ASSESSING SHARED RISK AND PROTECTIVE FACTOR WORK IN ALASKA

SAFE STATES

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Introduction

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.

Risk factors are the characteristics or situations that increase the probability that an individual will become a victim or perpetrator of injury and/or violence, while protective factors are the characteristics or situations that mitigate the risk of an individual will become a victim or perpetrator of injury and/or violence. Risk and protective factors can be attributed to each level of the social ecology: individuals, families, organizations, communities, and societies. Shared risk and protective factor (SRPF) approaches are efforts to improve multiple population health and quality-of-life outcomes by aligning diverse, multi-sector interventions that positively and equitably impact social determinants of health. Applying a SRPF approach involves addressing these shared factors and integrating prevention strategies that recognizes these connections.

Understanding shared risk and protective factors of violence and injury can help us plan how to prevent multiple forms of violence and injury at once. For example, organizations working on child maltreatment, youth violence, and suicide prevention could work together on strategies that increase family and community connectedness. Since community connectedness is a shared protective factor across these types of violence (and other types of violence, as well), pooling resources to take action on this shared protective factor could have a broad violence prevention impact in the community.

Alaska is one of many states working to approach their primary prevention work through the lens of SRPFs in order to maximize the effects of their prevention efforts. This type of approach requires both an understanding of the theoretical framework behind these efforts, as well as a practical understanding of how to align current and future efforts in this regard.

The History of SRPF Work in AK

While these surveys and interview respondents provide a glance into the work, to understand the full spectrum of SRPF work happening in Alaska, it is important to understand those working in it and the history behind it.

When the Alaska Statewide Violence and Injury Prevention Partnership (ASVIPP) a statewide coalition of partners involved in state, local, and tribal injury prevention - began developing a plan for addressing injury in Alaska, SRPFs were one of the priority considerations. Similar to work done previously in Colorado, ASVIPP developed the Alaska Statewide Violence and Injury Prevention Plan, 2018. This plan included a shared factor matrix which aimed to:

- Strengthen and sustain effective violence and injury prevention and control measures.
- Outline goals and objectives that reflect current state and partner priorities, including violence and injury leading health indicators from Healthy Alaskans 2020 (HA2020), for the next five years (2018-2022).
- Highlight risk and protective factors for each prioritized health topic area and summarize shared risk and protective factors for prioritized health topic areas.
- Identify strategies and/or recommendations missing from existing HA2020 and other strategic plans (if applicable) that may help guide the work of Alaskan violence and injury prevention stakeholders.

One particular partner, Strength-Based Strategies, has also done a significant amount of work around strategies to increase protective factors among Alaskan adolescents. Two specific reports have come out of this work and have helped frame the SRPF discussion in Alaska.

- Shared Risk and Protective Factors Impacting Adolescent Behavior and Positive Development (updated June 2020).
- More Matters: Strategies to Increase Protective Factors Among Alaska Adolescents (January 2021)

From 2018-2020, the Shared Risk and Protective Factors Workgroup, a group formed out of ASVIPP, began an ongoing process to compile common factors into a research-based, data-driven matrix to support the alignment of best practices amongst public and behavioral health initiatives and leverage future prevention resources. Topics include substance misuse, violence and injury prevention, high school graduation, child maltreatment, domestic violence and sexual assault, and transportation issues.

At the time, the workgroup recognized that it was only the beginning of the work and that the matrix was in no way inclusive of all health outcomes or risk and protective factors. An interactive process then helped the workgroup to create an action plan to advance priority shared risk and protective factors. Some of the action items that have been accomplished, include:

- Presenting information about Alaska shared risk and protective factors at the Division of Behavioral Health Comprehensive Prevention Grantee conference and the Alaska Public Health Summit
- Advocating for and securing two new protective questions for the Youth Risk Behavior Survey (YRBSS)
- Working with funders to promote inclusion of shared risk and protective factor concepts in requests for proposals

Next steps and recommendations from the workgroup have led them to where they are now in the SRPF work in Alaska. Future activities and potential considerations for the SRPF workgroup can be found in the detailed report.

There are also others across the state that are actively furthering the development of a SRPF framework in Alaska. Healthy Alaskans 2030 used the shared factors approach to set goals, determine priority indicators and identify best practices to improve the health and wellness of all Alaskans. The State's Section of Women's, Children's, and Family Health is researching shared protective factors associated with sexual violence. The Injury Prevention Unit is partnering with Tobacco Prevention and Control Unit to pilot the "Communities that Care" framework to impact youth tobacco use and injury and violence outcomes.

