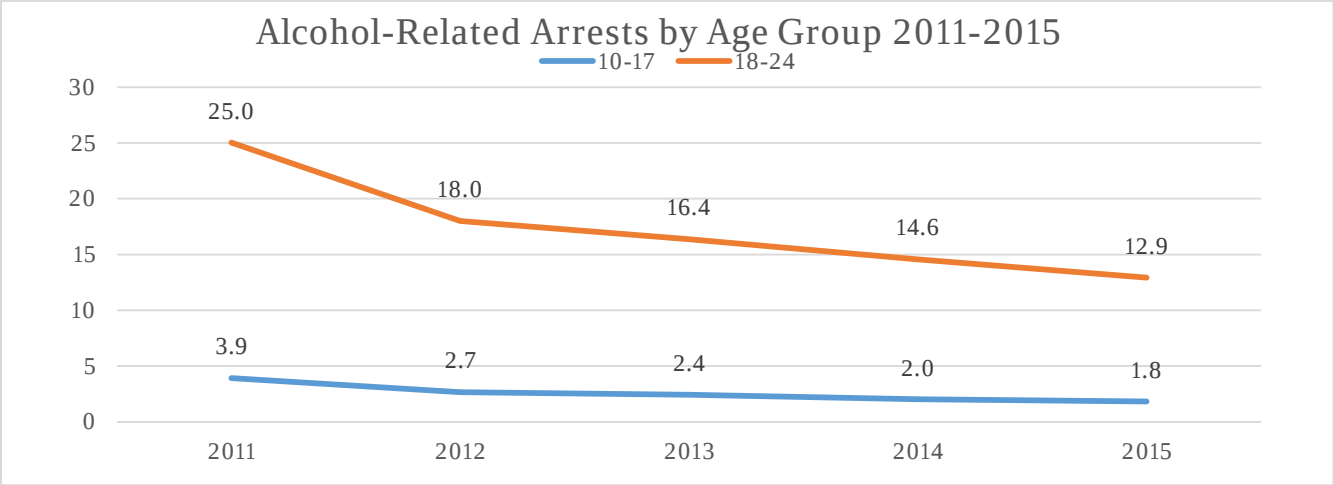
CORE FIGURE 5



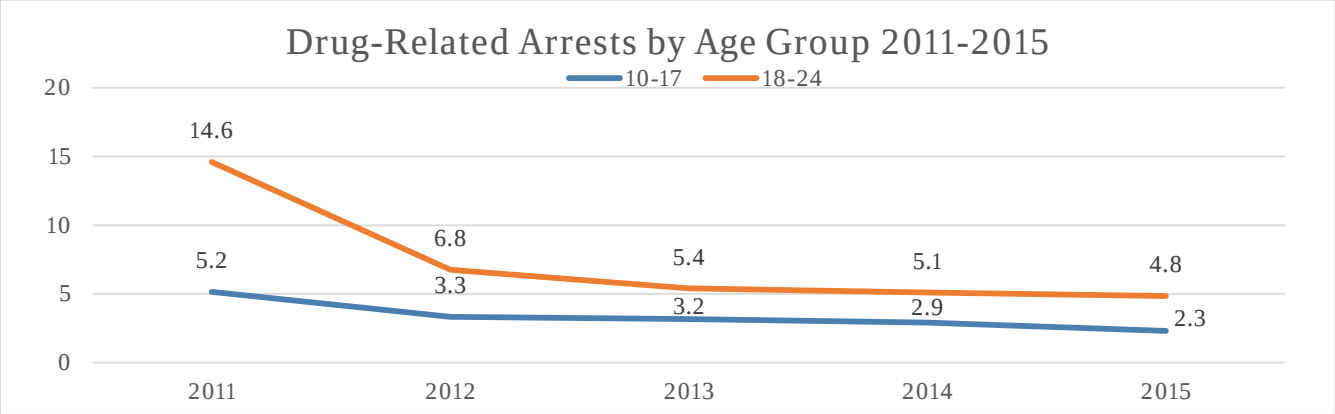
CORE FIGURE 6



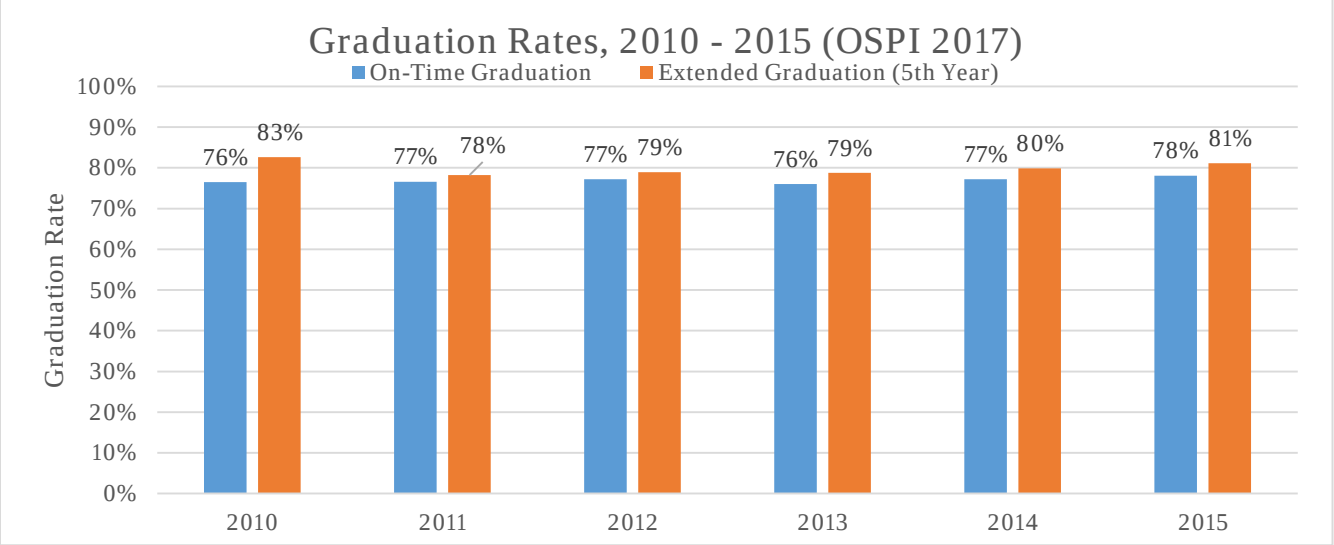
CORE FIGURE 7



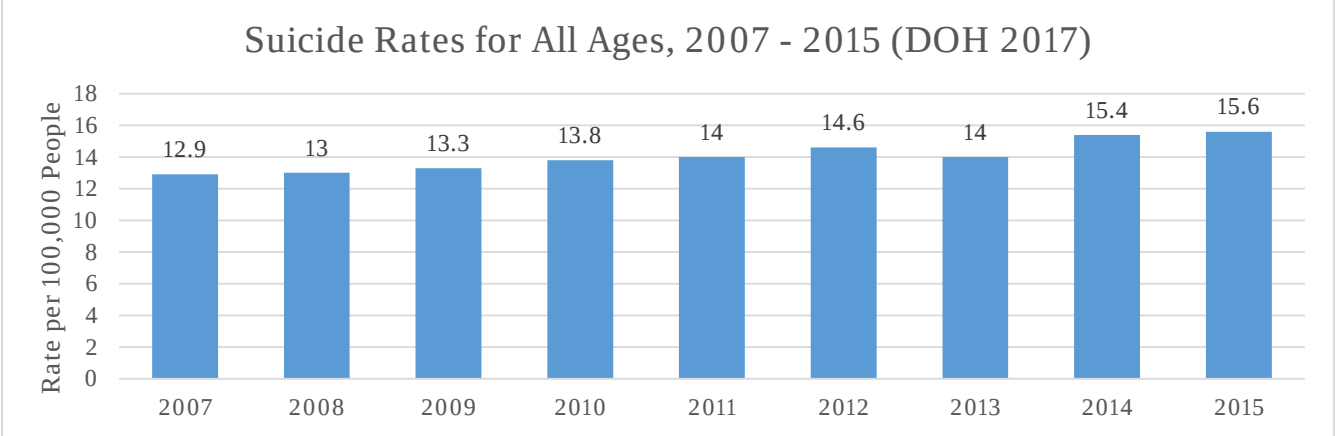
CORE FIGURE 8



CORE FIGURE 9

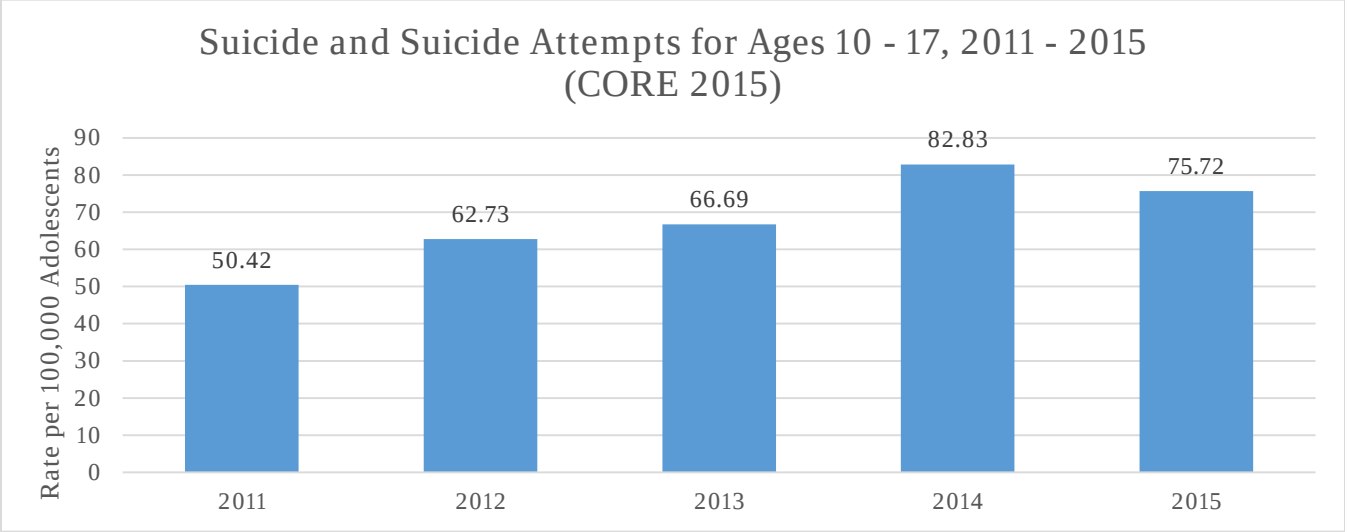


CORE FIGURE 10



Note: Data accessed from WA DOH Health Statistics 2/2017. Rate is per 100,000 people and is age-adjusted to the U.S. population in the year 2000.

CORE FIGURE 11



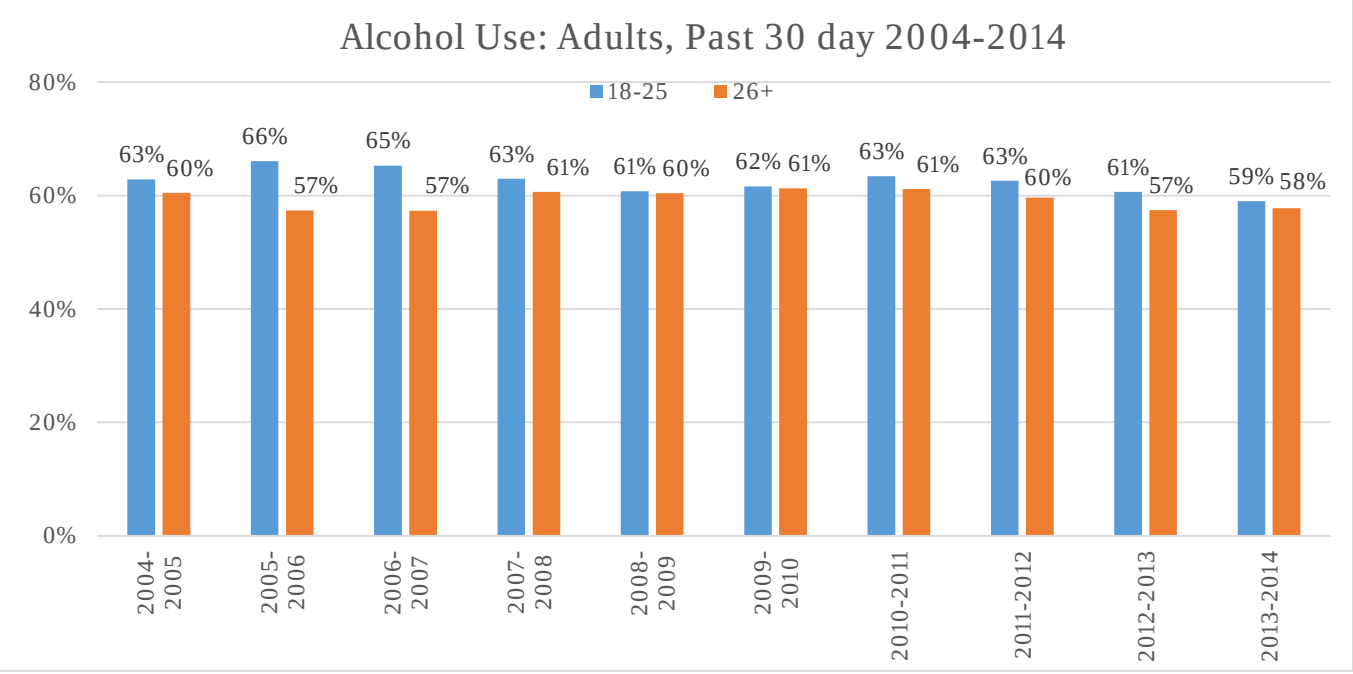
Note: Rate per 100,000 adolescents (age 10 - 17) for adolescents who committed suicide or were admitted for suicide attempts.

National Survey on Drug Use and Health (NSDUH): Figures NSDUH 1-8

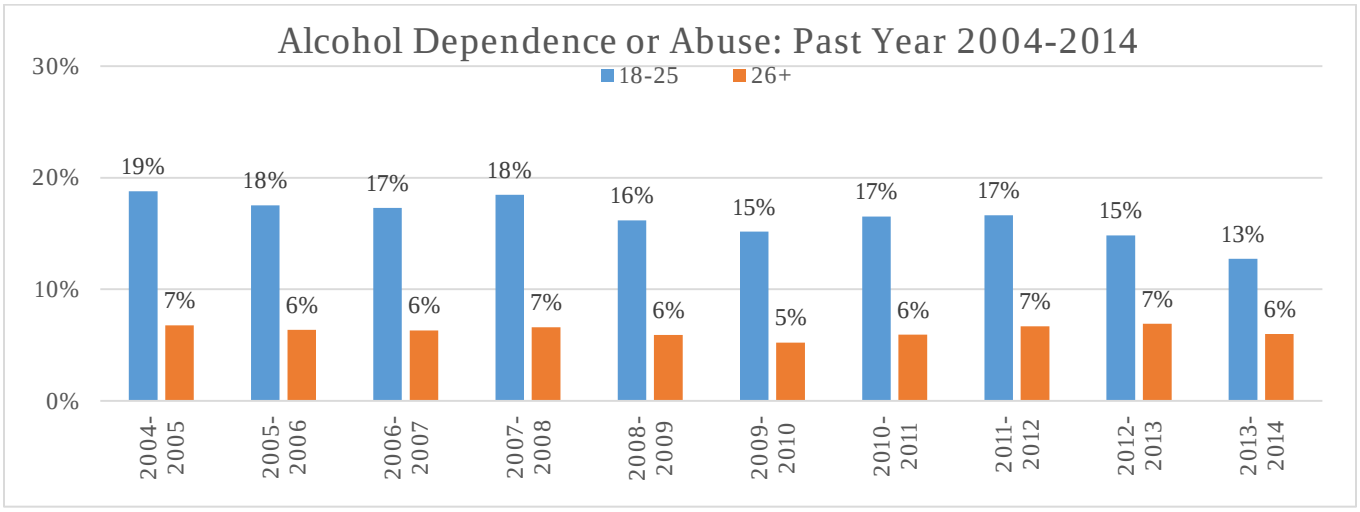
Notes:

