Ad Hoc Committee Background

The ad hoc committee King County Networks' Review that formed at our August worked to synthesize recent meeting discussions and to create a framework to organize our thinking and meeting processes. Choosing a scope is important for at least two reasons:

1. Scope will guide who should be involved. Who do we want in on the discussion about how we are co-creating the status quo, and how we might all work to reduce suicide and its associated risks, including Access I clinical disorders like depression and substance abuse, hostility, and vengefulness?
2. Scope will guide the portion of the community's effort that will be considered – What is the universe of programs and other resources that might be re-directed in some way to reduce suicide? (This doesn't necessarily mean their resources would go away; the resources might just be used differently, for example a curriculum change or an additional focus to an after school program).

DRAFT Parameters for Selecting a Scope for this Review

Based on the discussion so far, it seems that we would be satisfied with a scope with the following parameters:

1. Would invite work in multiple domains (school, faith, home, etc)
2. Would consider causal factors for youth depression and suicide including, but not limited to adverse childhood experiences
3. Would focus on a positive goal (possibly building a specific type of resilience that helps prevent depression and suicide)
4. Would enroll others who are already working to reduce youth depression and suicide in the effort – employ opportunistic leadership
5. Would invite dialogue about changes to multiple categories of health determinates (individual, community, societal)
6. Would set-up an expectation of continuous learning and improvement
7. Would set aside any cause-blame thinking. (We would work with causal factors only from the standpoint of preventing people from getting onto a trajectory toward suicide. For people who already are on that trajectory, we would take a lesson from the disability advocacy community: there are lots of reasons that a person be born deaf or become deaf. Regardless of those reasons, we assume an obligation to accommodate and to include in the meaningful activities of life. Accommodation might mean helping the person improve skills, for example, or it could mean changing the community in ways that make it more viable for deaf people to be engaged.)
8. Would not be so broad that we can't actually do anything.

Making the Next Steps More Concrete

We decided to create a matrix to help the group become more organized about recording our thinking, what we know and don't know, and about the core questions that could guide the Review. The idea is to begin to make concrete products that will help us be on the same page about what the options are for either a broad or narrow scope that would still clearly be about reducing suicide and depression.

The following pages are intended to guide us through a first use of the matrix so we can decide if recording information in this type of organized format will be helpful. We hope that using this matrix will help us think about "scope questions" like the ones we surfaced at the August meeting:

What balance do we want between population change and individual change (changing systems that serve individuals)? How might we build strategy that impacts macro suicide prevention vs. micro suicide prevention; and what ratio of time and attention to we want to place on each of these?

The terms in the Matrix are public health terms that are widely used.

The set across the top of the Matrix describes three types of population health determinates:

1. **Individual,**
2. **Community,**
3. **Society.**

The Family Policy Council has observed that comprehensive community initiatives that are effective in reducing the rate of a major social problem include strategic work that is intentionally developed in order to impact all three types of health determinates. SAMSA has also come to this conclusion, as have other organizations. For more information about the determinates of health and examples of policy tools and community strategies for each category, please see page four.

The set that runs down the left column of the Matrix are used to describe the focus of efforts:

A. **Indicated** – efforts focus on improving the lives of people who already have a problem in order to reduce the impact or escalation of that problem
B. **Select** – efforts focus on people with risk factors and/or a lack of protective/asset/resilience related to the problem
C. **Universal** – efforts focus on the entire population, or offer universal access to all

Each “box” in the matrix represents one a combination of public health determinates and one type of prevention or intervention work. So, Box 1A is a combination of work that is intended to reach to people who already have suicidal ideology or who have made a suicide attempt (Indicated) for the purpose of changing individual determinates of health (experience, program access).

Using the Matrix we can make a “map” of very complex information. Once we see the landscape of what is known by this group we can make decisions about what else we want to learn. Once we see the landscape of strategic options we can better make decisions about the mix that we might want to be within the scope of the review.

Laura will explain briefly the type of work that would be a good match for each box on the Matrix so we can all have a sense of the meaning of each one. You can take notes or write down your thoughts on the blank Matrix provided on the next page.

BLANK MATRIX

		1) Individual	2) Community (Micro Conditions)	3) Society (Macro-Social Conditions)
		Biological Traits Individual Experience Program Access	• Living, Working, School Conditions • Social, Family, & Community Networks	• Social Factors • Economic Factors • Political Factors
A) Indicated People with suicidal thoughts, intent, attempt		1A	2A	3A
B) Select People with risk factors for suicide and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		1B	2B	3B
C) Universal All people The disability parallel would be universal design – like curb cuts and elevators.		1C	2C	3C

AN ECOLOGICAL MODEL OF DETERMINANTS OF HEALTH

The Institutes of Medicine has determined that health, including behavioral health, is the result of many factors that influence development, lifestyle, and access to programs. Determinants of health are interactive and individually powerful, creating a dynamic environment for intervention & change.

