Prevention Research Sub-Committee Meeting

Wednesday, September 6, 2023, 10:00 am – 1:30

Theme: Interplay of Risk Factors for Mental Health and Substance Use in Adolescents

AGENDA

10:00 – 10:15	**Welcome & Introductions**
10:15 – 10:30	**Impromptu Networking**
10:30 – 11:30 (60 min)	**Risk Indices for Mental Health and Substance Use Disorder:** **HCA Draft MH Logic Model** Sandy Salivaras, Jaymie Vandagriff & Billy Reamer, and Sarah Mariani/Sonja Pipek DBHR Team
11:30 – 12:00 (30 minutes)	**Discussion** Scientists invited to provide discussion and feedback: Sarah Walker (UW Psychology), Michael McDonnel and team (PRISM/WSU)
12:00 – 12:20 (20 minutes)	**Discussion about PRSC Membership** Brittany Cooper and Kevin Haggerty
12:20 – 12:50 (30 minutes)	**Lunch Break**
12:50 – 1:00 (10 min)	**Research Briefs: topics for coming year?** Kevin Haggerty
1:00 – 1:20 (20 min)	**Chatterfall: Updates from the Prevention World**
1:20 – 1:30 (10 min)	**2023 Meetings – theme for December?** • Wednesday, December 6th

Introductions

- **WSU**: Brittany Cooper, Michael McDonnell, Jen Duckworth, Jessica Willoughby, Jordan Newburg, Clara Hill, Gitanjali Shrestha, Elizabeth Weybright, Cassandra Watters, Elanor Dizon, Heather Terral, Myah Houghten
- **Spokane regional health district**:
- **UW**: Kevin Haggerty, Sarah Walker, Beatriz Carlini, Jason Kilmer, Margaret Kuklinski, Linsey Kellum, Jim Leighty, Blair Brooke-Weiss, John Briney
- **DBHR**: Sarah Mariani, Erika Jenkins, Harrison Fontaine, Sonja Pipek, Sandy Salivaras, Jaymie Vandagriff, Rebecca Ruiz, Billy Reamer, Brittany Smith
- **OSPI:**
- **WA DOH:** Liz Wilhelm (Youth Cannabis and Commercial Tobacco Prevention Program (YCCTPP) Community Partnership Capacity Building Grants Coordinator)
- **WA DSHS RDA:** Irina Sharkova, Grace Hong
- **WA LCB:** Mary Segawa, Steve Ziegler, Sarah Okey (newly hired researchers)
- **WSIPP:** Amani Rashid
- **WASAP:** Ramona Leber
- **King County Dept of Human Services, Division of Behavioral Health & Recovery:** Jennifer Wyatt
- **King County Dept of Public Health:** Sarah Ross-Viles
- **Snohomish County Human Services Behavioral Health:**
- **Wahkiakum Community Network Coalition:**
- **Washington Traffic Safety Commission**:
- **NWPTTC, U of Nevada:**
- **Ballmer Group:** Kody Russell

Introductions and Impromptu networking

Everyone introduced themselves. Kevin Haggerty invited participants to consider these questions, then talk about them in smaller breakout rooms: "What do you give to PRSC? What do you take from PRSC? What keeps you coming to these meetings, and what do you get out of our time together?"

A couple of introductions of note:

- Mary Segawa introduced two new research unit members at the LCB, Steve Siegler and Sarah Okey. Steve is a social scientist and former practicing attorney whose work has been in opioid risk management on how to ensure access while limiting risks. Sarah's trained as a psychologist and does research on substance use.
- Amani Rashid, WSIPP, announced the release of the latest report on the I-502 initiative and that she is happy to chat about it: https://www.wsipp.wa.gov/ReportFile/1768/Wsipp_Initiative-502-and-Cannabis-Related-Public-Health-and-Safety-Outcomes-Third-Required-Report_Report.pdf
- We were honored to welcome two invited discussants today: Michael McDonnell, professor at WSU and director of Behavioral Health Innovations in the Dept of Psychology, and co-lead of the Treatment Research Workgroup and Sarah Walker, director of the UW CoLab for Community and Behavioral Health Policy in the Dept of Psychiatry & Behavioral Health Sciences at UW.

Risk Indices for Mental Health and Substance Use Disorder:

