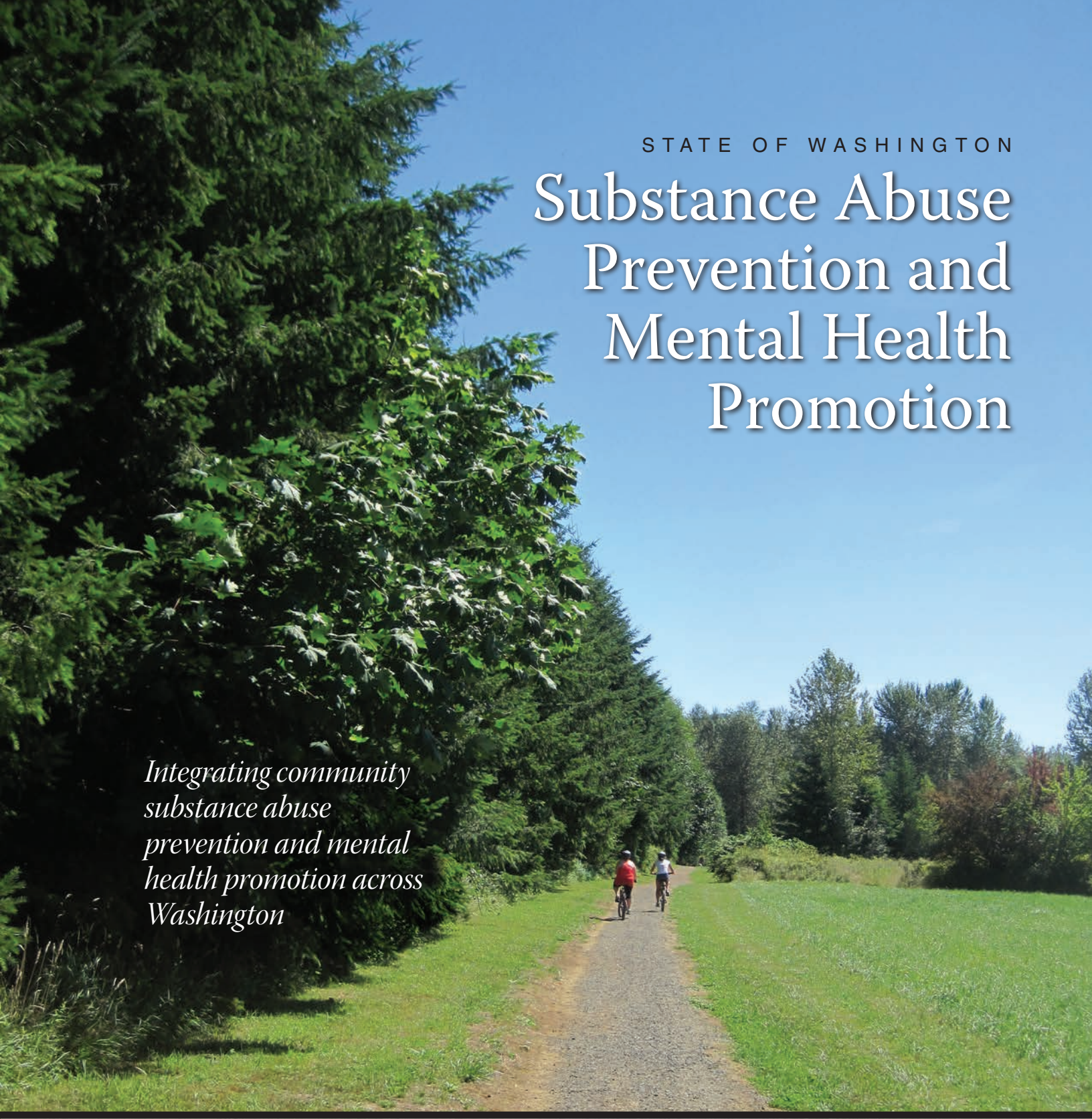

STATE OF WASHINGTON

Substance Abuse Prevention and Mental Health Promotion

Integrating community substance abuse prevention and mental health promotion across Washington

Five-Year Strategic Plan

Washington State Prevention Enhancement Policy Consortium

August 2012 *updated March 2013*

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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*. We are committed to providing the best service to the children, individuals, families, and communities of our state.

Through implementation of this plan, we will 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.

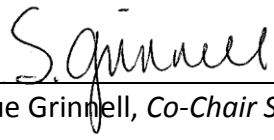
We would like to give special thanks to all of the partnering state and tribal agencies and organizations and to those individuals who participated as representatives serving on the State Prevention Enhancement Policy Consortium. A complete list of representatives can be found in the Appendix -*SPE Consortium Partner List* page 52.

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

Lastly, we would like to thank each of you who participated in the various information gathering opportunities through meetings, discussions, and review of documents. Specifically, we would like to recognize those who participated in the public review of this plan including the tribes that worked with us in the Consultation; and the representatives from Prevention Redesign Initiative Communities, Association of County Human Services, Drug-Free Communities grantees, local health jurisdictions, educational service districts, healthcare plan providers, and treatment providers. We appreciate your input and insight into the needs of our state and the opportunities to address those needs.

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

Sincerely,



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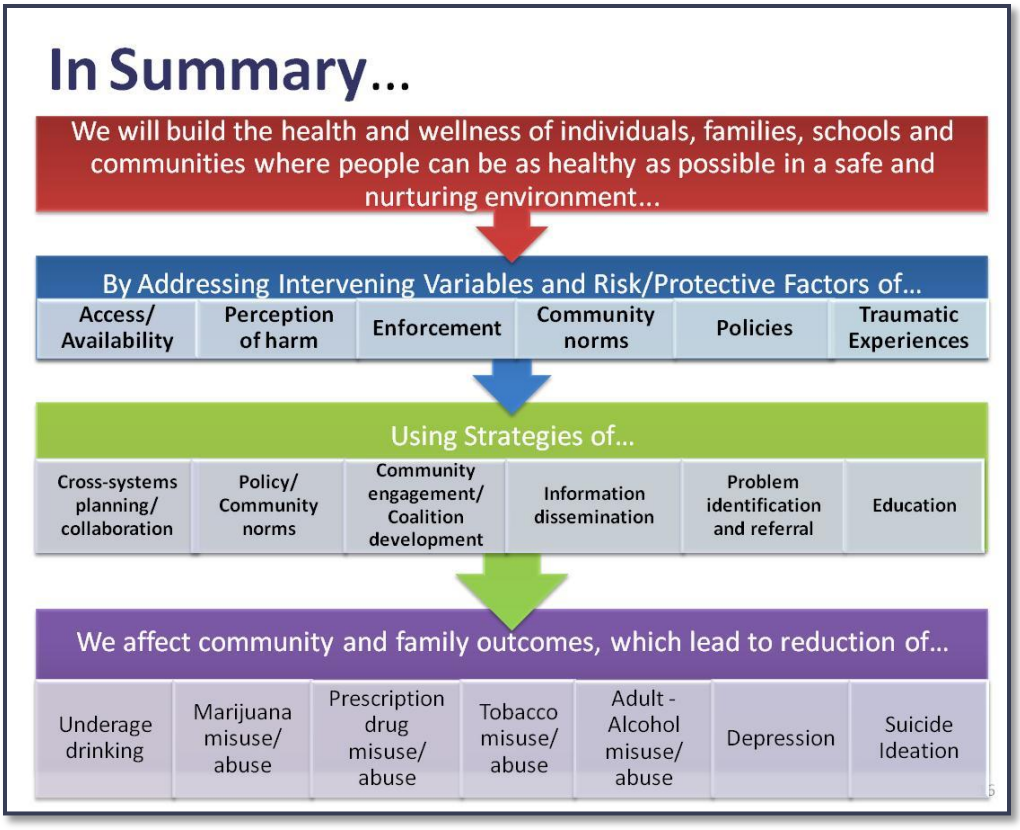
Chapter One: Executive Summary

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

The Washington State Prevention Enhancement Policy Consortium (hereafter referred to as the Consortium) is comprised of representatives from 22 state and tribal agencies and organizations. The goal of the Consortium is that through partnerships we will strengthen and support an integrated statewide system of community-driven substance abuse prevention, mental health promotion, and related issues.

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

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



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

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

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

Chapter Two: Prevention Background

Section 1: Overview of Prevention

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

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

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

Section 2: Risk and Protective Factors

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

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

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

[2] National Research Council and Institute of Medicine of the National Academies, 2009. http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx *(A list of risk factors can be found in the IOM Report Appendix E page 521.)* Accessed July 2012.

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 present compounded by less protective factors is associated with greater chance of problem behaviors developing. Conversely, less risk supported by greater presence of protection increases the likelihood of healthy development.

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

Section 3: Adverse Childhood Experiences

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

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

ACEs fall within two categories: abuse (physical, sexual, and verbal) and household dysfunction (substance abuse, parental separation/divorce, mental illness, battered mother, and criminal behavioral). Research has shown that there is a strong relationship between ACEs and a number of

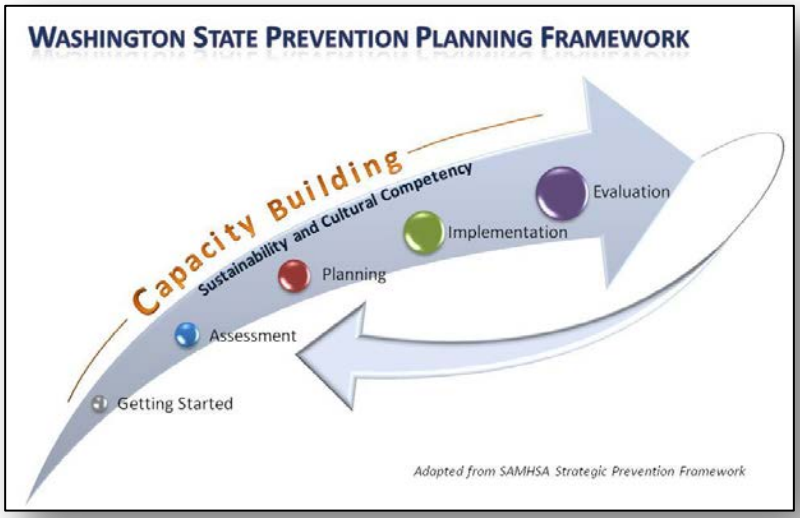
[3] Adverse Childhood Experiences, Center for Disease Control and Prevention, 2011 - http://www.cdc.gov/ace/index.htm. Accessed July 2012.
[4] Adverse Childhood Experiences, Center for Disease Control and Prevention, 2011 - http://www.cdc.gov/ace/pyramid.htm. Accessed July 2012.

problem behaviors including age of first use and any alcohol use.[5] The ACEs study seeks to understand the frequency of problem behaviors present in our communities based on the underlying relationship of initiation of risky behavior by an individual. By helping to identify more specifically the underlying causes related to adoption of certain behavior 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.

Section 4: Strategic Prevention Framework (SPF)

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

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



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

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

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. We conducted a data-informed assessment of needs and resources to support our selection of strategies that are research-based programs, policies, and practices that build on existing resources and guide our evaluation strategy.

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

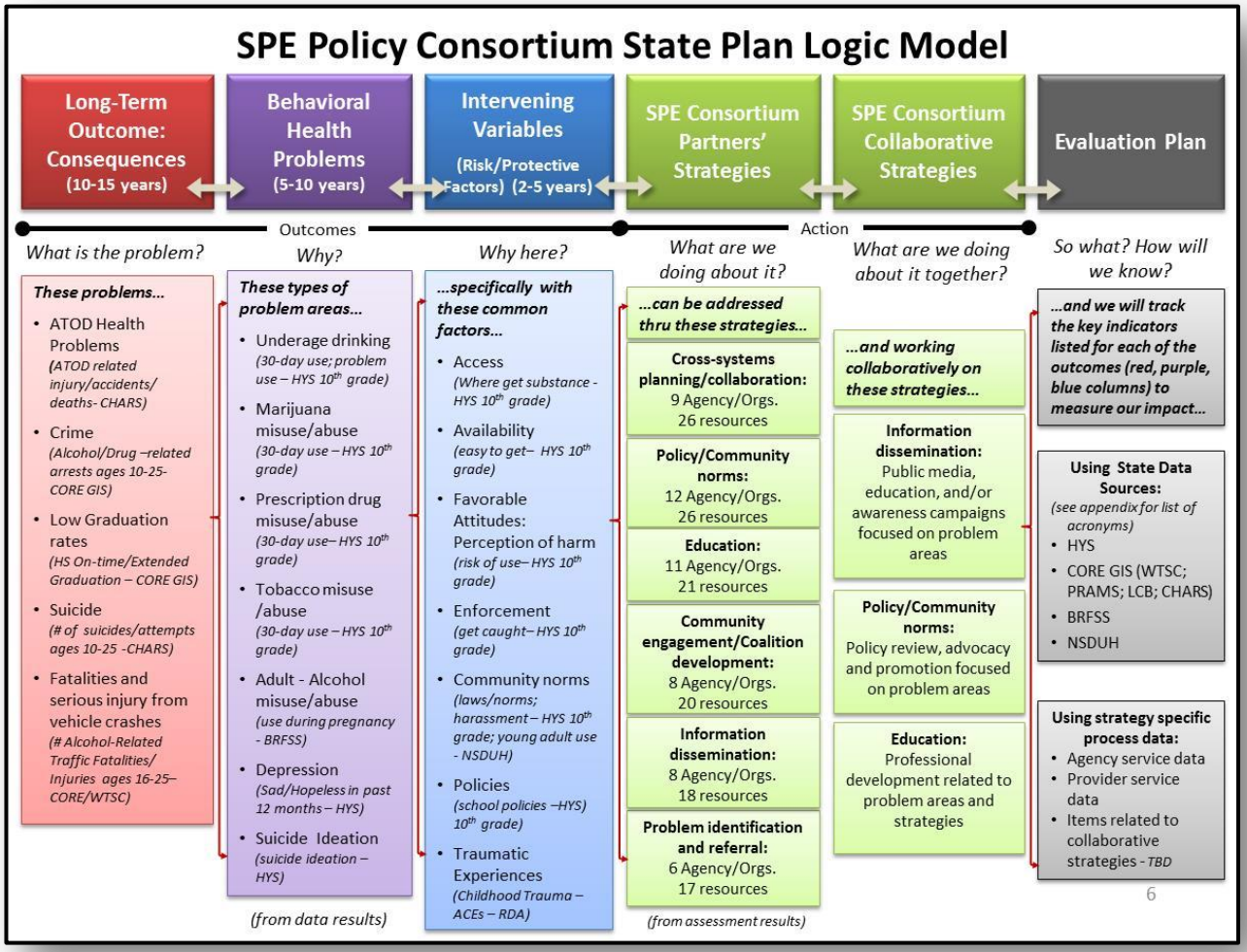
Chapter Three: Strategic Plan

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

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.

Logic Model

The logic model below was developed to provide an overview of the central elements of our Strategic Plan. (For a full page view, see Appendix - *Logic Model* page 107.) 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 Prevention Redesign Initiative.

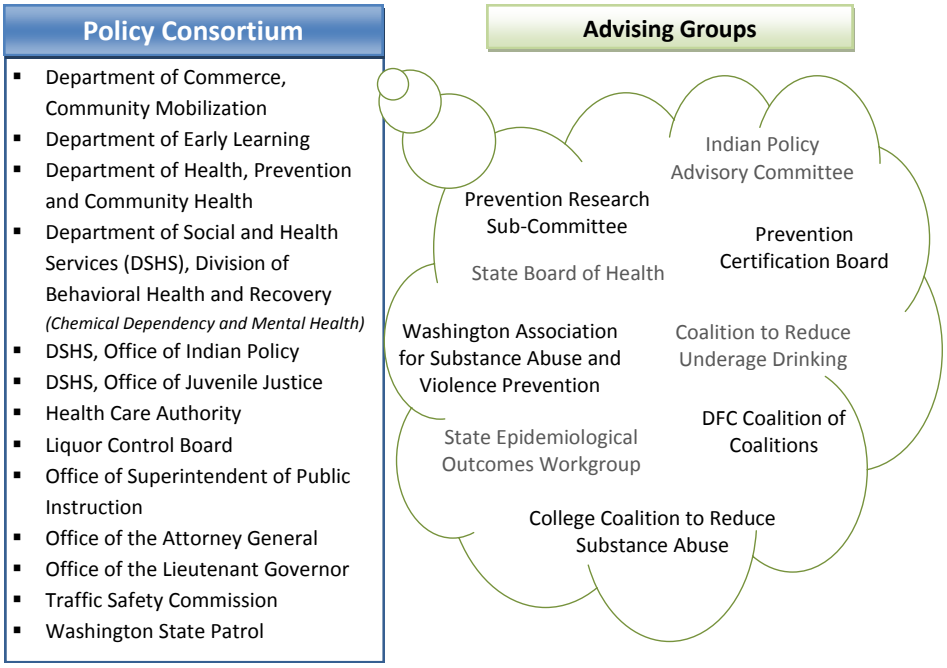


The first three columns of the logic model, ***Consequences***, ***Behavioral Health Problems,*** and ***Intervening Variables*** pull together the prioritization from the data assessment. The fourth column, ***SPE Consortium Partners' Strategies*** summarizes the information from the resources assessment.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

Section 1: Getting Started

Policy Consortium Structure and Organization

In October 2011, we convened the first meeting of the Consortium. Washington state agencies have a history of collaborating in a variety of venues for planning and implementing projects. Over 20 years ago, we established the Washington Interagency Network (WIN) that included representatives from various agencies that are engaged in substance abuse prevention. The newly formed Consortium builds from the original WIN group and integrates new partnerships with mental health and primary care representatives. (A complete list of Consortium members can be found in the Appendix - *SPE Consortium Partner List*, page 52)



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

The Consortium meets every other month and is currently co-chaired by the Department of Health, Division of Prevention and Community Health, and the Department of Social and Health Services, Division of Behavioral Health and Recovery. The Consortium has a Leadership Committee, which

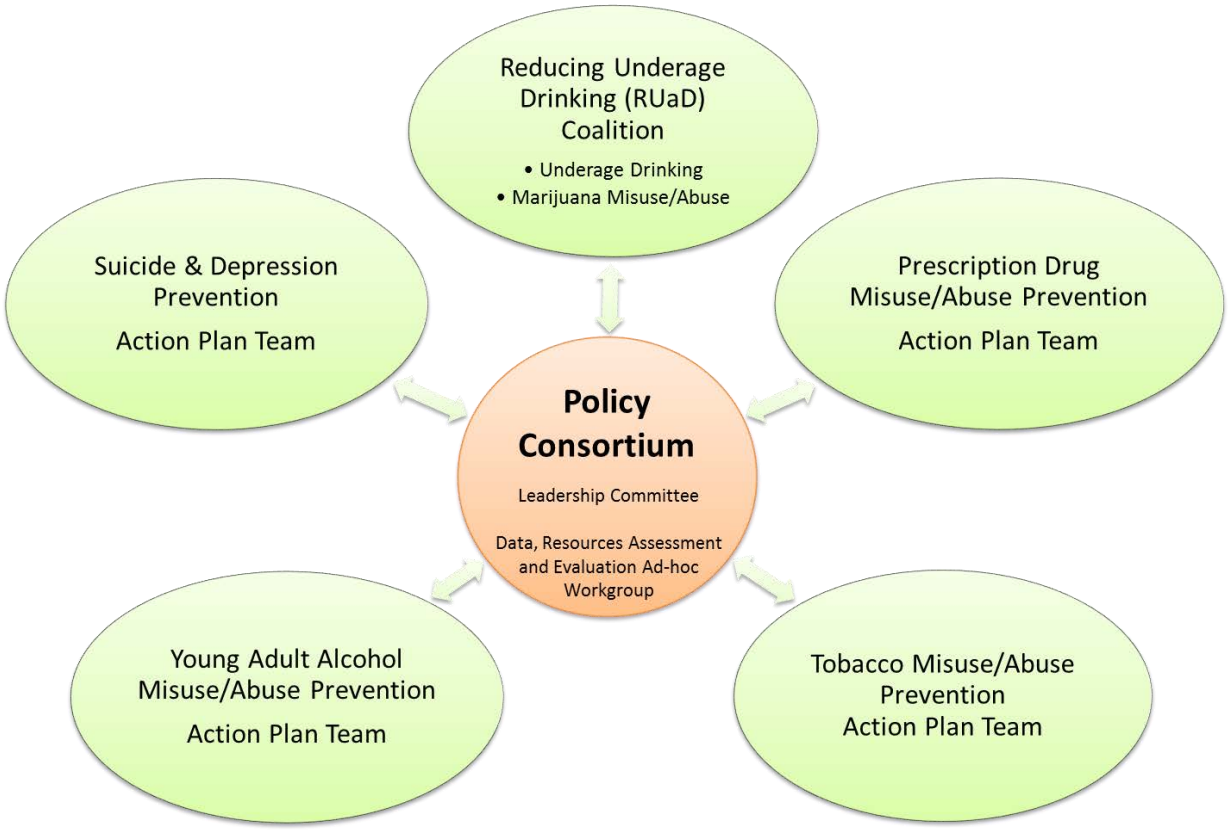
provides direction and guidance to ensure that the goals and objectives of the Strategic Plan are met. Beginning with the next election cycle, the Consortium Leadership will consist of Co-chairs: one from a state public agency and one from a statewide organization. There will also be two additional Consortium members. To increase continuity and focus, the co-chairs will serve staggered two-year terms, with annual elections to replace the outgoing co-chair. The Consortium also has an ad-hoc SPE Data, Resources Assessment and Evaluation Workgroup led by the State Epidemiological Outcomes Workgroup. This workgroup meets as needed to conduct annual assessments and to consider and oversee evaluation.

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

- Marijuana Prevention Team - Reducing Underage Drinking (RUaD)
- Prescription Drug Misuse/Abuse Prevention Team
- Suicide and Depression Prevention Team
- Tobacco Misuse/Abuse Prevention Team
- Underage Drinking Team – Reducing Underage Drinking (RUaD)
- Young Adult Alcohol Misuse/Abuse Team

This diagram shows our implementation structure.

Consortium Structure



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

Membership Recruitment and Retention

Consortium members are expected to:

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

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

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

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

Summary of the key decision-making processes and findings

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

Needs Assessment beginning in March 2012, and continuing through April 2012. Our Resources Assessment followed in April 2012, and concluded in May 2012. On June 11, 2012, we held an all-day planning session to review the findings from our assessments and develop the strategies and activities for our plan. Following the planning session, we began drafting this plan and seeking input. On June 12, 2012, we met with tribal leaders for a roundtable discussion meeting prior to a formal tribal consultation in July 2012. Additionally, we met with the community stakeholders which included representatives from counties, local health jurisdictions, treatment providers, healthcare plan providers, educational service districts, and coalitions to seek feedback into the proposed plan. In September 2012, the Consortium formed Learning Community Steering Committees to review in depth each problem area and prepare Action Plans for the Consortium to review and approve. In December 2012, the Consortium held a two-day planning meeting to conduct presentations on each problem area and propose and review Action Plans. Based on this review, the Consortium prioritized our 1-year Action Plans (see *Appendix Action Plans* beginning on page 108). Each year we will update the 1-Year Action Plans to make sure we are meeting our goals.

Mission Statement and Key Values

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

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

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

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

Section 2: Capacity Building

Outreach and Sustainability

The Consortium partners have committed to attending bi-monthly meetings along with supporting the collaborative efforts and strategies identified in this plan. Additionally, each partner has identified the specific resources that it devotes to supporting substance abuse prevention and mental health promotion. *(*See Appendix - *Matrix of Resources Identified in Resource Assessment focused on* beginning on page 102*.)*

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; Community Transformation Grant Leadership Team; System of Care Family, Youth and System Partner Roundtables; Association of Counties Human Services Prevention Sub-committee; and Federally Recognized Tribes as well as other non-traditional groups such as youth prevention groups, local coalitions, and foundations. We will also consult with the community at large as we further develop our specific activities within each strategy to gather community input and create partnerships.

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

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

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

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

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

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

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

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

Training/Technical Assistance

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

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

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

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

We have also built new elements within our various data systems that are supported by online training/technical assistance modules. This will provide information and guidance to local community providers to accurately and successfully use community-level data and service provision data in their planning efforts.

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

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

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

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

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

Workforce Development

In an effort to prepare for the opportunities that may become available through health care reform and to continue to advance our field, the Consortium reviewed three components of the current structure of our workforce. We commissioned feasibility studies on individual prevention professional certification, agency licensure, and rate setting for prevention services. We asked each study to

provide information about the current state system, what other states have done, the readiness of the field to meet requirements, the steps necessary for the state to consider for implementation, options for the state to consider, benefits and challenges to making the change, and how recommendations relate to the various potential impacts of health care reform. The following information provides an overview of each study's key findings and conclusions. For copies of the full reports go to www.TheAthenaForum.org/SPE.

Individual Prevention Professional Certification

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

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

Lastly, it was recommended that in addition to the already established Certified Prevention Professional, to consider providing opportunities for various levels of credentialing such as General Prevention Specialist or Associate Prevention Provider.

Agency Licensure

SFCC conducted an agency licensure feasibility study in conjunction with the professional certification study. There are approximately 375 agencies in Washington that currently provide prevention-related services. Washington State does not currently require prevention agencies or organizations to have a license in order to provide substance abuse prevention services. Although a few states have tiered staffing requirements in prevention contracts, very few states have agency licensure for prevention. In review of our current systems and in consideration of developing a structure, new rules to establish administrative standards for licensing would need to be proposed. SFCC recommends partnering with the established behavioral health stakeholder workgroup that is reviewing the Washington Administrative Code (WAC) to propose including prevention in the code. It was also suggested that we consider using the tiered certification structure to support staffing requirements within agency

licensure. In conclusion, while SFCC does recommend that we consider moving toward agency licensing, it is a process that will require careful examination before being implemented.

Prevention Service Rate Setting

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

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

The information from all three studies was presented to the Consortium for review. The Consortium decided to continue to examine these opportunities and to create a thorough process for review and stakeholder input prior to implementation. The Consortium further decided that based on the scope of work associated with these changes; the next step will be to prioritize which workforce development change to begin examining in-depth.

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

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

Data Assessment

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

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

Key Findings:

The SPE Data Workgroup came to the following summary conclusions:

- Overall, based on the prevalence, social and economic indicators above, alcohol ranks highest of substance use problems, followed by marijuana (2nd), and tobacco (3rd), and lastly prescription drugs (4th). We also included a review of methamphetamine (meth) use, which has the least overall impact of these five substances, yet, remains a concern as it is perceived to have high prevalence in specific populations and areas. (For more information, see Appendix - *Data Assessment* page 59.)
- Based on the prevalence, trends, and impact of substance use, underage drinking remains the number one priority for prevention.
- Marijuana is ranked second due to high prevalence and increasing use among youth.
- Both substance use and mental health disorders are more prevalent among youth and young adults, and therefore our efforts should be focused on this age range.

Analysis and Prioritization of Data:

The data conclusions and recommendations related to substance misuse/abuse and mental health indicators were presented to the Consortium in three consecutive meetings *(see Appendix - Data Assessment page 59)*.

What is the problem?

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

Why?

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

Substance Abuse

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

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

Mental Health

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

Why here?

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

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

Problem Areas (5-10 years)	Intervening Variables (Risk/Protective Factors) (2-5 years)
Adult Alcohol misuse/ abuse	▪ Community norms ▪ Sense of connectedness to community ▪ Favorable Attitudes: Perception of harm (i.e., perception of benefits of limited use/moderation) ▪ Promotion of alcohol ▪ Availability ▪ Enforcement ▪ Traumatic childhood experiences (i.e., at the time of traumatic experience and retrospectively from adulthood)
Underage Drinking	▪ Access to alcohol ▪ Availability of alcohol ▪ Policies ▪ Promotion of alcohol ▪ Community norms ▪ Enforcement (i.e., lack of enforcement and perception of lack of enforcement) ▪ Traumatic childhood experiences (i.e., at the time of traumatic experience and retrospectively from adulthood)
Marijuana misuse/ abuse	▪ Availability ▪ Favorable Attitudes: Perception of harm ▪ Enforcement (i.e., inconsistent application of laws in light of de-emphasis) ▪ Adults who use ▪ Laws (i.e., confusion about laws) ▪ Traumatic childhood experiences (i.e., at the time of traumatic experience and retrospectively from adulthood)
Prescription Drugs misuse/ abuse	▪ Availability (i.e., over prescribing, unused medication, and 'doctor shopping') ▪ Supply (i.e., abundant supply of prescription drugs) ▪ Favorable Attitudes: Perception of harm (i.e., misuse of prescribed and non-prescribed drugs and improper use of medications) ▪ Enforcement (i.e., unclear under the influence laws) ▪ Community norms ▪ Traumatic childhood experiences (i.e., at the time of traumatic experience and retrospectively from adulthood)

Problem Areas (5-10 years)	Intervening Variables (Risk/Protective Factors) (2-5 years)
Tobacco misuse/ abuse	▪ Policies (i.e., inconsistent policies and enforcement of policies in schools) ▪ Laws (i.e., preemption and local laws) ▪ Access (i.e., hookah lounges) ▪ Promotion of tobacco (i.e., targeted advertising to low-income/minority populations) ▪ Favorable Attitudes: Perception of harm ▪ Traumatic childhood experiences (i.e., at the time of traumatic experience and retrospectively from adulthood)
Depression	▪ Community norms (i.e., stigma of MH screenings, MH screening not part of routine health screening, and community awareness and knowledge regarding treatability) ▪ Perception of stigma ▪ Connection to other mental health disorders (i.e., anxiety) ▪ Traumatic childhood experiences (i.e., at the time of traumatic experience and retrospectively from adulthood)
Suicide Ideation	▪ Teens and young adults suicidal ideation ▪ Connection to other mental health disorders ▪ Traumatic childhood experiences (i.e., at the time of traumatic experience and retrospectively from adulthood)

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

Resources Assessment

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

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

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

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

Key Findings:

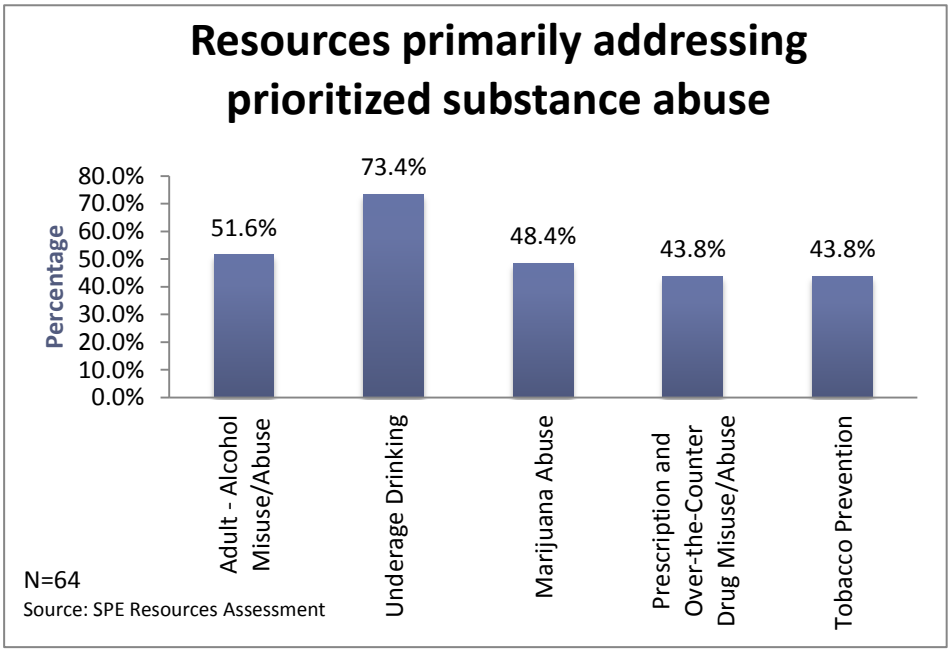
Resource information was collected via an online survey and through interviews. Twenty-five (25) agencies/organizations participated in the survey and over 60 resources were identified that directly or indirectly address substance abuse prevention/mental health promotion. Detailed information from the resources assessment can be found in Appendix - *Resources Assessment* beginning on page 92. Below is a summary of key information analyzed[7].

Most common focus areas being addressed:

- General Substance Abuse (75%)
- Drinking and Driving (55%)
- Adverse Childhood Experiences (47%)
- General Mental Health (45%)
- Other Illicit Drugs (44%)
- Family relationships (42%)
- Education (41%)

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

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



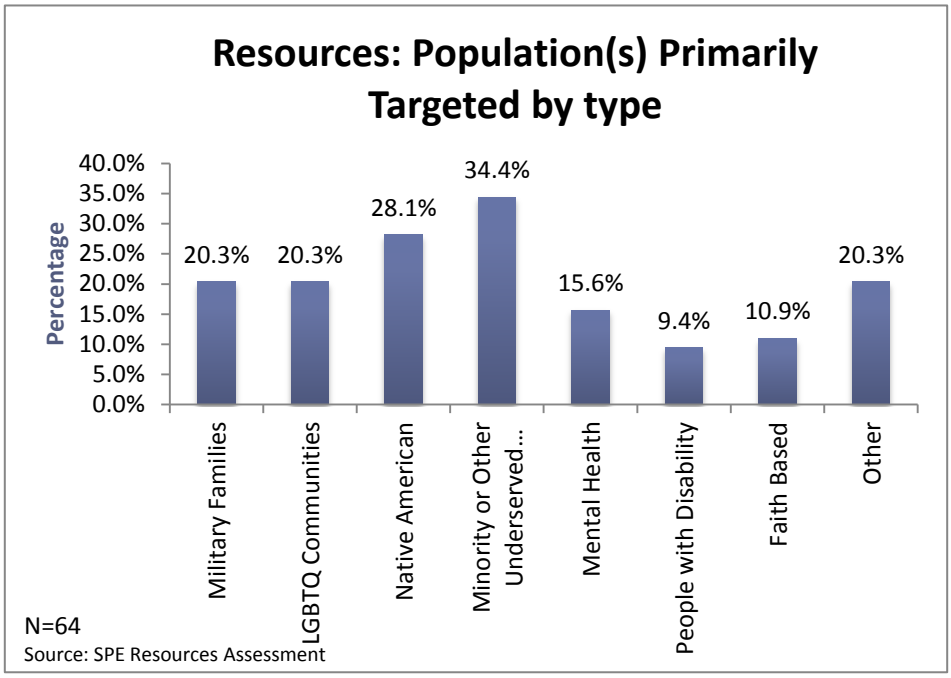
Most common strategies:

- Policy/Community Norms (59.4%)
- Cross-system Planning/ Collaboration (57.8%)
- Education (youth education/skill building; parent education/family support; other educational programs) (32.8%)
- Community Engagement/Coalition Development (46.9%)
- Information Dissemination (32.8%)
- Problem Identification and Referral (28.1%)

Target Populations:

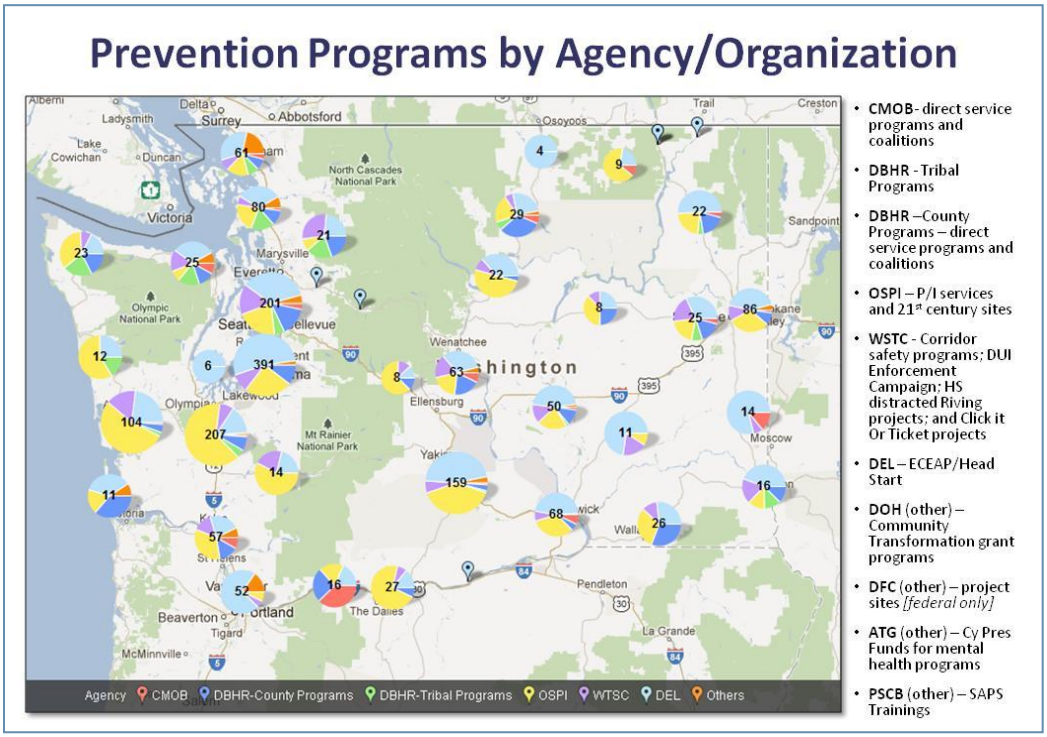
- While we have broad coverage on all ages, these resources most often focus on *adolescences*, *young adults and adults.*
- *Minority or other underserved* populations (34%) was the most common specific population targeted followed by *Native American/Tribes* (28%) and then *LGBTQ* (20%) and *mental health* (20%)

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

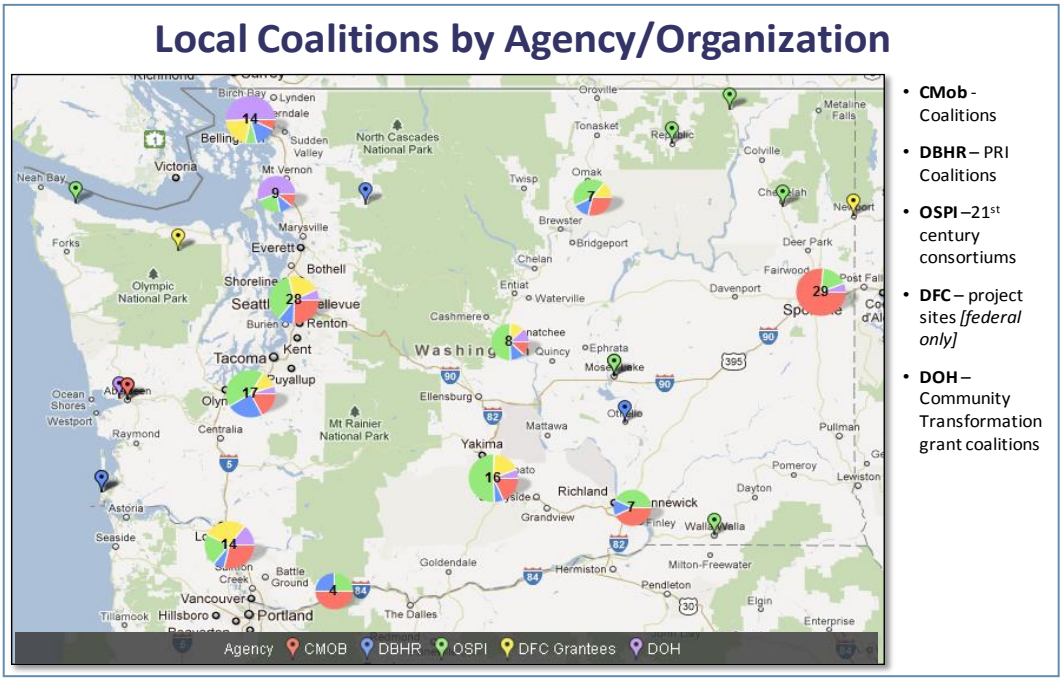


Services by Location *(Full size maps and acrnoym list are available in* Appendix - *Maps* page 95.*)*

We have broad distribution of prevention services across the state. Below is a map illustrating the prevention programs by state agency/organization where local location was available.