MACRO CONDITIONS

Macro conditions form the socio-cultural context around and foundation for healthy decisions. Relevant public policy is highly strategic. Some macro conditions, such as war or recession, may not be influenced much by state or local government.

SOCIAL FACTORS
- Cultural values, norms & expectations
- Accepted roles of friends, neighbors, families, etc.
- Racism, discrimination & disproportionality

ECONOMIC FACTORS
- Economic forces & conditions
- Long-term prospects for employment, entrepreneurship, self-sufficiency & wealth
- Poverty
- Access to & distribution of credit & assets

POLITICAL FACTORS
- Public will
- Public engagement
- Marginalization or exclusion from civic life due to legal or citizenship status

EXAMPLE PUBLIC POLICY TOOLS

- Tax policy & strategy related to distribution of wealth, investment & savings incentives, etc.
- Regulations, quality assurance & incentives
- Investment in infrastructure & human capital
- Legal status & non-discrimination
- Job & wealth creation

EXAMPLE COMMUNITY STRATEGIES

- Social marketing
- Civic engagement & partnership development related to community norms
- Community & economic development
- Inclusion & outreach to marginalized groups

MACRO DETERMINANTS

Macro determinants of health influence individual needs and day-to-day decisions. They are influenced by social determinants and individual traits. Relevant public policy is tactical, focusing on target populations, geographic areas or discrete conditions.

LIVING, WORK & SCHOOL CONDITIONS
- Access to housing, transportation & goods & services
- Quality of the natural & built environment
- Safety conditions
- Access to health, recreation & healthcare
- Employment & socioeconomic status
- Education status
- Quality of accessible education
- Disability or special needs

SOCIAL, FAMILY & COMMUNITY NETWORKS
- Intergenerational & extended family connections
- Social capital & relationship building
- Sense of neighborhood
- Civic & community organizations

EXAMPLE PUBLIC POLICY TOOLS

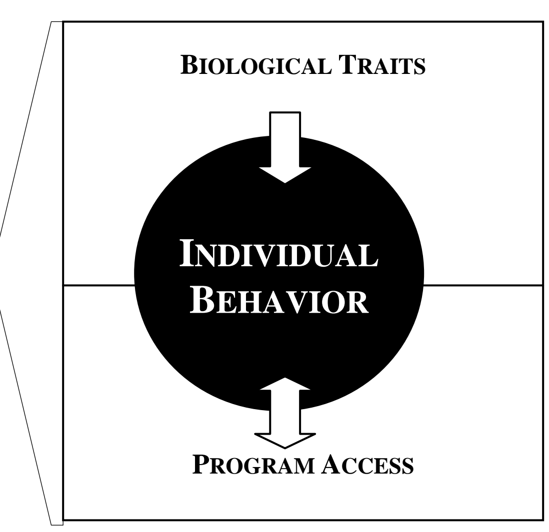
- Zoning, planning & inspection
- Investment in public space & art
- Rule making
- Workplace safety & wage regulation
- Social services & provision of basic needs
- Collaboration & partnership

EXAMPLE COMMUNITY STRATEGIES

- Innovation in service delivery
- Review of Community Efforts
- Professional training
- Neighborhood & leadership development
- Community organizing & engagement

MICRO DETERMINANTS

Individual characteristics, such as biological traits, life experience, and values may determine health decisions. Much health-related public policy is intended to produce specific objectives for individuals or target populations.



EXAMPLE PUBLIC POLICY TOOLS

- Access to & integration of services
- Sliding scale & fee structures
- Eligibility, needs testing & documentation
- Accountability

EXAMPLE COMMUNITY STRATEGIES

- Service enhancements, such as funding to include broader population
- Partnership to integrate services & improve access points
- Parenting education

Adapted from Institute of Medicine, *The Future of the Public's Health in the 21st Century,* (National Academies Press: Washington DC), 2003.

The Matrix can be used to record different types of information.

1. What kinds of strategies might be a “fit” for each box? What are some examples of these strategies?
2. Which research supports this box – what does it say?
3. What facts do we know about people or health determinates for each box? What do we think is true, but would need to verify?
4. What is the primary approach that is used currently by the community and service system for each box?
5. What actions are emerging that might give us an opening for opportunistic leadership/partnership?
6. What core questions would we be asking if we were focused on each box?
7. Who do we really WANT to be working with, and where does their role/work best fit on this Matrix?

