2023-2027

Washington State
Substance Use Disorder Prevention
and Mental Health Promotion

Five-Year Strategic Plan

Prepared by the Washington State Prevention Enhancement (SPE) Policy Consortium

Washington State Health Care Authority

Washington State Department of HEALTH

HCA 82-0123 (08/23)

Acknowledgements

The Washington State Prevention Enhancement (SPE) Policy Consortium have joined efforts to present the Substance Use Disorder (SUD) Prevention and Mental Health Promotion (MHP) Five-Year Strategic Plan (2023–2027). The SPE Policy Consortium membership partners are committed to providing equitable, accessible, and comprehensive behavioral health prevention and promotion services to the youth, individuals, families, and communities of our state. This Strategic Plan helps inform our efforts through a focused, data-driven framework that ensures we are looking at policy and program decisions for behavioral health with an equity lens.

After conducting a thorough needs and resources assessment and gap analysis, the SPE Policy Consortium updated this 2023–2027 Strategic Plan to include targets, goals, and outcomes in SUD and Mental Health (MH) indicators. Through implementation of this plan, we continue to build the health and wellness of individuals, families, schools, and communities where people can be as healthy as possible in a safe and nurturing environment.

We would like to give special thanks to all the partnering state and tribal agencies and organizations and to those individuals who participate as representatives serving on the SPE Policy Consortium. A complete list of representatives can be found in Appendix - SPE Policy Consortium Partner List. Over the years, many people contributed to the three previously published Strategic Plans, and we thank every one of you for collaboratively enhancing and expanding the Washington State prevention and promotion system.

For the past decade, the SPE Policy Consortium has been co-led and supported by the Washington State Health Care Authority and the Washington State Department of Health, in partnership with all of our Consortium partners, members, and workgroup participants. We appreciate the continued support of the state's prevention and health promotion efforts to move our field forward to meet the needs in the future of behavioral health services.

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

Sincerely,

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Contents

Executive summary

The Washington State Prevention Enhancement (SPE) Policy Consortium (hereafter referred to as the SPE Policy Consortium) was originally formed in 2011 is comprised of representatives from over 20 state agencies, organizations, and tribal partners working on statewide efforts to prevent substance use disorder (SUD) and promote mental health. Included within the SPE Policy Consortium are six workgroups:

- Mental Health and Suicide Prevention Workgroup
- Opioid Prevention Workgroup
- Problem Gambling Prevention Workgroup
- Washington Breathes: Commercial Tobacco and Vapor Products Workgroup
- Washington Healthy Youth (WHY) Coalition: Underage Drinking & Youth Cannabis Prevention
- Young Adults Cannabis & Alcohol Prevention Workgroup

Our mission, vision, and key values

Mission: The SPE Policy Consortium, through partnerships and collaboration, will strengthen and support an integrated, statewide system of community-driven SUD prevention, behavioral and mental health promotion, and related themes.

Vision: A state where all individuals, families, youth, and communities can be as healthy as possible in a safe and nurturing environment.

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

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

Our goals and strategic process

The SPE Policy Consortium is guided by a comprehensive strategic plan to guide this work at the state level. This current 2023–2027 Five-Year Strategic Plan outlines the programmatic and policy goals for the State of Washington that contribute to improving the well-being of individuals, families, youth, schools, and communities.

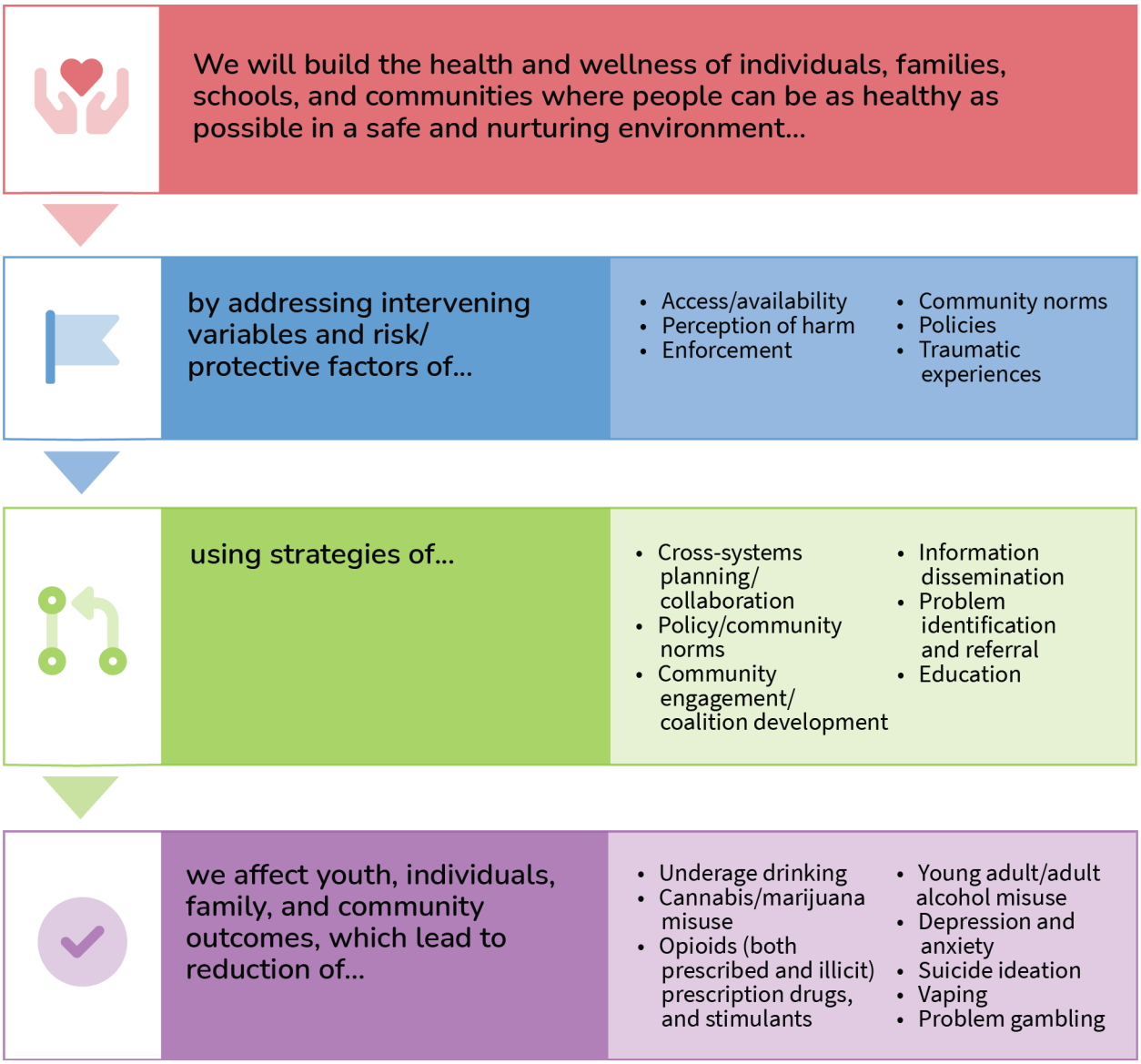
The **key elements** of our work are:

- **Overall intended impact:** Identify how to reduce harm and save lives of all community members.
- **Intervening variables:** Identify the risks that can cause harm to people, and identify protections and resources that keep people safe and healthy. Example: age restrictions for alcohol and commercial tobacco sales.
- **Strategies:** Identify and use strategies that increase those protections and reduce risk and harms. Example: increase age limit for commercial tobacco sales.

The diagram below 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.

Summary of key elements

In summary



Priority areas of focus

Focusing on a data driven process, the SPE Policy Consortium completed a needs assessment that identified the following priority areas:

- Cannabis/marijuana misuse
- Commercial tobacco misuse
- Depression and anxiety
- Opioids, both prescribed and illicit, other prescription drugs, and stimulants.
- Problem gambling
- Suicide ideation
- Underage drinking
- Vaping
- Young Adult/Adult – Alcohol misuse

This Five-Year Strategic 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.

We have made progress in many areas since the inception of the SPE Policy Consortium in 2011 and look forward to furthering implementation and collaboration to sustain the state's SUD prevention and mental health promotion efforts, with both policy and practice. The SPE Policy Consortium works to build strong collaborative relationships within communities and promote the use of evidence-based prevention and wellness services, as well as culturally-attuned programs for Tribes and other priority populations. This is reflected in the needs prioritization data, strategic plan framework, and accomplishments section.

The SPE Policy 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 state and community level strategic prevention planning and services. Below are the **five Strategic Objectives from the SPE Policy Consortium which are centered around health equity** and explained in greater detail in the Planning section:

- **Strategic Objective One**: Strengthen state collaboration to prevent initiation of substance use and promote mental health.
- **Strategic Objective Two**: Utilizing needs assessment data in Washington State, create and disseminate communication plans, campaigns, trainings, and resources to better serve populations in need.
- **Strategic Objective Three:** Implement environmental strategies to: reduce access and availability of substances; change community and social norms of substance use; and reduce stigma in accessing behavioral health services.
- **Strategic Objective Four**: Commit and dedicate efforts to implementing SUD prevention and mental health promotion programs to strengthen protective factors and reduce risk factors.
- **Strategic Objective Five**: Strengthen the long-term sustainability of the behavioral health promotion and SUD prevention workforce.

Chapter 1: The Purpose of the SPE Policy Consortium

Prevention and wellness key principles

Prevention frameworks

According to the Preventing Mental, Emotional and Behavioral Disorders Among Young People Report[1] (also known as the Institute of Medicine [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 SPE Policy Consortium acknowledges the importance of supporting effective prevention and health promotion strategies to improve the lives of young people, their families, and communities. Addressing risk and protective factors 'upstream' reduces the costs of treatment services and other socioeconomic devastation. Prevention and promotion programs that are supported by best practices can keep young people healthy and away from choices that lead to harms.

The prevention field relies heavily on research and frameworks to inform our work to effectively create positive outcomes in building healthy families and communities. These frameworks include following the Strategic Prevention Framework for strategic planning; the Risk and Protective Factor scales to understand the needs of the community; applying the Adverse Childhood Experiences (ACEs) and Positive Childhood Experiences (PCEs) models to build our knowledge of risk and protection and inform policy and systems work; the Social Development Strategy model (SDS); the White Bison Wellbriety Movement for Tribes; and health equity frameworks to implement culturally and linguistically appropriate and adaptive programs for communties and Tribes. In Washington, we also follow the national guidance that encourages use of evidence-based practices, recognizing the value of supporting efforts and programs that include adaptations and innovations that meet culturally relevant needs.

Did you know?

Tobacco: Any reference to 'tobacco' refers to commercial tobacco, not the sacred and traditional use of tobacco by some indigenous communities.

Cannabis: Recently, the Washington State Legislature passed a bill[2] with the intent of replacing the use of the word "marijuana" with the word "cannabis." This change was motivated by the desire to move away from negative connotations and historical biases associated with the word "marijuana." Using the word "cannabis" (considered more neutral and scientifically accurate) is more inclusive and respectful, as the term is associated with the cultural and medicinal importance of the plant. We will primarily use the word "cannabis" throughout this document, though "marijuana" may still be used in certain contexts.

[1] Preventing Mental, Emotional and Behavioral Disorders Among Young People Report nap.nationalacademies.org/12480

[2] RCW 69.50.710 app.leg.wa.gov/RCW/default.aspx?cite=69.50.710

Key ideas and principles

The SPE Policy Consortium plays a leading role in preventing the harms and consequences of substance use and mental health disorders. We value protecting public health and recognize that policies affect behaviors by focusing on these key ideas:

- **Protect youth:** We advocate for best practices policies to prevent and reduce youth substance use.
- **Build healthy community and family:** We support policies that advocate for efforts to build safe and healthy communities and families. We support prevention efforts that reduce the normalization of alcohol, commercial tobacco, and non-medical cannabis expansion and attitudes towards use in communities.
- **Balance economic growth and health cost:** We support balancing state economic growth while also recognizing the cost of health care associated with treatment of non-communicable diseases, behavioral health disorders and other negative health consequences of substance use.
- **Protect vulnerable populations:** We protect against intended and unintended substance use consequences and health disparities and support policies that promote standards for health promotion and health equity.

SPE Policy Consortium key principles

- **We work to prevent youth access to alcohol and other drugs**, which is imperative to their continued health and development. The adolescent brain is still growing, and underage substance use affects short-term educational and long-term life outcomes. Elements of this work includes preventing youthful marketing on media platforms, compliance enforcement efforts, and reducing access/availability.
- **We work to educate the broader community** about the importance of reducing access and availability of substances to prevent youth and young adult access, and steer clear of social norms that promote the use of substances.
- **We promote the inclusion and education of research in policymaking** as new trends are emerging and new impairing substances are introduced into the market, both legally and illegally, to better support our youth and families through prevention.
- **We implement programs that further the development of positive youth development** through an array of community and school-based programs that work to develop strong skills for wellbeing in youth and families, including evidence-based programs that increase life skills and resiliency in youth, programs that enhance skills to decrease suicide ideation, and programs for parents/caregivers to teach and model emotional wellness to their youth. We train and support communities to include healthy practices, norms, and policies, such as using public education and positive social marketing to promote refusal skills and reduce normalization of substance use or implementing mental health first aid training within educational and healthcare systems to screen for early signs of ideation. We recognize the importance of traditional healing and support the inclusion of alternative/traditional healings for consideration.

- **We support public policies that support public behavioral health and safety, including:**
    - Reduced/limited access for products, especially for youth.
    - Reduced/limited availability of products, especially for youth.
    - Limit density of purchase locations of products.
    - Reduced/limited product types, especially those that are appealing to youth.
    - Reduced/limited promotion, advertising, and clear labeling.
    - Regulating price of products.
    - Ensuring equity practices within legal markets.

Did you know?

The Prevention Research Subcommittee (PRSC) and the Washington Healthy Youth (WHY) coalition hemp-derived cannabinoids workgroup created a handful of research briefs on emerging substance use and mental health promotion topics. The briefs highlight the benefits and uses of prevention science and can be shared with statewide partners.

Check them out here: theathenaforum.org/prevention-101/research-briefs

Chapter 2: The SPE Policy Consortium Five-Year Strategic Plan

What guides our strategic planning work

The field of SUD prevention science has evolved quite significantly over the past 35 years and continues to progress as we consider the influence of current trends, including an evolving behavioral health field that recognizes and supports physical and mental health integration. 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. It is also important to recognize the traditional knowledge and culturally tailored promising practices that might be as or more effective for Tribal youth and prevention.

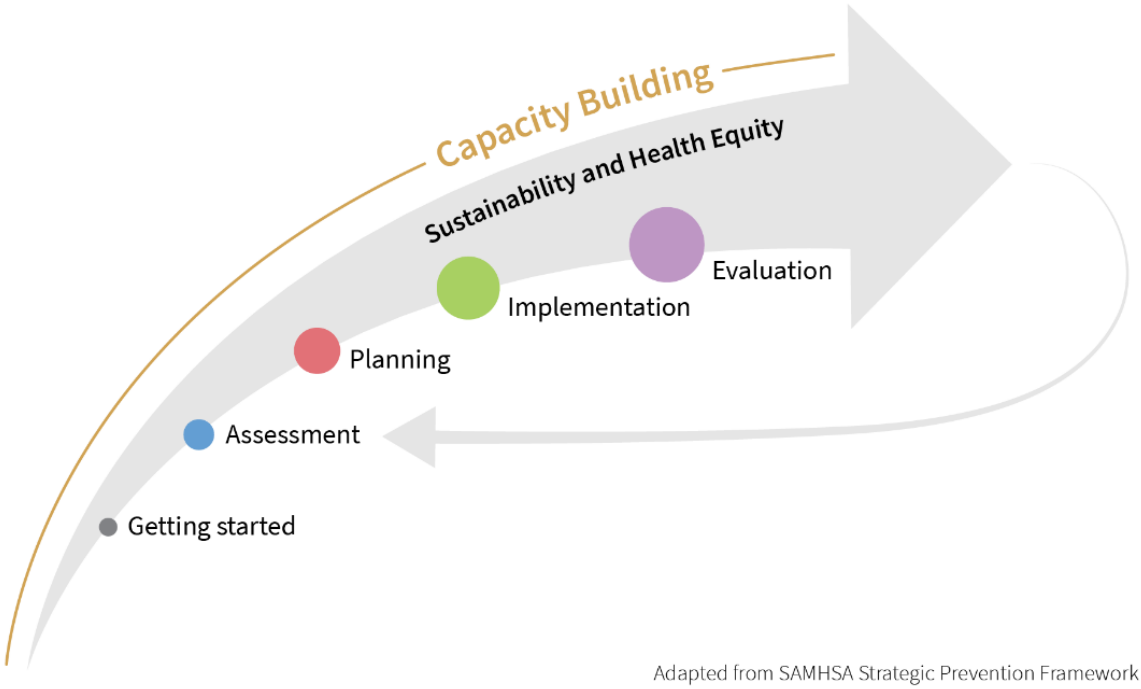
This is the purpose of the SAMHSA Strategic Prevention Framework (referred to as the SPF), which provides a comprehensive and consistent approach to consideration of substance misuse and related behavioral health problems (SAMHSA, 2019). The SPF was originally developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).[3] 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 SPE Policy Consortium has broad involvement and ownership in the process of writing and updating this strategic plan, leading to mutually agreed-upon goals and priorities. Every other year since 2011, we have conducted a data-informed assessment of needs and resources to support our selection of research-based programs, policies, practices, and strategies that build on existing state resources, and meets the goals of the SPE Policy Consortium. We use the SPF framework outlined on the next page in our coordinated strategic planning process.

[3] Substance Use Disorder Mental Health Services Administration (SAMHSA), 2011 - samhsa.gov/resource/ebp/strategic-prevention-framework Accessed July 2019.

This diagram is the Prevention Strategic Planning Framework, outlining the steps taken from assessment through evaluation.

Washington State Prevention Planning Framework



Adapted from SAMHSA Strategic Prevention Framework

The SPE Policy Consortium first begins with initiating the strategic planning cycle with its workgroups and members. We identify the capacity needs of the Consortium to mobilize and coordinate this work over a 1 to 2-year planning cycle. We then assess our state's needs, resources, readiness, and gaps. The SPE Policy Consortium works in collaboration with the State Epidemiological Outcomes Workgroup (SEOW) and state agency partners and organizations to review the SPE Policy Consortium theoretical frameworks, review relevant data, examine state-level resources, develop new and continued priorities, and develop the strategic plan. By understanding these contributing factors, the SPE Policy Consortium can be ready to develop the strategic plan, including goals, objectives, and priorities for the SPE Policy Consortium to implement and accomplish over the next five years. The practice of doing this work with a health equity and sustainability lens is implemented at all stages of the framework. Furthermore, in reviewing the results from reporting and evaluation, the cycle starts over to ensure we are assessing our work and revisiting each step of the framework to improve the overall prevention system.

SPE Policy Consortium Logic Model

The logic model was developed to provide an overview of the central elements of our Strategic Plan. For a full-page view, see Appendix - Logic Model page. This logic model overlays various logic model planning frameworks that are used by the SPE Policy Consortium partners. Furthermore, this logic model format is being used to promote strategic planning in local community coalitions through the Community Prevention and Wellness Initiative (CPWI).

SPE Policy Consortium State Plan Logic Model

Long-term Outcome Consequences 10-15 years	Problem Areas 5-10 years	Intervening Variables (Risk Protective Factors) 2-5 years	SPE Consortium Partners' Strategies	SPE Consortium Collaborative Strategies	Evaluation Plan
	Outcomes		Actions		
What is the problem?	**Why?**	**Why here?**	**What are we going to do?**	**How can we do it together?**	**So what? How will we know?**
These problems... • **Chronic disease** (ATOD Attributable Deaths - CHARS) • **Crime** (Alcohol/Drug –related arrests ages 10-25 - UCR) • **Low graduation rates** (HS On-time/Extended Graduation – OSPI) • **Suicide** (# of suicides/attempts ages 10-25 - CHARS) • **Fatalities and serious injury from vehicle crashes** (# Alcohol-Related Traffic Fatalities/ Injuries ages 16-25 - WTSC)	**These types of problem areas...** • **Underage drinking** (30-day use; problem use – HYS 10th grade) • **Cannabis/marijuana misuse** (30-day use – HYS 10th grade) • **Any opioid/ prescription drug misuse** (30-day use– HYS 10th grade) • **Commercial tobacco misuse** (30-day use – HYS 10th grade) • **Vaping** (30-day use- HYS 10th grade) • **Young adult/adult alcohol misuse** (Use during pregnancy – PRAMS, YAHS) • **Anxiety** (Within last 2 weeks- HYS 10th grade) • **Depression** (Sad/Hopeless in past 12 months – HYS 10th grade) • **Suicide ideation** (Suicide ideation – HYS) • **Problem gambling** (Past 12 months - HYS 10th grade)	**...specifically with these common factors...** • **Access** (Where get substance - HYS 10th grade) • **Availability** (Easy to get– HYS 10th grade) • **Perception of harm** (Risk of use– HYS 10th grade) • **Enforcement** (Get caught– HYS 10th grade) • **Community norms** (Laws/norms; harassment – HYS 10th grade; young adult use - NSDUH) • **Hope scale** (Agency and capacity - HYS 10th grade)	**...can be addressed through these strategies...** • **Cross-systems planning/ collaboration** 12 Agency/Orgs., 46 resources • **Policy/ community norms** 12 Agency/Orgs., 46 resources • **Education/ alternatives** 10 Agency/Orgs., 121 resources • **Community engagement/ coalition development** 8 Agency/Orgs., 34 resources • **Information dissemination** 10 Agency/Orgs., 43 resources • **Problem identification and referral** 5 Agency/Orgs., 17 resources	**...and working collaboratively on these strategies...** • **Cross-systems planning/ collaboration** SPE Policy Consortium Membership, SPE Policy Consortium Workgroups, inter and intra agency collaborative projects • **Information dissemination** Public media, education, and/or awareness campaigns focused on problem areas • **Policy/community norms** Policy review, advocacy and promotion focused on problem areas • **Education** Professional development related to problem areas and strategies	**...and we will track the key indicators listed for each of the outcomes (red, purple, blue columns) to measure our impact...** **Using state data sources:** (see appendix for list of acronyms) • HYS • CORE GIS (WTSC; PRAMS; LCB; CHARS) • BRFSS • NSDUH • YAHS **Using strategy specific process data:** • Agency service data • Provider service data

SPE Policy Consortium's Primary Strategies

Strategic Objective One

Strengthen state collaboration to prevent initiation of substance use and promote mental health.

1. Improve agency representation and diversity in voices in SPE Policy Consortium membership and workgroup membership.
2. Deepen the SPE Policy Consortium and workgroup members' understanding of the mission, vision, and membership requirements.
3. Develop equity ad-hoc workgroup for SPE Policy Consortium.
4. Engage SPE Policy Consortium partners during off-months in planning and policy discussions.
5. Explore and encourage opportunities for collaboration among SPE Policy Consortium members and workgroups.
6. Create an evaluation plan for all strategies listed within the Strategic Plan.

Strategic Objective Two

Utilizing needs assessment data in Washington State, create and disseminate communication plans, campaigns, trainings, and resources to better serve populations in need.

1. Collect and analyze qualitative and quantitative data on behavioral health needs and inequities to make data-driven, informed decisions on policy and programming.
2. Consider assessing cultural protective factors to understand strength-based approaches to overcome historical trauma.
3. Support the communication and dissemination of Health Youth Survey and Young Adult Survey results.
4. SPE workgroups address emergent issues through communication outlets, including online presence, and to various networks and stakeholders.
5. Disseminate public education, communication tools, and resources, ensuring best practices in prevention messaging and alignment with prevention goals.

Strategic Objective Three

Implement environmental strategies to reduce access and availability of substances; change community and social norms of substance use; and reduce stigma in accessing behavioral health services.

1. Review policies within state task forces, agencies, workgroups, and organizations regarding SUD, suicide prevention, and mental health support to analyze and understand what consequences this will have on the state of youth and other vulnerable populations in Washington State.
2. Work collaboratively with SPE Policy Consortium partners and agencies on submitting collective decision packages and agency request legislation and review federal legislation/rulemaking to promote and support public and behavioral health initiatives.
3. Utilize the SPE Policy Consortium as a vehicle to inform internal systems, outside networks, and partners about policies and needs.
4. Support public policy at the community and local levels to change risk and protective factors surrounding substance use and mental health needs.

Strategic Objective Four

Commit and dedicate efforts to implementing an ongoing cycle of SUD prevention and mental health promotion programs to strengthen protective factors and reduce risk factors.

1. Develop a shared definition of prevention, the continuum of care, evidence-based practices, and prevention services across the lifespan and for all populations, including youth, young adults, parents, and populations of focus, including Tribes.

2. Utilize data to guide and inform prevention and mental health promotion decision-making.
3. Through each SPE Policy Workgroup, provide valuable educational tools and resources for Tribal members, parents, guardians, coalitions, prevention partners, influential adults, and other community members.
4. Partner agencies to implement and evaluate upstream, primary prevention and mental health promotion services to prevent misuse and substances throughout the lifespan through evidence and research based, promising, and culturally attuned adaptations to programs.
5. Explore how the Problem Gambling Prevention program can be integrated with other behavioral health prevention work in the state.
6. Monitor emerging mental health and drug trends to deploy prevention and intervention resources quickly.

Strategic Objective Five

Strengthen the long-term sustainability of the behavioral health promotion and SUD prevention workforce.

1. Support, share, and advocate for training and credentialing to enhance the prevention and promotion workforce in Washington State across all levels of prevention positions: Tribal prevention providers; local, community, county, state prevention contractors and providers; community and school-based prevention/intervention employees; and interns and fellows.
2. Provide opportunities for SPE Policy Consortium to network and information share to allow for activation of providers engaging in prevention programs and strategies.
3. Share and support program efforts, data sharing, and evaluation tools to reduce duplication of efforts and services and increase capacity.
4. Assist with ideas for recruitment and retention of qualified and committed prevention and promotion staff at all levels, while promoting self-care and wellness so that providers can sustain and retain their positions.

Future direction of the SPE Policy Consortium

As the SPE Policy Consortium continues to implement this strategic plan, we have several recommendations and ideas for next steps for how this group will implement strategies to continue making a difference for all Washingtonians.

Strategic planning

SPE Policy Consortium partners will begin working on the mini-update to this Strategic Plan in Spring of 2024, after new bi-annual data is released from the Washington State Healthy Youth Survey and Young Adult Survey in 2024. The mini update of the plan should be finalized in early 2025 to reflect new indicator data and targets for implementation.

To begin this work, a subgroup of the SPE Policy Consortium will be created to participate in a strategic planning writing group, including members and leads of the six (6) workgroups. This will ensure further discussion and collaboration to advance the strategies in our action plan, and ensure these efforts are aligned and coordinated.

Strategy development

Below are recommendations for the SPE Policy Consortium to focus on in the next five-year implementation cycle of this plan. For planning purposes, each of these recommendations are included under the appropriate Strategic Objective.

Strategic objective	Recommendations for further work
Strategic Objective One: Strengthen state collaboration to prevent initiation of substance use and promote mental health.	• Identify ways to build interagency relationships, communicate about services, and coordinate services and activities within the SPE. • Develop the Problem Gambling Prevention Workgroup to be included in the SPE Policy Consortium efforts. Learn prevalence rates and needs among all populations of focus. • Ensure the SPE Policy Consortium is focused through specific tasks to address health equity issues and health disparities around substance misuse prevention and mental health promotion services for populations of focus and Tribal communities. • Create a workgroup of the SPE Policy Consortium focused on the strategic planning and needs/resources assessment work to coordinate and track the full planning process of each cycle.
Strategic Objective Two: Utilizing needs assessment data in Washington State, create and disseminate communication plans, campaigns, trainings, and resources to better serve populations in need.	• Develop a shared definition of prevention and evidence-based practices across state prevention agencies across SPE Policy Consortium partners. • Expanding data collection and analysis methods to understand needs and gaps across all populations of focus. • Explore data among native youth as well as cultural protective factors. • Promote public education campaigns that are inclusive of all voices and promote key upstream prevention and mental health promotion messages.
Strategic Objective Three: Implement environmental strategies to: reduce access and availability of substances; change community and social norms of substance use; and reduce stigma in accessing behavioral health services.	• Evaluate policy statements created in 2022 and prepare for upcoming legislative sessions. • Encourage sustainable funding directed towards environmental strategies that have an impact on reducing substance use risk factors. • Create a State Prevention agenda to guide priorities and funding decisions.
Strategic Objective Four: Commit and dedicate efforts to implementing an ongoing cycle of SUD prevention and mental health promotion programs to	• Explore the sustainability of prevention services beyond discretionary grant funding for primary prevention and mental health promotion services. • Integrate SUD primary prevention services for parents into primary care, to be insurance and Medicaid billable. • Explore new initiatives for priority substance use/mental health needs.

Strategic objective	Recommendations for further work
strengthen protective factors and reduce risk factors.	• Identify ways to ensure that native youth have access to and are participating in prevention/promotion programming.
Strategic Objective Five: Strengthen the long-term sustainability of the behavioral health promotion and SUD prevention workforce.	• Increase diversity and representation in the prevention and promotion workforce. • Tailoring and adapting programs and policies to fit the diverse set of community needs.

Chapter 3: SPE Policy Consortium Strategic Prevention Framework (SPF) Implementation

As outlined on the following pages, the Strategic Prevention Framework (SPF) helps the SPE Policy Consortium improve and enhance prevention and promotion efforts across Washington State.

Getting started

Washington State agencies have a history of collaborating in a variety of venues for planning and implementing prevention strategies. Over 25 years ago, the Washington Interagency Network (WIN) was established to include representatives from various agencies engaged in substance use disorder SUD prevention. This has now evolved to the SPE Policy Consortium as it stands today. A complete, current list of SPE Policy Consortium members can be found in the Appendix – SPE Policy Consortium Members.

Health equity in the getting started phase

The SPE Policy Consortium aims to protect against intended and unintended substance use consequences and health disparities and support policies that promote standards for health promotion and health equity.

Through active and intentional outreach and recruitment, the SPE Policy Consortium leadership ensures representation of key state agencies, organizations, and Tribal government or Urban Indian programs are involved the six (6) Workgroups as well as the larger Consortium.

SPE Policy Consortium

- Commission on Asian Pacific American Affairs (CAPAA)
- Commission on Hispanic Affairs (CHA)
- Department of Children, Youth, and Families (DCYF)
    - Juvenile Rehabilitation (JR)
- Department of Health (DOH)
    - Division of Prevention and Community Health (PCH)
- Department of Social and Health Services (DSHS)
    - Aging and Long-Term Services Administration (ALTSA)
    - Research and Data Analysis (RDA)
- Drug Enforcement Agency (DEA) Washington Office
- Foundation for Healthy Generations
- Health Care Authority (HCA)
    - Division of Behavioral Health and Recovery (DBHR)
    - Clinical Quality and Care Transformation (CQCT)
    - Office of Tribal Affairs (OTA)
- Liquor Cannabis Board (LCB)
- Mentor Washington
- Northwest High Intensity Drug Trafficking Area (NW HIDTA)
- Office of Superintendent of Public Instruction (OSPI)
- Office of the Attorney General (AG)
- University of Washington (UW)
- Washington Poison Center (WAPC)
- Washington State Department of Labor and Industries (L&I)
- Washington State Hospital Association (WSHA)
- Washington State Institute for Public Policy (WSIPP)
- Washington State Patrol (WSP)
- Washington State University (WSU)
- Washington Traffic Safety Commission (WTSC)

SPE Policy Consortium Advising Groups

- College Coalition for Substance Use Disorder Prevention (CCSAP)
- Prevention Certification Board (PSCBW)
- Prevention Research Subcommittee (PRSC)
- State Board of Health (SBOH)
- State Epidemiological Outcomes Workgroup (SEOW)
- WA Association Substance Use Disorder and Violence Prevention (WASAVP)
- Washington Healthy Youth Coalition (WHY)

As an established group since 2011 when the first SPE Policy Consortium meeting convened, we have followed a developed structure for quite some time. The SPE Policy Consortium supports the following six (6) workgroups to develop and implement plans for each strategy related to each problem area:

- Mental Health Promotion and Suicide Prevention Workgroup
- Opioid Prevention Workgroup
- Problem Gambling Prevention Workgroup (created in 2023)
- Washington Breathes: Commercial Tobacco and Vapor Products Workgroup
- Washington Healthy Youth (WHY) Coalition: Underage Drinking & Youth Cannabis Prevention
- Young Adults Cannabis & Alcohol Prevention Workgroup

Did you know?

Information about the SPE Policy consortium and our current and past work can be found online.

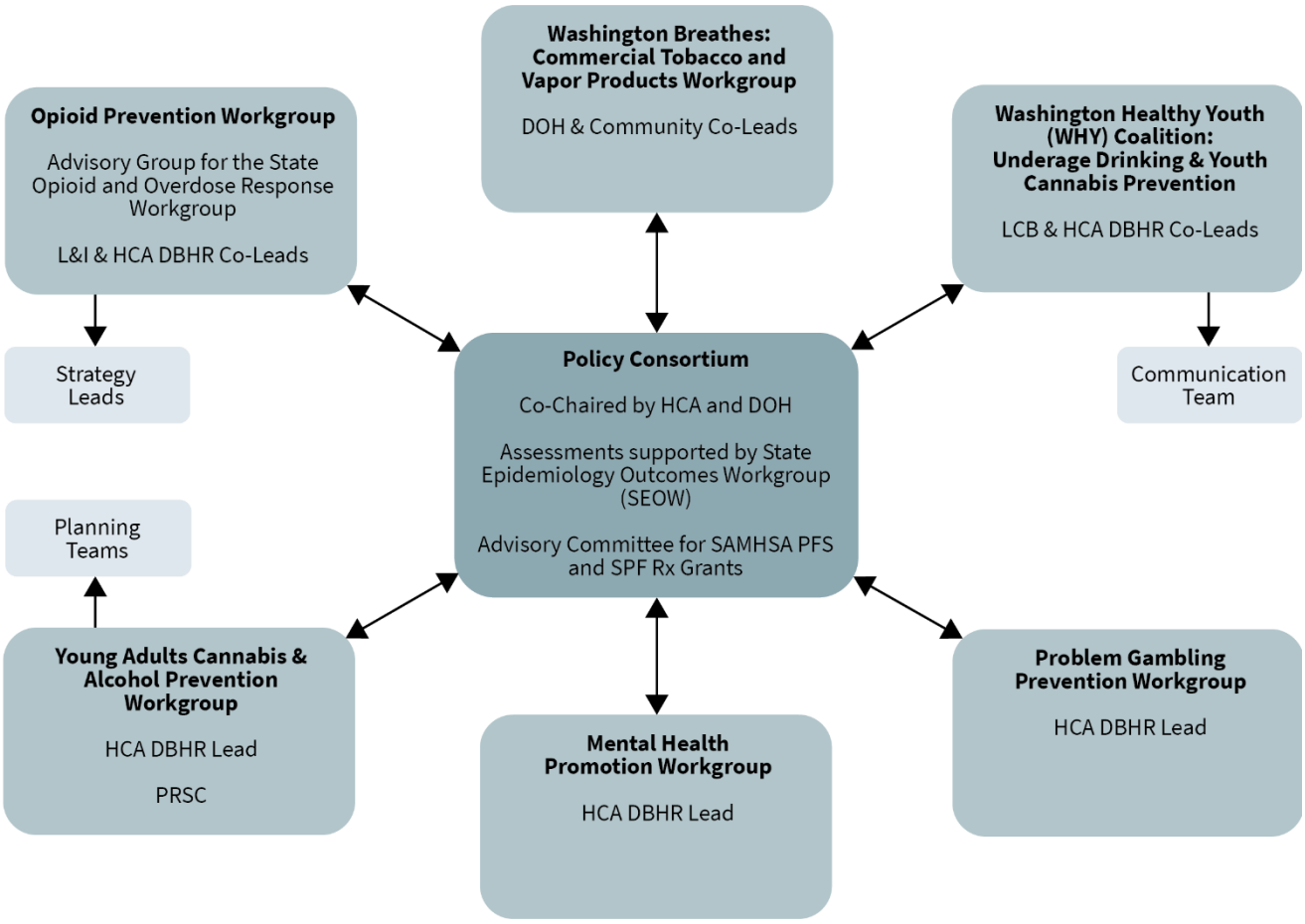
Each of the SPE Policy Consortium Workgroups have developed their own Action Plans to guide their work with their respective workgroup members.