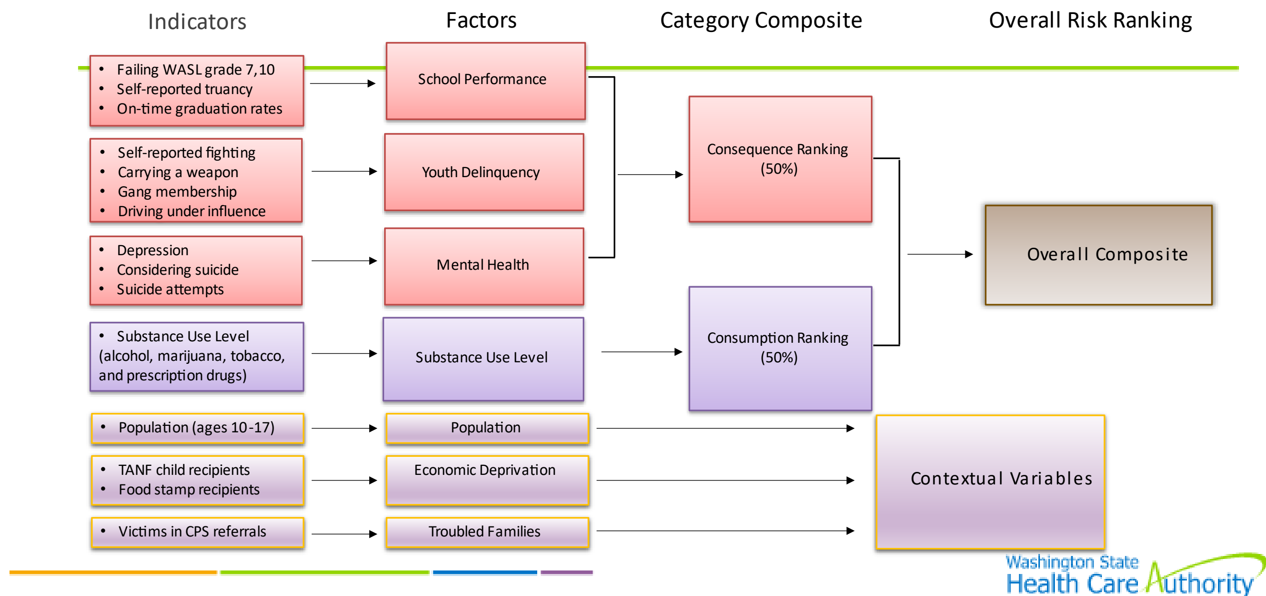
HCA Draft MH Logic Model

Sandy Salivaras, Jaymie Vandagriff & Billy Reamer, and Sarah Mariani/Sonja Pipek

DBHR Team

Sandy Salivaras began with an introduction to the new mental health index (slides attached).

DBHR has a substance use index and have recently developed one for mental health. They use these data to identify communities that are higher risk/higher need to become eligible for DBHR support via the CPWI effort.



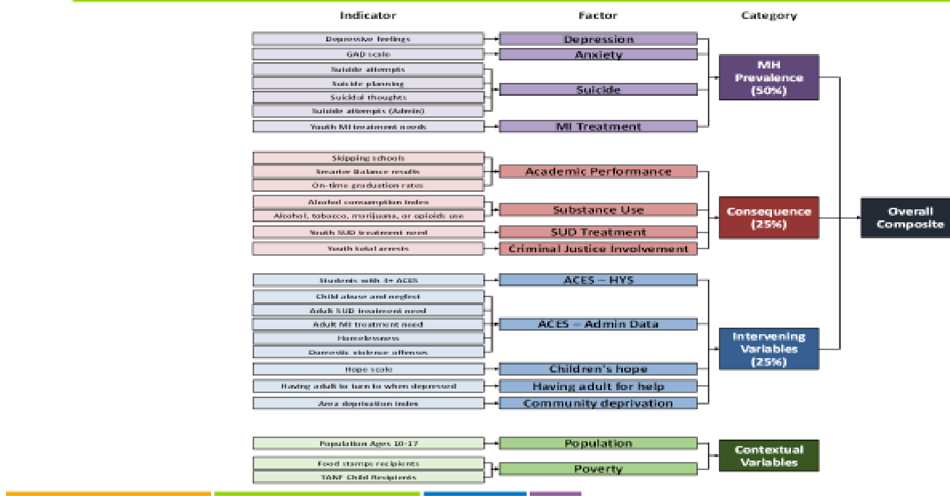
Earlier this year DBHR worked with the RDA and DSHS to develop a mental health risk methodology.

Measures are based on a literature review to find contextual, intervening, consequence and prevalence variables; then looked at which ones have stronger relationship with poorer mental health outcomes. (see slide next page and in slide deck).

Showed a peek at what the index looks like

- Listed by school district, region, ESD, County. Shows an overall risk score for mental health, based on a rated scale. Also shows number of youth and poverty score, and size of school district. Small = 1000 or fewer; Medium is 1001-4000; large is more than 4000
- The index also identifies 'school districts like us'
- https://theathenaforum.org/cpwi_coalitions
- https://www.dshs.wa.gov/ffa/research-and-data-analysis/community-risk-profiles

Community Mental Health Risk Index Methodology



Questions and comments

- Steve Zeigler asked about how these indices can help identify appropriate interventions, as regions are different and would interventions be different? Billy Reamer said the team will share more on that and will hope it answers some of this question.

- Kevin Haggerty looked at interventions on Blueprints that prevent suicide, and one of the questions he has about this index is that the early indicators/upstream indicators for younger populations are missing from this this index. Sandy Salivaras: maybe because the measure that were most strongly related to poor mental health were chosen. Sonja Pipek: will be asking for more input on these indices and about what we are missing.

- Sarah Mariani: in general, for those less familiar with what we do, is that this is one sliver of what we do. Short answer: based on these indices, data books are created for CPWI communities that will help them get a better profile. The CPWI model is based on the CTC, Collective Impact and ?? models. This risk index is to identify NEED; the next level for identified communities is to look more closely at their risk profiles, outcomes, all the indicators in the logic model, to understand more about what's happening locally and where the priorities might be. This is where community planning stems from and where communities then select EBPs for SUD and suicide prevention. Then move to implementing the plan, which includes pre-post tests and overall evaluation that WSU provides for the state as a whole to answer the question of 'are we seeing results'. And the answer is yes!

- DBHR originally started this work on SUD; now working to integrate mental health and its interplay with SUD. Want to promote mental health first, not just as a correlate on SUD prevention. Wanting to prioritize our resources to get out to areas with highest need.

- Brittany Cooper in chat: HCA folks, I'm wondering if you could ever envision creating a single combined index, instead of separate ones … since it does seem a bit artificial to keep them separate (since they often go together and there are shared RPFs).

- Now need to build a logic model – and that's where we're going next.

- Brittany Cooper in chat: I was wondering if you have looked at the correlation between the SUD risk ranking and the MH ranking? I assume the same communities that are high on one are likely high on the other as well.
  - Grace Hong: We have not done a statistical analysis on the correlation. But we do see that a large number of communities rated high on MH risks are CPWI communities, which were selected based on SUD index. So, I think if we do conduct a correlational analysis, there will be a significant association.