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

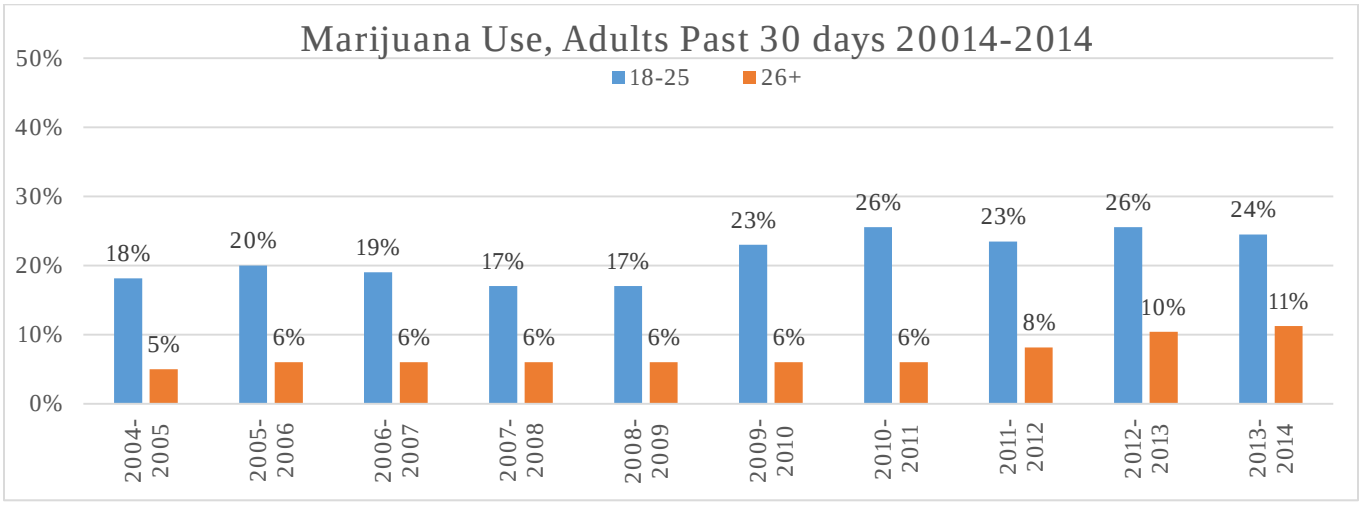
NSDUH - FIGURE 1



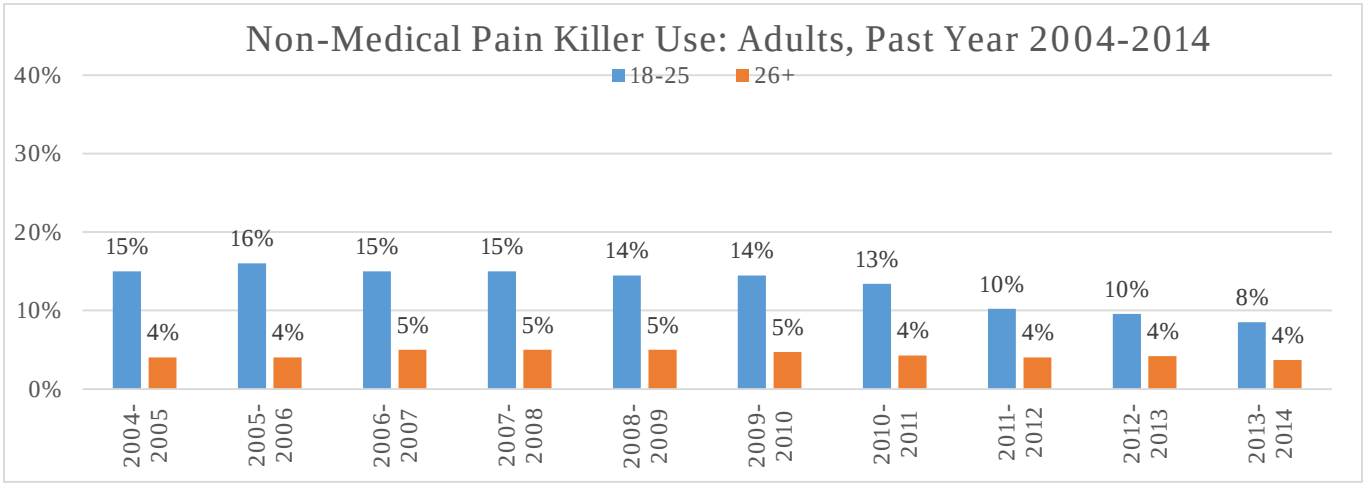
NSDUH - FIGURE 2



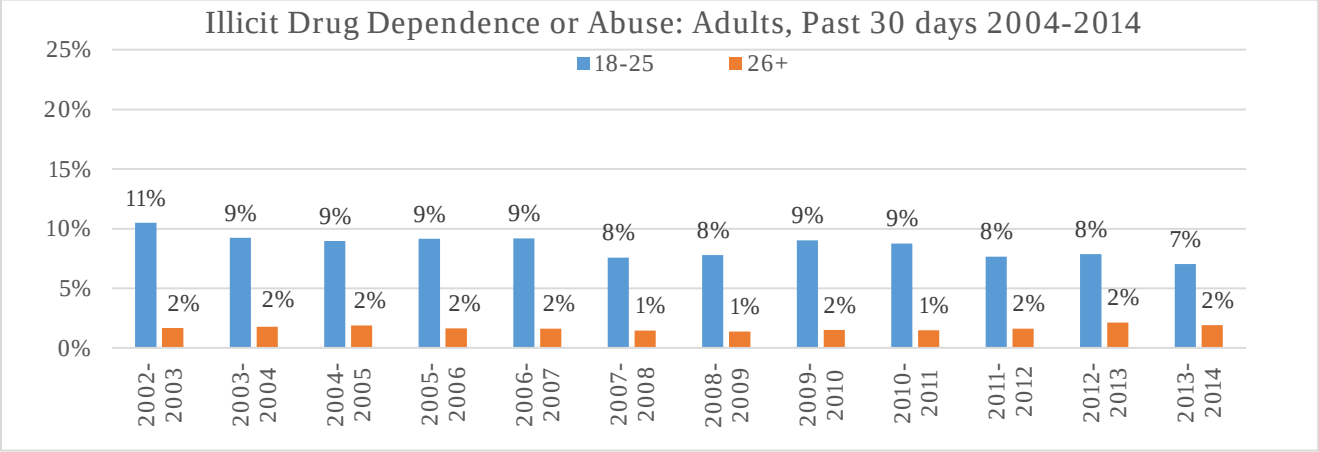
NSDUH - FIGURE 3



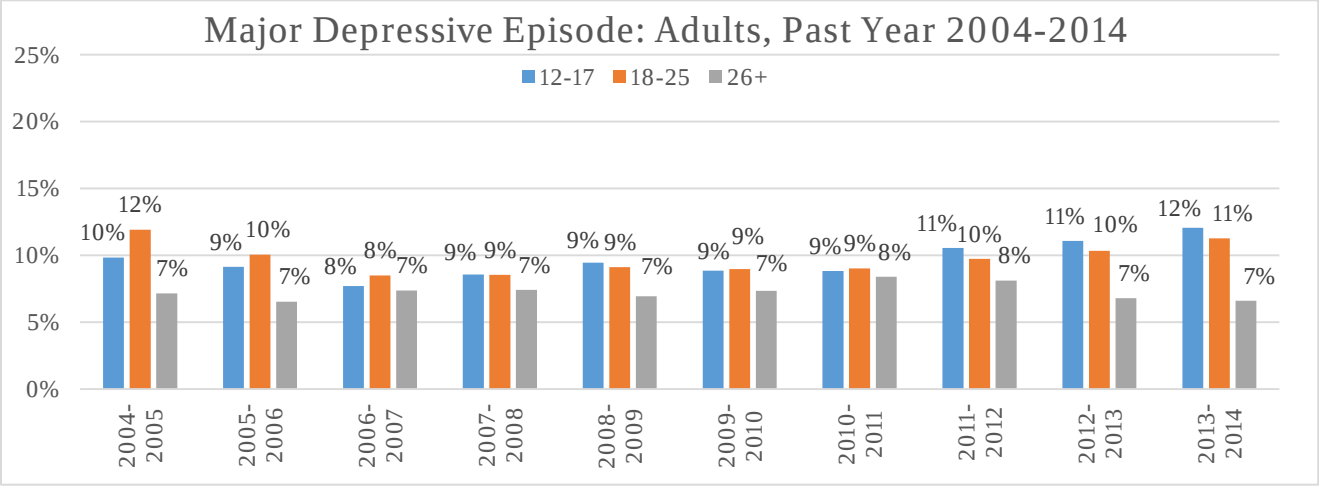
NSDUH - FIGURE 4



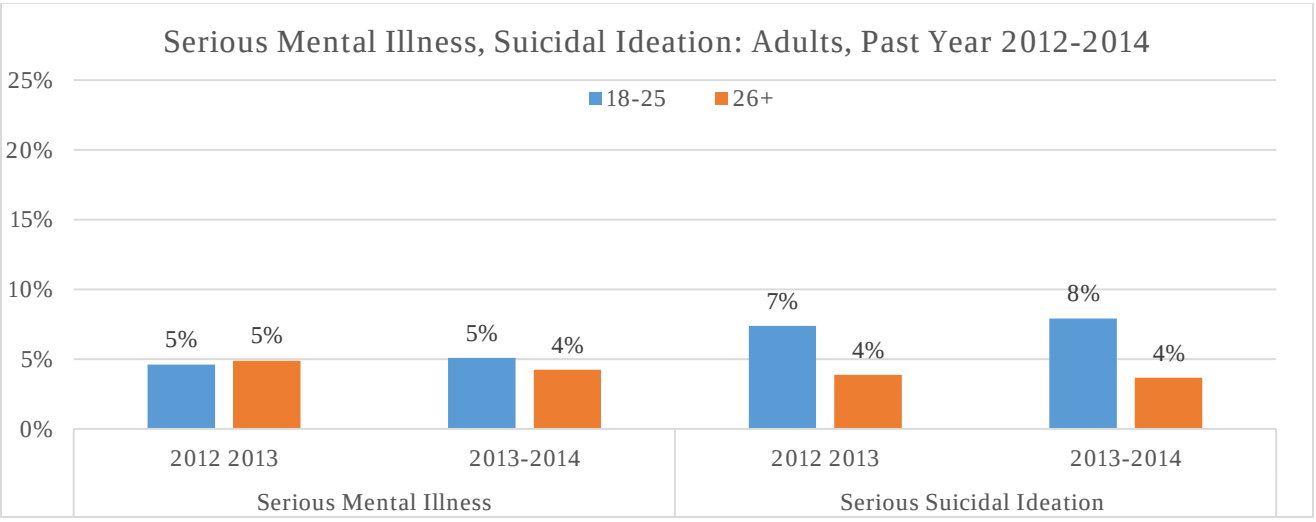
NSDUH - FIGURE 5



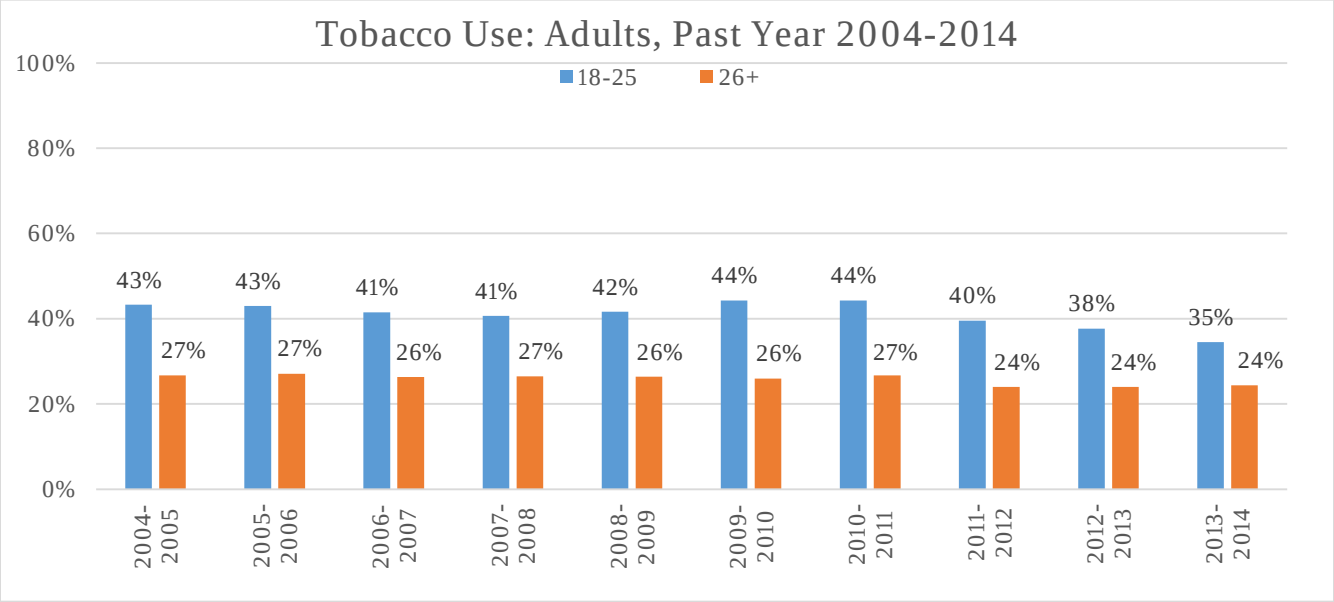
NSDUH - FIGURE 6



NSDUH - FIGURE 7



NSDUH - FIGURE 8

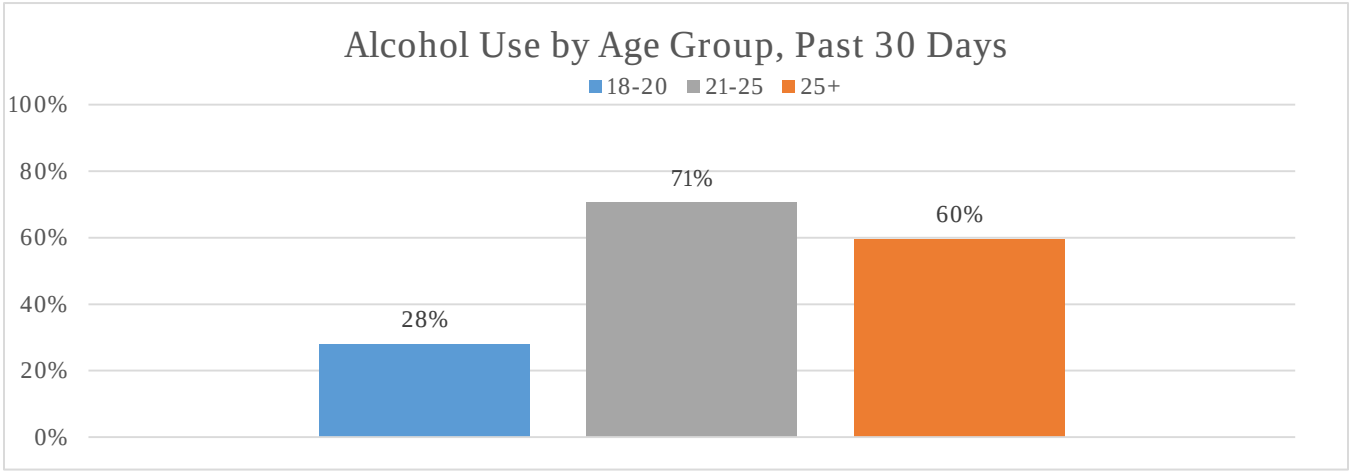


Behavioral Risk Factors Surveillance System (BRFSS): Figures BRFSS 1-5

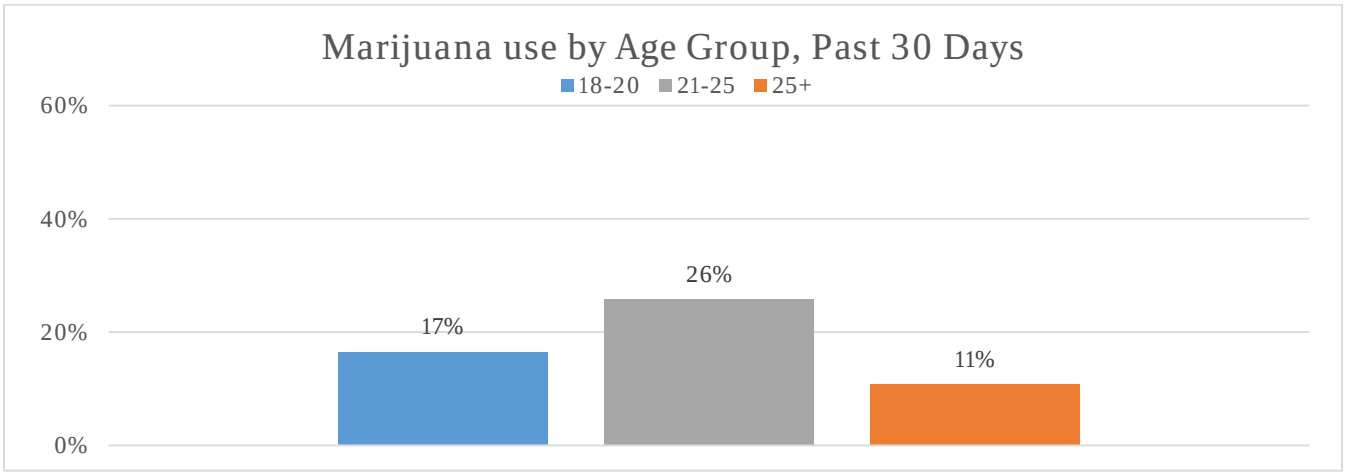
Notes:

- The BRFSS enables the Center for Disease Control and Prevention (CDC), state health departments, and other health agencies to monitor modifiable risk factors for chronic diseases and other leading causes of death.
- National and statewide annual telephone survey.
- Collects information on health behaviors and preventive practices.
- Respondents: adults 18 years and older.
- Sample size (2010): approximately 20,000 in Washington State.
- Annual Survey in 2013 was provided for the Strategic Plan Update 2015.
- Sample size (2015): approximately 16,000 in Washington State.
- Measuring Serious Psychological Distress (BRFSS)
  - Measured by Kessler-6 distress scale.
  - Serious psychological distress – defined as a score of 13 or more on K-6.