Check it out here:
theathenaforum.org/spe

To encourage active participation, we make a significant effort to provide accurate and timely communication with all members and the advisory groups. We keep them updated on the SPE Policy 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 SPE Policy Consortium meets every other month as a full SPE Policy Consortium with workgroups meeting in the interim. All the partnering agencies of the current SPE Policy Consortium have agreed to participate in the SPE Policy Consortium. HCA has committed to providing support for the SPE Policy Consortium and leverage in-kind and federal support and implementation of the strategic planning process.

SPE Policy Consortium structure



The SPE Policy Consortium created workgroups and connected with existing workgroups to oversee the implementation of Action Plans focused on each of our identified problem areas to accomplish the goals and mission laid out in a strategic plan. Workgroups are the principal vehicles through which SPE Policy Consortium collaborates on a sustained and formal basis. The SPE Policy Consortium's strategic plans from the workgroups outline the goals to promote policies, projects, and partnerships for issues under jurisdiction of the working group.

Capacity building

Capacity building in the SPF refers to building resources and readiness to address prevention and mental health promotion needs at the state and local levels. This includes expanding the diversity and experience of the SPE Policy Consortium Members; growing and diversifying the behavioral health workforce through trainings and technical assistance; and expanding service delivery.

Capacity building in membership

The SPE Policy Consortium recruits new members as needed. When an individual from a partner agency 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 the participation of new members. As new members join the SPE Policy Consortium 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.

Capacity building in the prevention/promotion workforce

The SPE Policy Consortium is committed to building ongoing capacity in our state to support a strong, relevant, and vital substance use disorder SUD prevention and mental health promotion workforce. Our goals are to enhance the capacity of the workforce by disseminating trainings and technical assistance to prevention providers and to promote and incentivize the professional certification of individuals in the workforce.

The SPE Policy Consortium has engaged in statewide prevention needs assessments since 2003 to understand the current state of the workforce. The 2021 survey was conducted in coordination with the Health Care Authority (HCA), Social Development Research Group (SDRG) and the Northwest Prevention Technology Transfer Center (NW PTTC) in cooperation with the other nine PTTCs across the United States. The NW PTTC was created in 2018 to improve the implementation and delivery of effective substance use disorder SUD prevention interventions and provide training and technical assistance services to local and state prevention providers. The SPE Policy Consortium has a close partnership with the PTTC to expand the capacity of the prevention and promotion workforce.

Did you know?

Washington State prevention providers and contractors participated in a 2021 Washington State Prevention Providers Workforce Assessment Survey. Results from the 2021 survey help establish a baseline of knowledge and have enhanced workforce development strategies both short and long term.

Check out the survey results here: theathenaforum.org/report-2021-washington-state-prevention-providers-workforce-assessment-survey-0

These 2021 results show that more than 80% of prevention providers are satisfied with their current position and more than 50% of the workforce is experienced with six or more years of work experience in the field. Both 2016 and 2021 survey results show that many of the prevention providers who responded to the survey are highly motivated, educated, and skilled. However, we do see a sizeable percentage of respondents, 27%, who appear to be relatively new to prevention, with two years or less of experience.

There have been significant efforts to invest in the behavioral health workforce, particularly to professionalize the prevention field, at both a state and national level. The primary way to do this is to standardize the expectation of a professional certification in prevention. In Washington, the Prevention Specialist Certification Board of Washington (PSCBW) remains the certifying body for Certified Prevention Professionals (CPP). The PSCBW is an all-volunteer, peer review, International Certification & Reciprocity Consortium (IC&RC) member board.

Since 2011, The Washington State Health Care Authority (HCA)/Prevention Section has had a requirement of CPP certification for state prevention staff and prevention coalition coordinators under contract with HCA. Some counties and local agencies require certification within the scope of their contracts and/or hiring practices; however, there is not a universal state requirement for a prevention certification. Roughly 100 individuals hold a CPP certification in Washington and only 17% of respondents on the 2021 Workforce Development survey reported being certified.

Statewide, SPE Policy Consortium partner agencies promote and contribute to expanding the reach and impact of prevention and promotion services through workforce development efforts. This includes identifying new positions and recruitment strategies to support expanded community and state level prevention contractors; high school or college internship and fellowship programs; and providing technical assistance and training to retain the current workforce and enhance and professionalize their skills.

Capacity building in service delivery

The SPE Policy Consortium is responsible for the state-level planning and implementation of collaborative strategies to address SUD prevention and mental health promotion. The SPE Policy Consortium has the unique role of a state-level coalition to implement strategies that contribute to an overall collective impact for our state.

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

Health equity in the capacity building phase

Culture and language play a significant role in the design, delivery, accessibility, acceptability, and effectiveness of prevention services and activities.

SPE Policy Consortium agencies and partners are dedicated to efforts to increase the capacity of staff to provide culturally and linguistically appropriate trainings, resources, and support to all populations of focus.

CLAS standards guide much of the work that SPE Policy Consortium agencies build their policies and practices on. View the CLAS guide at: **minorityhealth.hhs.gov /Assets/PDF/clas%20standards%20doc_v06.28.21.pdf**

Assessment: Needs, resources, and gaps

The SPE Policy Consortium followed the SPF to assess the needs, resources, and gaps of substance use and mental health disorders among Washingtonians using state level data. To conduct the needs assessment, the SPE Policy Consortium partners with the State Epidemiological Outcomes Workgroup (SEOW)

to gather and interpret relevant data. To conduct the resources assessment, the SPE Policy Consortium developed an ad hoc workgroup that prepared and implemented the resources assessment survey of SPE Policy Consortium members and prevention partners across the state. The results of each of the assessments are briefly highlighted below, with the full versions included in the Appendix - Assessment of the strategic plan.

Data assessment

In conducting the needs assessment, DBHR led the initial data gathering and presentation to the SEOW. The goal was to work with the SEOW to discuss and gather recommendations from the workgroup on which indicators were relevant in presenting to SPE Policy Consortium members. Following recommendations, the indicators were provided to the SPE Policy Consortium for review and comment. The SPE Policy Consortium took the info back to their workgroups and made further recommendations on data indicators of interest.

In the spring and summer of 2022, data presentations on recommended indicators from the SEOW were reviewed with the SPE Policy Consortium. The presentation covered trends and updated data on consequence, consumption, and intervening variables related to substance use and mental health disorders. The SPE Policy Consortium requested additional data elements and data related to health disparities by race/ethnicity, gender, sexual orientation, and disability status. A presentation on the methodologic changes that occurred with the 2021 HYS survey[4] was discussed and the effect it has on tracking trends over time and the development of recommended targets.

Special considerations for the COVID-19 pandemic

The COVID-19 pandemic led to several important changes in behavioral health data collection and data trends. One of the key data sources for the needs assessment is the Washington State Healthy Youth Survey (HYS). Due to the unexpected shift to primarily remote learning in 2020, the HYS was not administered in fall 2020 as it was originally intended. Instead, the HYS Planning Committee (HYSPC) determined it would be best to delay the survey to fall 2021. This ensured a process could be created for students who needed to take the survey remotely and it allowed the HYSPC to add a small number of COVID-19-related questions to support future preparedness and response in schools and communities. In addition, the decision was made to expand e-survey/online survey administration across the state. All of this led to factors that may or may not have had an impact on the results:

1. Delaying the survey by a year means a change in the cohort of students being surveyed. The HYS has historically been offered in Fall of even years to students in grades 6, 8, 10, and 12, so roughly the same cohort of students were ultimately being surveyed every two years as they advanced.
2. The HYSPC chose to halt plans for a more extensive evaluation of the e-survey mode compared to paper that was scheduled for HYS 2020. Instead, the shift to an e-survey mode without the in-depth comparison makes it more difficult to determine whether the survey mode (paper vs e-survey) has an effect on how students answer questions. Only a very small number of schools elected to do the survey on paper in 2021.
3. Schools were allowed to administer the e-survey remotely in Fall 2021 to accommodate students who may be doing hybrid or fully distanced learning. The vast majority of students took the survey in-person at school, though a small number did take the survey remotely. The potential impact of having students complete the survey remotely is still being assessed.

[4] Healthy Youth Survey (askhys.net)

4. Finally, the pandemic itself has led to massive changes in the lives of Washington youth. Increases and decreases in HYS 2021 data may be more a reflection of the pandemic and its effect on our lives than a change that would have happened if the pandemic had not occurred. **This means that trend data from before the pandemic and during/after the pandemic should be interpreted with caution.** For example, a large decrease in one particular risk behavior on school property may be explained by a new school education campaign or program or it may be explained by the fact that students are doing more remote learning.

Key findings

Key findings on substance use and mental health behaviors are based on data obtained from the Washington State Healthy Youth Survey (HYS) and the National Survey on Drug Use and Health (NSDUH).

- Overall, based on prevalence, misuse of alcohol remains the most concerning substance issue among youth. Misuse of alcohol also continues to remain the most concerning SUD issue among adults.
- Cannabis/marijuana ranks second for youth. In 2021, the prevalence of cannabis/marijuana use among 10th grade students was 7.2 percent and there has been no change over time from 2010–2018. Students who identify as lesbian, gay, bisexual, transgender, and queer (LGBTQ+), with a disability, and/or living in insecure housing are most likely to report cannabis/marijuana use. Cannabis/marijuana ranks third among adults with rates increasing overtime.
- Commercial tobacco use by high school youth ranks third as a substance of concern and continues to decline since 2010. Students who identify as lesbian, gay, bisexual, with a disability, and/or living in insecure housing are most likely to report smoking cigarettes in the past 30 days. Among adults, commercial tobacco ranks second highest with a decrease overtime among young adults aged 18 to 25 but has remained stable over time for adults 26 years of age and older.
- The fourth substance of concern among both youth and adults is the use of painkillers (opioids) to get high. With opioid-related overdoses declared a crisis nationwide and, in the state, the potentially fatal implications of misuse warrants continued efforts towards further decreasing painkiller (opioids, both prescription and illicit, including fentanyl) misuse rates.
- Finally, the 5th ranked concern among both youth and adults is methamphetamine use. We will continue to monitor methamphetamine trends and other illicit drugs.
- Mental health concerns are also prioritized as there is an increase in prevalence overtime in depression and suicide ideation, suicide planning, and suicide attempts among youth. The 2021 HYS data show some student populations are more heavily affected than others, including students who identify as female, students who identify as LGBTQ+, students with disabilities, and students from lower income households.

Health equity in the assessment phase

The Needs Assessment conducted in this Strategic Plan update included a review of the data in terms of health disparities. In addition to race/ethnicity, the review also included disparities by sexual orientation, gender identity, and disability status. For further details, please see the Appendix 4 – Needs Assessment.

To address data gaps, partners who work on the Healthy Youth Survey (HYS) have expanded categories in the race and ethnicity survey questions to include additional subpopulation demographic options in the Asian/Asian American category. Additional race/ethnicity

disaggregation is being explored as part of the 2023 HYS revision process.

The Healthy Youth Survey planning committee added sexual orientation and gender identity questions to the survey for grades 8 to 12.

SPE Policy Consortium Partners continue to work with American Indian/Alaskan Native (AI/AN) liaisons to develop a plan to expand Tribal and AI/AN inclusive questions for the Healthy Youth Survey.

COVID-19 Student Survey (CSS)

With the postponement of the Healthy Youth Survey (HYS) in Fall 2020 due to the COVID-19 pandemic, a separate COVID-19 Student Survey (CSS) was developed and then administered in March 2021 and February 2022 to collect data on adolescent health behaviors during the pandemic. The CSS included similar questions as HYS, but also included questions specific to the COVID-19 pandemic, including protective strategies, school performance, and worries.

Results from the first COVID-19 Student Survey in 2021 included about 65,000 middle and high school students in Washington and showed that many of them reported feeling sad or depressed most days during the pandemic. However, most students in each grade reported a high degree of resilience, saying they were optimistic about the future.

Among the findings:

- Some students reported concerns about the financial impacts of COVID-19 on their families:
    - Worry about parents or guardians losing their job (32% at the high school level and 43% at the middle school level);
    - Worry about being unable to afford housing (high school: 27%, middle school: 37%); and
    - Worry about not having enough to eat (high school: 17%, middle school: 27%).
- Of those surveyed, 58% of high school students and 45% of middle school students reported feeling sad or depressed on most days during the past year.
- Remote learning was challenging. Nearly 70% of middle and high school students said they felt it was harder to do their schoolwork this year than it was last school year.
- Substance use was down. Students reported lower levels of cigarette, electronic cigarette, alcohol, and cannabis/marijuana use during the pandemic compared to data collected from pre-pandemic state data sources.
- The survey results also show resilience among many students: More than 90% of participating students in each grade were at least slightly hopeful, and nearly 60% of all responding students reported feeling optimistic or hopeful about the future.

Additional information about the COVID-19 Student Survey including results can be found here: k12.wa.us/student-success/health-safety/2022-covid-19-student-survey-results/2021-covid-19-student-survey-results

Additional findings

Additional conclusions noted and discussed through the data assessment are listed below. Please review the data tables and charts provided in Appendix – Data Assessment for further details.

- **Suicide deaths continue to rise in Washington youth**. Suicide death rates among Washington youths aged 10 to 17 years old has increased by 69% from 2010 to 2020. The suicide death rate among youth aged 18 to 25 increased by 30% from 2010 to 2020. In Washington State, suicide is the second leading cause of death for 15 to 24 years old.[5] In 2021, among 10th grade students in WA state, one in five (19.6%) of

[5] Washington State Department of Health (doh.wa.gov/you-and-your-family/injury-and-violence-prevention/suicide-prevention/youth-suicide-prevention/youth-suicide-faqs)

students seriously considered suicide in the past year. Female 10th graders are more likely to report seriously considering attempting suicide when compared to their male counterparts. Females are also more likely than males to put together a suicide plan and to attempt suicide. The 2021 HYS data show some student populations are more heavily affected than others, including students who identify as female, students who identify as LGBTQ+, students with disabilities, and students from lower income households.

- **A large proportion of youth report feeling sad or hopeless in the past 12 months**. Almost two in five (38%) of 10th graders reported feeling so sad or hopeless for two weeks or more during the past year that they stopped doing their usual activities. This rate has significantly increased since 2010 when 30% of 10th graders reported feeling sad or hopeless. Females (50.2%) and American Indian/Alaska Natives (50.4%) are more likely to report higher rates of feeling sad. In addition, students who identified as having a sexual orientation other than heterosexual, as well as students who identified as having a disability, were also more likely to report higher rates of feeling sad or hopeless.
- **Alcohol use among youth continues to decline**. In 2021, 8.4% of 10th grade students reported drinking alcohol in the last 30 days. Alcohol use is higher among students who identify as LGBTQ+, students with disabilities, and students from lower income households.
- **Cannabis/Marijuana use declined after remaining stable for several years**. The proportion of 10th grade high school students using cannabis/marijuana did not change much from 2010 (20%) to 2018 (18%), and then substantially decreased to 7% in 2021. AI/AN youth, youth who identify as LGBTQ+, youth with a disability, and youth living in insecure housing report high rates of cannabis/marijuana use when compared to their counterparts.
- **Personal/non-medical cannabis/marijuana use increasing in young adults ages 18 to 25**. Past 30-day personal / non-medical cannabis/marijuana use has significantly increased in the young adult age group from 43.5% in 2014 to 51.2% in 2021; this increase is being driven by those age 21 to 25. Past 30-day use by young adults under the age of 21 has remained stable overtime. Among 21- to 25-year-olds, there is an increasing trend in getting cannabis/marijuana from a retail store (8.8% in 2014 vs 74.4% in 2021). Among 18- to 20-year-olds, there is an increasing trend in getting marijuana by giving money to someone to get it for them (23.3% in 2014 vs. 39.8% in 2021). We also see an increasing trend in 19- to 20-year-olds, getting cannabis/marijuana from parents with permission (5.8% in 2014 vs. 13.95 in 2021).
- **Disparities in reported misuse of opioids to get high impact American Indian/Alaska Native, youth identifying as LGBTQ+, youth with a disability, and youth living in insecure housing**. The proportion of 10th grade high school students who report misuse of opioids to get high has declined by almost 60 percent from 8.3% in 2010 to 3.6% in 2018. This rate decreased even further in 2021 to 1.0% of 10th grade students reporting misuse of opioids. In 2021, youth who report living in insecure housing (4.0%) are more likely to report using opioids to get high compared to 10th grade youth who report living in secure housing (0.8%).
- **Disparities reported in cigarette use among LGBTQ+ identifying and youth living in insecure housing**. Youth who identify as LGBTQ+ are more likely to report smoking cigarettes (4.9%) compared to heterosexual youth (1.1%). Youth who report living in insecure housing are more likely to report cigarette use (10.2%) compared to youth who report living in secure housing (1.2%).
- **Youth who gamble have higher rates of substance use and poor rates of mental**

health outcomes. In 2010, 9.4% of youth in grades 8, 10, and 12 reported that they have gambled in the past 12 months. Youth who gamble are more likely to drink alcohol (20.8%) compared to youth who do not gamble (8.4%). They are also more likely to report e-cigarettes/vape use (15.7% vs. 7.7%) and report smoking cigarettes (5.5% vs. 1.8%). Youth who gamble report feeling sad or hopeless at a higher rate (47.3%) than youth who do not gamble (37.9%).

- **Fentanyl overdose deaths among young people in Washington State remain low, but any overdose death is too many.** Among people under 30, fentanyl-involved deaths started climbing statewide in 2016.[6] By 2019, it had surpassed other opioid categories of deaths among that age group, at the rate of 4 per 100,000. By 2020, fentanyl-involved deaths had doubled to 8 per 100,000 among people under 30. In 2021,[7] there were 50 deaths among youth ages 10 to 17 from any opioid, and 311 deaths among young people ages 18 to 24 from any opioid.

Analysis and prioritization of data

Based on the broader question of "What are the problems we are intending to address?" and the various implications that these SUD and mental health disorders have on society, the SPE Policy Consortium will maintain its focus on its previously identified five long-term outcomes consequences.

Data conclusions and recommendations related to substance misuse and mental health were presented and addressed with the SEOW and the SPE Policy Consortium during the Spring and Summer of 2022.

Long-term outcome consequences

- Chronic disease/injury/death related to alcohol, commercial tobacco, and opioid use;
- Crime;
- Low high school graduation rates;
- Teen and young adult suicide; and
- Fatalities and serious injury from traffic crashes.

Problem areas

The SPE Policy Consortium continues to maintain its focus on the following intermediate outcomes also known as problem areas.

Substance misuse

The top four ranked misused substances from the Data Assessment (for details see Appendix 4) are: alcohol, cannabis/marijuana, commercial tobacco, and prescription opioids. Based on the prevalence by age, underage alcohol use is a top priority. It is agreed that specific emphasis also be placed on strategies related to alcohol use for the 18 to 25 age range and cannabis/marijuana use for the 21 to 25 age range. The SPE Policy Consortium continues to emphasize the importance of continuing to watch "trending" substances, vapor product misuse, opioid misuse, and heroin use, which has shown increased use, hypothesized to be related to the reduced access of prescription opiates. Nationally, there has been an opioid crisis and Washington State also follows the national response in addressing this concern as opioid-related disease shows a significant burden, including youth painkiller misuse, prescription and illicit opioid and SUD treatment admissions, overdose hospitalizations, and deaths from fentanyl and related drugs.

It was decided to use the term 'misuse' to account for important distinctions related to

[6] New ADAI Report: Dramatic Increases in Opioid Overdose Deaths Due to Fentanyl Among Young People in WA adai.uw.edu/new-report-youth-fentanyl/

[7] WA Department of Health Opioid and Drug Overdose Data doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/opioids/overdose-dashboard

each substance. Specifically, regarding cannabis/marijuana it is important to note that the SPE Policy Consortium is cognizant that medical cannabis use remains legal in this state, recreational cannabis use is also legal for adults over the age of 21; therefore, not all cannabis use is considered misuse. Similarly, prescription drugs when prescribed appropriately and taken as prescribed, are not considered harmful or misuse. Regarding tobacco, it is important to recognize that in some cultures, tobacco is used for cultural traditions and ceremonies and would not be considered misuse.

Mental health

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

Intervening variables

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

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

Risk/protective factors

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

	• Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Commercial tobacco use	• Access (e.g., hookah lounges) • Availability of commercial tobacco • Favorable Attitudes: Perception of harm • Laws (e.g., preemption and local laws) • Promotion of commercial tobacco (e.g., targeted advertising to low-income/minority populations) • Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Opioids/prescription drug misuse	• Access to prescription drugs (e.g. not prescribed to them and prescriptions provided) • Access to any opioid, including illicit fentanyl • Access to other illicit drugs (e.g. stimulants) • Availability (e.g., over prescribing, unused medication, and 'doctor shopping') • Community norms • Enforcement (e.g., unclear under the influence laws) • Supply (e.g., abundant supply of prescription drugs) • Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Depression and anxiety	• Community norms (e.g., stigma of MH screenings, MH screening not part of routine health screening, and community awareness and knowledge regarding treatability) • Connection to other mental health disorders (e.g., anxiety) • Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)
Suicide ideation	• Connection to other mental health disorders • Teen and young adult suicidal ideation • Traumatic childhood experiences (e.g., at the time of traumatic experience and retrospectively from adulthood)

Following a review of each of these problem areas, six common intervening variables were identified, to address:

- Access
- Availability
- Favorable attitudes
- Perception of harm
- Community norms
- Enforcement
- Policies

These intervening variables are used as the basis for the development of strategies in planning.

Resources assessment

"I alone cannot change the world, but I can cast a stone across the water to create many ripples."
- Mother Teresa

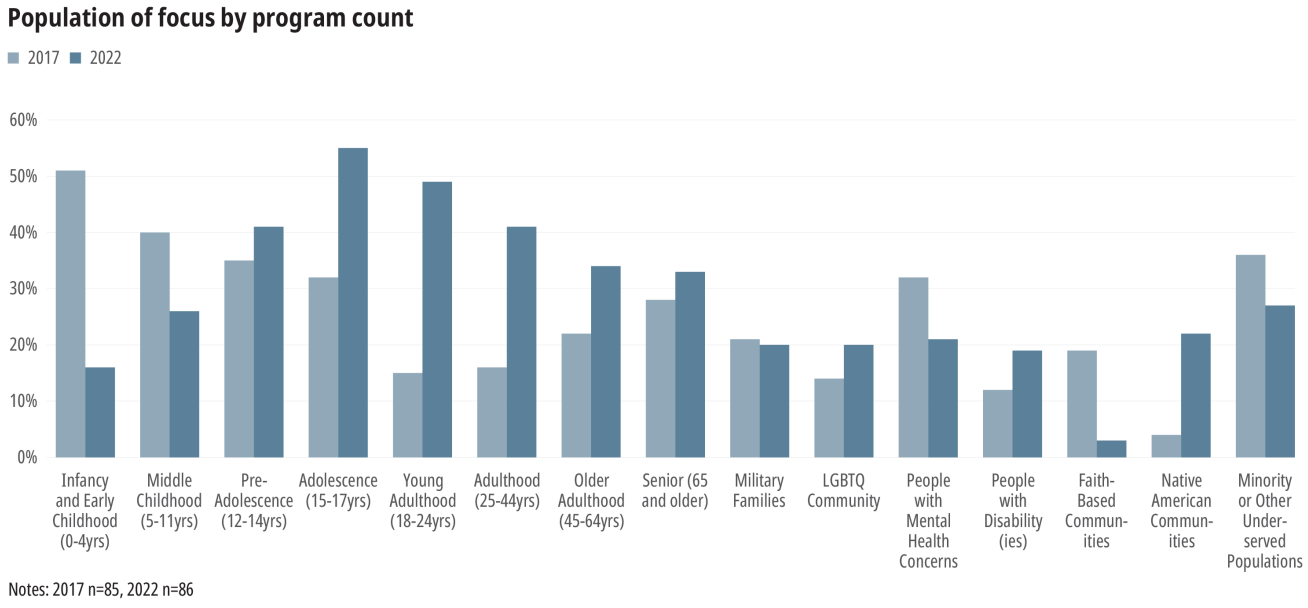
Resources in this context is another name for programs, initiatives, or strategies. Many people and organizations across the state of Washington are doing great work to prevent SUD and promote mental health. What follows is an overview of the most notable efforts by the members of the SPE Policy Consortium. This is not intended to be an exhaustive list. There are many local efforts, many powered by volunteers and donated materials, which help protect and support the behavioral health of Washington's youth, families, and communities.

Resources overview

- Participating Organizations – 9
- Total Number of Programs – 61
- Total Number of People Served/Reached – 64 million (some duplicate counts)
- Total State Funds - $18 million
- Total Federal Funds - $28 million
- Other Funding - $1.8 million

Gaps and challenges

While there is much to celebrate, our research has illuminated some areas for improvement in design. From the needs assessment, we learned that young adults, teens who identified as LGBTQ+, and teens who reported having a disability were among the highest in exhibiting behavioral health disparities. Despite this, the resources designed for these populations were among the lowest in number and funding, suggesting that existing prevention supports are not reaching these groups. There were also fewer prevention programs designed for the very young (pre-K), military families, and senior adults (65+), with most efforts being focused on the general population and adolescents. More work needs to be done to ensure that services are reaching and helping those who need them the most.



Notes: 2017 n=85, 2022 n=86

Strengths to build on

Balanced methods: Washington prevention efforts are diverse and comprehensive when it comes to strategy type. Information and media campaigns are the most common method of building awareness and resilience, but there are projects in policy development, direct education, healthy alternative activities like mentorship programs, and community development.

Proven effectiveness: Throughout the projects reviewed, there was a strong emphasis on evidence-based programs and strategies. Partnerships with three of the world's leading prevention research institutions in the University of Washington, Washington State University, and the Washington State Institute for Public Policy help to ensure that the SPE members are made aware of and utilizing the most effective means of reducing SUD and promoting mental health.

Upstream focus: Overall, the programs and projects in Washington are designed to address the root causes of behavioral health problems through reducing risks and increasing protections. By working on these core issues, the SPE Policy Consortium members are avoiding the tendency to focus on specific substances or unwanted behaviors and solving problems before they start.

Tribal prevention programs

The SPE Policy Consortium would like to especially acknowledge the work of the 29 Federally Recognized Tribes of Washington, as well as the Urban Indian health organizations, who are using culturally appropriate and relevant strategies to address the risk and protective factors specific to their communities. Many adaptations of existing programs, as well as the creation of new ones such as the Healing of the Canoe Project, have been implemented by and for Native youth and adults, keeping central the idea that culture is prevention.

Collaborative history

Beginning in October 2011, as part of the State Prevention Enhancement grant, the SPE Policy Consortium began working on a few specific prevention projects with coordinated funding. Since then, these collaborative projects have been maintained and expanded to include the Washington Prevention Summit, the Spring Youth Forum, the Healthy Youth Survey, CORE GIS data collection and analysis, College Coalition, Suicide Prevention Plan, Opioid Executive Order Plan (safe medication storage and disposal), Prescriber Education Program, Washington State Prescription Drug Monitoring Program, youth cannabis/marijuana use prevention media campaigns, Addictions, Drug & Alcohol Institute (ADAI) surveillance, evidence-based practices development, State Epidemiological Outcomes Workgroup, the I-502 Cannabis Surveillance Program, and public education campaigns such as Not a Moment Wasted and Focus On. Other agency specific programs like the Community Prevention and Wellness Initiative (DBHR) and the Youth Cannabis & Commercial Tobacco Prevention Program (DOH) utilize these collaborative programs in all phases of their work.

This cooperative arrangement extends beyond the utilization of shared resources like the Healthy Youth Survey or our evidence-based program registry. Through the formation of partnerships and working relationships, members of the SPE Policy Consortium will frequently connect with others regarding projects that utilize only one agencies funding or staff, ensuring that networks are established across provider groups which can create mutual systems of support. CPWI coalitions funded by HCA in Eastern Washington are often implementation supporters of Target Zero projects funded by the Washington Traffic Safety Commission. And some prevention funding opportunities from DOH are designed specifically to build capacity in high needs communities which currently do not have CPWI coalitions. Conferences and training events often contain individuals working on grants from multiple agencies, and regional collaboratives are formed which contain networks that touch

three or more programs from this section. The positive effects of this interdependence can be hard to quantify in an assessment like this, but we recognize and celebrate the value it brings to everyone's work.

Planning

Past plans

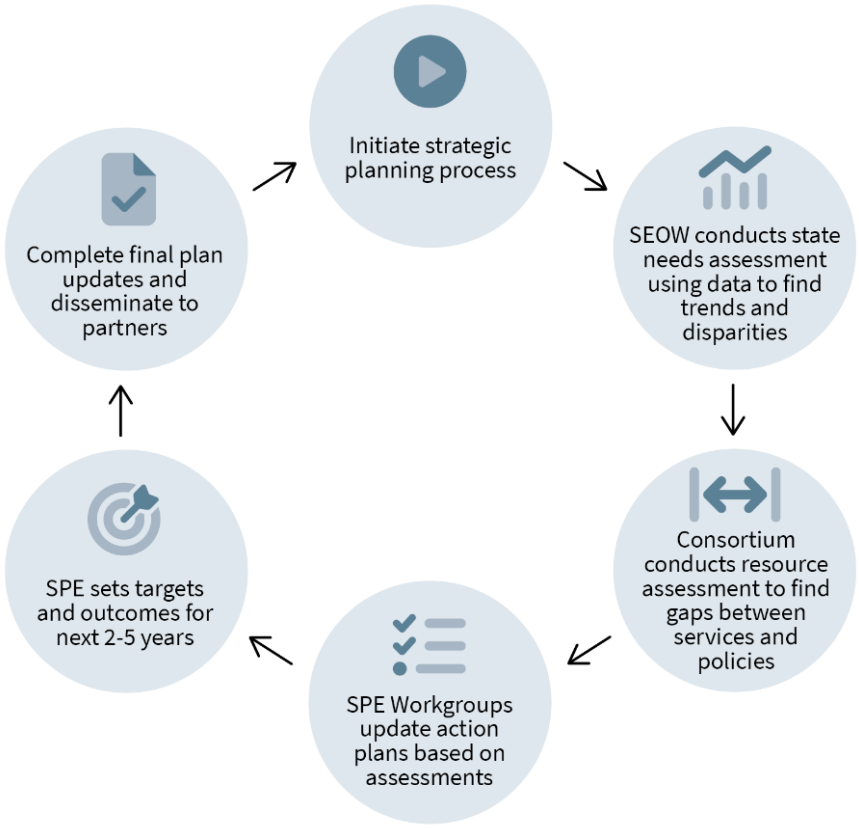
August 2012
March 2013
June 2014
November 2015
November 2017
October 2019

The SPE Policy Consortium first convened in October 2011 and initiated the strategic planning process to develop the first five-year strategic plan for 2012–2017. Through this initial assessment, we were able to identify problem areas, as well as map current resources and partnerships that support SUD prevention and mental health promotion. We selected collaborative strategies from which to move forward in developing detailed Action Plans for each of our prioritized problem areas.

Now, every two years, an interim update to the Strategic Plan is completed through a new needs assessment and priority indicator and target review. Every four years a comprehensive update is made to the Strategic Plan. In 2021, the SPE Policy Consortium initiated the planning process for this five-year strategic plan (2023–2027). This current plan is reflective of the last decade of efforts and accomplishments of the SPE Policy Consortium our goals, objectives, and plans for the next five years.

The strategic plan follows the natural model of the SPF as outlined in Chapter 2. The typical planning cycle is as follows:

Policy Consortium Strategic Planning Process



The SPE Policy Consortium works through the process of the SPF by convening SPE Policy Consortium members, identifying ways to build capacity among state prevention and mental health promotion providers, and conducting assessments to understand the current and historical trend data in the state. The needs and resources assessment planning process is completed in two ways:

1. Overall statewide SUD/MH data review, target setting, and action planning.
2. Individual Workgroup data review, target setting, and action planning.

A key value of the SPE Policy Consortium is to honor and support the current efforts of each of the partners. Using the information from our Resources Assessment, as described in the section prior, we were able to review our current state-level supports for SUD prevention and mental health promotion, and to identify key opportunities to coordinate our services and efforts.

Health equity in the planning phase

- On the state level, in the Federal publication National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice, Washington State is cited as one of six states that have passed and signed legislation requiring or strongly recommending cultural and linguistic competency for its health care

workforce. (In Washington State's case, the legislation takes the form of a requirement.)
- Each Workgroup and the SPE Policy Consortium as a whole review the needs/resources assessments to identify gaps in service delivery, particularly for populations of focus that may be underserved or under resourced.
- These Action Plans include how our State's most vulnerable will be served through prevention and promotion resources are created by each Workgroup and approved by the SPE Policy Consortium.

Implementation

To accomplish our goal, the SPE Policy Consortium has a consistent history and commitment to continuing support for the current resources directed to these efforts, as well as opportunities for partnerships and collaborative projects within identified strategies. The SPE Policy Consortium to review and update our strategies and the status of current resources as needed.

The SPE Policy 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.

The implementation of strategies includes workgroup implementation and maintenance of their action plans as written in the planning section of this publication. Each workgroup is responsible for completing action items and following up with the larger coalition to review if action items are accomplished. Leadership of each workgroup is responsible for providing bi-monthly updates on action plan progress to the SPE Policy Consortium staff, as well as committing to hosting a presentation at the SPE meetings at least once annually.

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

Health equity in the implementation phase

- The SPE Policy Consortium honors cultural celebrations, monthly awareness activities that promote the wellbeing and support of populations of focus (i.e. Pride Month, Black History Month), and incorporate discussions on how to better collaborate and serve our Tribal communities statewide.
- Collectively, SPE Policy Consortium partner agencies provide health equity trainings for state and contracted staff, provide translated materials for public education campaigns, and promote the utilization of culturally attuned prevention/promotion programs.

Health equity in prevention

As previously described, one of the core values of the SPE Policy Consortium to address health disparities and promote health equity in prevention. We feel it is critical to reduce inequities and inequalities that lead to substance misuse, SUD, and mental health challenges in all populations, including Black, Indigenous and Native American, Latino, Asian, Native Hawaiian, Pacific Islander and other persons of color; LGBTQ+ persons; members of religious minorities; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affective by persistent poverty or inequality. To effectively address these inequities, we must understand the factors that cause them, and ensure that all agencies and partners are equipped to implement programs and prevention approaches to move the needle.

The SPE Policy Consortium prioritizes Diversity, Equity, and Inclusion (DEI) efforts throughout our work and are dedicated to building an equitable prevention system that includes the voices of those with a broad range of lived

experience as well as underserved populations and their communities.

