



UTAH

The Power in a Plan: Utah's Progress Toward Using Shared Risk and Protective Factors

SHARED RISK AND PROTECTIVE FACTORS (SRPF)

Many injury and violence-related issues are complex, interconnected, and often share the same root causes, such as poverty, inequity, and historical trauma. Understanding the overlapping or shared causes of injuries and violence can help public health professionals better address injuries and violence in all its forms.

A variety of factors can increase or decrease the likelihood of injury and violence. *Risk factors* make it more likely that people will experience injuries and violence. Examples of risk factors include rigid social norms about what is “masculine” and “feminine,” a lack of education and job opportunities, and family conflict. *Protective factors* can increase resilience when encountering risk factors and make it less likely that people will experience injuries and violence. Examples of protective factors include connections to caring adults or access to mental health and substance abuse services.



The Utah Violence and Injury Prevention Program's (UT-VIPP) initial push toward using a shared risk and protective factor (SRPF) approach came as a result of their partnership with the Centers for Disease Control and Prevention (CDC) through the CoreSVIPP cooperative agreement. As part of their work for CoreSVIPP, UT-VIPP decided to include the Adverse Childhood Experience (ACE) module in their state Behavior Risk Factor Surveillance System ([BRFSS](#)) survey and helped fund data collection for one year. The BRFSS is a telephone survey of US adults in all 50 states that collects data on health-related risk behaviors, chronic health conditions, and use of preventive services. As part of the BRFSS survey, the [ACE module](#) asks questions about adverse childhood experiences that occurred before the respondent turned 18. This ACE module allowed for the collection of insightful data that were used by UT-VIPP, as well as many other partners.

Since that first year, many partner organizations--including the state's Division of Substance Abuse and Mental Health (DSAMH), the Commission on Criminal and Juvenile Justice within the Governor's office, the Coalition Against Sexual Assault, and the Domestic Violence Coalition--have contributed to paying for the ongoing inclusion of the ACE module in Utah's BRFSS. The data have generated discussions about SRPFs among many partners and make it worth the financial support by this broad array of agencies.

SHARED RISK AND PROTECTIVE FACTOR AND SUICIDE PREVENTION: A TALE OF TWO STRATEGIC PLANS

The Utah DSAMH has been one of the UT-VIPP's strongest partners in moving toward using a Shared Risk and Protective Factor (SRPF) approach to addressing public health issues. The relationship between the two agencies began in the early 2010s when DSAMH and UT-VIPP each realized that neither agency was doing any work on suicide prevention despite Utah's alarmingly high suicide statistics. Both agencies committed to starting a coordinated effort, and created the Utah Suicide Prevention Coalition, co-chaired by the two state agencies.

Once the DSAMH and VIPP created the Utah Suicide Prevention Coalition, they quickly realized the need for a statewide suicide prevention strategic plan. Following the approach used in the 2012 National Strategy for Suicide Prevention and building on the work that they saw happening in [Colorado](#), the Utah Coalition developed a statewide suicide prevention strategic plan for 2017-2021 that focuses on risk and protective factors at every level of the social-ecological model. Utah's plan includes nine core areas that are connected to levels of the social-ecological model (SEM). They include:

Protective Factors for Suicide	Level of SEM
<ul style="list-style-type: none">• Increase availability and access to quality physical and behavioral health care• Increase social norms supportive of health seeking and recovery	Societal
<ul style="list-style-type: none">• Reduce access to lethal means• Increase connectedness to individuals, family, community and social institutions by creating safe and supportive school and community environments• Increase safe media portrayals of suicide and adoption of safe messaging principles	Community
<ul style="list-style-type: none">• Increase coping and problem-solving skills	Interpersonal
<ul style="list-style-type: none">• Increase support to survivors of suicide loss• Increase prevention and early intervention for mental health problems, suicide ideation and behaviors, and substance misuse• Increase comprehensive data collection and analysis regarding risk and protective factors for suicide to guide prevention efforts	Individual

Utah's suicide prevention strategic plan includes goals and strategies for increasing protective factors in each of the nine areas to prevent suicide in both the general population as well as those at increased risk.