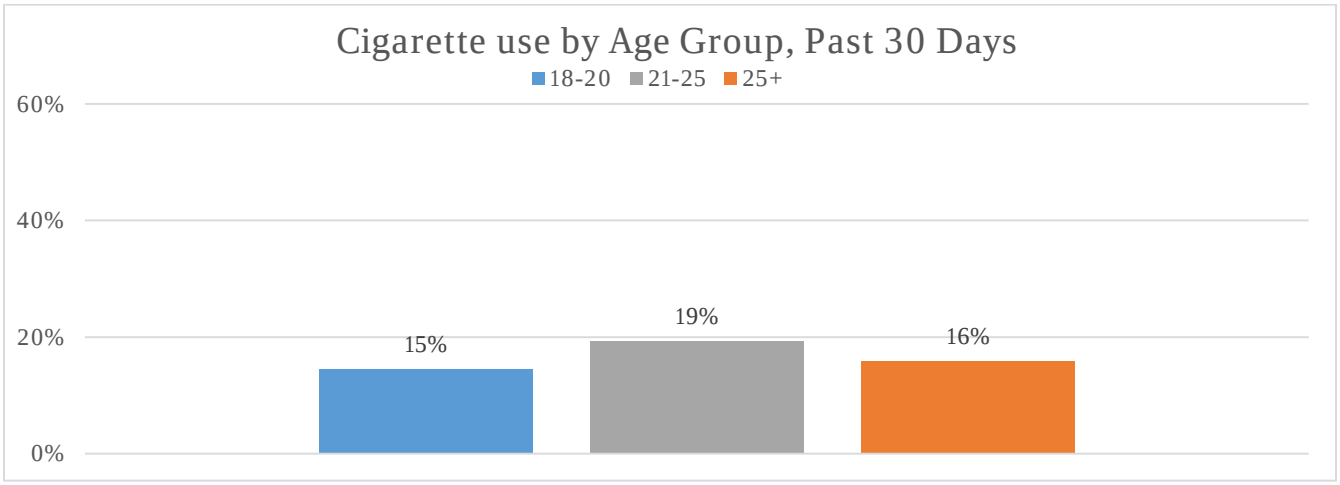
BRFSS FIGURE 1



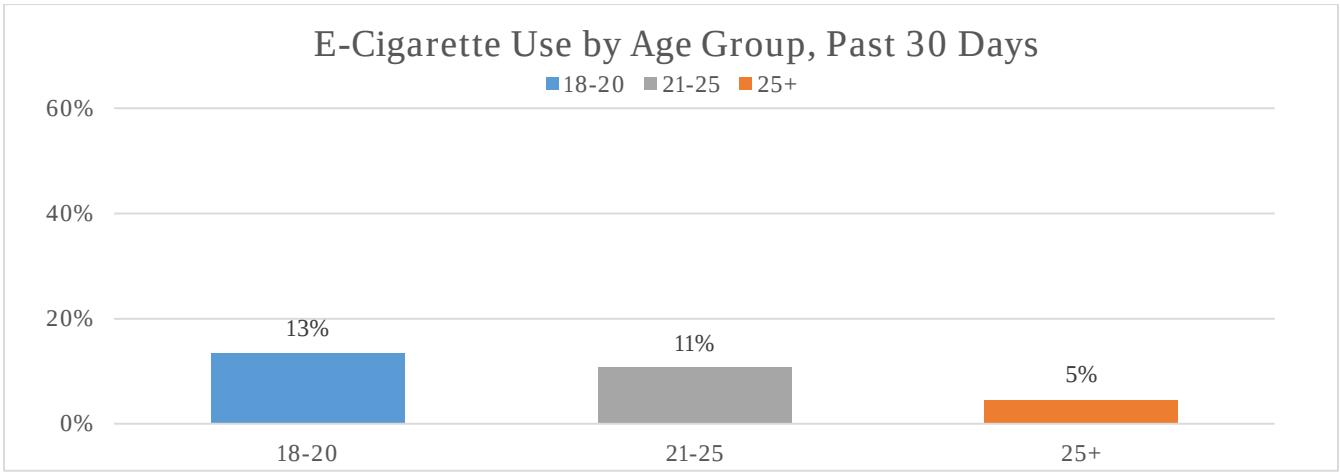
BRFSS FIGURE 2



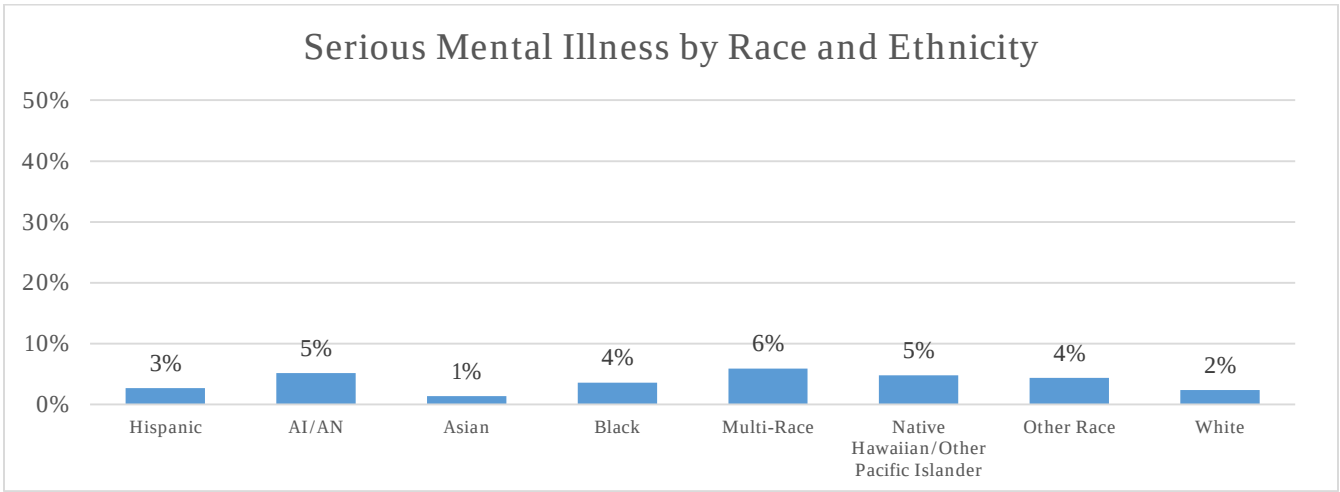
BRFSS FIGURE 3



BRFSS FIGURE 4



BRFSS FIGURE 5



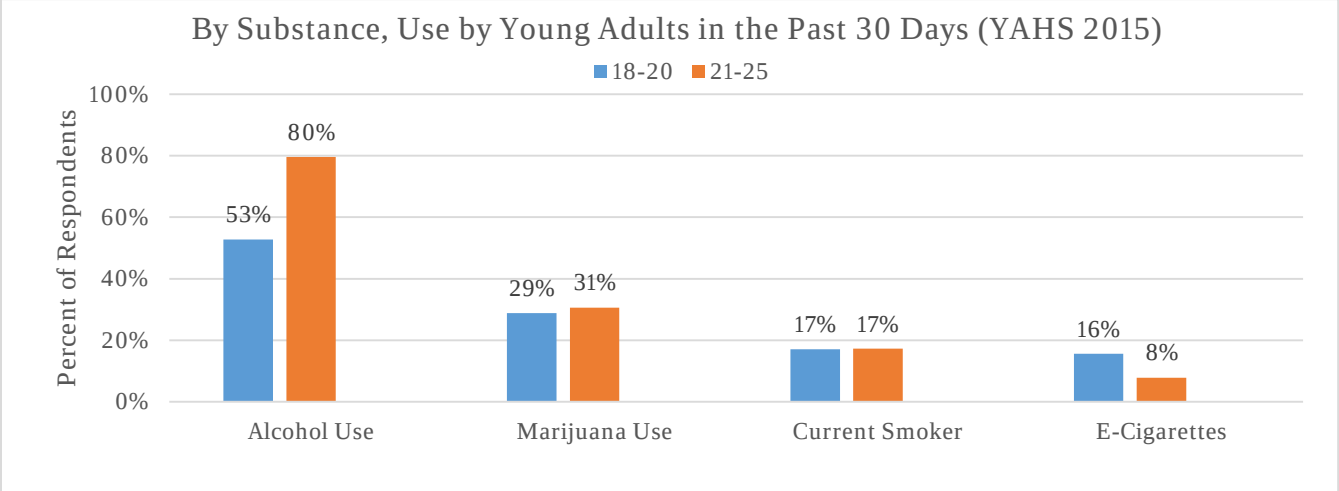
Young Adult Survey 2014: Figures 1-2

Center for the Study of Health and Risk Behaviors at the University of Washington and the Department of Social and Health Services and the Washington State Epidemiological Outcomes Workgroup

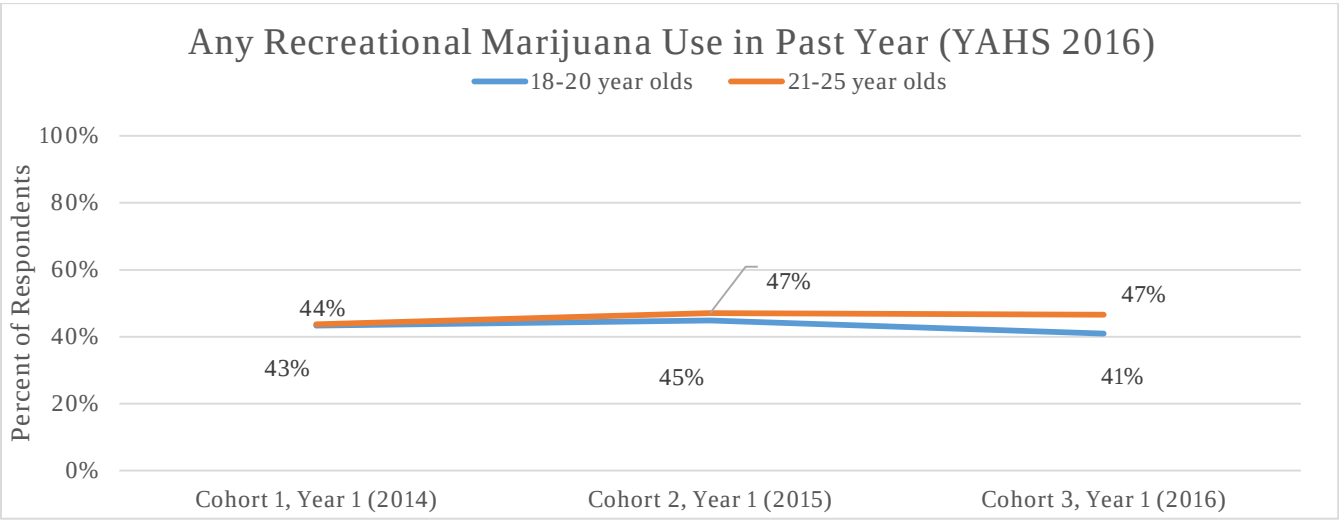
Notes:

- First Statewide Young Adult Survey in Washington State.
- Online survey that measures marijuana and other substance use, perceptions of harm, risk factors, and consequences among young adults (18-25 years old) living in Washington State.
- Administered annually. Follow-up interviews with prior years' participants have been conducted to assess changes in young adults' marijuana use over time
- The first wave of survey conducted early July of 2014 and
    - Survey Participation (2014): 2,101
    - Survey Participation (2015): 1677 new participants, 1203 cohort 1 one-year follow up
    - Survey Participation (2016): 2493 new participants, 1005 cohort 1 two-year follow up, 1180 cohort 2 one-year follow-up

YAHS FIGURE 1



YAHS FIGURE 2

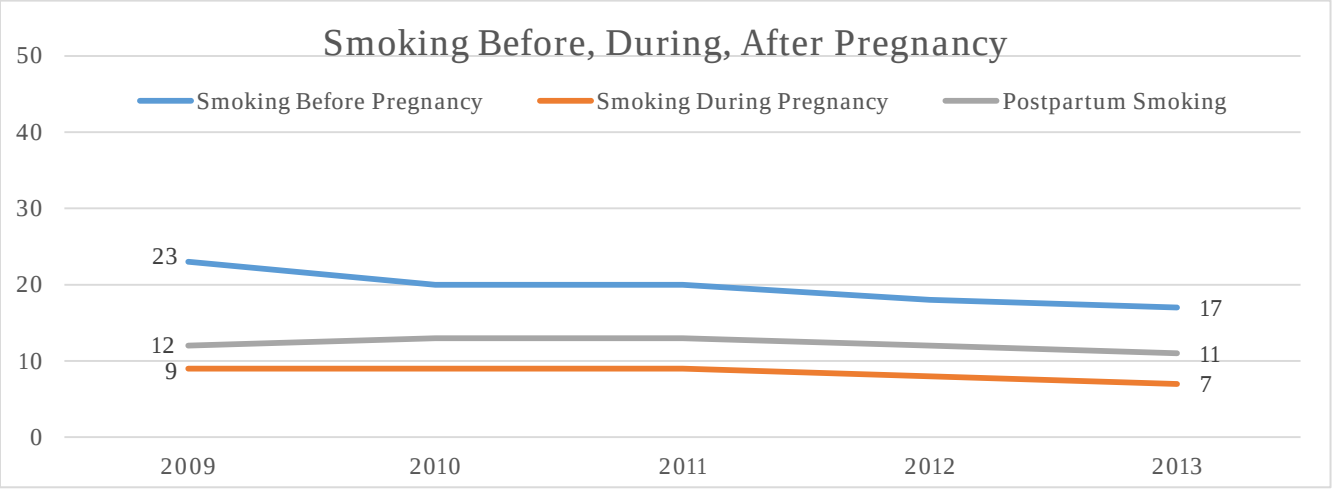


Pregnancy Risk Assessment Monitoring System (PRAMS): Figures PRAMS 1-7

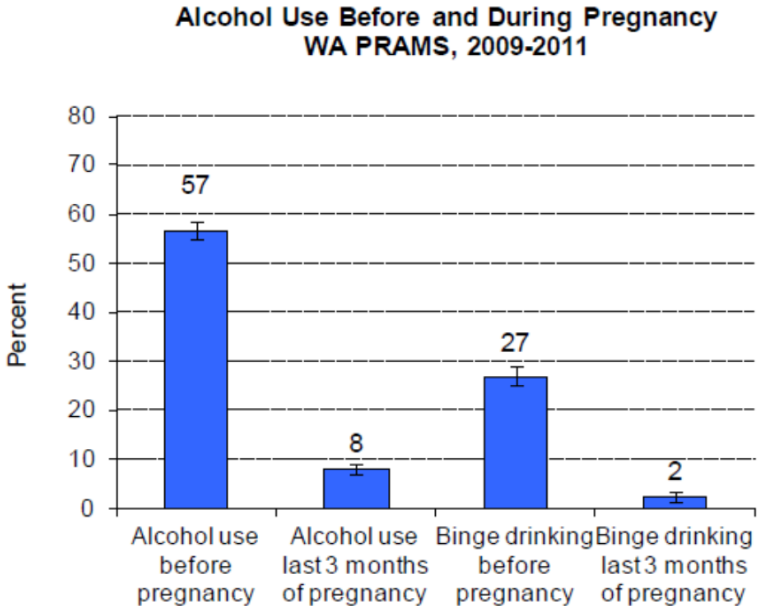
Notes:

- National and statewide mail and telephone survey.
- Collects data on new mothers' behaviors and experiences before, during, and shortly after pregnancy.
- Respondents: new mothers 2 to 6 months after delivering a baby.
- Sample size: approximately 1,800 surveys mailed each year in Washington with about a 76% response rate.
- PRAMS information was included in the 2017 update to include 2009-2011 data with limited new data for 2013.