The SPE Policy Consortium aims to protect against intended and unintended substance use consequences and health disparities and support policies that promote standards for health promotion and health equity. The SPE Policy Consortium aims to understand the implications of how structures, systems, policies, and programs provide risk or buffer against risk for various populations, such as communities of color or other underserved populations. We aim to identify how racial/ethnic groups; marginalized groups (e.g. LGBTQIA+ people); special populations such as children, older adults, or young adults' those representing geographic diversity (rural, remote, frontier); and the medically underserved are experiencing rates of substance use or mental health disorders at different rates than their counterparts. We know that the COVID-19 pandemic has only exacerbated existing health inequities, causing an even greater toll on priority populations and individuals.

By understanding how underserved populations have been disproportionately affected, our State can have more tailored and focused funding, policies, and system support to those most in-need. Some of the SPE Policy Consortium's goals to advance health equity in prevention and promotion work include:

- Working to expand prevention and behavioral health workforce, increasing diversity and representation within the field.
- Expanding data collection and access to data to better understand the diversity of individuals and promote equity-driven decision making.
- Ensuring public education and awareness is developed using community voice from priority populations and is culturally and linguistically tailored and applicable for all populations.
- Understanding how to tailor and adapt evidence-based, research-based, and promising programs and services to the cultural, demographic, and social needs of diverse individuals.

Strategic health equity efforts from the SPE Partners

- Increased prevention funding and allocations to Tribes to implement culturally adapted evidence-based programs and trainings and conferences to Tribal members across Washington State.
- Collaboratively engaged and consulted with Tribes regarding prevention and mental health promotion programming and policy.
- Ensuring community-based prevention funding initiatives are accessible and adaptable for Tribes.

Evaluation

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 underpin SUD prevention.

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

These data sets provide information on social impact indicators, as well as local community and service level data. Our partners have developed sound data-sharing agreements that allow for the SPE to easily collect and compile valuable data not only for our assessments, but also to use in our evaluation of prevention and promotion strategy implementation.

The SPE Policy Consortium, under the guidance of the SEOW, selected the best measures

available that provide points from which we can monitor our progress. This is not intended to be a finite list of all possible measures related to these issues. Targets set in the previous Strategic Plan updates were primarily based on 2018 HYS outcomes. The COVID-19 pandemic necessitated methodologic changes in data collection for surveys administered since 2020 including the HYS and the National Survey on Drug Use and Health (NSDUH). Due to these changes, we are not able to use the most recent rates to evaluate whether we met or exceeded targets set for 2021. We will not include the most recent rates into our evaluation review nor into the trend analysis, as we cannot separate the effects of methodologic changes from true changes in the outcomes.

Moving forward, for indicators from the Healthy Youth Survey (HYS), additional considerations were made for the COVID-19 pandemic and the break in trends from HYS 2018 (pre-pandemic) to HYS 2021. For these indicators, concrete targets were set based on HYS 2018 pre-pandemic data. As in previous target updates, the SPE Policy Consortium's goal was to have 5% reductions in two-three years and 10% reductions in four-five years. However, with some outcomes, the SPE Policy Consortium reductions based on projected trends and desire of change. Targets set for 2023 and 2025 in this current plan reflect previous target setting measures. For HYS 2021 pandemic-era data, statements were included to acknowledge the substantially different results and identify general directional targets.

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

Long-term outcomes data indicators

↑ Increase | ↓ Decrease | ● No change

Long-term outcomes: Consequences	Trend period	Age category	Baseline data point	Latest data point	Trend
Injury prevention *(per 100,000 by age group)*					
Alcohol-injury related hospitalizations[1]	2010-2019	10-17 years	12.5	9.7	●
		18-25 years	69.2	52.5	●
Any non-fatal drug overdose hospitalizations[2]	2016-2020	10-17 years	70.8	73.7	●
		18-25 years	91.2	83.3	●
Any non-fatal opioid overdose hospitalizations[2]	2016-2020	10-17 years	3.9	3.7	●
		18-25 years	17.0	17.4	●
Alcohol-related deaths[1]	2010-2019	10-17 years	3.7	3.1	●
		18-25 years	16.6	17.2	●
Any drug-related deaths[3]	2016-2020	10-17 years	1.4	3.4	●
	2010-2020	18-25 years	10.9	22.6	↑
Opioid-related deaths[3]		18-25 years			
Any opioid	2010-2020		8.3	19.3	↑
Prescription opioids	2010-2020		5.4	17.4	●
Heroin	2010-2020		1.7	2.2	↑
Synthetic opioids (not methadone)	2016-2020		2.5	16.8	↑
Crime *(per 1,000 population)*					
Alcohol-related arrests	2010-2020	10-17 years	4.8	0.6	↓
		18-25 years	25.8	3.9	↓
Drug-related arrests	2010-2020	10-17 years	4.8	0.5	↓
		18-25 years	13.7	2.4	↓
Low graduation rates					
High school extended graduation rate[4]	2010-2021		83.0	85.6	●
Suicide *(per 100,000 population)*					
Intentional self-harm hospitalizations[2]	2016-2020	10-17 years	78.3	83.7	●
		18-25 years	76.3	67.6	●
Suicide death rates[3]	2010-2020	10-17 years	3.5	5.7	↑
		18-25 years	14.5	18.8	↑

Long-term outcomes: Consequences	Trend period	Age category	Baseline data point	Latest data point	Trend
Fatalities and serious injuries from traffic crashes *(number of young drivers testing positive)*					
Young drivers in serious injury crashes positive for alcohol[5]	2010-2020	16-17 years	6	5	
		18-20 years	51	24	
		21-25 years	92	80	
Young drivers in fatal crashes positive for any alcohol[5]	2010-2020	16-17 years	3	1	
		18-20 years	18	16	
		21-25 years	43	31	
Young drivers in fatal crashes positive for Delta-9 THC[5]	2010-2020	16-17 years	1	3	
		18-20 years	6	6	
		21-25 years	7	17	

Notes:
Trend tells us if the outcome has been changing for a given period of time (see Trend Period for starting and end points). The trend for this report was determined to a decreasing trend or an increasing trend if there was a statistically significance difference at the $p<0.05$ level between the starting and ending time points. Trends were evaluated using the JoinPoint Regression Program (4.8.0.1). The JoinPoint software was used to fit weighted least-squares regression models to the estimated proportions of the logarithmic scale at an overall alpha level of 0.05.

Many rates for the 10-17 age group are suppressed. When there is a small number of health events in a small population, problems with statistical instability may occur. Our level of confidence in the data was determined by a measure of reliability called relative standard error (RSE). When RSE was 25% or greater, data is not shown, due to statewide restrictions on publishing death data with small numbers.

1. Produced by Washington Department of Social and Health Services, Research and Data Analysis.
2. Washington State Department of Health, Comprehensive Hospital Abstract Reporting System
3. Washington State Department of Health, Center for Health Statistics, Death Certificate Data
4. The percent of students in the freshman cohort who graduate including those students who stay in school and take more than four years to complete their degree. Source: Office of Superintendent of Public Information, Graduation and Dropout Statistics for Washington.
5. Washington Traffic Safety Commission/Fatality Analysis Reporting System (FARS)

HYS 2021 directional targets

- Substance use indicators: HYS 2021 substance use indicators (alcohol, commercial tobacco, e-cig/vape, cannabis/marijuana, other drugs) substantially decreased from HYS 2018 (pre-pandemic). For 2023 and beyond, the target is to limit any increase or "bounce back" to below pre-pandemic levels and then continue to decrease.
- Mental health indicators: HYS 2021 mental health indicators (depression and suicidality) slightly decreased from HYS 2018 (pre-pandemic). For 2023 and beyond, the target is to limit any increase or "bounce back" to below pre-pandemic levels and then continue to decrease.

Intermediate outcomes data indicators: Behavioral health problems

Notes: HYS targets are based on 2018 rates. The SPE set 2021 and 2023 target during the last plan update in the summer of 2019. 2025 targets are a continuum of those reductions. YAHS and PRAMS target are based on the most recent data with a 5% reduction in 2023 and a 10% reduction in 2025.

Alcohol, tobacco, and vapor product use

Alcohol use (10th grade)	HYS 2016	HYS 2018	HYS 2021	Target 2023	Target 2025
Drank alcohol in last 30 days	20.3%	18.5%	8.4%	15.0%	14.0%
Experimental use of alcohol	8.7%	8.6%	3.8%	7.0%	6.0%
Heavy use of alcohol	6.2%	5.2%	3.4%	4.0%	3.0%
Problem drinking	6.8%	6.2%	3.2%	4.5%	4.0%
Binge drinking	10.9%	9.6%	5.5%	7.0%	6.5%

Young adult alcohol use (past month use)	YAHS 2019	YAHS 2020	YAHS 2021	Target 2023	Target 2025
Age 18-20 past year use	39.1%	33.5%	40.1%	38.1%	36.1%
Age 21-25 past year use	68.1%	70.0%	67.9%	64.5%	61.1%
Age 18-25 past year use	56.5%	56.3%	56.9%	54.1%	51.2%

Pregnant women alcohol use	PRAMS 2018	PRAMS 2019	PRAMS 2020	Target 2023	Target 2025
Any alcohol use during the last 3 months of pregnancy	14.0%	9.7%	6.6%	6.3%	5.9%

Tobacco use (10th grade)	HYS 2016	HYS 2018	HYS 2021	Target 2023	Target 2025
Tobacco use in past 30 days (all tobacco, excluding e-cigarettes)[1]	10.2%	7.9%	3.5%	7.5%	7.1%
Smoked cigarettes in last 30 days	6.3%	5.0%	1.9%	4.8%	4.5%

E-cigarettes/vapor products use (10th grade)	HYS 2016	HYS 2018	HYS 2021	Target 2023	Target 2025
Current e-cigarettes and/or vape use[2]	12.7%	21.2%	7.6%	20.1%	19.1%
Marijuana vaping (% of students who use marijuana who vape it)[3]	5.1%	6.5%	3.5%	6.2%	5.9%

Cannabis/marijuana, painkiller, and polysubstance use

Cannabis/marijuana use (10th grade)	HYS 2016	HYS 2018	HYS 2021	Target 2023	Target 2025
Used marijuana in last 30 days	17.2%	17.9%	7.2%	12.0%	9.0%
Used marijuana 6+ days	7.7%	7.1%	3.2%	6.0%	5.5%

Young adult recreational cannabis/marijuana use	YAHS 2019	YAHS 2020	YAHS 2021	Target 2023	Target 2025
Age 18-20 past year use	43.7%	40.4%	44.9%	42.7%	40.4%
Age 21-25 past year use	49.6%	52.3%	55.2%	52.4%	49.7%
Age 18-25 past year use	47.2%	47.9%	51.2%	48.6%	46.1%

Painkiller use (10th grade)	HYS 2016	HYS 2018	HYS 2021	Target 2023	Target 2025
Misused painkillers in last 30 days	4.4%	3.6%	1.0%	2.0%	1.5%

Polysubstance use (10th grade)	HYS 2016	HYS 2018	HYS 2021	Target 2023	Target 2025
Current (past 30 day) polysubstance use[4]	13.6%	13.4%	4.8%	12.7%	12.1%
Current alcohol users also use marijuana	55.4%	58.2%	45.2%	55.3%	52.4%
Current marijuana users also use alcohol	65.5%	60.3%	52.9%	57.3%	54.3%
Current cigarette users also use marijuana	75.3%	73.3%	65.2%	69.6%	66.0%

Depression, suicide, and bullying

Depression (10th grade)	HYS 2016	HYS 2018	HYS 2021	Target 2023	Target 2025
Sad/hopeless in past 12 months	34.5%	40.0%	38.1%	36.0%	34.1%

Suicide (10th grade)	HYS 2016	HYS 2018	HYS 2021	Target 2023	Target 2025
Suicide ideation	20.6%	23.0%	19.6%	20.7%	19.6%
Suicide plan	17.0%	17.9%	15.6%	16.1%	15.2%
Suicide attempt	10.1%	10.0%	8.2%	9.0%	8.5%

Bullied/Harassed/Intimidated (10th grade)	HYS 2016	HYS 2018	HYS 2021	Target 2023	Target 2025
Bullied in the past 30 days	20.7%	19.3%	13.3%	17.4%	16.4%

Data Sources: HYS – Healthy Youth Survey, YAHS – Young Adult Health Survey, PRAMS – Pregnancy Risk Assessment Monitoring System

1. Includes: a) cigarettes; b) chewing tobacco, snuff, or dip; c) cigars, cigarillos, or little cigar; d) tobacco that tastes like candy fruit or alcohol; e) pipe; f) hookah. Not all types of tobacco were asked in all years.
2. HYS survey question only asked about e-cigarettes use in 2012 and was changed in 2014 to ask about e-cigarette use/ vaping. Although these may be considered synonymously, possibly some respondents did not recognize that e-cigarette use is considered vaping. This could potentially have reduced the number who responded affirmatively to the question in 2012.
3. Change in wording in 2021 from 2018.
4. Includes cigarettes, alcohol, marijuana, and illegal drug use.

Short-term outcomes: Intervening variables

Access

10th graders who got alcohol	HYS 2010	HYS 2018	HYS 2021
Got it from friends	36.3%	37.7%	35.3%
Got it at a party	31.3%	23.8%	25.1%
From home without permission	15.3%	20.8%	21.4%
From home with permission	13.8%	11.7%	26.2%
Gave money to someone else to get it for them	18.3%	11.0%	10.2%
Bought it from a store	7.2%	7.0%	7.5%

10th graders who got marijuana	HYS 2014	HYS 2018	HYS 2021
Report getting it from a friend	61.3%	53.9%	56.8%
Report gave someone money	18.8%	14.9%	19.3%

10th graders who used electronic vapor products	HYS 2016	HYS 2018	HYS 2021
Bummed from someone	26.8%	35.3%	34.9%
Paid someone	16.1%	21.1%	19.0%
Bought it from a store	10.1%	7.8%	3.7%

Young adults who got marijuana	YAHS 2014	YAHS 2018	YAHS 2021
Report getting it from a friend (age 18-20)	72.9%	63.8%	65.6%
Report getting it from a friend (age 21-25)	67.5%	33.8%	26.4%
Report getting it from a store (age 21-25)	8.8%	80.0%	75.6%

State licensing of liquor licenses	LCB 2010	LCB 2020	LCB 2021
Number of active retail liquor licenses	14,425	18,376	18,473

Synar report 2019 – 2020 comparison	2020	2022	2023
Retailer Violation Rate (RVR)	12.2%	14.7%	16.7%

State licensing of marijuana store licenses	LCCB 2016	LCCB 2020	LCCB 2021
Retail an producer/processors	1,415	1,807	1,787

Availability

10th graders: Report "sort of" or "very easy" to get...	HYS 2010	HYS 2018	HYS 2021
Alcohol	56.2%	47.8%	40.7%
Marijuana	54.3%	49.2%	31.6%
Cigarettes	52.7%	34.7%	26.3%

Opioid access	PMP 2012	PMP 2018
Patients with any opioid prescription (per 1,000)	98.2	69.2

Community norms

Alcohol: 10th graders	HYS 2010	HYS 2018	HYS 2021
Report "adults in the community think it's wrong" or "very wrong"	75.5%	80.0%	NA
Report "parents talked about it"	55.0%	61.4%	60.9%

Marijuana: 10th graders	HYS 2010	HYS 2018	HYS 2021
Report "parents think it's wrong" or "very wrong"	89.8%	89.6%	90.6%
Report "adults think it's wrong to use marijuana"	82.0%	80.7%	NA

Marijuana: 10th graders	HYS 2014	HYS 2018	HYS 2021
Report "parents talked about not using marijuana"	60.8%	60.2%	58.3%

Laws: 10th Graders	HYS 2010	HYS 2018	HYS 2021
Report laws and norms are favorable towards drug use	34.5%	29.5%	NA

Young adult marijuana use (age 18-25)	NSDUH 2013-2014	NSDUH 2018-2019	NSDUH 2019-2020
Report marijuana use in past 30 days	24.5%	31.8%	32.0%

Enforcement

10th graders	HYS 2010	HYS 2018	HYS 2021
Think police would catch a kid drinking (response of "yes" or "YES!")	26.0%	25.7%	29.8%
Think police would catch a kid smoking marijuana (response of "yes" or "YES!")	31.2%	30.0%	32.6%

Perception of harm

Alcohol: 10th graders	HYS 2010	HYS 2018	HYS 2021
Drinking once or twice a day has no risk or slight risk	27.5%	23.6%	16.6%

Marijuana: 10th graders	HYS 2014	HYS 2018	HYS 2021
Regular marijuana has no risk or slight risk	27.2%	34.8%	28.5%

Hope scale[1]

10th graders	HYS 2018	HYS 2021
Highly hopeful	47.0%	44.0%
Moderately hopeful	29.1%	27.4%
Slightly hopeful	16.9%	20.6%
No or very low hope	6.9%	7.9%

1. Hope reflects a future oriented mindset and motivational process by which an individual has an expectation towards attaining a desirable goal. Research has linked hope with overall physical, psychological, and social well-being. The Children's Hope Scale is an assessment of agency (ability to initiate and sustain action towards goals) and pathways (capacity to find a means to carry out goals).

The SPE Policy Consortium will continue to review these indicators regularly and update and revise as necessary to have the best measures in place. We will also monitor related indicators, such as health care costs, individual productivity, and employment outcomes; however, they are not included in the preceding tables. For young adults, we continue to enhance our efforts to collect data from those individuals who do not attend college. Other efforts to enhance evaluation and data gathering efforts are to identify additional measures for both pregnant women and substance use during and post pregnancy and expand current measures and scope of mental health data collection.

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

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

Health equity in the evaluation phase

SPE Policy Consortium partner agencies have increased efforts to collect health disparity data as we evaluate the outcomes of prevention services that are delivered throughout the state. This is accomplished from the development of new data collection systems, including collection of military status, veteran's status, LGBTQ, and additional racial subcategories for prevention service implementation, as well as collecting high quality data on both sex and gender for our statewide Healthy Youth Survey. Collecting both sex and gender on student surveys allows communities to better understand and meet the needs of all youth.

Sustainability

The SPE Policy 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 SUD prevention and mental health promotion. See Appendix – SPE Policy Consortium Members.

Furthermore, the SPE Policy Consortium is committed to working collaboratively 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 Youth Advisory Workgroup, Youth and System Partner Roundtables, Accountable Communities of Health (ACHs), and Federally Recognized Tribes, as well as other non-traditional groups such as youth prevention groups, community-based organizations, local coalitions, and foundations. We will also consult with the community at large as we further develop our specific activities within each strategy to gather community input and create partnerships.

Appendix

Acronyms and abbreviations of state agencies and organizations

Agency/Organization - Resource	Acronym
American Indian Health Commission	AIHC
Attorney General Office	AG
Commission on Asian Pacific American Affairs	CAPAA
College Coalition on Substance misuse, Advocacy, and Prevention	CCSAP
Department of Children Youth and Families	DCYF
Department of Health	DOH
Dr. Robert Bree Collaborative	Bree Collaborative
Department of Labor & Industries	L&I
Department of Social and Health Services	DSHS
Drug Enforcement Agency	DEA
Educational Service District	ESD
Foundation for Healthy Generations	Healthy Gen
Health Care Authority (HCA) and HCA/Division of Behavioral Health & Recovery	HCA/DBHR
Indian Policy Advisory Committee	IPAC
Liquor and Cannabis Board	LCB
Northwest Hight Intensity Drug Trafficking Area	NW HIDTA
Office of Superintendent of Public Instruction	OSPI
Prevention Specialist Certification Board of Washington	PSCBW
State Board of Health	SBOH
State Epidemiological Outcome Workgroup	SEOW
University of Washington	UW
University of Washington Addictions, Drug, and Alcohol Institute	UW ADAI
Washington Association for Substance use disorder and Violence Prevention	WASAVP
Washington Breaths Statewide Commercial Tobacco Coalition	WA Breathes
Washington State Prevention Research Sub-Committee	PRSC

SPE Policy Consortium partner list

Partner Agency/Organization	SPE Policy Consortium Representative
American Indian Health Commission (AIHC)	Currently Vacant
Attorney General Office	Kelly Richburg, Senior Policy Analyst
Commission on Asian Pacific American Affairs (CAPAA)	Currently Vacant
College Coalition for Substance use disorder Prevention (CCSAP)	Jason Kilmer, University of Washington Associate Professor Psychiatry & Behavioral Sciences School of Medicine
Department of Children Youth and Families (DCYF)	Jennifer Helseth, Health Systems Analyst
Department of Health (DOH), Prevention and Community Wellness	Heidi Glesmann , SPE Consortium Co-chair (Interim), Commercial Tobacco Prevention Manager, YCCTPP Mary Kellington, Safe Medication Return Program Manager Jennifer Kang, PMP Operations Manager Micah Zimmermaker, Youth Commercial Tobacco Prevention Coordinator Kyle Unland, Community Prevention Section Manager Liz Wilhelm, Community Grants Coordinator
Department of Labor & Industries (L&I)	Jaymie Mai, Pharmacy Director, Opioid Prevention Workgroup Co-Lead
Health Care Authority (HCA) and Division of Behavioral Health & Recovery (DBHR)	Sarah Mariani, SPE Consortium Co-chair, Section Manager, Substance Use Disorder Prevention and Mental Health Promotion Section Alicia Hughes, Development and Strategic Initiatives Supervisor, Opioid Prevention Workgroup Co-Lead Kasey Kates, CPWI and School-Based Services Supervisor, Washington Healthy Youth (WHY) Coalition: Underage Drinking & Youth Cannabis Prevention Co-Lead Sandy Salivaras, Prevention Research and Evaluation Manager, HCA/DBHR Erika Jenkins, Policy & Project Manager, Opioid Prevention Workgroup Co-lead Billy Reamer, Prevention System Manager, Mental Health Promotion Workgroup Co-Lead

Partner Agency/Organization	SPE Policy Consortium Representative
	Ray Horodowicz, Prevention System Manager, Washington Breathes Commercial Tobacco and Vapor Products Workgroup Co-Lead Isaac Wulff, Prevention System Manager, SPE Staff Rachel Oliver, Prevention System Manager, Young Adult Cannabis & Alcohol Prevention Workgroup Co-Lead Lucilla Mendoza, Tribal Behavioral Health Administrator
Department of Social and Health Services (DSHS), Office of Indian Policy (OIP)	Currently Vacant
Drug Enforcement Agency (DEA), Seattle Office	Melissa Brown
Foundation for Healthy Generations (Healthy Gen)	Julie Peterson, Executive Director
Indian Policy Advisory Committee (IPAC)	Currently Vacant
Liquor and Cannabis Board (LCB)	Mary Segawa, Public Health Education Liaison, Washington Healthy Youth (WHY) Coalition: Underage Drinking & Youth Cannabis Prevention Co-Lead
Northwest High Intensity Drug Trafficking Area (NW HIDTA)	Eliza Powell, Prevention & Treatment Manager
Office of Superintendent of Public Instruction (OSPI)	Dixie Grunenfelder, Director of K12 System Supports Doua Kha, Supervisor, Student Behavior & Support Program Anna Marie Dufault, Assistant Superintendent, Student Engagement & Support
Prevention Specialist Certification Board of Washington (PSCBW)	Liz Wilhelm, President
Prevention Voices	Currently Vacant
State Board of Health (SBOH)	Michelle Davis, Executive Director Molly Dinardo, Health Policy Advisor
State Epidemiological Outcome Workgroup (SEOW)	Sandy Salivaras, Prevention Research and Evaluation Manager, HCA/DBHR
Washington Association for Substance use disorder and Violence Prevention (WASAVP)	Mike Graham-Squire, Drug Free Communities Manager, Neighborhood House

Partner Agency/Organization	SPE Policy Consortium Representative
Washington Breaths Statewide Commercial Tobacco Coalition (WA Breathes)	Micah Zimmermaker, Youth Commercial Tobacco Prevention Coordinator, DOH
Washington Healthy Youth Coalition (WHY)	Kasey Kates, CPWI and School-Based Services Supervisor Mary Segawa, Public Health Education Liaison Martha Williams, Prevention System Manager, HCA/DBHR
Washington Poison Center (WAPC)	Alex Sirotzki Meghan King
Washington State Commission on Hispanic Affairs (CHA)	Currently Vacant
Washington State Hospital Association (WSHA)	Brittany Weiner, Assistant Director of Behavioral Health Tina Seery, Senior Director Safety & Quality
Washington State Institute for Public Policy (WSIPP)	Amani Rashid, Senior Research Associate
Washington State Patrol (WSP)	Lt. Courtney Stewart, Field Operations Bureau
Washington State Prevention Research Sub-Committee (PRSC)	Gitanjali Shrestha, Assistant Research Professor, Dept. of Human Development
Washington State University (WSU)	Gitanjali Shrestha, Assistant Research Professor, Dept. Of Human Development Jennifer Duckworth, Assistant Professor, Dept. of Human Development
Washington Traffic Safety Commission (WTSC)	Pam Pannkuk, Deputy Director Wade Alonzo, Program Director Staci Hoff, Research Director

SPE Policy Consortium membership structure and history

Through active engagement and intentional recruitment, the SPE Policy Consortium ensures representation of key state agencies and organizations in our ongoing work. SPE Policy Consortium members are expected to:

- Participate in a minimum of 2/3 of the meetings within a calendar year.
- Represent the SPE Policy 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 SUD prevention and mental health promotion.
- Think about how projects/programs align with their agency interests, goals, programs, and projects, advise on possible state implications.
- Explore opportunities for collaboration and coordination.

To encourage active participation, we make a significant effort to provide accurate and timely communication with all members and the advisory groups. We keep them updated on the SPE Policy 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 SPE Policy Consortium recruits new members as needed. In the event 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 if new members. As new members join the SPE Policy Consortium 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.

The SPE Policy 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 SPE Policy Consortium meets every other month throughout the year and is currently co-chaired by leaders of the Health Care Authority (HCA), Division of Behavioral Health and Recovery and Department of Health (DOH), Division of Prevention and Community Health, . Each of the five SPE Policy Consortium Workgroups are co-led by members of the Consortium, ensuring diversity in representation across partners and agencies. The SPE Policy Consortium partners with the State Epidemiological Outcomes Workgroup (SEOW) to support the needs assessments and to consider and oversee evaluation of this Strategic Plan.

See an overview of the upcoming tasks for the SPE Policy Consortium on the next page.

Task	Lead	2022	2023	2024	2025	2026	2027
Consortium bi-monthly meetings	HCA/DBHR	✓	✓	✓	✓	✓	✓
Review leadership and Workgroup reps	Consortium			✓		✓	
Set evaluation targets for selected indicators	Consortium		✓		✓		✓
Workgroup meetings every 1–2 months	Workgroup Leads	✓	✓	✓	✓	✓	✓
Workgroup Action Plan implementation	Workgroups	✓	✓	✓	✓	✓	✓
Biennial review of resources	Consortium		✓		✓		✓
Biennial review of data assessment	SEOW		✓		✓		✓
Update to Strategic Plan	Consortium, Workgroup Leads, Leadership				✓		✓

Local and community application

While this plan is specific to statewide prevention and promotion efforts, there are many local organizations and partners who help ensure the work is completed and customized to community needs. This process is iterative, with input from communities serving to guide and prioritize the statewide initiatives, and state level resources being directed towards effective strategies and positive community health processes. This plan can serve as one supporting resource in this conversation as a source of key data trends, awareness of broader initiatives, and connection to potential partnerships.

Data source

The Data Assessment portion of this plan is perhaps the most comprehensive, and yet concise, source of high-level information about the behavioral health landscape of Washington, especially with regards to primary prevention of SUD and promotion of mental health. While the information in this plan's assessment section could be obtained elsewhere, it will likely be found under other data and findings, making it less relevant. Communities can review these portions of the plan and use them as a comparison to their own data or use it to fill in any gaps in understanding where appropriate.

Initiative awareness

There is no other document available in Washington that gathers such a diversity of work from so many partners. The success of local efforts often depends on just one or two more pieces of information or connections, so being aware of what else is being done in your area to prevent SUD or promote mental health could mean the difference between success and stagnation. This plan and the Resource Assessment section can assist communities in that broader awareness and understanding of complimentary efforts. It can also serve to demonstrate to local decision makers where a program that is known in a community fit into the larger system, which can build support and increase engagement.

Increased partnerships

Like awareness of programs and strategies, increasing local awareness of the state agencies and organizations involved in this work can expand opportunities and resource potentials. For instance, if a community is already involved in Program A, but it could use some support or enhancement, they might develop that support by connecting with other agencies who manage Program B or C. The SPE Policy Consortium partner list may be able to shed light on who their key points of contact are and could help to establish these connections.

Logic model

Long-term Outcome Consequences 10-15 years	Problem Areas 5-10 years	Intervening Variables (Risk Protective Factors) 2-5 years	SPE Consortium Partners' Strategies	SPE Consortium Collaborative Strategies	Evaluation Plan
	Outcomes			Actions	
What is the problem?	**Why?**	**Why here?**	**What are we going to do?**	**How can we do it together?**	**So what? How will we know?**
These problems... • **Chronic disease** (ATOD Attributable Deaths - CHARS) • **Crime** (Alcohol/Drug –related arrests ages 10-25 - UCR) • **Low graduation rates** (HS On-time/Extended Graduation – OSPI) • **Suicide** (# of suicides/attempts ages 10-25 - CHARS) • **Fatalities and serious injury from vehicle crashes** (# Alcohol-Related Traffic Fatalities/ Injuries ages 16-25 - WTSC)	**These types of problem areas...** • **Underage drinking** (30-day use; problem use – HYS 10th grade) • **Cannabis/marijuana misuse** (30-day use – HYS 10th grade) • **Any opioid/ prescription drug misuse** (30-day use– HYS 10th grade) • **Commercial tobacco misuse** (30-day use – HYS 10th grade) • **Vaping** (30-day use- HYS 10th grade) • **Young adult/adult alcohol misuse** (Use during pregnancy – PRAMS, YAHS) • **Anxiety** (Within last 2 weeks- HYS 10th grade) • **Depression** (Sad/Hopeless in past 12 months – HYS 10th grade) • **Suicide ideation** (Suicide ideation – HYS) • **Problem gambling** (Past 12 months - HYS 10th grade)	**...specifically with these common factors...** • **Access** (Where get substance - HYS 10th grade) • **Availability** (Easy to get– HYS 10th grade) • **Perception of harm** (Risk of use– HYS 10th grade) • **Enforcement** (Get caught– HYS 10th grade) • **Community norms** (Laws/norms; harassment – HYS 10th grade; young adult use - NSDUH) • **Hope scale** (Agency and capacity - HYS 10th grade)	**...can be addressed through these strategies...** • **Cross-systems planning/ collaboration** 12 Agency/Orgs., 46 resources • **Policy/ community norms** 12 Agency/Orgs., 46 resources • **Education/ alternatives** 10 Agency/Orgs., 121 resources • **Community engagement/ coalition development** 8 Agency/Orgs., 34 resources • **Information dissemination** 10 Agency/Orgs., 43 resources • **Problem identification and referral** 5 Agency/Orgs., 17 resources	**...and working collaboratively on these strategies...** • **Cross-systems planning/ collaboration** SPE Policy Consortium Membership, SPE Policy Consortium Workgroups, inter and intra agency collaborative projects • **Information dissemination** Public media, education, and/or awareness campaigns focused on problem areas • **Policy/community norms** Policy review, advocacy and promotion focused on problem areas • **Education** Professional development related to problem areas and strategies	**...and we will track the key indicators listed for each of the outcomes (red, purple, blue columns) to measure our impact...** **Using state data sources:** (see appendix for list of acronyms) • HYS • CORE GIS (WTSC; PRAMS; LCB; CHARS) • BRFSS • NSDUH • YAHS **Using strategy specific process data:** • Agency service data • Provider service data

Data assessment

The tables below summarizes findings from a review of substances.

Substance Use Baseline Ranking 2011

The table presented below provides a summary of findings of substances for which data was available up to the year 2011.

Trend: ↑ Increase | ↓ Decrease | • No change

Ranking		Alcohol	Cannabis/ Marijuana	Tobacco[2]	Opioid Misuse[3]	Meth[4]
Prevalence	Youth	1st	2nd	3rd	4th	5th
	Adults	1st	3rd	2nd	4th	N/A
Change over time[1]	Youth	•	↑	•	•	•
	Adults	•	•	•	•	•
Economic impact		1st	2nd	3rd	2nd	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 ranking		**1st**	**2nd**	**3rd**	**4th**	**5th**

Notes:
Substances are ranked from the highest prevalence to the lowest. Ranking is based on the prevalence of substance use among all youth (Grade 6, 8, 10, and 12) reporting use in the 2010 Healthy Youth Survey.

1. The change over time is the differences between 2004 through 2010 for youth (HYS). Opioid misuse (pain killer use to get high) is based on years 2006 through 2010. The change over time for adults (18+) is between years 2002-2003 and 2008-2009 for marijuana, alcohol, tobacco, and opioid misuse (nonmedical use pain reliever). Except for youth marijuana use, there has not been any discernible increasing or decreasing trends in these five substances among youth and adults.
2. Tobacco indicator use for youth is cigarettes smoked during the past 30 days. For adults, tobacco includes adults who smoked cigarettes during the past 30 days.
3. Painkiller misuse is based on youth reporting that they used a painkiller to get high in the past 30 days. In adults, opioid misuse (prescription pain reliever misuse) is based on reported use in the past year.
4. Youth methamphetamine use is based on youth reporting that they used methamphetamines in the past 30 days.

New Plan Ranking 2021

The table below summarizes findings from a review of substances up until 2021.

Trend: ↑ Increase | ↓ Decrease | ● No change

Ranking		Alcohol	Cannabis/ Marijuana	Tobacco[2]	Opioid Misuse[3]	Meth[4]
Prevalence	Youth	1st	2nd	3rd	4th	5th
	Adults	1st	3rd	2nd	4th	5th
Change over time[1]	Youth	↓	●	↓	↓	●
	Adults	●	↑	↓ Age 18-25 ● Age 26+	↓ Age 18-25 ● Age 26+	●
Overall ranking		**1st**	**2nd**	**3rd**	**4th**	**5th**

Notes: Substances are ranked from the highest prevalence to the lowest. Ranking is based on the prevalence of substance use among all youth (Grade 6, 8, 10, and 12) reporting use in the 2021 Healthy Youth Survey.

1. The change over time is the difference between 2010 through 2018 for youth (HYS). The change over time for adults is between 2013-2014 and 2018-2019 for marijuana, alcohol and tobacco. Adult meth use is between 2016-2017 and 2018-2019. Adult Pain reliever use is between 2015-2016 and 2018-2019. The corona disease 2019 (COVID 19) necessitated methodologic changes in data collection for both the HYS and the NSDUH most recent surveys administered in 2020 and 2021. Due to these changes, we did not include the most recent rates into the trend analysis as we cannot separate the effects of methodologic changes from true changes in the outcomes.
2. Tobacco indicator use for youth is all tobacco use, excluding e-cigarettes. For adults, tobacco included all tobacco products.
3. Painkiller misuse is based on youth reporting that they used a painkiller to get high in the past 30 days. In adults, prescription pain relievers misuse is based on reported use in the past year.
4. Youth methamphetamine use is based on youth reporting that they had ever once in their life used methamphetamines. Adult use is within the past year.

Economic impact

ROI for prevention services

These costs can be reduced if greater investments are made 'up stream' in effective and cost-beneficial prevention programs that keep young people healthy and away from choices that may lead to harms.

Substance use and mental health problems in Washington's young people can be reduced through high-quality delivery of effective prevention programs and policies.