- We also have over 169 coalitions working at the local level to support coordinated prevention and promotion efforts.



http://batchgeo.com/map/0b6e7fef8f2cc9d0047cd9a4868dc670

Prevention activities supported by coordinated funding streams

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

Beginning in October 2011, as part of this State Prevention Enhancement grant, the Consortium began working on four (4) specific prevention projects with coordinated funding. Prior to the start of this grant we had multiple projects supported by coordinated funding including the State Prevention Summit conference, Spring Youth Forum conference, four Reducing Underage Drinking strategies, Healthy Youth Survey, CORE GIS data collection and analysis, College Coalition, and Prevention Redesign Initiative. As part of the state Prevention Redesign Initiative, some of the Consortium partners have been involved in this process to support local coalitions. We are currently supporting 34 local prevention activities (local coalitions) that include coordinated funds from Division of Behavioral Health and Recovery and Office of the Superintendent of Public Instruction, which are paired in many cases with Department of Health Community Transformation grant neighborhoods, Community Mobilization coalitions and Drug-Free Communities coalitions. We will also begin supporting 18 additional communities beginning in July 2013. Where possible, we are looking to facilitate cross-agency communication to support aligning their local work in these areas when it fits the needs of the communities.

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

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

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

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

Common goals, objectives, and strategies for coordinating services

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

What are we doing about it?

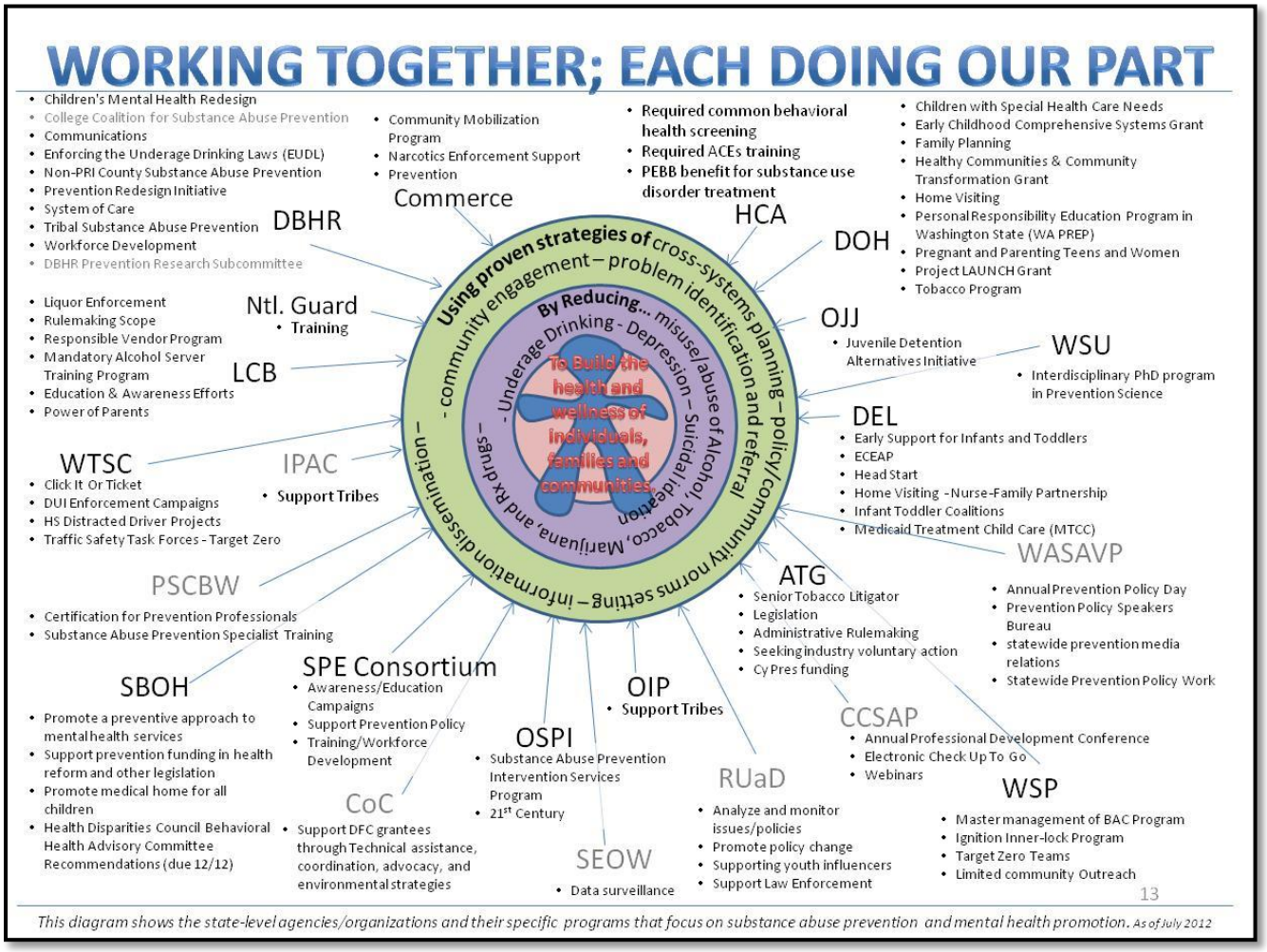
As mentioned previously, a key value of the Consortium is to honor and support the current efforts of each of the partners. Using the information from our Resources Assessment, we were able to review our current state-level supports for substance abuse prevention and mental health promotion, and to identify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

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

Strategy	Number of agencies/organizations providing a resource in this strategy	Number of resources directly or indirectly using this strategy
Cross-systems Planning/Collaboration:	16	37
Policy/Community norms:	15	38
Education:	15	21
Community Engagement/Coalition Development:	14	30
Information Dissemination:	9	21
Problem Identification and Referral:	6	18

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

Below is an illustration of the state level agencies and organizations and their specific programs/initiatives that focus on substance abuse prevention and mental health promotion. For a full page diagram see Appendix - *Diagram of Resources* page 97.



In our assessment we reached beyond the traditional substance abuse prevention focused agencies to include agencies and organizations that will assist in building connections for primary care and behavioral health integration efforts, for example the State Board of Health and the Health Care

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

Authority. These two state entities play a fundamental role in partnering with the agencies that have primary care as their principal focus.

Strategic direction for strategies, activities, and policy initiatives

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

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

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

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

SPE Consortium Collaborative Strategies

What are we doing about it together?

Collaborative Strategies: Prevention activities and policies supported by coordinated resources

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

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

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

Action Plan Strategies by Behavioral Health Problem - See *Appendix Action Plans* beginning on page 108 for a summary of the specific partners committed to contributing to working on each Action Plan.

Alcohol
Workgroup Team: Work with existing College Coalition and Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to implement SPE strategies.
• ***Policy:*** Develop method for collecting statewide data on young adults for both those attending college and not attending college.
• ***Policy:*** Promote the use of SBIRT among universities and colleges.
• ***Policy:*** Promote the use of SBIRT for use with pregnant women.
Underage Drinking
Workgroup Team: Integrate with the state Reducing Underage Drinking Coalition (RUaD) to support the established priorities which include: Analyze and Monitor Issues/Policies; Promote Policy Change; Supporting Youth Influencers; and Support Law Enforcement.
• ***Policy:*** Conduct surveillance on data regarding Initiative 1183 (alcohol privatization) and Initiative 502 (recreational marijuana use).
• ***Information Dissemination/Public Awareness:*** Ensure broad coverage of press release for HYS Data of Underage Alcohol and Marijuana Use.
• ***Information Dissemination/Public Awareness:*** Promote news stories such as investigative journalism about true impacts of I-1183 and I-502.

Marijuana

Workgroup Team: Expand RUaD coalition focus to form one Coalition to address underage drinking and marijuana use.

- ***Policy:*** Engage state agencies, community partners, and local providers to monitor impacts of I-502 on state and communities and advocate for prevention best practices with Liquor Control Board in rule making for marijuana industry.
- ***Education/Professional Development:*** Training/conference for state prevention community to focus on implementation, emerging issues, accurate tracking, statewide coordination.
- ***Information Dissemination/Public Awareness:*** Communications campaign to educate the public regarding marijuana risks, resources, and understanding the new law pursuant to passage of Initiative 502 and disseminate via schools, community coalitions and networks, public health, and law enforcement.
- ***Information Dissemination/Public Awareness:*** Website - Resources and FAQs

Tobacco

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

- ***Policy:*** Provide education and information on the creation of no-smoking policies to create smoke-free workplaces specifically targeting college and state agencies.
- ***Policy*:** Convince motion picture industry to change industry policy to eliminate depictions of tobacco use in youth-rated movies.
- ***Policy:*** Increase tobacco prevention funding by providing information to policy makers on the impacts of prevention.
- ***Education/Workforce development:*** Provide training and technical assistance to healthcare clinics to screen for tobacco use and refer to cessation resources in order to increase number of patients screened.
- ***Information Dissemination/Public Awareness:*** Provide Point of Sale retailer education and conduct the Community Assessment Neighborhood Stores (CANS) Surveys; and share the results and other impact information with policy makers.
- ***Information Dissemination/Public Awareness:*** Establish and maintain public awareness of the causal link between smoking in movies and youth smoking.

Prescription Drugs

Workgroup Team: Establish statewide workgroup to implement SPE strategies. Work collaboratively with existing statewide Take Back Your Meds Coalition and Unintentional Poisoning Workgroup.

- ***Policy:*** Promote value of Prescription Monitoring Program and seek opportunities to ensure funding for program to continue.
- ***Policy:*** Promote the use of the Emergency Department best practices model for prescribing medications among hospitals.
- ***Education/Workforce Development:*** Provide presentation and online information to local communities regarding prescription drug abuse statistics and strategies for prevention.

Depression & Suicide Ideation

Workgroup Team: Establish a statewide workgroup to implement SPE strategies.

- ***Education/Workforce Development:*** Package key elements of intervention and training for use: 1) by communities experiencing multiple youth suicides in short time frames, needing community management and response intervention; 2) for communities as part of emergency response/ crisis plans for a wide variety of natural disasters, emergency planning; and 3) proactively provide information on best practices used by communities both to help prevent such tragedies and respond quickly and effectively if they occur.
- ***Information Dissemination/Public Awareness:*** Collect data and resources to provide to communities including 1) Prevention and intervention material to reduce potential for youth suicide and depression and 2) Response (Post-intervention) to communities experiencing crisis of multiple suicides/contagion.

Section 5: Implementation

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

Prevention activities and policies supported by Consortium Partners

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

Agency - Resource (List of Acronyms is available in the Appendix - *List of Agencies Acronyms and Abbreviations*, page 51)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
ATG - Senior Tobacco Litigator, Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action	x					
CCSAP - Webinars	x	x				
CCSAP - Year End Professional Development Conference	x					
CCSAP - Electronic Check Up to Go	x	x				
DBHR - System of Care	x	x	x		x	
DBHR - Prevention Redesign Initiative	x	x	x	x	x	x
DBHR - Children's Mental Health Redesign	x	x	x		x	x
DBHR - Non-PRI County Substance Abuse Prevention	x	x	x	x	x	x
DBHR - Tribal Substance Abuse Prevention	x	x	x	x	x	x
DBHR - Enforcing the Underage Drinking Laws (EUDL)	x					
DBHR - College Coalition For Substance Abuse Prevention	x	x	x	x	x	x
DBHR - Workforce Development	x	x	x			
DBHR - Communications	x	x	x	x	x	x
DBHR - Prevention Research Subcommittee	x		x	x	x	
DEL - Infant Toddler Regions		x	x			
DEL - Home Visiting Programs	x	x	x			x
DEL - Head Start	x	x	x			
DEL - Early Support for Infants And Toddlers	x	x	x			x
DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool		x				
DEL - Medicaid Treatment Child Care Program	x	x		x	x	x
DOH - Tobacco Program	x					
DOH - Project Launch Grant		x	x			
DOH - Home Visiting	x	x	x	x		x
DOH - Early Childhood Comprehensive Systems Grant		x				
DOH - Children With Special Health Care Needs		x				x

Agency – Resource (List of Acronyms is available in the Appendix - ***List of Agencies Acronyms and Abbreviations***, page 51)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
DOH - Personal Responsibility Education Program in Washington State (WA PREP)			x			
DOH - Pregnant and Parenting Teens And Women			x		x	
DOH - Coordinated School Health Program	x	x			x	
DOH - Healthy Communities & Community Transformation Grant	x	x	x			x
DOH - Family Planning	x	x	x		x	x
Commerce - Community Mobilization	x		x	x	x	
OJJ - Juvenile Detention Alternatives Initiative				x		
HCA - Service	x					x
HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.	x	x	x			x
HCA - Required Training on Adverse Childhood Experiences	x	x	x			x
HCA - PEBB Benefit for Substance Use Disorder Treatment	x					
IPAC - Support Tribes	x	x	x	x		x
LCB - Agency Initiatives	x					
LCB - Power of Parents	x					
LCB - Liquor Enforcement	x					
LCB - Rulemaking Scope	x					
LCB - Responsible Vendor Program	x					
LCB - Mandatory Alcohol Server Training Program	x					
LCB - Education and Awareness Efforts	x					
Nat'l Guard - Training	x	x		x		
OIP - Support Tribes	x	x	x	x		x
OSPI - Substance Abuse Prevention Intervention Services Program	x	x	x			
PSCBW - Certification for Prevention Professionals	x	x	x	x	x	
PSCBW - Substance Abuse Prevention Specialist Training	x					
RUaD - Analyze and Monitor Issues/Policies	x					
RUaD - Promote Policy Change	x					
RUaD - Supporting Youth Influencers	x					
RUaD - Support Law Enforcement	x					
SEOW - Data Surveillance	x	x	x	x		
CoC - Federal Drug Free Communities Support Program	x					
WASAVP - Annual Prevention Policy Day	x		x		x	
WASAVP - Statewide Prevention Policy Work	x		x	x	x	
WASAVP - Statewide Prevention Medial Relations	x		x	x	x	
WASAVP - Prevention Policy Speakers Bureau	x				x	

Agency - Resource (List of Acronyms is available in the Appendix - ***List of Agencies Acronyms and Abbreviations***, page 51)	General Substance Abuse	General Mental Health Promotion	Adverse Childhood Experiences	Crime/Delinquency	Violence	Primary Healthcare
SBOH - Health Disparities Council Behavioral Health Advisory Committee	x	x				
SBOH - Support Prevention Funding in Health Reform and Other Legislation	x					x
SBOH - Promote Medical Home for All Children	x	x				
SBOH - Promote A Preventive Approach to Mental Health Services						x
WSP - Master Management of BAC Program	x			x	x	
WSP - Limited Community Outreach	x			x	x	
WSP - Ignition Inner-Lock Program	x					
WSP - Target Zero Teams	x			x		
WSU - Interdisciplinary PhD Program in Prevention Science	x	x	x	x	x	
WTSC - Click It or Ticket	x					
WTSC - HS Distracted Driver Projects	x					
WTSC - DUI Enforcement Campaigns	x					
WTSC - Traffic Safety Task Forces - Target Zero	x					

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

Structural Support for Collaboration

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

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

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

we established a learning community structure to provide guidance on presentations and information to be prepared (see *Appendix - Learning Community Steering Committees* on page 107 for list of Steering Committees). Each Steering Committee was responsible to create and provide presentations on information such as, additional data, literature reviews that emphasize leverage points for meaningful action, expert panels to discuss issues in-depth, and action plans. Upon agreement on each action plan, an Action Plan Team was established to carry out the tasks. Each year we will review and update the Action Plans as needed to make sure we are meeting our goals. See *Appendix - Action Plans* beginning on page 108 for a summary of the specific partners committed to contributing to working on each Action Plan.

Additionally, the Consortium will look to involve new partners based on strategic direction and projects within this plan. For example, we are interested in asking the Washington Association of Sheriffs and Police Chiefs to join the Consortium to assist in addressing the law enforcement objectives. We are also interested in inviting the Department of Labor and Industries to participate in the development of the activities of our action plans related to workplace and employment. Lastly, we will seek youth involvement in our planning through our established youth leadership network.

Implementation plan and a 5-year timeline

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

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

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

Implementation Plan Timeline

Task	Lead	Y1	Y2	Y3	Y4	Y5
Policy Consortium						
Consortium bi-monthly meetings	DBHR	X	X	X	X	X
Renew leadership positions biennially	Consortium	X	X	X	X	X
Set evaluation targets for selected indicators	Consortium	X				
Steering Committee meetings		X				
Underage Drinking (RUaD)	Steering Committee	X				

Task	Lead	Y1	Y2	Y3	Y4	Y5
Alcohol	Steering Committee	X				
Marijuana	Steering Committee	X				
Tobacco	Steering Committee	X				
Prescription Drugs	Steering Committee	X				
Depression	Steering Committee	X				
Suicide Ideation	Steering Committee	X				
Establish Action Plan Teams	Each Team	X				
Establish meeting schedules for Action Plan Teams	Each Team	X				
Annual review of resources assessment	Resources Assessment Workgroup/Consortium	X	X	X	X	X
Annual review of data assessment	SEOW/Consortium	X	X	X	X	X
Public media, education, and or awareness campaigns						
Identify emerging opportunities	Consortium	X	X	X	X	X
Prioritize messages to be developed	Consortium	X				
Identify issues for 1st campaign	Consortium	X				
Develop detailed work plan for campaign	Action Plan Team	X				
Implement work plan for 1st campaign	Action Plan Team	X	X	X		
Develop message	Action Plan Team	X				
Test message	Action Plan Team	X				
Refine message	Action Plan Team	X				
Establish method to disseminate strategies	Action Plan Team		X			
Disseminate message via state partners	Consortium		X			
Disseminate message via local communities	Consortium		X			
Develop detailed work plan for 2nd campaign	Action Plan Team		X			
Implement work plan for 2nd campaign	Action Plan Team			X	X	
Develop detailed work plan for 3rd campaign	Action Plan Team			X		
Implement work plan for 3rd	Action Plan Team			X	X	X

Task	Lead	Y1	Y2	Y3	Y4	Y5
campaign						
Policy review, advocacy and promotion						
Identify emerging opportunities	Consortium	X	X	X	X	X
Develop action initiative for local coalitions to use for 1st priority initiative	Action Plan Team	X		X		X
Develop message	Action Plan Team	X		X		X
Test message	Action Plan Team	X		X		X
Refine message	Action Plan Team	X		X		X
Establish method to Disseminate strategies	Action Plan Team		X		X	
Disseminate message via state partners	Consortium		X		X	
Disseminate message via local communities	Consortium		X		X	
Develop detailed work plan for 2nd initiative	Action Plan Team		X			
Implement work plan for 2nd initiative	Action Plan Team			X	X	
Develop detailed work plan for 3rd initiative	Action Plan Team			X		
Implement work plan for 3rd initiative	Action Plan Team			X	X	X
Review screening practices	Steering Committee	X		X		X
Determine effective methods to integrate prevention into screening	Action Plan Team		X		X	
Meet with primary care and behavioral health care providers	DOH, DBHR, HCA, SBOH		X		X	
Develop understanding of Medicaid among prevention providers	HCA	X		X		X
Professional development across all systems						
Identify emerging opportunities	Consortium	X	X	X	X	X
Develop work plan for 'new professional orientation'	Action Plan Team	X				

Task	Lead	Y1	Y2	Y3	Y4	Y5
Identify resources	Action Plan Team	X				
Establish process	Action Plan Team	X				
Create bureau of mentors	Action Plan Team		X			
Provide mentorship	Action Plan Team		X	X	X	X
Determine training topics to be included in cross systems training	Consortium	X	X	X	X	X
Identify host agency for training	Action Plan Team	X	X	X	X	X
Determine method for delivering training	Action Plan Team	X	X	X	X	X
Arrange logistics	Action Plan Team	X	X	X	X	X
Conduct training	Action Plan Team	X	X	X	X	X
Follow-up from training	Action Plan Team	X	X	X	X	X
Follow up from results of feasibility studies						
Prioritize timeframe for each study	Consortium	X				
Establish Teams to thoroughly review all findings and develop next steps	Consortium	X				
Determine if new requirements will be put into place and timeframe for implementing	Consortium		X			
If needed, develop work plan	Consortium		X			
If needed, establish Team to implement work plan	Consortium		X			
Follow up from Primary Care Demonstration Projects						
Present at Consortium meeting	Demonstration Project sites	X				
Coordinate presentations to take place at state conference	DBHR	X				
Integrate related information into DOH trainings	DOH, DBHR	X				
Establish Team to thoroughly review all findings and develop next steps	Consortium	X				
Determine if additional projects should be supported	Consortium		X			
If so, develop work plan	Action Plan Team		X			

Task	Lead	Y1	Y2	Y3	Y4	Y5
If so, establish Team to implement work plan	Consortium		X			
Continue to examine integrating data reporting systems with additional partners						
Presentation at Consortium meeting of various data systems	Consortium Partners	X				
Determine if additional systems would be combined/connected	Consortium Partners	X				
If so, develop work plan	Action Plan Team		X			
If so, establish Team to implement work plan	Consortium		X			

Plan for Cultural Competency

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

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

As individuals, we are committed to increasing our understanding of cultural competency and moving through cultural knowledge, awareness, and sensitivity to competence.[10] We also understand that cultural competence extends the concept of self-determination to the community. Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g., neighborhood, civic, and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers). [11]

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

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.

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

- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders, and communities.

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

[13] "Promoting Cultural Diversity and Cultural Competency- Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs Goode, T., 2002, NCCC, GUCDC.
Click on Resources and Tools for checklists that reflect these values and principles in policy and practice. Accessed June 2012.
[14] Taylor, T., & Brown, M., 1997, Georgetown University Child Development Center, (GUCDC) University Affiliated Program.

Section 6: Evaluation

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

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

The Consortium partners have a number of reporting systems that support our ability to compile data related to each level of analysis on our intended outcomes. A complete list of data sources used by Consortium partners is included in the *Appendix - Washington State Key Data Sources*, *page 57*. These data provide information on social impact indicators, as well as local community and service level data. Although, due to the complexities of the various funding allocation methods used by state agencies and the focus of services being delivered, we are not able to combine all service data collection systems; we currently have two state agencies committed to using a single system to collect service data from their respective providers. Furthermore, as one of our recent enhancements from the SPE grant projects, the Strategic Prevention Framework planning module has been added on the demo system of the prevention MIS. We will be able to begin testing, pre-loading data, and training staff and providers for full implementation of the new planning module with the start of the next fiscal year, July 2013. Regardless of which system is 'holding' the data, we have developed significant data-sharing agreements that allow for us to easily collect and compile valuable data not only for our assessments, but also to use in our evaluation.

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

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

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

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

Intermediate Outcomes: Behavioral Health Problems	Source/ Year Baseline[16]	Update	Target 2017 *10% decrease*
Underage Drinking	**HYS 2010**	**HYS 2012**	
▪ Drank Alcohol In Last 30 Days*	10th Grade: 27.7%	23.3%	24.8%
▪ Experimental Use of Alcohol	10th Grade: 10.9%	8.5%	9.9%
▪ Heavy Use of Alcohol	10th Grade: 8.2%	7.1%	7.2%
▪ Problem Drinking	10th Grade: 10.4%	9.4%	9.0%
▪ Binge Drinking (any)	10th Grade: 16.2%	14.3%	14.6%
▪ Alcohol consumption composite score of experimental, heavy and problem[17]	10th grade: 1.6		1.0
Marijuana Misuse/Abuse	**HYS 2010**	**HYS 2012**	
▪ Used Marijuana In Last 30 Days*	10th Grade: 20.0%	19.3%	18.0%
▪ Used Marijuana 6+ Days	10th Grade: 8.4%		7.6%
Prescription Misuse/Abuse	**HYS 2010**	**HYS 2012**	
▪ Used Pain Killer In Last 30 Days*	10th Grade: 8.3%	6.0%	7.5%
▪ Used Ritalin-Type Drug In Last 30 Days	10th Grade: 3.5%	2.8%	3.2%
Tobacco Misuse/Abuse	**HYS 2010**	**HYS 2012**	
▪ Smoked Cigarettes In Last 30 Days*	10th Grade: 12.7%	9.5%	11.4%
Adult - Alcohol Misuse/Abuse	**BRFSS 2010**		
▪ Women Report Alcohol Use any time During Pregnancy*	17.0%		15.3%
Depression	**HYS 2010**	**HYS 2012**	
▪ Sad/Hopeless In Past 12 Months*	10th Grade: 29.8%	30.9%	26.8%
Suicide Ideation	**HYS 2010**	**HYS 2012**	
▪ Suicide Ideation*	10th Grade: 17.6%	18.8%	15.8%

*Signifies primary target.

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

[17] Consumption scores range from 1 to 4:

1 - No drinking: no drinking past 30 days and no binging past 2 weeks
2 - Experimental: 1-2 days drinking past 30 days and no binging past 2 weeks
3 - Heavy: 3-5 days drinking past 30 days and/or 1 binge past 2 weeks
4 - Problem: 6+ days drinking past 30 days and/or 2+ binge past 2 weeks

Short-term Outcomes: Intervening Variables	Source/ Year Baseline[18]
Access	**HYS 2010** ▪ 10th graders who got alcohol: – 7% bought it from a store – 18% gave money to someone to get it for them – 55% got it from friends or at a party – 27% home w/o permission ▪ 10th graders who ever used 'pain killers to get high': – 30% report using own prescription – 29% report getting it from a friend **LCB 2010** ▪ 14,425 state licenses (rate of 2.15/1000 persons) *[note: expect significant increase per I-1183]*
Availability	**HYS 2010** ▪ 10th graders: – 56% report sort of or very easy to get alcohol – 54.4% report sort of or very easy to get marijuana – 52.7% report sort of or very easy to get cigarettes
Community norms	**HYS 2010** ▪ 10th graders: – 75.5% report that 'adults in the community think it's wrong or very wrong' – 70% saw 'anti-alcohol ads' – 55% parents talked about it ▪ 34.5 % of 10th graders report laws and norms favorable toward drug use ▪ 8% of 10th graders report 'harassed due to health/disability' **NSDUH 2008/ 2009** ▪ 17% of young adults (18-25 years) report marijuana use in past 30 days
Enforcement	**HYS 2010** ▪ 10th graders: – 26% think the police would catch a kid drinking (response of 'yes' or 'YES!') – 31.2% think the police would catch smoking marijuana (response of 'yes' or 'YES!')

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

Short-term Outcomes: Intervening Variables	Source/ Year Baseline[18]
Perception of harm	**HYS 2010** ▪ 10th grade: – 27% think that there is no or slight risk to using marijuana regularly
Policies	**HYS 2010** ▪ 10th graders: – 33.9% think school policies about alcohol and drugs are usually enforced (response of 'definitely yes') – 25.2% think 'no smoking policies' at school are usually enforced (response of 'definitely yes')
Traumatic Experiences	**BRFSS 2010** ▪ ACE: Family Alcohol Use For those that live w/ anyone who has a problem drinker/alcoholic: – 20% Report Binge Drinking – 25% Report Smoking Cigarettes ▪ ACE: Family Drug Use For those that live w/ anyone who used illegal street drugs or who abused prescription medications: – 28% Binge Drinking – 33% Cigarettes – 18% Marijuana – 2% Pain Killer ▪ ACE: Family Mental Illness For those that live w/ anyone who was depressed, mentally ill, or suicidal: – 20% Binge Drinking – 22% Cigarettes – 12% Marijuana ▪ ACE: Incarcerated Household Member For those that live w/ anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility: – 25% Binge Drinking – 38% Cigarettes – 21% Marijuana – 3% Pain Killer ▪ Childhood Trauma – Source: *RDA Report 11.178: Nov. 2012.* – 1.7 = Average number of ACES for Medicaid youth age 12-17 (SFY 2008 data) – 28.3% = Percentage of the identified DSHS youth clients during state fiscal year (SFY) 2008 that had experienced 3 or more ACES

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

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

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

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

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

Below is a table showing the reporting elements baseline from state fiscal year 2011 and the projected five-year target.

Measure	Baseline (State FY11)	Target (State FY16)
Percentage of communities[19] reporting data to the grantee system[20]	90.6%	100%
Percentage of communities submitting process data through grantee system. [21]	90.6%	100%

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

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

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

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

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

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

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

Appendix

APPENDIX

1. List of Agencies Acronyms and Abbreviations

- Attorneys General Office (ATG)
- College Coalition for Substance Abuse Prevention (CCSAP)
- Department of Commerce (Commerce)
- Community Mobilization (CMOB)
- 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 Control Board (LCB)
- Office of Indian Policy (OIP)
- Office of Juvenile Justice (OJJ)
- Office of Superintendent of Public Instruction (OSPI)
- 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 Coalition to Reduce Underage Drinking (RUaD)
- Washington National Guard (Nat'l Guard)
- Washington State Patrol (WSP)
- Washington State Prevention Research Sub-Committee (Px Research Sub-Committee)
- Washington Traffic Safety Commission (WTSC)

2. SPE Consortium Partner List

Partner Agency/Organization	Policy Consortium Representative
Attorneys General Office (ATG)	Rusty Fallis, Assistant Attorney General
College Coalition for Substance Abuse Prevention (CCSAP)	Jason Kilmer, Research Assistant Professor and Asst. Director of Health/ Wellness, University of Washington
Department of Commerce (DOC), Community Mobilization (CMOB)	Ramona Leber, Community Mobilization Program Manager
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*** Sue Grinnell, Director of Division of Prevention and Community Wellness
Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR)	***Consortium Co-chair*** Michael Langer, Behavioral Health Administrator Mark Nelson, Children's Long-term Inpatient Program, Program Administrator
Department of Social and Health Services (DSHS), Office of Indian Policy (OIP)	Colleen Cawston, Senior Director
Department of Social and Health Services (DSHS), Office of Juvenile Justice (OJJ)	Ryan Pinto, Director
Health Care Authority (HCA)	Barbara Lantz, Quality and Care Management Manager
Indian Policy Advisory Committee (IPAC)	Charlene R. Abrahamson, Director of Behavioral Health for Confederated Tribes of the Chehalis Reservation
Liquor Control Board (LCB)	Mary Segawa, Alcohol Awareness Program Manager
Office of Superintendent of Public Instruction (OSPI)	Dixie Grunenfelder, Program Supervisor Student Assistance / Dropout Prevention
Prevention Specialist Certification Board of Washington (PSCBW)	Gunthild Sondhi, President
State Board of Health (SBOH)	Michelle Davis, Executive Director
State Epidemiological Outcome Workgroup (SEOW)	Alice Huber, SEOW Co-chair; Evaluation and Quality Assurance Administrator, DBHR
Washington Association for Substance Abuse and Violence Prevention (WASAVP)	Derek Franklin, President
Washington Coalition to Reduce Underage Drinking (RUaD)	Scott Waller, Prevention Systems Integration Lead, DBHR
Washington State Drug Free Communities Coalition of Coalitions (CoC)	Bill James, Past Co-Chair
Washington State Patrol (WSP)	Captain Wes Rethwill, Fields Operations Bureau
Washington State Prevention Research Sub-Committee	Laura Hill, Associate Professor Dept. of Human Development, Washington State University
Washington Traffic Safety Commission (WTSC)	Shelly Baldwin, Impaired Driving Program Manager

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

- State Prevention Enhancement Project Manager: *Sarah Mariani, Prevention Systems Integration Manager*
- Support Staff: *Cristal Connelly, Center for Substance Abuse Prevention Fellow*

The following DBHR staff contributed to the success of SPE grant projects:

- Primary Care Demonstration Project: *Julie Bartlett, Prevention System Manager*
- Certification, Licensure, and Rates Feasibility Studies: *Julia Greeson, Prevention System Manager*
- MIS Reporting Enhancements: *Aaron Starks, Prevention and Treatment Data Analyst, and Elizabeth Speaker, SPE Systems Coordinator*
- Training System Enhancements: *Scott Waller, Prevention Systems Integration Lead, and Raye Shilen, SPE Training Coordinator*
- Data Needs Assessment: *Linda Becker, Prevention Research Manager and Grace Hong, Research Manager*

3. Brief Overview of Strategic Prevention Framework (SPF)

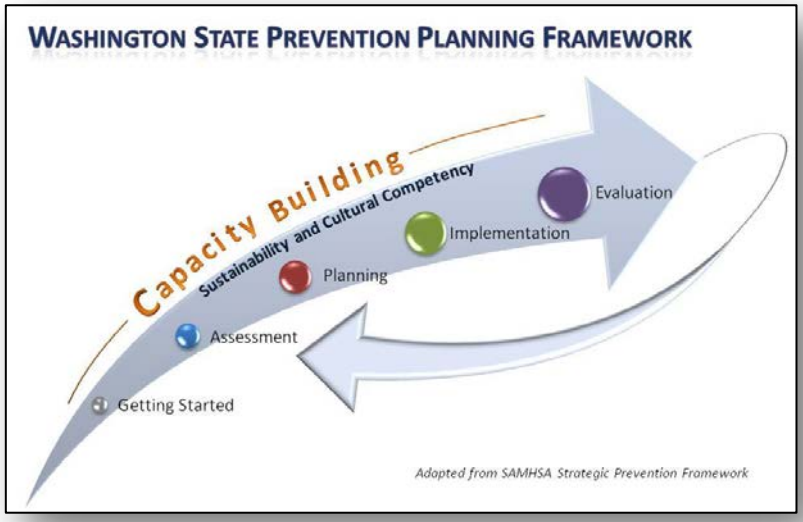
The Strategic Prevention Framework (SPF) was originally developed by the federal Substance Abuse and Mental Health Services Administration.[23] SAMSHA's Strategic Prevention Framework is a comprehensive planning process designed to help states and communities build the infrastructure necessary for effective and sustainable prevention. The Strategic Prevention Framework (SPF) uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span. The SPF is built on a community-based risk and protective factors approach to prevention and a series of guiding principles that can be utilized at the federal, state/tribal and community levels.