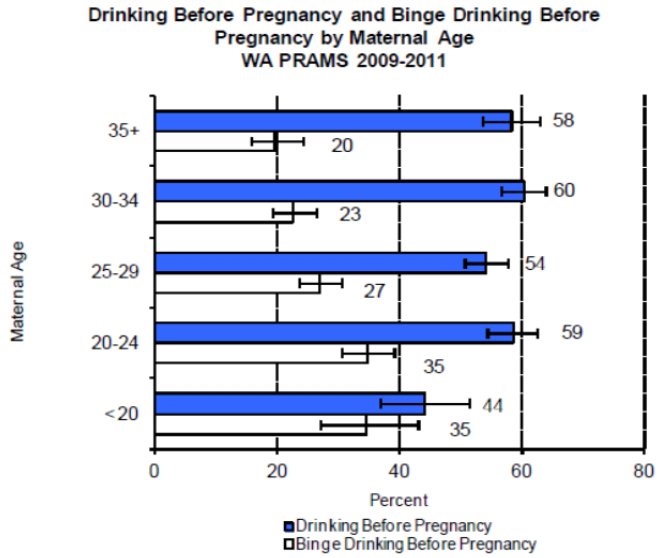
PRAMS FIGURE 1

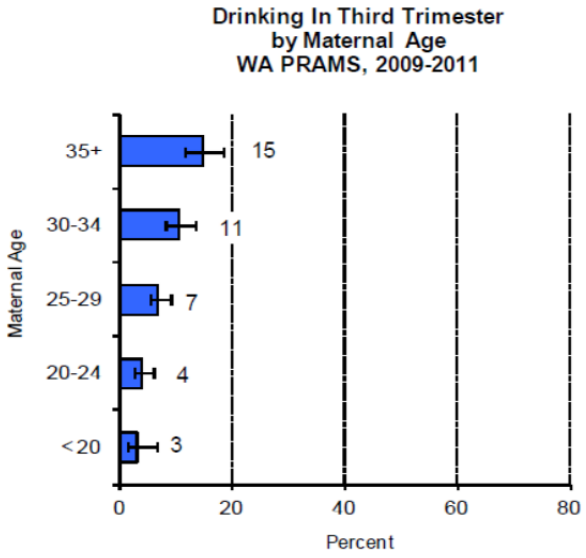


PRAMS FIGURE 2

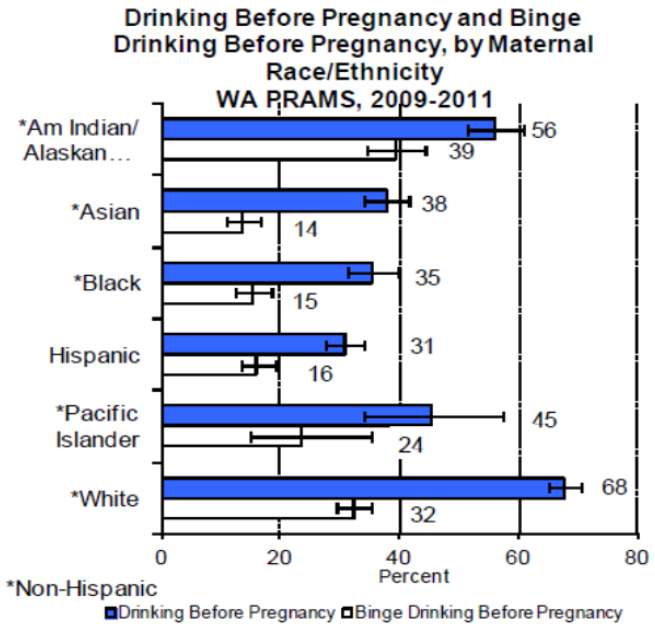


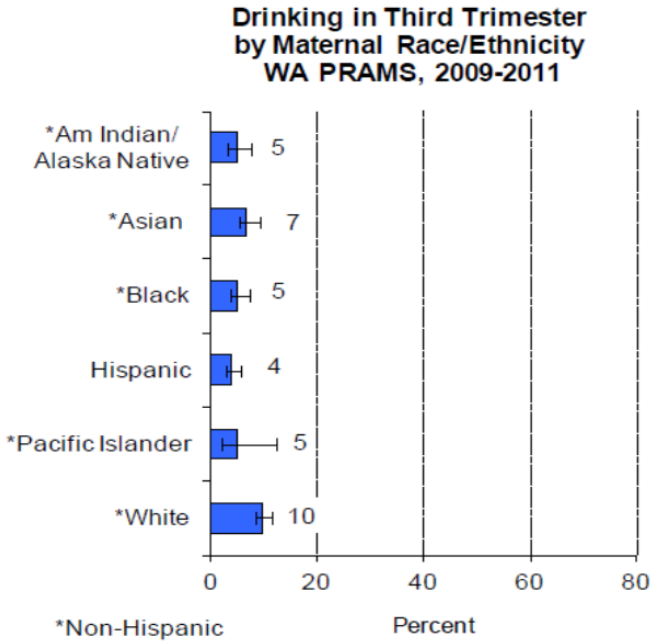
PRAMS FIGURE 3 & 4



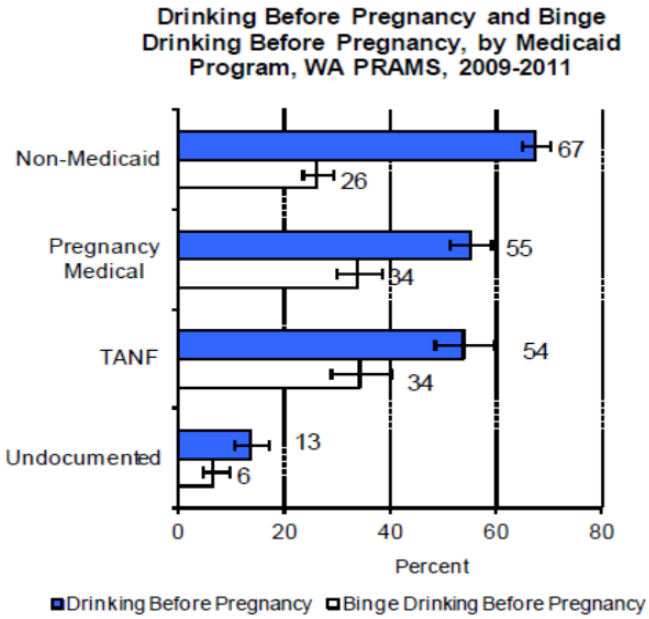


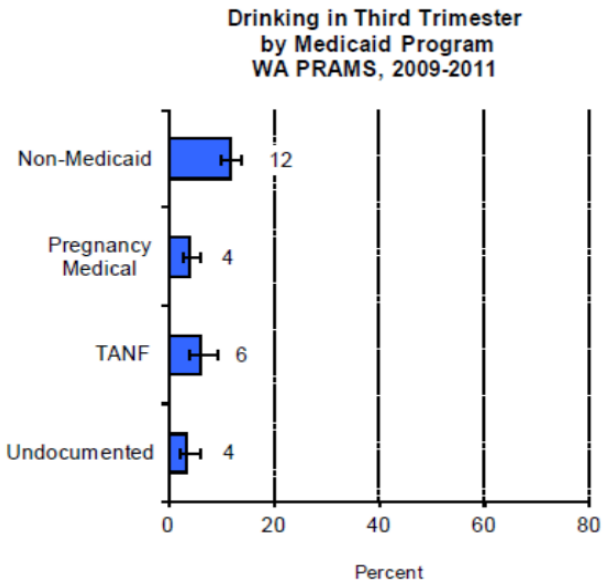
PRAMS FIGURE 5 & 6





PRAMS FIGURE 7 & 8



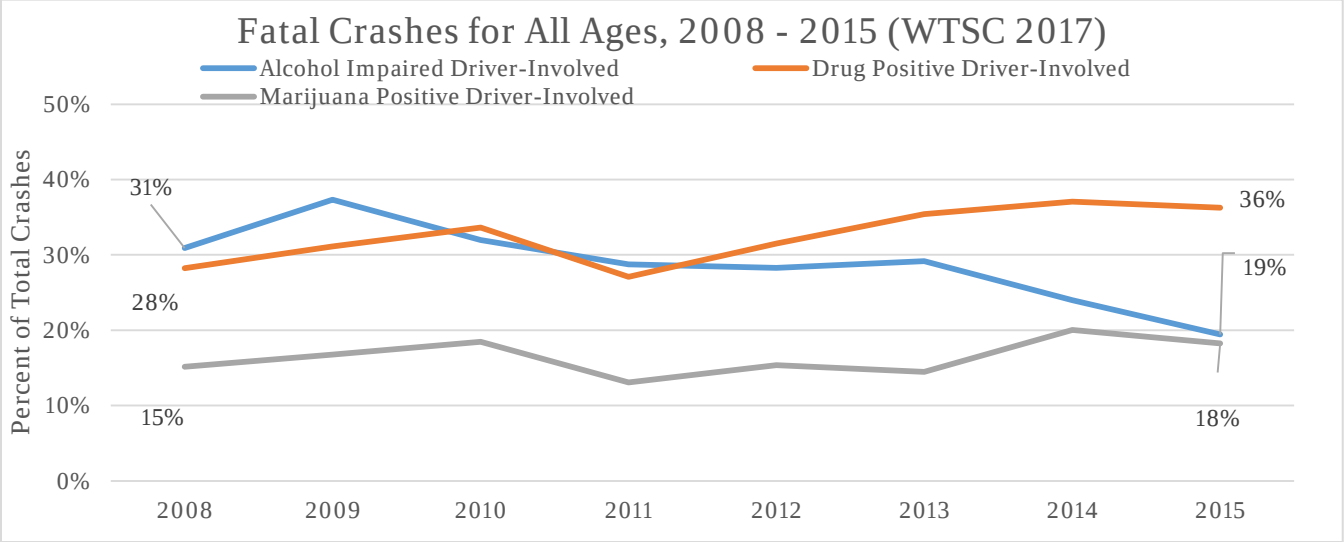


Traffic Data: Figures Traffic Data 1-2
Fatality Analysis Reporting System (FARS)

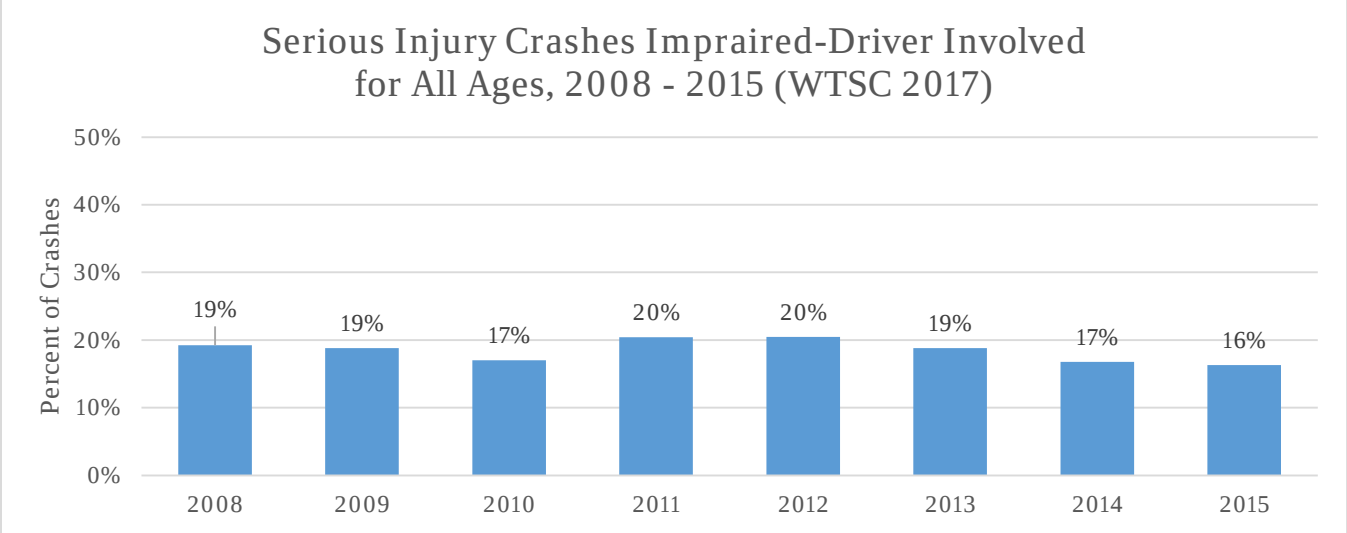
Notes:

- Nationwide census with data regarding fatal injuries suffered in motor vehicle traffic crashes.
- Maintained by National Highway Traffic Safety Administration (NHTSA).
- Data available yearly from 1975.
- Collects data on crashes involving a motor vehicle traveling on a traffic way customarily open to the public and resulting in the death of a person within 30 days of the crash.
- Increased use of "ignition interlock devices."

FARS FIGURE 1



FARS FIGURE 2

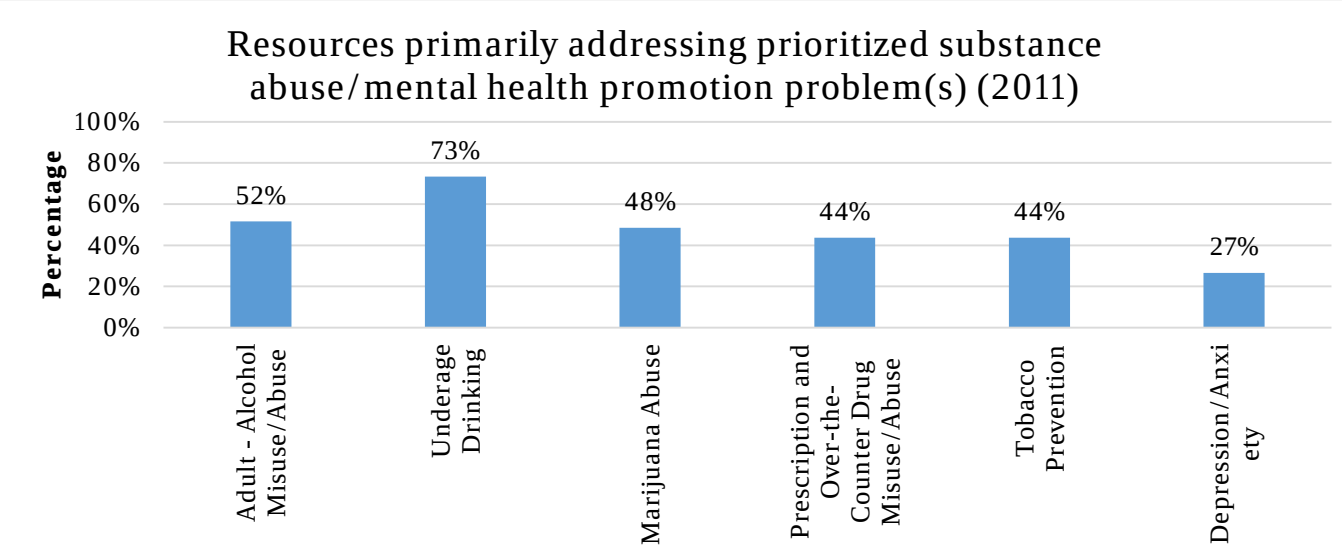


5. Resources Assessment

Resources primarily addressing prioritized substance abuse problem(s):

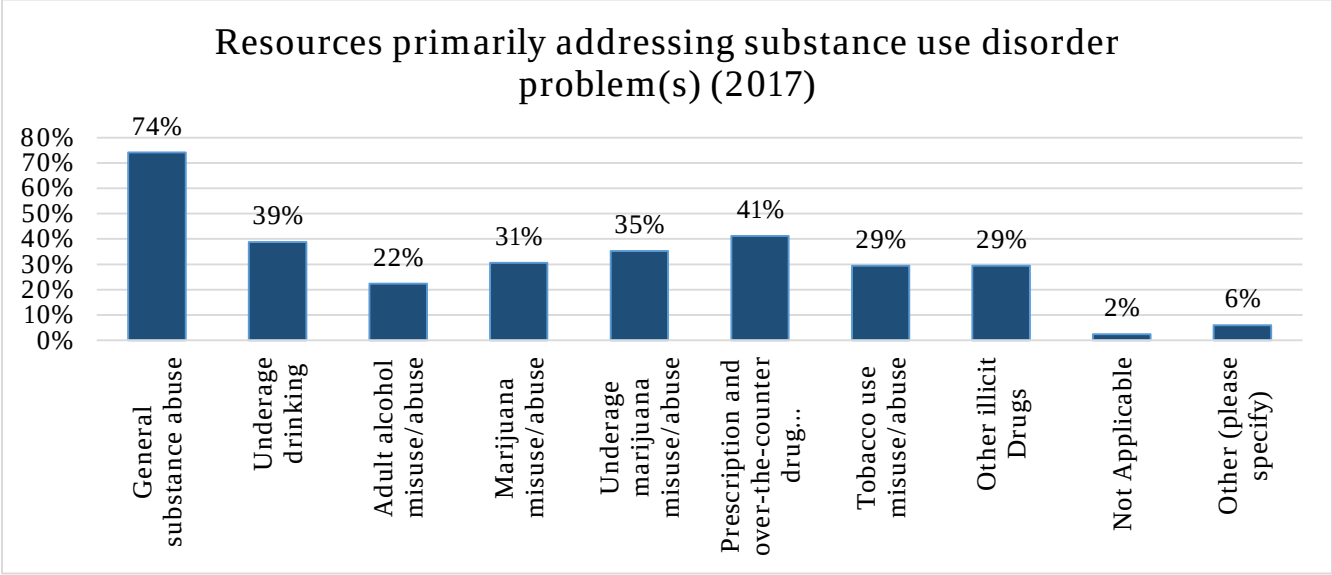
The information that follows is a summary of the survey results of the Resources Assessment. Consortium partners responded to a series of questions regarding funding and resources they provide. A compilation of the Resources Assessment presentation provided *is available online at:* *www.TheAthenaForum.org/SPE*.

RESOURCES ASSESSMENT FIGURE 1



Note: Source - SPE Resources Assessment 2011, n=64

RESOURCES ASSESSMENT FIGURE 2



Note: Source – SPE Resources Assessment 2017, n=85

RESOURCES ASSESSMENT FIGURE 3

Resources Focused on Substance Abuse	General Substance Abuse	Underage Drinking	Adult Alcohol Misuse/Abuse	Marijuana Misuse/Abuse	Underage Marijuana Misuse/Abuse	Prescription and over-the-counter drug misuse/abuse	Tobacco prevention	Other Illicit Drugs
AGO - Litigation, Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action	X						X	
AGO - Opioid Summit	X					X		
AGO - Tobacco 21	X						X	
CCSAP - Webinars	X	X		X	X		X	
CCSAP -Year End Young Adult Professional Development Conference	X	X	X	X	X	X	X	X
DBHR - Community Prevention and Wellness Initiative (CPWI)	X	X			X	X	X	
DBHR - Community-based Marijuana Services Grants	X			X				
DBHR - Community-based Opioid/Prescription Services Grants	X					X		
DBHR - Evidence Based Practice Workgroup	X	X	X	X	X	X		
DBHR - Healthy Youth Survey	X	X			X	X	X	X
DBHR - Prescription Provider Education	X					X		
DBHR - Prescription Safe Storage Training	X					X		
DBHR - Prevention Summit/SYF/Coalition Institute	X	X	X	X	X	X	X	X
DBHR - Public Education Campaign On Opiate Misuse/Abuse Prevention	X					X		
DBHR - Start Talking Now - Website for Parents	X	X		X	X	X	X	X
DBHR - The Athena Forum - Website for Prevention Professionals/Partners	X	X	X	X	X	X	X	X
DBHR - Tribal Prevention and Wellness Programs	X	X		X	X	X	X	
DBHR - Underage Drinking Use Media Campaign	X	X						
DBHR - UW Tele Pain	X					X		
DBHR - WA-SBIRT Trainings	X		X	X		X		X
DBHR - Workforce Development, Trainings, and Technical Assistance	X	X	X	X	X	X	X	X
DBHR - Young Adult Health Survey								
DEL - Early Support for Infants and Toddlers	X							

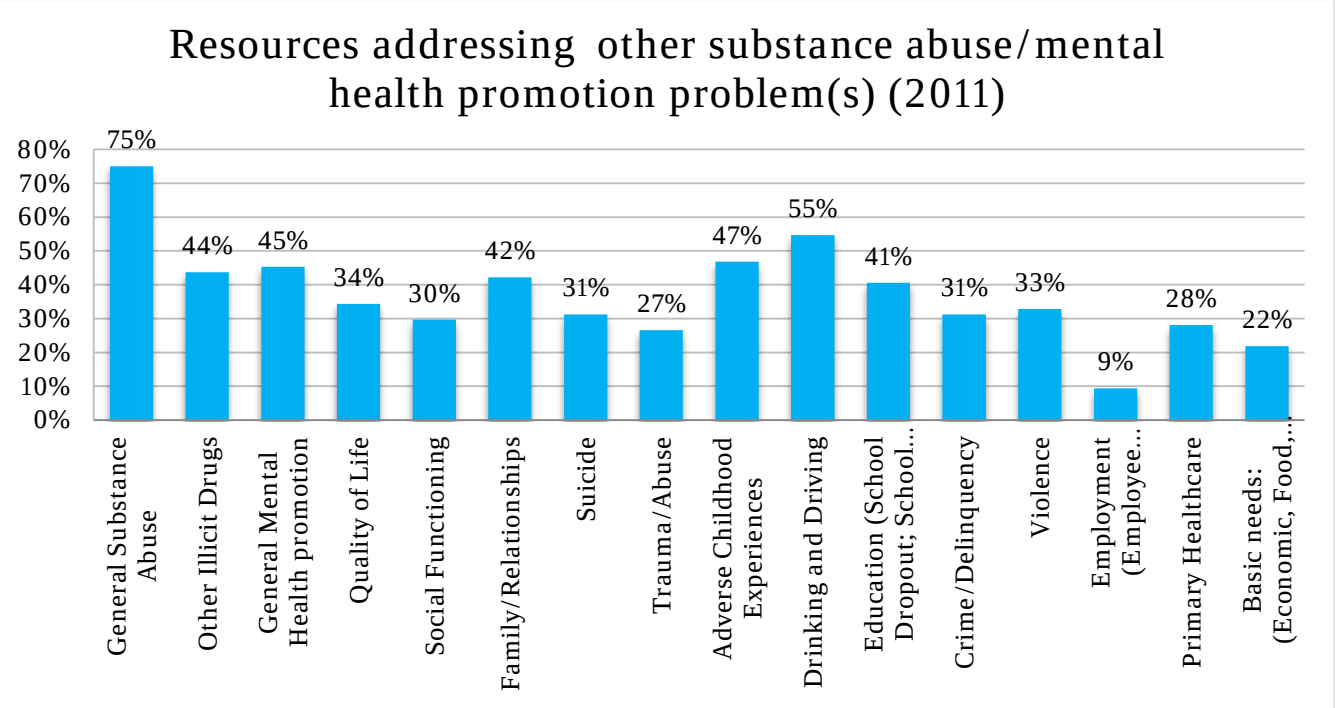
Resources Focused on Substance Abuse	General Substance Abuse	Underage Drinking	Adult Alcohol Misuse/Abuse	Marijuana Misuse/Abuse	Underage Marijuana Misuse/Abuse	Prescription and over-the-counter drug misuse/abuse	Tobacco prevention	Other Illicit Drugs
DEL - ECEAP Early Childhood Education Economic Assistance Program State Preschool								X
DEL - Head Start	X							
DEL - Home Visiting Programs- 4 EBPs	X							
DEL - Infant Toddler Regions								X
DOH - Mandatory (E2SHB 2793) Suicide Prevention Trainings for Health Care Professionals						X		
DOH - Suicide Prevention Plan Implementation Workgroup			X			X		
DOH - National Violent Death Reporting System						X		X
DOH - Prevention for States Prescription Drug Overdose Grant								X
DOH - Statewide Suicide Prevention Plan						X		
DOH - State Overdose Response Plan						X		X
DOH - Children with Special Health Care Needs								X
DOH - Family Planning	X							X
DOH - Home Visiting	X							X
DOH - Project LAUNCH Grant								X
DOH - Tobacco County Profiles	X						X	
DOH - Listen2YourSelfie.org	X			X	X			
DOH - Marijuana Health Disparities Contracts	X			X	X		X	
DOH - Tobacco Related Disparities in WA State (health equity)	X							
DOH - WA Tobacco Facts	X						X	X
DOH - YMPEP Regional Grants	X			X	X			
DOH - Prescription Drug Monitoring Program (PMP)	X					X		
DOH - Mass Media resources	X							
DOH - Tobacco Sustainability Plan	X						X	
DOH - Marijuana Prevention Toolkit	X			X	X		X	
HCA - Mental Health Services Insurance Benefit for Medicaid Eligible and Public Employee	X					X		X
HCA - New initiative on Opioid Prescribing						X		