Benefit-cost analyses by the Washington State Institute for Public Policy[8] show that many effective **prevention programs produce economic benefits to Washington State that exceed the costs of offering them.**[9] [10]

More than 70 prevention programs have been shown in high-quality research studies to reduce problems like substance use and mental health problems and to improve wellbeing.[11]

These programs can be offered to children, youth, and families in schools, community agencies, primary care, and other community-wide settings where they live, work, and play.

[8] Washington State Institute for Public Policy, WSIPP, wsipp.wa.gov

[9] For example, Positive Action, a school-based program aimed at improving social and emotional learning and the school climate, returned $29 in benefits per dollar invested because of reductions in anxiety, early substance use, and crime. The Good Behavior Game, another school-based program, returned $63 per dollar invested.

[10] Washington State Health Care Authority. *Substance use disorder prevention programs funded by cannabis excise tax revenues*. March 2021. PowerPoint Presentation to the House Commerce & Gaming Committee.

[11] Abuse, S., US, M. H. S. A., & Office of the Surgeon General (US. (2016). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health [Internet].

Intermediate outcomes summary data

⚠ Intermediate outcomes summary data: Behavioral health problems

↑ Increase | ↓ Decrease | • No change

Alcohol, tobacco, and vapor product use

Alcohol use (10th grade)	HYS 2010	HYS 2012	HYS 2014	HYS 2016	HYS 2018	HYS 2021	Trend 2010-2018
Drank alcohol in last 30 days	27.7%	23.3%	20.6%	20.3%	18.5%	8.4%	↓
Experimental use of alcohol	10.9%	8.5%	9.2%	8.7%	8.6%	3.8%	•
Heavy use of alcohol	8.2%	7.1%	5.8%	6.2%	5.2%	3.4%	↓
Problem drinking	10.4%	9.4%	6.9%	6.8%	6.2%	3.2%	↓
Binge drinking	16.2%	14.3	10.6%	10.9%	9.6%	5.5%	↓

Young adult alcohol use (past month use)	YAHS 2014	YAHS 2017	YAHS 2018	YAHS 2019	YAHS 2020	YAHS 2021	Trend 2014-2021
Age 18-20 past year use	46.3%	42.8%	42.4%	39.1%	33.5%	40.1%	↓
Age 21-25 past year use	74.1%	68.9%	72.1%	68.1%	70.0%	67.9%	↓
Age 18-25 past year use	63.2%	59.3%	61.1%	56.5%	56.3%	56.9%	↓

Pregnant women alcohol use	PRAMS 2012	PRAMS 2016	PRAMS 2017	PRAMS 2018	PRAMS 2019	PRAMS 2020	Trend 2012-2020
Any alcohol use during the last 3 months of pregnancy	12.1%	9.8%	11.4%	14.0%	9.7%	6.6%	•

Tobacco use (10th grade)	HYS 2010	HYS 2012	HYS 2014	HYS 2016	HYS 2018	HYS 2021	Trend 2010-2018
Tobacco use in past 30 days (all tobacco, excluding e-cigarettes)[1]	17.7	16.4%	15.8	10.2%	7.9%	2.1%	↓
Smoked cigarettes in last 30 days	12.7%	9.5%	7.9	6.3%	5.0%	1.9%	↓

E-cigarettes/vapor products use (10th grade)	HYS 2010	HYS 2012	HYS 2014	HYS 2016	HYS 2018	HYS 2021	Trend 2010-2018
Current e-cigarettes and/or vape use[2]	-	3.9%	18.0%	12.7%	21.2%	7.6%	NA*
Marijuana vaping (% of students who use marijuana who vape it)[3]	-	-	5.4%	5.1%	6.5%	3.5%	NA*

Cannabis/marijuana, painkiller, and polysubstance use

Cannabis/marijuana use (10th grade)	HYS 2010	HYS 2012	HYS 2014	HYS 2016	HYS 2018	HYS 2021	Trend 2010-2018
Used marijuana in last 30 days	20.0%	19.3%	18.1%	17.2%	17.9%	7.2%	•
Used marijuana 6+ days	8.4%	8.6%	7.8%	7.7%	7.1%	3.2%	↓

Young adult recreational cannabis/marijuana use	YAHS 2014	YAHS 2017	YAHS 2018	YAHS 2019	YAHS 2020	YAHS 2021	Trend 2014-2021
Age 18-20 past year use	43.3%	43.4%	44.4%	43.7%	40.4%	44.9%	•
Age 21-25 past year use	43.7%	49.8%	50.9%	49.6%	52.3%	55.2%	↑
Age 18-25 past year use	43.5%	47.4%	48.5%	47.2%	47.9%	51.2%	↑

Painkiller use (10th grade)	HYS 2010	HYS 2012	HYS 2014	HYS 2016	HYS 2018	HYS 2021	Trend 2010-2018
Misused painkillers in last 30 days	8.3%	6.0%	4.6%	4.4%	3.6%	1.0%	↓

Polysubstance use (10th grade)	HYS 2010	HYS 2012	HYS 2014	HYS 2016	HYS 2018	HYS 2021	Trend 2010-2018
Current (past 30 day) polysubstance use[4]	18.9%	16.9%	14.7%	13.6%	13.4%	4.8%	↓
Current alcohol users also use marijuana	52.7%	57.6%	56.6%	55.4%	58.2%	45.2%	•
Current marijuana users also use alcohol	72.8%	69.5%	64.3%	65.5%	60.3%	52.9%	↓
Current cigarette users also use marijuana	73.9%	74.5%	70.7%	75.3%	73.3%	65.2%	•

Depression, suicide, and bullying

Depression (10th grade)	HYS 2010	HYS 2012	HYS 2014	HYS 2016	HYS 2018	HYS 2021	Trend 2010-2018
Sad/hopeless in past 12 months	29.8%	30.9%	34.9%	34.5%	40.0%	38.1%	↑

Suicide (10th grade)	HYS 2010	HYS 2012	HYS 2014	HYS 2016	HYS 2018	HYS 2021	Trend 2010-2018
Suicide ideation	17.6%	18.8%	20.5%	20.6%	23.0%	19.6%	↑
Suicide plan	12.4%	14.3%	16.4%	17.0%	17.9%	15.6%	↑
Suicide attempt	7.2%	7.8%	10.2%	10.1%	10.0%	8.2%	↑

Bullied/Harassed/Intimidated (10th grade)	HYS 2010	HYS 2012	HYS 2014	HYS 2016	HYS 2018	HYS 2021	Trend 2010-2018
Bullied in the past 30 days	24.3%	25.1%	22.6%	20.7%	19.3%	13.3%	↓

Notes: Trend tells us if the outcome has been changing over a given period (see Trend Period for starting and end points). The trend for this report was determined to be increasing or decreasing if there was a statistically significance difference at the $p<0.05$ level between the starting and ending time points.

*Not Applicable – For this report, each indicator needed a minimum of four data points to determine trend.

Data Sources: HYS – Healthy Youth Survey, YAHS – Young Adult Health Survey, PRAMS – Pregnancy Risk Assessment Monitoring System

1. Includes: a) cigarettes; b) chewing tobacco, snuff, or dip; c) cigars, cigarillos, or little cigar; d) tobacco that tastes like candy fruit or alcohol; e) pipe; f) hookah. Not all types of tobacco were asked in all years.
2. HYS survey question only asked about e-cigarettes use in 2012 and was changed in 2014 to ask about e-cigarette use/ vaping. Although these may be considered synonymously, possibly some respondents did not recognize that e-cigarette use is considered vaping. This could potentially have reduced the number who responded affirmatively to the question in 2012.
3. Change in wording in 2021 from 2018.
4. Includes cigarettes, alcohol, marijuana, and illegal drug use.

Health disparities data

Health Disparities Data by Gender at Birth, Sexual Orientation, Disability Status, and Housing Insecurity, Washington State 10th Grade Students

Subpopulation, 2021

Red highlighted data indicates a statistically significant difference at the p<0.05 level

Behavioral health problem	Gender at birth[1]		Sexual orientation (LGB)[2]		Disability status[3]		Housing insecurity[4]	
	Female	Male	LGB	Hetero-sexual	Disability	No disability	Insecure housing	Secure housing
Smoked cigarettes in past 30 days	2.3%	1.6%	4.9%	1.1%	3.8%	0.8%	10.2%	1.7%
Drank alcohol in past 30 days	9.7%	7.0%	13.5%	7.2%	15.8%	6.3%	15.1%	8.1%
Used marijuana or hashish in past 30 days	7.9%	6.4%	13.9%	5.8%	11.5%	5.4%	16.6%	6.7%
Binge drinking in past 2 weeks	6.0%	4.9%	9.3%	4.8%	8.4%	4.7%	11.5%	5.1%
Pain killer use in past 30 days	1.2%	0.8%	2.3%	0.7%	3.0%	0.4%	4.0%	0.8%
Sad/hopeless in past 12 months	50.2%	25.4%	65.9%	29.0%	61.2%	28.5%	52.8%	36.5%
Suicide ideation	26.2%	12.6%	46.3%	11.5%	38.2%	13.0%	36.5%	18.5%
Suicide plan	20.8%	10.3%	34.8%	9.2%	30.5%	10.0%	26.0%	14.7%
Suicide attempt	11.6%	4.5%	20.9%	4.3%	18.2%	4.2%	16.3%	7.2%
Bullied in the past 30 days	16.3%	10.1%	23.1%	10.2%	25.7%	8.6%	21.7%	12.7%
Anxiety[5]	55.0%	23.1%	67.5%	29.7%	61.8%	36.0%	47.2%	38.9%

Data Source: Washington State Healthy Youth Survey, 2021, Grade 10

Note: For more information on confidence intervals and significance, frequency reports can be found at www.askhys.net.

1. What sex/gender were you at birth, even if you are not that gender today?
2. Which of the following best describes you? Respondents who selected "Gay or Lesbian" or "Bisexual" are reported in the LGB results. Respondents who selected "Heterosexual (straight)" are reported in the Heterosexual results. Respondents who selected "Questioning/not sure", "Something else fits better", or "I don't know what this question is asking" are not included in the results
3. Students who answered yes to any of the four questions about disability were reported in the disability results. 1) Do you have any physical disabilities or long-term health problems lasting or expected to last 6 months or more? 2) Do you have any long-term emotional problems or learning disabilities lasting or expected to last 6 months or more? 3) Would other people consider you to have a disability or long-term health problem including physical health, emotional, or learning problems? 4) Are you limited in any activities because of a disability or long-term health problem including physical health, emotional, or learning problems expected to last 6 months or more?
4. This column presents results for two groups of students – those with insecure housing and those with secure housing. Students were asked, "Are your current living arrangements the results of losing your home because your family cannot afford housing?" Students who selected "yes" are reported in the insecure housing results and respondents who selected "no" are reported in the secure housing results.
5. Anxiety is the sum of scores form two HYS questions for a Generalized Anxiety Disorder scale: 1) How often over the last 2 weeks were you bothered by: feeling nervous, anxious or on edge, and 2) How often over the last 2 weeks, were you bothered by: Not being able to stop or controlling worrying.

Health Disparities Data by Race, Washington State 10th Grade Students,
Mutually Exclusive, 2021

In comparison to other races: Rate is significantly lower | Rate is significantly higher

Behavioral health problem	Statewide	Race					Ethnicity
		White - NH	AI/AN - NH	Asian - NH	Black - NH	NHOPI - NH	Hispanic
Smoked cigarettes in past 30 days	3.5%	2.3%	3.6%	0.6%	2.5%	3.7%	1.1%
Drank alcohol in past 30 days	8.7%	9.5%	6.3%	4.6%	3.6%	8.5%	8.0%
Used marijuana or hashish in past 30 days	7.5%	8.0%	11.6%	1.2%	6.8%	6.1%	7.1%
Binge drinking in past 2 weeks	5.7%	5.1%	6.3%	3.2%	4.9%	8.4%	6.8%
Pain killer use in past 30 days	1.0%	0.8%	2.7%	1.0%	0.7%	1.2%	1.0%
Sad/hopeless in past 12 months	38.2%	37.5%	45.3%	29.2%	29.3%	40.5%	42.6%
Suicide ideation	19.5%	20.9%	27.1%	16.5%	15.6%	13.1%	17.1%
Suicide plan	15.5%	16.4%	26.0%	14.9%	10.4%	14.0%	14%
Suicide attempt	8.2%	7.8%	18.4%	5.4%	6.9%	4.0%	8.4%
Bullied in the past 30 days	13.7%	14.7%	21.4%	7.2%	12.2%	9.5%	11.5%

Notes: NHOPI refers to Native Hawaiians and Other Pacific Islanders. AI/AN refers to American Indian and Alaska Natives. Race/ethnic groups represented in this table are mutually exclusive, except for Hispanic which represents Hispanic or Latino/Latina alone or in combination with another race/ethnicity.

Highlighted data, green (lower rate) or red (higher rate), indicate a statistically significant difference between a race or ethnicity when compared to rest of the statewide sample at the $p<0.05$ level. For example, among Asian students, 1.2% indicated they used marijuana or hashish in the past 30 days. This rate is highlighted green to indicate that this rate is significantly lower when compared to the rest of the statewide sample. For more information on confidence intervals and significance, frequency reports can be found at www.askhys.net.

Data source: Healthy Youth Survey, 2021, Grade 10

Health Disparities Data by Race, Alone or in Combination with Another Race/Ethnicity, Washington State 10th Grade Students
Not Mutually Exclusive, 2021

In comparison to other races: Rate is significantly lower | Rate is significantly higher

	American Indian or Alaska Native (AIAN)		Asian or Asian American		Black or African American		Hawaiian or Other Pacific Islander (NHPI)		White or Caucasian Non-Hispanic		Hispanic or Latino/Latina	
	AIAN	Non-AIAN	Asian	Non-Asian	Black	Non-Black	NHPI	Non-NHPI	White	Non-White	Hispanic	Non-Hispanic
Smoked cigarettes in past 30 days	2.7%	1.9%	1.1%	2.1%	2.1%	1.9%	3.0%	1.9%	2.3%	1.4%	1.1%	2.1%
Drank alcohol in past 30 days	11.9%	8.2%	5.5%	8.9%	6.0%	8.6%	10.5%	8.3%	9.8%	6.2%	8.0%	8.7%
Used marijuana or hashish in past 30 days	13.0%	6.9%	3.2%	7.9%	10.2%	7.0%	8.2%	7.2%	8.5%	5.2%	7.1%	7.5%
Binge drinking in past 2 weeks	7.8%	5.4%	3.9%	5.8%	5.4%	5.5%	7.1%	5.5%	5.3%	5.8%	6.8%	5.7%
Pain killer use in past 30 days	2.4%	0.9%	1.1%	1.0%	1.9%	0.9%	1.5%	1.0%	0.9%	1.2%	1.0%	1.0%
Sad/hopeless in past 12 months	50.4%	37.5%	32.4%	39.1%	37.8%	38.1%	43.0%	37.9%	39.2%	36.5%	42.6%	38.2%
Suicide ideation	26.5%	19.3%	18.4%	19.8%	20.2%	19.6%	21.8%	19.6%	21.2%	17.3%	17.1%	19.5%
Suicide plan	22.7%	15.3%	15.7%	15.6%	14.8%	15.7%	16.8%	15.6%	16.9%	13.7%	14.0%	15.5%
Suicide attempt	17.5%	7.7%	7.2%	8.4%	9.4%	8.1%	9.5%	8.1%	8.0%	8.5%	8.4%	8.2%
Bullied in the past 30 days	20.7%	13.0%	8.7%	14.1%	13.3%	13.3%	11.5%	13.4%	15.3%	10.3%	11.5%	13.7%

Data Source: Healthy Youth Survey, 2021, Grade 10

Notes: The race/ethnicity columns present results for two groups of students in each of the race categories – those that identify as the race indicated alone or in combination with another race/ethnicity and the rest of the statewide sample. Highlighted data, green (lower rate) or red (higher rate), indicate a statistically significant difference between a race or ethnicity when compared to rest of the statewide sample at the $p<0.05$ level. For example, among AI/AN students, 13.0% indicated they used marijuana or hashish in the past 30 days. This rate is highlighted red to indicate that this rate is higher compared to non-AIAN students (6.9%) at the $p<0.05$ level. For more information on confidence intervals and significance, frequency reports can be found at www.askhys.net.

Data charts of primary data used

This section includes charts of data that were considered as part of our assessment. It is organized into 3 sections as described in our Logic Model: Long-term outcomes (consequences); Intermediate outcomes (problem areas); and Short-term outcomes (intervening variables).

Long-term outcomes (consequences)

What are the problems we are trying to address?

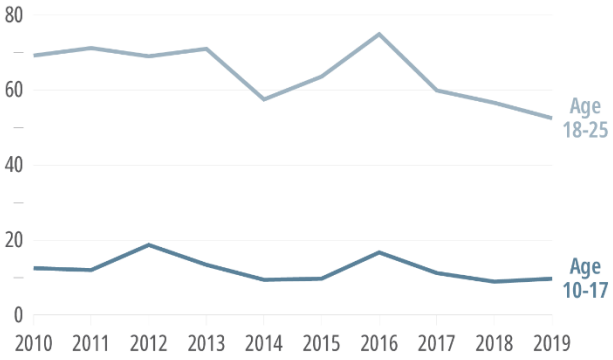
Substance use related injuries and deaths

Hospitalizations

Non Fatal Hospitalization Rates Involving Alcohol by Age Group

Washington, 2016-2020

Rate per 100,000 population



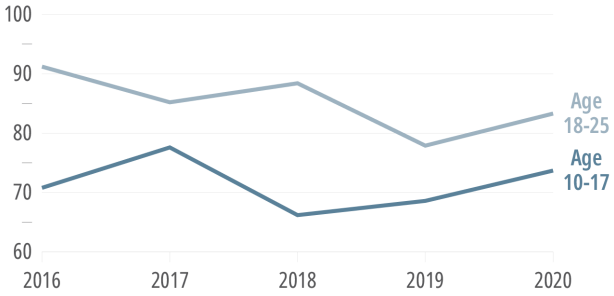
Produced by Washington Department of Social and Health Services, Research and Data Analysis

	Age 10-17	Age 18-25
2010	12.5	69.2
2011	12	71.2
2012	18.7	69
2013	13.4	71.0
2014	9.4	57.5
2015	9.7	63.6
2016	16.7	74.9
2017	11.2	59.9
2018	8.9	56.6
2019	9.7	52.5

Non Fatal Hospitalization Rates Involving Drug-Overdoses by Age Group

Washington, 2016-2020

Rate per 100,000 population



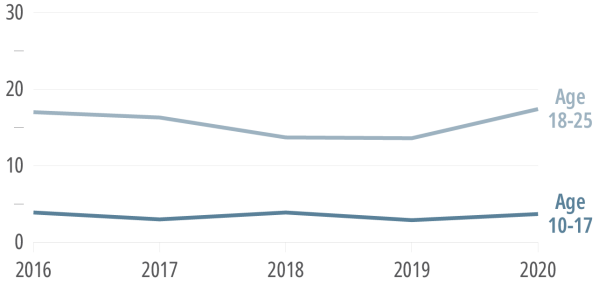
Washington State Department of Health, Comprehensive Hospital Abstract Reporting System; Since the last quarter of 2015, only ICD-10-CM is used. The deprecation of ICD-9-CM makes tracking trend across 2015 unreliable. 2001-2020; All drug overdoses T36-T50: Poisoning by drugs, medicaments and biological substances

	Age 10-17	Age 18-25
2016	3.9	17
2017	3	16.3
2018	3.9	13.7
2019	2.9	13.6
2020	3.7	17.3

Any Non Fatal Hospitalization Rates Involving Opioid Overdoses by Age Group

Washington, 2016-2020

Rate per 100,000 population



Washington State Department of Health, Comprehensive Hospital Abstract Reporting System; Since the last quarter of 2015, only ICD-10-CM is used. The deprecation of ICD-9-CM makes tracking trend across 2015 unreliable.; Opioid overdoses T40.0X: Poisoning by opium, T40.1X: Poisoning by heroin, T40.2X: Poisoning by other opioids, T40.3X: Poisoning by methadone, T40.4X: Poisoning by synthetic narcotics, T40.60: Poisoning by unspecified narcotics, T40.69: Poisoning by other narcotics.

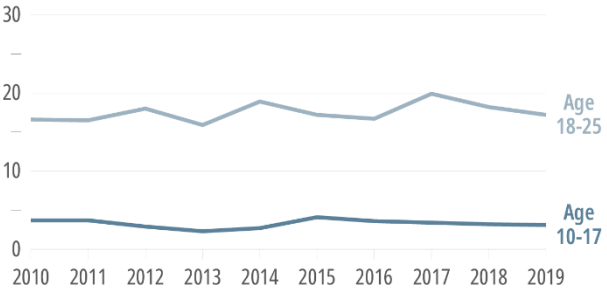
	Age 10-17	Age 18-25
2016	70.8	91.2
2017	77.6	85.2
2018	66.2	88.4
2019	68.6	77.9
2020	73.7	83.3

Deaths

Alcohol-Related Death Rates by Age Group

Washington, 2010-2019

Rate per 100,000 population



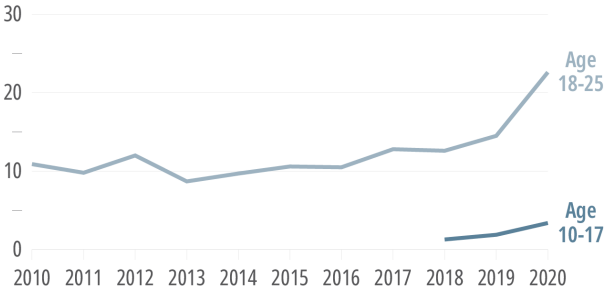
Produced by Washington Department of Social and Health Services, Research and Data Analysis

	Age 10-17	Age 18-25
2010	3.7	16.6
2011	3.7	16.5
2012	2.9	18
2013	2.3	15.9
2014	2.7	18.9
2015	4.1	17.2
2016	3.6	16.7
2017	3.4	19.9
2018	3.2	18.2
2019	3.1	17.2

Any Drug-Related Death Rates by Age Group

Washington, 2010-2020

Rate per 100,000 population

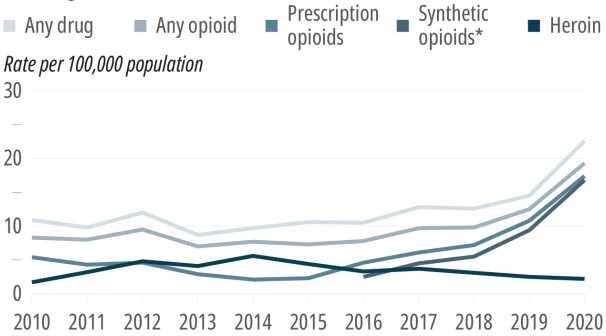


Washington State Department of Health, Center for Health Statistics, Death Certificate Data; When there is a small number of health events in a small population, problems with statistical instability may occur. Our level of confidence in the data was determined by a measure of reliability called relative standard error (RSE). When RSE was 25% or greater, data is not shown, due to statewide restrictions on publishing death data with small numbers.

	Age 10-17	Age 18-25
2010		10.9
2011		9.8
2012		12
2013		8.7
2014		9.7
2015		10.6
2016		10.5
2017		12.8
2018	1.3	12.6
2019	1.9	14.5
2020	3.4	22.6

Opioid Overdose Death Rates Aged 18-25 by Drug Type

Washington, 2010-2020



*Not methadone. Data unavailable for 2010-2015.

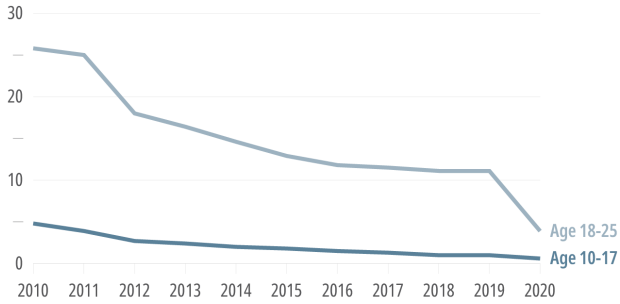
Washington State Department of Health, Center for Health Statistics, Death Certificate Data

	Any drug	Any opioid	P.O.	S.O.	Heroin
2010	10.9	8.3	5.4		1.7
2011	9.8	8.0	4.3		3.2
2012	12	9.5	4.6		4.8
2013	8.7	7.0	2.9		4.1
2014	9.7	7.7	2.1		5.6
2015	10.6	7.3	2.3		4.4
2016	10.5	7.8	4.6	2.5	3.3
2017	12.8	9.7	6.1	4.5	3.7
2018	12.6	9.8	7.2	5.5	3.1
2019	14.5	12.5	10.8	9.4	2.5
2020	22.6	19.3	17.4	16.8	2.2

Crime

Arrests, Alcohol Violation by Age Group
Washington, 2010-2020

Rate per 1,000 population

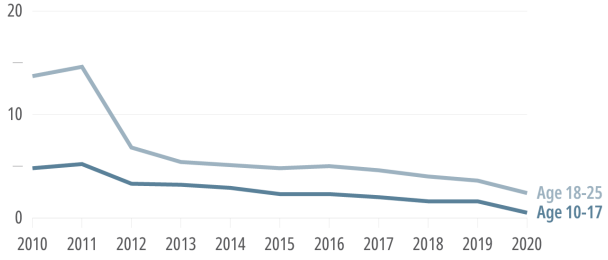


State Source: Washington Association of Sheriffs and Police Chiefs: Uniform Crime Report, National Incident-Based Reporting System; Population Estimates: Washington State Office of Financial Management, Forecasting Division

	Age 10-17	Age 18-25
2010	4.8	25.8
2011	3.9	25.0
2012	2.7	18.0
2013	2.4	16.4
2014	2.0	14.6
2015	1.8	12.9
2016	1.5	11.8
2017	1.3	11.5
2018	1.0	11.1
2019	1.0	11.1
2020	0.6	3.9

Arrests, Drug Law Violation by Age Group
Washington, 2010-2020

Rate per 1,000 population



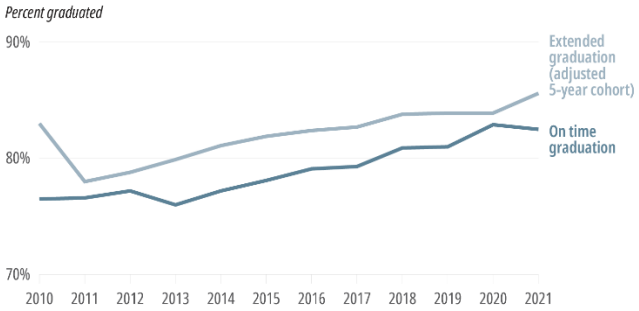
State Source: Washington Association of Sheriffs and Police Chiefs: Uniform Crime Report, National Incident-Based Reporting System; Population Estimates: Washington State Office of Financial Management, Forecasting Division

	Age 10-17	Age 18-25
2010	4.8	13.7
2011	5.2	14.6
2012	3.3	6.8
2013	3.2	5.4
2014	2.9	5.1
2015	2.3	4.8
2016	2.3	5.0
2017	2.0	4.6
2018	1.6	4.0
2019	1.6	3.6
2020	0.5	2.4

Graduation rate

High School On-Time / Extended Graduation Rates

Washington, 2010-2021



Source: Office of Superintendent of Public Information, Comprehensive Education Data and Research Systems
Note: The five year graduation rate includes students that graduated in 4 years and those that graduated in 5 years.

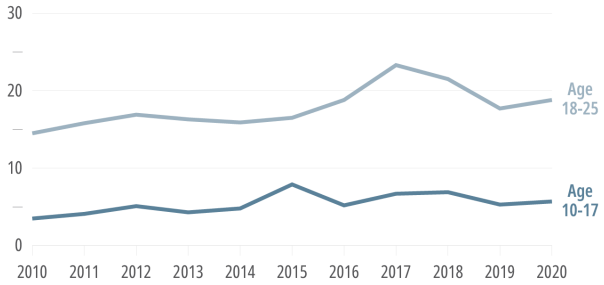
	On time	Extended*
2010	76.5%	83%
2011	76.6%	78%
2012	77.2%	78.8%
2013	76%	79.9%
2014	77.2%	81.1%
2015	78.1%	81.9%
2016	79.1%	82.4%
2017	79.3%	82.7%
2018	80.9%	83.8%
2019	81%	83.9%
2020	82.9%	83.9%
2021	82.5%	85.6%

*Adjusted 5 year cohort

Suicide and self-inflicted injuries

Suicide Death Rates by Age Group
Washington, 2010-2020

Rate per 100,000 population



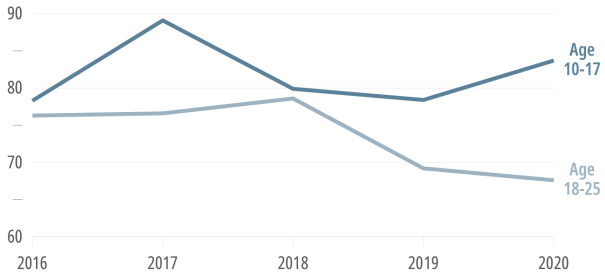
The suicide death rate among 11–17-year-olds increased by 69% from 2010 to 2020 (p<.05). The suicide death rate among 18–25-year-olds increased by 30% from 2010 to 2020 (p<.05).

Washington State Department of Health, Center for Health Statistics, Death Certificate Data

	Age 10-17	Age 18-25
2010	3.5	14.5
2011	4.1	15.8
2012	5.1	16.9
2013	4.3	16.3
2014	4.8	15.9
2015	7.9	16.5
2016	5.2	18.8
2017	6.7	23.3
2018	6.9	21.5
2019	5.3	17.7
2020	5.7	18.8

Hospitaliaztion / Emergency Department Visit Rates for Intentional Self-harm by Age Group
Washington, 2016-2020

Rate per 100,000 population



Hospitalization Data: Washington State Department of Health, Comprehensive Hospital Abstract Reporting System; Population Estimates: Washington State Office of Financial Management, Forecasting Division, single year intercensal estimates

	Age 10-17	Age 18-25
2016	78.3	76.3
2017	89.1	76.6
2018	79.9	78.6
2019	78.4	96.2
2020	83.7	67.6

Fatalities and serious injuries from traffic crashes

Young drivers ages 16 to 17 are required to meet the graduated driver's license (GDL) requirements. These are young drivers who typically still live at home, have more parental oversight, and are still considered minors. Their behavior can be heavily influenced by their peers. Fortunately, we see very small numbers of impaired drivers in fatal crashes in this age group. Among young drivers ages 18 to 20, there is a notable increase in the number of impaired drivers in fatal crashes from those ages 16 to 17. This is likely due to the disappearance of parental oversight as they legally become adults in society. Alcohol prevalence is lower for this age group than the 21 to 25 age group. Impaired driving is most prevalent among young drivers ages 21 to 25, due in large part to the legality for them to consume both alcohol and cannabis. However, among drivers in fatal crashes positive for any drugs, there is little difference in prevalence between 18 to 20 and 21 to 25 age groups of drivers.

Number of Young Drivers in Fatal Crashes Positive for Any Alcohol
Washington, 2010-2020

✓ Driver positive for any alcohol
✗ Driver not positive for alcohol

Year	Number of drivers in fatal crashes					
	16-17 years old		18-20 years old		21-25 years old	
	✓	✗	✓	✗	✓	✗
2010	3	14	18	28	43	49
2011	7	12	13	28	36	44
2012	0	4	11	25	29	54
2013	1	19	15	33	26	49
2014	1	14	9	32	31	48
2015	2	15	6	44	35	63
2016	1	16	6	42	40	62
2017	1	8	16	42	31	75
2018	1	19	10	35	26	67
2019	1	7	12	27	35	68
2020	1	8	16	42	31	75

Fatality Analysis Reporting System, Washington Traffic Safety Commission

Number of Young Drivers in Fatal Crashes that were Impaired (Positive for Alcohol >= 0.08 and/or Drugs)
Washington, 2010-2020

✓ Driver impaired
X Driver not impaired

Year	Number of drivers in fatal crashes					
	16-17 years old		18-20 years old		21-25 years old	
	✓	X	✓	X	✓	X
2010	4	13	17	29	46	46
2011	7	12	15	16	33	47
2012	1	3	15	21	36	47
2013	2	18	23	25	33	12
2014	1	14	20	21	38	41
2015	2	15	15	35	47	51
2016	7	10	15	33	50	52
2017	2	7	23	35	41	65
2018	1	19	17	28	31	62
2019	2	6	17	23	44	59
2020	6	13	18	38	38	46

Fatality Analysis Reporting System, Washington Traffic Safety Commission

Number of Young Drivers in Fatal Crashes Positive for Delta-9 THC
Washington, 2010-2020

✓ Driver positive for D9-THC
X Driver not positive for D9-THC

Year	Number of drivers in fatal crashes					
	16-17 years old		18-20 years old		21-25 years old	
	✓	X	✓	X	✓	X
2010	1	16	6	40	7	85
2011	1	18	3	38	7	73
2012	0	4	4	32	4	79
2013	0	20	10	38	6	69
2014	0	15	12	29	19	60
2015	1	16	6	44	18	80
2016	6	11	8	40	31	71
2017	1	8	10	48	21	85
2018	0	20	11	34	17	76
2019	1	7	9	30	25	78
2020	3	6	6	52	17	89

Fatality Analysis Reporting System, Washington Traffic Safety Commission

Number of Young Drivers in Serious Injury Crashes Positive for Alcohol
Washington, 2010-2020

✓ Driver positive for alcohol
✗ Driver not positive for alcohol

Year	Number of drivers in fatal crashes					
	16-17 years old		18-20 years old		21-25 years old	
	✓	✗	✓	✗	✓	✗
2010	6	105	51	239	92	342
2011	4	83	41	209	89	274
2012	6	74	36	171	79	276
2013	6	51	26	162	71	240
2014	1	66	20	150	66	254
2015	5	61	32	162	78	258
2016	5	89	19	194	74	302
2017	11	81	26	169	82	306
2018	7	60	33	156	95	255
2019	2	69	28	153	78	247
2020	5	62	24	179	80	305

Fatality Analysis Reporting System, Washington Traffic Safety Commission

Number of Young Drivers in Serious Injury Crashes Impaired by Alcohol or Drugs
Washington, 2010-2020

✓ Driver impaired
✗ Driver not impaired

Year	Number of drivers in fatal crashes					
	16-17 years old		18-20 years old		21-25 years old	
	✓	✗	✓	✗	✓	✗
2010	30	106	45	219	81	354
2011	26	100	46	194	70	263
2012	12	82	43	148	75	282
2013	14	69	40	135	60	237
2014	16	75	31	137	54	244
2015	6	60	34	160	82	254
2016	7	87	23	191	83	294
2017	12	81	27	168	92	296
2018	7	60	39	150	97	253
2019	2	69	31	150	81	244
2020	5	62	31	172	97	288

Fatality Analysis Reporting System, Washington Traffic Safety Commission

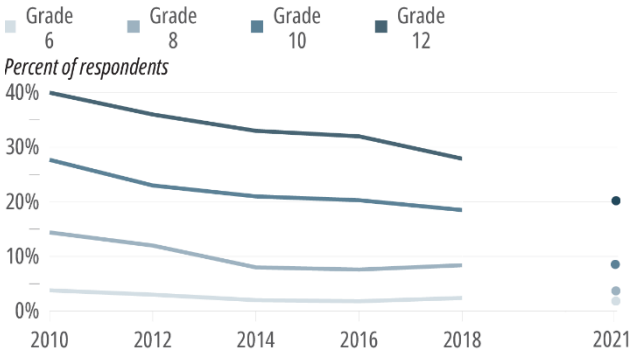
Problem areas (intermediate outcomes)

What are the problem areas?