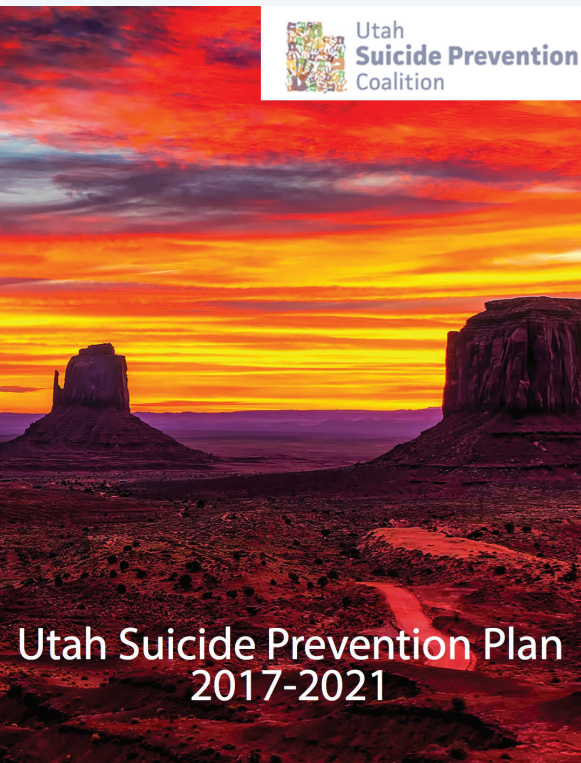
DEVELOPING THE UTAH VIOLENCE AND INJURY PREVENTION STRATEGIC PLAN WITH A SRPF FOCUS:

Recently the Utah VIPP Rape Prevention and Education ([RPE](#)) manager became the UT-VIPP's Program and Policy Director, largely funded by CDC's Core State Violence and Injury Prevention Program ([SVIPP](#)). Programs in sexual and intimate partner violence adopted a SRPF approach before many other injury and violence areas. Thus, working previously with the RPE program gave the new Program and Policy Director comfort with a SRPFs approach meaning she was able to bring this expertise to the wider UT-VIPP. Her experience was helpful in moving towards developing a strategic plan focused on SRPFs. While getting different groups out of their silos had long been talked about, the Program and Policy Director was able to bring her experiences from RPE to bear and began turning talk into action by engaging partners in SRPF approaches connected to the VIPP's work. Capitalizing on growing interest in SRPFs generated by the ACEs data and the statewide suicide prevention plan, the VIPP was primed to make a significant, agency-wide shift toward a SRPF approach.

Knowing that they wanted to move in this direction, the UT-VIPP sent a team to the 2017 Shared Risk and Protective Factors Conference in [Colorado](#). Following the conference, UT-VIPP staff also called several other states to get additional suggestions on how to implement SRPF approaches.

Inspired by their colleagues in Colorado, the Utah VIPP hosted their own half day conference with state and local partners from a variety of different areas in 2018. Using CDC's [Connecting the Dots](#) document as a foundation, they presented their intention and vision for using a SRPF approach to partners at the meeting. UT-VIPP staff then invited partners to brainstorm all of the risk and protective factors that affect their respective areas of interest. From this extensive list, UT-VIPP staff selected eight areas that represented SRPF that have the greatest impact on the violence and injury topics that they address:

- 1) Access and utilization of healthcare and resources for mental and physical health
- 2) Cultural context and social norms
- 3) Laws and policies
- 4) Employment and economics
- 5) Physical environment
- 6) High risk activities
- 7) Connectedness
- 8) Family or self-history of behavior, personality or skills.



Utah Suicide Prevention Plan
2017-2021

ADVERSE CHILDHOOD EXPERIENCES (ACES)

ACEs are stressful or traumatic events experienced in childhood, including abuse and neglect. They may also include household dysfunction, such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health and social problems throughout a person's lifespan. ACEs are also cumulative, meaning the more ACEs a child is exposed to, the higher likelihood they will experience some numerous health, social, and behavioral problems later in life, including a shorter life expectancy. Preventing ACEs and providing support to those who have experienced them could have a significant positive impact on population health and longevity.

More information:

<https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences>

<https://www.cdc.gov/violenceprevention/acestudy/index.html>

To further refine the categories, UT-VIPP leadership invited stakeholders, including their Injury Community Implementation Board, other UT-VIPP staff, a local health department injury work group, and the statewide Coalition to Prevent Child Abuse, to a series of workshops where participants were asked to discuss and rank each of the eight categories based on four criteria: relevance/importance, feasibility/acceptability, impact, and funding.