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

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

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

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



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

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

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

Cultural competence

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

Cultural competence requires that organizations[24]:

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

Sustainability

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

Getting Started

Purpose: Initiate the process.

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

Capacity: Mobilizing your state system and building capacity

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

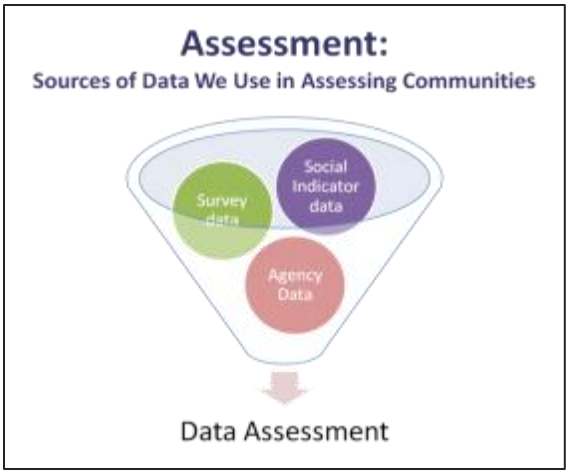
- Build effective Consortium.
- Clear roles and structure.
- Strategies for involvement of stakeholders and community.

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

Purpose: Identify needs, resources, and gaps.

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

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



Planning: Develop a strategic prevention plan

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

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

Implementation: Implement evidence-based prevention strategies

Purpose: Implement the plan.

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

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

Purpose: Evaluate the plan, and refine as needed.

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

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

4. Washington State Key Data Sources

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

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

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

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

- Healthy Youth Survey (HYS)/AskHYS.net - The information from the HYS can be used to identify trends in the patterns of behavior over time. In October 2002, 2004, 2006, and 2008, 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.doh.wa.gov/healthyyouth/default.htm

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

- Performance Based Prevention System (PBPS) - A web-based MIS, PBPS, collects administrative and outcome data on all DBHR's Substance Abuse Prevention and Treatment Block Grant funded substance abuse prevention services. https://kitservices2.kithost.net/waprevent2011/

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

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

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

- Catalyst – This web-based system intended to collect and provide summary information pertaining to Department of Health's Tobacco Prevention and Control project and Community Transformation grant activities statewide. https://fortress.wa.gov/doh/catalyst/home/default.asp

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

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

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

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

5. Data Assessment

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

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

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 - no change	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**

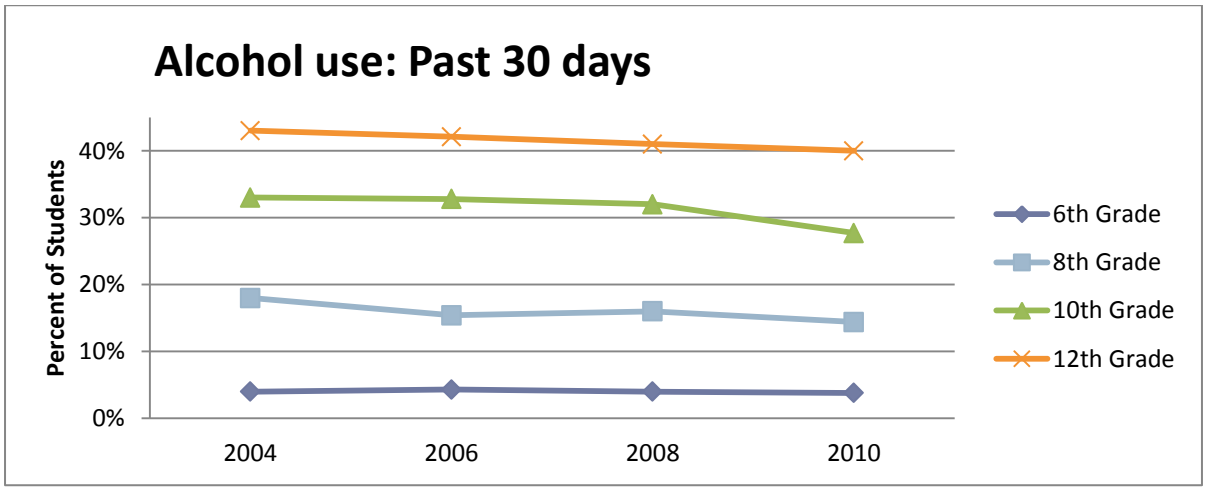
Following charts are the main data that were considered as part of our assessment:

Health Youth Survey (HYS): *Figures HYS 1-14*

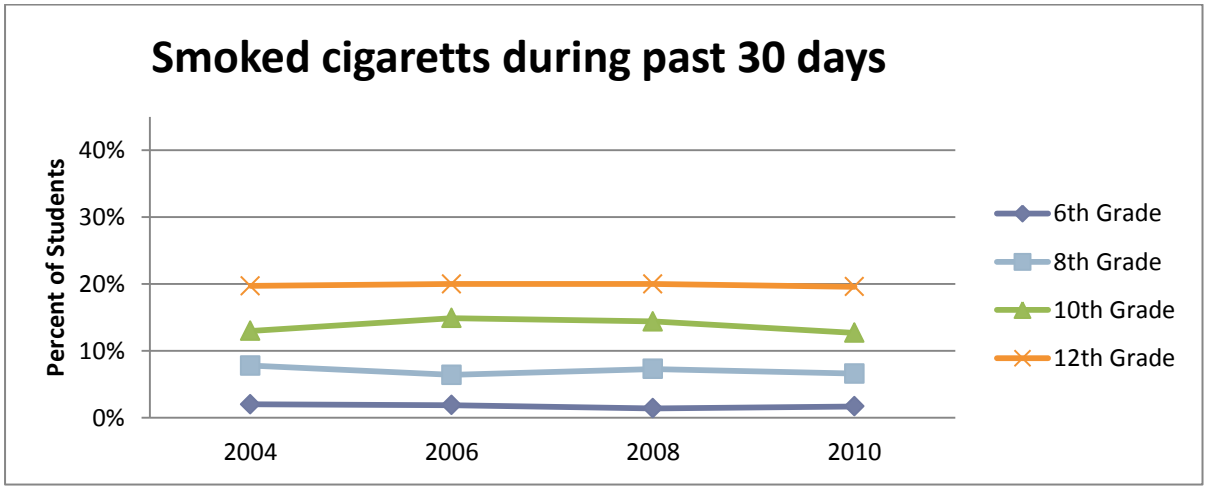
Notes:

- 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

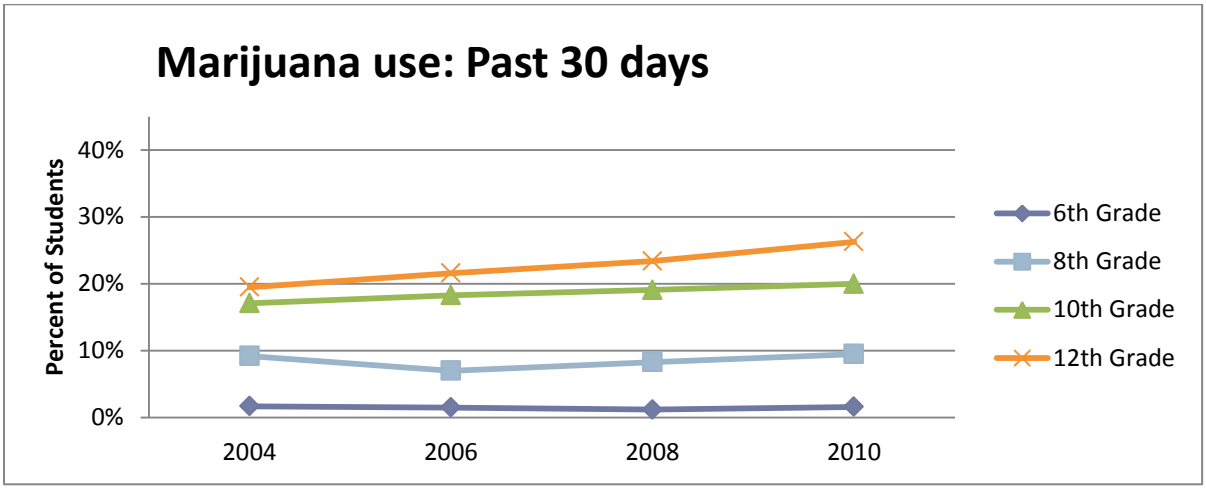
HYS - Figure 1



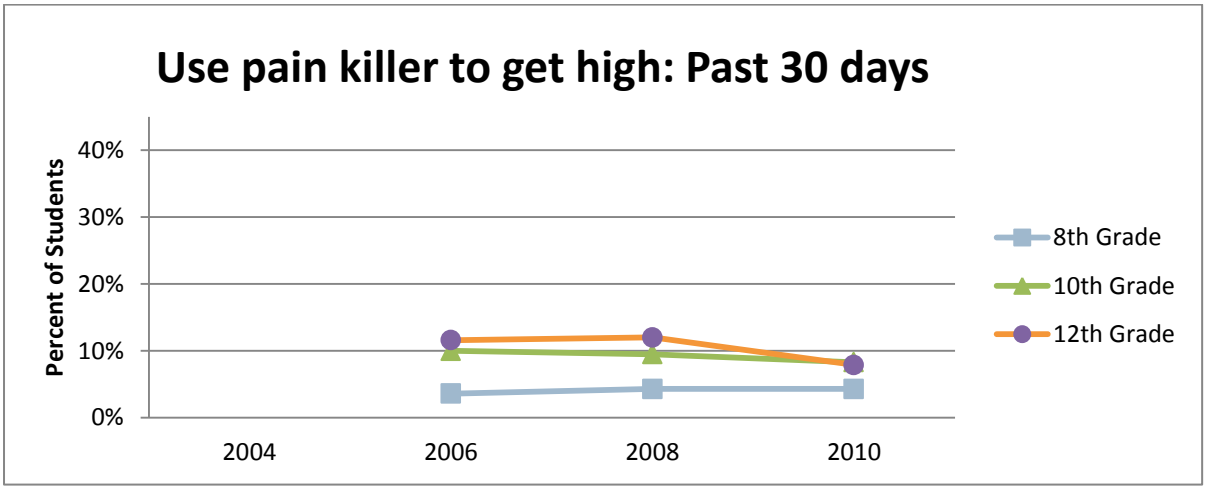
HYS - Figure 2



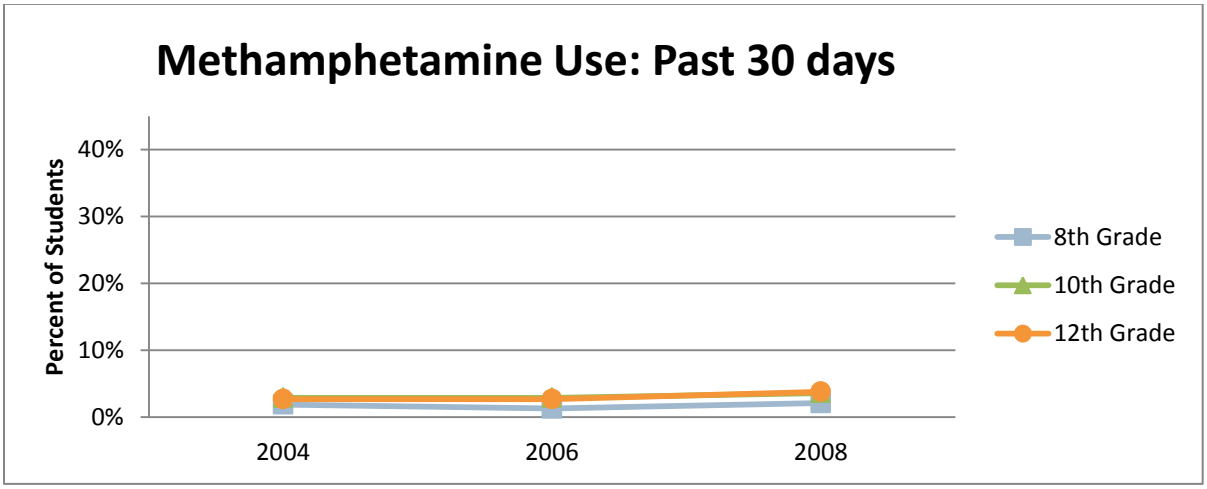
HYS - Figure 3



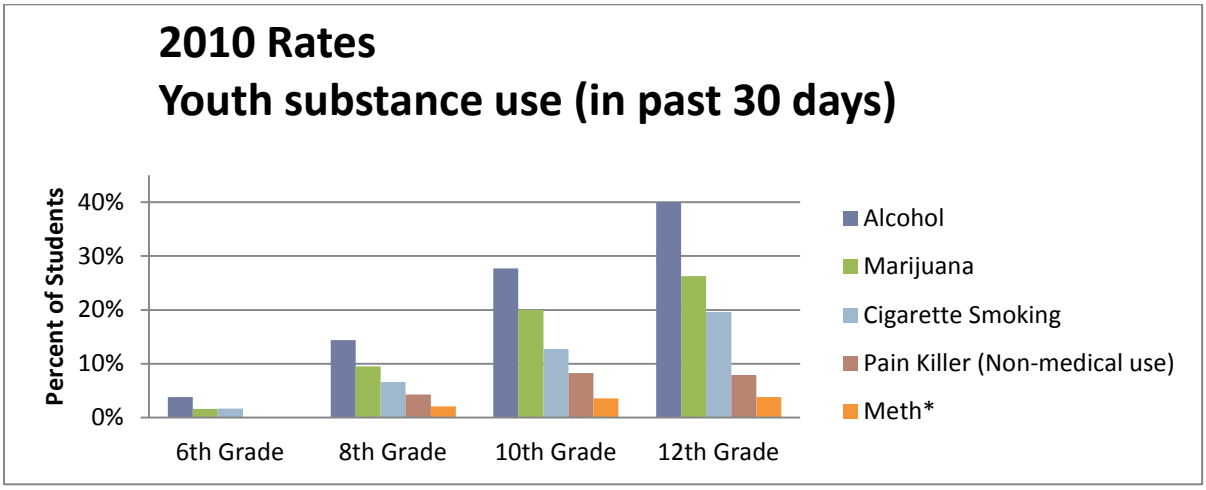
HYS - Figure 4



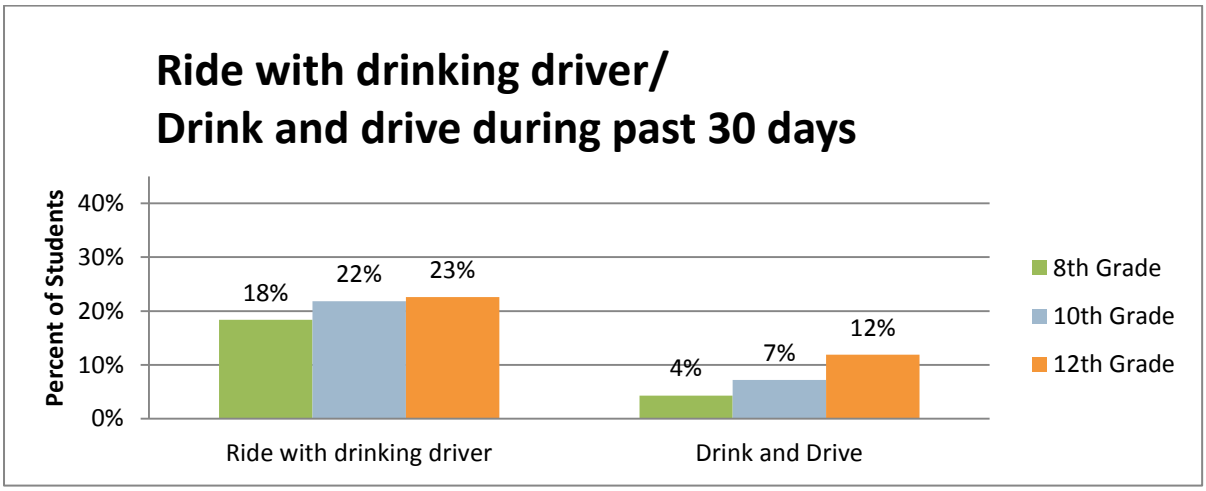
HYS - Figure 5



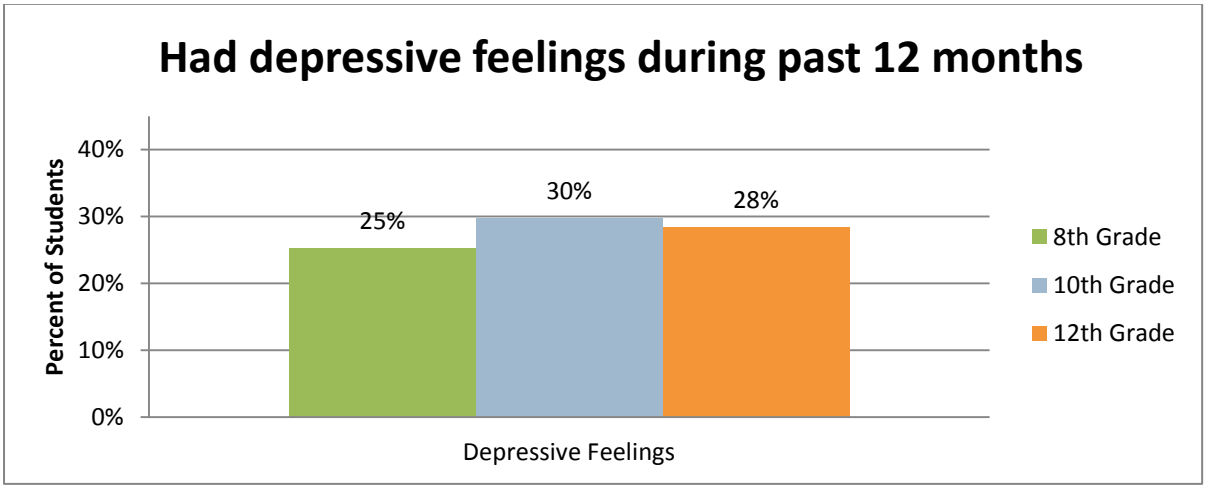
HYS - Figure 6



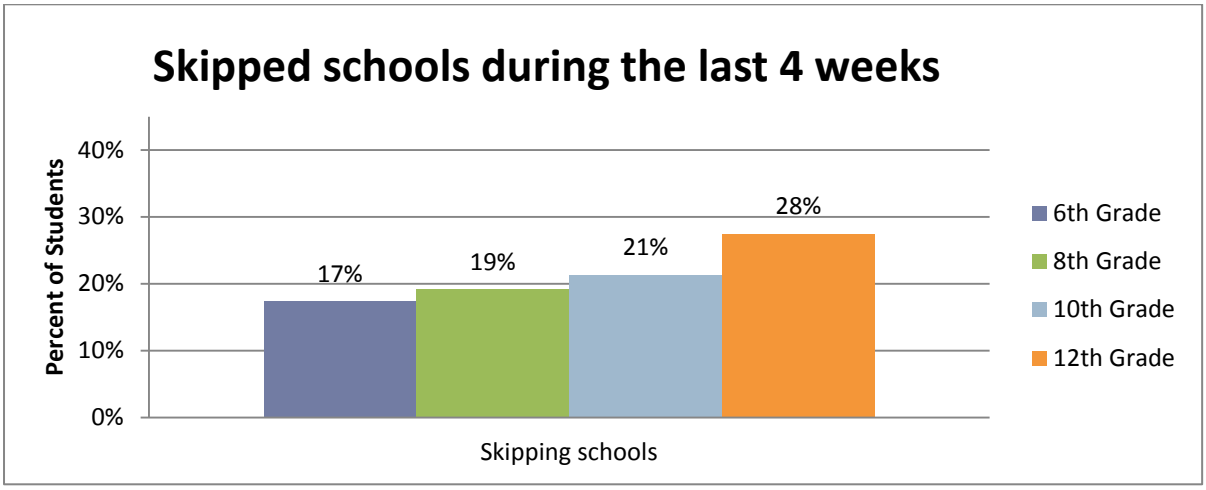
HYS - Figure 7



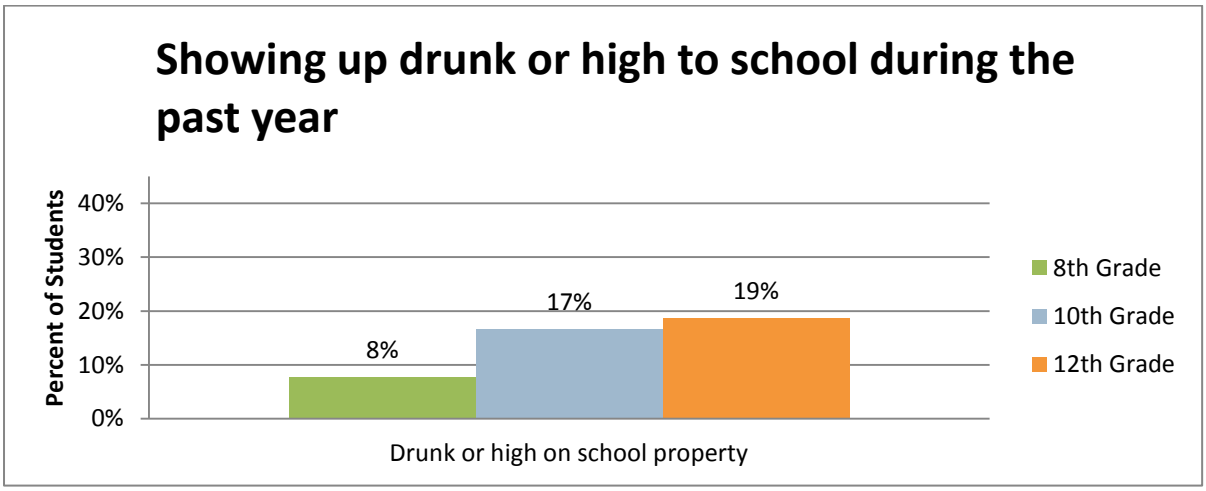
HYS - Figure 8



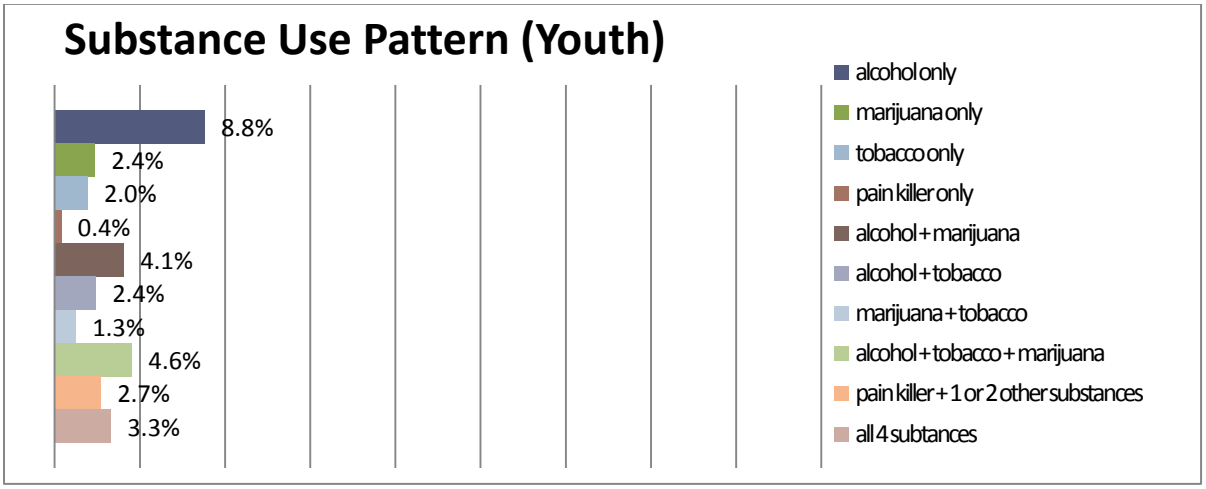
HYS - Figure 9



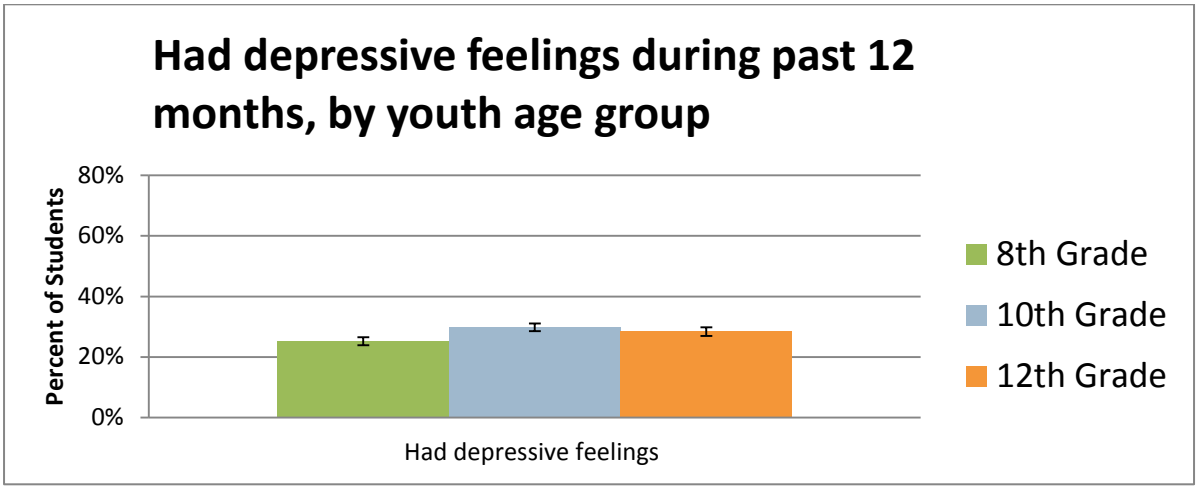
HYS - Figure 10



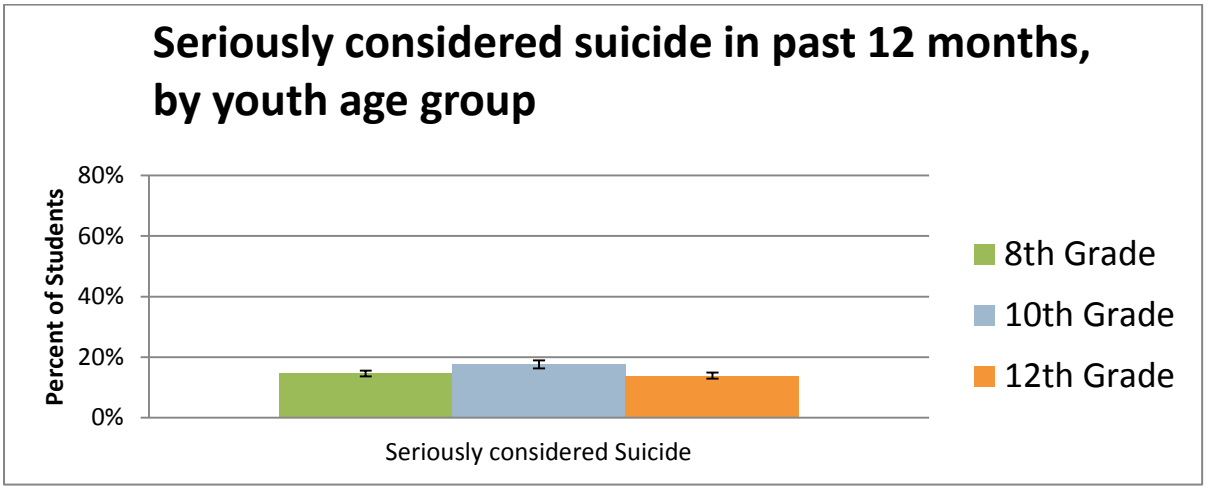
HYS - Figure 11



HYS - Figure 12



HYS - Figure 13



HYS - Figure 14

Correlation between substance use and negative consequences (Odds Ratio)

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

Source: 2010 HYS.

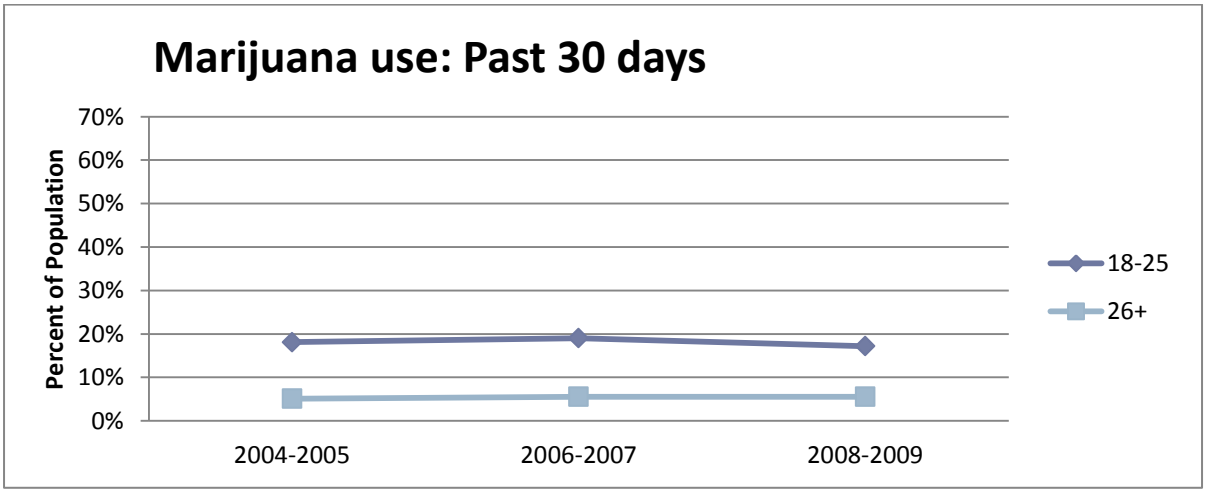
* Used pain killers to get high

National Survey on Drug Use and Health (NSDUH): *Figures NSDUH 1-18*

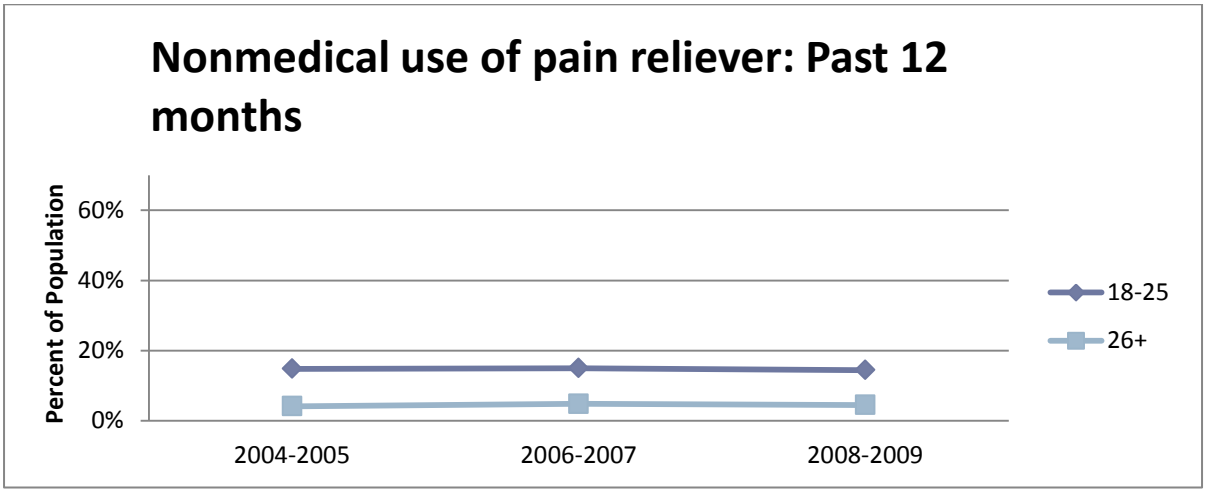
Notes:

- 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).