Alcohol

HYS Current (30-Day) Alcohol Use

2010-2021



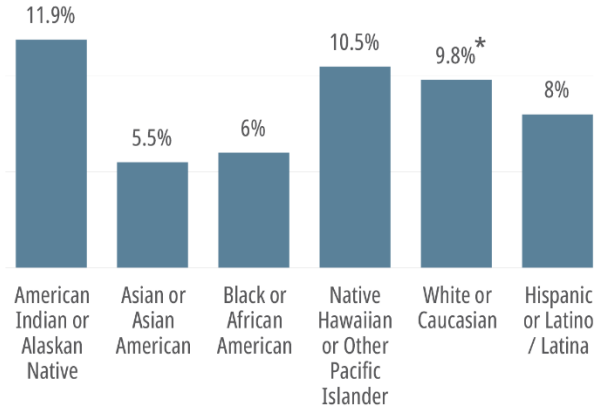
Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
6	3.8%	3.0%	2.0%	1.8%	2.4%	2.2%
8	14.4%	12.0%	8.0%	7.6%	8.4%	3.6%
10	27.7%	23.0%	21.0%	20.3%	18.5%	8.4%
12	40.0%	36.0%	33.0%	32.0%	27.9%	20.0%

HYS 10th Grade Current (30-Day) Alcohol Use by Race/Ethnicity

Alone or in combination with another race/ethnicity, 2021

Percent of respondents

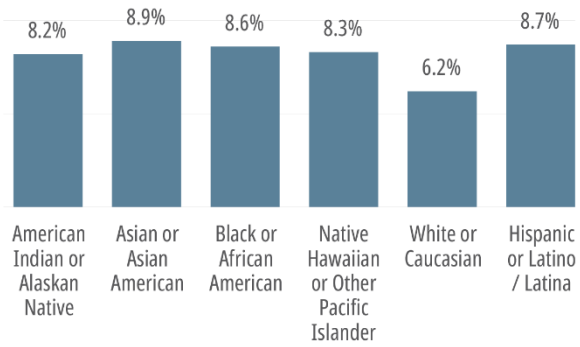


Washington State Healthy Youth Survey; Bars with an asterisk next to their rate show that that the rate is significantly higher when compared to their counterparts. For example, among White-Non Hispanic students, 9.8% indicated they drank alcohol in the past 30 days. This rate is highlighted to indicate that it is higher compared to Non-White students (6.2%) at the p<0.05 level."

HYS 10th Grade Current (30-Day) Alcohol Use by Race/Ethnicity

Alone without any other race/ethnicity categories, 2021

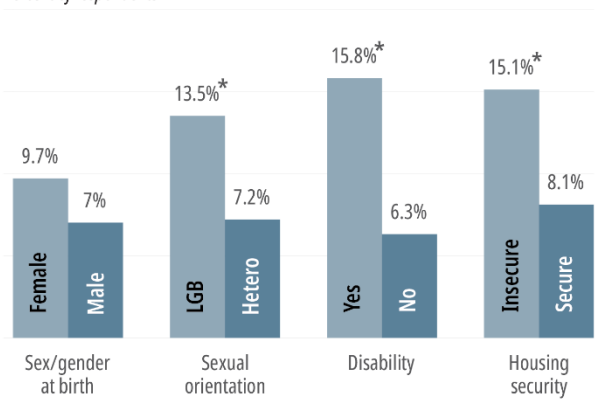
Percent of respondents



Washington State Healthy Youth Survey

HYS 10th Grade Current (30-Day) Alcohol Use by Gender, Sexual Orientation, Disability, and Housing Status
2021

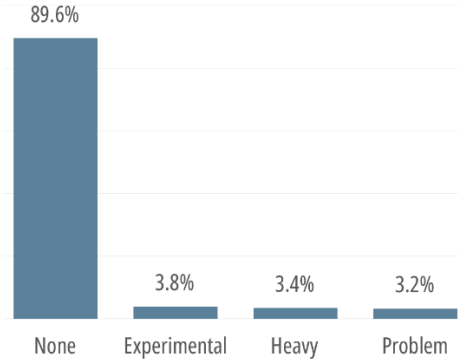
Percent of respondents



Washington Young Adult Health Survey; Bars with an asterisk next to their rate show that that the rate is significantly higher when compared to their counterparts. For example, 10th grades students who selected "gay or lesbian" or "bisexual" have significantly higher rates of alcohol use compared to their heterosexual counterparts.

HYS 10th Grade Current (30-Day) Level of Alcohol Use
2021

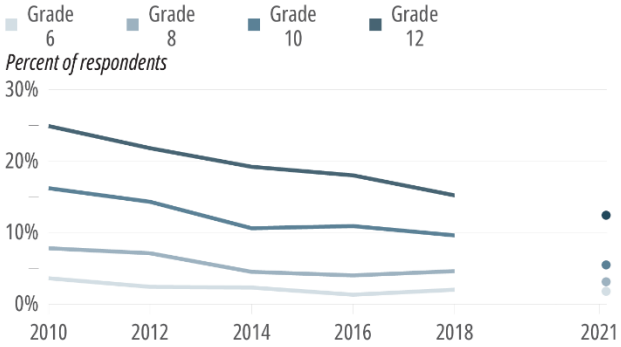
Percent of respondents



Washington State Healthy Youth Survey

HYS Binge Drinking

2010-2021

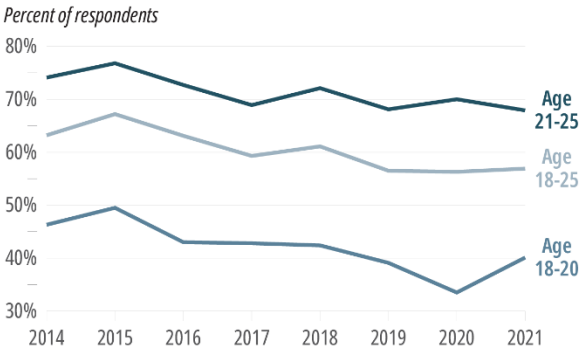


Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
6	3.6%	2.4%	2.3%	1.3%	2.0%	1.9%
8	7.8%	7.1%	4.5%	4.0%	4.6%	2.8%
10	16.2%	14.3%	10.6%	10.9%	9.6%	5.5%
12	24.9%	21.8%	19.2%	18.0%	15.2%	12.4%

Young Adult Alcohol Use in the Past Month by Age Group

2014-2021



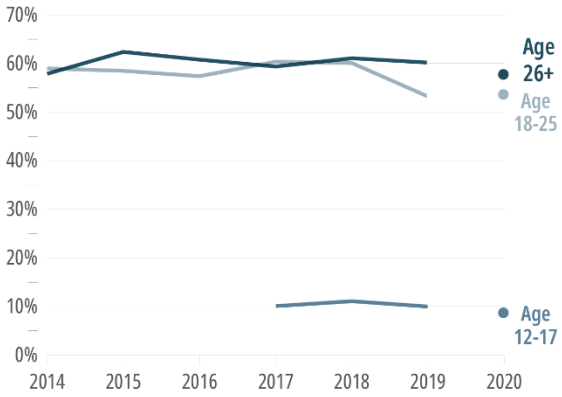
Washington Young Adult Health Survey

	Age 18-20	Age 21-25	Age 18-25
2014	46.3%	74.1%	63.2%
2015	49.5%	76.8%	67.2%
2016	43.0%	72.7%	63.1%
2017	42.8%	68.9%	59.3%
2018	42.4%	72.1%	61.1%
2019	39.1%	68.1%	56.5%
2020	33.5%	70.0%	56.3%
2021	40.1%	67.9%	56.9%

Past Month Alcohol Use by Age Group

2014-2020

Percent of respondents



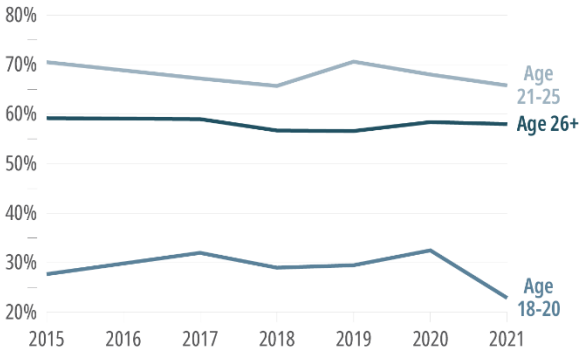
National Survey on Drug Use and Health; There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

	Age 12-17	Age 18-25	Age 26+
2014		59.0%	57.9%
2015		58.5%	62.4%
2016		57.4%	60.8%
2017	10.1%	60.4%	59.4%
2018	11.1%	60.1%	61.1%
2019	10.0%	53.2%	60.2%
2020	8.9%	53.5%	58.0%

Past 30 Day Alcohol use by Age Group

2015-2021

Percent of respondents

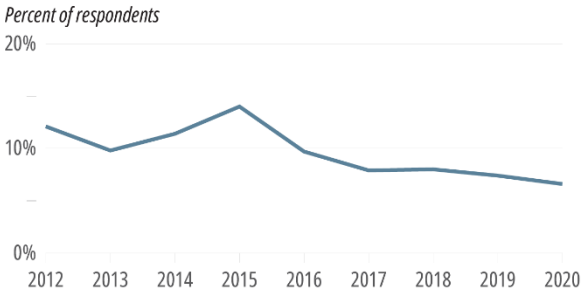


Washington State Behavioral Risk Factor Surveillance System

	Age 18-20	Age 21-25	Age 26+
2015	27.7%	70.5%	59.2%
2017	32.0%	67.2%	59.0%
2018	29.0%	65.7%	56.7%
2019	29.5%	70.6%	56.6%
2020	32.5%	68.0%	58.4%
2021	22.9%	65.8%	58.0%

Maternal Alcohol Use During the Last 3 Months of Pregnancy

2012-2020



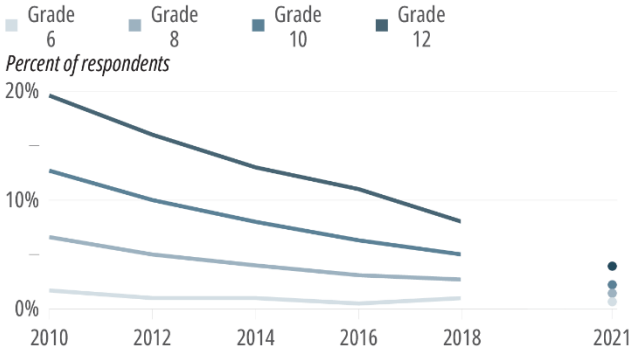
Pregnancy Risk Assessment Monitoring System, Washington State

2012	12.1%
2013	9.8%
2014	11.4%
2015	14.0%
2016	9.7%
2017	7.9%
2018	8.0%
2019	7.4%
2020	6.6%

Commercial Tobacco

HYS Current (30-Day) Cigarette Use

2010-2021

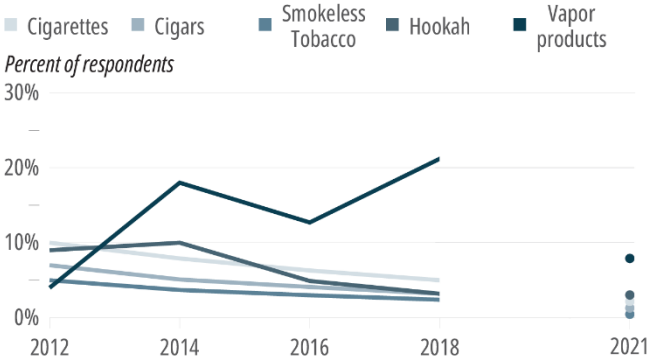


Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
6	1.7%	1.0%	1.0%	0.5%	1.0%	0.8%
8	6.6%	5.0%	4.0%	3.1%	2.7%	1.3%
10	12.7%	10.0%	8.0%	6.3%	5.0%	1.9%
12	19.6%	16.0%	13.0%	11.0%	8.0%	3.8%

HYS 10th Grade Tobacco Use by Type

2012-2021



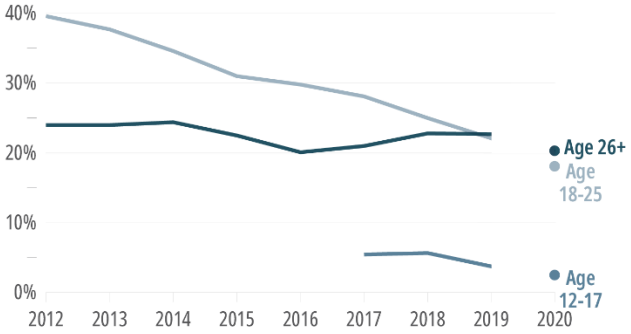
Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2012	2014	2016	2018	2021
Cigarettes	10.0%	7.9%	6.3%	5.0%	1.9%
Cigars	7.0%	5.1%	4.1%	3.2%	1.1%
Smokeless	5.0%	3.7%	3.0%	2.4%	0.6%
Hookah	9.0%	10.0%	4.9%	3.2%	2.3%
Vapor	4.0%	18.0%	12.7%	21.2%	7.6%

Past Month Tobacco Use by Age Group

2012- 2020

Percent of respondents



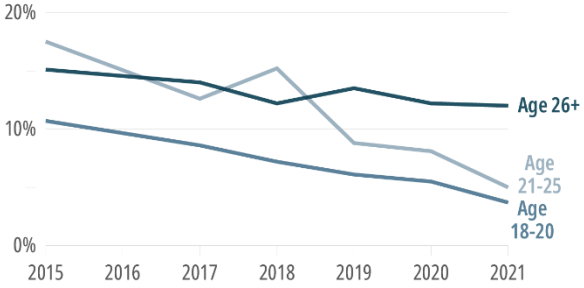
National Survey on Drug Use and Health; There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

	Age 12-17	Age 18-25	Age 26+
2012		39.6%	24.0%
2013		37.7%	24.0%
2014		34.6%	24.4%
2015		31.0%	22.5%
2016		29.8%	20.1%
2017	5.46%	28.1%	21.0%
2018	5.66%	25.0%	22.8%
2019	3.75%	22.1%	22.7%
2020	2.64%	17.9%	20.2%

Past 30 Day Cigarette Use by Age Group

2015-2021

Percent of respondents

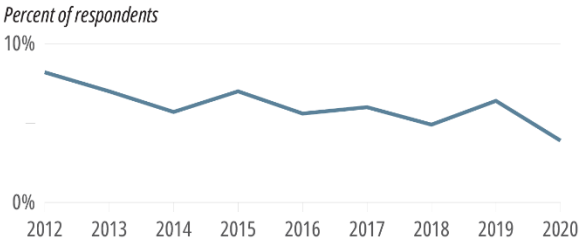


Washington State Behavioral Risk Factor Surveillance System

	Age 18-20	Age 21-25	Age 26+
2015	10.7%	17.5%	15.1%
2017	8.6%	12.6%	14.0%
2018	7.2%	15.2%	12.2%
2019	6.1%	8.8%	13.5%
2020	5.5%	8.1%	12.2%
2021	3.7%	5.0%	12.0%

Maternal Smoking During the Last 3 Months of Pregnancy

2012-2020



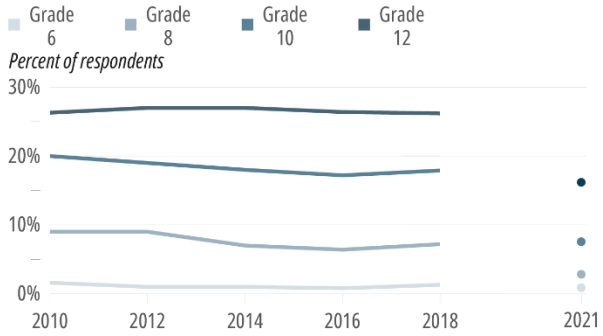
Pregnancy Risk Assessment Monitoring System, Washington State

2012	8.2%
2013	7.0%
2014	5.7%
2015	7.0%
2016	5.6%
2017	6.0%
2018	4.9%
2019	6.4%
2020	3.9%

Cannabis/Marijuana

HYS Current (30-Day) Marijuana Use

2010-2021

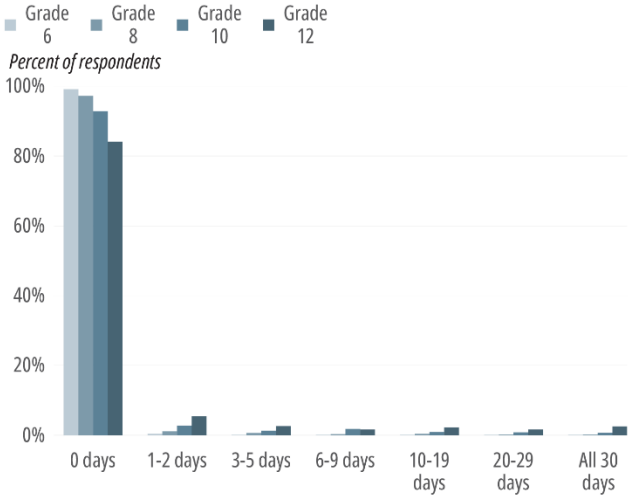


Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
6	1.6%	1.0%	1.0%	0.8%	1.3%	0.9%
8	9.0%	9.0%	7.0%	6.4%	7.2%	2.8%
10	20.0%	19.0%	18.0%	17.2%	17.9%	7.2%
12	26.3%	27.0%	27.0%	26.4%	26.2%	15.9%

HYS Number of Days Used Marijuana

2021



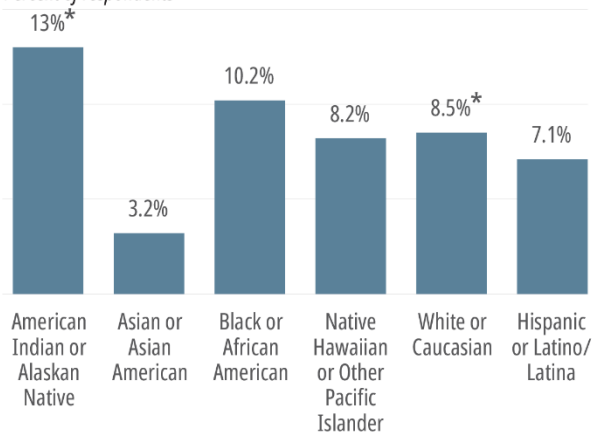
Washington Young Adult Health Survey

	6	8	10	12
0 days	99.1%	97.2%	92.8%	84.1%
1-2 days	0.4%	1.1%	2.7%	5.4%
3-5 days	0.1%	0.6%	1.3%	3.6%
6-9 days	0.1%	0.3%	1.8%	1.6%
10-19 days	0.1%	0.4%	0.9%	2.2%
20-29 days	0.1%	0.2%	0.8%	1.6%
30 days	0.1%	0.2%	0.7%	2.5%

HYS 10th Grade Current (30-Day) Marijuana Use by Race/Ethnicity

Alone or in combination with another race/ethnicity, 2021

Percent of respondents

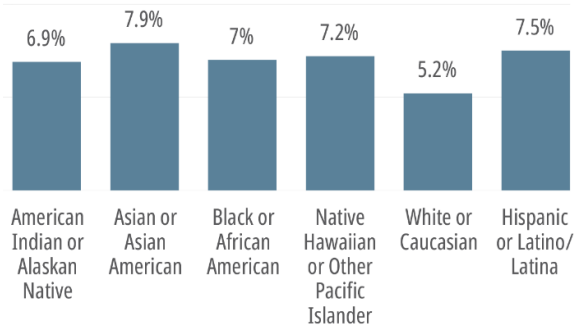


Washington State Healthy Youth Survey; Bars with an asterisk next to their rate show that that the rate is significantly higher when compared to their counterparts. For example, among AIAN students, 13.0% indicated they used marijuana or hashish in the past 30 days. This rate is highlighted to indicate that it is higher compared to Non-AIAN students (6.9%) at the p<0.05 level.

HYS 10th Grade Current (30-Day) Marijuana Use by Race/Ethnicity

Alone without any other race/ethnicity categories, 2021

Percent of respondents

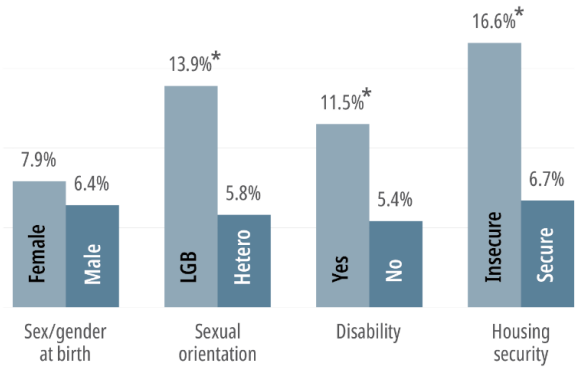


Washington State Healthy Youth Survey

HYS 10th Grade Current (30-Day) Marijuana Use by Gender Identity, Sexual Orientation, Disability, and Housing Status

2021

Percent of respondents

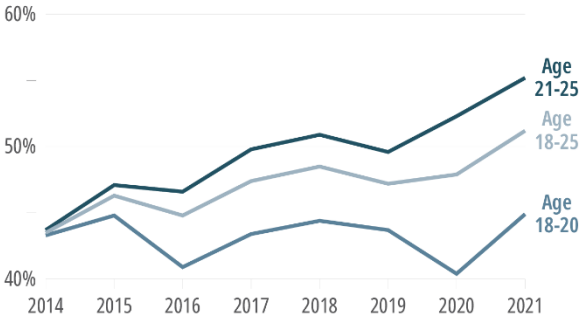


Washington Young Adult Health Survey; Bars with an asterisk next to their rate show that that the rate is significantly higher when compared to their counterparts. For example, 10th grades students who selected "gay or lesbian" or "bisexual" have significantly higher rates of marijuana use compared to their heterosexual counterparts.

Young Adult Recreational Marijuana Use in the Past Year by Age Group

2014-2021

Percent of respondents



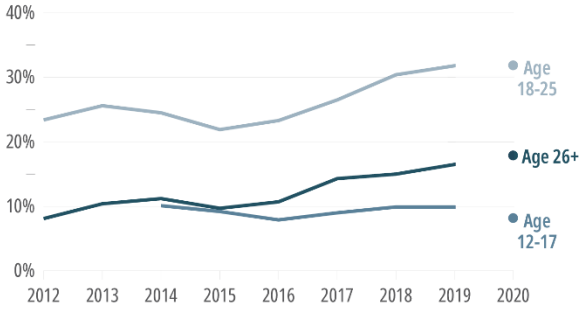
Washington Young Adult Health Survey

	Age 18-20	Age 21-25	Age 18-25
2014	43.3%	43.7%	43.5%
2015	44.8%	47.1%	46.3%
2016	40.9%	46.6%	44.8%
2017	43.4%	49.8%	47.4%
2018	44.4%	50.9%	48.5%
2019	43.7%	49.6%	47.2%
2020	40.4%	52.3%	47.9%
2021	44.9%	55.2%	51.2%

Past Month Marijuana Use by Age Group

2012- 2020

Percent of respondents



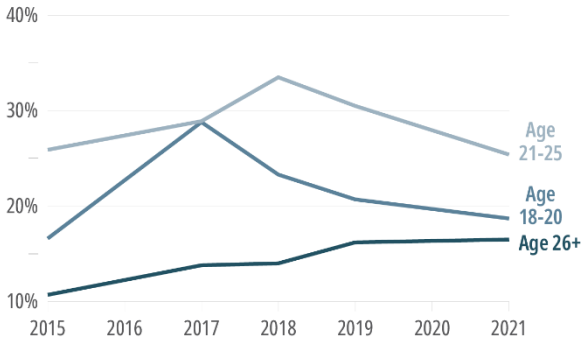
National Survey on Drug Use and Health; There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

	Age 12-17	Age 18-25	Age 26+
2012		23.4%	8.1%
2013		25.6%	10.4%
2014	10.1%	24.5%	11.2%
2015	9.2%	21.9%	9.7%
2016	7.9%	23.3%	10.7%
2017	9.0%	26.5%	14.3%
2018	9.9%	30.4%	15.0%
2019	9.9%	31.8%	16.5%
2020	8.3%	32.0%	17.9%

Past 30 Day Marijuana Use by Age Group

2015-2021

Percent of respondents



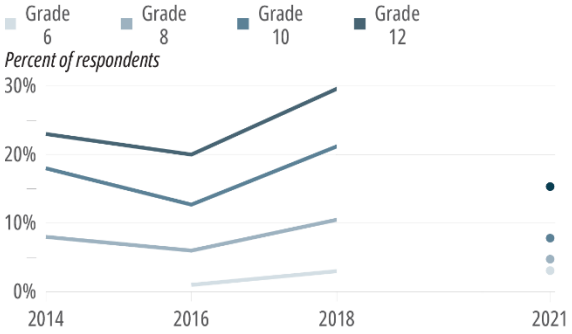
Washington State Behavioral Risk Factor Surveillance System

	Age 18-20	Age 21-25	Age 26+
2015	16.6%	25.9%	10.7%
2017	28.8%	28.9%	13.8%
2018	23.3%	33.5%	14.0%
2019	20.7%	30.5%	16.2%
2021	18.7%	25.4%	16.5%

E-Cig/Vape

HYS E-Cigarette/Vapor Product Use

2014-2021



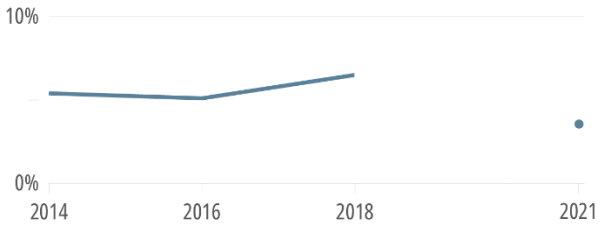
Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2014	2016	2018	2021
6		1.0%	3.0%	3.0%
8	8.0%	6.0%	10.5%	4.8%
10	18.0%	12.7%	21.2%	7.6%
12	23.0%	20.0%	29.6%	15.1%

HYS 10th Grade Current (30-Day) Marijuana Vaping

2014-2021

Percent of respondents

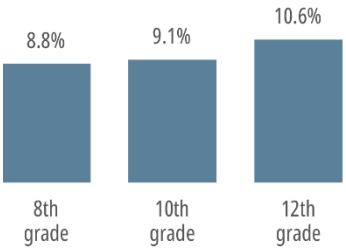


Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

2014	5.4%
2016	5.1%
2018	6.5%
2021	3.5%

HYS Student Gambling
2021

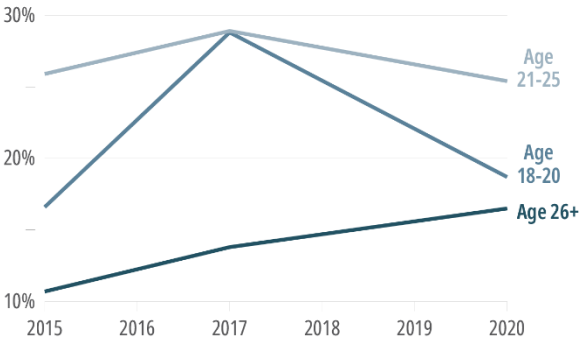
Percent of respondents



Washington State Healthy Youth Survey

Current (30-Day) E-Cigarette Use by Age Group
2015-2020

Percent of respondents



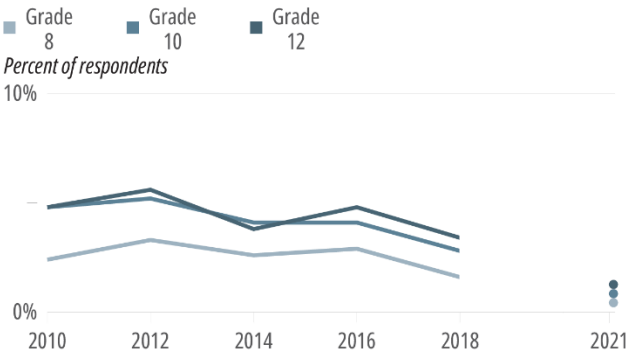
Washington State Behavioral Risk Factor Surveillance System

	Age 18-20	Age 21-25	Age 26+
2015	16.6%	25.9%	10.7%
2017	28.8%	28.9%	13.8%
2020	18.7%	25.4%	16.5%

Other illicit drugs

HYS Lifetime Methamphetamine Use

2010-2021

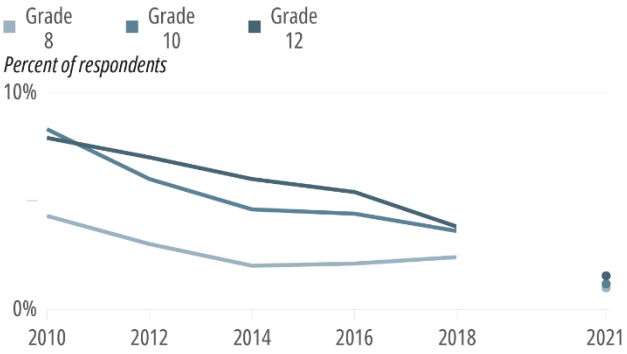


Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
8	2.4%	3.3%	2.6%	2.9%	1.6%	0.5%
10	4.8%	5.2%	4.1%	4.1%	2.8%	0.8%
12	4.8%	5.6%	3.8%	4.8%	3.4%	1.2%

HYS Current (30-Day) Painkiller Use

2010-2021

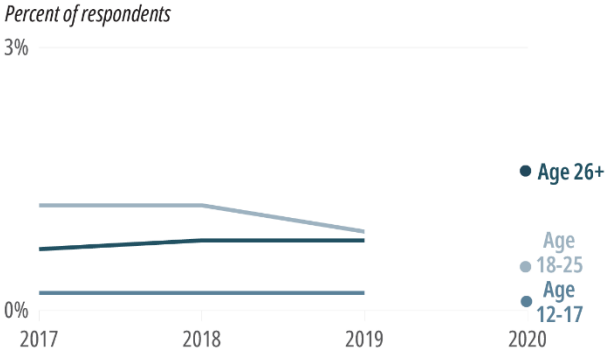


Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
8	4.3%	3.0%	2.0%	2.1%	2.4%	1.0%
10	8.3%	6.0%	4.6%	4.4%	3.6%	1.0%
12	7.9%	7.0%	6.0%	5.4%	3.8%	1.3%

Past Year Methamphetamine Use by Age Group

2017- 2020



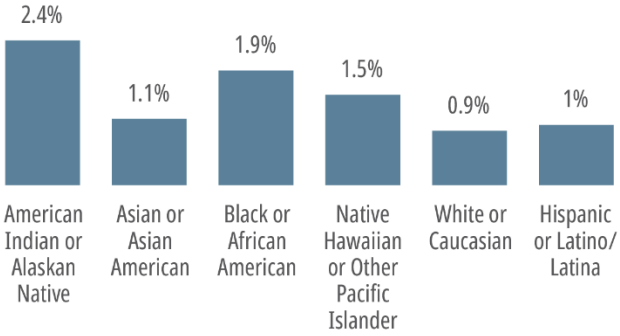
National Survey on Drug Use and Health; There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

	Age 12-17	Age 18-25	Age 26+
2017	0.2%	1.2%	0.7%
2018	0.2%	1.2%	0.8%
2019	0.2%	0.9%	0.8%
2020	0.1%	0.5%	1.6%

HYS 10th Grade Current (30-Day) Painkiller Use by Race/Ethnicity

Alone or in combination with another race/ethnicity, 2021

Percent of respondents

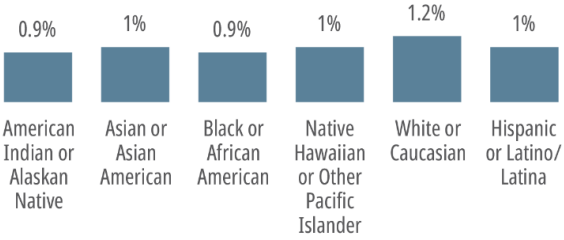


Washington State Healthy Youth Survey

HYS 10th Grade Current (30-Day) Painkiller Use by Race/Ethnicity

Alone without any other race/ethnicity categories, 2021

Percent of respondents

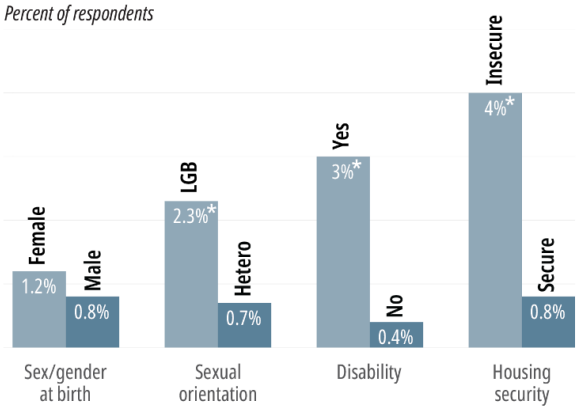


Washington State Healthy Youth Survey

HYS 10th Grade Current (30-Day) Painkiller Use by Gender, Sexual Orientation, Disability, and Housing Status

2021

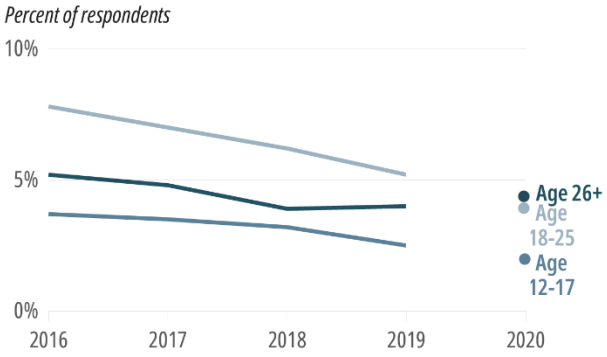
Percent of respondents



Washington Young Adult Health Survey; Bars with an asterisk next to their rate show that that the rate is significantly higher when compared to their counterparts. For example, 10th grades students who selected "gay or lesbian" or "bisexual" have significantly higher rates of pain killer use compared to their heterosexual counterparts.