These strategic activities have led to the integration of a SRPF lens across several ongoing efforts in Alaska. Alaska boasts dedicated organizations and partners committed to advancing work around SRPFs and is well poised to continue operationalizing this approach. Alaska boasts dedicated organizations and individuals committed to advancing work around SRPFs.

The Purpose of this Report

The effort to align SRPF work has become a top priority for partners across Alaska. To help build long term investment in SRPF work and continue momentum, a temperature check was needed to gauge where partners stand in their understanding of and readiness to integrate dedicated activities to support a SRPF approach.

This report aims to provide an overview the work and to help with this alignment process. A readiness assessment relative to the SRPF approaches work answers the following questions:

1. How well do partners in Alaska working on violence understand shared risk and protective factors?
    - What are the attitudes and beliefs towards using shared risk and protective factors approaches to violence and injury prevention?
2. What is needed to move forward with a shared risk and protective factors approach within Alaska?
    - Which sectors are engaged in SRPF work and which sectors are missing from the conversation?
    - What is the language surrounding SRPFs work in Alaska currently?
    - What barriers or misconceptions remain to implementing SRPF activities in Alaska?
    - What resources are available to support SRPF activities?

The insight gained from these questions equips Alaska with the necessary background to establish and communicate a unifying vision for SRPF work.

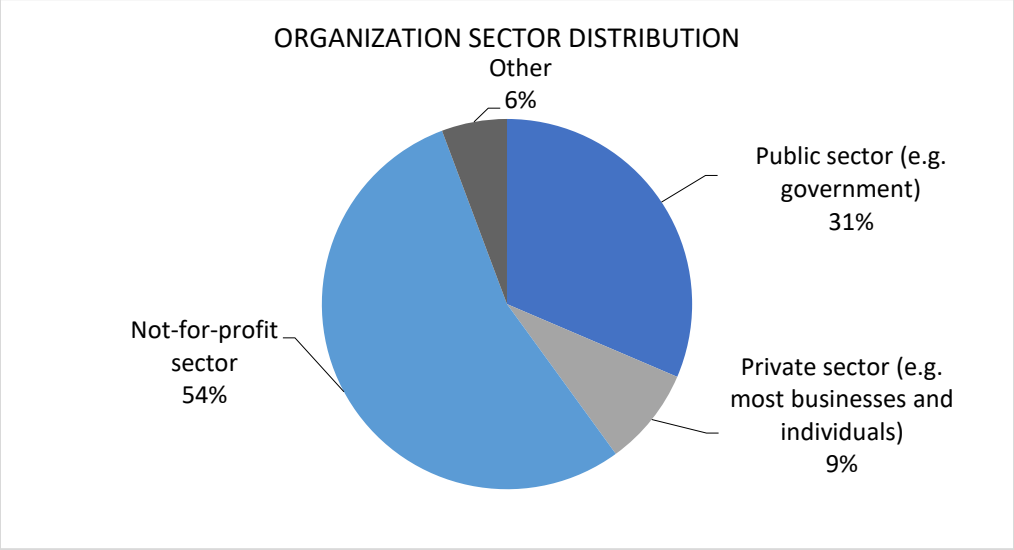
Process Overview

To answer these questions, the Safe States Alliance conducted an evaluation consisting of online surveys and key informant interviews across stakeholders identified by the Alaska SRPF team consisting of representatives from Alaska's Injury Prevention Unit within the Alaska Division of Public Health and the Center for Safe Alaskans. Respondents to the surveys and interviews included those currently active in SRPF work, individuals in the SRPF workgroup and individuals that might be a good fit for SRPF work in Alaska.

The online surveys focused on overall readiness to take on SRPF approaches across Alaska. Questions looked at the attitudes and beliefs about SRPFs, the current landscape of SRPF approaches across the state, the existing barriers, and resources available to carry this work forward (See Appendix A for Online Survey Instrument).

The key informant interviews helped to provide the "narrative around the numbers." (See Appendix B for Key Informant Interview Instrument). Both interviews and surveys were conducted virtually, and respondents' responses were kept anonymous, though some demographic information was collected for cross tabulation purposes.