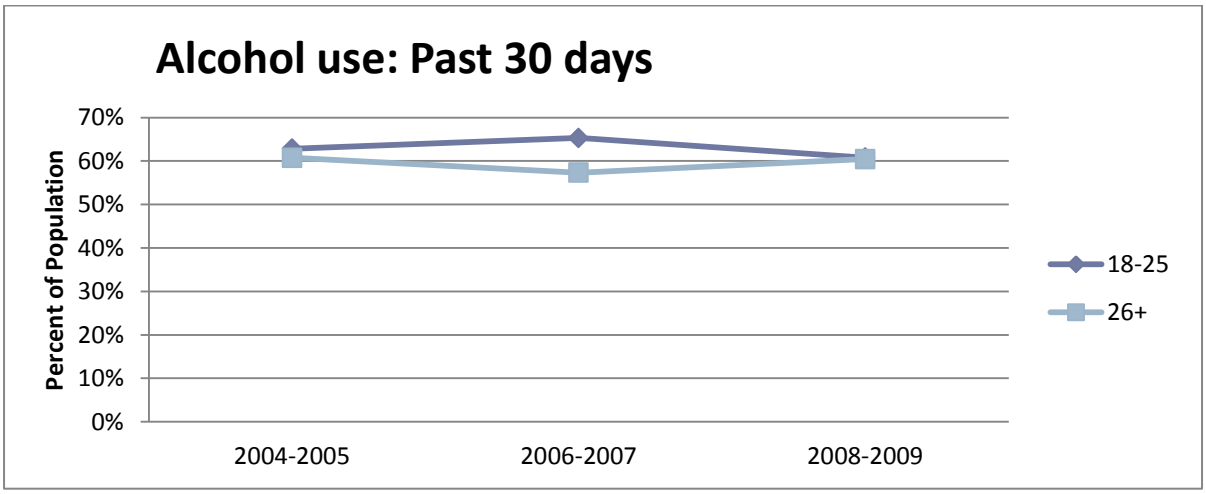
NSDUH - Figure 1



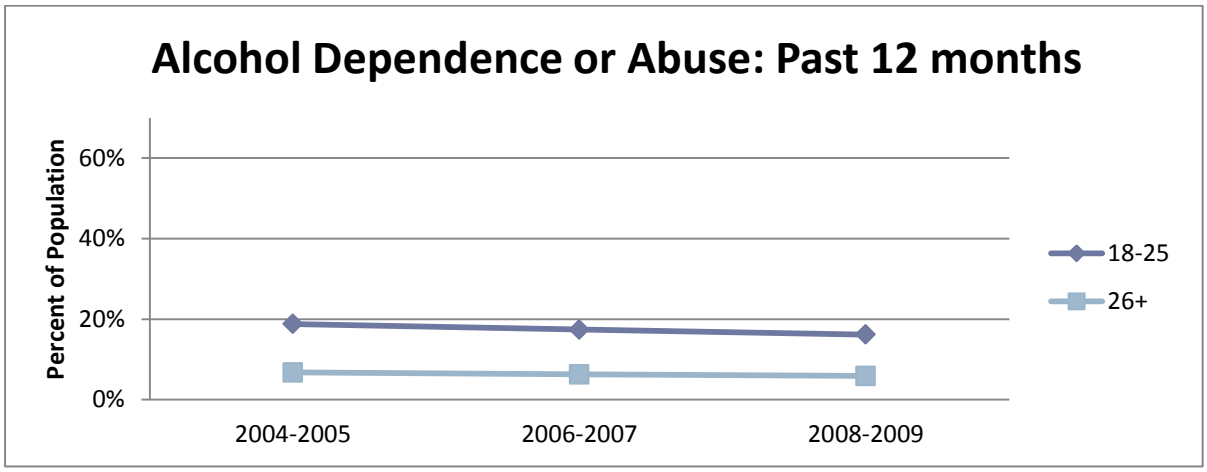
NSDUH - Figure 2



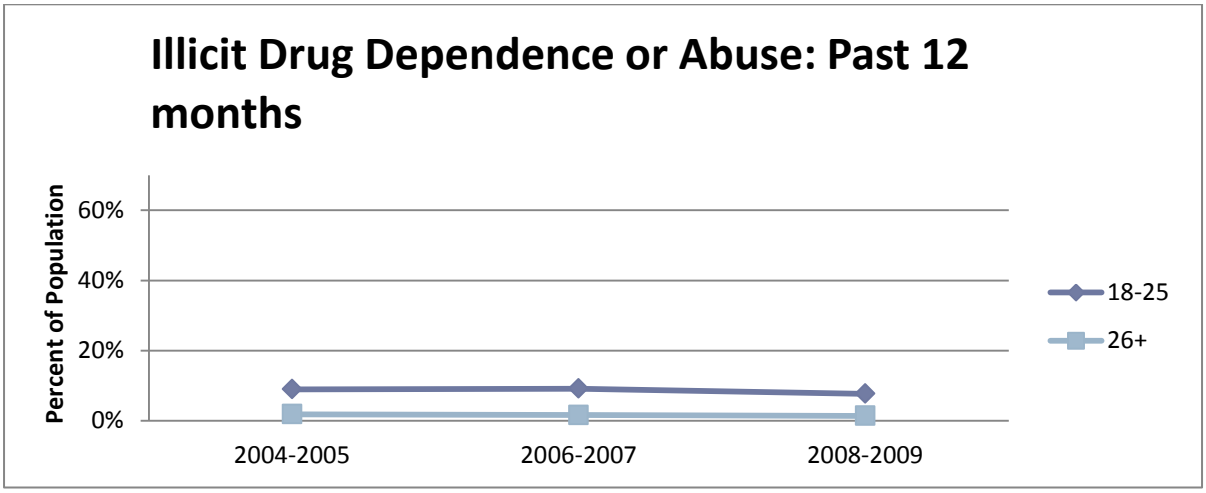
NSDUH - Figure 3



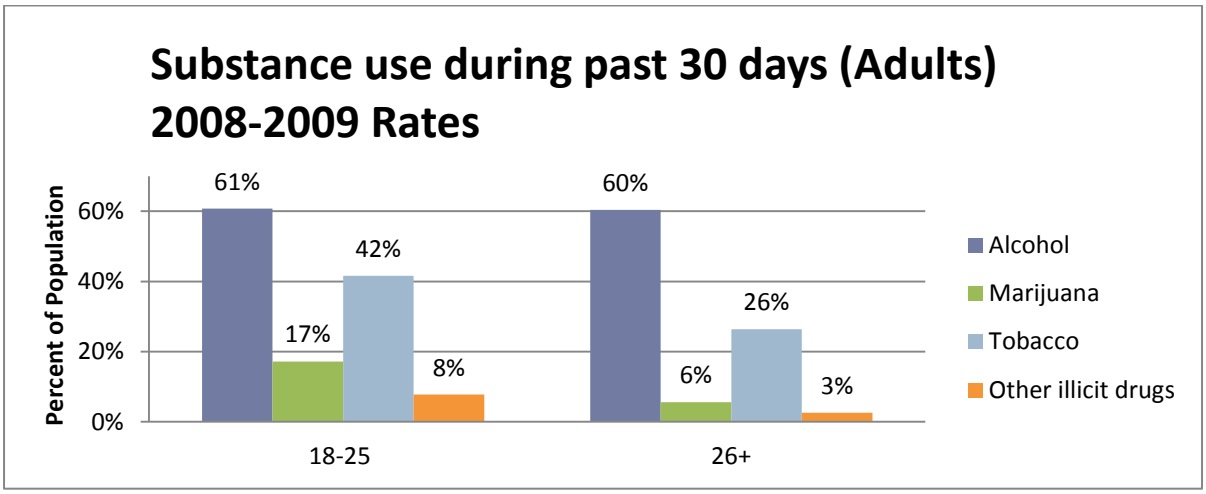
NSDUH - Figure 4



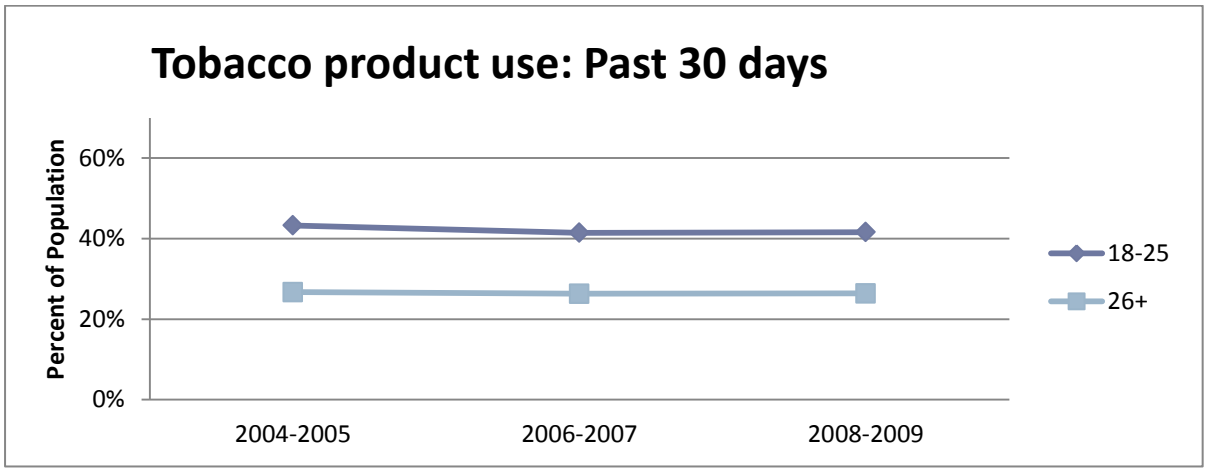
NSDUH - Figure 5



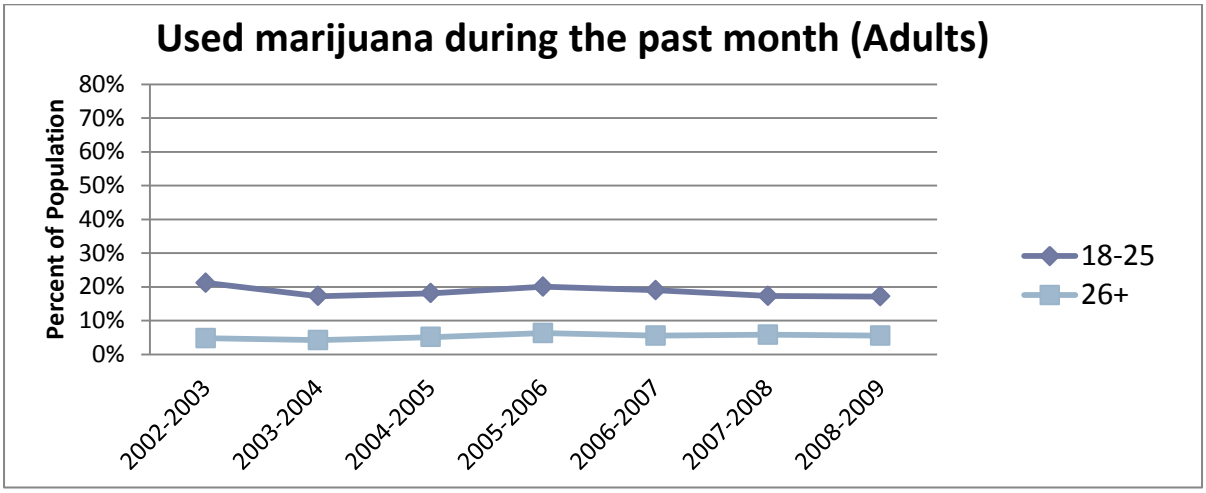
NSDUH - Figure 6



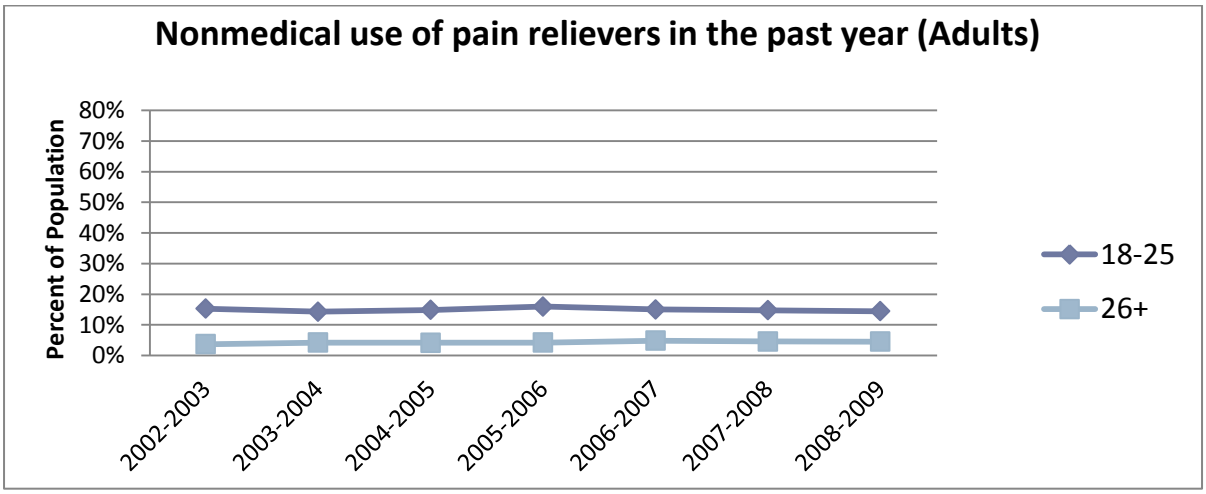
NSDUH - Figure 7



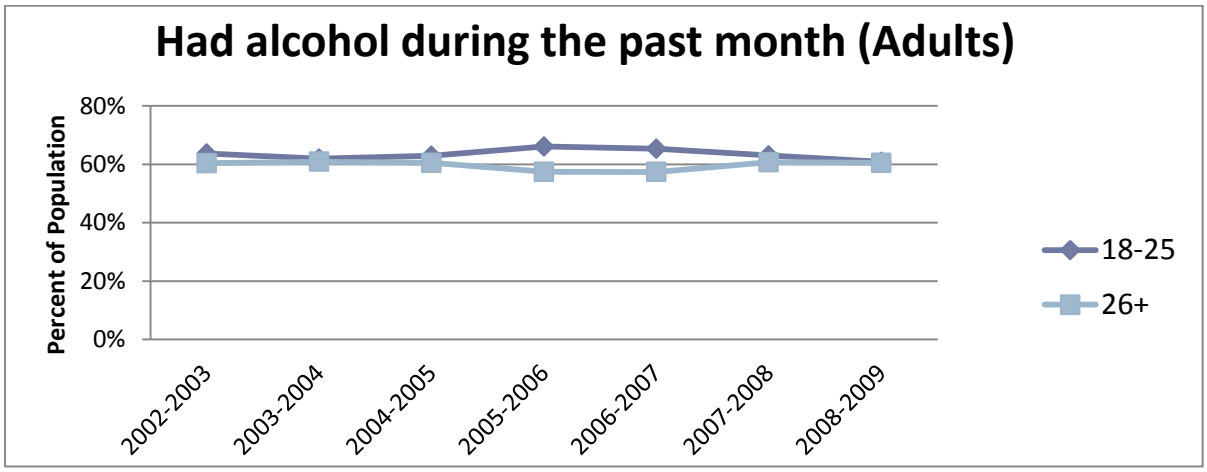
NSDUH - Figure 8



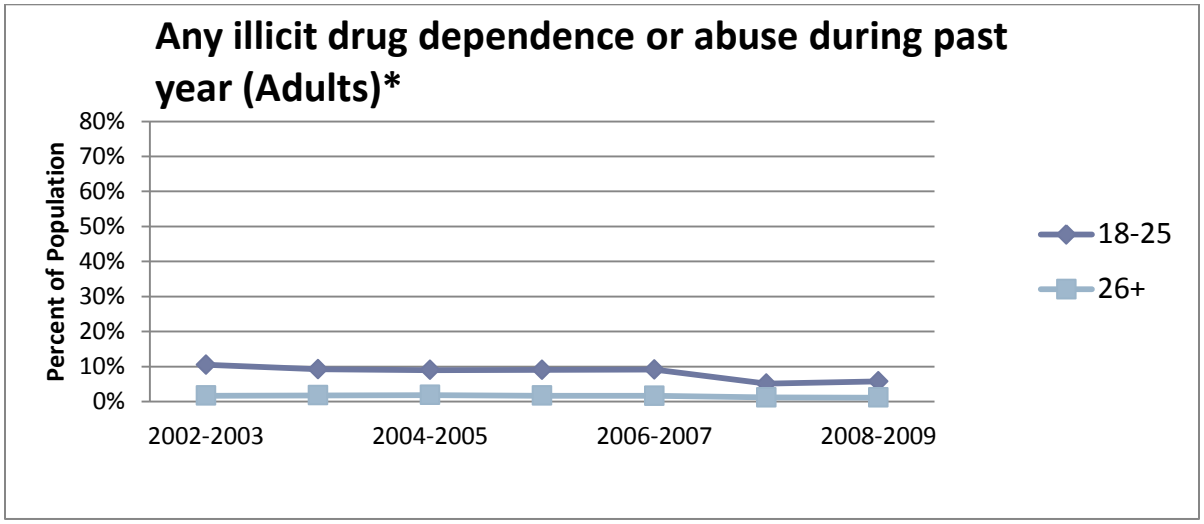
NSDUH - Figure 9



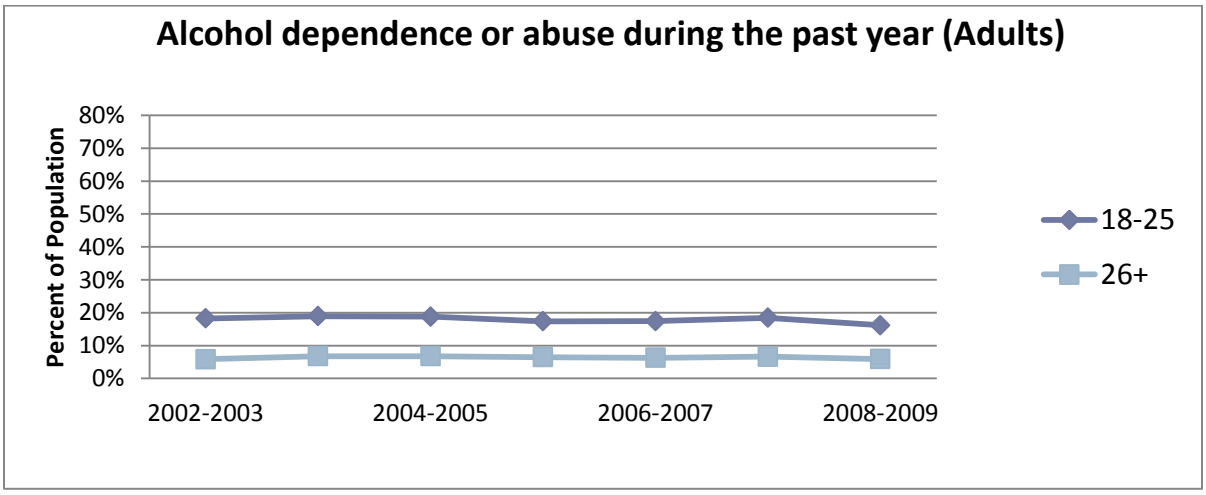
NSDUH - Figure 10



NSDUH - Figure 11



NSDUH - Figure 12



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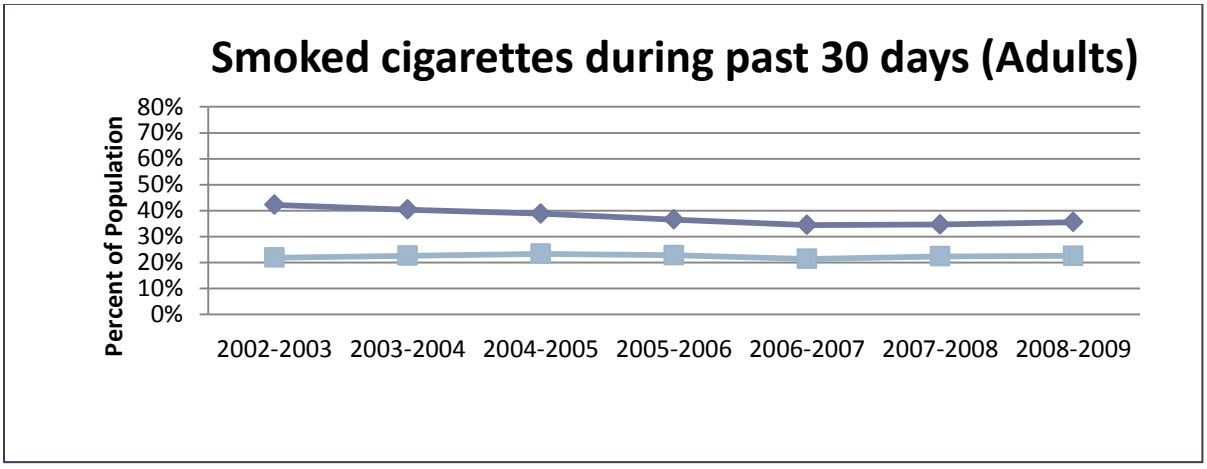
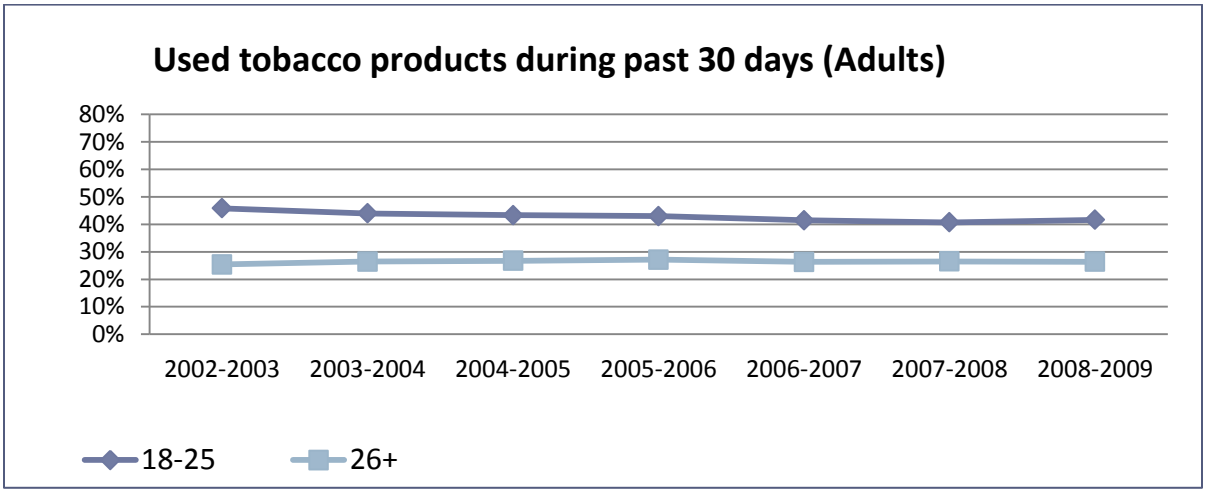
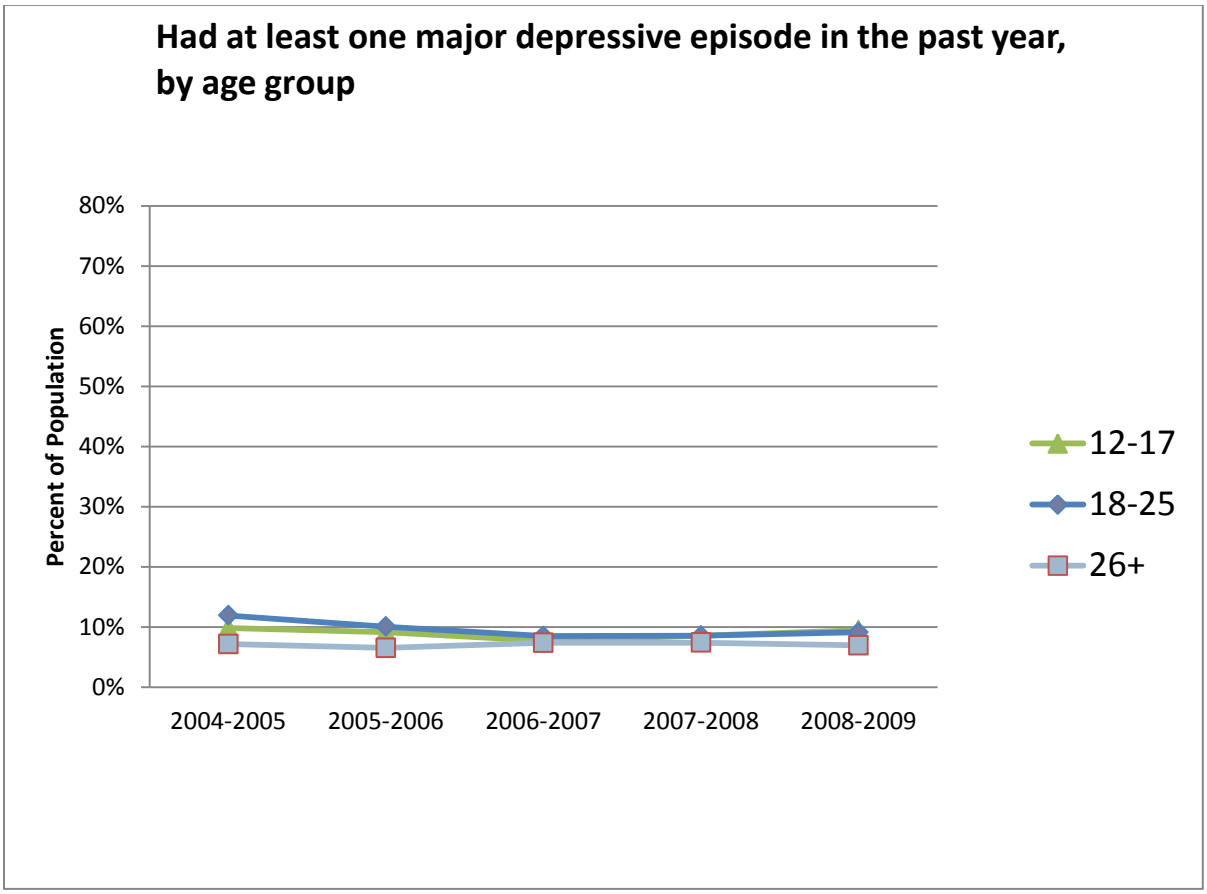


NSDUH - Figure 14



NSDUH - Figure 15



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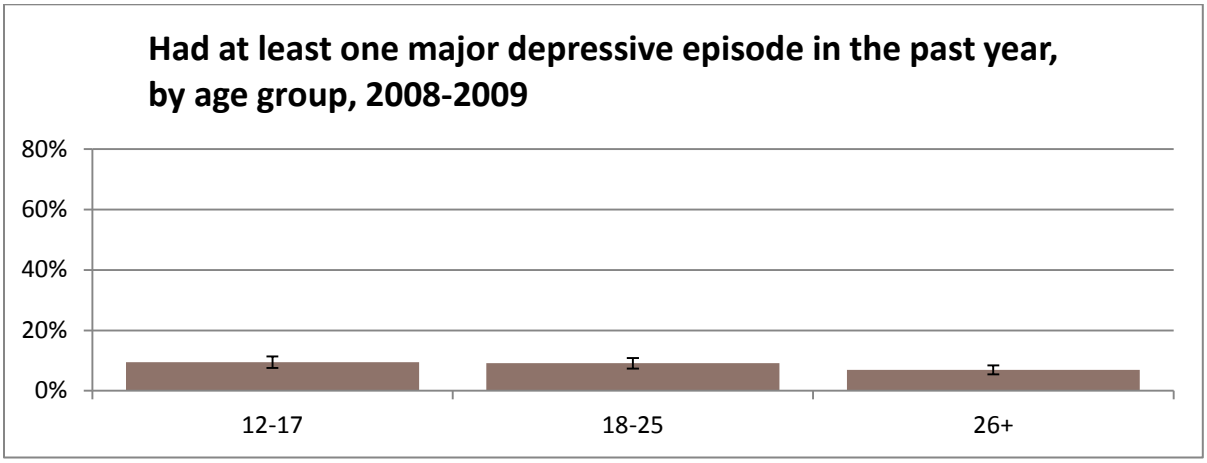
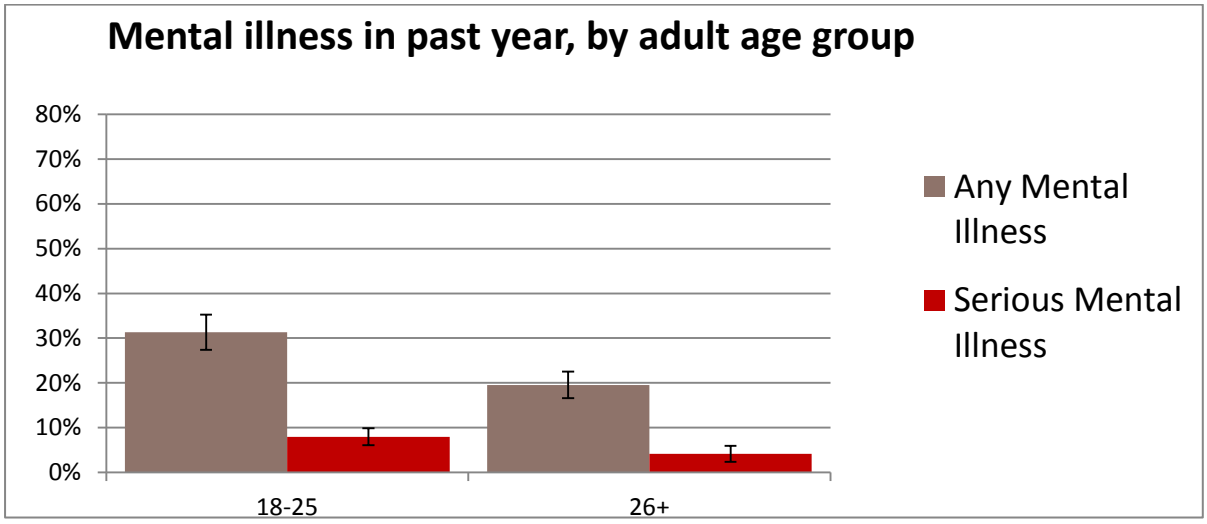


NSDUH - Figure 17



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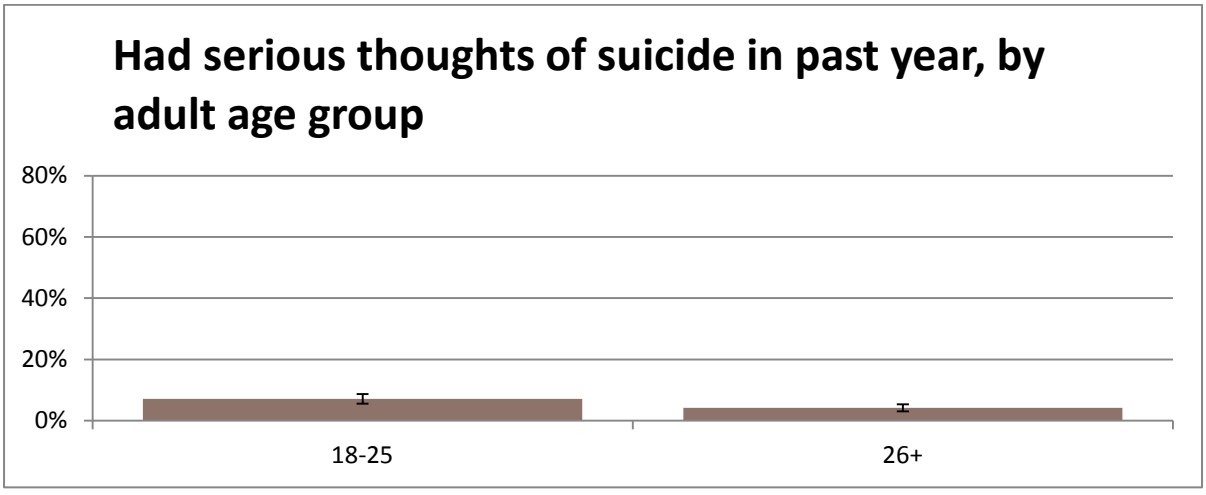
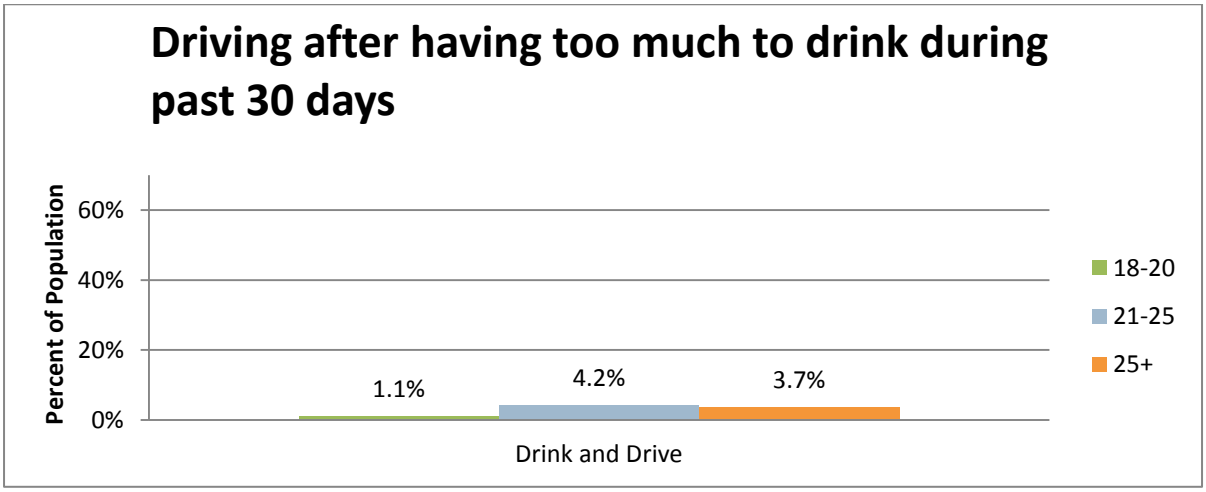


Behavioral Risk Factors Surveillance System (BRFSS): *Figures BRFSS 1-27*

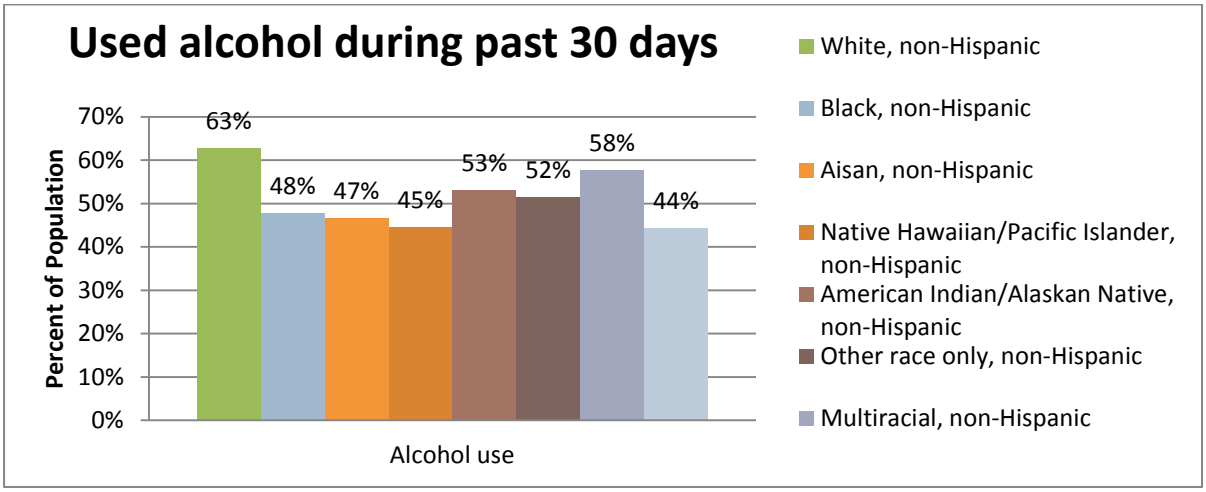
Notes:

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

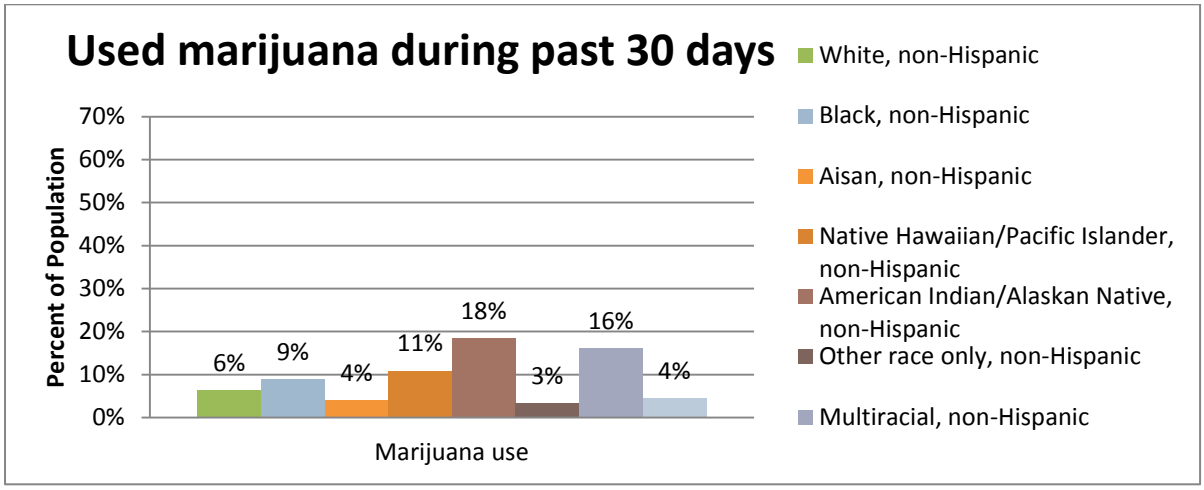
BRFSS - Figure 1



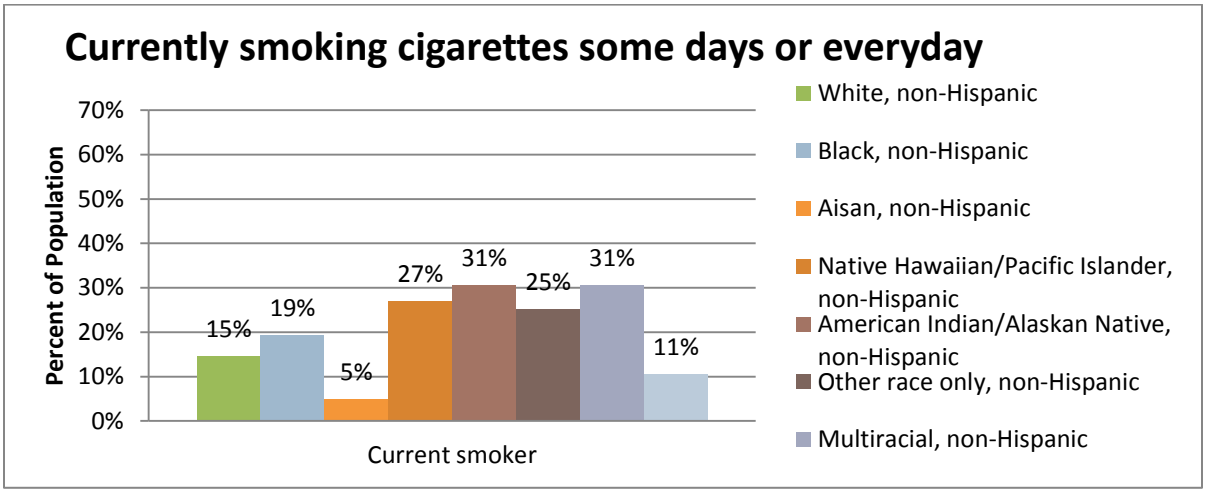
BRFSS - Figure 2



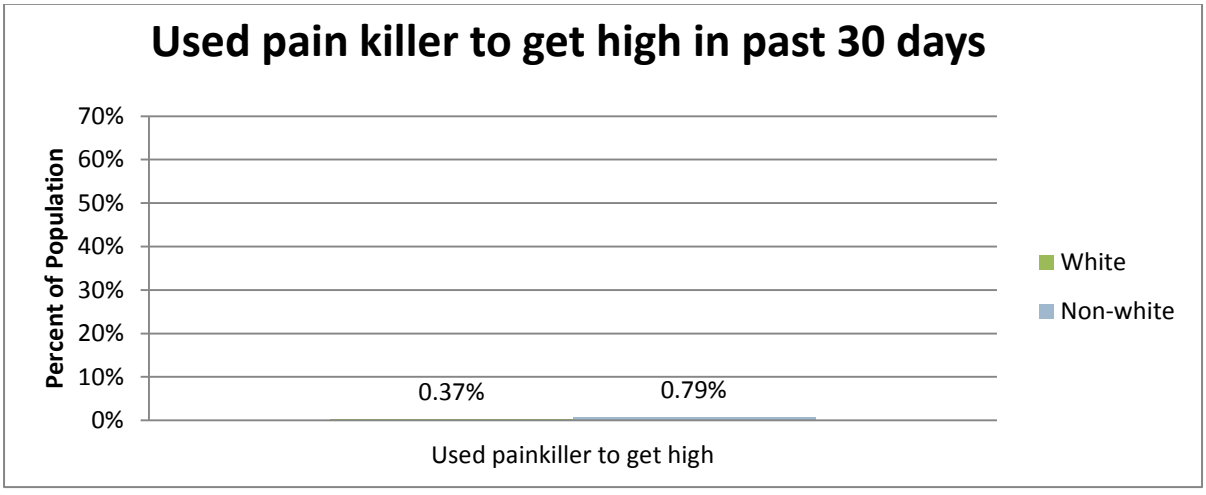
BRFSS - Figure 3



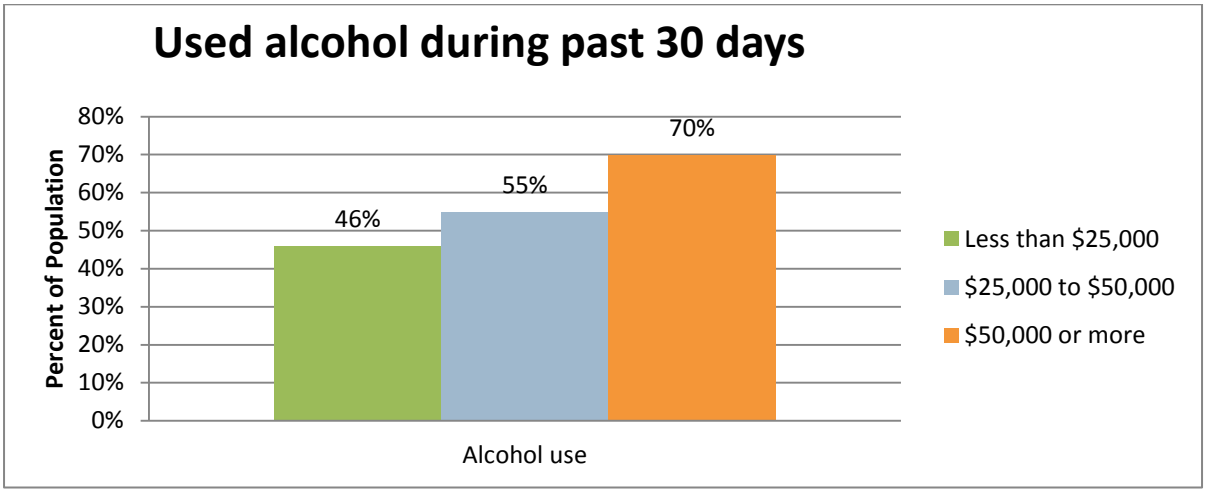
BRFSS - Figure 4



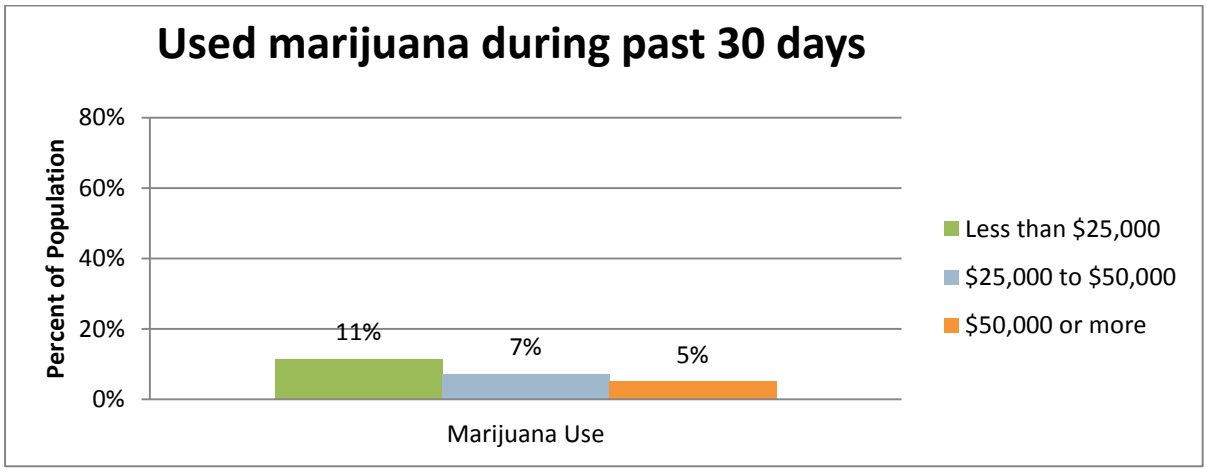
BRFSS - Figure 5



BRFSS - Figure 6



BRFSS - Figure 7



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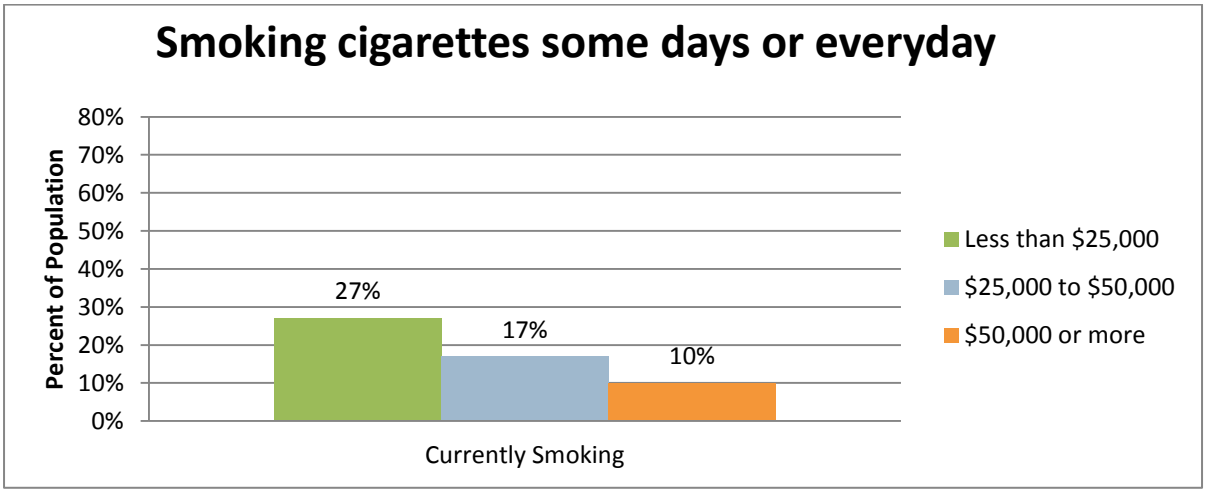
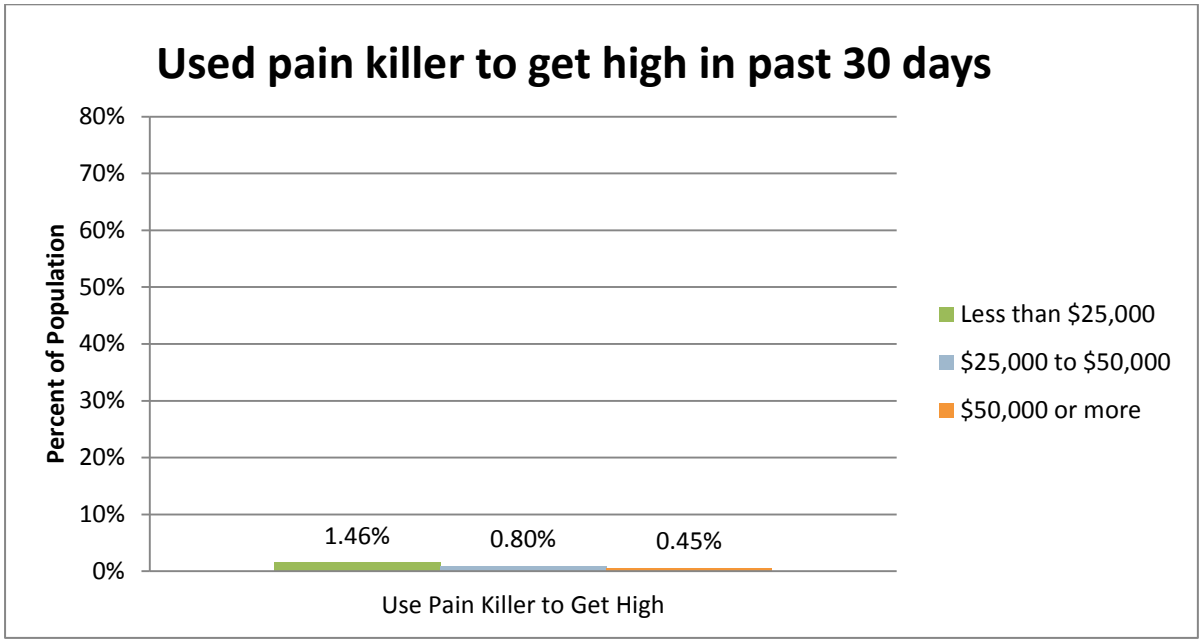


BRFSS - Figure 9



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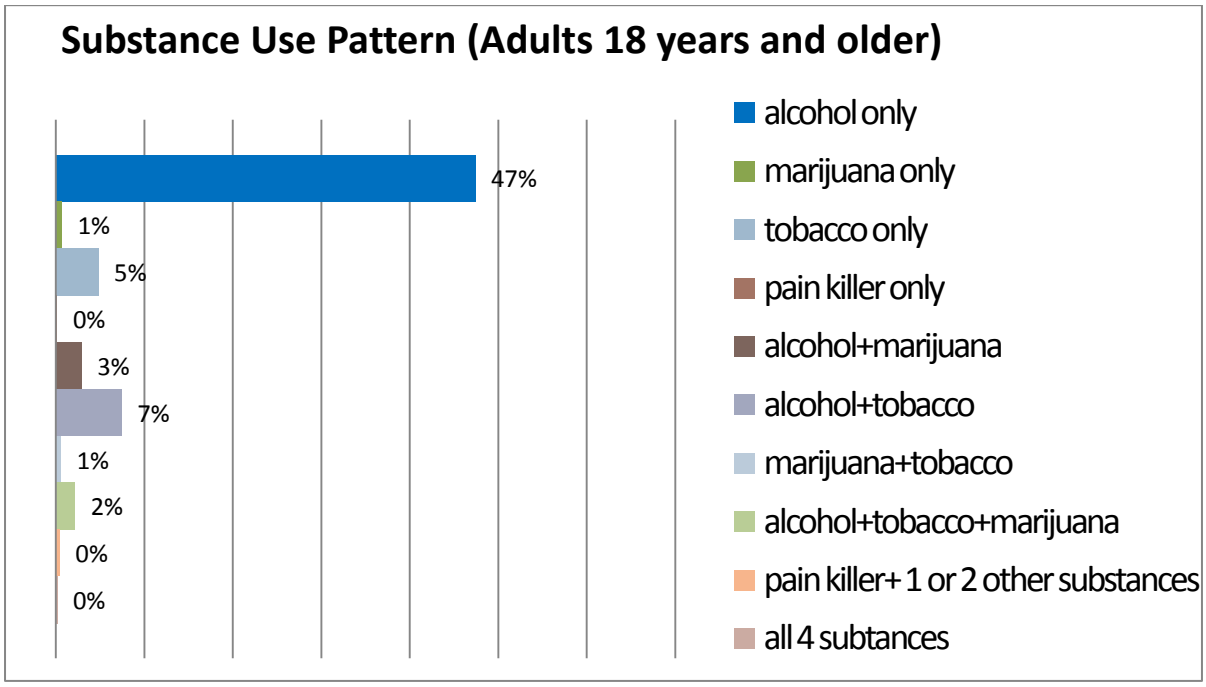

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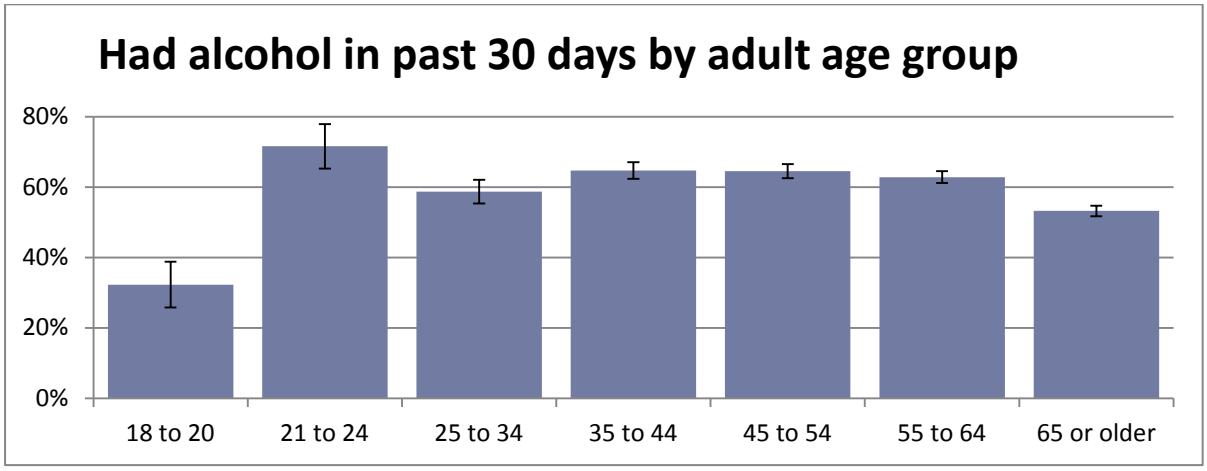

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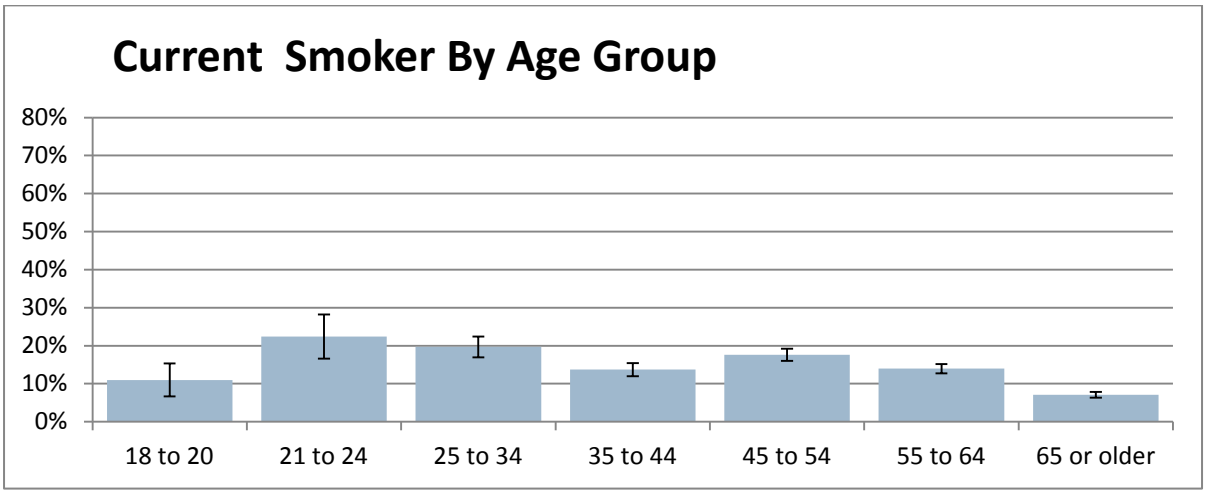
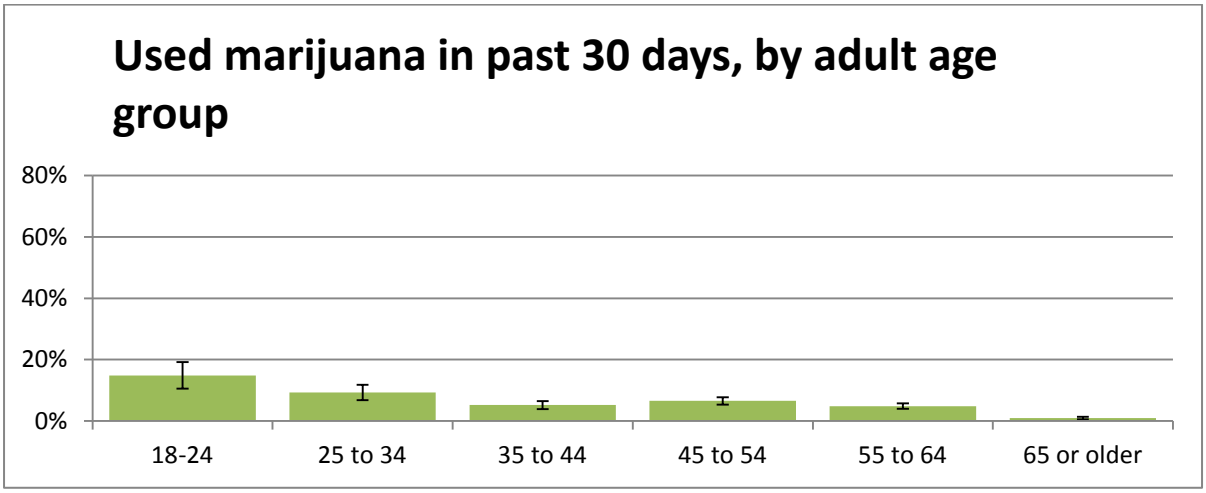
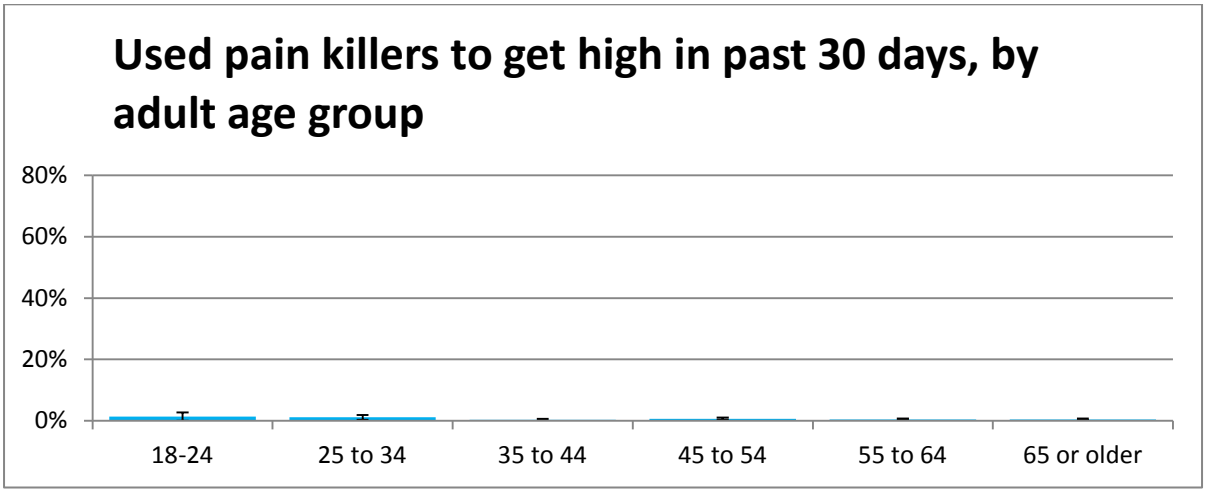


BRFSS - Figure 13



BRFSS - Figure 14



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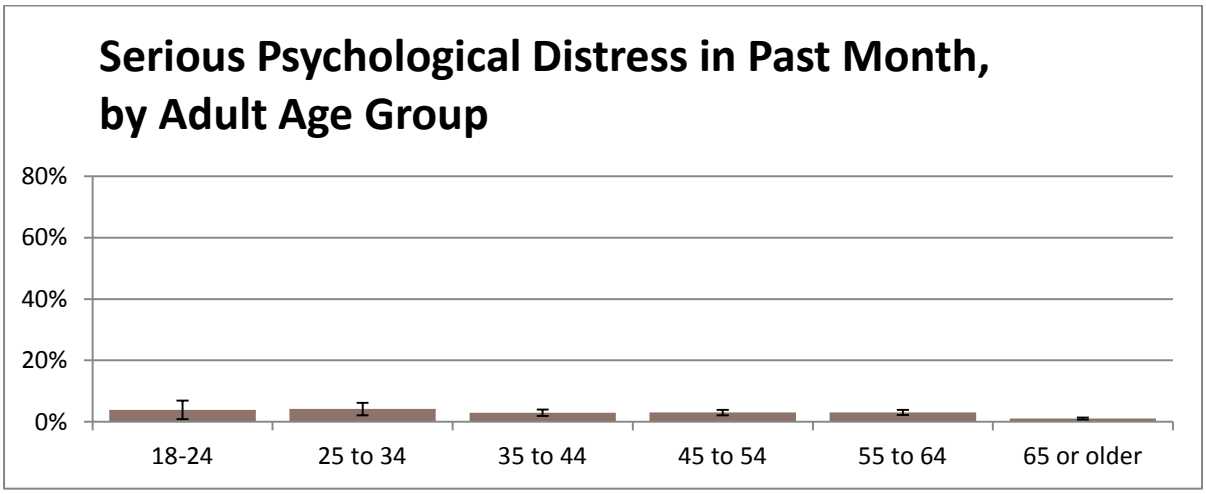

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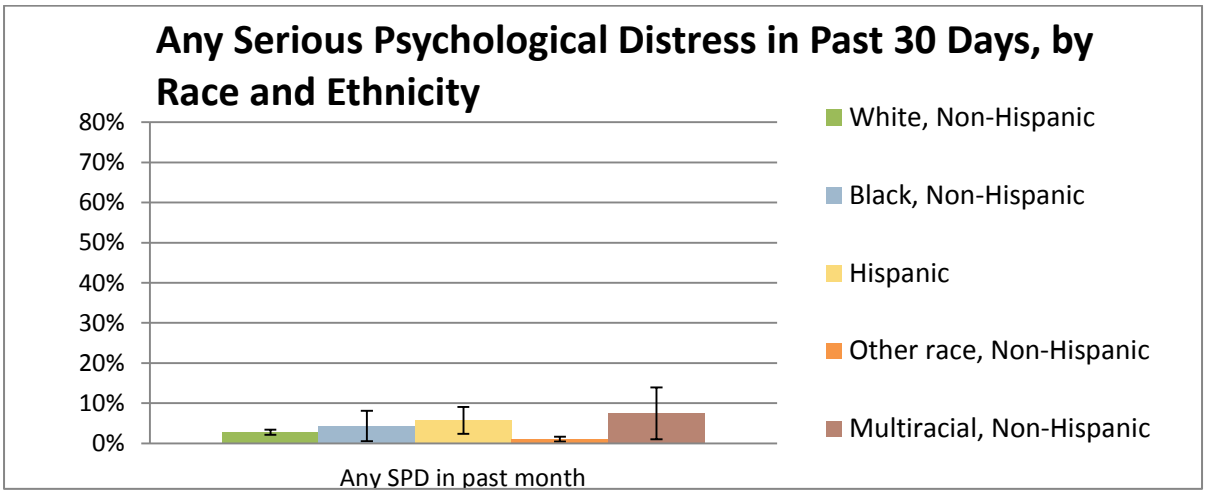
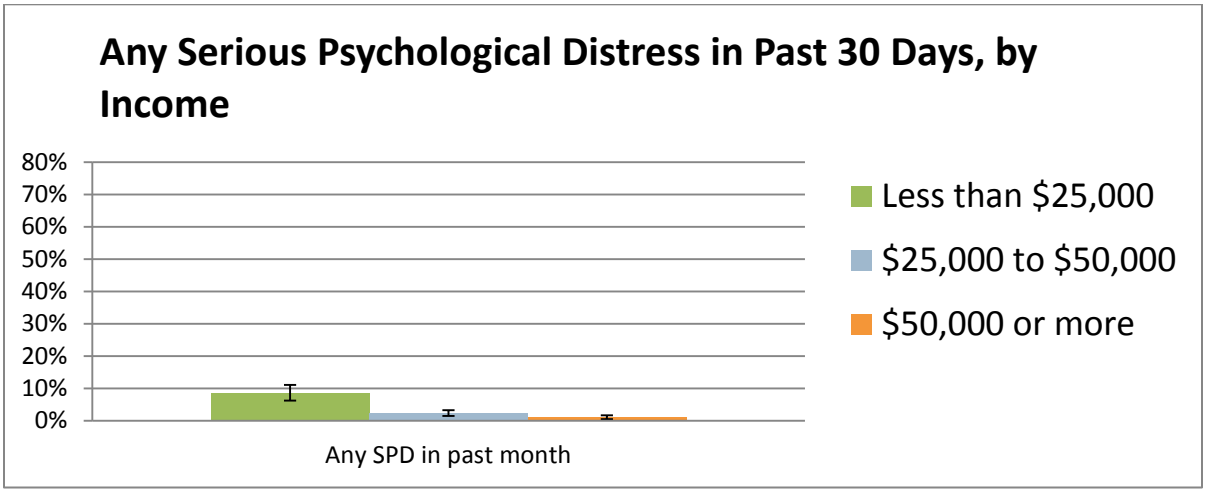


BRFSS - Figure 17



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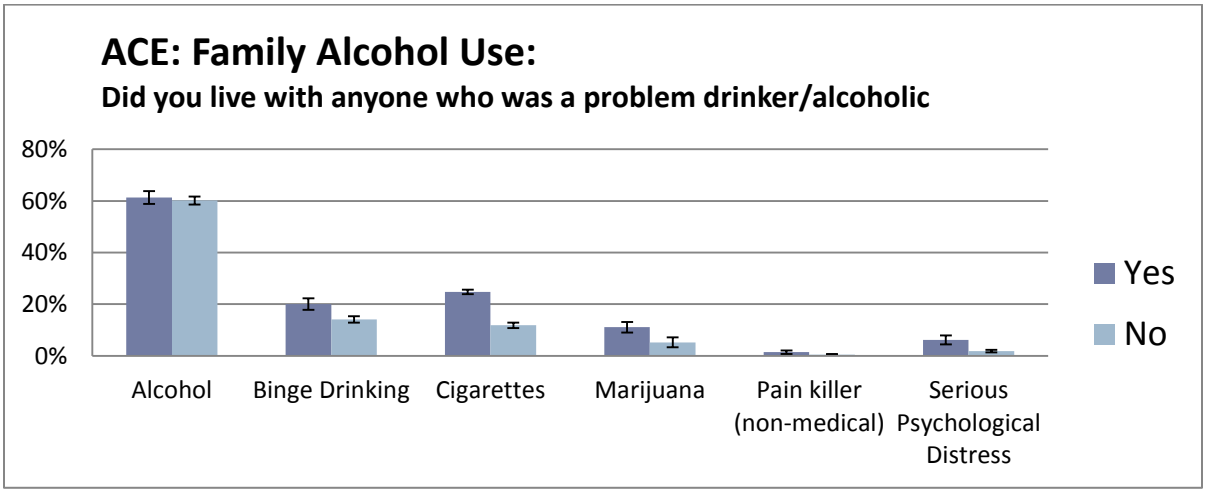
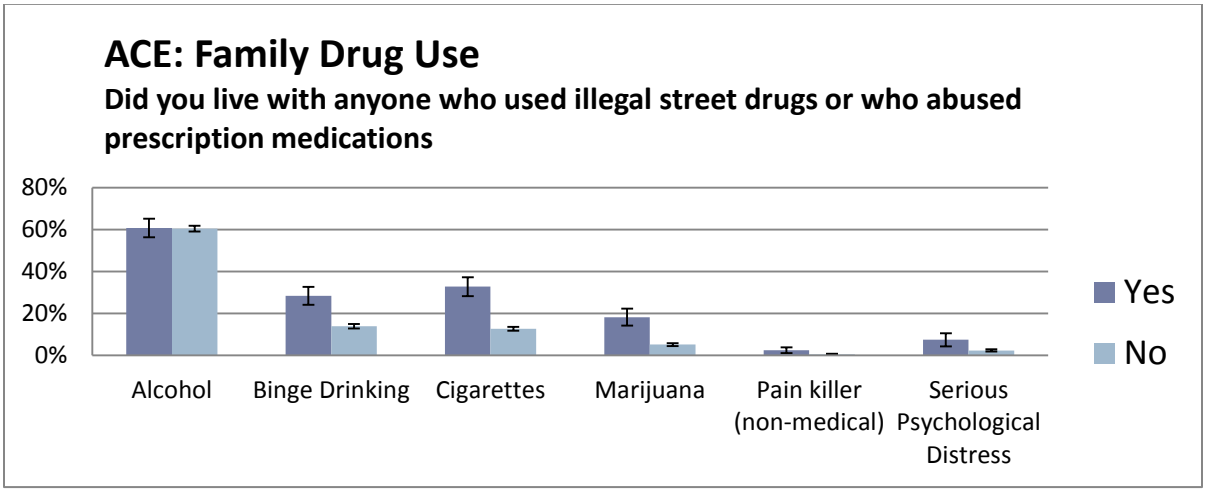
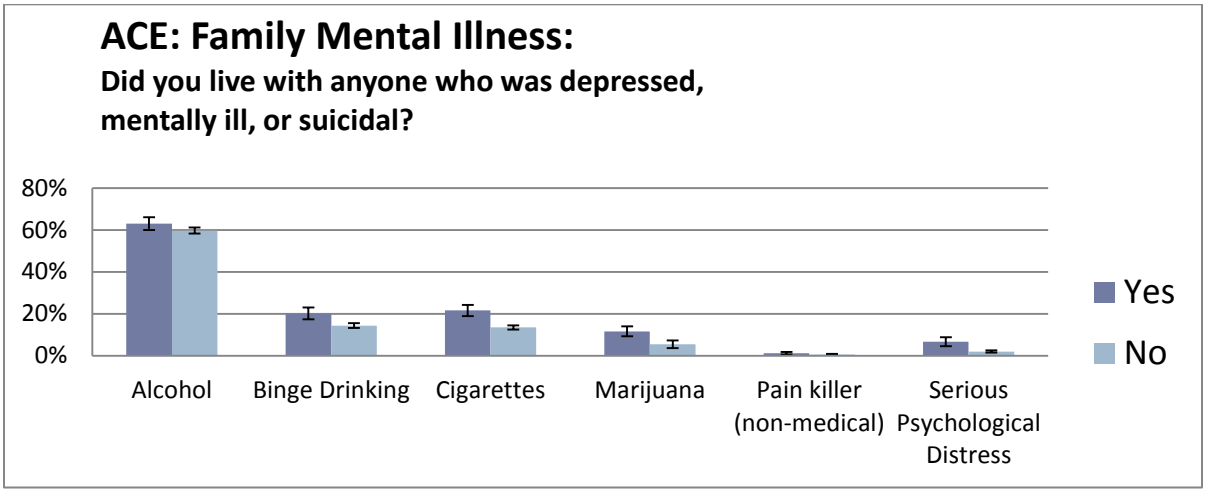