Past Year Prescription Pain Reliever Misuse by Age Group

2016-2020

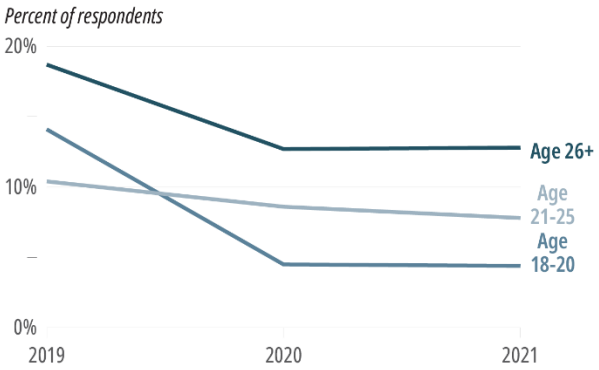


National Survey on Drug Use and Health; There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

	Age 12-17	Age 18-25	Age 26+
2016	3.7%	7.8%	5.2%
2017	3.5%	7.0%	4.8%
2018	3.2%	6.2%	3.9%
2029	2.5%	5.2%	4.0%
2020	2.0%	3.9%	4.4%

Past Year Prescription Pain Medication Use to Get High by Age Group

2019-2021



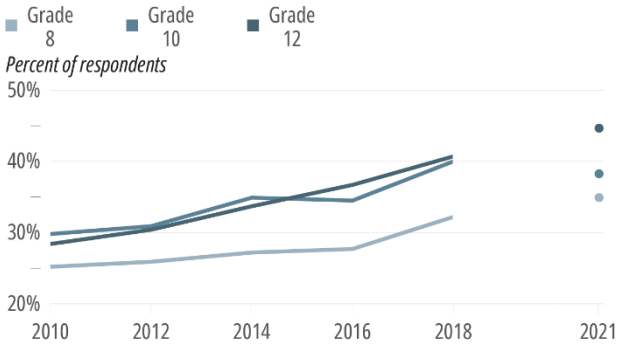
Washington State Behavioral Risk Factor Surveillance System

	Age 18-20	Age 21-25	Age 26+
2019	14.1%	10.4%	18.7%
2020	4.5%	8.6%	12.7%
2021	4.4%	7.8%	12.8%

Mental health

HYS Sad or Hopeless Feelings Almost Every Day in Two-Week Period in Past Year

2010-2021

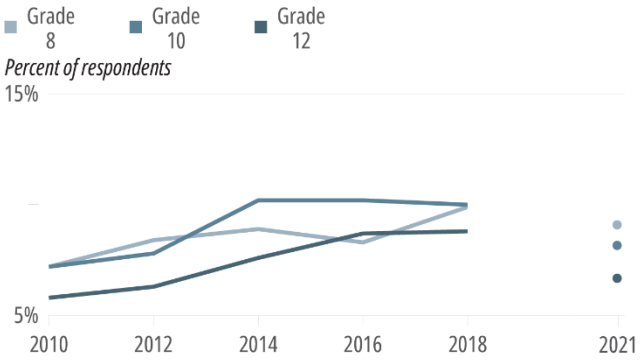


Washington State Health Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
8	25.2%	25.9%	27.2%	27.7%	32.2%	35.0%
10	29.8%	30.9%	34.9%	34.5%	40.0%	38.1%
12	28.4%	30.4%	33.7%	36.7%	40.7%	44.7%

HYS Any Suicide Attempt in Past 12 Months

2010-2021

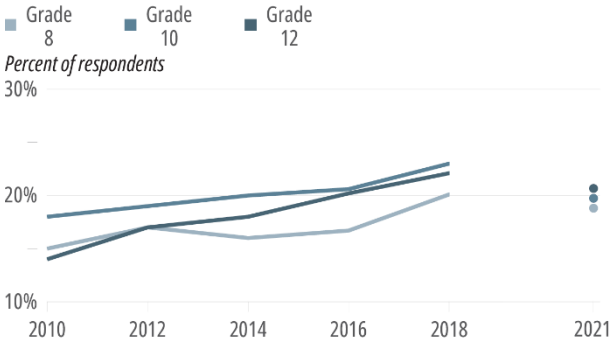


Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
8	7.2%	8.4%	8.9%	8.3%	9.9%	9.1%
10	7.2%	7.8%	10.2%	10.2%	10.0%	8.2%
12	5.8%	6.3%	7.6%	8.7%	8.8%	6.7%

HYS Seriously Considered Suicide in Past 12 Months

2010-2021



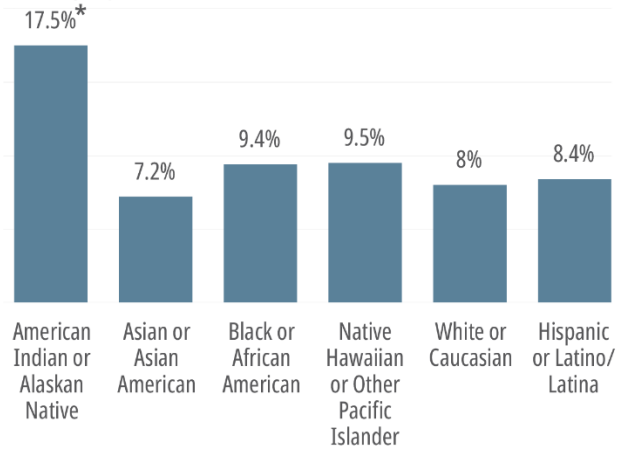
Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
8	15.0%	17.0%	16.0%	16.7%	20.1%	19.0%
10	18.0%	19.0%	20.0%	20.6%	23.0%	19.6%
12	14.0%	17.0%	18.0%	20.2%	22.1%	20.4%

HYS 10th Grade Suicide Attempts in Past 12 Months by Race/Ethnicity

Alone or in combination with another race/ethnicity, 2021

Percent of respondents

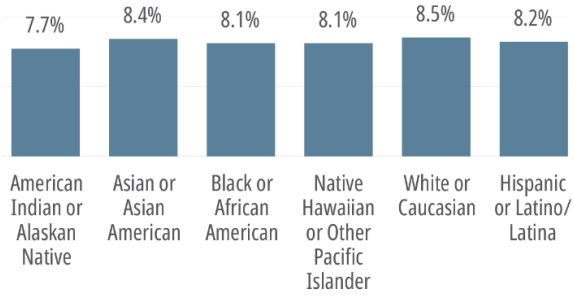


Washington State Healthy Youth Survey; Bars with an asterisk next to their rate show that that the rate is significantly higher when compared to their counterparts. For example, among AIAN students, 21.1% indicated they attempted sucide. This rate is highlighted to indicate that it is higher compared to Non-AIAN students (7.7%) at the p<0.05 level.

HYS 10th Grade Suicide Attempts in Past 12 Months by Race/Ethnicity

Alone without any other race/ethnicity categories, 2021

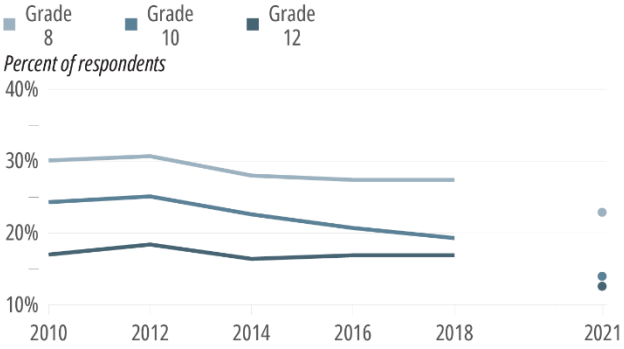
Percent of respondents



Washington State Healthy Youth Survey

HYS Current (30-Day) Bullying

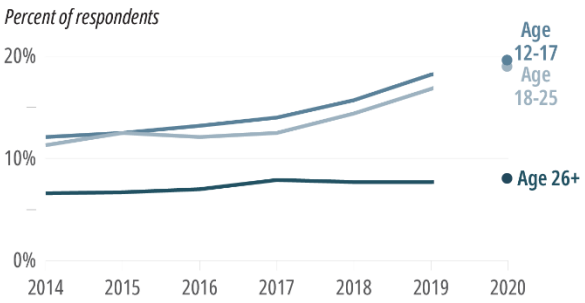
2010-2021



Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	2010	2012	2014	2016	2018	2021
8	30.1%	30.7%	28.0%	27.4%	27.4%	22.8%
10	24.3%	25.1%	22.6%	20.7%	19.3%	13.3%
12	17.0%	18.4%	16.4%	16.9%	16.9%	12.7%

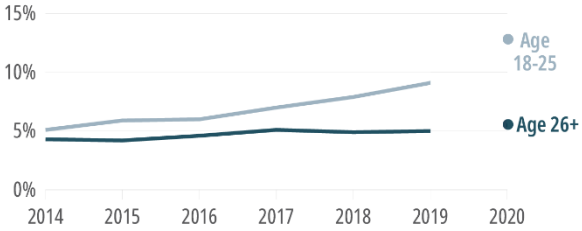
Major Depressive Episode in the Past Year by Age Group
2014-2020



National Survey on Drug Use and Health; There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

	Age 12-17	Age 18-25	Age 26+
2014	12.1%	11.3%	6.6%
2015	12.5%	12.5%	6.7%
2016	13.2%	12.1%	7.0%
2017	14.0%	12.5%	7.9%
2018	15.7%	14.4%	7.7%
2019	18.2%	16.8%	7.7%
2020	19.6%	19.5%	8.0%

Serious Mental Illness in the Past Year by Age Group
2014-2020

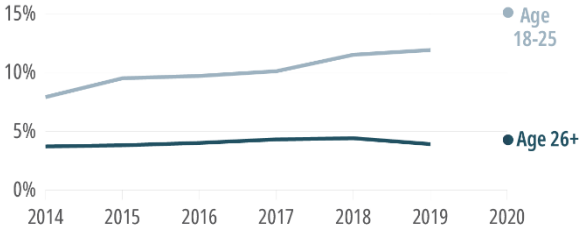


National Survey on Drug Use and Health; There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

	Age 18-25	Age 26+
2014	5.1%	4.3%
2015	5.9%	4.2%
2016	6.0%	4.6%
2017	7.0%	5.1%
2018	7.9%	4.9%
2019	9.1%	5.0%
2020	12.9%	5.5%

Had Serious Thoughts of Suicide in the Past Year by Age Group
2014-2020

Percent of respondents



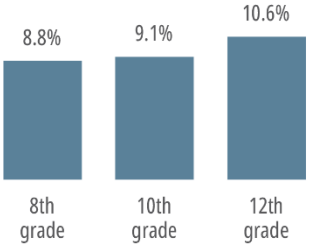
National Survey on Drug Use and Health; There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

	Age 18-25	Age 26+
2014	7.9%	3.7%
2015	9.5%	3.8%
2016	9.7%	4.0%
2017	10.1%	4.3%
2018	11.5%	4.4%
2019	11.9%	3.9%
2020	15.1%	4.3%

Gambling

HYS Student Gambling
2021

Percent of respondents



Washington State Healthy Youth Survey

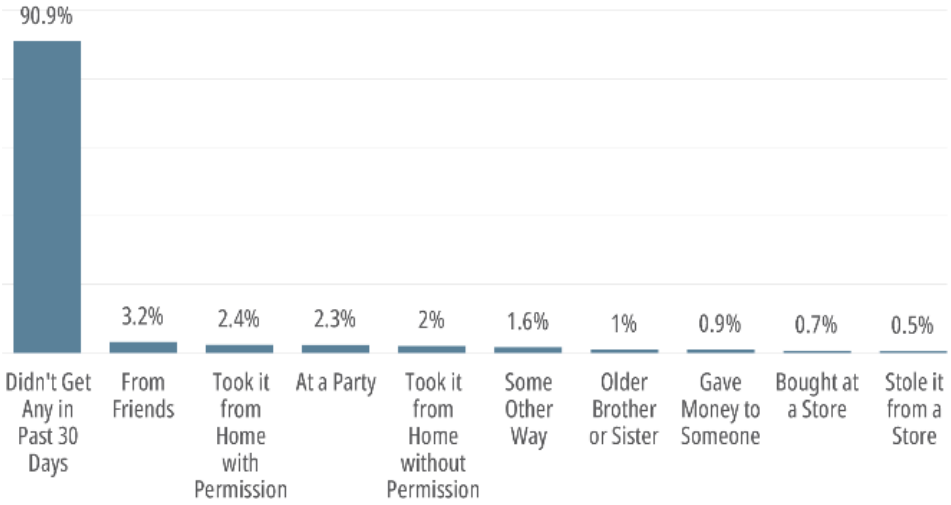
Short-term outcomes (intervening variables)

Why are these problems present in our state?

Access

HYS 10th Grade Alcohol Access
2021

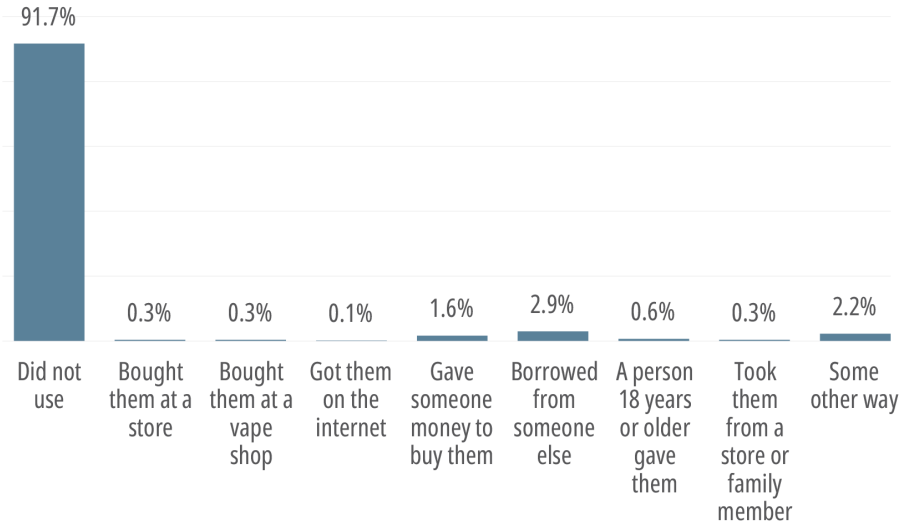
Percent of respondents



Washington State Healthy Youth Survey

HYS 10th Grade Electronic Vapor Product Access
2021

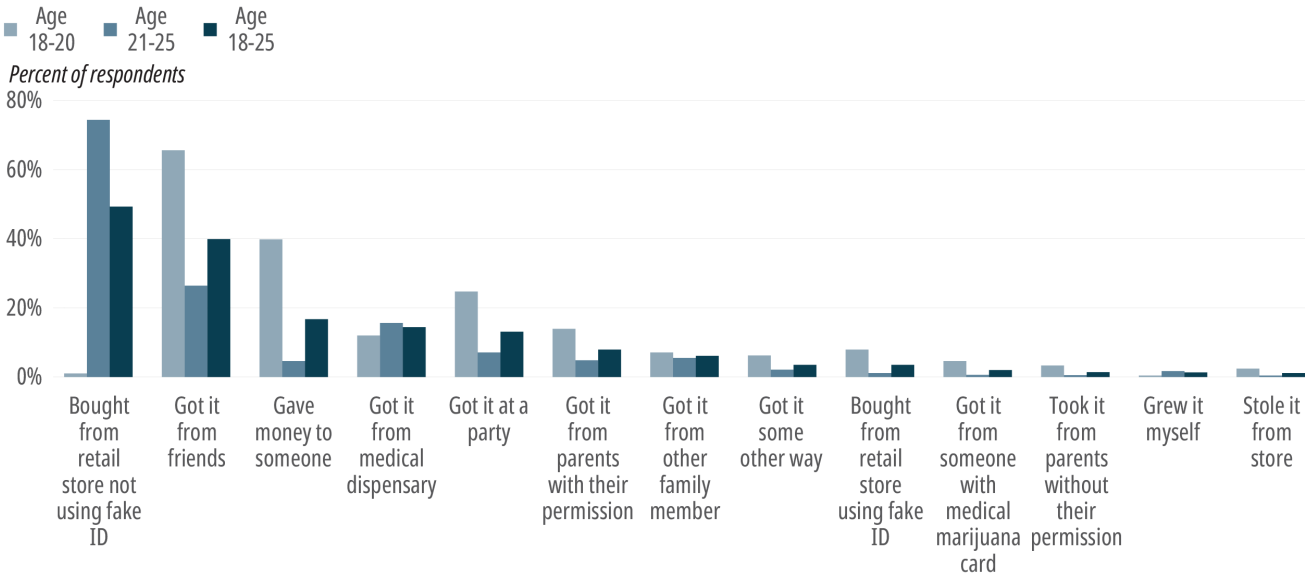
Percent of respondents



Washington State Healthy Youth Survey

How Young Adults Obtained Marijuana by Age Group

2021



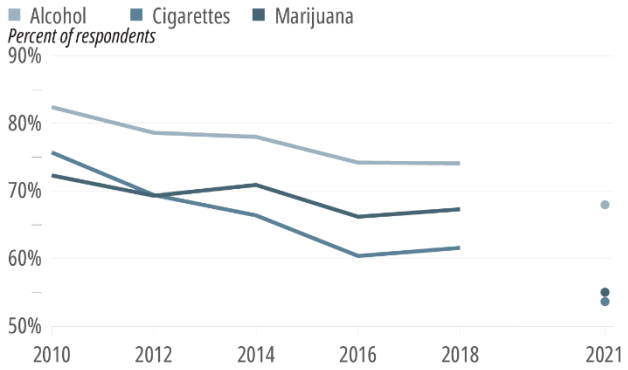
Washington Young Adult Health Survey

	Age 18-20	Age 21-25	Age 18-25
Bought from retail store not using fake ID	1.0%	74.4%	49.3%
Got it from friends	65.6%	26.4%	39.9%
Gave money to someone	39.8%	4.6%	16.7%
Got it from medical dispensary	12.0%	15.6%	14.4%
Got it at a party	24.7%	7.1%	13.1%
Got it from parents with their permission	13.9%	4.8%	7.9%
Got it from other family member	7.1%	5.5%	6.1%
Got it some other way	6.2%	2.1%	3.5%
Bought from retail store using fake ID	7.9%	1.1%	3.5%
Got it from someone with medical marijuana card	4.6%	0.6%	2.0%
Took it from parents without their permission	3.3%	0.5%	1.4%
Grew it myself	0.4%	1.7%	1.3%
Stole it from store	2.4%	0.4%	1.1%

Availability

HYS 10th Grade Alcohol, Marijuana, Cigarette Availability

Response of "Possibly not Hard", 2010-2021



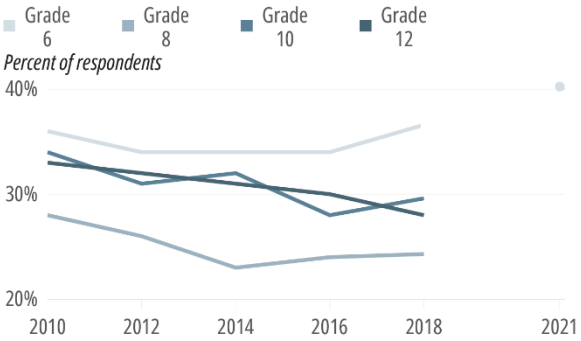
Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	Alcohol	Cigarettes	Cannabis/ Marijuana
2010	82.4%	75.7%	72.3%
2012	78.6%	69.4%	69.3%
2014	78.0%	66.4%	70.9%
2016	74.2%	60.4%	66.2%
2018	74.1%	61.6%	67.3%
2021	67.6%	53.6%	53.9%

Community norms

HYS Laws and Norms Favorable to Substance Use

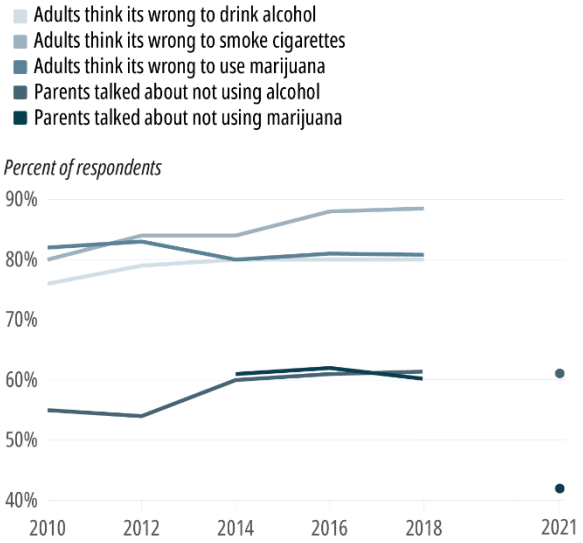
2010-2021



Washington State Healthy Youth Survey; 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.; 2021 data was not collected for grades 8,10, and 12.

	2010	2012	2014	2016	2018	2021
6	36.0%	34.0%	34.0%	34.0%	36.6%	40.9%
8	28.0%	26.0%	23.0%	24.0%	24.3%	
10	34.0%	31.0%	32.0%	28.0%	29.6%	
12	33.0%	32.0%	31.0%	30.0%	28.0%	

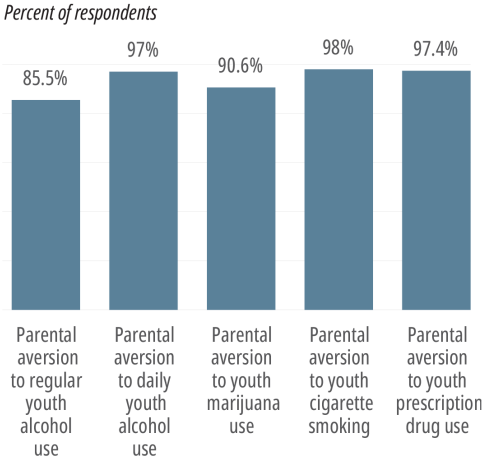
HYS 10th Grade Community Protection and Prevention
2010-2021



Washington State Healthy Youth Survey; 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed. 2021 data was only collected for parents talking about not using alcohol and marijuana.

	2010	2012	2014	2016	2018	2021
Adults think its wrong to drink alcohol	76.0%	79.0%	80.0%	80.0%	80.0%	N/A
Adults think its wrong to smoke cigarettes	80.0%	84.0%	84.0%	88.0%	88.5%	N/A
Adults think its wrong to use marijuana	82.0%	83.0%	80.0%	81.0%	80.8%	N/A
Parents talked about not using alcohol	55.0%	54.0%	60.0%	61.0%	61.4%	60.9%
Parents talked about not using marijuana	N/A	N/A	61.0%	62.0%	60.2%	41.7%

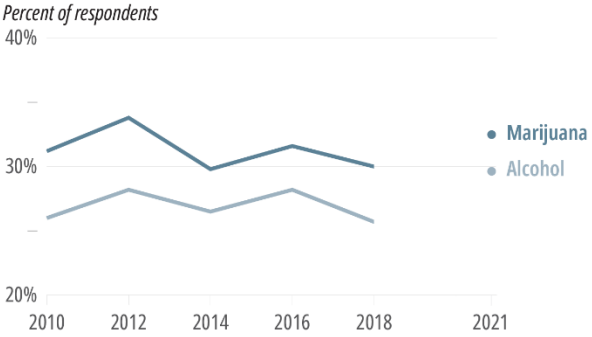
HYS 10th Grade Parents Say Drug Use is Wrong or Very Wrong
2021



Washington State Healthy Youth Survey

Enforcement

HYS 10th Grade Police Enforcement of Youth Using Alcohol or Marijuana
Response of "Yes", 2010-2021



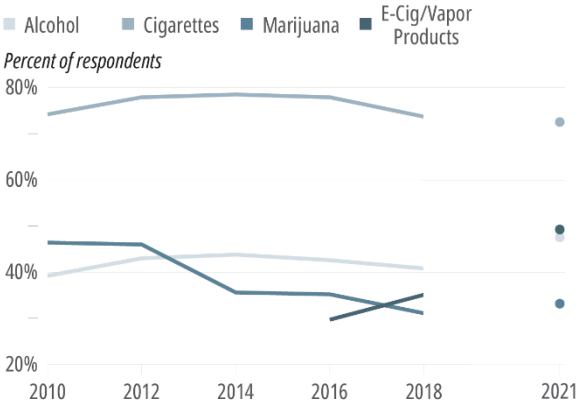
Washington State Healthy Youth Survey; There is no connecting line between 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	Alcohol	Cannabis/ Marijuana
2010	26.0%	31.2%
2012	28.2%	33.8%
2014	26.5%	29.8%
2016	28.2%	31.6%
2018	25.7%	30.0%
2021	29.8%	32.6%

Perception of harm

HYS 10th Grade Perceived Great Risk from Regular Use of Alcohol, Tobacco, Marijuana, and E-Cigarette/Vapor Product

2010-2021



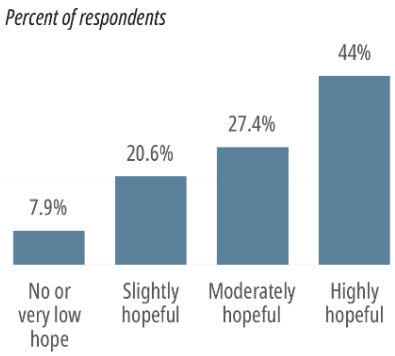
Washington State Healthy Youth Survey; 2018 and 2021 to indicate caution should be used when comparing estimates between 2021 and prior years because of methodological changes for 2021. Due to these changes, significance testing between 2021 and prior years was not performed.

	Alcohol	Cigarettes	Marijuana	E-Cig
2010	39.2%	74.2%	46.4%	
2012	43.0%	77.9%	46.0%	
2014	43.8%	78.5%	35.6%	
2016	42.6%	77.9%	35.2%	29.7%
2018	40.8%	73.7%	31.1%	35.1%
2021	47.8%	72.6%	33.1%	49.6%

Hope scale

HYS 10th Grade Hope Scale

2021



Washington State Healthy Youth Survey

Washington State key data sources

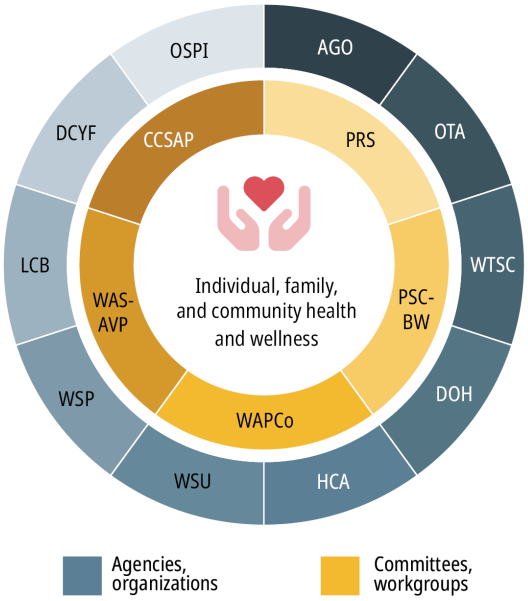
In Washington State, we have a wealth of data from our key related collection systems including the following:

- **Behavioral Risk Factor Surveillance System (BRFSS)** – Since 1984, this national health survey system tracks information on a vast array of health conditions, health-related behaviors, and risk and protective factors about adult (18 years and older) health. cdc.gov/brfss
- **Comprehensive Hospital Abstract Reporting System (CHARS)** – Provides coded hospital inpatient discharge information (derived from billing systems) available for 1987 to 2021. doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS
- **Community Outcomes and Risk Evaluation Geographic Information System (CORE GIS)** – A comprehensive time-series collection of data related to substance use and misuse, and the risk factors that predict substance use among youth. dshs.wa.gov/ffa/research-and-data-analysis/about-rda
- **Center for Health Statistics, Washington State Department of Health** – Collects data recorded on death certificates. Data from these records help to inform public health program planning and evaluation through monitoring on causes of death. doh.wa.gov/data-and-statistical-reports/health-statistics
- **COVID-19 Student Survey (CSS)** – The CSS was administered during March 2021 and February 2022 to students in grades 6 to 12 to collect data on adolescent health during the COVID-19 pandemic. k12.wa.us/student-success/health-safety/2022-covid-19-student-survey-results
- **Healthy Youth Survey (HYS)** – A statewide school survey administered every two years (since 2002) to students in grade 6, 8, 10, and 12. The survey collects data on health risk behaviors that contribute to morbidity, mortality, and social problems among youth. The information from the HYS can be used to identify trends in the patterns of behavior over time. askhys.net
- **High Intensity Drug Trafficking Area (HIDTA)** – The U.S. Department of Justice maintains HIDTA through the National Drug Intelligence Center. The Northwest HIDTA produces market analyses specific to the Pacific Northwest.
- **Integrated Client Database (ICD)** – DSHS' longitudinal client database containing ten or more years of detailed service risks, history, costs, and outcomes.
- **Mental Health Consumer Information System (MHCIS)** – Demographic information for all mental health consumers and non-Medicaid mental health service data are entered into MHCIS.
- **National Survey on Drug Use and Health (NSDUH)** – National ongoing survey with information about alcohol, tobacco, cannabis/marijuana, and other drug use, as well as mental health-related issues conducted by the U.S. Substance Use Disorder and Mental Health Services Administration (SAMHSA). National Survey on Drug Use and Health | CBHSQ Data (samhsa.gov)
- **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. washingtonstatereportcard.ospi.k12.wa.us/
- **Substance Use Disorder Prevention and Mental Health Promotion Online Data Reporting System (Minerva 2.0)** – A web-based management information system, collects administrative and outcome data on all DBHR's funded SUD prevention and mental health promotion community services.

- **Pregnancy Risk Assessment Monitoring System (PRAMS)** – launched in 1987, the Washington State Department of Health in cooperation with the Centers for Disease Control maintains the PRAMS surveillance project which collects state-specific, population-based data on maternal attitudes and experience before, during and shortly after pregnancy.
- **ProviderOne** – This system records and stores all Medicaid claims for outpatient and residential SUD treatment services and all encounter data for Medicaid-funded outpatient mental health managed care services and residential claims for mental health treatment.
- **Student Assistance Prevention and Intervention Services Program (SAPISP) Database** – This web-based reporting system is used to monitor service provisions and student outcomes throughout the school year of participants in the local SAPISP Programs.
- **Traffic Safety and Target Zero Teams Reports** – These statistical mapping documents are generated on a 42-day rotational cycle and include information on collisions, DUI arrests, other moving vehicle violations, and traffic fatalities.
- **Treatment and Assessment Reports Generation Tool (TARGET)** – This system records outpatient demographic and service encounter data for SUD, and client and service encounter information for both Medicaid and non-Medicaid-funded services.
- **Washington Association of Sheriffs and Police Chiefs (WASPC)** – Receives Uniformed Crime Reporting (UCR) and National Incident-Based Reporting System (NIBRS) data from local law enforcement agencies. UCR program collects statistics on violent crime and property crime. NIBRS presents quantitative and qualitative data that describes each incident and arrest on violent crime and property crime. waspc.org
- **Washington State Liquor and Cannabis Board (LCB)** – LCB produces data about the number of liquor and cannabis/marijuana vendors, cannabis/marijuana prices, and the results of retail compliance checks.
- **Washington State Statistical Analysis Center (SAC)** – SAC produce a report called "Monitoring Impacts of Recreational Marijuana Legislation" that was cited in this report.
- **Washington Tracking Network (WTN)** – Provides users with data and information about environmental health hazards, population characteristics, and health outcomes statewide. doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn
- **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. wtsc.wa.gov/research-data
- **Young Adult Health Survey (YAHS)** – Statewide online survey going into its 9th year of data collection in Washington State, with the aim of collecting information about health behaviors in young adults aged 18 to 25 in Washington State. The survey/study allows for comparisons of youth adults over time and includes follow-up with the same participants over time. sites.uw.edu/uwwyahs

Diagram of resources

Working together, each doing our part



Agencies and organizations

AGO
- Litigation, Legislation, Administrative Rulemaking, and Seeking Industry Voluntary Action
- Tobacco 21

OTA
- Support Tribes and Urban Indian Health Organizations in SUD BH including Prevention
- Funding for Health Integration Transformation

WTSC
- Click it or Ticket
- DUI enforcement campaigns
- HS distracted driver projects
- Traffic Safety Task Forces - Target ZeroHCA

DOH
- 2021-2025 Commercial Tobacco Prevention and Control Strategic Plan
- Washington State Tobacco Quitline
- 2Morrow Health smartphone app
- Children with Special Health Care Needs
- WA Statewide Suicide Prevention Plan and Action Alliance for Suicide Prevention
- Mandatory (E2SHB 2793) suicide prevention trainings for health care professionals
- Family Planning
- Home Visiting
- Media: Listen2YourSelfie.org
- Personal Responsibility Education Program in Washington State
- CDC's Prevention Prescription Drug Overdose Grant
- Prescription Drug Monitoring Program
- Project LAUNCH Grant
- Washington State Overdose Response Plan
- Youth Cannabis and Commercial Prevention Program Contractors - Community Grantees, Regional Networks and Priority Population

HCA
- Mental Health Services and Substance Use Disorder insurance benefit for Medicaid eligible and Public Employees
- Community Prevention and Wellness Initiative (CPWI)
- Community-based organization grants for marijuana, opioid, and suicide prevention
- Tribal Prevention and Wellness Programs
- Evidence Based Practice Workgroup
- Mental Health Promotion and Suicide Prevention Projects
- Provider Education, UW TelePain
- Prevention Summit/Spring Youth Forum/Coalition Institute
- The Athena Forum
- Media: Underage Drinking Prevention, Start Talking Now - Website for Parents, Opioid Prevention
- Workforce Development, Trainings, and Technical Assistance
- Young Adult Health Survey, Healthy Youth Survey

WSU
- Interdisciplinary Ph.D. Program in Prevention Science
- CPWI Evaluation

WSP
- State Patrol Target Zero Teams (TZT)

LCB
- Compliance Checks
- Premises Checks
- Education/Training/Technical Assistance (Licensing, Enforcement, and Public Health and Prevention)
- Website (laws and rules, education pages, resources)
- Liquor and cannabis enforcement
- Mandatory Alcohol Server Training (MAST)
- Printed materials
- Responsible Vendor Program (RVP)
- Rulemaking scope

DCYF
- Early Support for Infants and Toddlers
- ECEAP: Early Childhood Education Economic Assistance Program State Preschool
- Head Start
- CBCAP
- ECLIPSE

OSPI
- LifeSkills
- Project AWARE
- Student Assistance Program
- Suicide Prevention Program

Committees and workgroups

PRS
- Promotes evidence-based practice and collaborative research

PSCBW
- Certification for Prevention Professionals

WASAVP
- Action Alerts
- Annual meeting at Prevention Summit in Yakima
- Annual Policy Platform for prevention
- Monitoring and advocating for prevention with State Legislature
- Occasional position papers relevant to prevention
- Prevention Policy Day each January/February in Olympia
- WASAVP website www.WASAVP.org

CCSAP
- Year End Young Adult Professional Development Conference
- Webinars

Resource assessment

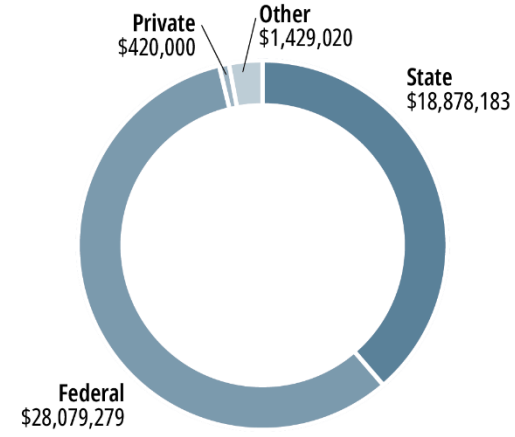
The following represents the programs and strategies of current SPE Policy Consortium members who responded to our inquiries. There may be programs within our partner organizations which have positive outcomes for the prevention of SUD and/or promotion of mental health that did not make it into this analysis. Additionally, there are many local programs and services which have great value to these efforts which are not represented, but overall, this is the most comprehensive attempt to gather this information. If, in reviewing this information, you discover a gap in understanding, please consider getting involved with the SPE Policy Consortium by contacting your organization representative or reaching out to the co-chairs.

Part 1 – Overview and analysis

Funding snapshot

While many community support programs use local resources to implement, the primary prevention of SUD is still funded mostly through federal grants, many of which operate on short-term, discretionary cycles. This creates an uncertainty and natural turnover in key staff and organizational capacity at both the state and local level and threatens sustained efforts.