- Margaret Kuklinski: kudos for this work! This is one part of the process for getting to better outcomes for kids. What are the malleable levers, the things we can change that then lead to improved outcomes. Blueprints is one resource to find effective programs; this provides info about the malleable risk and protective factors addressed by the programs. Next step for this index is to identify the RPF that are linked to the outcomes. HYS data will be very helpful.

Billy Reamer shared about the logic model

There are two aspects to creating a logic model for this work

1. Building a logic model with the measures we currently have
2. Creating a more comprehensive theory of change -- if we could design this more comprehensive logic model, what are the items we need to add?

He showed us a spreadsheet organized into logic model format from consequences on the left to long term outcomes on the right: Consequences - match indices (red column) (statewide goals to address) – problems we have measures for (see bottom row), aligning with work Sandy showed as well as aligning with outcomes on the right – factors – Focus populations – possible strategies – community engagement process (important that we have community level folks participating in these processes and choosing measures) – short term results – longer term results

Community: *State of Washington* | *Funding Source:* State MHPP

Priority: Mental Health Promotion & Suicide Prevention

	Consequences	Problem	Factors	Focus Population Universal/Selective/Indicated	Possible Strategies	Community Engagement	Short	Long
Logic	Academic Performance Skipping School Smarter Balance results On-time graduation rates	Self Report symptoms of Depression	Depressive feelings	*Define the focus population of the interventions here* **Universal** - General population in Washington **Selective** - Youth and Young adults identifying as LGBTQ in Washington **Selective** - Young Adults in Washington **Selective** - Youth in Grades 8-10 in WA	**Information Dissemination:** Community Awareness raising activities Youth Mental Health First Aid Training Campaigns **Education:** EBP programs from the WA MHP EBP list **Alternative Activities:** After school programs and high-risk hours programming **Problem Identification and Referral:** screening programs **Community-Based Process:** Assessment, Planning, Capacity Building, Implementation, Evaluation, Sustainability, DD **Environmental:** Policy, Social Norms efforts	*What Processes are used to engage community?* None at the time of the development of this logic model.	*Measures from "Factors" column* Reduce the number of students (Grades 8 & 10 combined) reporting depressive symptoms as reported on the WA HYS from X% in 2021 to Y% in 2023	*Measures from "Problem" column* Reduce the number of students (Grades 8 & 10 combined) reporting depressive symptoms as reported on the WA HYS from X% in 2021 to Y% in 2027
	Substance Use Alcohol, Tobacco, Marijuana, or Opioid Use	Self Report symptoms of Anxiety	General Anxiety Disorder (GAD) scale	**Universal** - General population in Washington			Reduce the number of students (Grades 8 & 10) reporting GAD scale scores of x or higher from X% in 2021 to Y% in 2023	Reduce the number of students (Grades 8 & 10) reporting symptoms of anxiety from X% in 2021 to Y% in 2027
	Criminal Justice Involvement Youth total arrests	Suicide Attempts as measured by the Community Outcomes Risk Evaluation (CORE)	Self-report Suicidal Thoughts Suicide Plan Suicide attempts	**Universal** - General population in Washington			Reduce the number of students (Grades 8 & 10) reporting Suicidal Thoughts, Suicide Plans, and Suicide Attempts from X%, X% and X% in 2021 to Y%, Y%, and Y% in 2023	Reduce Suicide Attempts from X% in 2021 to Y% in 2027 as measured by CORE
		Mental Illness Treatment as measured by the Integrated Client Database (ICDB)	Youth Mental Health Treatment	**Universal** - General population in Washington			Reduce the number of Washington youth (12-18) in need of mental health treatment from X% in 2021 to Y% in 2023	Reduce the number of Washington youth (12-18) in need of mental health treatment from X% in 2021 to Y% in 2027 as measured by ICDB 5-year average
		Adverse Childhood Experience Score (4+ ACES)	Child Abuse and Neglect Adult SUD treatment need Adult MI treatment need Homelessness Domestic Violence offenses	**Universal** - General population in Washington			Reduce the number of Adult SUD treatment need from X% in 2021 to Y% in 2023 (ICDB) Adult MI treatment need from X% in 2021 to Y% in 2023 (ICDB) Homelessness from X% in 2021 to Y% in 2023 (OSPI) Domestic Violence offenses	Reduce the number of youth (Grades 8, & 10) reporting 4+ ACES from X% in 2021 to Y% in 2027
Measures and	CORE & HYS	HYS, CORE, & ICDB	HYS, CORE, ICDB, & OSPI	Census Data	CSAP Strategies	Meeting minutes	HYS, CORE, ICDB, & OSPI	HYS, CORE, & ICDB