We have several BIG versions of the Matrix that we can record thoughts and information on tonight.

Let’s start with one of the seven questions above, and try using the Matrix to record and organize information. We can record information on sticky notes and then post them. If something comes up that doesn’t match the Matrix question that we are working on, we can post that note on the Matrix that does match. That way, free-flowing thoughts can be organized and recorded in a way that supports mapping the complex set of information that we are trying to track and think about as a part of defining the scope for Review.

WHAT KINDS OF STRATEGIES MIGHT BE A "FIT" FOR EACH BOX? EXAMPLES OF THESE STRATEGIES ARE..

		1) Individual Biological Traits Individual Experience Program Access	**2) Community** (Micro Conditions) • Living, Working, School Conditions • Social, Family, & Community Networks	**3) Society** **(Macro-Social Conditions)** • Social Factors • Economic Factors • Political Factors
A) Indicated People with suicidal thoughts, intent, attempt		1A	2A	3A
B) Select People with risk factors for suicide and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		1B	2B	3B
C) Universal All people The disability parallel would be universal design – like curb cuts and elevators.		1C	2C	3C

WHICH RESEARCH SUPPORTS THIS BOX – WHAT DOES IT SAY?

		1) Individual Biological Traits Individual Experience Program Access	**2) Community** (Micro Conditions) • Living, Working, School Conditions • Social, Family, & Community Networks	**3) Society** **(Macro-Social Conditions)** • Social Factors • Economic Factors • Political Factors
A) Indicated People with suicidal thoughts, intent, attempt		1A	2A	3A
B) Select People with risk factors for suicide and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		1B	2B	3B
C) Universal All people The disability parallel would be universal design – like curb cuts and elevators.		1C	2C	3C

WHAT FACTS DO WE KNOW ABOUT PEOPLE OR HEALTH DETERMINATES FOR EACH BOX?
WHAT DO WE THINK IS TRUE, BUT WOULD NEED TO VERIFY?

		1) Individual Biological Traits Individual Experience Program Access	**2) Community** (Micro Conditions) • Living, Working, School Conditions • Social, Family, & Community Networks	**3) Society** **(Macro-Social Conditions)** • Social Factors • Economic Factors • Political Factors
A) Indicated People with suicidal thoughts, intent, attempt		1A	2A	3A
B) Select People with risk factors for suicide and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		1B	2B	3B
C) Universal All people The disability parallel would be universal design – like curb cuts and elevators.		1C	2C	3C

WHAT IS THE PRIMARY APPROACH THAT IS USED CURRENTLY BY THE COMMUNITY AND SERVICE SYSTEM FOR EACH BOX?

		1) Individual Biological Traits Individual Experience Program Access	2) Community (Micro Conditions) • Living, Working, School Conditions • Social, Family, & Community Networks	3) Society (Macro-Social Conditions) • Social Factors • Economic Factors • Political Factors
A) Indicated People with suicidal thoughts, intent, attempt		1A	2A	3A
B) Select People with risk factors for suicide and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		1B	2B	3B
C) Universal All people The disability parallel would be universal design – like curb cuts and elevators.		1C	2C	3C

WHAT ACTIONS ARE EMERGING THAT MIGHT GIVE US AN OPENING FOR OPPORTUNISTIC LEADERSHIP/PARTNERSHIP?

		1) Individual Biological Traits Individual Experience Program Access	**2) Community** (Micro Conditions) • Living, Working, School Conditions • Social, Family, & Community Networks	**3) Society** **(Macro-Social Conditions)** • Social Factors • Economic Factors • Political Factors
A) Indicated People with suicidal thoughts, intent, attempt		1A	2A	3A
B) Select People with risk factors for suicide and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		1B	2B	3B
C) Universal All people The disability parallel would be universal design – like curb cuts and elevators.		1C	2C	3C

WHAT CORE QUESTIONS WOULD WE BE ASKING IF WE WERE FOCUSED ON EACH BOX?

		1) Individual Biological Traits Individual Experience Program Access	2) Community (Micro Conditions) • Living, Working, School Conditions • Social, Family, & Community Networks	3) Society **(Macro-Social Conditions)** • Social Factors • Economic Factors • Political Factors
A) Indicated People with suicidal thoughts, intent, attempt		1A	2A	3A
B) Select People with risk factors for suicide and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		1B	2B	3B
C) Universal All people The disability parallel would be universal design – like curb cuts and elevators.		1C	2C	3C

WHO DO WE REALLY WANT TO BE WORKING WITH, AND WHERE DOES THEIR ROLE/WORK BEST FIT ?