Resources Focused on Substance Abuse	General Substance Abuse	Underage Drinking	Adult Alcohol Misuse/Abuse	Marijuana Misuse/Abuse	Underage Marijuana Misuse/Abuse	Prescription and over-the-counter drug misuse/abuse	Tobacco prevention	Other Illicit Drugs
HCA - Substance Use Disorder insurance benefit for Medicaid Eligibles and Public Employees	X	X	X	X	X		X	X
IPAC - Support Tribes	X							
LCB - Liquor and Cannabis Enforcement	X	X	X	X	X		X	
LCB - Mandatory Alcohol Server Training (MAST)	X	X	X					
LCB - Printed materials	X	X	X	X	X			
LCB - Responsible Vendor Program (RVP)	X	X	X					
LCB - Rulemaking scope	X	X	X	X	X		X	
LCB - Technical Assistance/Education	X	X	X	X	X			
OIP - Support Tribes	X							
OSPI - Life Skills	X	X		X	X	X	X	
OSPI - Project AWARE	X	X			X			
OSPI - Student Assistance	X	X		X	X	X	X	X
OSPI - Suicide Prevention Program								
PSCBW - Certification for Prevention Professionals (CPP)	X							
PSCBW - Substance Abuse Prevention Skills Training (WA-SAPST)	X							
WAPCo - Washington Association of Prevention Coalitions	X	X		X	X	X	X	X
WASAVP - Action Alerts	X	X			X	X		X
WASAVP - Annual meeting at Prevention Summit in Yakima	X	X	X	X	X	X	X	X
WASAVP -Annual Policy Platform for prevention	X	X			X	X	X	
WASAVP -Monitoring and advocating for prevention with State Legislature	X	X		X	X	X	X	X
WASAVP - Occasional position papers relevant to prevention	X				X	X		
WASAVP - Prevention Policy Day each January/February in Olympia	X	X		X	X	X	X	X
WASAVP - WASAVP Website	X	X	X	X	X	X		X
WSU - Interdisciplinary Ph.D. Program in Prevention Science	X							
WTSC - Click it or ticket	X	X	X					
WTSC - DUI enforcement campaigns	X	X	X					

Resources Focused on Substance Abuse	General Substance Abuse	Underage Drinking	Adult Alcohol Misuse/Abuse	Marijuana Misuse/Abuse	Underage Marijuana Misuse/Abuse	Prescription and over-the-counter drug misuse/abuse	Tobacco prevention	Other Illicit Drugs
WTSC - HS distracted driver projects	X	X						
WTSC - Traffic Safety Task Forces - Target Zero	X	X						

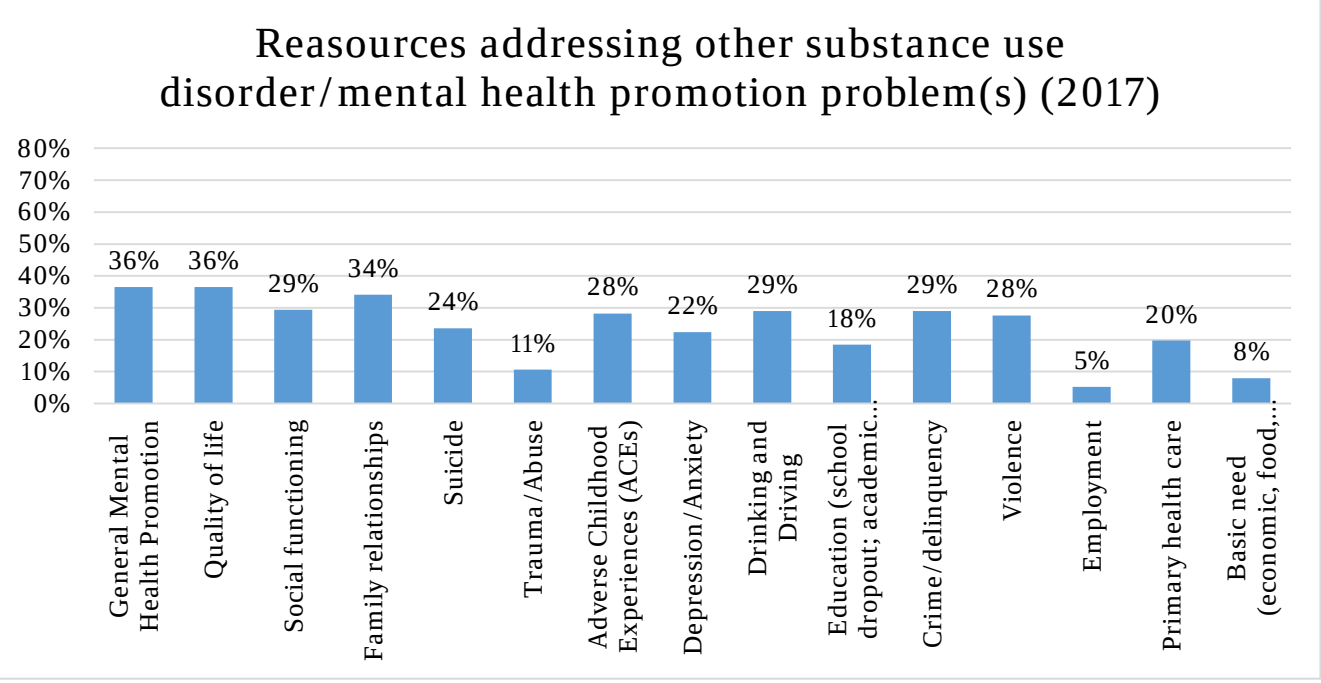
Resources focused on Mental Health

RESOURCES ASSESSMENT FIGURE 4



Note: Source – SPE Resources Assessment 2011, n=64

RESOURCES ASSESSMENT FIGURE 5



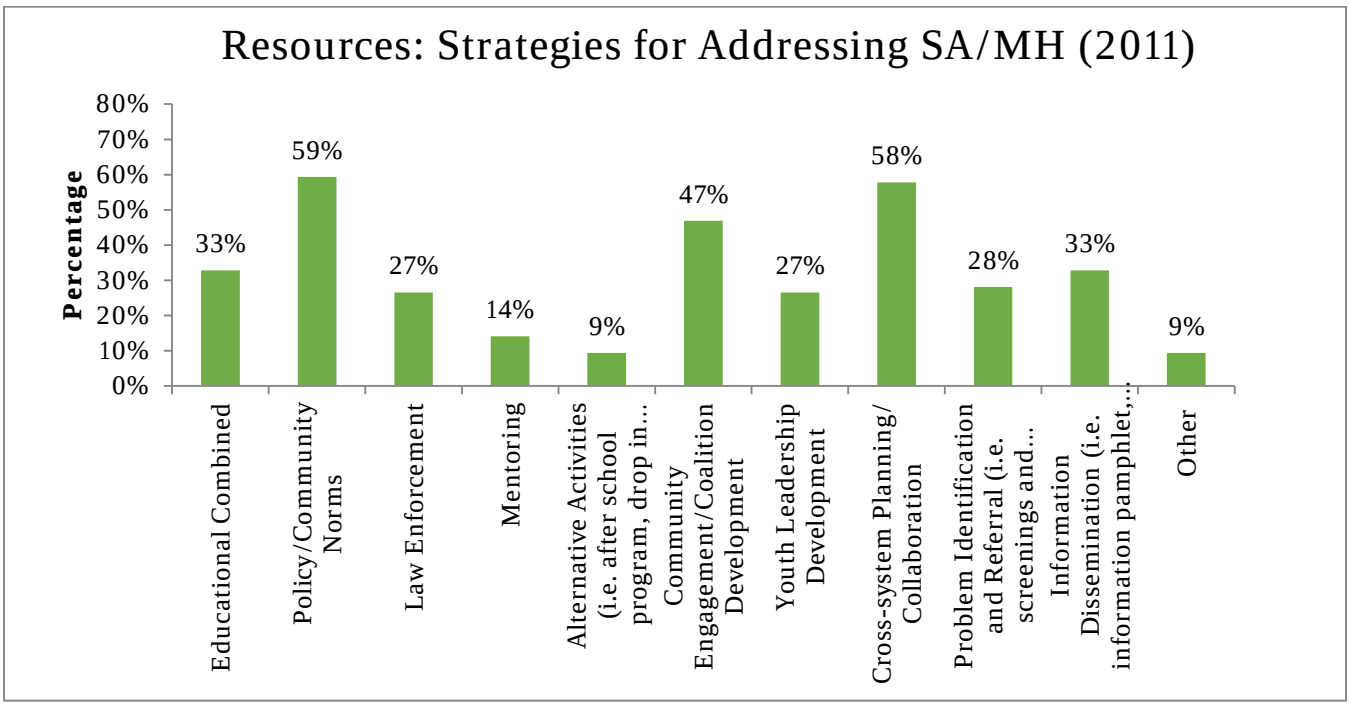
Note: Source – SPE Resources Assessment 2017, n=85

RESOURCES ASSESSMENT FIGURE 6

Resources focused on Mental Health	General Mental Health promotion	Quality of life	Social functioning	Family/ Relationships	Suicide	Trauma/Abuse	Adverse Childhood Experiences	Depression/Anxiety
CCSAP - Webinars	X							
CCSAP - Year End Young Adult Professional Development Conference	X	X	X					X
DBHR - Community Prevention and Wellness Initiative (CPWI)	X		X	X	X		X	X
DBHR - Community-based Marijuana Services Grants			X	X				
DBHR - Community-based Opioid/Prescription Services Grants			X	X				
DBHR - Evidence Based Practice Workgroup	X		X	X				
DBHR - Healthy Youth Survey	X	X		X	X			X
DBHR - Mental Health Promotion and Suicide Prevention Projects			X		X			X
DBHR - Prevention Summit/SYF/Coalition Institute	X	X			X		X	X
DBHR - Start Talking Now - Website for Parents	X	X		X				
DBHR - The Athena Forum - Website for Prevention Professionals/Partners	X	X	X	X	X	X	X	X
DBHR - Tribal Mental Health Promotion Mini Grants	X	X		X	X		X	X
DBHR - Tribal Prevention and Wellness Programs	X		X	X				
DBHR - Underage Drinking Use Media Campaign				X				
DBHR - Workforce Development, Trainings, and Technical Assistance	X			X	X			
DBHR - Young Adult Health Survey	X							X
DEL - Early Support for Infants and Toddlers	X	X	X	X			X	
DEL - ECEAP Early Childhood Education Economic Assistance Program State Preschool	X	X	X	X				
DEL - Head Start	X	X	X	X		X	X	
DEL - Home Visiting Programs- 4 EBPs	X	X	X	X			X	
DEL - Infant Toddler Regions	X	X	X	X		X	X	
DEL - Mental Health Consultant Role		X		X			X	
DEL - MTCC/ECLIPSE Program		X	X	X			X	
DOH - Contract for local youth suicide prevention efforts	X				X			
DOH - Mandatory (E2SHB 2793) Suicide Prevention Trainings for Health Care Professionals		X			X		X	X
DOH - Action Alliance for Suicide Prevention					X		X	X
DOH - Suicide Prevention Plan Implementation Workgroup	X	X	X	X	X	X	X	X

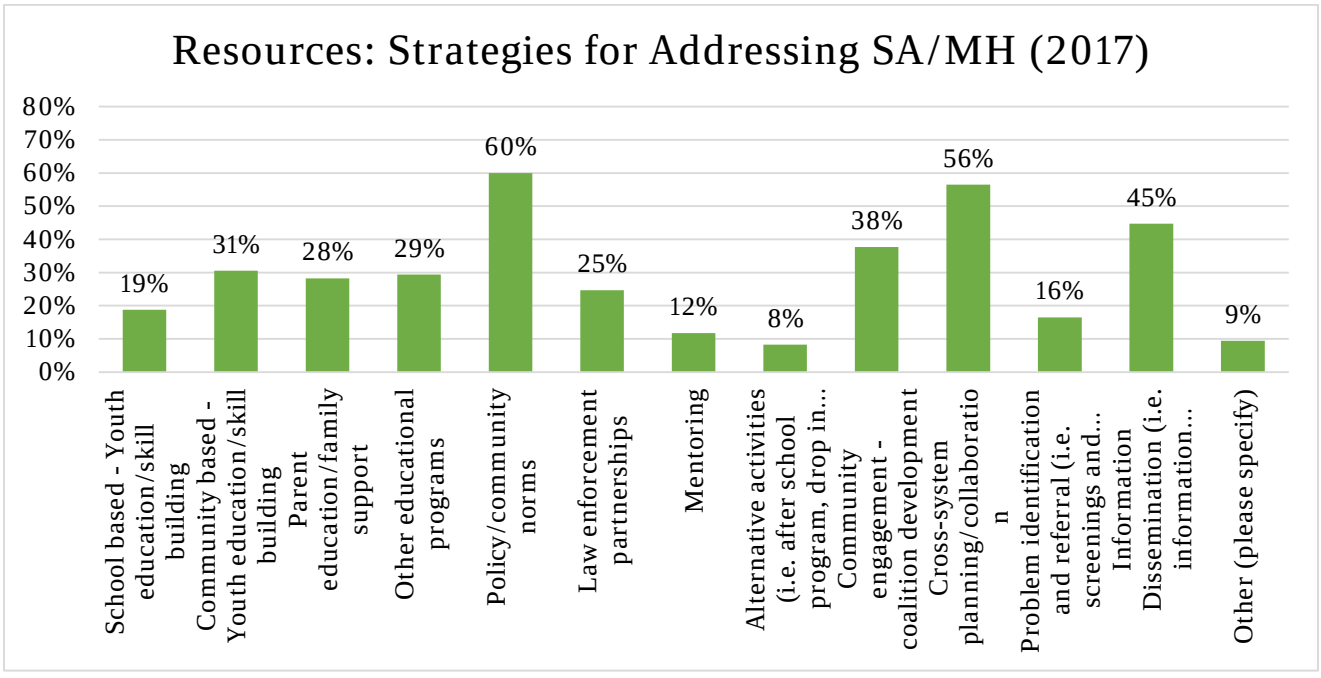
DOH - National Violent Death Reporting System		X						
DOH - Prevention for States Prescription Drug Overdose Grant	X				X			
DOH - SAMHSA youth suicide prevention grant	X	X	X	X	X			
DOH - Statewide Suicide Prevention Plan	X	X	X		X	X	X	X
DOH - State Overdose Response Plan		X						
DOH - Children with Special Health Care Needs				X				
DOH - Family Planning		X	X	X	X	X	X	
DOH - Home Visiting		X	X	X		X	X	
DOH - Personal Responsibility Education Program in Washington State (WA PREP)		X	X	X			X	
DOH - Project LAUNCH Grant		X	X	X			X	
DOH - TVPPC Program Strategic Plan (2017-2021)	X							X
DOH - Tobacco County Profiles	X							X
DOH - Listen2YourSelfie.org		X	X	X				
DOH - Marijuana Health Disparities Contracts								
DOH - Tobacco Related Disparities in WA State (health equity)	X							X
DOH - WA Tobacco Facts	X	X						
HCA - Mental Health Services Insurance Benefit for Medicaid Eligible and Public Employee	X	X	X	X	X	X	X	X
HCA - New initiative on Opioid Prescribing								
HCA - Substance Use Disorder insurance benefit for Medicaid Eligibles and Public Employees	X	X	X	X	X	X	X	
IPAC - Support Tribes	X						X	
LCB - Printed Materials		X						
OIP - Support Tribes	X						X	
OSPI - Life Skills			X					X
OSPI - Project AWARE	X	X	X					X
OSPI - Student Assistance			X	X				
OSPI - Suicide Prevention Program					X			X
PSCBW - Certification for Prevention Professionals							X	
PSCBW - Substance Abuse Prevention Skills Training (WA-SAPST)	X							
WAPCo - Washington Association of Prevention Coalitions		X						
WSU - Interdisciplinary Ph.D. Program in Prevention Science							X	
OSPI - Project AWARE	X							
OSPI - Student Assistance	X	X	X					X
OSPI - Suicide Prevention Program	X		X	X				
PSCBW - Certification for Prevention Professionals			X	X				
PSCBW - Substance Abuse Prevention Skills Training	X		X	X				
WAPCo - Washington Association of Prevention Coalitions		X			X			X
WSU - Interdisciplinary Ph.D. Program in Prevention Science	X				X		X	X