Community: *State of Washington* | **Funding Source:** State MHPP

Priority: Mental Health Promotion & Suicide Prevention

	Consequence	Problem	Factors	Focus Population Universal | Selective | Indicated	Possible Strategies	Community Engagement Process	Short	Long
	Academic Performance: Skipping School Smarter Balance results On-time graduation rates	Self Report symptoms of Depression	Depressive feelings	*Define the focus population of the interventions here* **Universal** - General population in Washington **Selective** - Youth and Young adults identifying as LGBTQ in Washington **Selective** - Young Adults in Washington **Selective** - Youth in Grades 8-10 in WA	**Information Dissemination:** Community Awareness raising activities Youth Mental Health First Aid Training Campaigns **Education:** EBP programs form the WA MHP EBP list **Alternative Activities:** After school programs and high risk hours programming **Problem Identification and Referral:** screening programs **Community-Based Process:** Assessment, Planning, Capacity Building, Implementation, Evaluation, Sustainability, DEI **Environmental:** Policy, Social Norms efforts **Training** to support community needs **Innovative** programs for Suicide	*What Process was used to engage community?* None at the time of the development of this logic model.	*Measures from "Factors" column* Reduce the number of students (Grades 8 & 10 combined) reporting depressive symptoms as reported on the WA HYS from % in 2021 to Y% in 2023	*Measures from "Problem"c* Reduce the number of stu (Grades 8 & 10 combin reporting depressive sympt reported on the WA HYS fr in 2021 to Y% in 2027
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Logic	Criminal Justice Involvement: Youth total arrests	Suicide Attempts as measured by the Community Outcomes Risk Evaluation (CORE)	Self-report: Suicidal Thoughts Suicide Plan Suicide attempts	**Universal** - General population in Washington			Reduce the number of students (Grades 8 & 10) reporting Suicidal Thoughts, Suicide Plans, and Suicide Attempts from X%, X% and X% in 2021 to Y%, Y%, and Y% in 2023 respectively	Reduce Suicide Attempts fr in 2021 to Y% in 2027 measured by CORE.
		Mental Illness Treatment as measured by the	Youth Mental Health Treatment	**Universal** - General population in Washington			Reduce the number of Washington youth (12-18) in need	Reduce the number o Washington youth (12-18) i

This logic model is based on current measures we already have.

Now the team is also working to develop a theory of change to see what in the research would be an ideal logic model, if we could get all the data pieces really needed? And the team is interested in inviting others to join a workgroup to help develop this more comprehensive model.

Jaymie Vandagriff: To provide context on the mental health evidence-based program list mentioned, here's a link to the current one - process for developing and rating programs is described on page 2. The analyses described in the footnote were analyses on HYS data conducted by WSU partners in a prior contract: https://theathenaforum.org/sites/default/files/public/mhpp_list_september_2023_-_final.pdf

Questions and comments

- Michael McDonnell in chat: For suicide I think you would want to assess belongingness, or thwarted belongingness, as an immediate risk factor in the logic model. From the treatment world, this is most familiar variable. Connection, caring contacts are variables that will prevent acting on suicidal thoughts. Caring Contacts is a preventive intervention that can be done in school.
  - Billy Reamer – these are exactly the types of things we're looking for, how are these measured at the population level, are there variables we can add to surveys, or are they difficult enough to measure and just ensure they are included in the strategies we're defining.
  - Kody Russell: I hope you are connected to the DOH team supporting Essentials for Childhood; we are working with WSU to develop some potential "community resiliency" questions... reciprocity, social bridging, collective efficacy, seeking/offering concrete support & help, collective hope...
  - Brittany Cooper: This aligns more closely with the goal of developing a theory of change logic model.

- Kevin Haggerty shared data from the Karl Hill's work with data from the Seattle Social Development Project (SSDP) showing long term outcomes (at age 39 he thinks) on major depression, anxiety, social phobia, suicide ideation/attempts/completion. Showed mediators to these outcomes (see slide). These are types of measures we already have in the HYS, e.g., general positive family functioning, positive family and school environment, bonding to family, bonding to school, that partially mediate the poor mental health outcomes. We already collect these data in HYS. We can think about how we use that data to help create more positive environments in schools and families.
  - Also, the researcher looked at the prevention paradox where the riskiest populations were not the ones with the highest suicide attempts, which argues for primary prevention/upstream and mental health promotion (e.g., the Good Behavior Game). In our work we know we have to continue to do this work upstream, and what we're seeing here so far is once we are already seeing the problems developing.
  - Kevin will send the presentation (and publication that goes with it – Karl is working on this) to Sonja Pipek/PRSC group. This was a presentation at SPR.

- Jaymie Vandagriff noted that the risk and protective factors are included in risk index; as well as ACES, the Hope scale.
  - Margaret Kuklinski suggests we share the CTC table showing the links between RPF and 6 behavioral outcomes. Protective factors include bonding/connectedness.

- Billy Reamer shared their current EBP list for mental health promotion. In order to address SUD, we have to look at mental health.
  https://theathenaforum.org/sites/default/files/public/mhpp_list_september_2023_-_final.pdf
  - Is this list on point? Do we need to be more focused, less focused etc.

Michael McDonnell – professor at WSU, treatment researcher, co-lead the Treatment Research Workgroup with Caleb Banta-Green. Couple of things big picture. Asking you to get even bigger in your thinking. On the treatment side we need your help! We have discussion in our treatment work about kids needing treatment – methamphetamine treatment. Also talking about overdose deaths. I'm also a co-occurring disorder researcher. All I've seen in last 20 years, esp. in the adult world is a continual separation of mental health and SUD treatment. We need a new understanding that social determinants of health are likely driving these issues. Invite you all to continue to engage the treatment community in this work. Continue to reach out to your treatment colleagues to include them. We treatment people do understand the importance of getting upstream – it's important that the treatment community understand this! Help the treatment folx get educated and on board with this model. Help to integrate these efforts from funder and policy perspective at the state all the way down to community level.

- Sarah Walker also hear more from the treatment side. Agrees with Michael's 'short list of requests.'
- Jennifer Wyatt: to Michael's point, and interested in how the continuum of care works to help young people prevent, treat, and recover from mental health and substance use disorders.

- Michael McDonnell: at the treatment side we are doing some great innovative things, we are responding to the emergency, we realize that people are struggling right now and much of the funding and attention is on this emergency response. AND we can't just keep responding to the emergencies. We have to do something different.
    - Billy Reamer: we are trying to stem the flow into the treatment system, so the treatment community can have the bandwidth and continue to provide that fabulous care.

Billy Reamer: In response to Kody's question about programs -- program is one of three legs to the intervention stool: grantees must do community awareness raising each year; must do direct service and some form of mental health training e.g. mental health first aid to train people for how to recognize/respond to crisis and normalize/address stigma. Have seen some fun/creative ways that communities have addressed these requirements.

