Prevention Research Sub-Committee Meeting

Wednesday June 23rd, 10:00 am – 1:30pm

Location: Zoom

Theme: Evidence-based programs and practices

Agenda

Time	Agenda Item
10:00 -10:15	Introductions
10:15-10:30	**Impromptu Networking** ● What do you hope to get from and give this community? ● In other words, why do you keep coming to these meetings?
10:30 – 11:00	**DBHR's Excellence in Prevention List: Updates & Recommendations for Substance Misuse & Mental Health Promotion Programs in WA State** **Brittany Cooper**, PhD, Washington State University Contact: brittany.cooper@wsu.edu
11:00 – 11:30	**Identifying and Supporting Child Mental Health Treatment EBPs in WA State: Project Overview & Next Steps** **Sarah Walker**, PhD, University of Washington Director, Evidence-based Practice Institute Contact: secwalkr@uw.edu
11:30-12:00	Lunch Break
12:00 - 12:30	**Lessons Learned on Creating a Compendium of EBPs for Hispanic Populations** **Luis Vargas**, PhD Consultant, National Latino Behavioral Health Association Contact: lavargasalba@msn.com
12:30-1:00	**General Discussion** What are the key takeaways and implications of these presentations for improving the adoption and implementation of EBPs in WA State?
1:00 – 1:20	**Round Robin**
1:20 – 1:30	**Next Meeting: Topics and Dates**

Notes:

- Introductions
  - **WSU**: Brittany Cooper, Clara Hill, Kelley Pascoe, Jordan Newburg, Kate Hampilos, Danna Moore, Elizabeth Purser
  - **UW**: Kevin Haggerty, Nicole Eisenberg, Sarah Cusworth Walker, Jason Kilmer, Jennifer Bailey, Liz Wilhelm
  - **DBHR**: Tyler Watson, Miranda Pollock, Sarah Mariani, Christine Steele, Cesar Zatarain, Angel Cheung, Gilda Yruretagoyena, Lauren Bendall, Liz Venuto
  - **WSIPP**: Eva Westly, Rebecca Goodvin, Marna Miller
  - **King County**: Margaret Soukup
  - **National Latino Behavioral Health Association**: Luis Vargas

- Announcement (K. Haggerty):
  - Tyler was able to create a repository for all PRSC related items (notes, mission statement, upcoming meetings), which can be found on the Athena Forum

- Impromptu Networking
  - In breakout rooms, please discuss the following:
    - What do you hope to get from and give to this community?
    - In other words, why do you keep coming to these meetings?
  - Post breakout room reflections and comments:
    - Learn and get updated with current research.
    - Learn more about EBPs, especially with Latino communities.
    - Soak in everything I can about how everyone's work comes together in practice.
    - Love learning from the Washington State prevention community.
    - Network with other prevention professionals; learn from others; learn about EBPs for Spanish speaking populations from Luis today.
    - Learn about the work of our partners in Prevention.
    - Meet other Washington researchers, and keep on learning!
    - Learn more about perspectives from the field, what's working, what's new, what are the challenges!
    - We get information that helps inform our work with communities to serve them the best we can.
    - To receive feedback on related projects that the partners here have subject matter expertise in.
    - Learn more about school services and support for communities.
    - Being relatively new to WA state, I'm looking forward to familiarizing myself with the Prevention research system here and stay up to date on best-practices.
    - To network and learn more about current research applicable to the work we do.

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- **DBHR's Excellence in Prevention List: Updates & Recommendations for Substance Misuse & Mental Health Promotion Programs in WA State**
  Brittany Cooper, PhD, Washington State University
  Contact: brittany.cooper@wsu.edu
  - WSU has been working with DBHR to improve and standardize the process for selecting and maintaining the lists of programs that benefit WA State and Washington communities.
    - Four primary tasks:
      - Develop criteria and tools to review and make recommendations about existing programs on the Excellence in Prevention (EIP) list.
      - Gather updated information on all programs & summarize in a spreadsheet (Program Directory).
      - Conduct HYS analyses to inform program recommendations.
      - Develop recommendations for DBHR to use in future review and decisions about programs.
    - Today's presentation focuses on the first and fourth primary tasks.
  - Primary Task #1: Develop criteria and tools to review and make recommendations about existing programs on the EIP list.
    - Excellence in Prevention Strategy List (EIP)