RESOURCES ASSESSMENT FIGURE 7



Note: Source – SPE Resources Assessment 2011, n=64

RESOURCES ASSESSMENT FIGURE 8



Note: Source – SPE Resources Assessment 2017, n=85

RESOURCES ASSESSMENT FIGURE 9

Resources by Strategy	Youth Education/Skill building - School based	Youth Education/Skill building - Community based	Parent education/family support	Other educational programs	Policy/community norms	Law enforcement	Mentoring	Alternative activities	Community engagement/ coalition development	Problem identification and referral	Information dissemination	Cross-system planning/ collaboration
AGO - Litigation, Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action					X							X
AGO - Opioid Summit					X							X
AGO - Tobacco 21					X							X
CCSAP - Webinars				X								
CCSAP -Year End Young Adult Professional Development Conference				X								
DBHR - Community Prevention and Wellness Initiative (CPWI)	X	X	X	X	X	X	X	X	X	X	X	X
DBHR - Community-based Marijuana Services Grants	X	X	X	X	X	X	X	X	X		X	X
DBHR - Community-based Opioid/Prescription Services Grants	X	X	X	X	X	X	X	X	X		X	X
DBHR - Evidence Based Practice Workgroup	X	X	X	X	X		X	X	X	X	X	X
DBHR - Healthy Youth Survey					X				X			X
DBHR - Mental Health Promotion and Suicide Prevention Projects		X	X		X		X		X		X	X
DBHR - Prescription Provider Education				X							X	
DBHR - Prescription Safe Storage Training				X							X	
DBHR - Prevention Summit/SYF/Coalition Institute	X	X	X	X	X	X	X	X	X	X	X	X
DBHR - Public Education Campaign On Opiate Misuse/Abuse Prevention			X								X	
DBHR - Start Talking Now - Website for Parents			X		X	X						X
DBHR - The Athena Forum - Website for Prevention Professional/Partners					X				X		X	X
DBHR - Tribal Mental Health Promotion Mini Grant	X	X	X	X	X		X	X	X	X	X	X
DBHR - Tribal Prevention and Wellness Programs	X	X	X	X	X	X	X	X	X	X	X	X
DBHR - Underage Drinking Use Media Campaign			X								X	
DBHR - UW Tele Pain				X							X	
DBHR - WA-SBIRT Trainings												
DBHR - Workforce Development, Trainings, and Technical Assistance	X	X	X		X		X		X		X	X
DEL - Early Support for Infants and Toddlers			X	X								

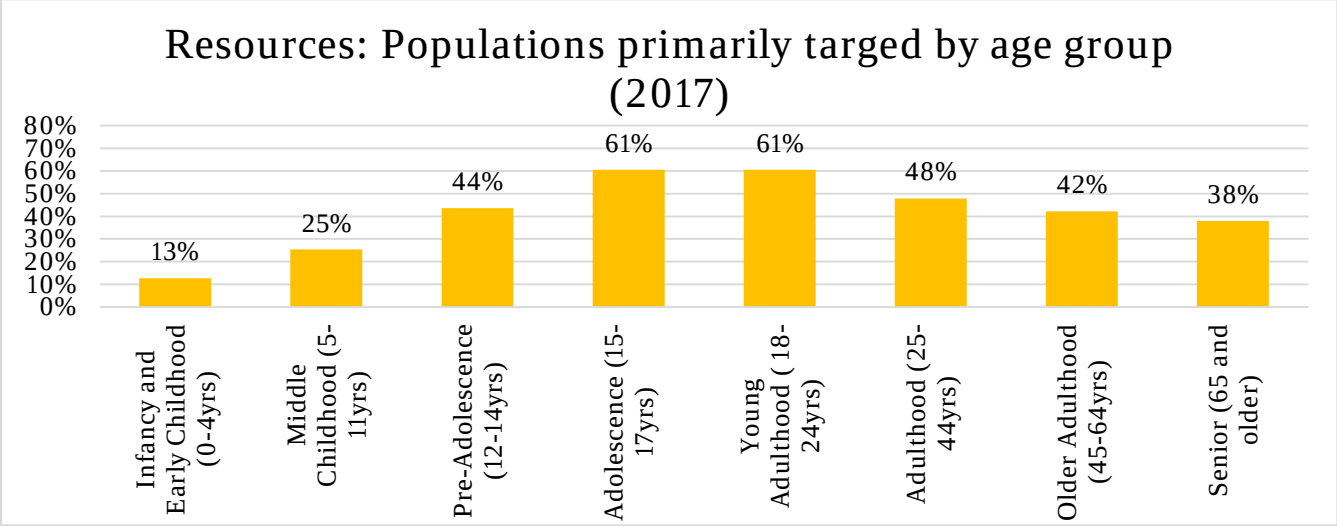
Resources by Strategy	Youth Education/Skill building - School based	Youth Education/Skill building - Community based	Parent education/family support	Other educational programs	Policy/community norms	Law enforcement	Mentoring	Alternative activities	Community engagement/ coalition development	Problem identification and referral	Information dissemination	Cross-system planning/ collaboration
DEL - ECEAP Early Childhood Education Economic Assistance Program State Preschool				X						X		
DEL - Head Start	X											
DEL - Home Visiting Programs- 4 EBPs		X	X		X		X		X			
DEL - Infant Toddler Regions					X		X		X	X		X
DOH – Contract for local youth suicide prevention efforts	X	X							X			
DOH - Mandatory (E2SHB 2793) Suicide Prevention Trainings for Health Care Professionals				X						X		X
DOH - Action Alliance for Suicide Prevention	X	X			X	X				X	X	
DOH - Suicide Prevention Plan Implementation Workgroup	X	X							X			
DOH - National Violent Death Reporting System				X						X		
DOH - Prevention for States Prescription Drug Overdose Grant	X	X			X	X						X
DOH - SAMHSA youth suicide prevention grant		X	X						X			
DOH - Statewide Suicide Prevention Plan					X	X						X
DOH - State Overdose Response Plan					X	X						X
DOH - Children with Special Health Care Needs			X						X	X	X	X
DOH - Family Planning	X	X	X	X		X				X	X	X
DOH - Home Visiting					X	X			X			X
DOH - Personal Responsibility Education Program in Washington State (WA PREP)	X	X	X	X	X				X	X	X	X
DOH - Project LAUNCH Grant			X	X	X	X			X	X	X	X
DOH - TVPPC Program Strategic Plan (2017-2021)					X	X						
DOH - Tobacco County Profiles											X	X
DOH - Listen2YourSelfie.org			X								X	
DOH - Marijuana Health Disparities Contracts					X	X						
DOH - Tobacco Related Disparities in WA State (health equity)					X	X						
DOH - WA Tobacco Facts				X	X						X	
DOH - YMPEP Regional Grants			X	X					X		X	X
DOH - Prescription Drug Monitoring Program					X	X					X	X
DOH - Mass Media resources											X	X

Resources by Strategy	Youth Education/Skill building - School based	Youth Education/Skill building - Community based	Parent education/family support	Other educational programs	Policy/community norms	Law enforcement	Mentoring	Alternative activities	Community engagement/ coalition development	Problem identification and referral	Information dissemination	Cross-system planning/ collaboration
DOH - Tobacco Sustainability Plan					X							X
HCA - Mental Health Services Insurance Benefit for Medicaid Eligible and Public Employee											X	X
HCA - New initiative on Opioid Prescribing					X						X	X
HCA - Substance Use Disorder insurance benefit for Medicaid Eligibles and Public Employees											X	X
IPAC - Support Tribes											X	X
LCB - Liquor and Cannabis Enforcement					X	X			X		X	
LCB - Mandatory Alcohol Server Training (MAST)					X						X	
LCB - Printed materials											X	
LCB - Responsible Vendor Program (RVP)					X	X					X	
LCB - Rulemaking scope					X							
LCB - Technical Assistance/Education				X	X						X	
OIP - Support Tribes					X						X	X
OSPI - Life Skills	X											
OSPI - Project AWARE	X	X										X
OSPI - Student Assistance	X											
OSPI - Suicide Prevention Program	X		X		X				X			X
PSCBW - Certification for Prevention Professionals				X								X
PSCBW - Substance Abuse Prevention Skills Training (WA-SAPST)				X								X
WAPCo - Washington Association of Prevention Coalitions					X		X		X		X	
WASAVP - Action Alerts		X			X							
WASAVP - Annual meeting at Prevention Summit in Yakima		X			X							X
WASAVP - Annual Policy Platform for prevention		X			X				X			
WASAVP -Monitoring and advocating for prevention with State Legislature		X			X				X			X
WASAVP - Occasional position papers relevant to prevention		X			X				X		X	
WASAVP - Prevention Policy Day each January/February in Olympia		X			X	X			X			
WASAVP - WASAVP Website		X			X				X		X	
WSU - Interdisciplinary Ph.D. Program in Prevention Science				X								X
WTSC - Click it or ticket					X	X						
WTSC - DUI enforcement campaigns					X	X						

Resources by Strategy	Youth Education/Skill building - School based	Youth Education/Skill building - Community based	Parent education/family support	Other educational programs	Policy/community norms	Law enforcement	Mentoring	Alternative activities	Community engagement/ coalition development	Problem identification and referral	Information dissemination	Cross-system planning/ collaboration
WTSC - HS distracted driver projects						X						X
WTSC - Traffic Safety Task Forces - Target Zero						X						X

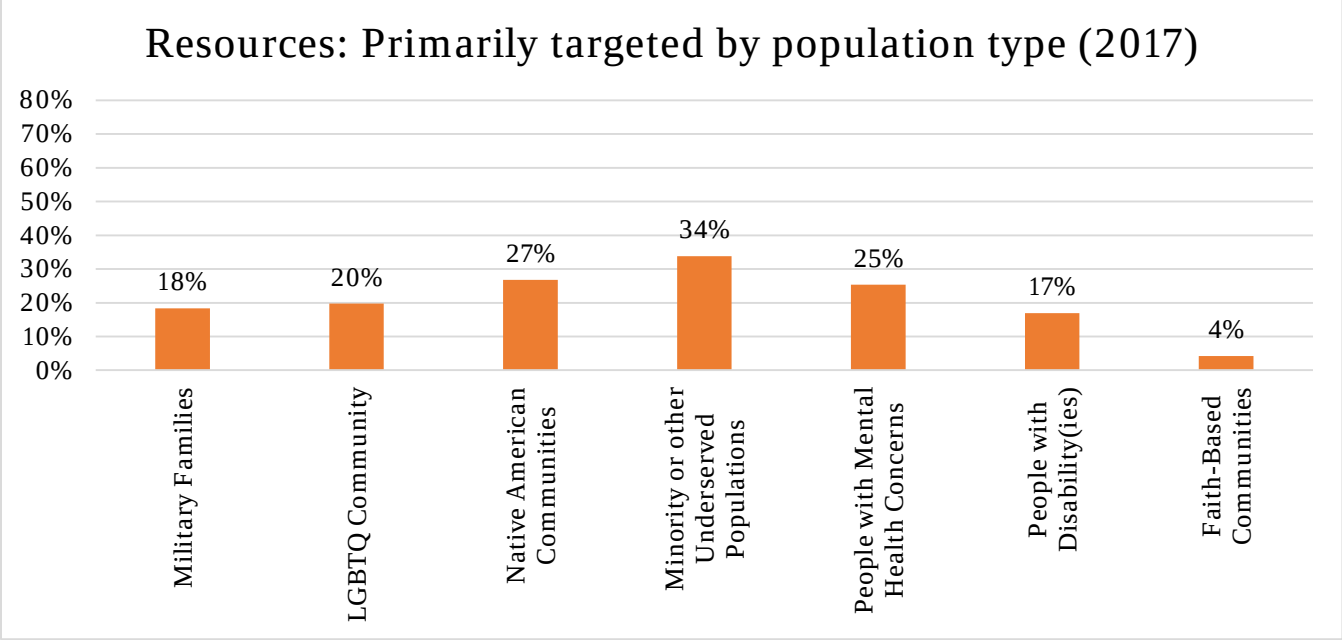
Resources by Targeted Age and Type

RESOURCES ASSESSMENT FIGURE 10



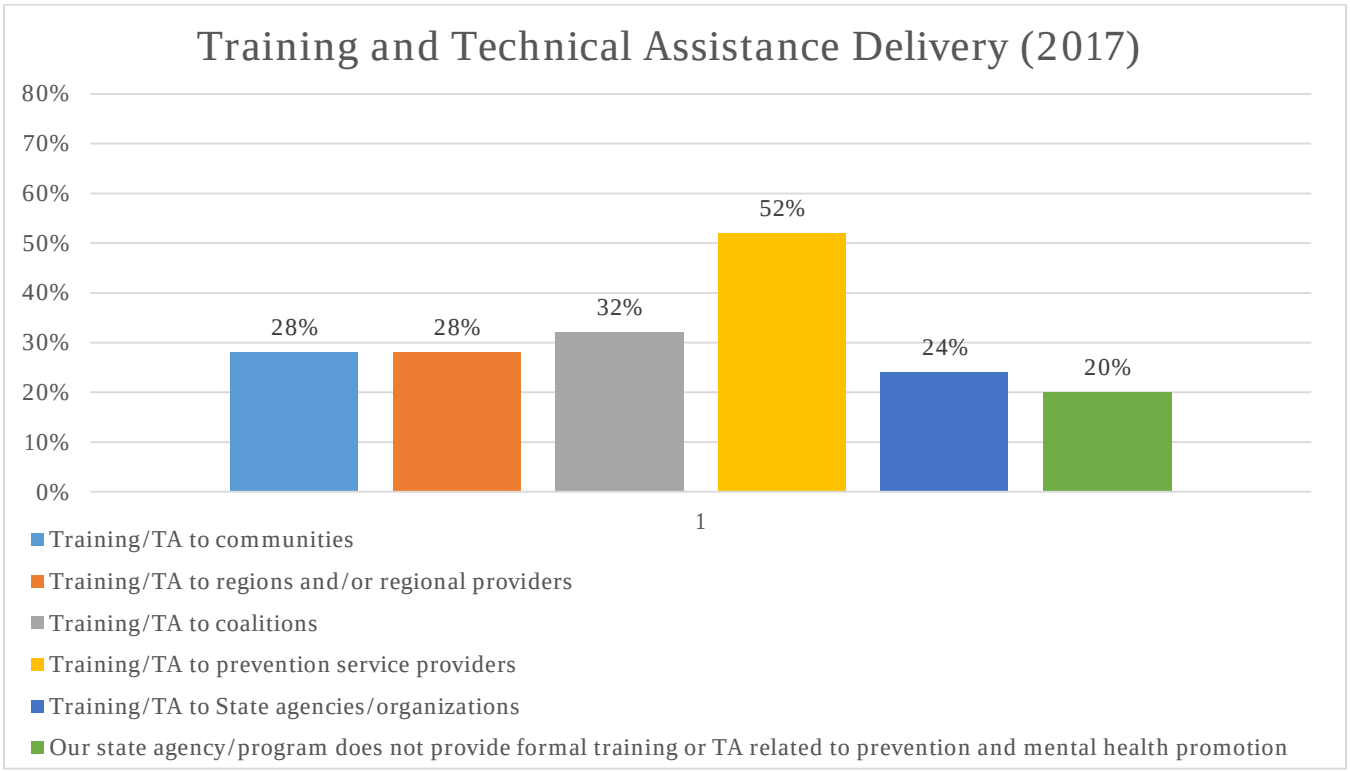
Note: Source – SPE Resources Assessment 2017, n=72