- Sarah Walker: her previous call was leg subcommittee call re expanding the mental health workforce. My question is about the practical implications of the mental health index for shifting the programmatic approach? It's about how DBHR prioritizes how they use their funds/package a support, yes?
    - Sarah Mariani: programmatically we already have been doing this; this is a refinement and a step forward for a more total look at risk indices. Have been using a simpler version of a risk index and now working to expand/make it more complete. The switch is that mental health promotion is the underpinning for the index rather than SUD. Hoping this will add more depth to the risk index.
    - Sonja:

Michael McDonnel: My only real question for you all, is are you overlaying these data with OD deaths, suicide deaths, treatment utilization, and treatment access? I know the treatment team is doing some interesting work around location

- From Grace Hong: Hi Michael, yes, suicide attempts (both self-reported and from administrative data) and treatment utilization are included in the MH index.

Kevin Haggerty shared in chat: Skagit County has been using the six vital conditions for their big planning---at the very center is belonging and civic muscle.... they are choosing this framework rather than Social Determinants as they see these as more concrete and actionable.
https://health.gov/our-work/national-health-initiatives/equitable-long-term-recovery-and-resilience/framework

- Kody Russell: Thanks for sharing the Thanks for sharing the framework Kevin; I believe that model grew out of some work from the Rippel Foundation and they built a really cool "Thriving Together Theater" system thinking game; https://rethinkhealth.org/thriving-together-theater/

Brittany Cooper: Part of the challenge, I assume, is that there are some funds that must target specific outcomes (SUD vs. mental health), right? So, even if you want to be holistic sometimes funding restrictions don't allow that in terms of programming?

Sarah Walker: It's a really strong model in my opinion - as part of the evaluation plan, you might clearly state how flexible your group is willing to be re: existing on the ground approaches (per Kody's comment) - and specify how inclusive a 'performance improvement' approach will be (e.g. residents, advocates, schools, other allied/relevant systems)

Jaymie Vandagriff: Thank you for the frameworks, Kevin and Kody, and yes, Brittany, that is a current factor :)
Michael McDonell: Just wanted to put this out there around suicide prevention. One challenge we have is that QPR, ASSIST etc. are great at increasing awareness and knowledge but to my awareness are not associated with reductions in suicidal behavior. Utilizing downstream approaches like the program Kevin described and specific feasible interventions to directly treat suicidal ideation (like caring contacts) would be something to consider, so addressing the downstream risks, universal screening, and specific treatment options for youth with suicidal thinking would be one strategy to consider.

Sarah Walker: one of the issues we deal with is that services are fragmented. Doing capacity building varies across departments/areas of state. She is advocating for collaborative efforts across state departments. Aware of city of Seattle initiative trying to do collaborative planning across departments. Ecology, walkability, etc. all impact well-being and mental health …. really hard to do this work trying to address this silo by silo. Impressed you are so thoughtful about it.

Sonja Pipek: you really hit the nail on the head. We need more voices to share this idea of the need for integration. One of the things we need to show is impact of what we're currently doing to request more funding and demonstrate it can't be siloed.

Sonja Pipek discussed next steps for this effort
The DBHR team is looking to shift risk index; did this on most recent round of grants provided. Do a RFA process for community based organizations. Work with coalitions as well as CBOs. Worked with RDA to develop the risk index; worked with WSU to develop the program/strategy list. Now stepping back to look more wholistically.

Hope to get feedback and insight from others to help develop the logic model.

Project Process to date:
History:
Beginning in 2019, as the result of a Decision Package request HCA/DBHR received funds for mental health promotion and suicide prevention. This state funding provided for $800,000 for community grants, public education and training and program support focused on mental health promotion and suicide prevention. With these funds we offer community-based organization (CBO) grants in the amount of $564,000 each year. For the initial rounds of grants a program list was identified and this process was again updated and refined through further exploration of mental health promotion and suicide prevention research of contributing factors and program evaluations in partnership with WSU the following biennium. Communities with high need were identified through a review of our Substance Use Risk Ranking, with a specific focus on elevating Mental Health indicators that were a part of the SU Risk Ranking. This high need community identification process was further explored in partnership with RDA/CORE group. RDA/CORE helped develop our first Mental Health Risk Index through a literature review beginning in 2022, with input from HCA/DBHR and work completed in partnership with WSU to formulate the mental health promotion and suicide prevention evidence-based program list. Both this evidenced-based program list and the Mental Health Risks Index were finalized in early 2023 and utilized in the most recent round of CBO grant funding. To take this work to the next level, we are forming a plan to integrate Mental Health Promotion and Suicide Prevention into DBHR/HCA's substance use prevention work. This will begin with identifying a Mental Health specific theory of change, drafting of a Mental Health Promotion and Suicide Prevention logic model to guide this work, and development of an evaluation plan. Follow-up work will continue in the future to scope a comprehensive and integrated plan for mental health promotion and substance use prevention.

The Ask:
A series of meetings has been identified below. This series of meeting is open to PRSC workgroup members and will include HCA/DBHR staff who focus on data, research, and evaluation, plus prevention leadership and subject matter experts currently on our team. We could utilize support from partners external to HCA/DBHR that are interested in joining us at this meeting series to help us achieve the outlined goals. Feel free to share this with additional colleagues that may be interested in supporting us in these efforts.

Mental Health Logic Model & Evaluation Planning

1. *November 7th, 2023 10:30am-12:00pm*
2. *November 13th, 2023 1pm – 2:00pm*
3. *December 7th, 2023 11am- 12:00pm*

* These meetings will build on one another, so attendance at all would be ideal to benefit the process. However, we welcome your attendance at those that fit your schedule.

Goals:

1. Identify a theory of change to guide Mental Health Promotion and Suicide Prevention work.
2. Finalize Logic Model for Mental Health Promotion and Suicide Prevention efforts.
3. Identify an Evaluation Plan.