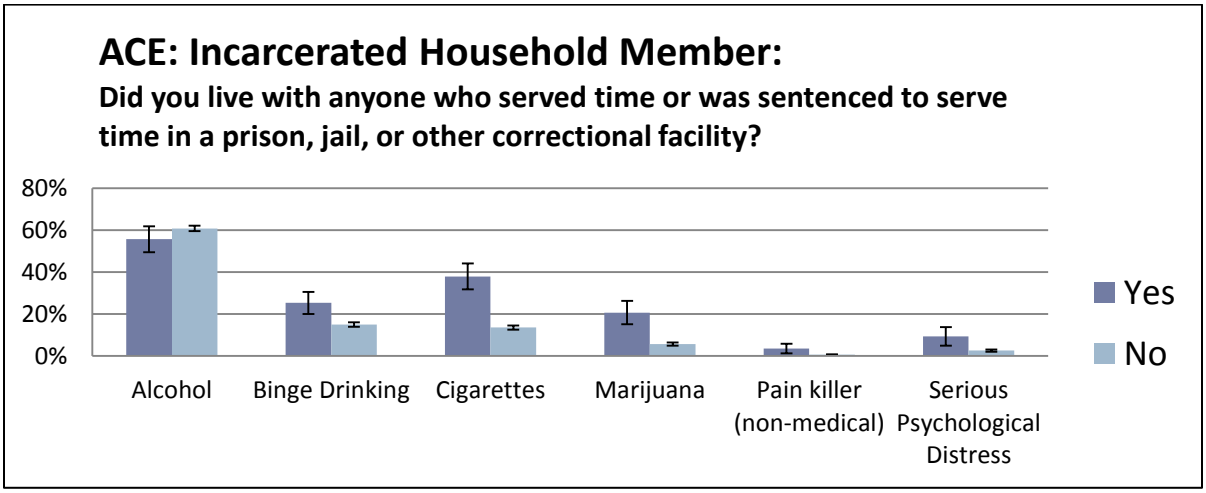
BRFSS - Figure 19



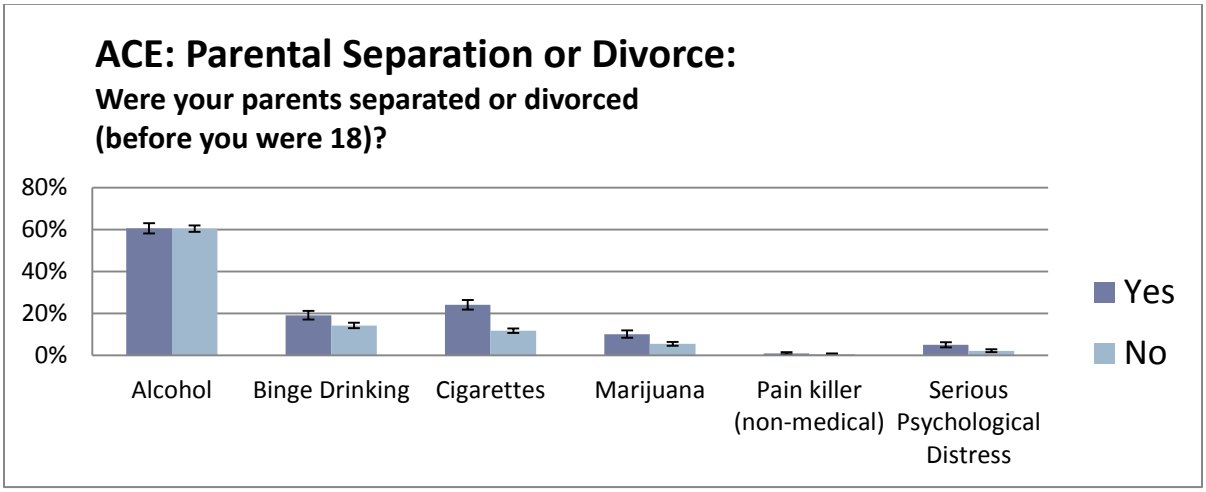
BRFSS - Figure 20



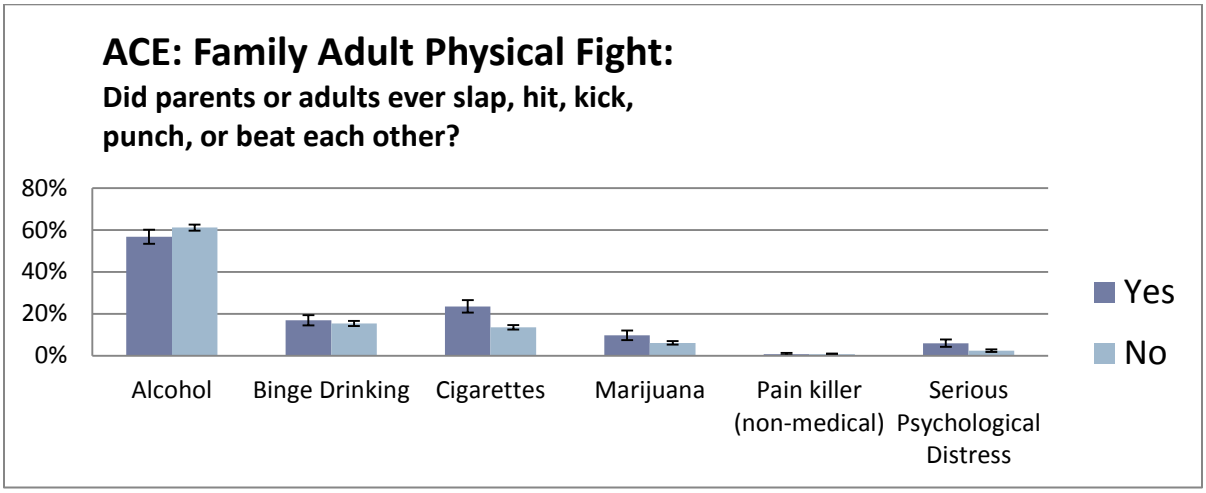
BRFSS - Figure 21



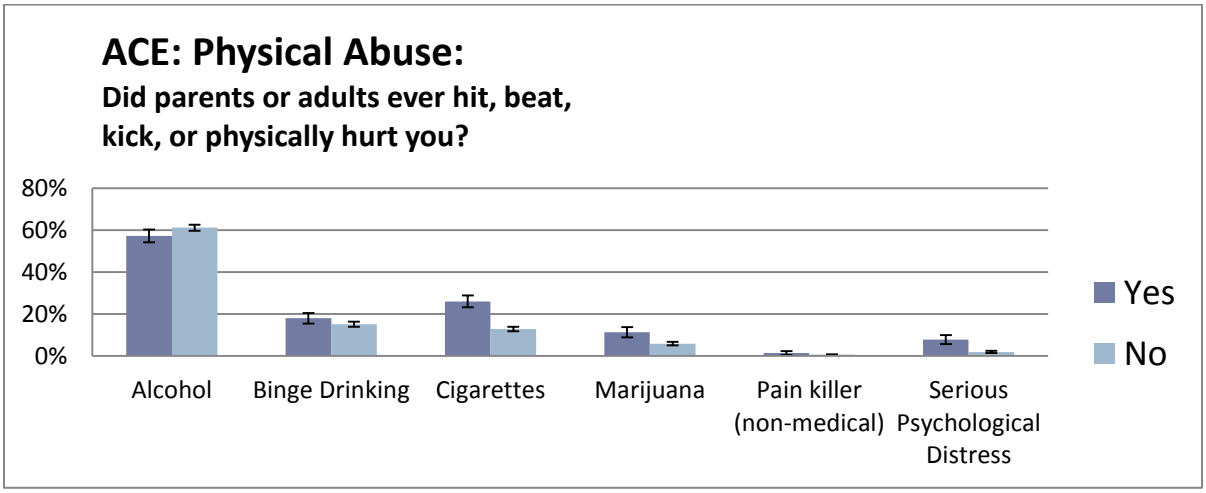
BRFSS - Figure 22



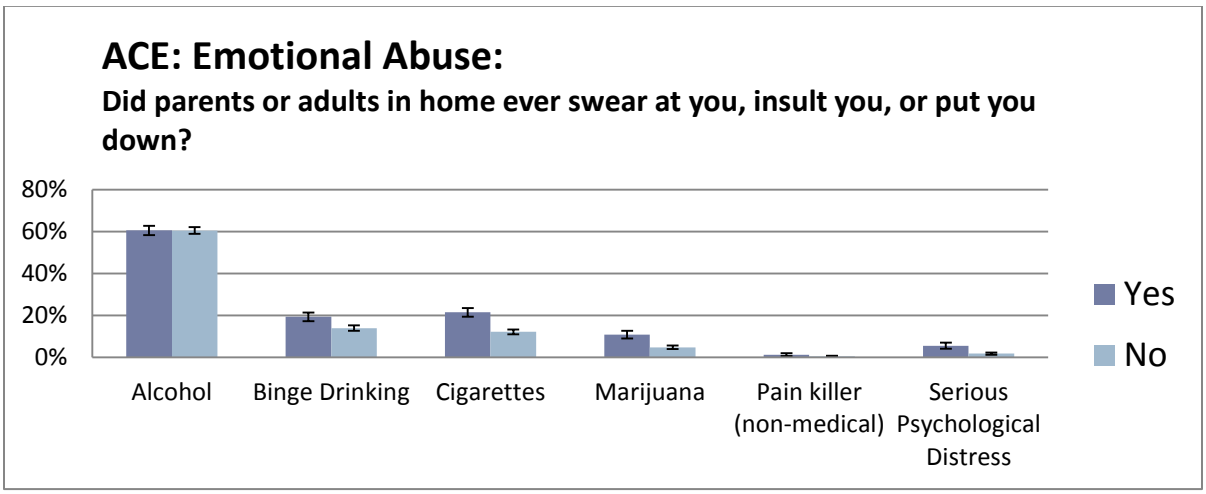
BRFSS - Figure 23



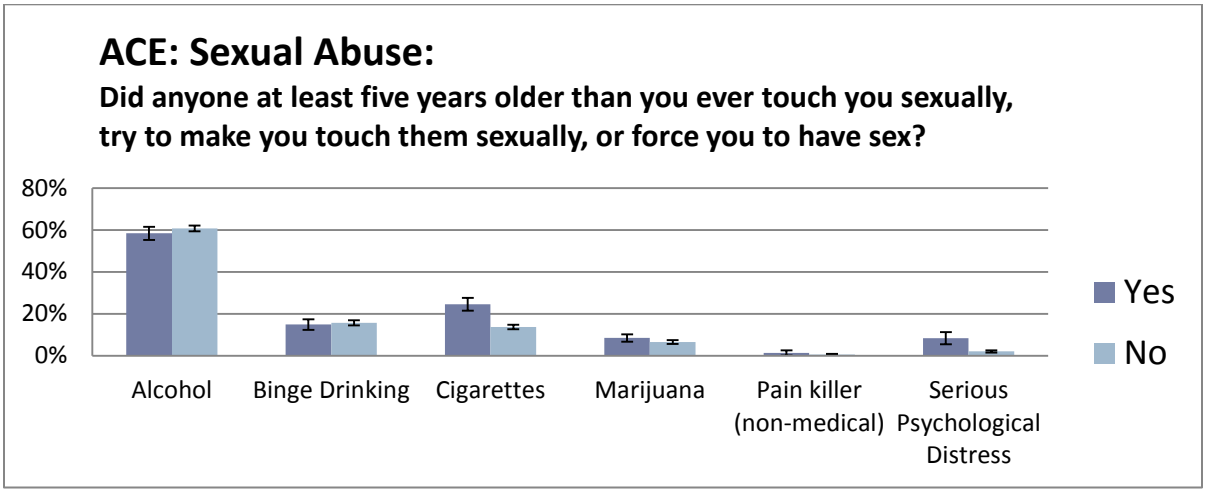
BRFSS - Figure 24



BRFSS - Figure 25



BRFSS - Figure 26



BRFSS - Figure 27

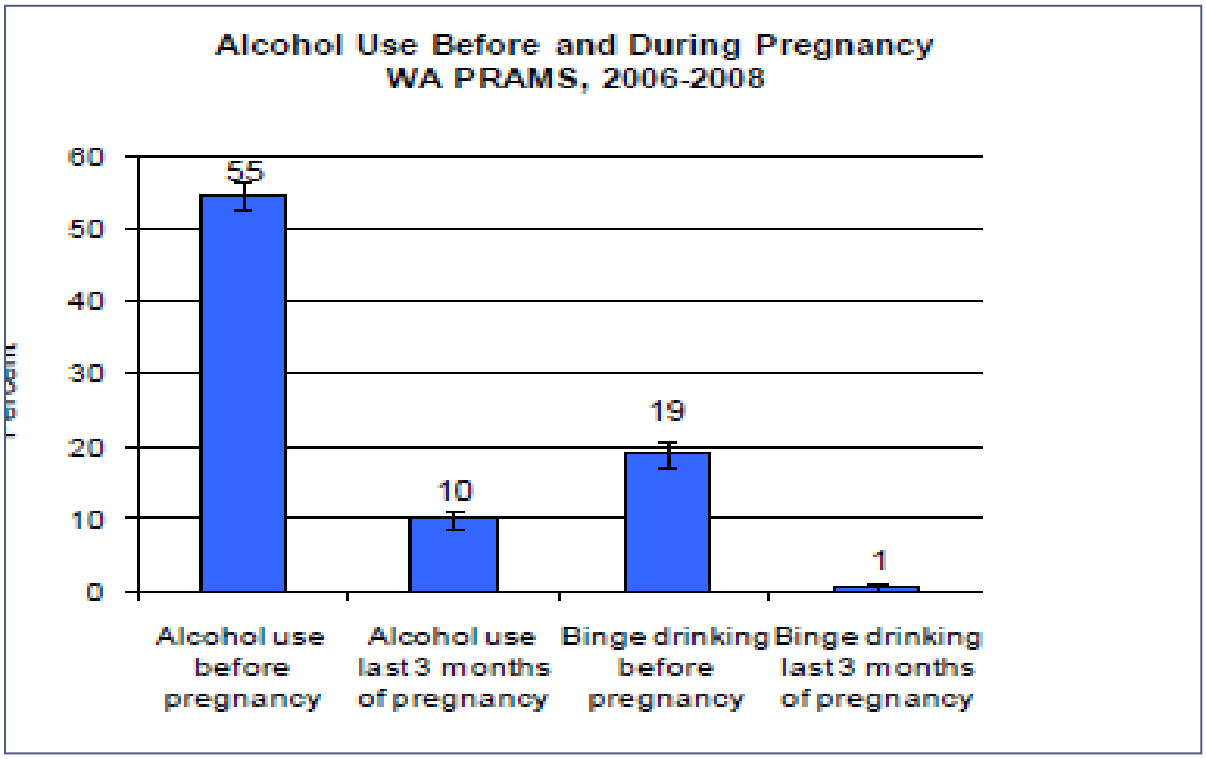
ACEs:	Drinking Alcohol	Binge Drinking	Smoking Cigarettes	Using Marijuana	Using Pain Killers to Get High	Serious Psychological Distress
Family Drinking	1.05	1.54	2.46	2.28	2.92	3.53
Family Drug Use	1.01	2.47	3.36	4.15	5.18	3.40
Family Mental Illness	1.15	1.51	1.77	2.28	1.96	3.45
Household Members Incarcerated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

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

Notes:

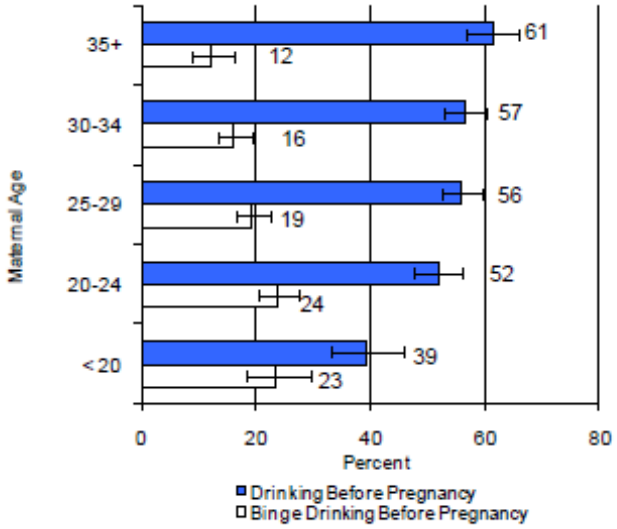
- National and statewide mail and telephone survey.
- Collects data on new mothers' behaviors and experiences before, during, and shortly after pregnancy.
- Respondents: new mothers 2 to 6 months after delivering a baby.
- Sample size: approximately 1,800 surveys mailed each year in Washington with about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

PRAMS - Figure 1

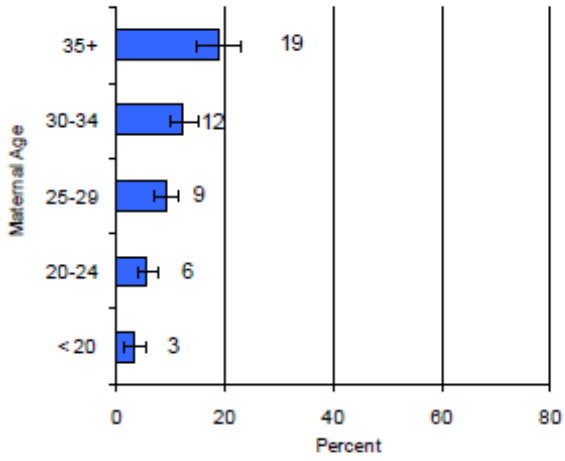


PRAMS - Figure 2

Drinking and Binge Drinking Before Pregnancy by Maternal Age, 2006-

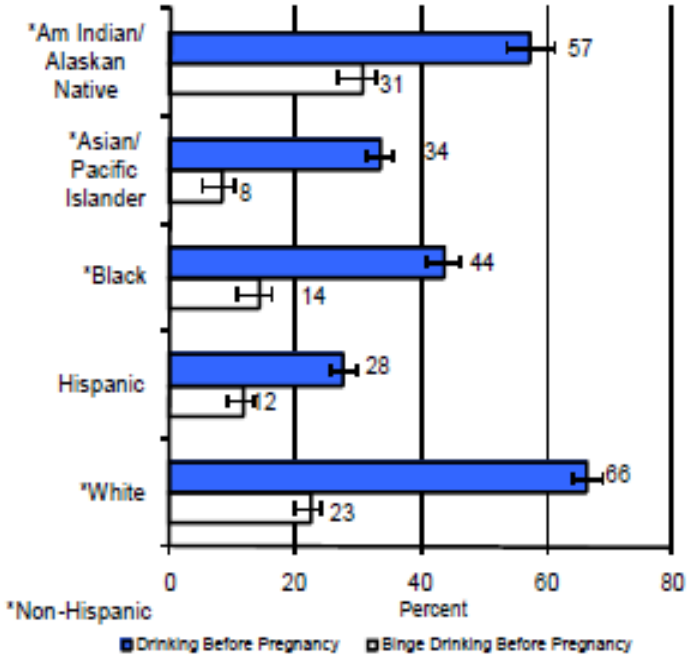


Drinking In Third Trimester by Maternal Age, 2006-2008

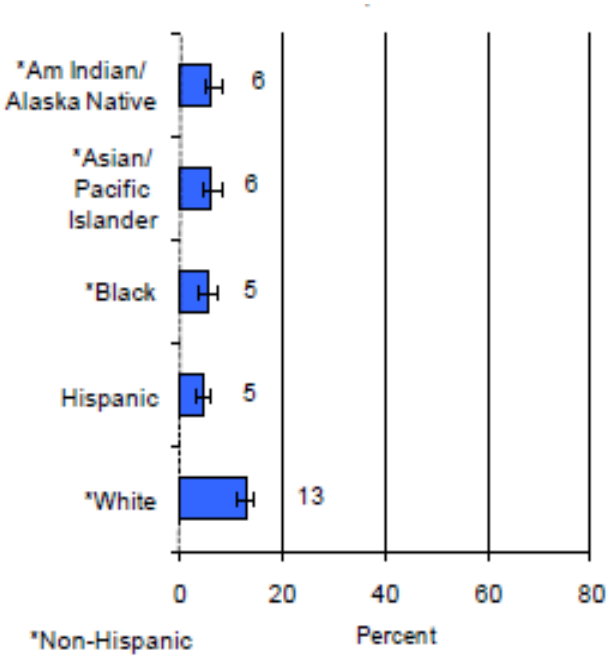


PRAMS - Figure 3

Drinking and Binge Drinking Before Pregnancy by Maternal Race/Ethnicity, 2006-2008



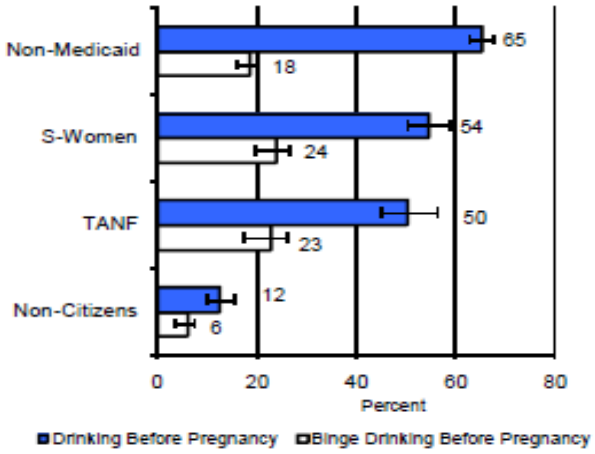
Drinking In Third Trimester by Maternal Race/Ethnicity, 2006-2008



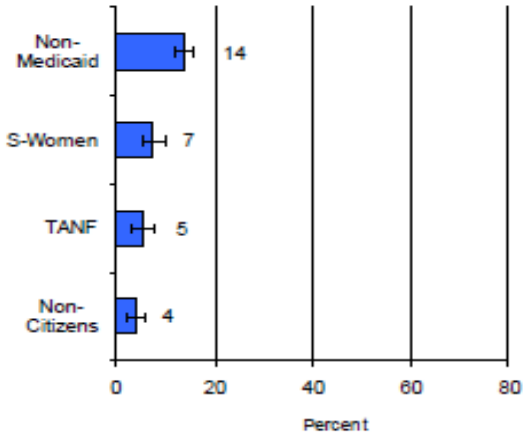
PRAMS - Figure 4

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

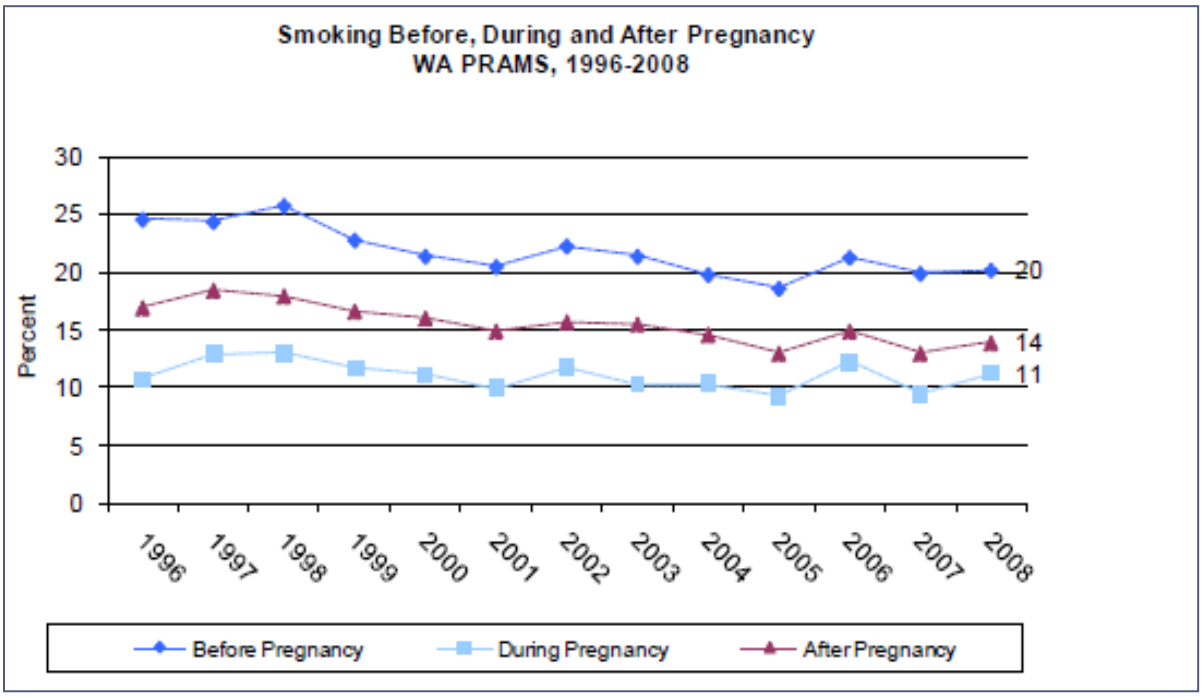
Drinking and Binge Drinking Before Pregnancy by Medicaid Program, 2006-2008



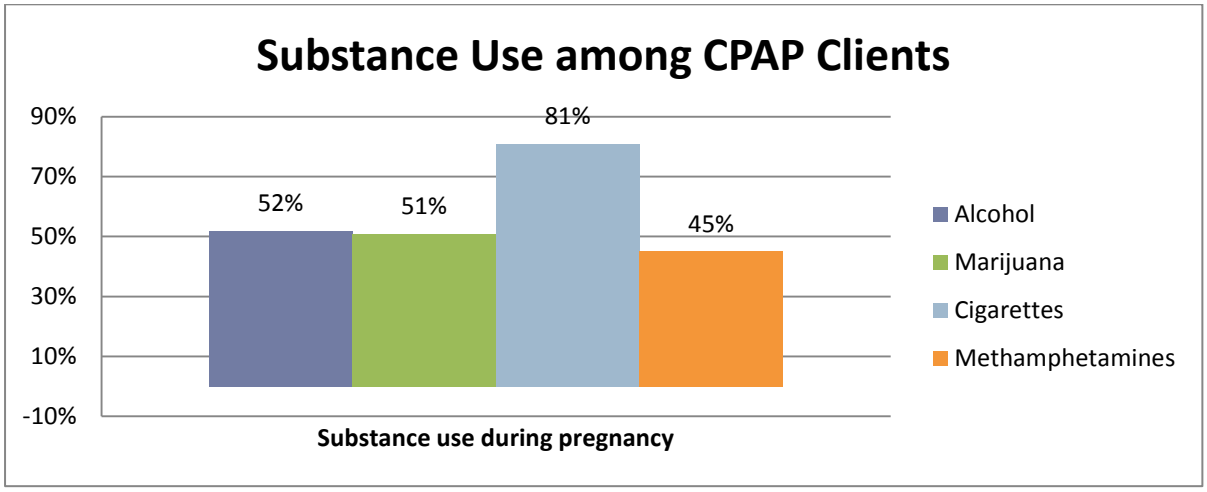
Drinking In Third Trimester by Medicaid Program, 2006-2008



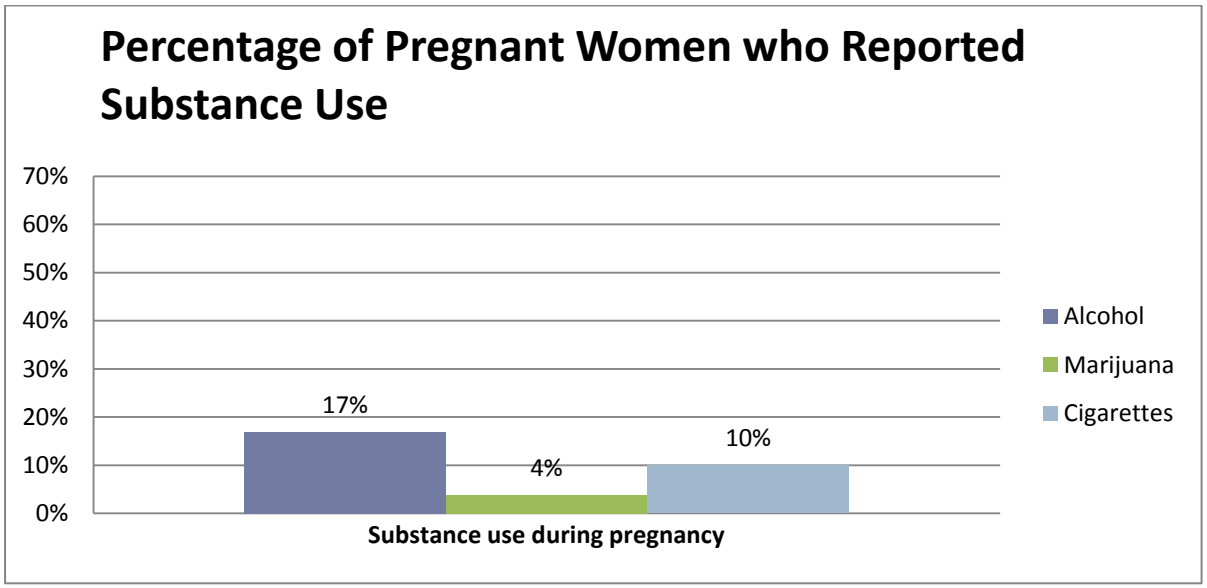
PRAMS - Figure 5



PRAMS - Figure 6



PRAMS - Figure 7

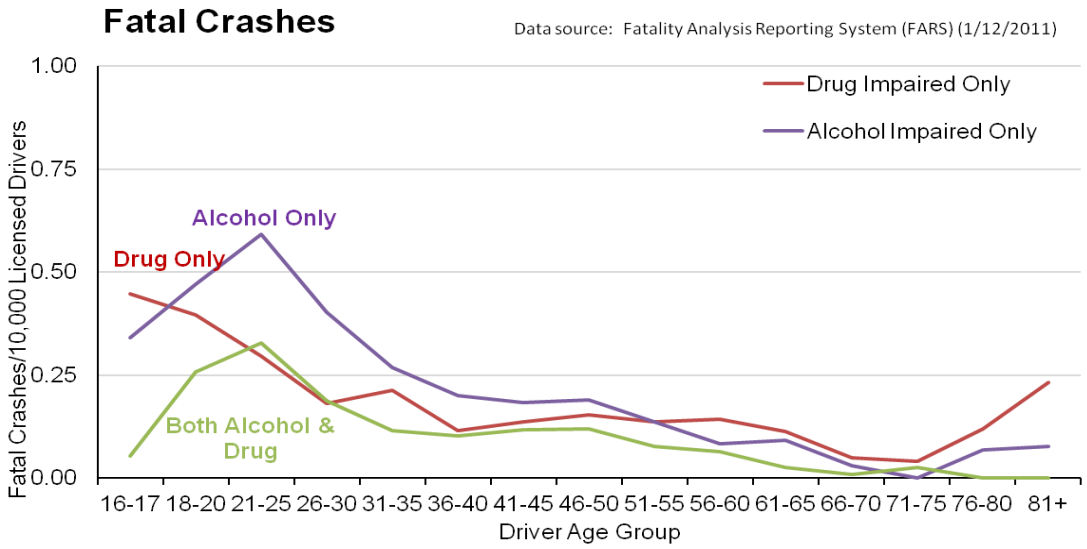


Traffic Data: *Figures Traffic Data 1-3*
Fatality Analysis Reporting System (FARS)

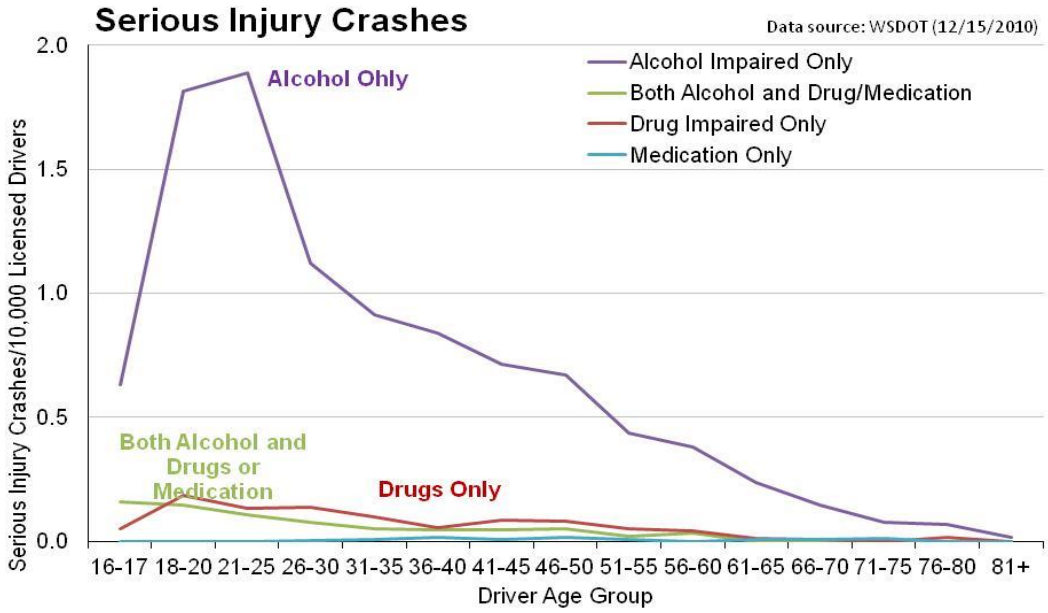
Notes:

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

Traffic Data - Figure 1



Traffic Data - Figure 2



Traffic Data - Figure 3

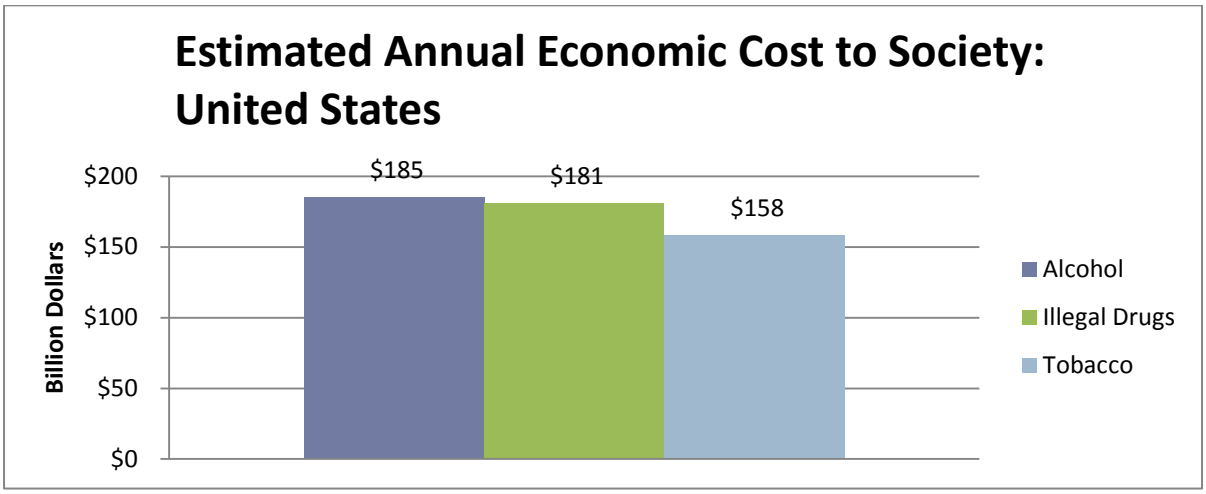
Traffic Fatalities - WSDOT, Target Zero Priority One

	2003-2005		2006-2008		2006-2008 vs. 2003-2005	
	Deaths	% of Total Deaths	Deaths	% of Total Deaths	Percent Change in Number of Deaths	
	1,816	100.0%	1,725	100.0%		-5.0%
Priority One						
Alcohol/Drug Impaired Driver-Involved	794	43.7%	828	48.0%		4.3%
Drinking Driver-Involved	706	38.9%	712	41.3%		0.8%
Alcohol Impaired Driver-Involved	557	30.7%	544	31.5%		-2.3%
Drug Impaired Driver-Involved	412	22.7%	474	27.5%		15.0%
Run off the Road*	771	42.5%	722	41.9%		-6.4%
Speeding Involved	707	38.9%	693	40.2%		-2.0%

Source: WSDOT, Target Zero, Young Drivers Presentation.
Note: 1. Target Zero Priorities

Economic Data: *Figures Economic Data 1-2*

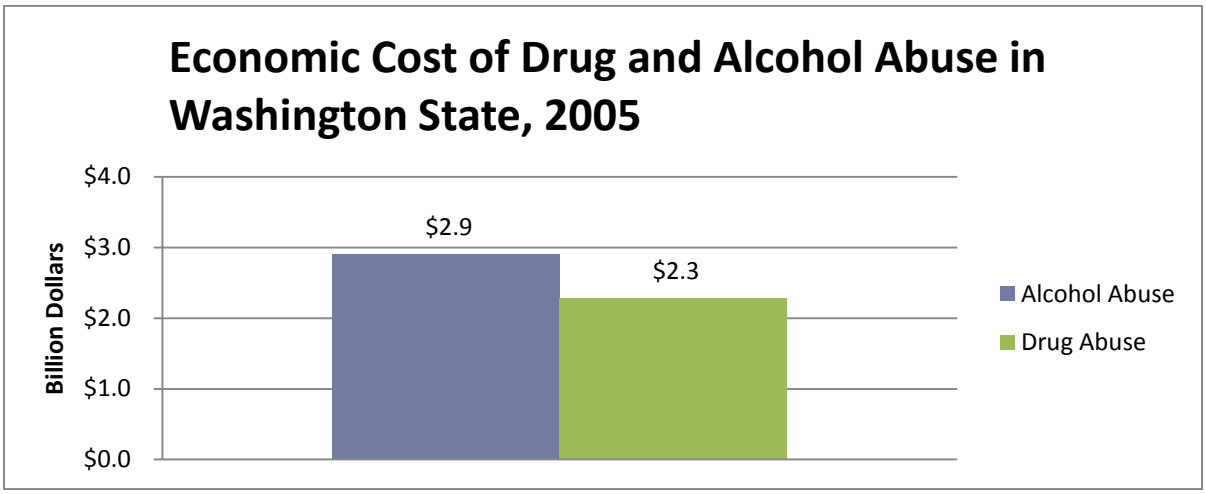
Economic Data - Figure 1



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

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

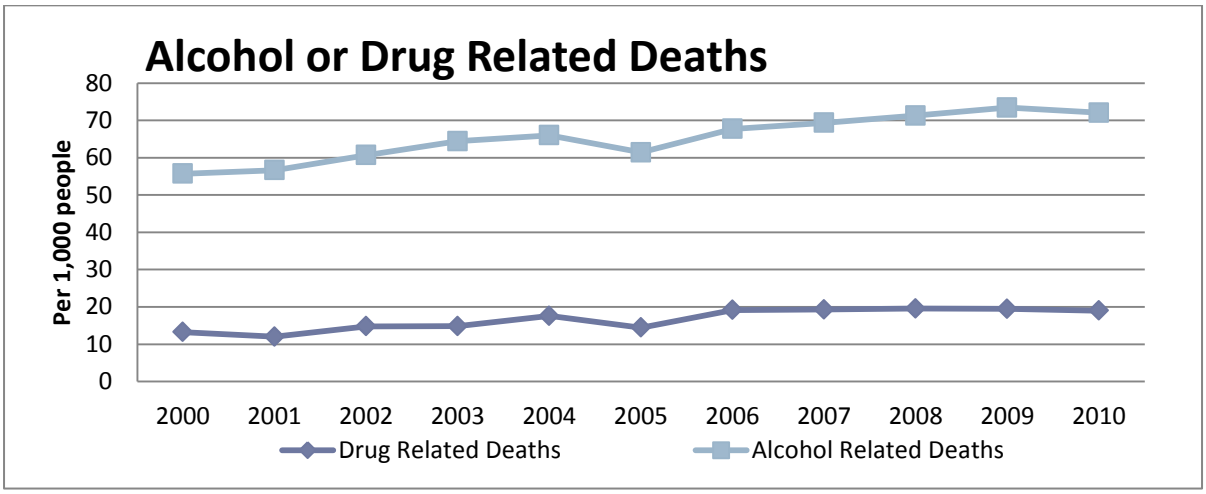
Economic Data - Figure 2



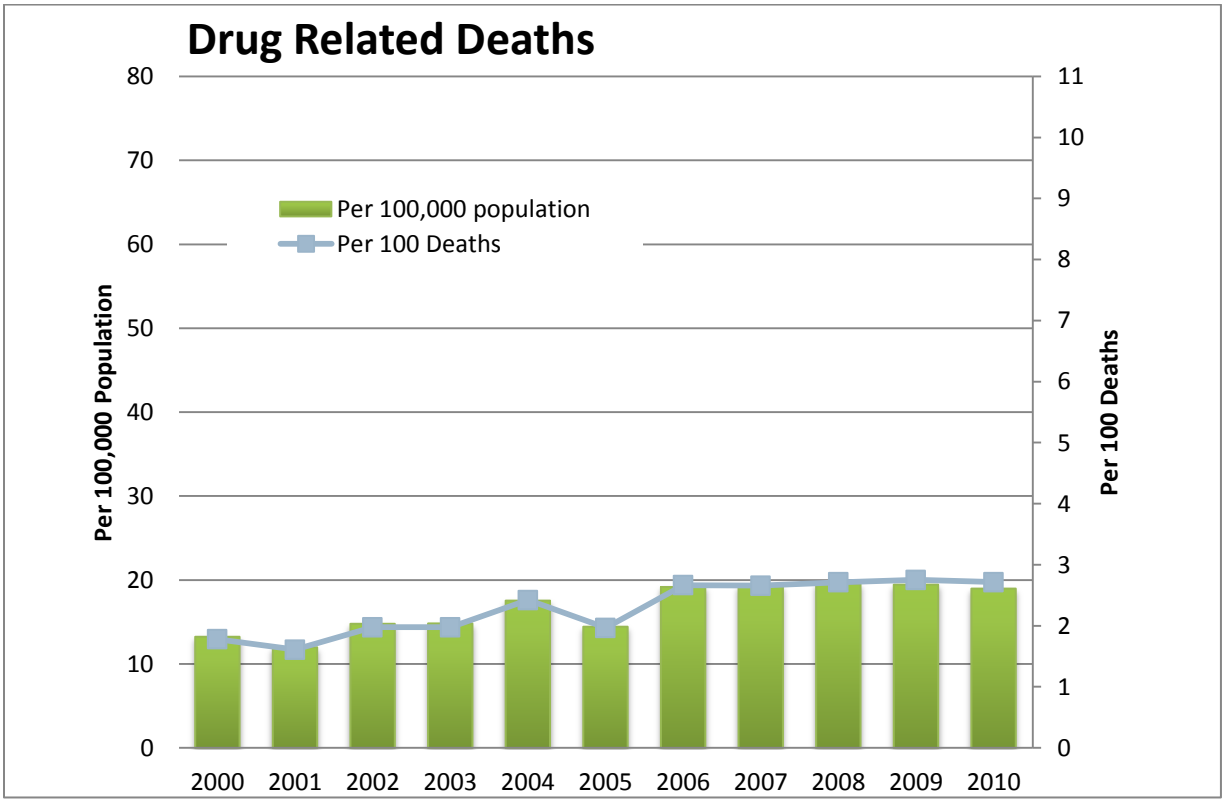
Source: Computed from Wickizer, T. The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