Funding by source

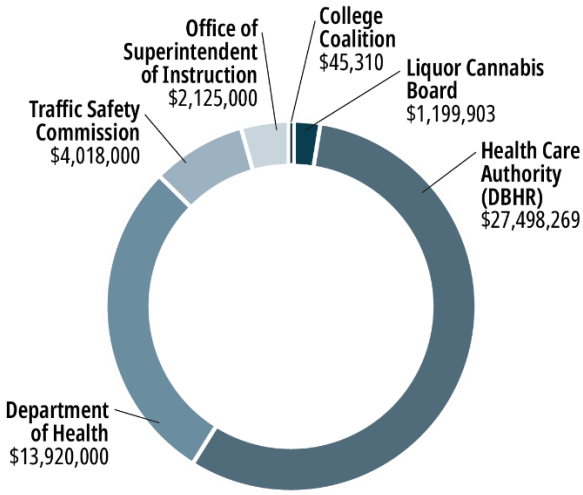


Totals without ECE

It's worth noting that the funding which has fewer short-term cycles and reapplication procedures create opportunities for more stable programs such as the Department of Health's Youth Cannabis and Commercial Tobacco Prevention Program, which is funded mostly by state excise taxes on cannabis, and the Health Care Authority's Community Prevention and Wellness Initiative, which utilizes mostly block grant funding from SAMHSA and braids it with state and other resources to create more predictable service supports.

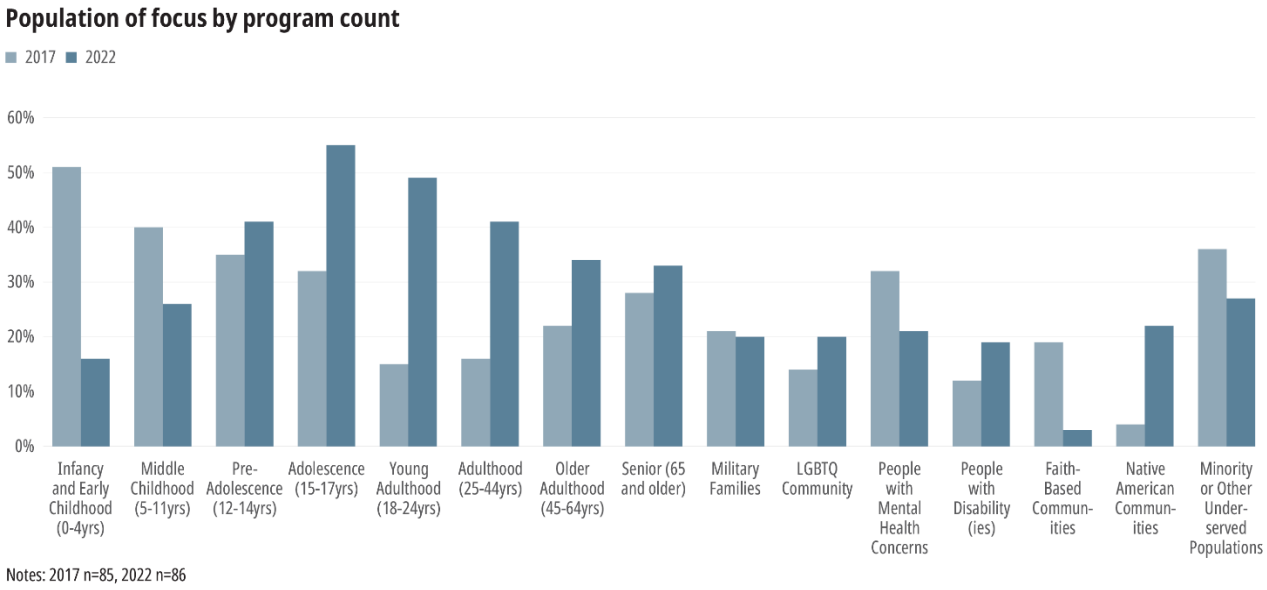
While the Department of Health and the Health Care Authority are two of the larger resource pools, there are many SPE Policy Consortium partners who dedicate funding to this effort, as well as some who dedicate time and effort on a more voluntary basis. An example of this is the Prevention Specialist Certification Board of Washington, which is run entirely by volunteers, often on their personal time, so that our prevention workforce can be given a pathway to professional development and certification.

Funding by organization



Key findings

Health equity: While Washington is considered a leader among states in SUD prevention and mental health promotion, there are still gaps and inconsistencies in how services are distributed and who they benefit most. For instance, while the state needs assessment discovered severe disparities of use among youth who identify as disabled or LGBTQ+, the resource assessment discovered that those are two of the sub-populations with the lowest number of programs specifically designed for their needs.



Notes: 2017 n=85, 2022 n=86

Diverse approach: Most researchers agree that community level change is best achieved through a wide variety of strategies and tactics. While the most common type of intervention among the respondents to this assessment is information dissemination, also known as media or public awareness campaigns, there is a wide range of programs across the state-level system. It is also encouraging to note that cross-system planning, and community engagement are the next most common strategy type and that caregiver education is the most common variety of direct service.

Universal emphasis: Research and best practice has proven that focusing on the root causes of SUDs and general promotion of mental health is cost effective and more efficient in addressing numerous problems at once. While some funding sources require a focus on specific substances, the following graph demonstrates that Washington prevention providers are primarily focused on addressing general substance misuse and universal promotion of mental health, while still fulfilling the requirements of specific funding requests.

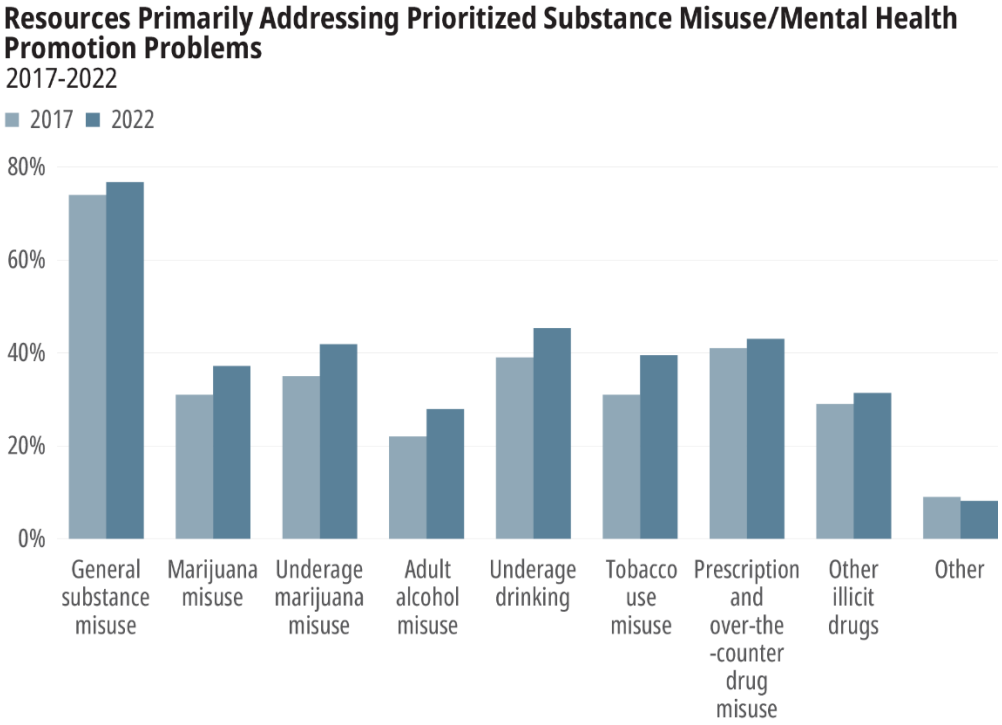
Shared risk factors: While the resources assessed are primarily concerned with the prevention of SUD and promoting mental health, most of them simultaneously address other social issues such as criminal behavior and academic achievement. By recognizing the impact of these programs on numerous life domains, it helps to build the case for primary prevention as a cost-effective and ethical approach to addressing multiple societal issues.

Part 2 – Full data tables

What follows is a full list of responses to questions in the resource assessment, categorized by organization, program, and response categories. If you need any assistance with interpreting this information or have some general questions that these tables do not help

to explain, please reach out to the planning team or SPE Policy Consortium staff or chairs.

Resources primarily addressing prioritized SUD problem(s)



Resources focused on substance use disorder prevention

Resources focused on substance use disorder prevention		General substance misuse	Under-age drinking	Adult alcohol misuse	Cannabis misuse	Under-age cannabis misuse	Prescription and over-the-counter drug misuse	Tobacco use misuse	Other illicit drugs
AGO	Litigation, Legislation, Administrative Rulemaking, And Seeking Industry Voumintary Action	✔					✔	✔	✔
AGO	Tobacco 21	✔						✔	
CCSAP	Webinars	✔	✔		✔	✔		✔	
CCSAP	Year End Young Adult Professional Development Conference	✔	✔	✔	✔	✔	✔	✔	✔
DCYF	CBCAP	✔						✔	
DCYF	Early Support for Infants and Toddlers	✔							
DCYF	ECLIPSE	✔							
DCYF	Head Start	✔							
DOH	2Morrow Health smartphone app							✔	
DOH	Children with Special Health Care Needs								✔
DOH	DOH evaluates and approves mandatory (E2SHB 2793) suicide prevention trainings for health care professionals						✔		
DOH	DOH's Suicide Prevention Plan Implementation Workgroup			✔			✔		
DOH	Drug Prescription Monitoring Program	✔					✔		
DOH	Family Planning	✔							✔
DOH	Home Visiting	✔		✔	✔		✔	✔	✔
DOH	Marijuana Health Disparities Contracts	✔			✔	✔			
DOH	Mass Media resources	✔							
DOH	National Violent Death Reporting System						✔		✔
DOH	Prevention for States Prescription Drug Overdose Grant: CDC's Prevention for States Prescription Drug Overdose Grant								✔
DOH	Project LAUNCH Grant	✔	✔	✔	✔	✔	✔	✔	✔
DOH	Tobacco Sustainability Plan	✔						✔	
DOH	TVPPCP Regional & Priority Population Contracts	✔						✔	
DOH	WA Statewide Suicide Prevention Plan						✔		
DOH	Washington State Overdose Response Plan						✔		✔
DOH	Washington State Tobacco Quitline							✔	

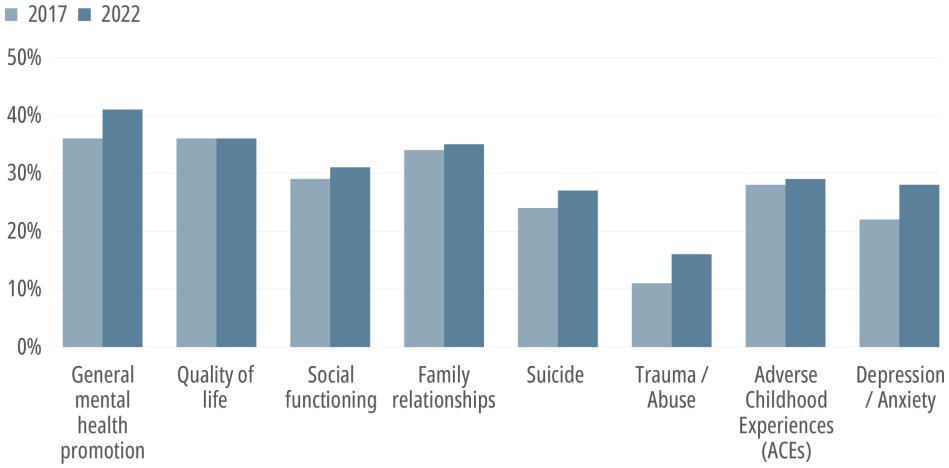
Resources focused on substance use disorder prevention		General substance misuse	Under-age drinking	Adult alcohol misuse	Cannabis misuse	Under-age cannabis misuse	Prescription and over-the-counter drug misuse	Tobacco use misuse	Other illicit drugs
DOH	YMPEP Regional Grants	✓			✓	✓			
HCA	Community Prevention and Wellness Initiative (CPWI)	✓	✓			✓	✓	✓	
HCA	Community-based organization Cannabis Prevention Grants	✓			✓				
HCA	Community-based organization Opioid Prevention Grants	✓					✓		
HCA	Evidence Based Practice Workgroup	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Healthy Youth Survey	✓	✓			✓	✓	✓	✓
HCA	Mental Health Services insurance benefit for Medicaid eligibles and Public Employee	✓					✓		✓
HCA	Prescription Provider Education	✓					✓		
HCA	Prevention Summit/Spring Youth Forum/Coalition Insititute	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Public Education Campaign on Opioid Misuse Prevention	✓					✓		
HCA	Start Talking Now - Website for Parents	✓	✓		✓	✓	✓	✓	✓
HCA	Add HCA Student Assistance Prevention and Intervention Services Program (SAPISP)	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Substance Use Disorder insurance benefit for Medicaid eligibles and Public Employees	✓	✓	✓	✓	✓		✓	✓
HCA	The Athena Forum - Website for Prevention Professionals/Partners	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Tribal Prevention and Wellness Programs	✓	✓		✓	✓	✓	✓	
HCA	Underage Drinking Prevention Media Campaign	✓	✓						
HCA	UW TelePain	✓					✓		
HCA	Workforce Development, Trainings, and Technical Assistance	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Young Adult Health Survey	✓	✓	✓	✓	✓	✓	✓	
IPAC	Support Tribes	✓							
LCB	Compliance Checks	✓	✓		✓	✓		✓	
LCB	Education/Training/Technical Assistance (Licensing, Enforcement, and Public Health and Prevention)	✓	✓	✓	✓	✓			
LCB	Liquor and cannabis enforcement	✓	✓	✓	✓	✓		✓	
LCB	Mandatory Alcohol Server Training (MAST)	✓	✓	✓					

Resources focused on substance use disorder prevention		General substance misuse	Under-age drinking	Adult alcohol misuse	Cannabis misuse	Under-age cannabis misuse	Prescription and over-the-counter drug misuse	Tobacco use misuse	Other illicit drugs
LCB	Premises Checks	✓	✓	✓	✓	✓		✓	
LCB	Printed materials	✓	✓	✓	✓	✓			
LCB	Responsible Vendor Program (RVP)	✓	✓	✓					
LCB	Rulemaking scope	✓	✓	✓	✓	✓		✓	
OIP	Support Tribes	✓							
OSPI	LifeSkills	✓	✓		✓	✓	✓	✓	
OSPI	Project AWARE	✓	✓			✓			
OSPI	Student Assistance	✓	✓		✓	✓	✓	✓	✓
OTA	Funding for Health Integration Transformation	✓	✓	✓	✓	✓	✓	✓	✓
OTA	Support Tribes and Urban Indian Health Organizations in SUD BH including Prevention	✓	✓	✓	✓	✓	✓	✓	✓
PSCBW	Certification for Prevention Professionals	✓							
PSCBW	Substance Abuse Prevention Skills Training (WA-SAPST)	✓							
WAPCo	Washington Association of Prevention Coalitions	✓	✓		✓	✓	✓	✓	✓
WASAVP	Action Alerts	✓	✓			✓	✓		✓
WASAVP	Annual meeting at Prevention Summit in Yakima	✓	✓	✓	✓	✓	✓	✓	✓
WASAVP	Annual Policy Platform for prevention	✓	✓			✓	✓	✓	
WASAVP	Monitoring and advocating for prevention with State Legislature	✓	✓		✓	✓	✓	✓	✓
WASAVP	Occasional position papers relevant to prevention	✓				✓	✓		
WASAVP	Prevention Policy Day each January/February in Olympia	✓	✓		✓	✓	✓	✓	✓
WASAVP	WASAVP website www.WASAVP.org	✓	✓	✓	✓	✓	✓		✓
WSP	State Patrol Target Zero Teams (TZT)	✓	✓	✓	✓	✓	✓		✓
WSU	Interdisciplinary Ph.D. Program in Prevention Science	✓							
WTSC	click it or ticket	✓	✓	✓					
WTSC	DUI enforcement campaigns	✓	✓	✓					
WTSC	HS distracted driver projects	✓	✓						
WTSC	Taffic Safety Task Forces - Target Zero	✓	✓						

Resources focused on mental health

Resources Addressing Other Mental Health Promotion Problems

2017-2022



SPE Resources Assessment | 2017 n=85, 2022 n=86

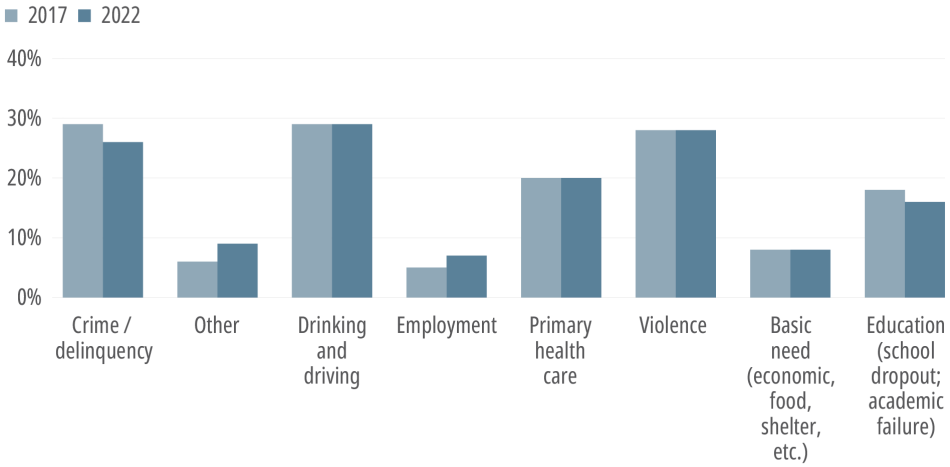
Resources focused on mental health

Resources focused on mental health		General mental health promotion	Quality of life	Social functioning	Family relationships	Suicide	Trauma / Abuse	Adverse Childhood Experiences (ACEs)	Depression / Anxiety
CCSAP	Webinars	✓							
CCSAP	Year End Young Adult Professional Development Conference	✓	✓	✓					✓
DCYF	CBCAP	✓	✓	✓	✓		✓	✓	✓
DCYF	Early Support for Infants and Toddlers	✓	✓	✓	✓			✓	
DCYF	ECEAP Early Childhood Education Econonic Assisstance Program State Preschool	✓	✓	✓	✓				
DCYF	ECLIPSE	✓	✓	✓	✓		✓	✓	✓
DCYF	Head Start	✓	✓	✓	✓		✓	✓	
DOH	2017-2021 TVPPC Program Strategic Plan		✓	✓	✓		✓	✓	✓
DOH	2Morrow Health smartphone app	✓							
DOH	Children with Special Health Care Needs				✓				
DOH	Contract for local youth suicide prevention efforts	✓				✓			
DOH	DOH evaluates and approves mandatory (E2SHB 2793) suicide prevention trainings for health care professionals		✓			✓		✓	✓
DOH	DOH's Action Alliance for Suicide Prevention					✓		✓	✓
DOH	DOH's Suicide Prevention Plan Implementation Workgroup	✓	✓	✓	✓	✓	✓	✓	✓
DOH	Drug Prescription Monitoring Program								
DOH	Family Planning		✓	✓	✓	✓	✓	✓	
DOH	Home Visiting	✓	✓	✓	✓		✓	✓	✓
DOH	Listen2YourSelfie.org - MJ delete - done in 2018		✓	✓	✓				
DOH	National Violent Death Reporting System		✓						
DOH	Personal Responsibility Education Program in Washington State (WA PREP)		✓	✓	✓			✓	
DOH	Prevention for States Prescription Drug Overdose Grant: CDC's Prevention for States Prescription Drug Overdose Grant	✓				✓			
DOH	Project LAUNCH Grant	✓	✓	✓	✓	✓	✓	✓	✓
DOH	SAMHSA youth suicide prevention grant	✓	✓	✓	✓	✓			

Resources focused on mental health		General mental health promotion	Quality of life	Social functioning	Family relationships	Suicide	Trauma / Abuse	Adverse Childhood Experiences (ACEs)	Depression / Anxiety
DOH	TVPPCP Regional & Priority Population Contracts	✓							✓
DOH	WA Statewide Suicide Prevention Plan	✓	✓	✓		✓	✓	✓	✓
DOH	Washington State Overdose Response Plan		✓						
DOH	Washington State Tobacco Quitline	✓							
HCA	Community Prevention and Wellness Initiative (CPWI)	✓		✓	✓	✓		✓	✓
HCA	Community-based organization Marijuana Prevention Grants			✓	✓				
HCA	HCA Community-based organization Mental Health Promotion/ Suicide Prevention grants	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Community-based organization Opioid Prevention Grants			✓	✓				
HCA	Evidence Based Practice Workgroup		✓		✓	✓			
HCA	Healthy Youth Survey	✓	✓		✓	✓			✓
HCA	Mental Health Promotion and Suicide Prevention Projects	✓		✓		✓			✓
HCA	Mental Health Services insurance benefit for Medicaid eligibles and Public Employee	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Prevention Summit/Spring Youth Forum/Coalition Insititute	✓	✓			✓		✓	✓
HCA	Start Talking Now - Website for Parents	✓	✓		✓				
HCA	Student Assistance Prevention and Intervention Services Program (SAPISP)	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Substance Use Disorder insurance benefit for Medicaid eligibles and Public Employees	✓	✓	✓	✓	✓	✓	✓	
HCA	The Athena Forum - Website for Prevention Professionals/Partners	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Tribal Mental Health Promotion Mini Grants	✓	✓		✓	✓		✓	✓
HCA	Tribal Prevention and Wellness Programs	✓			✓	✓			
HCA	Underage Drinking Prevention Media Campaign				✓				
HCA	Workforce Development, Trainings, and Technical Assistance	✓			✓	✓			
HCA	Young Adult Health Survey								✓
IPAC	Support Tribes	✓						✓	
LCB	Printed materials		✓						

Resources focused on mental health		General mental health promotion	Quality of life	Social functioning	Family relationships	Suicide	Trauma / Abuse	Adverse Childhood Experiences (ACEs)	Depression / Anxiety
OIP	Support Tribes	✓						✓	
OSPI	LifeSkills			✓					✓
OSPI	Project AWARE	✓	✓	✓					✓
OSPI	Student Assistance			✓	✓				
OSPI	Suicide Prevention Program					✓			✓
OTA	Funding for Health Integration Transformation	✓	✓	✓	✓	✓	✓	✓	✓
OTA	Support Tribes and Urban Indian Health Organizations in SUD BH including Prevention	✓	✓	✓	✓	✓	✓	✓	✓
PSCBW	Certification for Prevention Professionals							✓	
WSU	Interdisciplinary Ph.D. Program in Prevention Science	✓						✓	

Resources Addressing Other Substance Use Disorder/Mental Health Promotion Problems
2017-2022



SPE Resources Assessment | 2017 n=85, 2022 n=86

Resources focused on other behavioral health issues

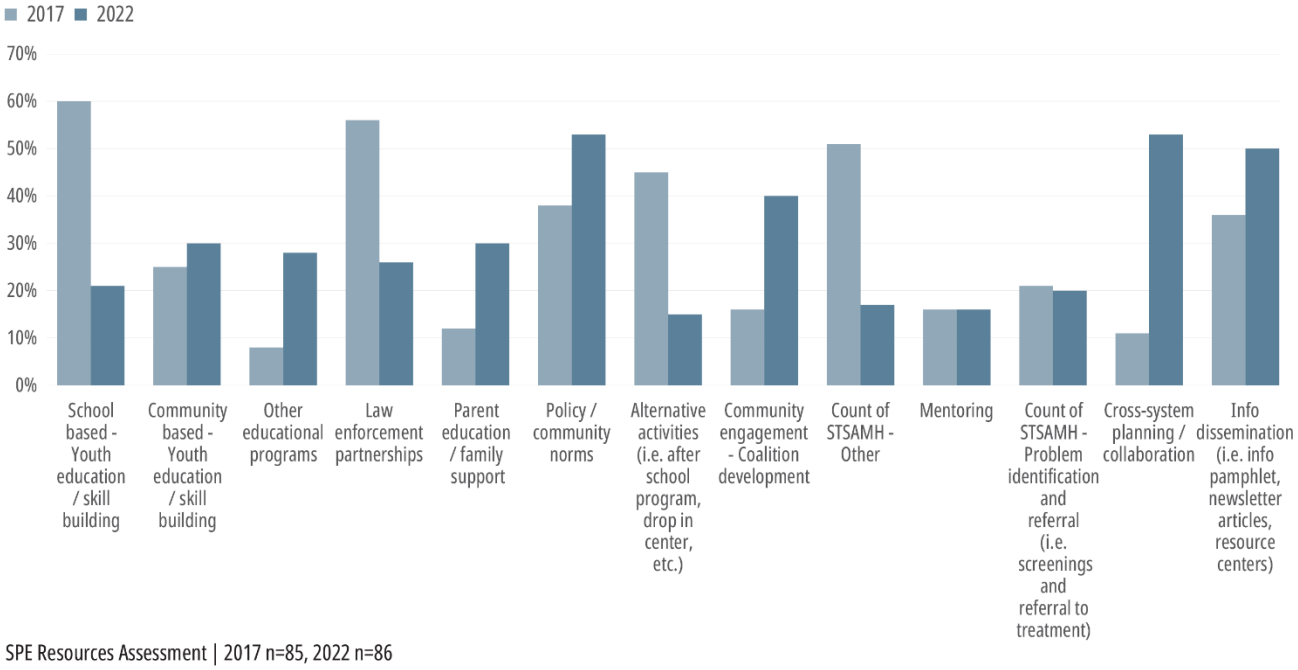
Resources focused on other behavioral health issues		Crime / delinquency	Other	Drinking and driving	Employment	Primary health care	Violence	Basic need (economic, food, shelter, etc.)	Education (school dropout; academic failure)
DCYF	Community-Based Child Abuse Prevention (CBCAP)				✓		✓		
DOH	2017-2021 TVPPC Program Strategic Plan					✓		✓	
DOH	2Morrow Health smartphone app								
DOH	Children with Special Health Care Needs		✓			✓		✓	✓
DOH	Contract for local youth suicide prevention efforts								✓
DOH	DOH evaluates and approves mandatory (E2SHB 2793) suicide prevention trainings for health care professionals					✓	✓		
DOH	DOH's Action Alliance for Suicide Prevention					✓	✓		
DOH	DOH's Suicide Prevention Plan Implementation Workgroup					✓	✓		
DOH	Drug Prescription Monitoring Program								
DOH	Family Planning			✓		✓	✓	✓	✓
DOH	Home Visiting		✓			✓	✓	✓	✓
DOH	Listen2YourSelfie.org - MJ delete - done in 2018								✓
DOH	National Violent Death Reporting System	✓	✓			✓	✓		
DOH	Personal Responsibility Education Program in Washington State (WA PREP)		✓						✓
DOH	Prevention for States Prescription Drug Overdose Grant: CDC's Prevention for States Prescription Drug Overdose Grant	✓					✓		
DOH	Project LAUNCH Grant	✓	✓		✓		✓		✓
DOH	SAMHSA youth suicide prevention grant						✓		
DOH	TVPPCP Regional & Priority Population Contracts							✓	
DOH	WA Statewide Suicide Prevention Plan					✓	✓		
DOH	Washington State Overdose Response Plan	✓				✓	✓		
HCA	Community Prevention and Wellness Initiative (CPWI)	✓							✓
HCA	Evidence Based Practice Workgroup	✓							
HCA	Healthy Youth Survey	✓		✓					✓

Resources focused on other behavioral health issues		Crime / delinquency	Other	Drinking and driving	Employment	Primary health care	Violence	Basic need (economic, food, shelter, etc.)	Education (school dropout; academic failure)
HCA	Mental Health Promotion and Suicide Prevention Projects			✓					
HCA	Mental Health Services insurance benefit for Medicaid eligibles and Public Employee	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Prevention Summit/Spring Youth Forum/Coalition Insititute			✓					
HCA	Substance Use Disorder insurance benefit for Medicaid eligibles and Public Employees	✓		✓	✓	✓	✓	✓	✓
HCA	The Athena Forum - Website for Prevention Professionals/ Partners			✓	✓				✓
HCA	Tribal Mental Health Promotion Mini Grants			✓	✓		✓		
HCA	Tribal Prevention and Wellness Programs	✓					✓		
IPAC	Support Tribes					✓			
LCB	Liquor and cannabis enforcement	✓		✓					
LCB	Mandatory Alcohol Server Training (MAST)	✓		✓					
LCB	Printed materials			✓					✓
LCB	Responsible Vendor Program (RVP)	✓		✓					
LCB	Rulemaking scope	✓		✓					
OIP	Support Tribes	✓				✓			
OSPI	Project AWARE								✓
OSPI	Student Assistance			✓					
OTA	Funding for Health Integration Transformation			✓		✓			
OTA	Support Tribes and Urban Indian Health Organizations in SUD BH including Prevention			✓		✓			
PSCBW	Certification for Prevention Professionals	✓					✓		
PSCBW	Substance Abuse Prevention Skills Training (WA-SAPST)								
WAPCo	Washington Association of Prevention Coalitions	✓		✓			✓		
WASAVP	Action Alerts						✓		
WASAVP	Annual Policy Platform for prevention	✓					✓		

Resources focused on other behavioral health issues		Crime / delinquency	Other	Drinking and driving	Employment	Primary health care	Violence	Basic need (economic, food, shelter, etc.)	Education (school dropout; academic failure)
WASAVP	Monitoring and advocating for prevention with State Legislature			✓			✓		
WASAVP	Occasional position papers relevant to prevention	✓					✓		
WASAVP	Prevention Policy Day each January/February in Olympia			✓					
WASAVP	WASAVP website www.WASAVP.org			✓			✓		
WSP	State Patrol Target Zero Teams (TZT)			✓					
WSU	Interdisciplinary Ph.D. Program in Prevention Science	✓				✓	✓		
WTSC	click it or ticket			✓					
WTSC	DUI enforcement campaigns			✓					
WTSC	HS distracted driver projects	✓	✓	✓					
WTSC	Taffic Safety Task Forces - Target Zero	✓	✓	✓					

Strategies for Addressing Substance Misuse & Mental Health

2017-2022



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Resources by strategy

Resources by strategy		School based - Youth education / skill building	Community based - Youth education / skill building	Other educational programs	Law enforcement partnerships	Parent education / family support	Policy / community norms	Alternative activities (i.e. after school program, drop in center, etc.)	Community engagement - coalition development	Count of STSAMH - Other	Mentoring	Count of STSAMH - Problem identification and referral (i.e. screenings and referral to treatment)	Cross-system planning / collaboration	Information Dissemination (i.e. information pamphlet, newsletter articles, resource centers
AGO	Litigation, Legislation, Administrative Rulemaking, And Seeking Industry Voumintary Action				✓		✓						✓	✓
AGO	Tobacco 21						✓						✓	✓
CCSAP	Webinars			✓										
CCSAP	Year End Young Adult Professional Development Conference			✓										
DCYF	CBCAP		✓			✓	✓		✓	✓	✓	✓	✓	✓
DCYF	Early Support for Infants and Toddlers			✓		✓								
DCYF	ECEAP Early Childhood Education Econonic Assisstance Program State Preschool			✓						✓		✓		
DCYF	ECLIPSE			✓		✓	✓		✓		✓			✓
DCYF	Head Start	✓												
DOH	2017-2021 TVPPC Program Strategic Plan					✓				✓		✓		
DOH	2Morrow Health smartphone app							✓			✓			
DOH	Children with Special Health Care Needs					✓			✓			✓	✓	✓

Resources by strategy		School based - Youth education / skill building	Community based - Youth education / skill building	Other educational programs	Law enforcement partnerships	Parent education / family support	Policy / community norms	Alternative activities (i.e. after school program, drop in center, etc.)	Community engagement - coalition development	Count of STSAMH - Other	Mentoring	Count of STSAMH - Problem identification and referral (i.e. screenings and referral to treatment)	Cross-system planning / collaboration	Information Dissemination (i.e. information pamphlet, newsletter articles, resource centers
DOH	Contract for local youth suicide prevention efforts	✓	✓						✓					
DOH	DOH evaluates and approves mandatory (E2SHB 2793) suicide prevention trainings for health care professionals			✓								✓		
DOH	DOH's Action Alliance for Suicide Prevention	✓	✓		✓		✓						✓	
DOH	DOH's Suicide Prevention Plan Implementation Workgroup		✓			✓			✓					
DOH	Drug Prescription Monitoring Program				✓		✓						✓	✓
DOH	Family Planning	✓	✓	✓	✓	✓						✓	✓	✓
DOH	Home Visiting					✓	✓		✓	✓		✓	✓	
DOH	Listen2YourSelfie.org - MJ delete - done in 2018		✓											✓
DOH	Marijuana Health Disparities Contracts			✓			✓						✓	
DOH	Mass Media resources												✓	✓
DOH	National Violent Death Reporting System				✓		✓						✓	

Resources by strategy		School based - Youth education / skill building	Community based - Youth education / skill building	Other educational programs	Law enforcement partnerships	Parent education / family support	Policy / community norms	Alternative activities (i.e. after school program, drop in center, etc.)	Community engagement - coalition development	Count of STSAMH - Other	Mentoring	Count of STSAMH - Problem identification and referral (i.e. screenings and referral to treatment)	Cross-system planning / collaboration	Information Dissemination (i.e. information pamphlet, newsletter articles, resource centers
DOH	Personal Responsibility Education Program in Washington State (WA PREP)	✓	✓	✓		✓			✓			✓	✓	✓
DOH	Prevention for States Prescription Drug Overdose Grant: CDC's Prevention for States Prescription Drug Overdose Grant				✓		✓						✓	
DOH	Project LAUNCH Grant			✓		✓	✓		✓	✓		✓	✓	✓
DOH	SAMHSA youth suicide prevention grant	✓	✓			✓	✓		✓			✓	✓	
DOH	Tobacco Sustainability Plan	✓			✓			✓						
DOH	TVPPCP Regional & Priority Population Contracts	✓			✓			✓		✓				✓
DOH	WA Statewide Suicide Prevention Plan		✓				✓	✓	✓			✓	✓	✓
DOH	Washington State Overdose Response Plan				✓		✓						✓	
DOH	Washington State Tobacco Quitline							✓		✓	✓			✓
DOH	YMPEP Regional Grants			✓		✓			✓				✓	✓

Resources by strategy		School based - Youth education / skill building	Community based - Youth education / skill building	Other educational programs	Law enforcement partnerships	Parent education / family support	Policy / community norms	Alternative activities (i.e. after school program, drop in center, etc.)	Community engagement - coalition development	Count of STSAMH - Other	Mentoring	Count of STSAMH - Problem identification and referral (i.e. screenings and referral to treatment)	Cross-system planning / collaboration	Information Dissemination (i.e. information pamphlet, newsletter articles, resource centers
HCA	Community Prevention and Wellness Initiative (CPWI)	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓
HCA	Community-based organization Marijuana Prevention Grants	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓
HCA	Community-based organization Opioid Prevention Grants	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓
HCA	Evidence Based Practice Workgroup		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
HCA	Healthy Youth Survey						✓		✓				✓	✓
HCA	Mental Health Promotion and Suicide Prevention Projects			✓		✓	✓		✓		✓		✓	✓
HCA	Mental Health Services insurance benefit for Medicaid eligibles and Public Employee									✓			✓	✓
HCA	Prescription Provider Education						✓						✓	
HCA	Prevention Summit/Spring Youth Forum/ Coalition Insititute		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
HCA	Public Education Campaign on Opioid Misuse Prevention			✓						✓			✓	