Contact:

Interested in engaging in this work, or learning more please connect with Billy Reamer: billy.reamer@hca.wa.gov

*Those that expressed interest at the meeting are already on a list to receive communication and meeting invitations.

Here are the people who volunteered:

1. Jason Kilmer: jkilmer@uw.edu
2. Heather Terral - heather.terral@wsu.edu
3. Jordan Newburg: Jordan.Newburg@wsu.edu
4. Brittany Cooper: Brittany.cooper@wsu.edu
5. Kevin Haggerty: haggerty@uw.edu
6. Sarah walker secwalkr@uw.edu
7. Eleanor Dizon: eleanor.dizon@wsu.edu
8. Gitanjali Shrestha: gshrestha@wsu.edu
9. Harrison Fontaine: Harrison.fontaine@hca.wa.gov
10. Kody Russell: kodyr@ballmergroup.com, depending upon time commitment. :-)
11. Houghten@wsu.edu
12. Grace Hong: ge.hong@dshs.wa.gov
13. Sarah Okey: Sarah.Okey@lcb.wa.gov

Brittany Cooper: FYI: Northwest PTTC is hosting a session on logic models in case folks from HCA are interested in attending to think more about how logic models can help inform planning. https://pttcnetwork.org/centers/northwest-pttc/event/strategic-tools-using-logic-models-organizational-planning-and

Kevin: PTTC this summer did a 2-day community leader meeting in Skagit County to bring all the cities together to address systemically how to create thriving communities. To systemically address how to address stigma and break down silos. Brought mental health, prevention and treatment groups together because those are the groups with TTCs. But there are so much silo-ization! One of his take aways: the idea that mental health is not preventable. There was a real sense in the room, like where we were 30 years ago in the substance use field.

Jordan Newberg: The idea that mental health isn't preventable--I think there has to be acknowledgement that a lot of behavioral and mental struggles are also reasonable reactions to the environment and there's only so much "coping" that an individual can do. But those coping skills also become just ways to survive and continue in the current context, not changing it. Just noting that and reiterating I appreciate this holistic view this group has!

Michael: could we pilot this with one community?

Sarah W: people like ownership

Sarah Mariani: In terms of interagency collaboration in prevention/promotion world, there is the state policy consortium getting ready to release their state plan. Attempts to do what Sarah Walker is talking about. This group focuses on where we can collaborate within the confines of funding streams & legislative directives.

Have been doing this for number of years with DOH how do we stop duplicating/redundancy? How do we build collaboratively and add to …? e.g. DOH is using the SUD risk index to help identify higher need communities. Their money has some different requirements than our money which can provide more flexibility …

Apart from the full continuum, as the Children's Behavioral Health Workgroup is developing their plan, we are in touch to work together with them to start to thread some of those needles. Even as funding sources coming from the Fed are becoming more discrete rather than less discrete.

- Our work around is collaborating to get to a model where a community can use different funding sources to address different parts of the issues
- Noting that we have a grand total of $546K to hand out to communities. This is state funding; don't have any federal funding that helps us to do this health promotion/suicide prevention. Part of this work is to demonstrate impact so can go back and obtain more funding.

Sarah Walker: just an FYI to this group - there is a proposal to fund "cultural wellness experts" out of Medicaid that would deliver services that could fit in the prevention bucket - but would be adjunct to Tx services in the clinical team space. State effort - and the policy proposal asks the state to do an analysis of how it should fit in their CMS state plan amendment.

Billy: trying to get to the place with a local effort can create a comprehensive prevention plan across all these areas. Include issues in the plan even though not addressed by our siloed funding stream, but they can then find funding for other services/strategies with other funding streams. Doing everything we can to make that path easier.

- Now that we have the HOPE scale, encourage communities to cross-tab their Hope scales with their depression/anxiety info and show how they can move back into place of wellness. Even the vast number of people who think of suicide or develop a plan don't actually carry it out … and find a way to move back to a place of wellness. We know how to do this work, just need to keep providing the supports to communities

Sarah Walker: a question for this group. Yes on prevention and everything. Also have needs across the continuum. It's fragmented – at local level and state level. We need cross-system 'stitchers'. Do you ever see CPWIs moving to work across the entire continuum? And to act more as collective impact advocates to integrate the continuum – within the region. See the benefit – your community-driven. You can draw a boundary around a region and can hold the space.

- Kevin comment: people are trying to do this to include mental health and SUD treatment provider as part of the coalitions. As they move more into planning/implementing for prevention, it's can be hard to keep them all at the table in an ongoing way.
- Billy: it depends on the community, structure, readiness. The model allows them to do things like this. Monroe, Grant County have done the work to solidify this approach. Others have started down the path but chosen to stay connected AND keep focus on prevention.

Heather Terral: The potential to fund cultural wellness experts sounds so promising

Kody Russell: FYI - robust Hope Science efforts being led through Administrative Office of the Courts - https://www.wacita.org/hope/. OSPI and DCYF are working on implementing and learning from science of hope.

Brittany Cooper: Thanks, Kody. That is really exciting work. Maybe we can ask OSPI and DCYF to present to our group about that.

Kody Russell: Kelly Warner-King at AOC would probably be the best person to ask and I would be happy to make the connection.

Margaret Kuklinski: hard to maintain prevention funding so need to advocate for keeping those streams working and not getting diverted to treatment.

Billy: an example is the mental health block grant funding that has been removed from prevention/promotion to treatment needs

Britany: Another example of that is the recent emphasis on harm reduction and how prevention can get lost in the discussion

Kody Russell: Sarah and team, are you open to including people who are outside this group; like Astrid Newell at DOH? I love "volun-telling". The Essentials for Childhood group has been talking about this for the last 1+ year and would love to learn alongside you all!