RESOURCES ASSESSMENT FIGURE 11



Note: Source – SPE Resources Assessment 2017, n=72

RESOURCES ASSESSMENT FIGURE 12

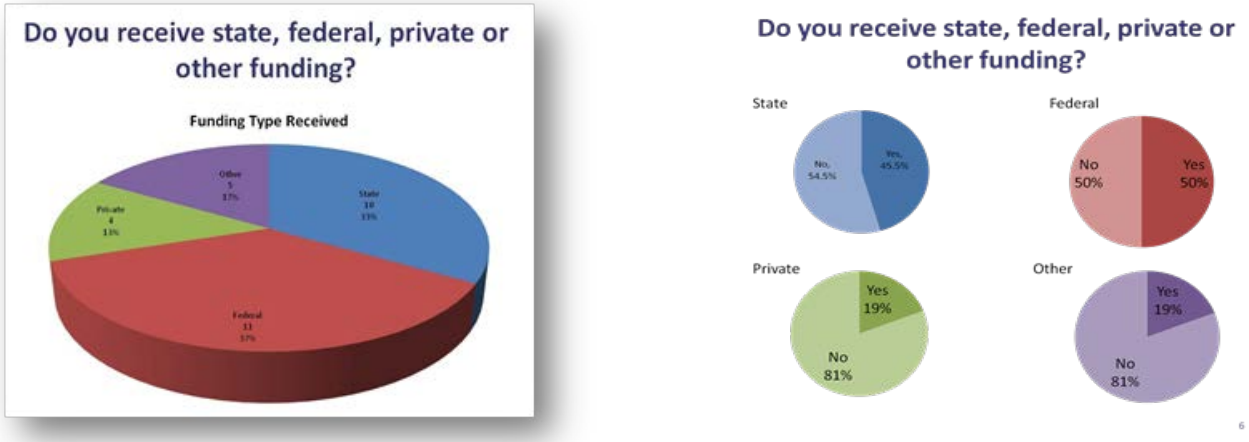


Note: Source – SPE Resources Assessment 2017, n=25

Funding Resources

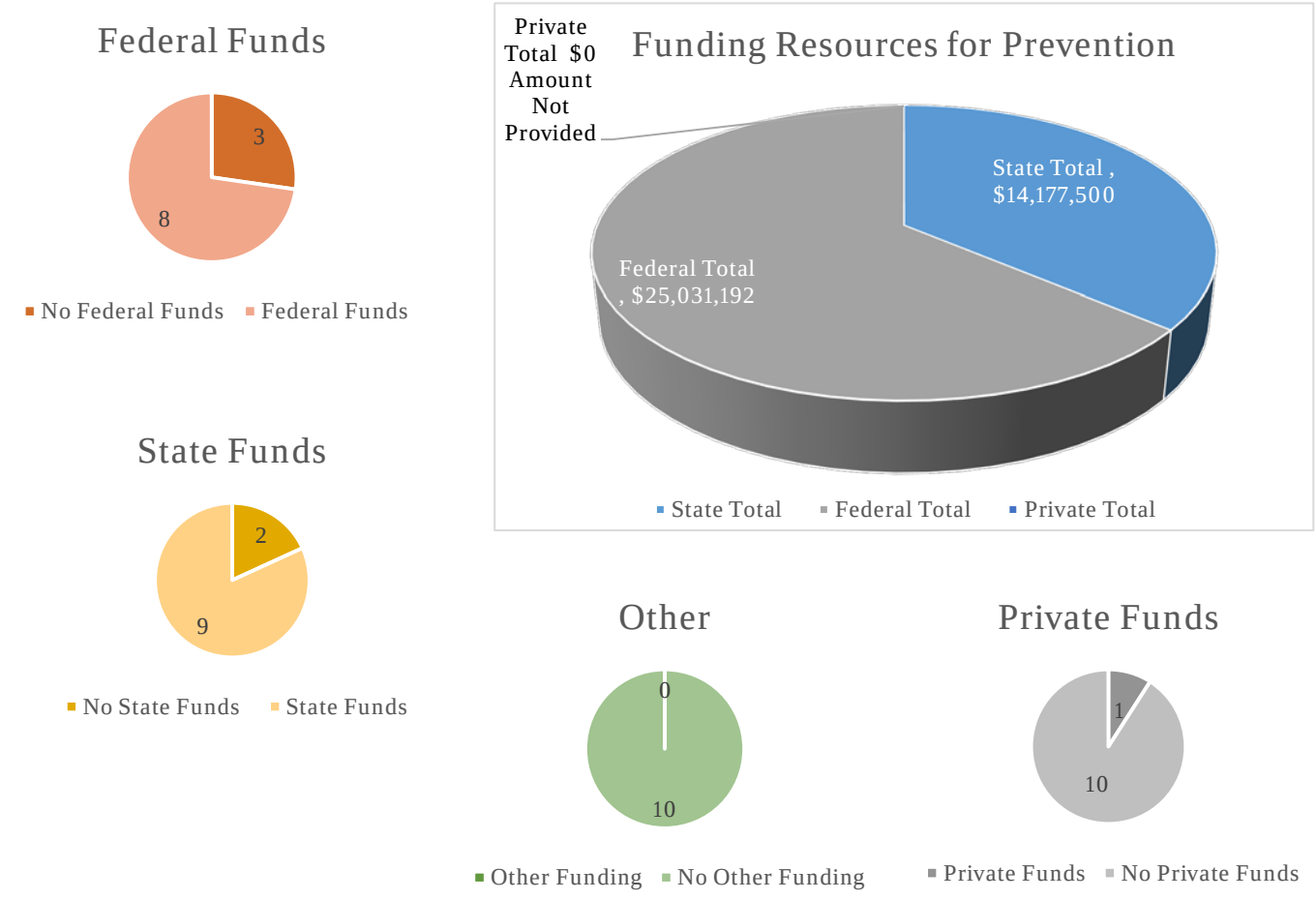
RESOURCES ASSESSMENT FIGURE 13

2011 Resources Assessment



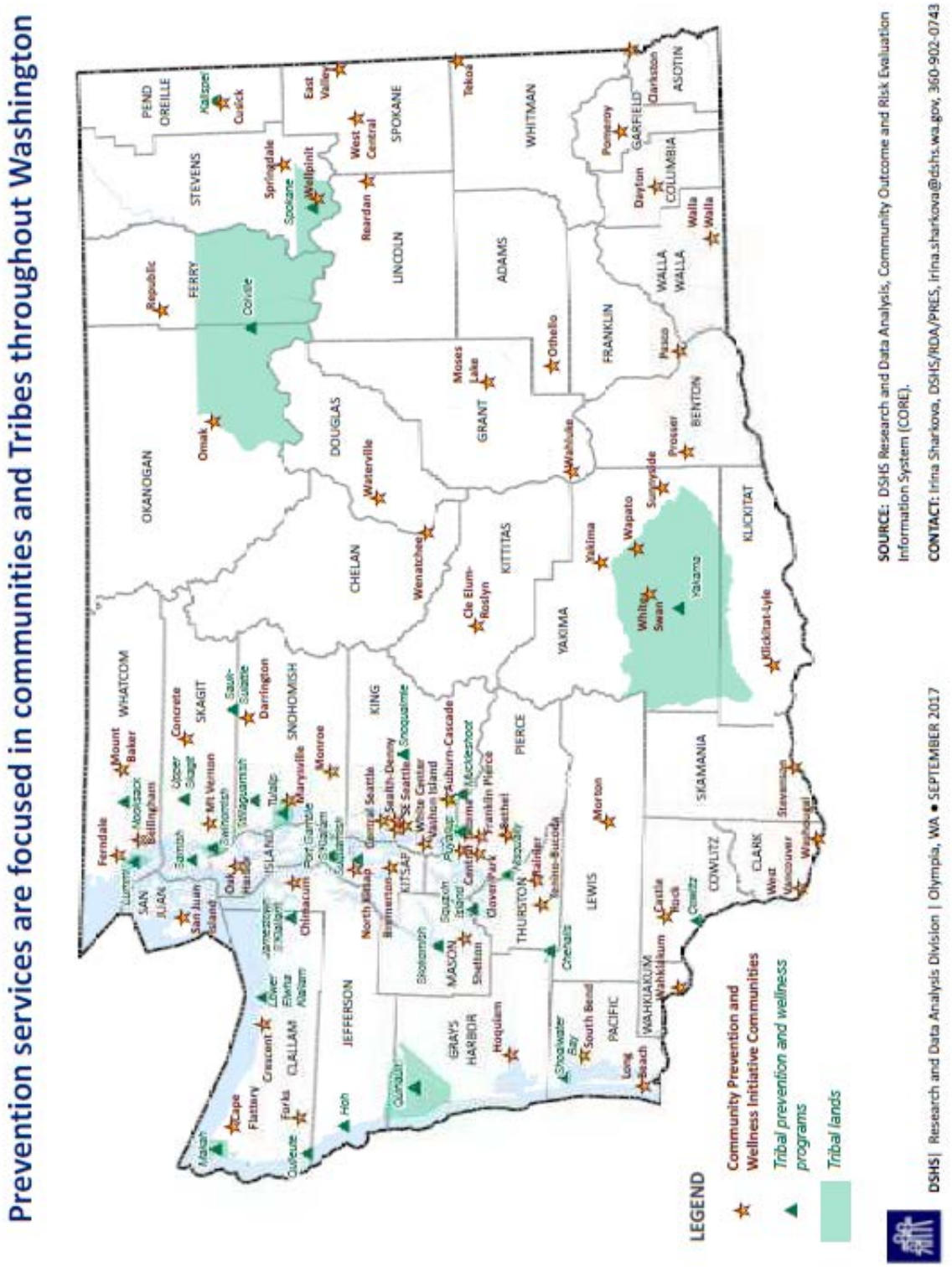
RESOURCES ASSESSMENT FIGURE 14

2017 Resources Assessment

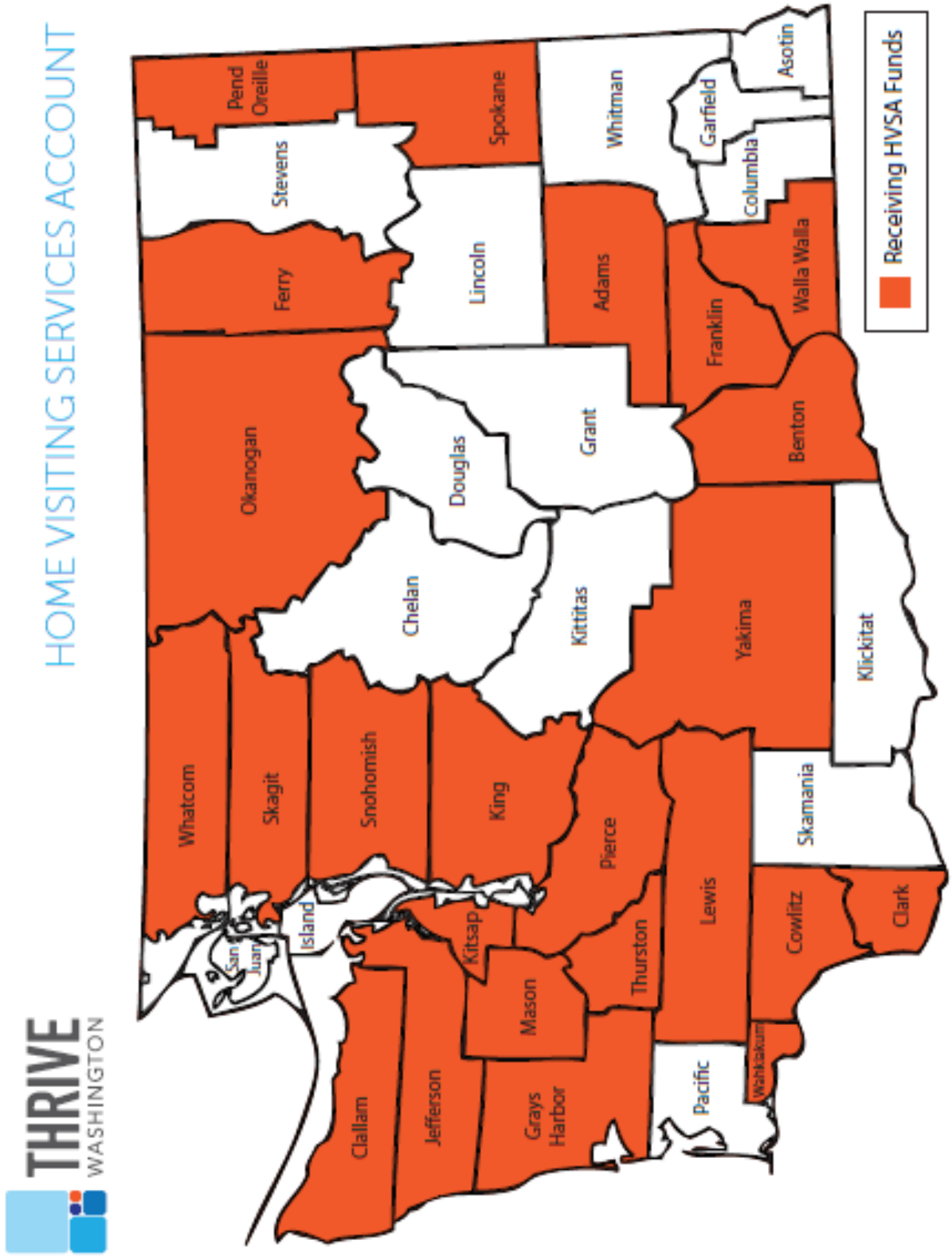


Prevention Services Maps in WA States

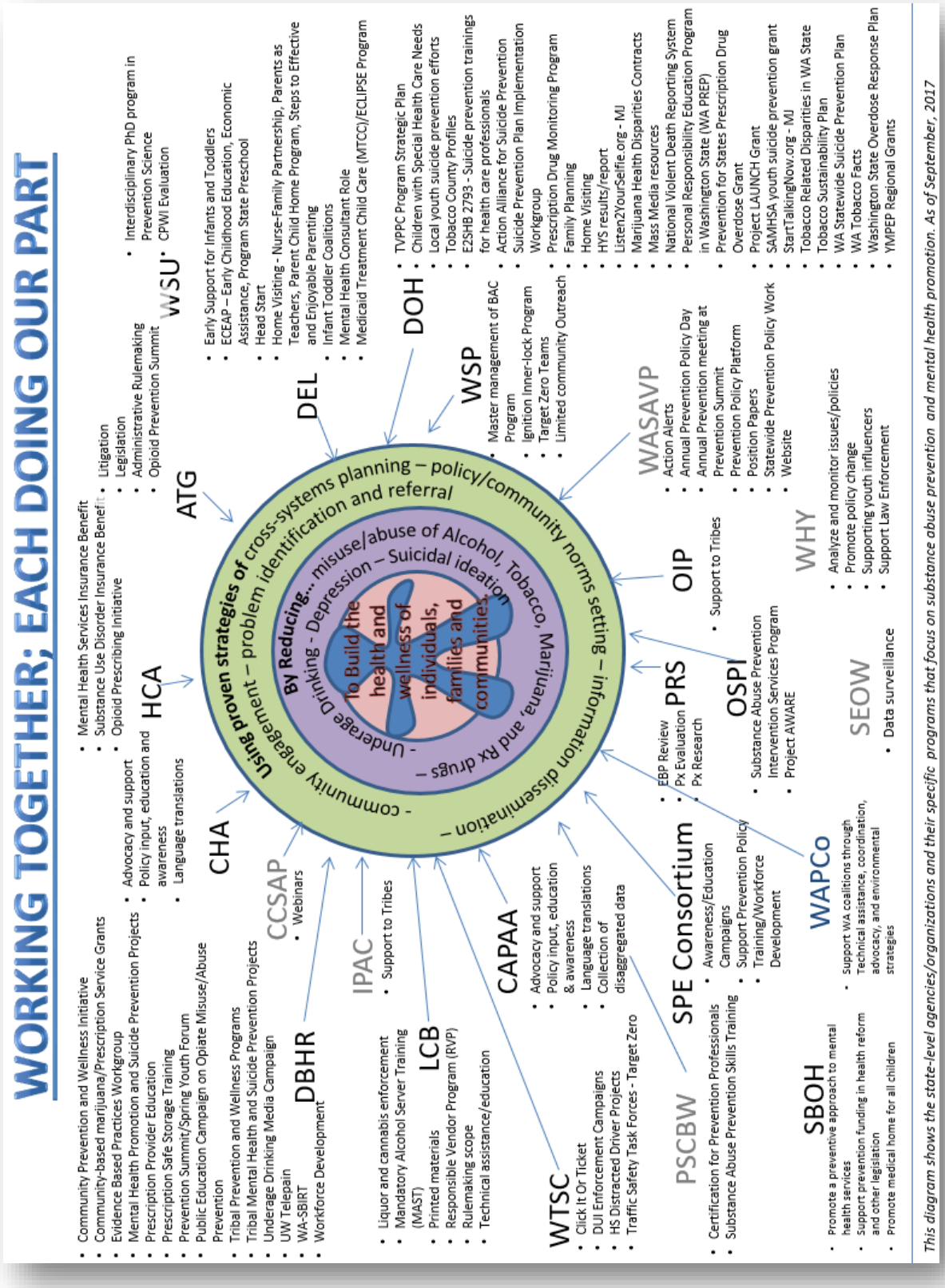
Community Prevention and Wellness Coalitions (CPWI) Coalitions and Tribal Prevention and Wellness Initiative Sites.



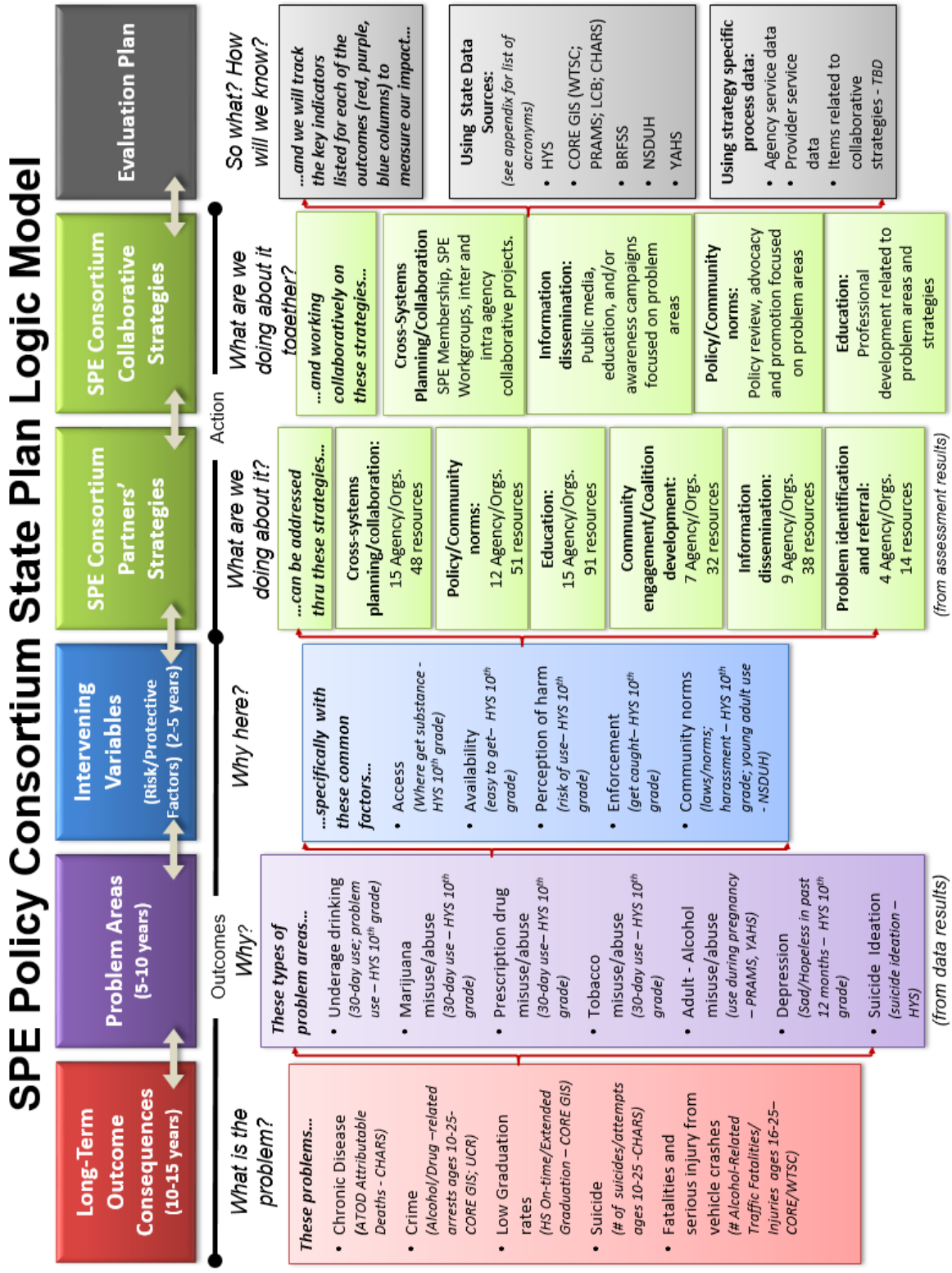
Home Visiting Sites in Washington



6. Diagram of Resources



7. Logic Model



8. List of Accomplishments

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

2013-2014

Coalition Activities

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

Engage Liquor Control Board in Rule Making

- LCB provided recommendations to the legislature on Medical Marijuana (MMJ). Support for the recommendations were based on demonstrating the impact to risk and protective factors that segments of MMJ (home grows allowed, tax breaks, and increased purchase amounts) have on youth and 18-21 year olds.
- The team continues to educate rule makers about these issues and to also communicate to the prevention field (Washington Association of Substance Abuse and Violence (WASAVP) and Coalition of Coalitions (CoC)).

Website and Resources & FAQs

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

Conference to Gather State Leaders and Key Stakeholders

- Youth Marijuana Use Prevention symposium, completed July 2013.

Let's Draw the Line between Youth and Alcohol

- Project reached 5,000 people in 42 communities.
- Let's Draw the Line project 2014: 34 Washington community groups participated in the project. Each community received up to $1,000 for completion of a Community Assessment of Neighborhood Stores (CANS) surveys and their choice of two other projects from a menu of 10 possible projects. The project concluded June 30, 2015.