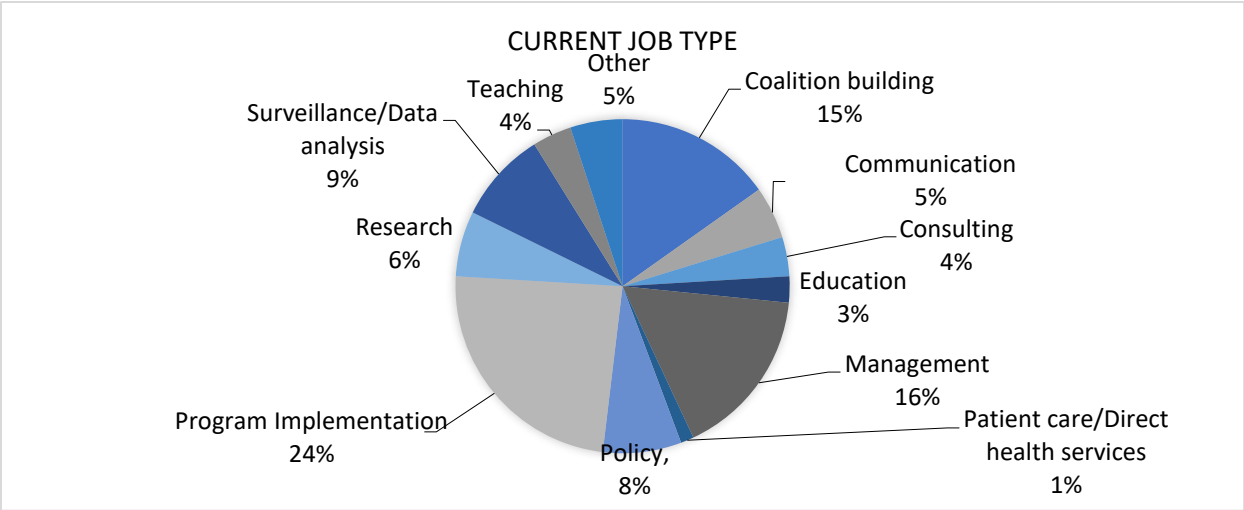
Among the partners surveyed (n=35), the majority indicated they were located in Anchorage, AK. The majority of those that responded to the survey also indicated that they had been working in their field for more than 10 years (49%) with their specific role as "management" (52%) or "program staff" (32%).

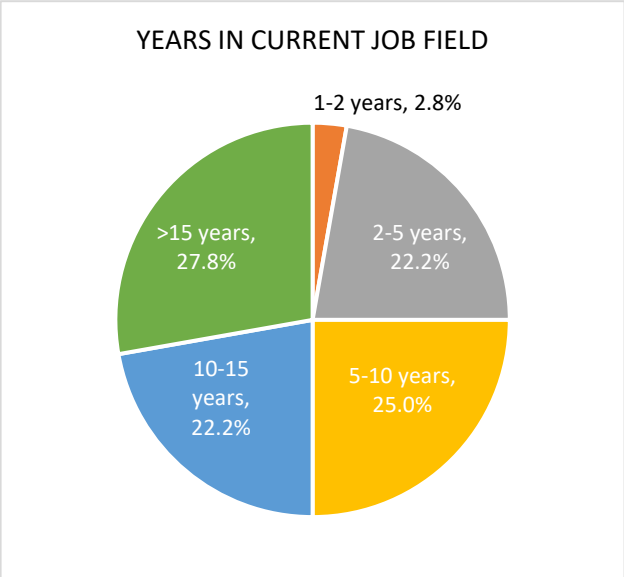


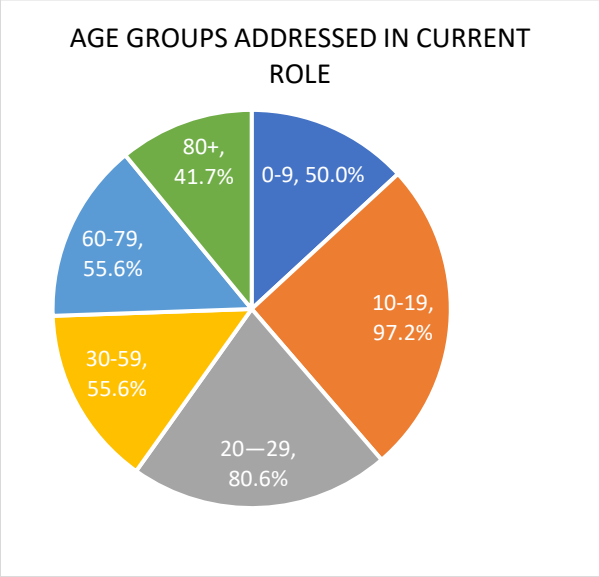
Most survey respondents also indicated that their organization was in the "non-profit sector" (54%) or "Public sector (ie: government)" (31%) and that they primarily work with both rural and populated areas (63%).