        - First list developed and supported by DBHR.
        - Currently contains: 86 direct services (i.e. programs) and 25 environmental strategies.
        - Pulls from three primary resources:
            1. SAMHSA's National Registry of Effective Programs and Practices (NREPP)
                - Most of the program information for EIP programs came from NREPP.
                - NREPP is no longer updated or supported by SAMHSA as of January 2018.
                - Prompted DBHR to want to review and update the EIP.
            2. The State of Oregon's List of Evidence-based Programs
            3. The Pacific Institute for Research and Evaluations' "Scientific Evidence for Developing a Logic Model on Underage Drinking: A Reference Guide for Community Environmental Prevention."
    - EIP Review & Recommendation Criteria
        - Goal: to create program review tools & provide recommendations to DBHR about the program review process.
        - Important for WA state communities to be able to implement programs, be supported in those implementations, and sustain programs.
        - WSU used the Blueprints "Promising" program designation as the standard for the review process.
        - Blueprints:
            - Most rigorous process among existing review tools/processes
            - Transparent process
        - WSU created the Prevention Program Review Decision Support Tool
            - Only inclusive of direct services (i.e., programs not environmental strategies)
            - Review criteria:
                1. Strength of evaluation evidence of interventions reducing substance misuse and promoting mental health.
                2. Strength of intervention specificity and documentation.
                3. Availability of implementation materials and support.
            - Criteria were established from several sources in a tired fashion:
                - Blueprints
                - WSIPP
                - California Evidence-based Clearinghouse for Child Welfare
                - Crime Solutions
                - NREPP
            - Preliminary findings

            - 42 programs were recommended to retain
            - 44 programs were recommended for reconsideration
        - Additional consideration for EIP Review
            - Programs with multiple versions
            - Cultural adaptations of programs already included
            - Implications for prevention providers implementing EIP programs
            - Impacts of removing programs with strong state infrastructure
            - Implications for special populations
- Primary Task #4: Develop recommendations for DBHR to use in future review and decisions about programs.
    - Compared WSU review process with:
        - DBHR program review submission survey
        - UW's Evidence-based Practice Institute website and application
    - Proposed recommendations to DBHR
        - Nominated Program Review: institute a standard application process, timeline, and review protocol to determine whether programs should be added to DBHR-supported lists.
            - Application sections: a) applicant information, b) general program information, c) program participants and implementation settings, d) targeted risk/protective factors and outcomes, e) program evaluation information, and f) program implementation information
        - Focused Evidence Review
            - Regular review of published literature and established program registries.
            - Identify and update evaluation evidence for newly developed prevention programs and new evaluation evidence for existing DBHR-supported prevention programs.
- Discussion and Q&A:
    - Mary Segawa: How is a final determination made on programs recommended for reconsideration?
        - BC: This is still being worked out. WSU has made recommendations to DBHR and asked Kevin Haggerty to review and provide feedback. We are now reaching out to the PRSC through this presentation for feedback and are open to hearing from other stakeholders as well.
            - We would also like to recognize that the WSU recommendations are not the be-all and end-all.
        - SM: This is the first rollout of recommendations. Some additional considerations we are thinking about include:
            - The intersection of health equity and EBPs.