Utah is planning to use these rankings to condense the list further to approximately five broad categories. They will then identify goals and indicators for each of the SRPFs in those categories and create a statewide injury and violence prevention strategic plan based on those goals and indicators. The end result of this process is a state plan organized around SRPFs instead of injury and violence topics. If, for example, connectedness makes their final list then that section in the state plan will include goals and activities that support connectedness as it applies to all the different injury and violence topics it affects (e.g. suicide, youth violence, opioids, teen motor vehicle crashes, senior falls, child abuse and neglect, etc.). Utah expects this process to move people and funding out of their tradition silos, as the state plan sets the direction and expectation for how injury and violence prevention should be done.



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PARTNERSHIPS BETWEEN PUBLIC HEALTH & MENTAL HEALTH/SUBSTANCE ABUSE PREVENTION: EMBRACING DIFFERENCES IN FOCUS AND LANGUAGE

Collaborations between public health and mental health/substance abuse prevention partners to use SRPF approaches are a natural fit in some ways and challenging in others. Suicide and opioid overdose prevention are two areas that both partners have in common. Alcohol abuse and depression are risk factors for many injury and violence issues, meaning they are also of common interests.

One challenge that a public health and mental health/substance abuse collaboration can face is a difference in focus. Public health injury prevention practitioners, like those in Utah's VIPP, generally focus on upstream approaches; that is, they work to prevent injuries and violence before they occur. Additionally, the public health model looks at population-level health, and designs interventions with that goal in mind.

Conversely, mental health/substance abuse practitioners tend to work more downstream by providing support and treatment after illness or substance use have occurred. Additionally, mental health and substance abuse treatment is based on a medical model that works with individuals.

The suicide coordinator at the Utah DSAMH highlighted the difference between their work and the work of public health professionals by saying, "Because we are housed in DSAMH and we oversee treatment services, I think there is a forgetfulness about more upstream prevention work. While there is a lot of broad support for it, there is not a lot of [direct] support for it." Being aware of and sensitive to this difference is important, and addressing it directly can help ensure open and honest lines of communication between both agencies. Having the leaders of the two groups develop a personal relationship went a long way towards creating the will to work together and enabled the understanding and time needed to accommodate bridging differences in each agency's areas of focus.

Another significant barrier Utah faced in collaborating with partners was establishing a common language. For example, public health staff in Utah's VIPP staff often refer to "connectedness" as

an important protective factor. On the other hand, DSAMH staff use the term “bonding” to describe the same type of idea when referring to mental health and substance abuse prevention. While the two concepts overlap, they are not operationalized identically. Understanding the meaning of terms in different contexts and clearly defining them for each other is crucial for cross-discipline collaborations.

Defining terms and using common language is just as important within injury and violence prevention practice as it is outside of it. As Utah’s VIPP Policy and Program Manager noted, “Partners who work on violence have a greater familiarity with shared risk and protective factors from Connecting the Dots or other literature out there. Partners from motor vehicle are not very familiar with the language at all. If we sit and have a conversation about what [shared risk and protective factors] means or how it is applicable, both parties can pretty easily wrap their heads around it and see how it will develop to partner collaboration. But it’s not a shared language to start with a lot of times.” For example, positive parenting is a protective factor that is often addressed from a child abuse and neglect perspective, but given the importance of parent-teen contracts as a tool for promoting safety for new drivers, it is also be something motor vehicle partners can support.

Utah’s collaborations show that if we are on the same page about what we are working on (e.g., prevention, treatment, risk reduction, etc.), we also need to be on the same page when it comes to how we talk about it. Ensuring clarity among partners is an important step to take because it can prevent miscommunication that derail or delay collaborative work.



SAFE STATES

September 2018

SUMMARY

Many states have found that getting partners on board is one of the most important steps in moving forward with a SRPF approach. Utah’s experience demonstrates how a planning processes can be used to bring together many different partners to discuss ideas related to SRPFs and the possibilities for incorporating these ideas into action. Utah-VIPP increased the breadth of their partnerships by collecting and utilizing ACE data. Also, they significantly deepened their partnership with mental health by committing to addressing suicide and assembling a statewide coalition to write the state suicide prevention plan. Together these activities shifted their thinking so significantly that they’ve starting work on a larger statewide injury and violence prevention plan organized around SRPFs. Their next steps will be to finalize the state plan for injuries and violence and begin implementation of activities identified as priorities in the plan. Further, they will evaluate their efforts by collecting data that connects outcomes in multiple injury areas back to the core risk or protective factors prioritized in the state plan. Utah’s authentic collaborative spirit and willingness to adapt based on different perspectives and new information are why they have had success so far with their efforts to use a SRPF approach.