		1) Individual Biological Traits Individual Experience Program Access	2) Community (Micro Conditions) • Living, Working, School Conditions • Social, Family, & Community Networks	3) Society **(Macro-Social Conditions)** • Social Factors • Economic Factors • Political Factors
A) Indicated People with suicidal thoughts, intent, attempt		1A	2A	3A
B) Select People with risk factors for suicide and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		1B	2B	3B
C) Universal All people The disability parallel would be universal design – like curb cuts and elevators.		1C	2C	3C

LAURA's NOTES - STRATEGY

		Individual Determinates	Micro Conditions (Community)	Macro-Social Conditions (Society)
		Biological Traits Individual Experience Program Access	• Living, Working, School Conditions • Social, Family, & Community Networks	• Social Factors • Economic Factors • Political Factors
Indicated People with suicidal thoughts, self harm, intent, or suicide attempt		Prevention – screening for suicidal thoughts or intent Intervention – getting help for individuals who have suicidal thoughts and intent Postvention – helping individuals after a suicide to reduce the risk of a cluster	Strategies that change community conditions and social networks in order to help people who are already considering suicide. E.g.: peer education about what to do if a friend seems depressed; workplace policies that allow for family leave to care for a relative who is depressed or suicidal; integrating services to reduce holes in the safety net.	Reduce social and economic barriers to getting help, eg: changing public and private health insurance policy so that treatment for depression and suicide is covered without a limit on the number of medical visits/year.
Select People with risk factors for suicide, self harm, and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		Strategies that would identify youth ages 7-18 with risk factors predictive of depression and suicide and address those risks. For example, adult mentors for second graders who are loners along with friend-making skill building help and assignment to team work with kids who are perceived by the child as potential friends.	Develop/implement focused programming in multiple domains to improve risks and resiliency specific to depression and suicide; refer selected kids to program(s) in a domain appropriate for the child. Reconceptuualizing educational curricula so that they encompass authentic experiences and real work/contribution to community	Adoption of social-Emotional learning standards with supportive and effective intervention to improve social-emotional competence among youth with social-emotional challenges. (eg: Illinois and New York statutes)
Universal All people The disability parallel would be universal design – like curb cuts and elevators.		Strategies that would make individual supports (experience and program access) universally available to all – for example individuals receive counseling for a variety of reasons at mental health clinics in schools where regular classes are held and where it would be normal to go and talk about self.	Strategies to change policy, practice standards, norms. For example: Establishing the mental health clinics and associated classes in schools. Changing medical assessment protocol among certain doctors. Providing education in the workplace for parents – how to talk to your child. Changing norms to reduce denial.	Civic engagement & partnership development related to community norms Public education campaigns – how to talk to your child about depression and suicide – asking directly saves lives.

LAURA'S NOTES>>> Which research supports this box – what does it say?

		Individual Determinates	**Micro Conditions** (Community)	**Macro-Social Conditions** (Society)
		Biological Traits Individual Experience Program Access	• Living, Working, School Conditions • Social, Family, & Community Networks	• Social Factors • Economic Factors • Political Factors
Indicated People with suicidal thoughts, intent, attempt				
Select People with risk factors for suicide and childhood depression The disability parallel would be the IDEA program – we notice and work with people based on early signs we know to be on a trajectory of risk for suicide in order to prevent escalation to disability or suicide completion		3 Categories of Risk (BRITA): Management of emotional responses in relation to stressful life events Values and belief systems Social and interpersonal communication issues	The Community Preparation model, Bruce Anderson, asserts that the community must be prepared to be inclusive of a wide range of people, and have response systems in place that are truly helpful.	
Universal All people The disability parallel would be universal design – like curb cuts and elevators.		Resilience (BRITA): Build connectedness to significant settings & social structures (peers) Resilience (Grotberg from BRITA) External supports and resources Internal, personal strengths, Social, interpersonal skills *	Social Ecology Perspective – Look up research by O'Rourke and Dalmau, '02; Curricula that encompasses authentic experience and real wk Foster development of multiple literacies that enable kids to read the world and better understand self Clearly articulate the human and futures oriented competencies likely to be useful and valued in diverse communities	

* The Resiliency Project at U of Penn, Andrew Shatte, PhD, has implemented and evaluated a program for teaching resiliency to high risk youth for ten years. All the kids are at risk for depression because of conflict or instability in their homes. Two years after program only 22% felt depressed while control group was at 44%! Girls tend to build r. through relationship, boys through gaining problem solving skills.