        - DBHR has a prevention advisory group with representatives from the provider network (CPWI) to help inform this process.
        - Would also like to interact with others in the prevention field as nationally, a program might seem easy to disseminate and implement but there might be factors specific to WA that facilitate/hinder the implementation.
        - Would also like to explore the state structures that are currently supporting this work. Want to avoid dismantling anything that currently works or that would jeopardize trust within the communities.
        - Would also like to make sure that communities have time to review the effectiveness of programs/practices that they are currently implementing in their communities.
    - Lauren Bendall: how is "culture" being defined? I'm trying to gauge what qualifies as a cultural adaptation.
        - *This question was not addressed during this session due to a lack of time.*
    - Nicole Eisenberg: Community partners that I've worked with sometimes get confused with the existence of multiple "program lists"... (e.g. which one should we follow, what are the differences, etc.). Thoughts on how to communicate with them the pros/cons of EIP vs Blueprints, Crime Solutions, others, etc.?
        - BC: Yes, communities get confused. Some of it is funding dependent (e.g. DMA list) in terms of what is included on the list. Goal is 1) as updates get made, we can increase the clarity around lists and criteria.
    - Eva Westley: So fascinating, Brittany! Following on Nicole's question - how is the EIP list used? Does it inform funding or programming supported by DBHR? Is it intended as a resource for practitioners?
        - BC: Agrees that this is confusing. One of the goals is that this list will increase clarity and transparency for communities.
        - SM: DBHR uses these lists to meet EBP requirements for the funds that are distributed to communities and schools. The lists are also meant to serve as a general resource.
    - Margaret Soukup: When do you think the application will be available?
        - BC: We are probably still a ways off, especially considering this is the first round of feedback and recommendations.
    - Sarah Walker: excited that you all are looking at rapid evidence reviews as an option for your center.

- **Identifying and Supporting Child Mental Health Treatment EBPs in WA State: Project Overview & Next Steps**
  Sarah Walker, PhD, University of Washington
  Director, Evidence-based Practice Institute

Contact: secwalkr@uw.edu

- CoLab - EBPI - UW
- Wanted to come in with a lens about quality
  - "Quality care is culturally responsive, client-centered, and informed by evidence when possible"
    - Embedded clinical coaching
    - Supervisory tools for quality
    - Leadership and organizational development
- Motivating question for this approach to EBP: How can we promote clinician flexibility within the definition of EB practice while retaining a focus on effective care?
  - Implementation is always going to be very local, down to the 1-1 interactions with clients
    - APA recognizes client needs and clinician skill are a part of evidence-based practice.
    - We also want to maintain the focus on effective care.
  - Tracking delivery of effective child mental health clinical practices within Medicaid
    1. Was the provider trained in an effective clinical approach?
    2. Did the provider document intent to deliver the most active element of that approach? (in routine notes)
       a. Actions will have varied purposes (e.g. education, treatment, client "buy-in")
    3. Did the provider document delivery of a clinical element consistent with that approach? (in routine notes)
       a. On a session-by-session basis can this be documented?
  - The Reporting Guides list approved training entities
    - Paradigm shift from individual treatments to grouping practices under treatment families. There are now hundreds of protocols that have been tested in RCTs, but many share common features/elements.
    - Treatment approach is defined by its theory of change
      - What's the treatment approach? What is its theory of change? What is it a clinician will do to treat a presenting issue? What's the rationale for that action?
    - Who are the approved trainers?
      - Individuals deemed credible in providing training. Working towards approving organizations to train providers in-house.
  - Trainings must be consistent with the common elements of effective approaches
    - Essential clinical elements for treatment plans
    - Allowable clinical elements for progress notes
      - Likely to show up across treatment types/approaches

        - Reporting Guides don't prescribe the order of the elements. Approved elements include sessions focusing on engagement, measurement, and client feedback.
            - Allows for clinician flexibility
        - Pros and Cons
            - Cons
                - Complicated to determine whether a training entity has necessary expertise/methods to transfer knowledge of effective approaches.
                - Adding a new treatment category is involved and takes time to identify clinical elements among tested approaches.
                - Training and documentation alone are not a check on competent delivery of the clinical element.
            - Pros
                - We can track use of effective clinical approaches for all encounters, not just providers engaged with external consulting companies
                - We can build capacity with community-led orgs to qualify as training entities
                - We can approve provider agencies as trainers
        - But what about competency?
            - Literature unclear about frequency and approach of post-training support needed.
            - Providing training/manual will not promote competency.
            - We need to focus on other strategies to support competency: supervisory support, organization change.
            - This is a separate issue from what should "count" as an EBP.
    - Discussion and Q&A:
        - Brittany: Have you mentioned processes about promising practices?
        - Jordan Newburg: When considering these treatment approaches, do transdiagnostic manuals help or hinder that process?
            - SW: We list the ones we find helpful. They're great tools and resources, they're added as eligible entities.
        - Kevin Haggerty: We've been talking about clinical supervision and its impacts on treatment. Do you know of good studies that have demonstrated impacts of clinical supervision?
            - SW: Yes, this has been part of literature reviews. What kinds of supervision are most helpful for clinical elements? A big one is actual role play of using practices. Another is encouraging clinicians to measure progress and adjusting as needed for clients.
        - Brittany: It seems a lot of the work we do with DBHR for EBPs around prevention—some of it is driven by funding (and funding requirements). It