Death Data: *Figures Death Data 1-3*

Death Data - Figure 1

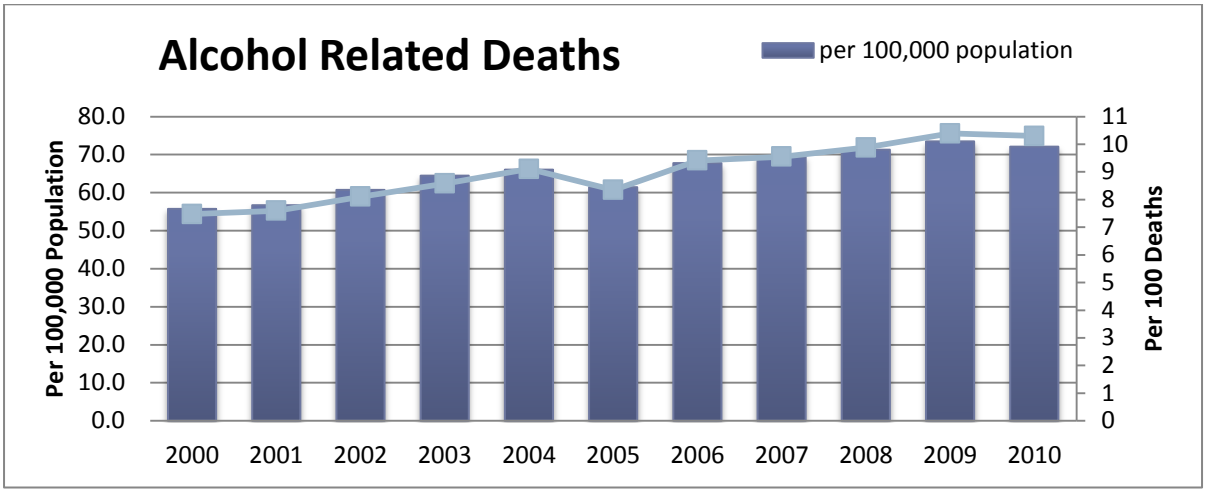


Death Data - Figure 2



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

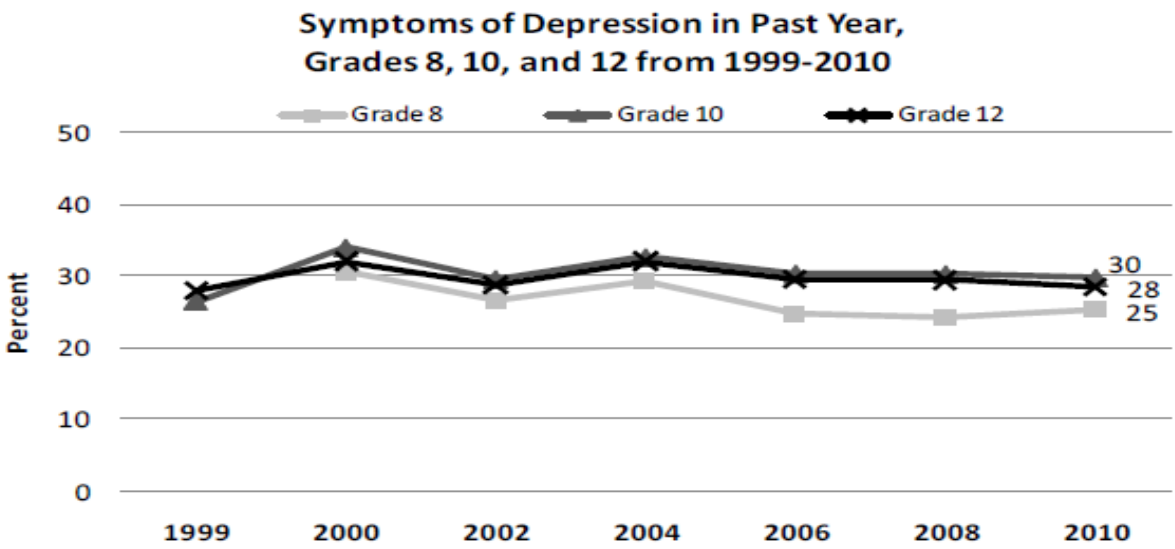
Death Data - Figure 3



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

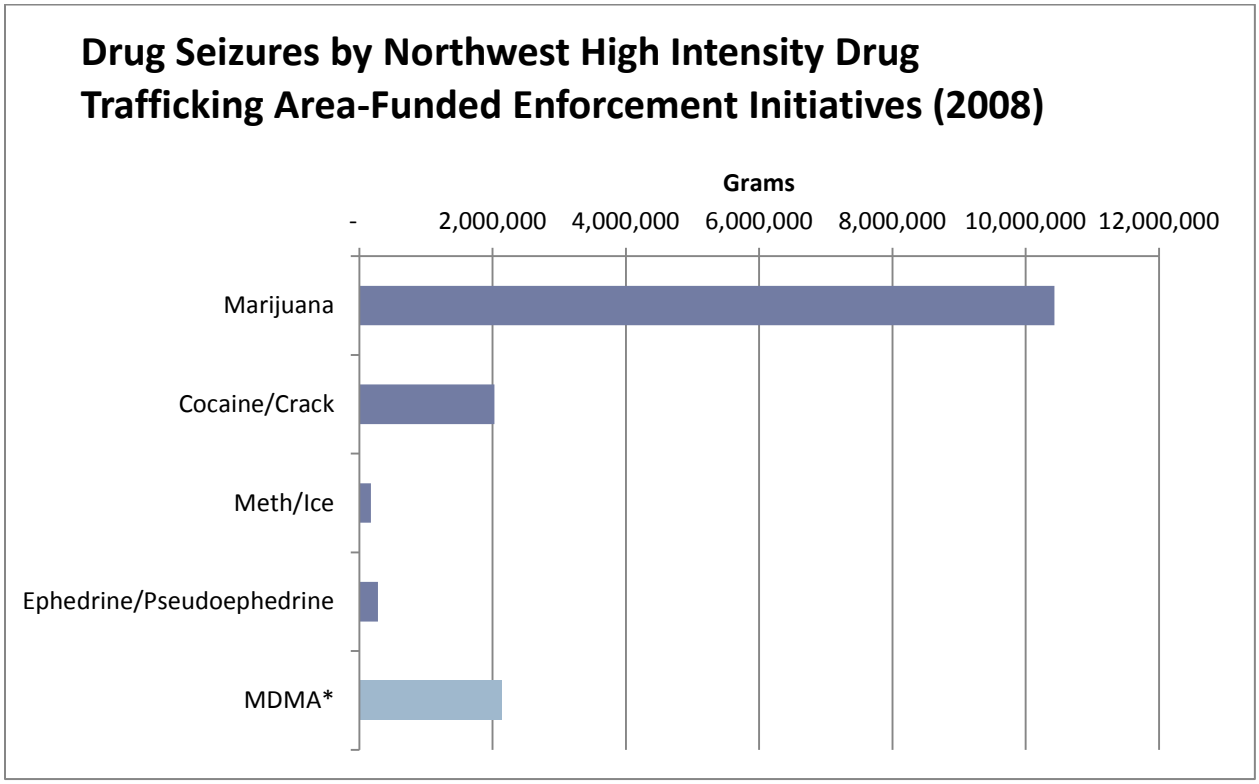
Other Data: *Figures Other data 1-2*

Other Data - Figure 1



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

Other Data - Figure 2

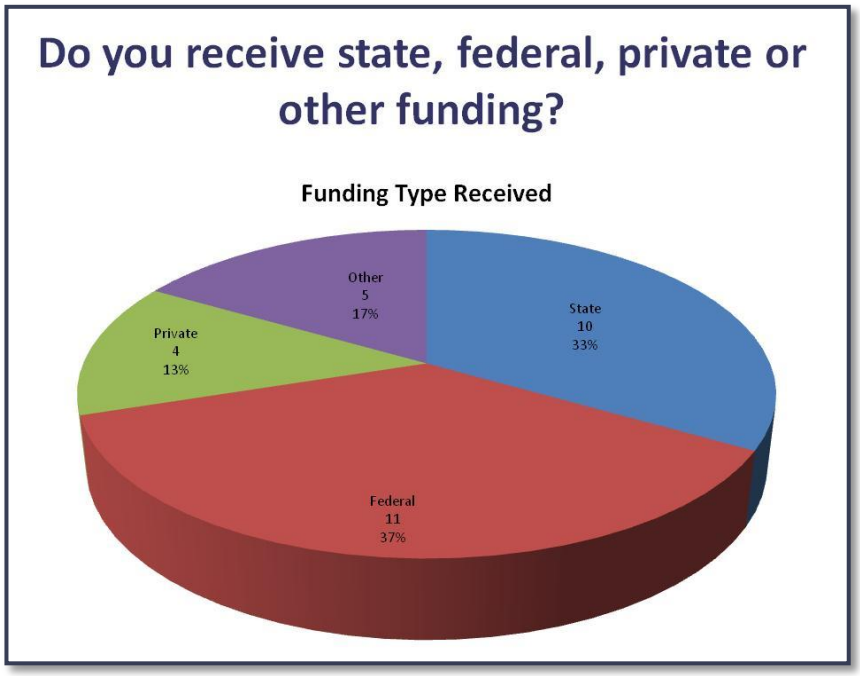


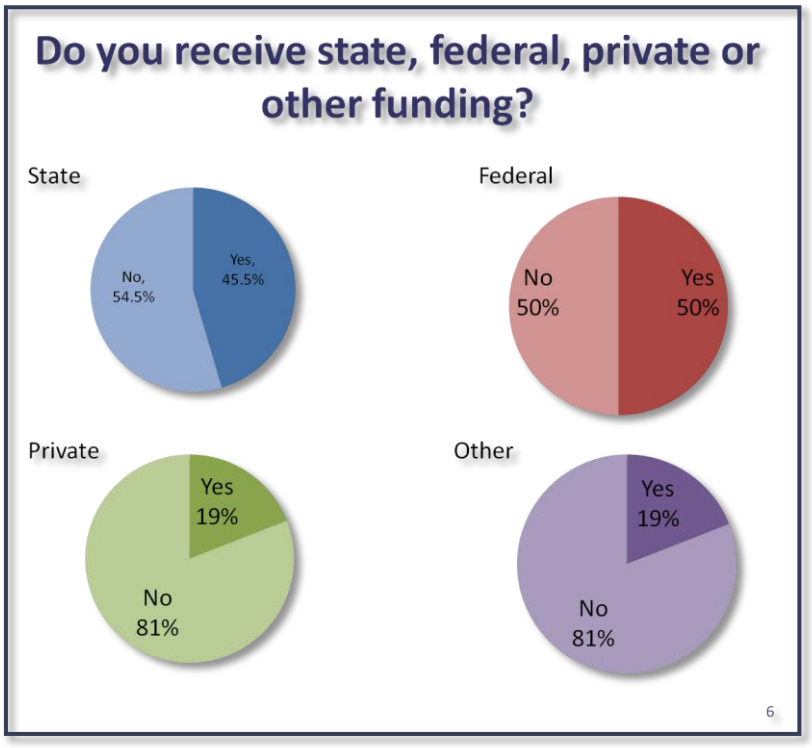
Source: Northwest HIDTA Threat Assessment and Strategy for Program year 2010

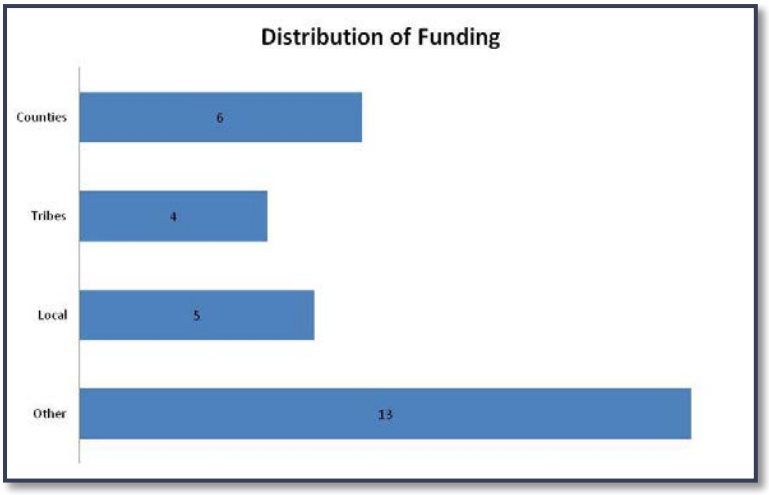
6. Resources Assessment

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

Funding Information






Distribution of Funding
Counties
6
Tribes
4
Local
5
Other
13

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

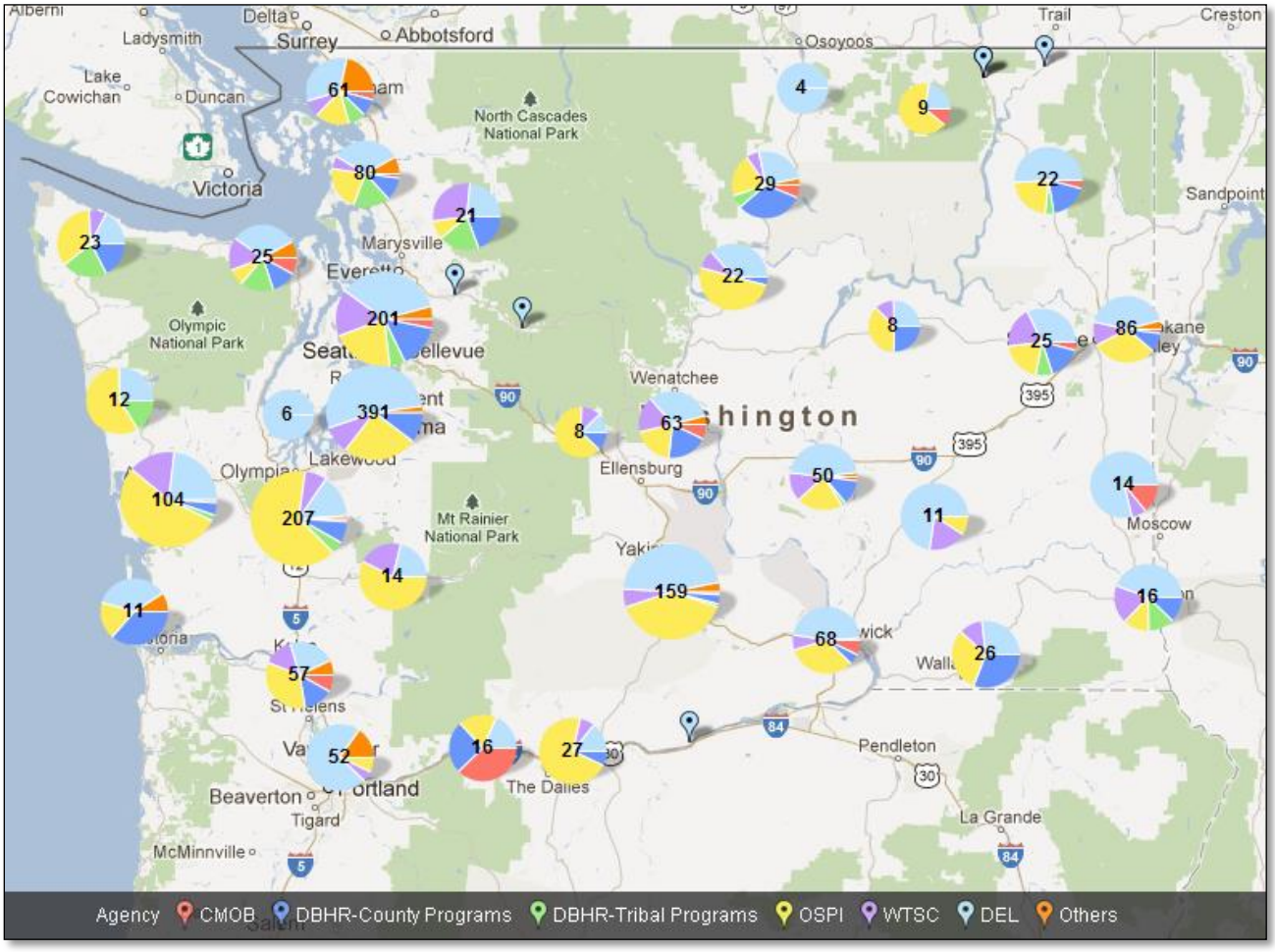
State Agency Resources allocated to Counties

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

Notes: (a list of acronyms can be found in Appendix - *List of Agencies Acronyms and Abbreviations* on page 51)

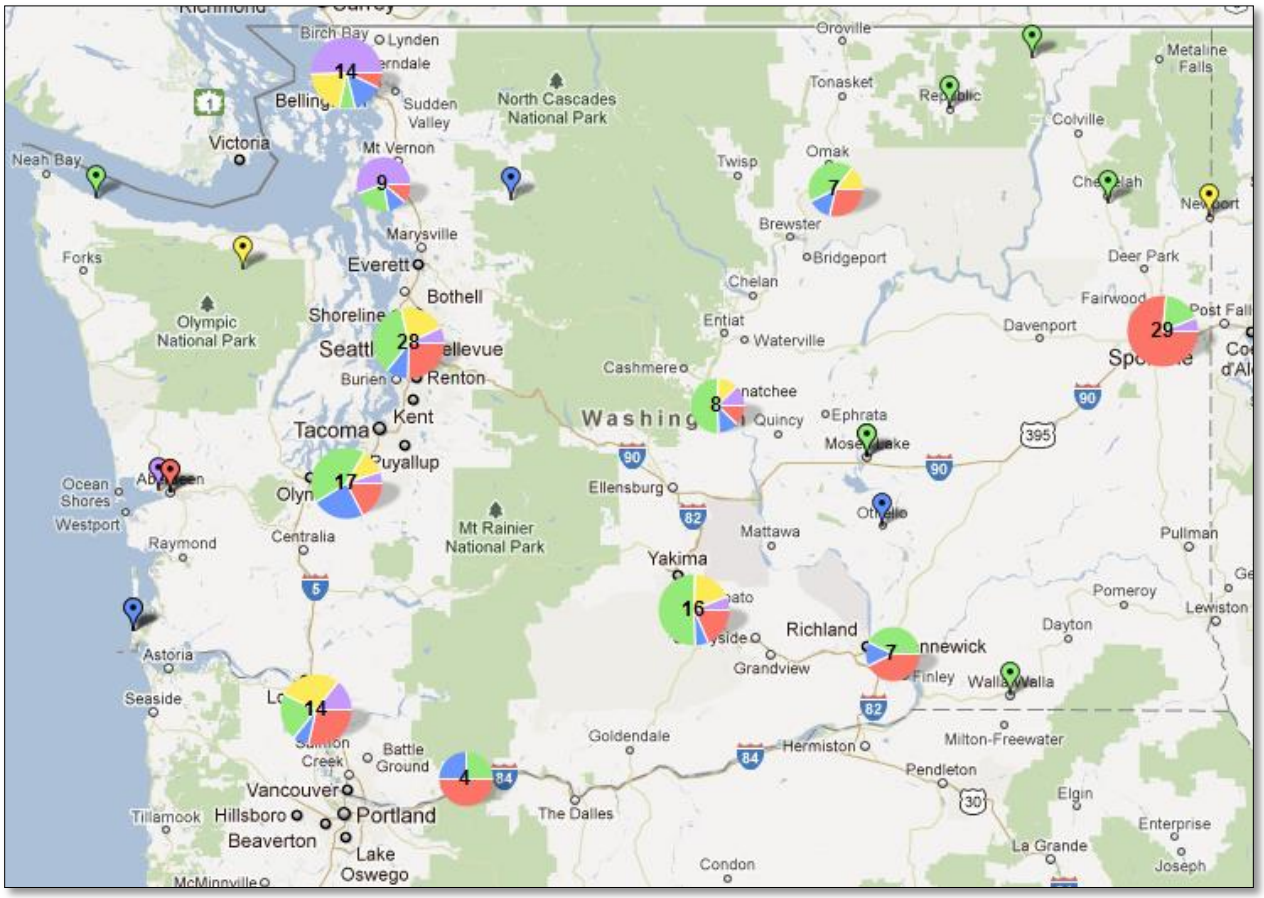
- CMOB - county allocations
- DBHR - county allocations for prevention services/PRI (not RUaD or other special grants)
- DEL - county allocations for ESIT (special programs not indicated - NFP/Home visiting)
- DOH - Local Health Jurisdictions
- WSP - target zero
- WTSC - task forces
- NW HIDTA - federal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

Prevention Programs by Agency/Organization



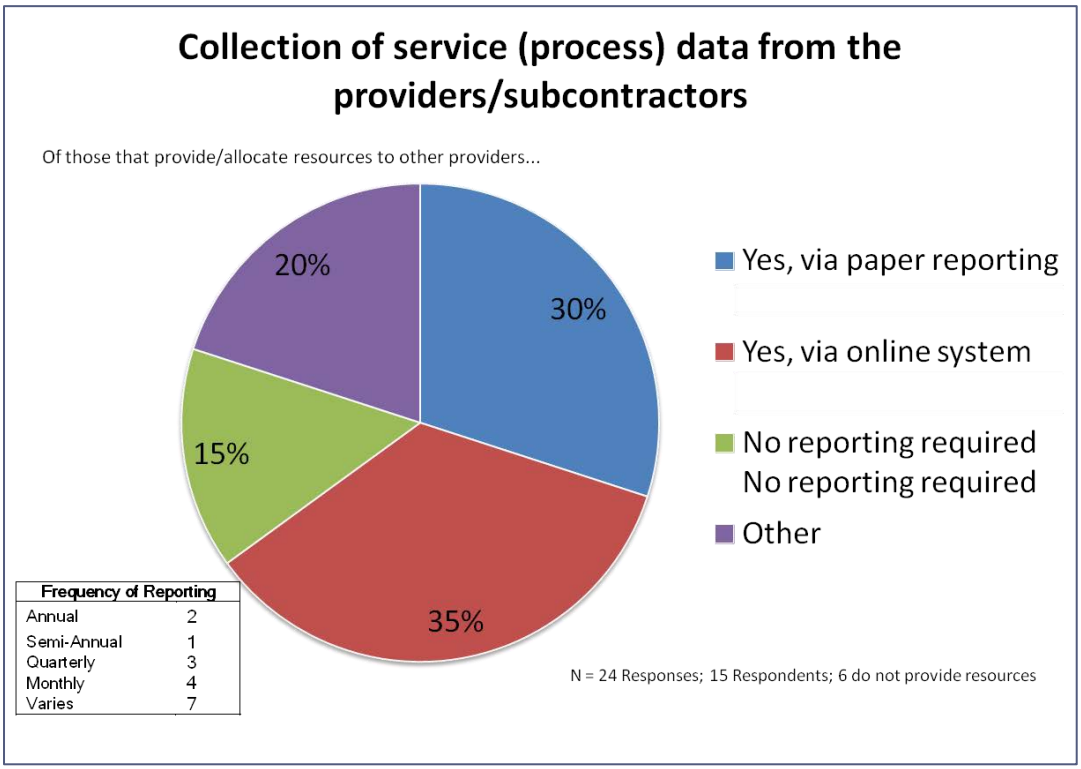
- **CMOB** - direct service programs and coalitions
- **DBHR** - Tribal Programs
- **DBHR** –County Programs – direct service programs and coalitions
- **OSPI** – P/I Services and 21st Century sites
- **WSTC** - Corridor safety programs; DUI Enforcement Campaign; HS Distracted Driving projects; and Click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

Coalitions by Agency/Organization



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

Collection of Evaluation Data



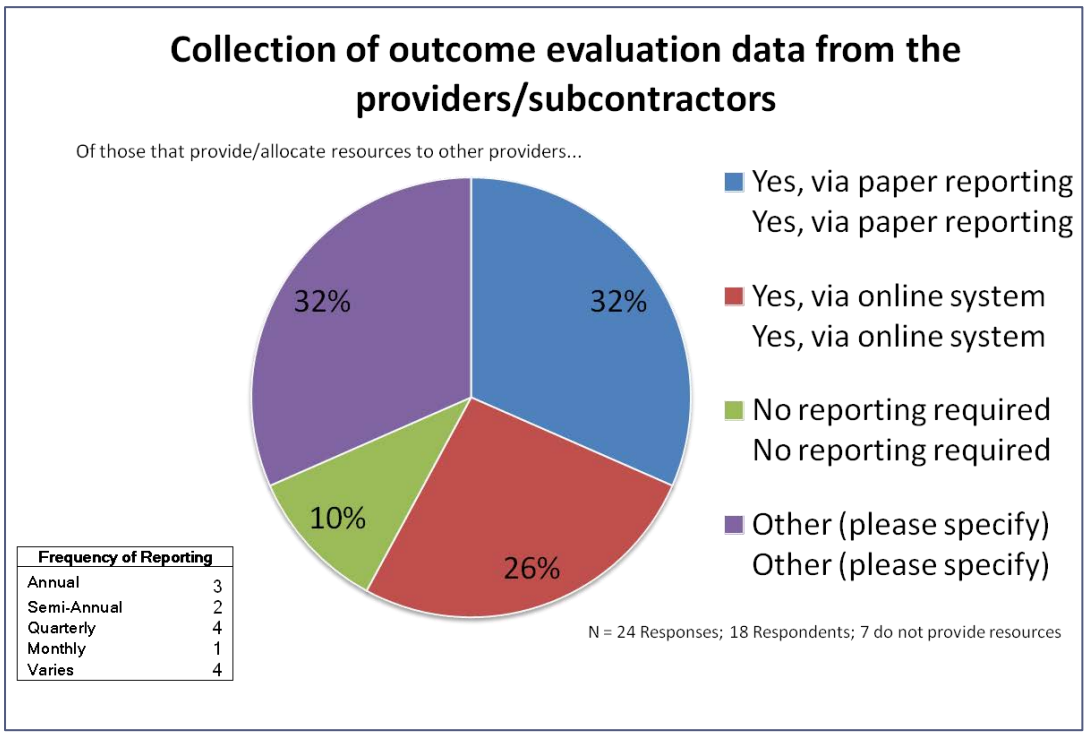
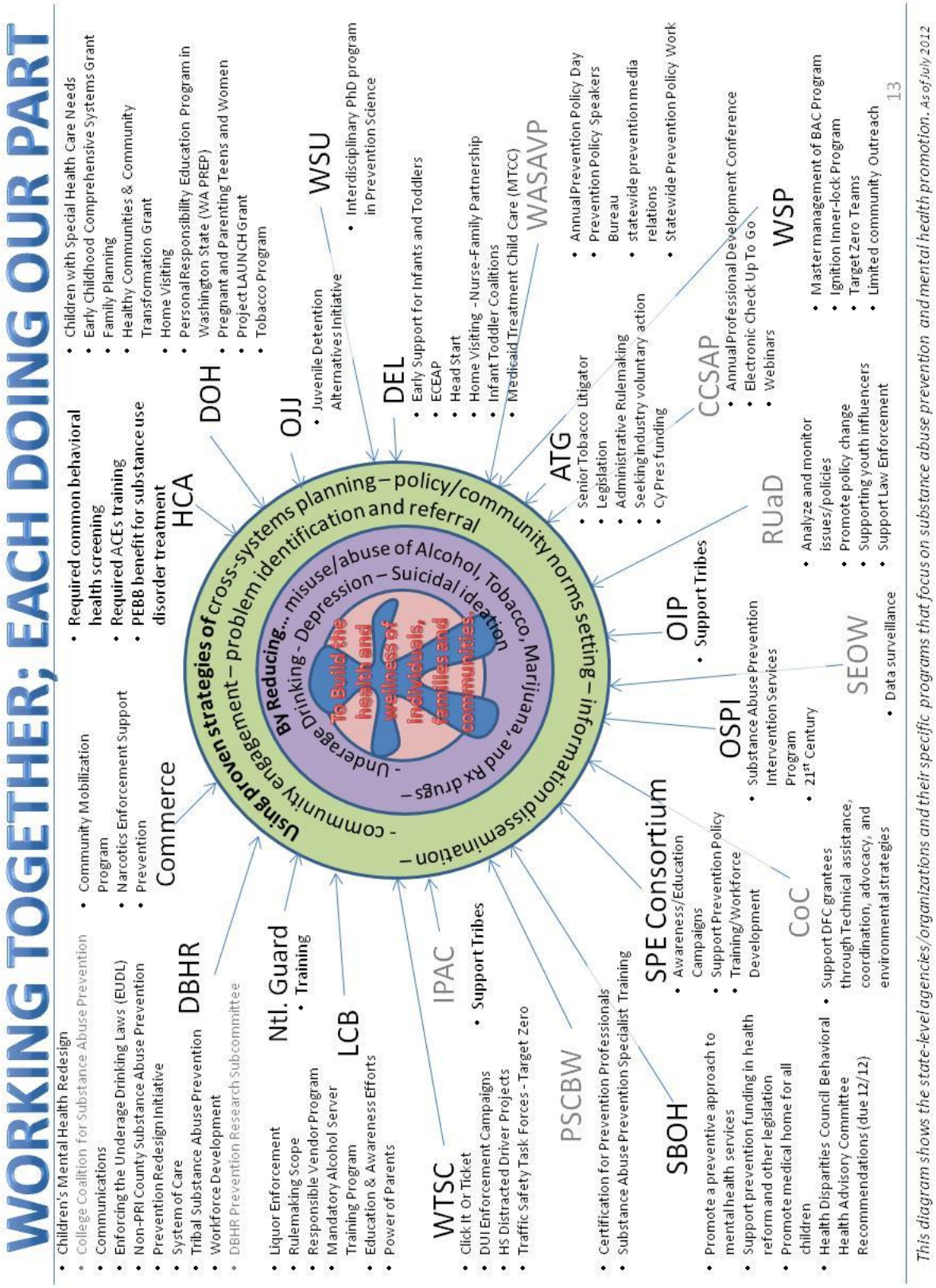
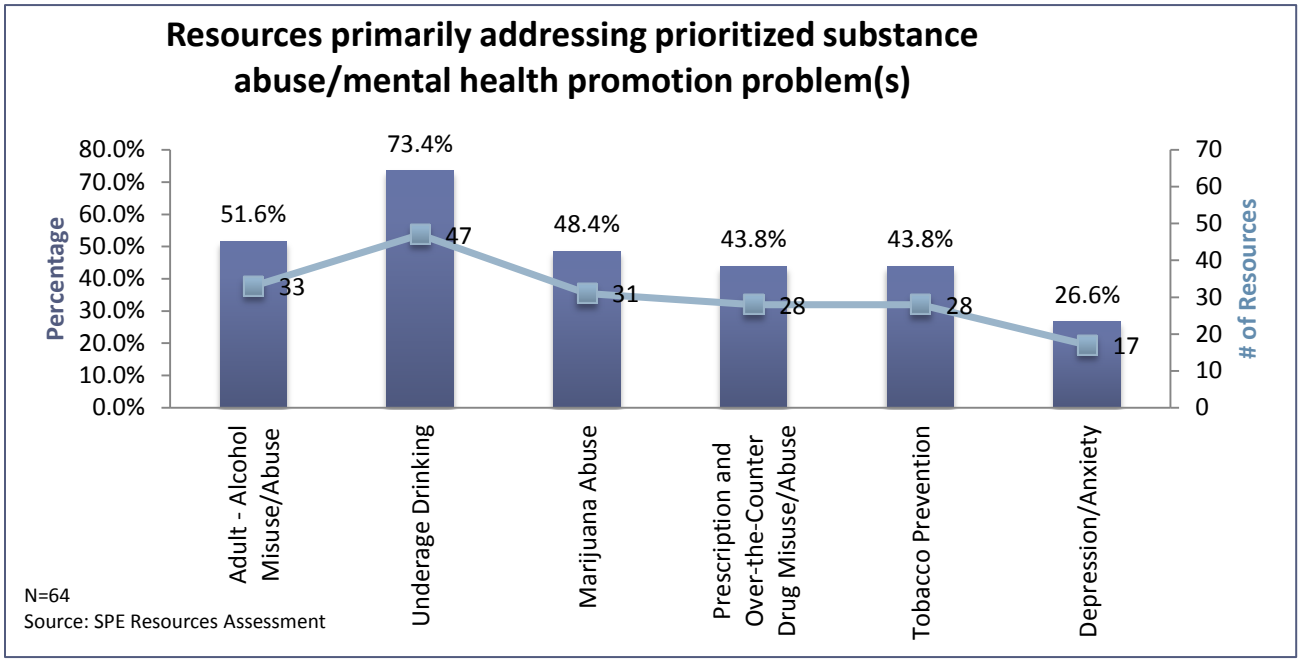
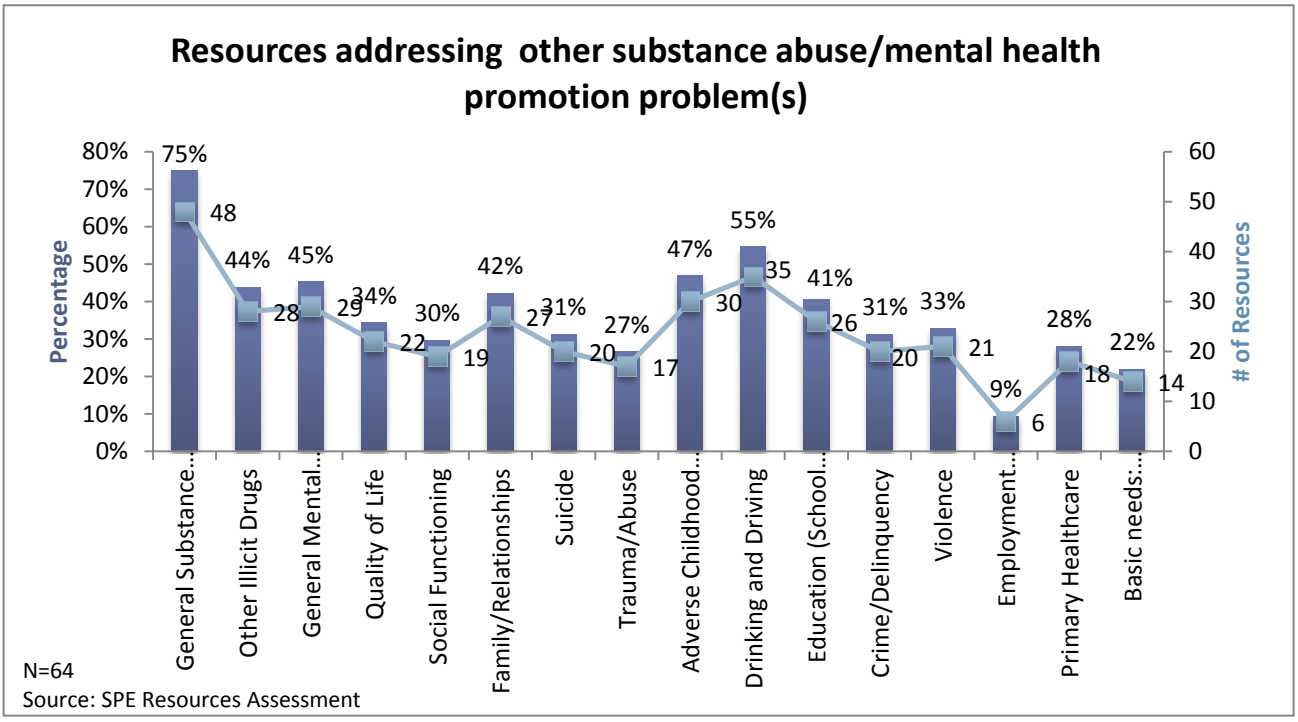