Steve Ziegler: Apologize for being a naïve idealist: Sarah Walker's comment about silos was well made -- curious if a big picture existed across state agencies -- to see where the overlap was in terms of work and ability to contribute. the best models are integrated models!

Kody Russell will talk with some legislators who are deeply interested in prevention and will connect them with the DBHR team

Discussion about PRSC Membership

Brittany: what are we doing well, how could we do better? This discussion was a good example of why we come together …

Idea: what we do is a collaborative dance. Trying to bring together the key people in WA state who are doing prevention work (see slide). (Linda Becker and Rico Catalano were co-chairs originally)

See slide on details of structure and mission

Brittany shared list of topics/themes this group has covered since Sept 2020.

Asking for input on topics

- Jordan: weaving trauma-informed care with some of these topics could be helpful
- How to leverage the science of hope?
- Jason: annual review of the young adult health survey, happy to provide
- Young adults SUD prevention & mental health promotion
- Jennifer Wyatt: hope plays a role in stigma and people's willingness to seek services; convey to practitioners why hope is so important in a way they will really understand.

Sarah M: have some $$ to look at Spanish speaking prevention services. Curious which programs have high quality adaptations, which programs are planning to do that for Spanish speaking families. What do we know about what's out there that we could support? KH: PTTC just did a Spanish speaking SDS series for only Spanish speakers; connect w Nicole

Kody: I'd encourage you to reach out to Walla Walla, Community Resilience Initiative - they have done a lot of great work with Spanish speaking farmers.

Brittany: showed slide with 5 objectives. Invited folx to annotate to show if they think we're meeting the objectives. Informal survey…

Are we achieving our objectives?

PRSC Objectives	★ = Yes, √ = Sort of, X = No
1. Supporting DBHR's evaluation of prevention services.	★ ✓ ✓ ✓
2. Assisting DBHR in (a) defining the criteria for determining that a service is evidence-based; and (b) establishing a protocol for review and acceptance to a list of evidence-based services.	★ ★ ★ ✓ ★ ★
3. Advocating for state funding of evidence-based and other effective prevention services.	★ ★ ✓ ★ ★ ✓ ✓
4. Establishing collaborations to initiate new research and share existing research on substance use disorder prevention and mental health promotion in order to improve DBHR's prevention services.	✓ ★ ★ ✓ ★ ★ ★ ?
5. Promoting implementation science through the collaborative knowledge exchange of prevention researchers, DBHR, and other prevention-related state agencies and community organizations.	★ ★ ★ ★ ★ ★ ★ ✓ ★ ★

Question: do these objectives still represent what we're trying to do with these meetings?

Sarah M: yes, this meeting is a great example; also, research briefs. Will call out: we have continued to expand using this group and research backing for more than just evaluation. Also supports all these other pieces

Sarah M: something NOT on here: during the intro Margaret, Harrison talking about a project working on with Margaret and looking to get some funding from NIDA. So, the idea of efforts that unfold from the meeting which lead to more work. So, we continue to have this engagement, even though some of the people coming change, but an indirect objective of 'what else do we all need to work on"? Letters of support, etc. How much resource has been brought into the state based on these discussions and this group? What's the annual ROI for research grants that support the work in this state (and nationally) based on this group getting together a few times/year.

Brittany: This point is seen in #4. It is unique, hear from other NPNs around the country and also our prevention research colleagues. What's cool: it's a simple model. We come together for presentations/discussions. And that sometimes leads to spin offs for other work because we have gotten to know each other.

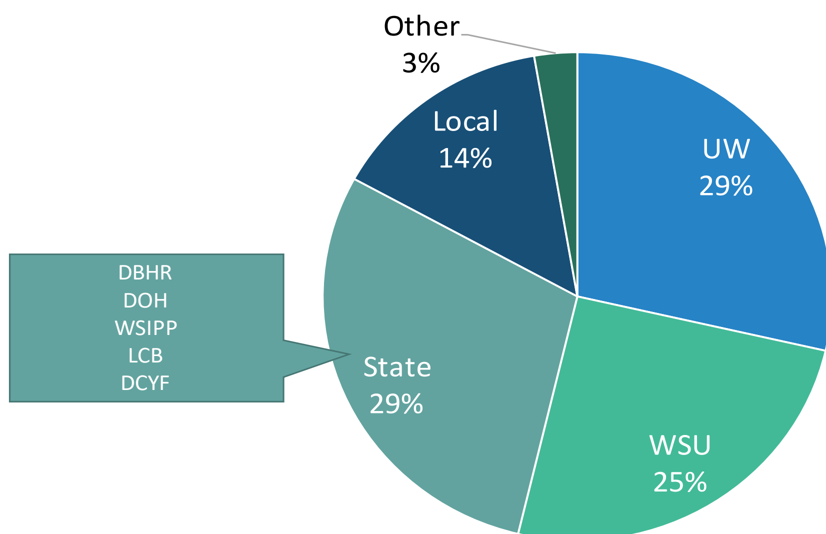
Mary Segawa: One thing that is not on here is the impact on prevention-related policy work.

Jason: started attending about 12 years ago. Most ever had in attendance live, in person was 12-15. Virtual provides an opportunity for more people to attend. (then led a round of happy birthday for one member ….)

Brittany pie chart on membership (see slide)

- Have seen increase in attendance during COVID
- Have about 30 people on average who attend
- What ideas does the group have about sectors we should see here, individuals we should invite, etc.?

Currently, there are **<u>147</u>** individuals on the PRSC email list. **About 20% attend regularly.**



Liz Wilhelm: I would suggest we continue to ask Seattle Children's researchers be invited. They might not see themselves in the UW category

Kevin Haggerty: the subcommittee part of this group is that this group is a subcommittee of the treatment group. Maybe we should be going back to that group? Is there anyone from this group that attends the committee that we are a subcommittee of? Sarah Walker maybe. Sarah Mariani says they do not attend the treatment meetings unless there is something specific they go for. In fact, we're not really a subcommittee anymore. We are an established committee. PRSC had been more active than the treatment group.