seems there's some overlap—you mentioned Medicaid reimbursement—but it seems less driven by funds. How do funds play into this area?

- SW: There isn't enhanced reimbursement. In the child mental health space, the state purchases sessions; however, not all of those must be evidence-based. In the Medicaid space, you have to think of different levers to use, like incentives. The only lever in place is that managed care places must report. Important to think about ways to track and incentivize.

- Luis Vargas: You were talking about competency and it's a multifaceted issue. Some of that competency has to do with treatment fidelity. There's another side focused on therapist-client relationships and the factors that improve outcomes based on that relationship. Sometimes a clinician might be delivering an EBP, but they aren't [great at the working alliance]. How do you assess some of that—of the client-therapist relationship?
    - SW: The short answer is that we're not, and we would like to; it's on our radar in two ways (1) what can we add to the approved elements that would include shared decision-making or similar elements/strategies? and (2) considering what should be the right quality metrics for an alternate payment; could one of those be a global, even 1-question, measure to clients that gets at their experience?
    - Treatment-agnostic check-ins are another factor to consider.

Lunch Break

- **Lessons Learned on Creating a Compendium of EBPs for Hispanic Populations**
  Luis Vargas, PhD
  Consultant, National Latino Behavioral Health Association
  Contact: lavargasalba@msn.com
    - Why create an eCompendium?
        - Hard to identify and select culturally appropriate EBPs for Latino communities.
        - This is a current gap in existing registries most of which usually include generic programs.
            - If they have information on EBPs that might be better suited to Latino populations, they are often limited and not easily accessible.
    - eCompendium
        - 6 national and state registries
        - Registry inclusion criteria:
            - Criteria that was comparable to other registries when assessing evidentiary support for programs.
            - Registry had to consider effect size of significant findings
            - Had to have evidence of sustained program effect on participants after the end of implementation.

        - Had to include programs targeting alcohol/drug misuse, tobacco/nicotine use, behavior or emotional functioning, suicide risk, or post-traumatic stress.
    - Included registries:
        - [Crime Solutions]
        - [Blueprints]
        - [CA Evidence-Based CH]
        - [Social Programs]
    - Two included were school specific
        - [CASEL]
        - [What Works Clearinghouse]

Categories and Descriptions Used for the Four Registries that List Programs that Can Be Implemented in a Variety of Settings

Category	Description
Focus Population	Families, parents, children, adolescents, or adults including brief description of the subpopulation (e.g., disadvantaged, divorced parents, etc.)
Program Name and Contact Information	E.g., Primary contact, website, developer, distributor, researcher
Target Problems or Risk Factors	E.g., Delinquency, alcohol and other drug problems, conduct or behavior problems, general risk
Level of Intervention	Universal, selective, or indicated
Setting	E.g., Behavioral health organization or agency, school, home, community, court, etc.
Latino program participants in the studies reviewed by the registry	Yes, No, or No Information. If Yes: Minimal (≤15%), Moderate (16% to 30%), Substantial (31% to 55%), Primary (56% to 99%), Exclusively (100%), or # Unknown
Type of Program	Generic, Culturally Informed/Responsive, Culturally Adapted, or Culture Specific
Strength of Evidentiary Support	2-Star program (good evidentiary support) 1-Star program (adequate evidentiary support)
Cost of the Program	Yes or No (If Yes, URL in which registry the cost information can be found)
Availability of the program in Spanish and/or Portuguese	Yes or No (If Yes, name of the registry that provides this information)
Registry and Program Description	Link to the registry site that describes the program