Law Enforcement Partnerships

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

I-1183 Advisory Committee

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

2014-2015

Let's Draw the Line between Youth and Alcohol

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

Law Enforcement Partnership

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

Policy Impact Team

- Clarified the process for reporting violations. It was determined that violations should be reported to Liquor Control Board (LCB). LCB's role is primary enforcer of marijuana laws and rules.
- Made available a literature review for stakeholders to use to advocate for the regulation of certain edibles due to inherent dangers.
    - Policy paper was available and provided to LCB for reference.
    - LCB enacted emergency rules to address concerns with marijuana edibles.
- White paper developed and distributed to stakeholders and policy makers to assist them in becoming better informed about powdered alcohol and its potential implications for underage drinking. The paper was read and/or discussed by agency officials, stakeholders, and legislators.
    - House Bill 5292 was passed and signed by the governor. The bill prohibits the possession, use, and sale of powered alcohol.
- Expansion of the Responsible Vendor Program to beer/wine retailers approved by the LCB. Beer/wine retailers are joining the RVP, and 15 coalitions are working with LCB to promote the RVP in order to increase compliance rates for no sales to minors.

Communications Impact Team

- Completed talking points for communities regarding marijuana legalization: June 2014. An info card for parents was translated into eight languages and distributed online and by the Washington Commission on Asian Pacific American Affairs.
- DBHR funded an updated translation of the Cambodian card, and a new translation in Mien. They were uploaded to the www.LearnAboutMarijuanaWA site overseen by the University of Washington Alcohol and Drug Abuse Institute. The plan was to print copies of the translated cards and make them available for ordering through the Washington Department of Enterprise Services webpage for publications. The information was posted on the Athena website.
- Communications staff updated the Marijuana Prevention Toolkit page on Athena with links to all of the translated cards.
- Printed 50,000 parent guides and fact cards and distributed to schools through ESDs. The Toolkit is online. Printed 50,000 parent guides and fact cards Toolkit is online and distributed to schools through ESDs.
- DOH launched a one-month radio and online marijuana educational campaign targeting parents. The campaign was announced by Governor Inslee on June 2014 with 34.8 million impressions and 38,888 visits to campaign website.
- A radio ad featuring Dr. Walker from the Children's Hospital aired statewide beginning May 2015 to educate parents about the state's laws regarding recreational marijuana use (I-502).
    - Parents were directed to the StartTalkingNow.org website for more information, and tips on talking with their kids about the risks of marijuana.

- In March, fact sheets and talking points were updated with the 2014 Healthy Youth Survey results. Updated tools are added online regularly.
- A new video for parents with prevention tips from a pediatrician was posted to the StartTalkingNow.org webpage on January 2015.
- The Start Talking Now (STN) homepage is currently under redesign. New pages are being created for parents in multiple languages. A Spanish language page for parents was completed June 2015.
- Prevention professional interview by Bea Mendez aired on the Univision, a Spanish language station.
- Launched a successful youth marijuana prevention media campaign: Listen2YourSelfie.org.
- Launched a successful parent and adult influencer campaign: Under The Influence...of you. (DOH YouTube page for videos and starttalkingnow.org for resources.)

2015-2017

Coalition Activities:

Kept members informed through consistent legislative updates on laws and rules that do or could impact underage alcohol and/or marijuana use.

- Promoted good policy decisions by providing feedback to the Liquor and Cannabis Board (formerly the Liquor Control Board) regarding marijuana packaging and labeling and the potential impact on children and youth.
- Provided information on emerging issues and current research and data through presentations on:
    - The National Academies of Science Report on the Health Effects of Cannabis and Cannabinoids, presented by Dr. Gillian Schauer and Dr. Tim McAfee.
    - Emerging Issues in Adolescent Treatment.
    - What Works in Prevention by Joe Neigel, Monroe Community Coalition Coordinator.
    - 2016 Washington State Healthy Youth Survey.
- Updated our Strategic Plan to reflect current needs and proposed activities.
- Increased Coalition membership with additional state agency representatives.

Communication Team:

- Served as advisory team for the Department of Health Youth Marijuana Prevention and Adult Influencer Campaigns as well as the DSHS Underage Drinking Prevention Media Campaign.
- Informed the update and redesign of the StartTalkingNow.org website (STN).
- Regularly posted new articles to the STN website and the Facebook page.
- Consistently increased Facebook page Likes and Shares.
- Translated parent page of STN into additional languages.
- Updated the Parent Guide, which has been added to the DSHS/DBHR Washington's Best Practices for Substance Abuse Prevention and Mental Health Promotion Guides (aka Toolkits) for distribution to prevention providers and partners across the state.

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

2013-2014

Workgroup Activities:

- Developed an action plan to provide outreach to colleges and universities and used training funds from Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant to support non-grantee sites with training.
- Coordinated conference in October 2014 to provide SBIRT Training to healthcare community.
- Department of Health (DOH) created online training for physicians, nurses, and other healthcare workers through the Washington Healthcare Improvement Network (WHIN) Institute.

2014-2015

Workgroup Activities:

- Provided a platform for Dr. Jason Kilmer, Dr. Paul Grossberg, and Dr. Jim Schaus to lead a one-day SBIRT training/conference to teach medical providers about SBIRT services.
- Disseminated the *Substance Abuse During Pregnancy: Guidelines for Screening and Management* best practice guide, via email and list serves.
    - http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy
- Completed Washington State Hospital Association (WSHA) Safe Deliveries Roadmap standards/QI project. Purpose of standards is to improve care and ensure comprehensive care including screening and referring for substance use/abuse. Standards finalized and vetted with all the subadvisory committees involved in developing them; released spring 2015. Project included recommended evidence-based standards for primary care for child-bearing age and pregnancy care. SBIRT is included in these standards.
- Women's Healthy messages portal page and factsheet were developed DOH webpage.
- DOH launched webpage health information for pregnant women.
    - http://www.doh.wa.gov/YouandYourFamily/WomensHealth
    - http://www.doh.wa.gov/YouandYourFamily/WomensHealth/Pregnancy
- College Coalition for Substance Abuse Prevention hosted a year-end conference.

2015-2017

Workgroup Activities:

- Disseminated the *Substance Abuse During Pregnancy: Guidelines for Screening and Management Best Practice Guide* at medical meetings/conferences and via email and Listserv.
- Continued to promote the Final Care Recommendations from the WSHA Safe Deliveries Roadmap standards available on: http://www.wsha.org/0513.cfm%20.
- College Coalition for Substance Abuse Prevention provided an end of the year conference May of 2017 and two additional webinars.
- Obtained data on alcohol and tobacco use for women during pregnancy from the 2014 Pregnancy Risk Assessment Monitoring System (PRAMS) survey for the State Prevention Enhancement needs assessment.
- Identified new members for the Young Adult and Pregnant Women Workgroup to sustain efforts.

- Implemented third iteration of the Young Adult Health Survey (N=2493) and follow-up surveys with cohorts 1 (N=1005) and 2 (N=1180).
- SBIRT trainings scheduled in Pierce and Snohomish counties for providers. Additional trainings occurred on college campuses throughout the state.
- Identified funding to increase substance misuse/abuse prevention best practice materials for young adults to be provided to local coalitions.

Tobacco Misuse/Abuse Prevention Team Accomplishments

2013-2014

Participated in and Presented at TAP Summit

- Tobacco-Free Alliance of Pierce County held summit in December 2013 and 117 people attended.
    - Included a call for advocates to join efforts with Heart, Lung, & American Cancer Society.
    - Held a health meeting to address the creation of a community driven, statewide tobacco coalition that will provide advocacy prevention funding.

Washington Health Improvement Network (WHIN)

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

The Fresh Air Campus Challenge

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

Tobacco Prevention Accomplishments

- Attorney General Ferguson, along with other state attorney generals in the US, will sign a letter to the FDA urging the FDA to ban menthol cigarettes.
- Staff from the Attorney General's office (AGO) sent a letter to R.J. Reynolds asking for information about recent magazine advertising campaigns, which raise concerns about youth exposure to cigarette advertising.
- Several public health organizations and six state attorney generals sent a letter to the CEO of Comcast (which owns Universal Studios) requesting that marketing materials for the upcoming feature film *Rush* be scrubbed of smoking and cigarette brand imagery.
- Partners met with Parent Teacher Association (PTA) Executive Director and provided information on movie smoking to help inform membership about the issue.
    - Resulted in a basis for making contact with the national PTA office.
    - Began work with staff at Legacy to arrange a meeting between federal Health and Human Service officials and the national PTA Executive Director to discuss grass roots involvement in the movie smoking issue.
- Washington is chairing a formed a workgroup of state AGOs that reviewed and updated priorities for AGOs' public health-related work under the Master Settlement Agreement (MSA) (there are other MSA issues, such as enforcing payment requirements, dealing with bankrupt tobacco companies, etc., that do not directly involve advancing public health).
- Washington participated in a work group which submitted comments to the (FDA) on its proposed rule regarding the deeming of certain products to be "tobacco products."

- Washington continues to chair a workgroup on smoking in the movies, which is actively working with other stakeholders to develop policy advocacy and media strategies. The ultimate goal is to eliminate smoking in youth-rated movies (a goal that was included in the SPE Strategic Plan).
- Washington continues to co-chair a workgroup that encourages and supports collaboration between state health departments, community based organizations, and state AGOs.
- Washington State University adopted tobacco-free campus policy.
- Built Athena page for Tobacco Abuse Prevention http://www.theathenaforum.org/tobacco.

2014-2015

Team Activities

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

2015-2017

Team Activities

- Participated in the development of the Department of Health – Attorney General Legislation to regulate vapor products and increase fees and fines for tobacco retailers, which passed in modified form in 2016.
- Contributed to the implementation of the vapor products legislation, RCW 70.345, especially during calendar year 2016.
- Planned and delivered a statewide webinar to address the state's vapor product law and the new FDA's Deeming Rule, state law implementation, and state agency roles. The webinar was a

collaborative effort involving the Office of the Governor, Department of Health, Office of the Attorney General, and the Liquor and Cannabis Board.
- Contributed to a House Committee on Commerce and Gaming session addressing agency roles, the implementation of the new state vapor law, and legal and regulatory issues.
- Advanced Tobacco 21 legislation farther than it had gone before.
- Contributed to the House Committee On Health Care and Wellness Legislative Work Session on the value of and need for an adequately funded comprehensive tobacco prevention and control program, trends in tobacco and vapor product use, health and fiscal impacts, best practices and the elements of a comprehensive program, the history of funding, return on investment, and tobacco-related disparities.
- Finalizing the state's Five-year Tobacco and Vapor Product Prevention and Control Sustainability and Strategic Plans (2 plans total).

Prescription Drug Misuse/Abuse Prevention Action Team Accomplishments

2013-2014

Information Dissemination to Communities

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

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

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

2014-2015

Information Dissemination to Communities

- Jennifer Sable presented the background (history and purpose) of the Unintended Poisoning Work Group (UPWG) and PMP. Also presented on Opioid Guidelines revision. Some of the major changes/updates we can expect to see in the release of these new guidelines are centered on the procedures and guidelines for Emergency Room Departments. Jennifer also let the group

know that ER departments and Safeway pharmacies are using the DOH "Take as Directed" brochures. The update released on June 2015.
- Alex Schwartz presented to the Pain Medicine Department at Harborview Medical Center on March 2015 and educated the physicians and health care team on the PMP.
- Presented to providers at Co-occurring Conference and to the College Coalition.

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

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

2015-2017

Team Accomplishments

- Pain and addiction nursing presentations included PMP promotion
    - Presentations at University of Washington Nursing Conference, Mason General Hospital, Washington Academy of Physicians Assistants, and Lake Roosevelt Community Health Center.
- Article on safe opioid use for Nursing Commission publication in May to all licensed nurses.
    - Draft principles shared with academic centers to promote evidence based pain treatment that is consistent across health service programs.
- Provided Weekly Telepain conference calls.
- Bree Collaborative finalized fact sheet on Opioid Medication.
    - DBHR promotes fact sheet on StartTalkingNow.org website.
    - Information from this sheet was used in the social media campaign message development.
- DBHR, L&I, and Bree Collaborative are planning for two provider education symposiums on opiate prescribing and ways to prevent opioid misuse and abuse among youth and adults.
    - Funded by the State Targeted Response to Address the Opioid Crisis grant funds. Symposiums will be held in fall 2017.
- Contracting with ADAI to redesign Good Sam Law awareness and Overdose prevention messaging focused on young adults.
    - ADAI conducted a conversation with youth at the Spring Youth Forum to learn more about social messaging appeal for 11th and 12th grade high school students.

- Conducted a six-week social media campaign to raise awareness. Messages were sent to all school districts and various community providers.
    - 100 national websites reviewed by ESD 112 and developed toolkit with final messages.
    - Washington's campaign modeled after the CADCA National Medicine Abuse Awareness Month.
    - Promoted Safe Use, Safe Disposal, and Safe Storage to prevent youth misuse and abuse.
- Developing a state-wide media campaign for late summer/ fall 2017 with State Targeted Response (STR) to the Opioid Crisis funds.
- UW ADAI completed review of existing patient resources in http://adai.uw.edu/pubs/pdf/2017medicationsafetyresources.pdf
- DBHR added a page on StartTalkingNow.org for parents and influential adults to access resources about opioid misuse and abuse prevention and services. www.starttalkingnow.org/parents/find-resources/prescription-drugs
- DBHR was awarded the State Targeted Response to Address the Opioid Crisis federal funds.
    - Eight prevention focused projects
- DBHR funded five additional Targeted Enhancement grants to implement/maintain secure medicine take-back projects.
- The AMDG continues to collaborate with Bree on the development of a dental guideline on prescribing opioids for acute dental pain.
- WSU, Pacific NW University and UW interdisciplinary programs have all agreed to work on an interdisciplinary curriculum project teaching about safe opioid prescribing.
    - The UMASS Medical School has been contacted to provide more information about their existing Opioid Safe Prescribing Curricula (OSTI) for the group to give comments if they want to use the existing resource or develop a new module.
- Office of the Insurance Commissioner is working with providers and insurers to identify and address issues around reimbursement for chronic pain management and medication-assisted treatment.

Mental Health Promotion Action Team Accomplishments

2013-2014

Team Accomplishments

- Suicide prevention training provided to coalitions in Battleground, North Kitsap, Gig Harbor, King County, Bellingham, Forks, Spokane, Wenatchee, and Grays Harbor. Information, strengths, and challenges were collected.
- Statewide Suicide Prevention Day launched on September 2013 with Governor's Proclamation. Multiple agencies held activities statewide.
- Collaboration with DOH and DBHR on training health care professionals in suicide prevention and youth suicide prevention activity.
- NW Indian College partnered with Colville Confederated Tribes last year to implement a Suicide Prevention project.
- University of Washington (UW) had funding for a suicide prevention project for students at the Seattle Campus. Funding was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Workgroup leads met with DSHS Secretary Quigley regarding suicide prevention with a focus on Native American communities.

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

2014-2015

HB 2315 Implementation

- Completed Statewide Suicide Prevention plan with statewide partners.

2015-2017

Team Accomplishments

- Successfully transitioned between multiple workgroup leads.
- Statewide Mental Health Awareness Month launched on May 1, 2017, with Governor's Proclamation. Multiple agencies held activities statewide.
- Collaboration with DOH and DBHR on youth suicide prevention mini grant opportunities.
- Fully integrated Mental Health Promotion and Suicide Prevention workgroups with co-leads from DOH and DBHR.
- Reviewed and approved outcome measures for workgroup plan.
- Completed a review of Mental Health Promotion measures and agreed to continue working on identifying measures that may be used in the future that are a better measure of mental health.

9. Significant Events Influencing the Field of Prevention from 2010-2017

Significant Events in WA 2010-2015	Year	Economic Event	Policy/ Law Change	Change in Funding
Passing of the Good Samaritan Laws / SB 1671 - Opioid overdose prevention	2010/ 2015		X	
Tobacco sales tax structure changes	2010	X	X	
Passage of Initiative 1183 liquor privatization	2011			
Strengthened managed care monitoring	2011		X	
Contract Language re: mental health services	2012		X	
Elimination of Family Policy Council funding	2012			X
Passing of I-502 Marijuana legalization for non-medical use	2012		X	
Elimination of Community Mobilization funding	2013			X
SIM Grant Awarded to Health Care Authority & Accountable Communities of Health	2013			X
Vast expansion of electronic cigarette industry/marketplace	2013		X	
Added SBIRT to Medical Benefit	2014		X	
Garret Lee Smith Grant awarded DOH	2014			X
House Bill 2315 passed (suicide prevention)	2014		X	
WA Prescription Drug Monitoring Program (PMP) State funded	2014		X	X
Significant decrease in youth perception of harm (marijuana use)	2014			
Opening of retail marijuana stores in WA State	2014	X	X	
DEA Rules on Rx Drugs and Drug Take-back Program ended	2015		X	
Youth Mental Health First Aid Pilot Efforts	2015			X
Oregon/ Alaska retail marijuana legalization	2015		X	

Potential developmental Screening for young children	2015		X	
Expansion of home visiting (2 million)	2015			X
SB 5052 passed: legalized medical marijuana/ home grows	2015	X	X	
Strengthened language in contract re: Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	2015		X	
Tax funding from I-502 for prevention and treatment programs allocated	2015		X	X
Tribes able to sell and produce marijuana legally	2015	X	X	
DBHR requires CPP credential for community coalition coordinators.	2015		X	
Health Care Reform - Behavioral Health Organizations (BHO)	2015/ 2016		X	
State Suicide Plan Published	2016			
State Opioid Plan Published	2016			
Fee for Service Program begins for AI/AN Individuals	2016	X		
Executive Order issued by the Governor on Reducing and Preventing Firearm Fatalities, Injuries, and Suicides	2016		X	
Executive Order issued by the Governor to address Opioid Crisis	2017		X	
WA State granted the State Targeted (STR) Response to the Opioid Crisis from SAMSHA	2017	X		

This report was originally prepared in 2011, to be implemented 2012-2017. A new planning process for 2018-2023 began in the fall of 2016. with the partners of the State Prevention Enhancement Policy Consortium by Lucilla Mendoza, MSW, Prevention System Development Manager; and Seth W. Greenfest, Ph.D., Prevention System Project Manager; under the leadership of Sarah Mariani, Behavioral Health Administrator, DBHR; and David Hudson, Section Manager of Community-Based Prevention, Office of Healthy Communities, Department of Health; with support from Chris Imhoff, Director, DBHR; and guidance from Michael Langer, Office Chief for the Office of Behavioral Health and Prevention, DBHR; and Janna Bardi, Director, Division of Prevention and Community Health Director, Department of Health.

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

State Prevention Enhancement Policy Consortium Partners

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