Brittany: Maybe we should do a PRSC/Tx exchange once a year -- where we get an update/present at each other's committees

Jennifer Wyatt attends those TRSC meetings, schedule permitting. Most important thing we can do is to stop seeing a separation. Invest in the continuum and collaboration between

How can we improve? Is the length too long? How address the drop off after lunch?

Any feedback – drop on chat or email Brittany (only 20 present after lunch)

- Jennifer – vote to condense, don't do the lunch break (was this a left over from the in person model?) Also likes the space for networking
- KH – we could give a couple of breaks instead …
- Eleanor – one thing about in person meetings is the ability to keep talking during lunch; could we open up the lunch time for that kind of interaction?

Research Briefs: topics for coming year?

This is an example of a spin off from this meeting. HCA and DBHR have been identifying topics legislators may need more info on. DBHR found some funds. This is a truly collaborative process involving many in this group plus some outside of PRSC.

Last year's research briefs are out in public and were just approved; new format that is a denser read than more open read we had submitted.
https://theathenaforum.org/prevention-101/research-briefs

Last Year's Research Briefs

- Keeping ALL Washington youth healthy: strategies for addressing disparities in local communities discusses strategies to reduce youth exposure to environments where substances are being sold, used, and promoted.
- Investing in behavioral health promotion programs protects youth discusses strategies proven to reduce the behavioral health challenges many Washington State youth face.
- Cannabis market regulation and public health and safety discusses good regulation practices for the cannabis market that support public health and safety.
- Balancing commerce and public health in disadvantaged communities discusses strategies to protect communities from potential harm of marketing and sales of health-compromising addictive products, such as alcohol, nicotine, and cannabis.
- Pricing of legal cannabis and taxation discusses how taxation can be an important tool in creating a balance between consumer needs and public health and safety.

Please use these! We should use these as localities work on policies etc.

Acknowledging authors: Maybe we could say "contributors include X, Y, and Z, among other collaborators across public health/px sectors" or something

- Action: Blair will get list of all authors to Sarah M

This summer, the PTTC and WSU focused on writing these briefs – will be available within the next month.

- Long term trends of youth substance use
- Social media, mental health and substance use
- What does and doesn't work in prevention – expanding on the DBHR document
- Developing community profiles for choosing prevention programs
- Program implementation

Ideas for next set of briefs

- Harm Reduction in Adolescence—Writing team established!
  - Jason Kilmer, Seema Clifasefi, grad student Chelsea Matthews, Jennifer Wyatt
  - A better understanding about how harm reduction can be provided for adolescents
- Strategic Prevention Communication--- across disciplines. PTTC work around stigma?
- The Power of Prevention – helpful to field and policy makers. Overlap between risk factors for fentanyl, commonality and need to address underlying risk factors with universal AND selective programming.
  - Brittany Cooper – treatment world is so burnt out and can only focus on what they have to. Maybe this could??
  - Sarah Mariani: Is prevention increase an answer to treatment workforce challenges?
  - Recovery is also an overlooked idea
  - Fentanyl/opioids is one place where this discussion comes up
  - Sarah Mariani: also think about other substances e.g. alcohol hazing laws. Non-lethal hospitalization for 18-24 year olds
  - Dearth of programming for 18-24 year olds, which is where we see the huge uptick in overdose deaths.
  - Sarah Mariani: the mantra about saving lives has gained a lot of traction, naloxone, etc. We have tried to share that prevention also saves lives and also saves some suffering and harm along the way. We can look at these early indicators, head them off and not only save their lives but also change the trajectory
    - Lifesaving prevention is more than overdose prevention
    - Saving lives is a message attached to many things
    - How increasing Px services could be an answer to Tx workforce burnout.
    - Jennifer Wyatt: Lots of people working together as opposed to depending solely on Tx

Jordan: There was an NPN panel on "making prevention obvious." Here's the website related to the panel I mentioned, Carlton Hall was the speaker. http://carltonhallconsulting.com/prevention-mastery.html

- Social media – youth and mental health
- Building a community profile, e.g. using local RPF data
- Program implementation – or maybe program adaptation

- Jason: What it means to do this with fidelity would have real world utility
- Jaymie – yes and then a follow up on adaptation
- Sarah M – as the workforce has changed fidelity feels like a new topic. At NPN last month. Implementation Science realm. How to speed up lag between research and practice? How to help practice world know about how to get broader use of EBPs and also how do we keep them relevant? WSU team/UW team specifically looking at parenting. How to get around the amount of time it takes to get published vs. micro-analyses and lit reviews.
- KH: this would be more a brief to practitioners. Would love to engage in program adaptation

Clarity on two:

1. Program adaptation
2. Shared RPF, Fentanyl and Saving Lives

Less clear: Strategic Communication needs to be more fully 'baked'

Sarah M: social media, media and youth – an emerging piece

- Another emerging topic around eating disorder prevention – may be too far a reach for this round. And interplay with SUD, Mental Health. Sonja: eating disorder does interrelate with social media and youth mental health
- Brief WSU is doing for PTTC will include some of this
- Parental role
- Sarah M: the Ugly Truth. Algorithms play a large role in social media consumption
- KH: website: children and screens

Brittany Cooper: Eating disorder prevention (and intersection with MH/SUD) as possible topic for future meeting?

Clara Hill is happy to help edit!

Interested in program adaptation:

- Brittany Cooper
- Jaymie Vandagriff

Interested in shared RPF:

- Kevin Haggerty
- Harrison Fontaine
- Rebecca Ruiz