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    - What has been counted as cultural adaptation varies:
        - Luis shared an example of switching images from white to black and lowering the reading level for a cultural adaptation.
        - Alternative example: University in California ran focus groups to figure out what resonated in terms of adaptation with the target population. Then worked with program developers to figure out what could change/adapt without compromising the strength of the program.
    - Lessons learned:
        - More to engaging in a culturally responsive, evidence-based practice than simply selecting an EBP.
        - Used the CDC definition for evidence-based practice (Puddy & Witkins, 2011).
        - Often the experiential and contextual evidence is minimized in order to prioritize research evidence.
            - Contextual and experiential evidence are often within the local communities where the program will be implemented.
            - All three types of evidence are essential to optimize the potential effectiveness of an EBP.
        - Created a guide to go with the compendium

    - Guide provides the conceptual framework
    - eCompendium assists and informs service providers, directors, administrators and education leaders to:
        - Select a research evidence-based program for conceptual fit to a Latino community.
        - Engage in a preliminary process of finding a good practical fit.
    - Guide facilitates the decision-making process in reviewing and incorporating the experiential and contextual evidence that is available in a particular community; it describes a process for the user to find the best practical fit for the selected program for the community in which the program will be implemented.
        - Tapping into local experience and expertise for their practice and their population.
        - Currently vetting EBPs is more focused on efficacy rather than effectiveness.
- Lack of attention is given to research-based, provider-participant relationship associated with positive outcomes of the program
    - Provider-participant relationship accounts for a substantial contribution to participant outcome independent of the specific program.
    - Relationship appears to account for at least as much participant benefit as, and possibly more than the program content/method/technique.
- Integrate provider-participant relationship training on these factors are likely to maximize the effectiveness without impacting treatment fidelity.
- Even "generic" EBPs are culturally based as they are developed by European researchers and implemented largely on European American samples
    - Represent Western ways of thinking, communication styles, values, norms and beliefs.
- Cultural aspect can also be a limiting factor:
    - Differences across Latino-specific populations for which Latino-adapted programs might not fit (e.g. program demonstrated efficacy with Puerto Ricans in NY might be different than a population in rural CA)
- Ethical issue: inadvertent yet surreptitious acculturation of the non-European American communities in which the generic EBPs are being implemented
- Steps forward:

        - Registries could provide more pertinent statistics, such as effect sizes, confidence intervals, or odds ratios.
            - More useful in selecting an EBP rather than only on statistical significance.
            - Learn more about the magnitude of difference.
        - Provide program outcomes that are de-aggregated by ethnic group and subgroup.
- **General Discussion (and discussion of Dr. Vargas's presentation):**
    - What are the key takeaways and implications of these presentations for improving the adoption and implementation of EBPs in WA State?
    - Brittany Cooper: Did you also consider implementation support/training available for these programs?
    - Brittany Cooper: Is the eCompendium available or still in progress?
        - LV: Currently working with a web manager to post the eCompendium. Ideally, we will post it in the next 6 weeks to 2 months. Will share with PRSC when it is available.
    - Brittany Cooper: Are there some aspects at a state level to focus on in terms of contextual evidence?
        - LV: Contextual evidence is multi-tiered and can be viewed in a "Bronfenbrennerian" way. Could develop contextual evidence at the state level (e.g. what is considered an evidence-based treatment and what are the implications put on that treatment and how does that impact availability?) and what are the policy implications.
    - Kevin Haggerty: We've evolved overall so much in the kinds of evidence we have, we now have to go deeper. Appreciated the discussion around odds ratio and effect sizes. Effect sizes are also dependent on the level (individual, school, community) change. Does the smaller effect size at the community level have a more profound effect than at a different level?
        - LV: Educating potential users of the program in those aspects. Effect size cannot be interpreted in isolation of the context in which it is delivered. More education about what goes into the programs to make it evidence-based. We also need to look at research not just on the method/protocol but also at the research on the provider-participant relationship. We need to consolidate those lines of research when considering EBPs.
        - KH: importance of training and supervision. How do we train the workforce to attend to those things? Important to focus on it.
    - Brittany: There are some implementation frameworks that call out the provider-client relationships as a mechanism for positive outcomes. Sometimes a program or method is designed to enhance those components (e.g. Intervention fidelity in combination with participant responsiveness and engagement produces outcomes), so, they aren't always separate lines of research.