Resources by strategy		School based - Youth education / skill building	Community based - Youth education / skill building	Other educational programs	Law enforcement partnerships	Parent education / family support	Policy / community norms	Alternative activities (i.e. after school program, drop in center, etc.)	Community engagement - coalition development	Count of STSAMH - Other	Mentoring	Count of STSAMH - Problem identification and referral (i.e. screenings and referral to treatment)	Cross-system planning / collaboration	Information Dissemination (i.e. information pamphlet, newsletter articles, resource centers
HCA	Start Talking Now - Website for Parents				✓	✓	✓						✓	✓
HCA	Substance Use Disorder insurance benefit for Medicaid eligibles and Public Employees									✓			✓	✓
HCA	The Athena Forum - Website for Prevention Professionals/ Partners						✓		✓				✓	✓
HCA	Tribal Mental Health Promotion Mini Grants	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Tribal Opioid Prevention Grants													
HCA	Tribal Prevention and Wellness Programs		✓	✓		✓	✓		✓	✓		✓		✓
HCA	Underage Drinking Prevention Media Campaign					✓								✓
HCA	UW TelePain			✓										✓
HCA	Workforce Development, Trainings, and Technical Assistance	✓	✓			✓	✓		✓		✓		✓	✓
HCA	Young Adult Health Survey								✓	✓			✓	
IPAC	Support Tribes												✓	✓

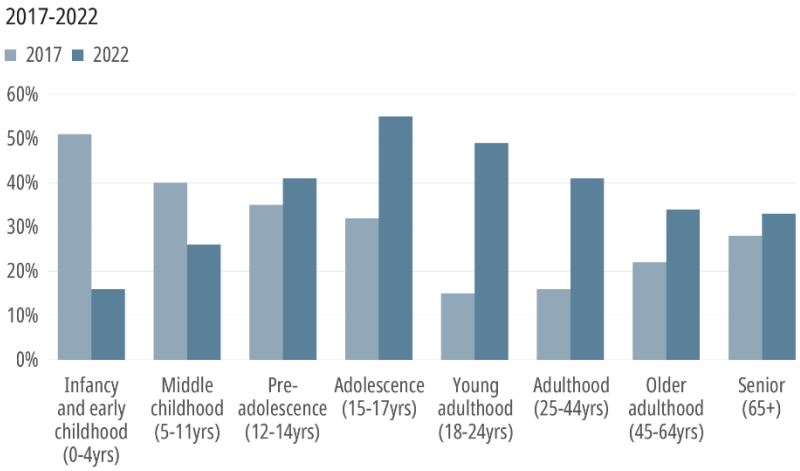
Resources by strategy		School based - Youth education / skill building	Community based - Youth education / skill building	Other educational programs	Law enforcement partnerships	Parent education / family support	Policy / community norms	Alternative activities (i.e. after school program, drop in center, etc.)	Community engagement - coalition development	Count of STSAMH - Other	Mentoring	Count of STSAMH - Problem identification and referral (i.e. screenings and referral to treatment)	Cross-system planning / collaboration	Information Dissemination (i.e. information pamphlet, newsletter articles, resource centers
LCB	Education/ Training/Technical Assistance (Licensing, Enforcement, and Public Health and Prevention)			✓			✓							✓
LCB	Liquor and cannabis enforcement				✓		✓		✓					✓
LCB	Mandatory Alcohol Server Training (MAST)						✓							✓
LCB	Printed materials													✓
LCB	Responsible Vendor Program (RVP)				✓		✓							✓
LCB	Rulemaking scope						✓							
OIP	Support Tribes						✓						✓	✓
OSPI	LifeSkills	✓												
OSPI	Project AWARE	✓	✓										✓	
OSPI	Student Assistance	✓												
OSPI	Suicide Prevention Program	✓				✓	✓		✓				✓	
OTA	Funding for Health Integration Transformation					✓	✓	✓	✓		✓	✓	✓	✓
OTA	Support Tribes and Urban Indian Health Organizations in SUD BH including Prevention					✓	✓	✓	✓		✓	✓	✓	✓

Resources by strategy		School based - Youth education / skill building	Community based - Youth education / skill building	Other educational programs	Law enforcement partnerships	Parent education / family support	Policy / community norms	Alternative activities (i.e. after school program, drop in center, etc.)	Community engagement - coalition development	Count of STSAMH - Other	Mentoring	Count of STSAMH - Problem identification and referral (i.e. screenings and referral to treatment)	Cross-system planning / collaboration	Information Dissemination (i.e. information pamphlet, newsletter articles, resource centers
PSCBW	Certification for Prevention Professionals			✓									✓	
PSCBW	Substance Abuse Prevention Skills Training (WA-SAPST)			✓									✓	
WAPCo	Washington Association of Prevention Coalitions						✓		✓		✓			✓
WASAVP	Action Alerts		✓				✓							
WASAVP	Annual meeting at Prevention Summit in Yakima		✓				✓		✓				✓	✓
WASAVP	Annual Policy Platform for prevention		✓				✓		✓					
WASAVP	Monitoring and advocating for prevention with State Legislature		✓				✓		✓				✓	
WASAVP	Occasional position papers relevant to prevention		✓				✓		✓					
WASAVP	Prevention Policy Day each January/ February in Olympia		✓		✓		✓		✓					
WASAVP	WASAVP website www.WASAVP.org		✓				✓		✓					✓
WSU	Interdisciplinary Ph.D. Program in Prevention Science	✓	✓	✓									✓	
WTSC	click it or ticket				✓		✓							

Resources by strategy		School based - Youth education / skill building	Community based - Youth education / skill building	Other educational programs	Law enforcement partnerships	Parent education / family support	Policy / community norms	Alternative activities (i.e. after school program, drop in center, etc.)	Community engagement - coalition development	Count of STSAMH - Other	Mentoring	Count of STSAMH - Problem identification and referral (i.e. screenings and referral to treatment)	Cross-system planning / collaboration	Information Dissemination (i.e. information pamphlet, newsletter articles, resource centers
WTSC	DUI enforcement campaigns				✔		✔							
WTSC	HS distracted driver projects				✔									
WTSC	Taffic Safety Task Forces - Target Zero				✔								✔	

Resources by targeted age and type

Populations Primarily Targeted by Age Group



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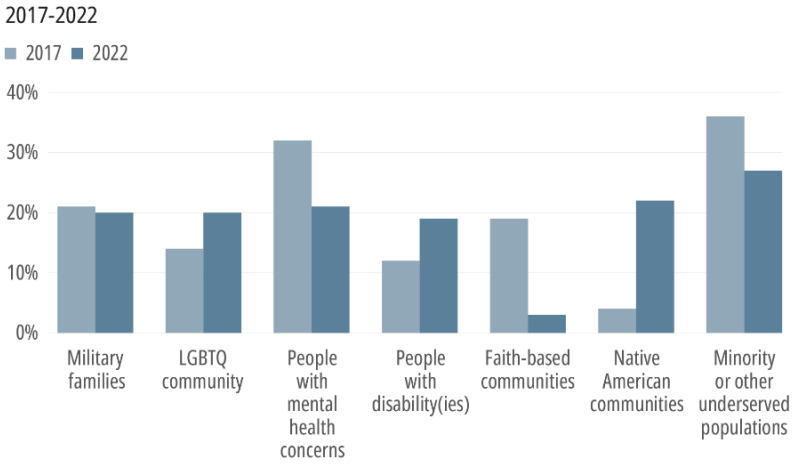
Resources primarily targeted by age group

Resources primarily targeted by age group		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 (65+)
DCYF	CBCAP	✓			✓	✓	✓		
DOH	2017-2021 TVPPC Program Strategic Plan	✓							
DOH	2Morrow Health smartphone app	✓	✓	✓	✓		✓		✓
DOH	Children with Special Health Care Needs	✓	✓	✓	✓				
DOH	Contract for local youth suicide prevention efforts			✓	✓	✓			
DOH	DOH evaluates and approves mandatory (E2SHB 2793) suicide prevention trainings for health care professionals		✓	✓	✓	✓	✓	✓	✓
DOH	DOH's Action Alliance for Suicide Prevention		✓	✓	✓	✓	✓	✓	✓
DOH	DOH's Suicide Prevention Plan Implementation Workgroup		✓	✓	✓	✓	✓	✓	✓
DOH	Family Planning			✓	✓	✓	✓		
DOH	Home Visiting	✓							
DOH	National Violent Death Reporting System				✓	✓	✓	✓	✓
DOH	Personal Responsibility Education Program in Washington State (WA PREP)			✓	✓				
DOH	Prevention for States Prescription Drug Overdose Grant: CDC's Prevention for States Prescription Drug Overdose Grant	✓	✓	✓	✓	✓	✓	✓	✓
DOH	Project LAUNCH Grant	✓							
DOH	SAMHSA youth suicide prevention grant			✓	✓	✓			
DOH	TVPPCP Regional & Priority Population Contracts	✓	✓	✓	✓		✓	✓	✓
DOH	WA Statewide Suicide Prevention Plan		✓	✓	✓	✓	✓	✓	✓
DOH	Washington State Overdose Response Plan				✓	✓	✓	✓	✓
DOH	Washington State Tobacco Quitline	✓	✓	✓	✓		✓	✓	✓
DOH	YMPEP Regional Grants								
HCA	Community Prevention and Wellness Initiative (CPWI)	✓	✓	✓	✓	✓			
HCA	Community-based organization Marijuana Prevention Grants				✓	✓			
HCA	Evidence Based Practice Workgroup		✓	✓	✓	✓	✓	✓	✓

Resources primarily targeted by age group		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 (65+)
HCA	Healthy Youth Survey			✓	✓				
HCA	Mental Health Promotion and Suicide Prevention Projects			✓	✓	✓	✓		
HCA	Mental Health Services insurance benefit for Medicaid eligibles and Public Employee			✓	✓	✓	✓	✓	✓
HCA	Prescription Provider Education			✓	✓	✓	✓	✓	✓
HCA	Public Education Campaign on Opioid Misuse Prevention				✓	✓			
HCA	Start Talking Now - Website for Parents		✓	✓	✓				
HCA	Substance Use Disorder insurance benefit for Medicaid eligibles and Public Employees			✓	✓	✓	✓	✓	✓
HCA	The Athena Forum - Website for Prevention Professionals/Partners	✓	✓	✓	✓	✓	✓	✓	✓
HCA	Tribal Mental Health Promotion Mini Grants		✓	✓	✓	✓	✓	✓	✓
HCA	Tribal Opioid Prevention Grants								
HCA	Tribal Prevention and Wellness Programs		✓		✓	✓	✓		
HCA	Underage Drinking Prevention Media Campaign			✓	✓				
HCA	UW TelePain		✓	✓	✓	✓	✓	✓	✓
HCA	Workforce Development, Trainings, and Technical Assistance		✓	✓	✓	✓	✓		
HCA	Young Adult Health Survey					✓			
LCB	Education/Training/Technical Assistance (Licensing, Enforcement, and Public Health and Prevention)					✓	✓	✓	✓
LCB	Liquor and cannabis enforcement				✓	✓	✓	✓	✓
LCB	Mandatory Alcohol Server Training (MAST)					✓	✓	✓	
LCB	Printed materials					✓	✓	✓	✓
LCB	Responsible Vendor Program (RVP)				✓	✓	✓	✓	✓
LCB	Rulemaking scope				✓	✓	✓	✓	✓
OSPI	LifeSkills			✓					
OSPI	Project AWARE		✓						
OSPI	Student Assistance			✓	✓				
OSPI	Suicide Prevention Program		✓	✓	✓				

Resources primarily targeted by age group		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 (65+)
OTA	Funding for Health Integration Transformation	✓	✓	✓	✓	✓	✓	✓	✓
OTA	Support Tribes and Urban Indian Health Organizations in SUD BH including Prevention	✓	✓	✓	✓	✓	✓	✓	✓
WAPCo	Washington Association of Prevention Coalitions	✓	✓	✓	✓	✓	✓	✓	✓
WASAVP	Annual meeting at Prevention Summit in Yakima			✓	✓	✓			
WASAVP	Monitoring and advocating for prevention with State Legislature			✓	✓	✓			
WASAVP	Prevention Policy Day each January/February in Olympia				✓	✓			
WASAVP	WASAVP website www.WASAVP.org			✓	✓	✓			
WSP	State Patrol Target Zero Teams (TZT)					✓	✓	✓	✓
WTSC	click it or ticket					✓	✓	✓	✓
WTSC	DUI enforcement campaigns				✓	✓	✓	✓	
WTSC	HS distracted driver projects				✓				
WTSC	Taffic Safety Task Forces - Target Zero				✓	✓	✓	✓	✓

Populations Primarily Targeted by Type



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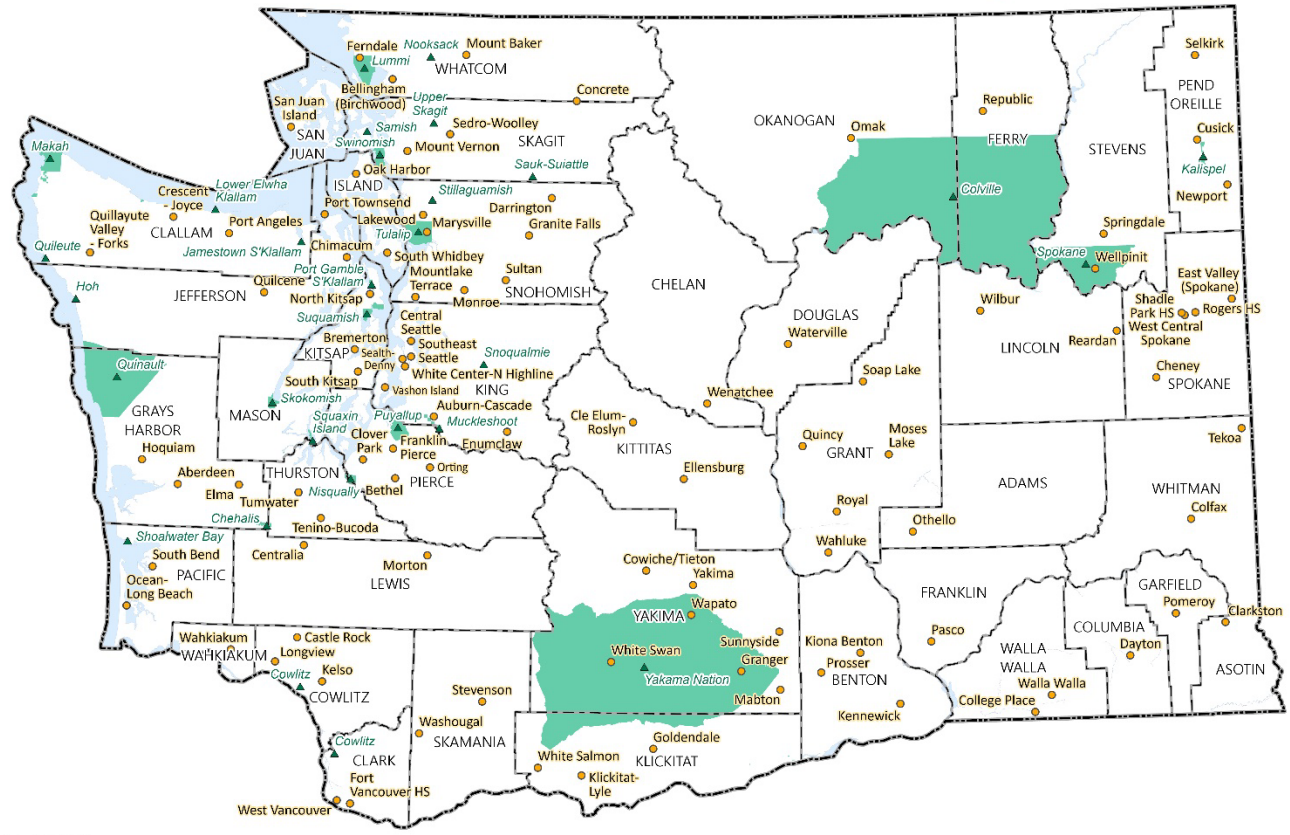
Resources primarily targeted by population type

Resources primarily targeted by population type		Military families	LGBTQ community	People with mental healthconcerns	People with disability(ies)	Faith-based communities	Native American communities	Minority or other underserved populations
DCYF	CBCAP	✓	✓	✓	✓		✓	✓
DOH	2017-2021 TVPPC Program Strategic Plan		✓	✓	✓		✓	✓
DOH	DOH evaluates and approves mandatory (E2SHB 2793) suicide prevention trainings for health care professionals	✓	✓	✓	✓		✓	✓
DOH	DOH's Action Alliance for Suicide Prevention	✓		✓		✓	✓	✓
DOH	DOH's Suicide Prevention Plan Implementation Workgroup	✓	✓	✓	✓	✓	✓	✓
DOH	Family Planning		✓	✓	✓			✓
DOH	Home Visiting	✓		✓	✓		✓	✓
DOH	Personal Responsibility Education Program in Washington State (WA PREP)		✓				✓	✓
DOH	Prevention for States Prescription Drug Overdose Grant: CDC's Prevention for States Prescription Drug Overdose Grant	✓	✓	✓	✓		✓	✓
DOH	Project LAUNCH Grant	✓						✓
DOH	SAMHSA youth suicide prevention grant		✓				✓	
DOH	WA Statewide Suicide Prevention Plan	✓	✓	✓	✓		✓	✓
DOH	Washington State Tobacco Quitline	✓						
HCA	Evidence Based Practice Workgroup	✓	✓	✓			✓	✓
HCA	Mental Health Promotion and Suicide Prevention Projects				✓			
HCA	Mental Health Services insurance benefit for Medicaid eligibles and Public Employee		✓	✓	✓		✓	
HCA	Prescription Provider Education	✓						
HCA	Prevention Summit/Spring Youth Forum/Coalition Insititute							✓
HCA	Start Talking Now - Website for Parents							✓
HCA	Substance Use Disorder insurance benefit for Medicaid eligibles and Public Employees		✓	✓	✓		✓	✓
HCA	The Athena Forum - Website for Prevention Professionals/Partners			✓			✓	✓
HCA	Tribal Mental Health Promotion Mini Grants	✓			✓			✓
HCA	Tribal Prevention and Wellness Programs							✓

Resources primarily targeted by population type		Military families	LGBTQ community	People with mental healthconcerns	People with disability(ies)	Faith-based communities	Native American communities	Minority or other underserved populations
HCA	Workforce Development, Trainings, and Technical Assistance	✓	✓	✓			✓	✓
LCB	Liquor and cannabis enforcement	✓	✓	✓	✓		✓	✓
OTA	Funding for Health Integration Transformation	✓	✓	✓	✓		✓	✓
OTA	Support Tribes and Urban Indian Health Organizations in SUD BH including Prevention	✓	✓	✓	✓		✓	✓
WAPCo	Washington Association of Prevention Coalitions	✓	✓	✓	✓	✓	✓	✓

Prevention services maps in Washington State

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



LEGEND

- Community Prevention and Wellness Initiative Communities
- *Tribal Prevention and Wellness Programs*
- *Tribal Lands*
- Counties

SOURCES: DSHS Research and Data Analysis, Community Outcome and Risk Evaluation Geographic Information System (CORE).
CONTACT: Irina Sharkova, DSHS/FFA/RDA, irina.sharkova@dshs.wa.gov, 360-902-0743.

September 14th, 2021

Significant events influencing the field of prevention, 2010-2022

Year	Significant Events in Washington	Economic Event	Policy/Law Change	Funding Change	Infra-structure
2010/2015	Passing of the Good Samaritan Laws / SB 1671 - Opioid overdose prevention		✓		
2010	Tobacco sales tax structure changes	✓	✓		
2010/2012	Passage of 2876 pain management rules for prescribing chronic opioid therapy in 2010 with rules adoption in 2011 and 2012		✓		
2011	Passage of Initiative 1183 liquor privatization		✓		
2011	Strengthened managed care monitoring		✓		
2012	Contract Language re: mental health services		✓		
2012	Elimination of Family Policy Council funding			✓	
2012	Passing of I-502 Marijuana legalization for non-medical use		✓		
2013	Elimination of Community Mobilization funding			✓	
2013	SIM Grant Awarded to Health Care Authority & Accountable Communities of Health			✓	
2013	Vast expansion of electronic cigarette industry/ marketplace		✓		
2014	Added SBIRT to Medical Benefit		✓		
2014	Garret Lee Smith Grant awarded DOH			✓	
2014	House Bill 2315 passed (suicide prevention)		✓		
2014	WA Prescription Drug Monitoring Program (PMP) State funded		✓	✓	
2014	Significant decrease in youth perception of harm (marijuana use)				
2014	Opening of retail marijuana stores in WA State	✓	✓		
2015	DEA Rules on Rx Drugs and Drug Take-back Program ended		✓		
2015	Youth Mental Health First Aid Pilot Efforts			✓	
2015	Oregon/Alaska retail marijuana legalization		✓		
2015	Potential developmental Screening for young children		✓		
2015	Expansion of home visiting (2 million)			✓	
2015	SB 5052 passed: legalized medical marijuana/ home grows	✓	✓		
2015	Strengthened language in contract re: Early and Periodic Screening, Diagnostic and Treatment (EPSDT)		✓		

Year	Significant Events in Washington	Economic Event	Policy/Law Change	Funding Change	Infra-structure
2015	Tax funding from I-502 for prevention and treatment programs allocated		✓	✓	
2015	Tribes able to sell and produce marijuana legally	✓	✓		
2015	DBHR requires CPP credential for community coalition coordinators		✓		
2015/2016	Health Care Reform - Behavioral Health Organizations (BHO)		✓		
2016	State Suicide Plan Published				✓
2016	State Opioid Plan Published				✓
2016	Fee for Service Program begins for AI/AN Individuals	✓			
2016	Executive Order issued by the Governor on Reducing and Preventing Firearm Fatalities, Injuries, and Suicides		✓		
2016	Surgeon General's Report "Facing Addiction in America" published, endorsing the effectiveness of evidence-based Community Coalition Prevention Models and other key practices implemented in WA State.		✓		
2017	Executive Order issued by the Governor to address Opioid Crisis		✓		
2017	WA State granted the State Targeted (STR) Response to the Opioid Crisis from SAMSHA			✓	
2018	HB 1047 passed: Establishes a uniform statewide drug take-back or safe medication return program		✓		
2018	Passage of 1427 pain management rules for prescribing acute and subacute opioids in 2017 with rules adoption in 2018 and 2019		✓		
2018	WA State awarded the State Opioid Response (SOR) Grant from SAMSHA			✓	
2018	DSHS Division of Behavioral Health and Recovery (DBHR) including Prevention Section, moved to Health Care Authority				✓
2018	H.R.2 Agricultural Improvement Act of 2018 (aka Farm Bill) Federal legislation that legalized hemp production in the United States.		✓		
2019	Executive Order issued by Governor Inslee to address the outbreak of vape-associated lung injury, directing the State Board of Health to temporarily ban flavored vapor products, including those containing THC.		✓		

Year	Significant Events in Washington	Economic Event	Policy/Law Change	Funding Change	Infra-structure
2019	HB 1873 Vapor products (both those including nicotine and those not including nicotine) taxed according to fluid volume.		✓		
2019	SHB 1095 Requires school districts to allow students to consume marijuana-infused products for medical purposes on school grounds, aboard a school bus, or while attending a school-sponsored event.		✓		
2019	ESSB 5298 The labels of DOH compliant marijuana products may include claims that describe the product's intended role in maintaining a structure or function of the body. The labels may also characterize the documented mechanism by which the product maintains a bodily structure or function.		✓		
2019	EHB 1074 Increased the minimum legal age of sale of tobacco and vapor products to 21 years of age.		✓		
2019	Washington State Department of Health Awarded $4.4 million for Opioid and Drug Overdose Surveillance and Prevention			✓	
2019	SB 5380 adds requirement for public high schools with more than 2,000 students to stock naloxone medication to reverse opioid overdoses. Also provides for training in administering naloxone, and requires public colleges & universities store the medication in dorms housing more than 100 students.		✓		
2019	Surgeon General's Advisory on Cannabis Use & the Developing Brain emphasizing the importance of protecting youth and pregnant women from the health risks of cannabis use			✓	
2019	Hemp-derived intoxicating products appear in the open market	✓			
2020	Gov. Jay Inslee declared a statewide emergency due to the spread of coronavirus (COVID-19) and issued a stay-at-home order for Washington residents	✓	✓		
2020	Governor Inslee signed E2SHB 2870 into law creating a Cannabis Social Equity Program.	✓	✓		
2020	Alcohol and cannabis businesses were deemed essential services	✓	✓		
2020	COVID-related allowances for home delivery, curbside delivery, cocktails to go	✓	✓		
2020	Commercial Tobacco Prevention and Cessation Strategic Plan was Published				

Year	Significant Events in Washington	Economic Event	Policy/Law Change	Funding Change	Infra-structure
2021	HYS administration moved from Fall 2020 to Fall 2022				
2021	The Consolidation of the Commercial Tobacco and Cannabis Program was formed at DOH, entitled the Youth Cannabis and Commercial Tobacco Prevention Program				✓
2022	New 988 Lifeline		✓		
2022	Social equity for cannabis licensing		✓		
2022	JUUL settlement: Must pay $438.5 mil for marketing to teens	✓	✓	✓	
2022	FDA denies authorization to market JUUL products; temporarily suspended the order for further review.		✓		
2023	All THC must be sold in licensed stores, prohibits synthetic cannabinoids		✓		

Truncated list of accomplishments from the SPE Workgroups

For a more comprehensive list, please see the full document at: theathenaforum.org/spe.

Washington Healthy Youth (WHY) Coalition: Underage Drinking & Youth Cannabis Prevention

Year	Accomplishment
2013-2015	• The coalition is renamed Washington Healthy Youth Coalition. The name change was necessary to reflect an emphasis on underage alcohol and cannabis/marijuana use. • Parent Tool Kit collaboratively developed with DOH, LCB, DBHR and Inga Manskopf and Dr. Leslie Walker of Seattle Children's Hospital for parents of middle school youth. • Let's Draw the Line project in 2014 provided 34 WA community groups up to $1,000 to complete a Community Assessment of Neighborhood Stores (CANS) surveys and their choice of two other environmental policy projects.
2015-2017	• House Bill 5292 was passed and signed by the governor. The bill prohibits the possession, use, and sale of powered alcohol. • Expansion of the Responsible Vendor Program to beer/wine retailers approved by the LCB. Prevention coalitions promoted the RVP to increase compliance rates for no sales to minors.
2017-2019	• Promoted good policy decisions by providing feedback to the Liquor and Cannabis Board regarding cannabis/marijuana packaging and labeling and the potential impact on children and youth.
2019-Current	• Promoted good policy decisions by providing feedback to the Liquor and Cannabis Board regarding cannabis/marijuana packaging and labeling and the potential impact on children and youth as well as regarding COVID-19 temporary allowances for liquor licenses. • Provided information on emerging issues and current research and data through presentations. • Created a Fact Sheet on Delta-8 to provide information and education. • Updated our Strategic Plan to reflect current needs using a data-informed, coalition-driven approach.

Young Adults Cannabis & Alcohol Prevention Workgroup

Year	Accomplishment
2013-2015	• Developed an action plan to provide outreach to colleges and universities and used training funds from Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant to support non grantee sites with training. • DOH created online training for physicians, nurses, and other healthcare workers through the Washington Healthcare Improvement Network (WHIN) Institute. • Disseminated the Substance Use Disorder During Pregnancy: Guidelines for Screening and Management best practice guide.

Year	Accomplishment
	• Completed Washington State Hospital Association (WSHA) Safe Deliveries Roadmap standards/QI project to ensure comprehensive care (SBIRT), screening and referring for substance use/misuse. • Women's Health education for the public pertaining to the use of substances during pregnancy were developed and updated via the DOH website.
2015-2017	• Disseminated the SUD During Pregnancy: Guidelines for Screening and Management Best Practice Guide. • Implemented SBIRT regional trainings for health care providers and college campuses statewide. • Data on alcohol and commercial tobacco use for women during pregnancy from the 2014 Pregnancy Risk Assessment Monitoring System (PRAMS) survey included in SPE Needs Assessment. • Implemented third iteration of the Young Adult Health Survey (N=2493) and follow-up surveys with cohorts 1 (N=1005) and 2 (N=1180).
2017-2019	• Identified funding to increase substance misuse prevention best practice materials for young adults to be provided to local coalitions. • Development and implementation of a communication strategy for young adult cannabis/marijuana prevention.
2019-Current	• Recruited new members for this workgroup – with representatives from WSU, DBHR, DOH, LCB, King County, and Young Adults representatives. • Conducted an assessment to Identify knowledge and data gaps around cannabis. • Developed a CAPSTONE project for a graduate student to address the gaps and have been using this to guide the work moving forward. • Hosted a WA Higher Education Water Cooler Chat Session to gain qualitative data on the state of prevention on college campuses and gain understanding on insights or limitation on the use of Harm Reduction Strategies. • Explored federal resources provided by National Drug Control Strategies and SAMHSA to incorporate into upcoming five-year action plan. • Expanded membership to include Department of Licensing, Washington Traffic Safety Commission and DOH Harm Reduction.

Washington Breathes: Commercial Tobacco and Vapor Products Workgroup

Year	Accomplishment
2013-2015	• Nov 2013 - Great American Smoke Out day took place on college campuses. • AG Ferguson signed a letter urging the FDA to ban menthol cigarettes. • Washington State University adopted tobacco-free campus policy. • The legislature considered three relevant bills with significant impact including raising smoking age to 21, raising fines and fees for commercial tobacco and regulating e-cigarettes, and allowing cigar bars as an exception to smoking in public places.

Year	Accomplishment
	• Promoted the SmartQuit app and encouraged other partners to add to their website and promote any other way possible. • Youth smoking rates continued to decline, as reported in the HYS results.
2015-2017	• Supported Legislation to regulate vapor products and increase fees and fines for commercial tobacco retailers, which passed in modified form in 2016. • Delivered a statewide webinar to address the state's vapor product law and the new FDA's Deeming Rule, state law implementation, and state agency roles. • Contributed to the House Committee On Health Care and Wellness Legislative Work Session on the value of and need for an adequately funded comprehensive tobacco prevention and control program. • Finalized the state's Five-year Tobacco and Vapor Product Prevention and Control Sustainability and Strategic Plans. • Advanced Tobacco 21 legislation further than it had gone before.
2017-2019	• DOH submitted a decision package for the 2019–2021 biennium for a comprehensive statewide Tobacco and Vapor Product Prevention and Control Program. Although the proposed funding was not received, $8.9 million was included in the Governor's proposed budget to account for the projected state revenue loss, should Tobacco and Vape 21 pass. • EHB 1074 was passed, raising the minimum legal sales age for commercial tobacco and vapor products to 21 years of age. • Incorporated tobacco cessation into the SOR grant, extending the reach of the WA State Tobacco Quitline and training of Tobacco Treatment Specialists.
2019-Current	• Release of Washington State's 2021–2025 Commercial Tobacco Prevention & Control Five Year Strategic Plan • Workgroup members participated in the initial meeting of the "WA Tobacco Coalition & Partnerships Initiative". This is what would become the WA Breathes Coalition in 2021. • Washington State Attorney General settled with JUUL, which included payments over 4 years, which totaled to $22.5 million dollars. • Decision package submitted by DOH for biennium 2024–26 and ongoing to continue the one-time funding provided in FY 2023 to all the continued rebuilding of a comprehensive statewide Commercial Tobacco Prevention Program.

Opioid Prevention Workgroup

Year	Accomplishment
2013-2015	• Athena page launched for opioid prevention resources. • HB 1565 passed to provide funding for Prescription Drug Monitoring. • Analyzed new DEA regulation on take-back of controlled substances. • Outreach provided to stakeholders, pharmacies, law enforcement, and local governments regarding existing and new drug take back programs and events. • Promoted DEA Take-Back event September 2014 to prevention partners.

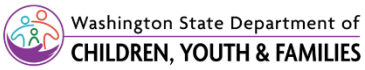
Year	Accomplishment
2015-2017	• Provided Weekly Telepain conference calls to WA State providers/prescribers. • ADAI redesigned Good Samarian Law awareness and Overdose prevention messaging focused on young adults. • WSU, Pacific NW University and UW interdisciplinary programs worked on an interdisciplinary curriculum project teaching about safe opioid prescribing. • Office of the Insurance Commissioner addressed issues around reimbursement for chronic pain management and medication-assisted treatment. • HCA received the State Targeted Response (STR) to the Opioid Crisis Grant in 2017, expanding services for opioid prevention programs in high-need communities, increasing prescriber/provider education, TelePain services, opioid prevention media campaign, and community/tribal prevention grants. • Starts with One and Tribal Opioid Prevention media campaigns launched.
2017-2019	• HCA received the State Opioid Response (SOR) grant in 2019, expanding services for opioid prevention programs in high-need communities, increasing prescriber/provider education, continued TelePain services, opioid prevention media campaign, and community/tribal prevention grants. • Drug Take-Back (safe medication return) law passed in 2018 (69.48 RCW). • Expanded rules and guidelines for opioid prescribing: Bree Opioid Metrics adopted July 2017; Bree/AMDG Dental Guideline on Prescribing Opioids for Acute Pain Management adopted September 2017; Bree/AMDG Prescribing Opioids for Postoperative Pain Supplemental adopted July 2018. • DOH Received Overdose Data to Action CDC Grant. • Implementation of HB 1427 Opioid Prescribing Rules.
2019-Current	• Multiple state opioid grants received: SOR, SOR II, SOR III, and SPF Rx. • DOH launched the state's first pharmacy-based safe medication pilot program in 2020. In 2021, the first full year of implementation, the system destroyed 143,108.7 pounds of collected drugs. • WSU received multiple grants for HRSA and SAMHSA for opioid and pain training for health profession students and clinics. • AMDG/Bree Collaborative developed guidelines: Collaborative Care for Chronic Pain 2019, Low Back Pain 2019, and Long-term Opioid Therapy Recommendations 2020. • DOH joined the BPBT effort in 2019, supporting Medicaid/PEBB/SEBB payers in the state utilizing a broader set of PMP data.

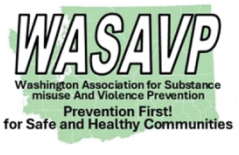
Mental Health Promotion and Suicide Prevention Workgroup

Year	Accomplishment
2013-2015	• Statewide Suicide Prevention Day launched September 2013 with the Governor's Proclamation. • NW Indian College partnered with Colville Confederated Tribes to implement a Suicide Prevention project. • Funding was provided by SAMHSA to the University of Washington (UW) for a suicide prevention project for students.

Year	Accomplishment
	• Forefront developed training curricula for nurses' schools and others in suicide prevention. • DOH submitted the 2014 suicide prevention SAMHSA grant, put together by MH Promotion Team Committee members. • Promoted establishment of permanent cross agency statewide suicide prevention and mental health promotion group. • Supported Mental Health First Aid Training implementation in collaboration with OSPI and DBHR. • Expanded Washington's data on suicide and violent death reporting statistics. • Completed Statewide Suicide Prevention plan with statewide partners. HB 2315 Implementation to ensure health professionals complete training in suicide assessment treatment, and management as part of continuing education.
2015-2017	• Statewide Mental Health Awareness Month launched on May 1, 2017, with Governor's Proclamation. • Integrated Mental Health Promotion and Suicide Prevention workgroups with co-leads from DOH and DBHR. • Completed a review of Mental Health Promotion measures for needs assessment and evaluation purposes.
2017-2019	• Suicide Prevention Decision Package received, resulting in State FTE to support this work, as well as state and local funding support for community-based prevention and promotion work. • HCA Decision Package received for MHPP community grants, resulting in 19 community grants, at just under $20k each.
2019-Current	• $900k of funding to implement 2 mental health triage teams to track individuals from hospital through to care. • Behavioral health mental health workers work with local high school for dual level classes to increase ease of transition into IHEs. • First Years Away From Home program through partnership at WSU is wrapping up and looking forward with additional funding. • Check-in with your self program implemented – An application-based personalized feedback program for young adults • SUD and Wellness campaign through Not a Moment Wasted is ongoing with a new buy launching in partnership with DOH near the end of January.

SPE Policy Consortium Partners





Contributions and thanks

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