Diagram of Resources

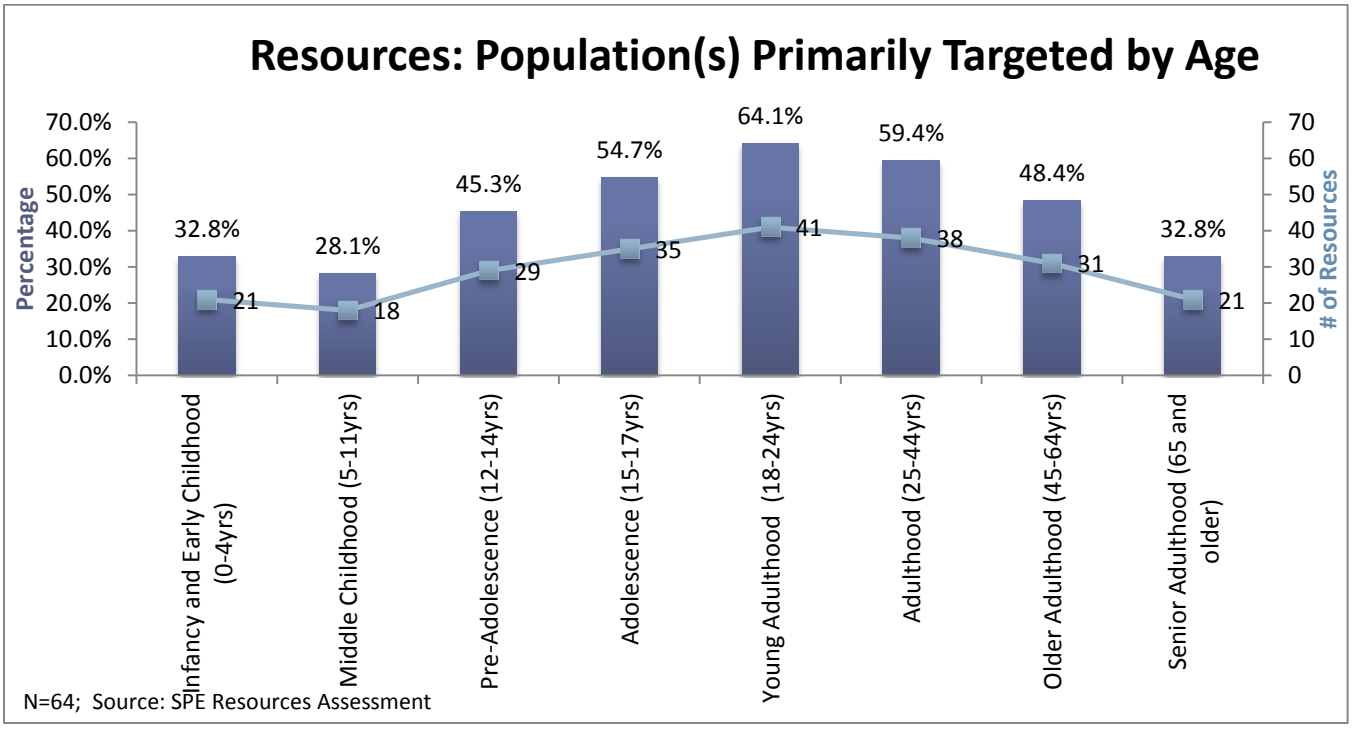


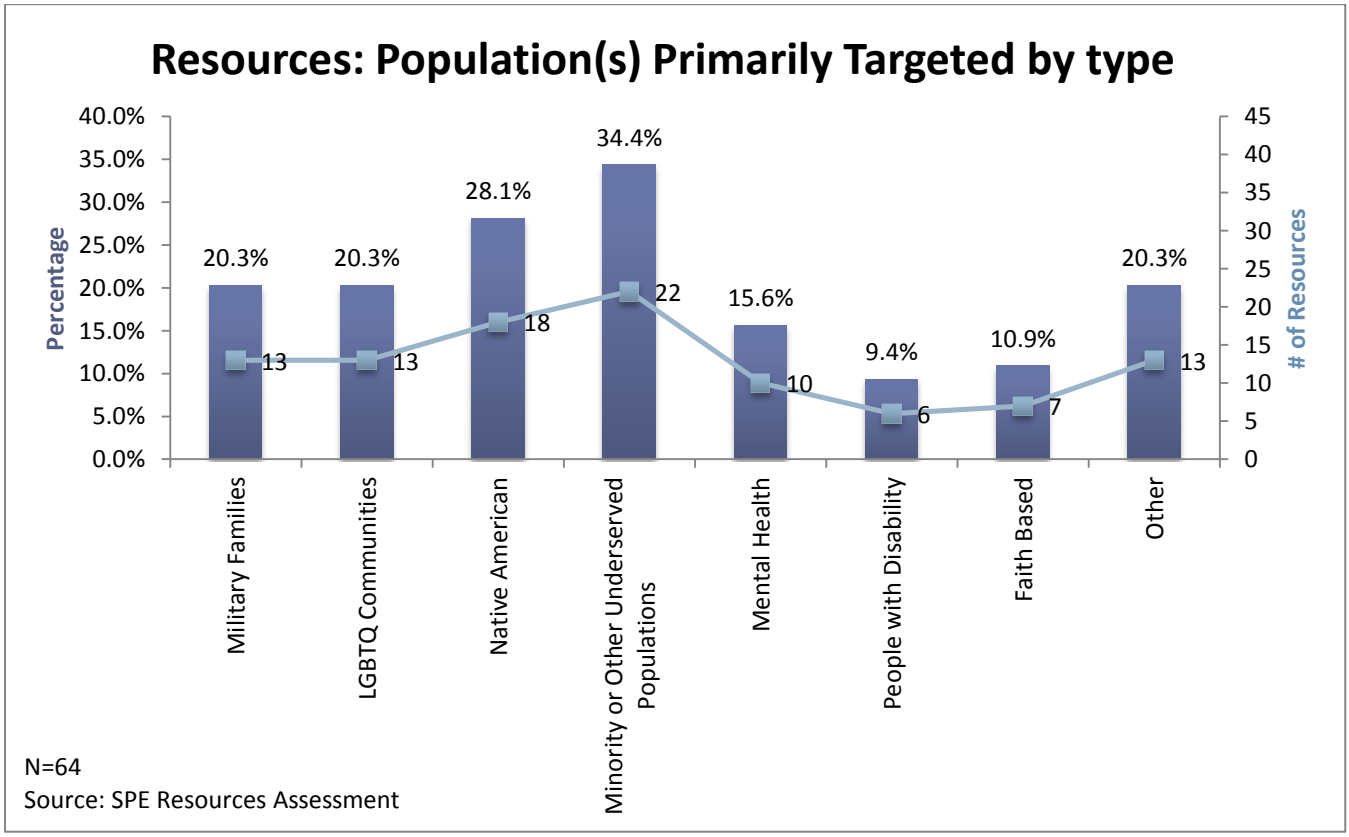
Summary of Resource Information[25]

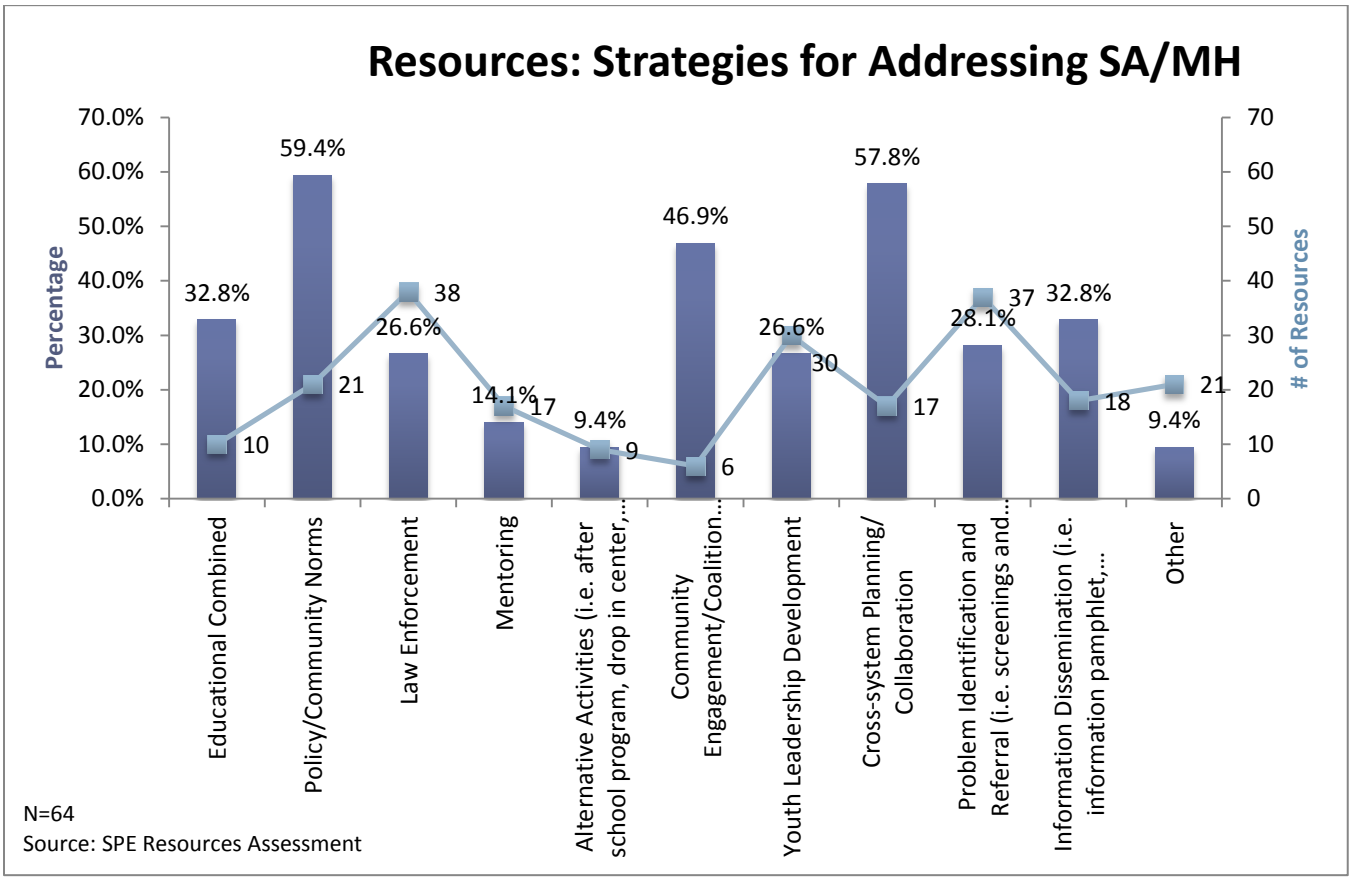




[25] Resources may be duplicated as agencies were allowed to select more than one area, therefore category totals will equal more than 100 percent if combined.


Resources: Population(s) Primarily Targeted by Age
Percentage
# of Resources
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
70
60
50
40
30
20
10
0
32.8%
28.1%
45.3%
54.7%
64.1%
59.4%
48.4%
32.8%
21
18
29
35
41
38
31
21
Infancy and Early Childhood (0-4yrs)
Middle Childhood (5-11yrs)
Pre-Adolescence (12-14yrs)
Adolescence (15-17yrs)
Young Adulthood (18-24yrs)
Adulthood (25-44yrs)
Older Adulthood (45-64yrs)
Senior Adulthood (65 and older)
N=64; Source: SPE Resources Assessment


Resources: Population(s) Primarily Targeted by type
Percentage
# of Resources
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
45
40
35
30
25
20
15
10
5
0
20.3%
20.3%
28.1%
34.4%
15.6%
9.4%
10.9%
20.3%
13
13
18
22
10
6
7
13
Military Families
LGBTQ Communities
Native American
Minority or Other Underserved Populations
Mental Health
People with Disability
Faith Based
Other
N=64
Source: SPE Resources Assessment


Resources: Strategies for Addressing SA/MH
Percentage
# of Resources
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
70
60
50
40
30
20
10
0
32.8%
59.4%
26.6%
14.1%
9.4%
46.9%
26.6%
57.8%
28.1%
32.8%
9.4%
10
21
38
17
9
6
30
17
37
18
21
Educational Combined
Policy/Community Norms
Law Enforcement
Mentoring
Alternative Activities (i.e. after school program, drop in center,...
Community Engagement/Coalition...
Youth Leadership Development
Cross-system Planning/ Collaboration
Problem Identification and Referral (i.e. screenings and...
Information Dissemination (i.e. information pamphlet,...
Other
N=64
Source: SPE Resources Assessment

Matrix of Resources Identified in Resource Assessment focused on Substance Abuse

Resources Focused on Substance Abuse	General Substance Abuse	Adult - Alcohol misuse/abuse	Underage drinking	Marijuana abuse	Prescription and over-the-counter drug misuse/abuse	Tobacco prevention	Other Illicit Drugs	Drinking and Driving
ATG - Senior Tobacco Litigator, Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action			x			x		
CCSAP - Webinars	x	x	x	x	x	x	x	x
CCSAP - Year End Professional Development Conference	x	x	x	x	x		x	x
CCSAP - Electronic Check Up To Go	x	x	x			x		x
DBHR - System of Care	x		x	x				
DBHR - Prevention Redesign Initiative	x	x	x	x	x	x	x	x
DBHR - Children's Mental Health Redesign	x		x	x	x			
DBHR - Non-PRI County Substance Abuse Prevention	x	x	x	x	x	x	x	x
DBHR - Tribal Substance Abuse Prevention	x	x	x	x	x	x	x	x
DBHR - Enforcing The Underage Drinking Laws (EUDL)		x	x					x
DBHR - College Coalition For Substance Abuse Prevention	x	x	x	x	x	x	x	x
DBHR - Workforce Development	x	x	x	x	x	x	x	x
DBHR - Communications	x	x	x	x	x	x	x	x
DBHR - Prevention Research Subcommittee	x	x	x	x	x	x	x	x
DEL - Home Visiting Programs	x							
DEL - Head Start	x							
DEL - Early Support For Infants And Toddlers	x							
DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool								
DEL - Medicaid Treatment Child Care Program	x						x	
DOH - Tobacco Program			x	x		x		
DOH - Home Visiting	x							
DOH - Coordinated School Health Program	x							
DOH - Healthy Communities & Community Transformation Grant						x		
DOH - Family Planning	x							x
Commerce - Community Mobilization	x	x	x	x	x		x	x
HCA - Service					x			
HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.	x	x		x	x		x	
HCA - Required Training On Adverse Childhood Experiences For The Primary Care Provider Community In The State Of Washington.	x	x	x	x	x	x	x	
HCA - PEBB Benefit For Substance Use Disorder Treatment	x	x		x	x		x	
IPAC - Support Tribes	x	x	x	x	x	x	x	
LCB - Agency Initiatives			x					x
LCB - Power Of Parents			x					
LCB - Liquor Enforcement	x	x	x					x
LCB - Rulemaking Scope	x	x						
LCB - Responsible Vendor Program	x	x	x				x	x
LCB - Mandatory Alcohol Server Training Program	x	x	x					

Resources Focused on Substance Abuse	General Substance Abuse	Adult - Alcohol misuse/abuse	Underage drinking	Marijuana abuse	Prescription and over-the-counter drug misuse/abuse	Tobacco prevention	Other Illicit Drugs	Drinking and Driving
LCB - Education And Awareness Efforts	x	x	x					x
Nat'l Guard - Training	x	x	x	x		x	x	
OIP - Support Tribes	x	x	x	x	x	x	x	
OSPI - Substance Abuse Prevention Intervention Services Program	x		x	x	x	x	x	
PSCBW - Certification For Prevention Professionals	x	x	x	x	x	x	x	x
PSCBW - Substance Abuse Prevention Specialist Training	x	x	x	x	x	x	x	x
RUaD - Analyze And Monitor Issues/Policies	x		x					x
RUaD - Promote Policy Change	x		x					x
RUaD - Supporting Youth Influencers	x		x					x
RUaD - Support Law Enforcement	x		x					x
SEOW - Data Surveillance	x	x	x	x	x	x	x	
CoC - Federal Drug Free Communities Support Program	x	x	x	x	x	x	x	x
WASAVP - Annual Prevention Policy Day	x		x	x	x	x		
WASAVP - Statewide Prevention Policy Work	x		x	x	x	x		x
WASAVP - Statewide Prevention Medial Relations	x		x	x	x	x	x	x
WASAVP - Prevention Policy Speakers Bureau	x		x	x	x	x	x	
SBOH - Health Disparities Council Behavioral Health Advisory Committee	x							
SBOH - Support Prevention Funding In Health Reform And Other Legislation						x		
WSP - Master Management Of BAC Program	x	x	x	x	x		x	x
WSP - Limited Community Outreach	x		x				x	x
WSP - Ignition Inner-Lock Program	x	x						x
WSP - Target Zero Teams	x	x	x	x	x		x	x
WSU - Interdisciplinary PhD Program In Prevention Science	x	x	x	x	x	x	x	x
WTSC - Click It or Ticket	x	x	x					x
WTSC - HS Distracted Driver Projects			x					x
WTSC - DUI Enforcement Campaigns		x	x					x
WTSC - Traffic Safety Task Forces - Target Zero			x					x

Matrix of Resources Identified in Resource Assessment focused on Mental Health

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

Matrix of Resources Identified in Resource Assessment by Strategy

Resources by Strategy	Youth Education/Skill building - School based	Youth Education/Skill building - Community based	Parent education/family	Other Educational programs	Policy/community norms	Law enforcement	Mentoring	Alternative Activities	Community engagement/ coalition development	Youth leadership development	Problem Identification and Referral	Information Dissemination	Cross-system planning/ collaboration
ATG - Senior Tobacco Litigator, Legislation, Administrative Rulemaking, And Seeking Industry Voluntary Action					x								
CCSAP - Webinars				x									
CCSAP - Year End Professional Development Conference				x					x			x	
DBHR - System of Care			x		x				x	x		x	x
DBHR - Prevention Redesign Initiative	x	x	x	x	x	x	x	x	x	x	x	x	x
DBHR - Children's Mental Health Redesign					x				x		x		x
DBHR - Non-PRI County Substance Abuse Prevention	x	x	x	x	x	x	x	x	x	x	x	x	x
DBHR - Tribal Substance Abuse Prevention	x	x	x	x	x	x	x	x	x	x	x	x	x
DBHR - College Coalition For Substance Abuse Prevention				x	x	x	x				x	x	x
DBHR - Workforce Development					x							x	x
DBHR - Communications												x	
DBHR - Prevention Research Subcommittee											x	x	x
DEL - Infant Toddler Regions					x		x		x		x		x
DEL - Home Visiting Programs		x	x										
DEL - Early Support For Infants And Toddlers			x	x							x		
DEL - ECEAP- Early Childhood Education Economic Assistance Program State Preschool				x							x		
DEL - Medicaid Treatment Child Care Program		x	x	x		x	x				x		x
DOH - Tobacco Program				x	x	x			x				
DOH - Project Launch Grant			x	x	x				x		x	x	x
DOH - Home Visiting			x		x				x				x
DOH - Early Childhood Comprehensive Systems Grant												x	x
DOH - Children With Special Healthcare Needs			x								x	x	x
DOH - Personal Responsibility Education Program In Washington State (WA PREP)	x	x	x	x					x	x	x		x
DOH - Pregnant And Parenting Teens And Women	x	x	x		x		x		x		x	x	x
DOH - Coordinated School Health Program			x	x	x				x				x
DOH - Healthy Communities & Community Transformation Grant				x	x		x	x	x	x	x	x	x
DOH - Family Planning	x	x	x	x		x				x	x	x	x
Commerce - Community Mobilization	x	x	x	x	x				x			x	x
OJJ - Juvenile Detention Alternatives Initiative					x	x		x	x		x		x
HCA - Service											x		
HCA - Required Common Behavioral Health Screening Guideline Across All Managed Care Organizations.											x		
HCA - Required Training On Adverse Childhood Experiences				x									
HCA - PEBB Benefit For Substance Use Disorder Treatment					x								

Resources by Strategy	Youth Education/Skill building - School based	Youth Education/Skill building - Community based	Parent education/family	Other Educational programs	Policy/community norms	Law enforcement	Mentoring	Alternative Activities	Community engagement/ coalition development	Youth leadership development	Problem Identification and Referral	Information Dissemination	Cross-system planning/ collaboration
IPAC - Support Tribes									x				x
LCB - Agency Initiatives			x	x	x							x	
LCB - Power Of Parents			x										
LCB - Liquor Enforcement					x	x							
LCB - Rulemaking Scope					x								
LCB - Responsible Vendor Program				x	x	x							
LCB - Mandatory Alcohol Server Training Program				x	x	x							
LCB - Education And Awareness Efforts				x	x				x				x
Nat'l Guard - Training				x					x				
OIP - Support Tribes									x				x
OSPI - Substance Abuse Prevention Intervention Services Program	x		x		x					x			
PSCBW - Certification For Prevention Professionals				x									
PSCBW - Substance Abuse Prevention Specialist Training				x									x
RUaD - Analyze And Monitor Issues/Policies					x				x	x			x
RUaD - Promote Policy Change			x		x				x	x		x	x
RUaD - Supporting Youth Influencers		x			x				x	x		x	x
RUaD - Support Law Enforcement					x	x			x	x			x
CoC - Federal Drug Free Communities Support Program	x	x	x	x	x		x		x	x		x	x
WASAVP - Annual Prevention Policy Day		x			x			x	x	x			x
WASAVP - Statewide Prevention Policy Work					x							x	
WASAVP - Statewide Prevention Medial Relations					x				x	x			
WASAVP - Prevention Policy Speakers Bureau					x				x	x			x
SBOH - Health Disparities Council Behavioral Health Advisory Committee					x				x				x
SBOH - Support Prevention Funding In Health Reform And Other Legislation					x				x				x
SBOH - Promote Medical Home For All Children													x
SBOH - Promote A Preventive Approach To Mental Health Services													x
WSP - Master Management Of BAC Program						x							
WSP - Limited Community Outreach	x												
WSP - Ignition Inner-Lock Program				x		x					x		
WSP - Target Zero Teams				x	x	x						x	x
WSU - Interdisciplinary PhD Program In Prevention Science				x			x						
WTSC - Click It or Ticket					x	x							
WTSC - HS Distracted Driver Projects						x				x			
WTSC - DUI Enforcement Campaigns					x	x							
WTSC - Traffic Safety Task Forces - Target Zero						x							x

7. Learning Community Steering Committees

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

Partner Agency/Organization	Alcohol	Underage Drinking	Marijuana	Tobacco	Prescription Drugs	Depression	Suicide Ideation
Attorneys General Office (ATG)	X	X		X			
College Coalition for Substance Abuse Prevention (CCSAP)	X		X				
Department of Commerce (DOC)	X		X				
Department of Early Learning (DEL)						X	
Department of Health (DOH)		X		X	X		
Division of Behavioral Health & Recovery (DBHR)	X	X	X	X	X	X	X
Health Care Authority (HCA)					X	X	X
Indian Policy Advisory Committee (IPAC)						X	
Liquor Control Board (LCB)	X	X					
Office of Indian Policy (OIP)						X	X
Office of Juvenile Justice (OJJ)	X						
Office of Superintendent of Public Instruction (OSPI)		X	X			X	X
Prevention Specialist Certification Board of Washington (PSCBW)	X						
State Board of Health (SBOH)				X	X		
State Epidemiological Outcome Workgroup (SEOW)	X		X	X	X	X	X
Washington Association for Substance Abuse and Violence Prevention (WASAVP)	X	X	X	X	X		
Washington Coalition to Reduce Underage Drinking (RUaD)	X	X					
Washington State Drug Free Communities Coalition of Coalitions (CoC)	X		X	X	X		
Washington State Patrol (WSP)	X		X		X		
Washington State Prevention Research Sub-Committee	X		X	X	X	X	X
Washington Traffic Safety Commission (WTSC)	X				X		

8. Action Plans

This table includes Action Plans for each Behavioral Health Problem area and summarizes the specific partners committed to contributing to working on each Action Plan. A list of acronyms can be found in Appendix 1 on page 51.

State Prevention Enhancement Strategic Plan - Year 1 Action Plans

Updated - March 2013

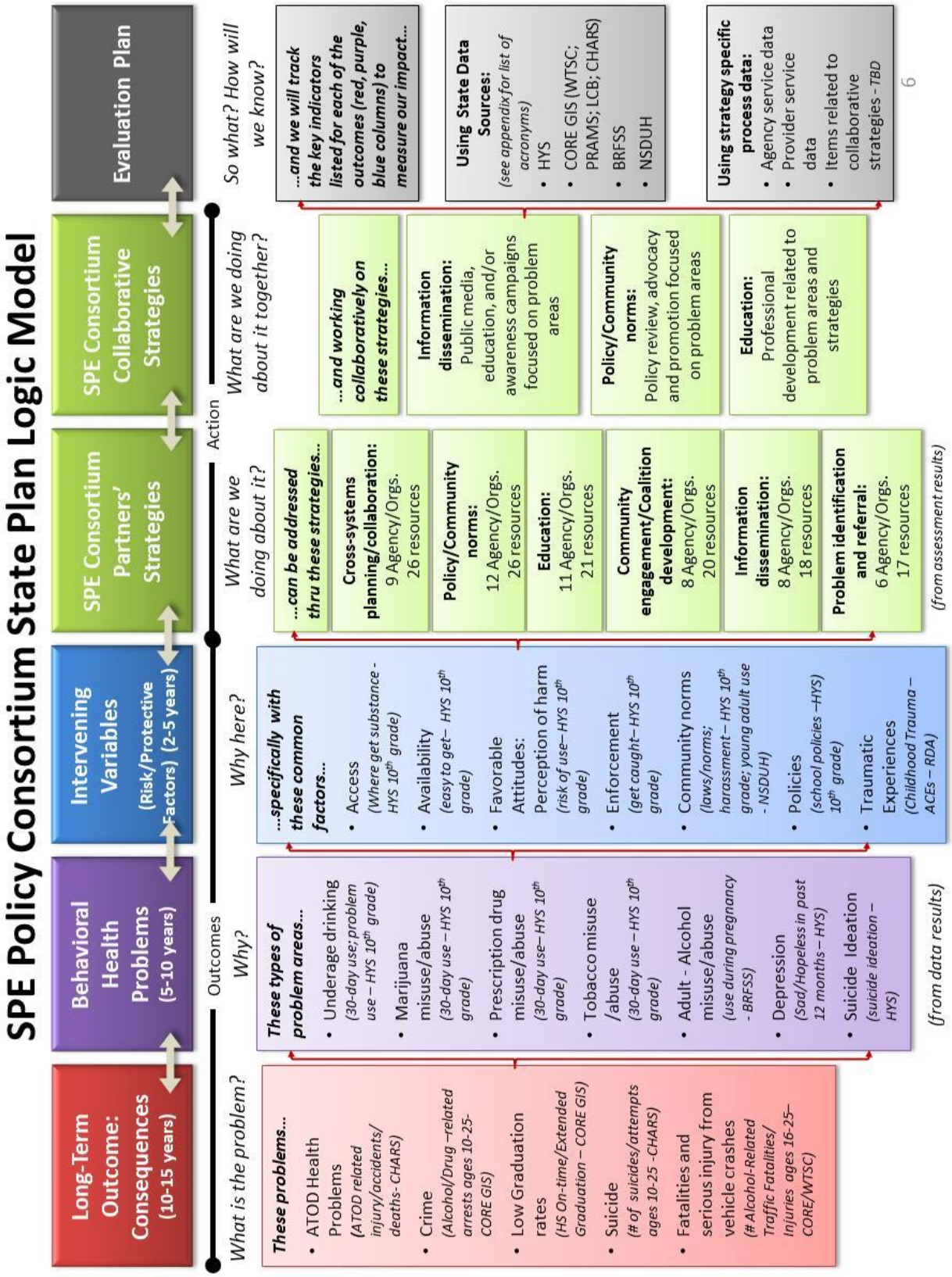
Partner Agency/Organization	SPE Policy Consortium											SPE Advising Groups												
	State/Government Agency											*Tribal*	*Statewide Organization/Association*											*Other*
	ATG	DOC	DEL	DOH	DBHR	HCA	LCB	OIP	OSPI	WSP		IPAC	CCSAP	CoC	PSCBW	Research	RUaD	SBOH	SEOW	WASAVP		Other		
Alcohol					X	X							X		X	X						X		
Workgroup Team: Work with existing College Coalition and Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to implement SPE strategies.					x								x		x	x						x		
• ***Policy:*** Develop method for collecting statewide data on young adults for both those attending college and not attending college.													x			x			x					
• ***Policy:*** Promote the use of SBIRT among universities and colleges.					x								x		x	x								
• ***Policy:*** Promote the use of SBIRT for use with pregnant women.					x	x							x		x	x								
Underage Drinking	X	X		X	X		X									X	X		X	X				
Workgroup Team: Integrate with the state Reducing Underage Drinking Coalition (RUaD) to support the established priorities which include: Analyze and Monitor Issues/Policies; Promote Policy Change; Supporting Youth Influencers; and Support Law Enforcement.	x			x	x		x													x				
• ***Policy:*** Conduct surveillance on data regarding Initiative 1183 (alcohol privatization) & Initiative 502 (recreational marijuana use).	x				x														x					
• ***Information Dissemination/Public Awareness:*** Ensure broad coverage of press release for HYS Data of Underage Alcohol & Marijuana Use.					x														x					
• ***Information Dissemination/Public Awareness:*** Promote news stories such as investigative journalism about true impacts of I-1183 & I-502.		x			x											x	x							
Marijuana		X		X	X		X			X				X			X		X	X				
Workgroup Team: Expand RUaD coalition focus to form one Coalition to address underage drinking and marijuana use.					x		x			x							x		x					
• ***Policy:*** Engage state agencies, community partners, and local providers to monitor impacts of I-502 on state and communities and advocate for prevention best practices with Liquor Control Board in rule making for marijuana industry.		x		x	x									x						x				
• ***Education/Professional Development:*** Training/conference for state prevention community to focus on implementation, emerging issues, accurate tracking, statewide coordination.		x			x															x				
• ***Information Dissemination/Public Awareness:*** Communications campaign to educate the public regarding marijuana risks, resources, and understanding the new law pursuant to passage of Initiative 502 and disseminate via schools, community coalitions and networks, public health, and law enforcement.				x	x		x										x			x				
• ***Information Dissemination/Public Awareness:*** Website- Resources & FAQ's					x		x															x		

State Prevention Enhancement Strategic Plan - Year 1 Action Plans

Updated - March 2013

	SPE Policy Consortium										SPE Advising Groups									
	State/Government Agency										*Tribal*	*Statewide Organization/Association*								*Other*
Partner Agency/Organization	**ATG**	**DOC**	**DEL**	**DOH**	**DBHR**	**HCA**	**LCB**	**OIP**	**OSPI**	**WSP**	**IPAC**	**CCSAP**	**CoC**	**PSCBW**	**Research**	**RUaD**	**SBOH**	**SEOW**	**WASAVP**	**Other**
Tobacco	**X**	**X**		**X**	**X**										**X**	**X**	**X**			
Workgroup Team : Establish State Inter-Agency workgroup to focus on SPE strategies.	x			x	x												x			x
• ***Policy:*** Provide education and information on the creation of no-smoking policies to create smoke-free workplaces specifically targeting college and state agencies.				x													x			
• ***Policy*** **:** Convince motion picture industry to change industry policy to eliminate depictions of tobacco use in youth-rated movies.	x	x																		
• ***Policy:*** Increase tobacco prevention funding by providing information to policy makers on the impacts of prevention.	x														x		x			
• ***Education/Workforce development:*** Provide training and technical assistance to healthcare clinics to screen for tobacco use and refer to cessation resources in order to increase number of patients screened.				x																
• ***Information Dissemination/Public Awareness:*** Provide Point of Sale retailer education and conducting the Community Assessment Neighborhood Stores (CANS) Surveys; and share the results and other impact information with policy makers.	x			x	x											x				
• ***Information Dissemination/Public Awareness:*** Establish and maintain public awareness of the causal link between smoking in movies and youth smoking.	x	x																		
Prescription Drugs		**X**		**X**	**X**	**X**				**X**					**X**		**X**	**X**	**X**	**X**
Workgroup Team: Establish statewide workgroup to implement SPE strategies. Work collaboratively with existing statewide Take Back Your Meds Coalition and Unintentional Poisoning Workgroup.		x		x	x	x				x					x		x	x		x
• ***Policy:*** Promote value of Prescription Monitoring Program and seek opportunities to ensure funding for program to continue.				x	x	x											x		x	x
• ***Policy:*** Promote the use of the Emergency Department best practices model for prescribing medications among hospitals.				x		x														
• ***Education/Workforce Development:*** Provide presentation and online information to local communities regarding prescription drug abuse statistics and strategies for prevention.		x		x	x	x														x
Depression & Suicide Ideation		**X**	**X**	**X**	**X**	**X**		**X**	**X**		**X**				**X**	**X**		**X**		**X**
Workgroup Team: Establish a statewide workgroup to implement SPE strategies.		x	x	x	x	x		x	x		x				x	x		x		x
• ***Education/Workforce Development:*** Package key elements of intervention and training for use: 1) by communities experiencing multiple youth suicides in short time frames, needing community management and response intervention; 2) for communities as part of emergency response/ crisis plans for a wide variety of natural disasters, emergency planning; and 3) proactively provide information on best practices used by communities both to help prevent such tragedies and respond quickly and effectively if they occur.			x		x															
• ***Information Dissemination/Public Awareness:*** Collect data and resources to provide to communities including 1) Prevention and intervention material to reduce potential for youth suicide and depression and 2) Response (Post-vention) to communities experiencing crisis of multiple suicides/contagion.			x															x		

9. Logic Model



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

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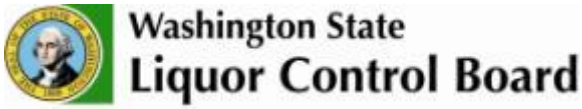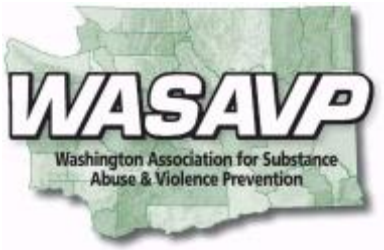
State Prevention Enhancement Policy Consortium Partners