        - LV: Yes! It's just not a universal thing or thought yet. Enhancing provider-client relationships and engagement can be a part of the protocol. Would also be helpful to disaggregate data by subgroups. If you have enough to disaggregate you could show whether those outcomes are possible/feasible for a certain ethnic group vs. another.
    - Kevin Haggerty: Also appreciated the comment around the context of where the EBP is being conducted and the emphasis on program fit.
        - BC: part of the intention behind the fit or misfit issues.
        - LV: We might assume that a culturally specific program might not be as good of a fit as a generic program. Ultimately, the user has to evaluate.
    - Rebecca Goodvin: There's some thoughts that it's potentially harmful to report effects by sub-populations because we might see interventions used aren't "evidence-based" for those groups, and where does that leave people?
        - LV: the question is harm to whom? To the policy makers who realize there isn't a program for a target population? Or is it harmful to the participants?
            - It is important to look at what those outcomes are because they can go both ways. For example, a program might not be helpful for one subgroup, or even more helpful for a different subgroup. Ask what are those differences and are we serving the population as well as we can?
        - BC: related and thinking about prior work with DBHR to explore programs/interventions developed for Native American populations. Do you change criteria? Do you risk harm by lowering the bar of rigor in some ways? What are the consequences, intended or not, by doing that?
            - SM: It ties to prevention ethics and the ethical obligation to serve populations and in doing so, serve them well. If we change criteria in a way that would make it appear interventions don't meet certain requirements, are we inadvertently saying a given population isn't capable? Instead, we're trying to think about it as an intentional change that is different but not better or worse. Ask what criteria might make sense given cultural and contextual factors as well as the available evidence.
            - LV: Yes, community-based evidence. You want to make sure you get input from the community before administering the program. If you run it through the community, they can give you feedback that is helpful in making those determinations. What do we do to be able to encourage the development of new programs? One aspect of registries that might stifle the development of innovative programs but the other is avoiding iatrogenic outcomes.
        - SM: reflecting on the community-based piece and certain components of what Luis presented that DBHR can use to help gather information and feedback from the communities and what becomes a part of the criteria.

- Nicole Eisenberg: Has had experience with Latino populations in South America. There is a tension between the programs that are available, and the programs communities deserve. Each community deserves the same protections from harm and the same level of evidence. Programs might exist but they haven't been tested with the same level of rigor or evaluation. How do you balance the need for service and programs with the length of time that it takes to evaluate the program rigorously? You don't want to lower the threshold (indicating that they are not worthy of the same level of evidence). How might we leverage different kinds of evidence/knowledge that we have and train communities in evaluation so implementations can reach the gold standard? What can you look at or what can you start doing?
  - LV: An important point about the encouragement to do a novel implementation. What are the things that you need to do as an agency to get enough evidence to support that? It's the expertise that you bring to those communities to help move these programs forward.
  - Danna Moore: AI/AN communities suggest that evidence-based practices do not necessarily provide evidence for Tribes, and that it also may not apply to individual tribal communities as each is unique. The main considerations are concerning considerations related to historical trauma, adverse childhood experiences, isolation, and tribal historical culture and ways of healing. They have preference for health providers that are from their tribal community.
    - BC: We tend to say, "evaluation evidence" and mean RCTs, but we need to look at salient risk/protective factors for group (as well as what might overlap with others). That is a different kind of research evidence that could guide the selection of programs. Do others have thoughts on that type of evidence or research as well?
    - DM: As we get into those communities it is important to include them in partnership (prefer partnership term vs. collaborator or consultant). Elevate their voices.
  - Sarah: general thank you for coordination and for the presentations. Really amazing to see the work that is happening and how this work is coming along. Another piece that we wanted to mention when Nicole was talking about balances was the old principles for effectiveness, which DBHR still uses. There are funding requirements tied to established interventions, but there is also funding for innovative interventions. That could be applied to community work. Could be a continued discussion for the EBP workgroup. If those principles of effectiveness still apply, should we run through, revise or add more?
    - BC: Agree. Time to look at those again and look at the literature, we could add more principles or clarify existing ones. Given Sarah's presentation, it seems like the treatment world might have already been moving in that direction. Worth exploring and identifying the core elements of prevention and the core mechanisms that drive the effectiveness of treatment and prevention programs.

        - LV: It is also important to think about the paradigms we use. Is the purpose of an intervention to show generalizability? Differential outcomes because of factors? Should we be looking at external validity or should we be developing a new metric of environmental validity? It brings up theoretical issues as well as policy implications.

- Round Robin
    - Kevin:
        - Working on the key initiatives for opioid treatment and addiction long-term. Just had a discussion with Frances Collins (NIH Director) who was talking to the surgeon general. How do we use current evidence and how do we improve on what we are doing?
            - Suggested revisiting Chapter 3 of the "Facing Addiction Book", which focuses on prevention.
        - PTTC and WA State are conducting a needs assessment of the workforce in WA state. They would really like people to participate in the workforce needs assessment. Win free entry into the NPN conference.
            - You can take the survey at the link: https://pttcnetwork.org/centers/northwest-pttc/news/northwest-pttc-2021-prevention-workforce-needs-assessment
        - DM: Has this link been sent to Employment Security Department and local job service centers? (suggestion for sharing)
        - DM: Has the PTTC survey of prevention been sent to jails or WASPC? (suggestion for sharing)
    - Brittany:
        - Presenting on building prevention capacity at NPN with others: SM, KH, MS, others.
        - Technically on sabbatical next year! Also helping to coordinate a SPR post-conference workshop, presenting along with colleagues in Colorado and Pennsylvania doing similar work to provide other models for how to do this work well. SPR is Aug 4-5, 2021 (two half-days).
            - SPR workshop is called Translating Prevention Science into Action: A Roadmap to Successful Prevention Researcher-State Agency-Community Collaborations: https://www.preventionresearch.org/2021-annual-meeting/post-conference-training-workshops/#pc2
    - Sarah:
        - Piggybacking off the workforce assessment survey -- it's important to get a broad set of feedback and to correctly assess how big the prevention workforce really is, what the avg education level is, etc.
        - Federal budget update: The President's budget that came out is promising in terms of SAMHSA allocations (increases). Increase to prevention was significantly less than other departments.

- Tyler:
    - COVID survey update: goal to assess overall well-being of youth during the pandemic. Survey was sent out in March. The team now has the results and will share them when appropriate.
    - Jason: Will send an email to the PRSC distribution list once the report is out, (estimates next week-ish).
- Jason:
    - David Anderson along with Tom Hall released a book titled, Leading Campus Drug and Alcohol Prevention -- great step for college administrators and grad schools. https://www.naspa.org/book/leading-campus-drug-and-alcohol-abuse-prevention-grounded-approaches-for-student-impact
    - MS noted that JK's work is also in the book :)
    - Danna asked about juvenile justice/jail representation. Resources needed for funding prevention. Especially with changes in laws and less individuals incarcerated for drug charges (but jails are often where they get screened/treated for SUDs and STIs). That is a system that could really be tapped into. How do we work upstream in this area?
        - LB (chat): NYS did a study around transitional care coordination to connect reentry populations with health care. It was primarily around substance use treatment and primary care. It was funded through STR, I'm not aware of if it was continued with STR funds
            - *state opioid response (SOR) funds
        - SM: HCA is trying to do work in this area. Primary prevention work opportunities.
        - KH: opportunity for future meeting discussion. Also, school data, especially since we will have COVID data.

- **Next Meeting: Topics & Dates**
    - Next date is 9.23.2021
    - Topic ideas
        - School-based prevention - COVID student data
        - Others can email with future ideas for themes