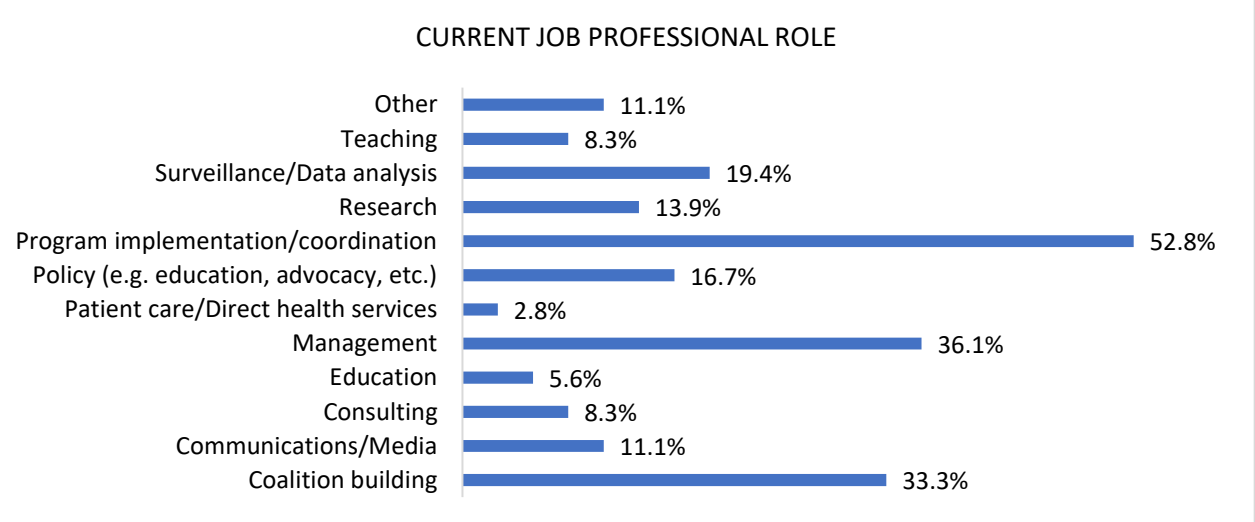
When asked about the areas with which individuals had the most experience, the following topics were the most cited: resilience work, youth and community violence, suicide, domestic and intimate partner violence, child abuse and neglect, and alcohol misuse. Most survey respondents mentioned that they with youth or on youth-centered prevention activities. This included evaluation work, at an individual- or population-level.

Across survey respondents, the majority indicated working with populations ages 0-29, and more specifically, 97% of those respondents addressed populations ages 10-19.



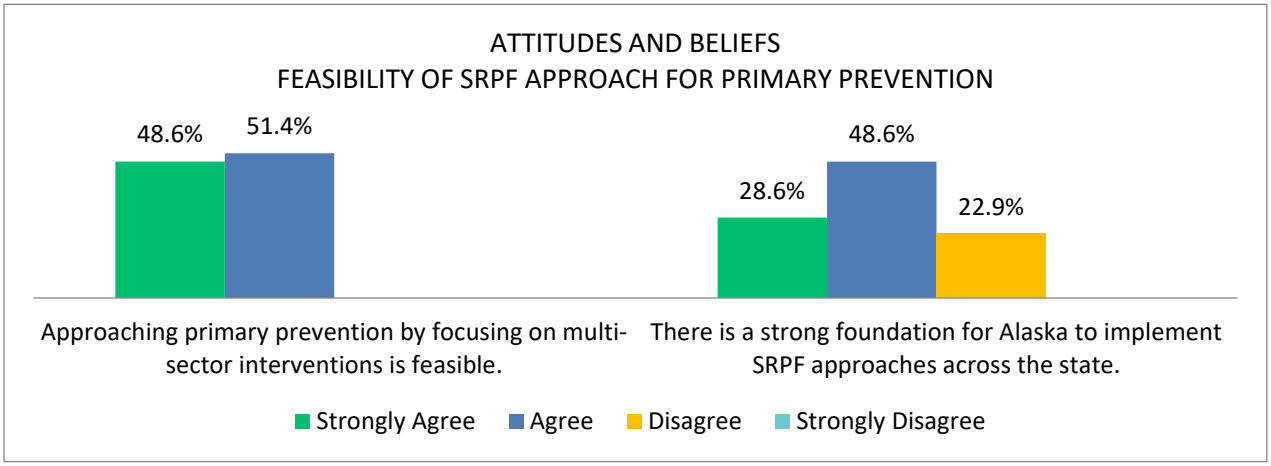




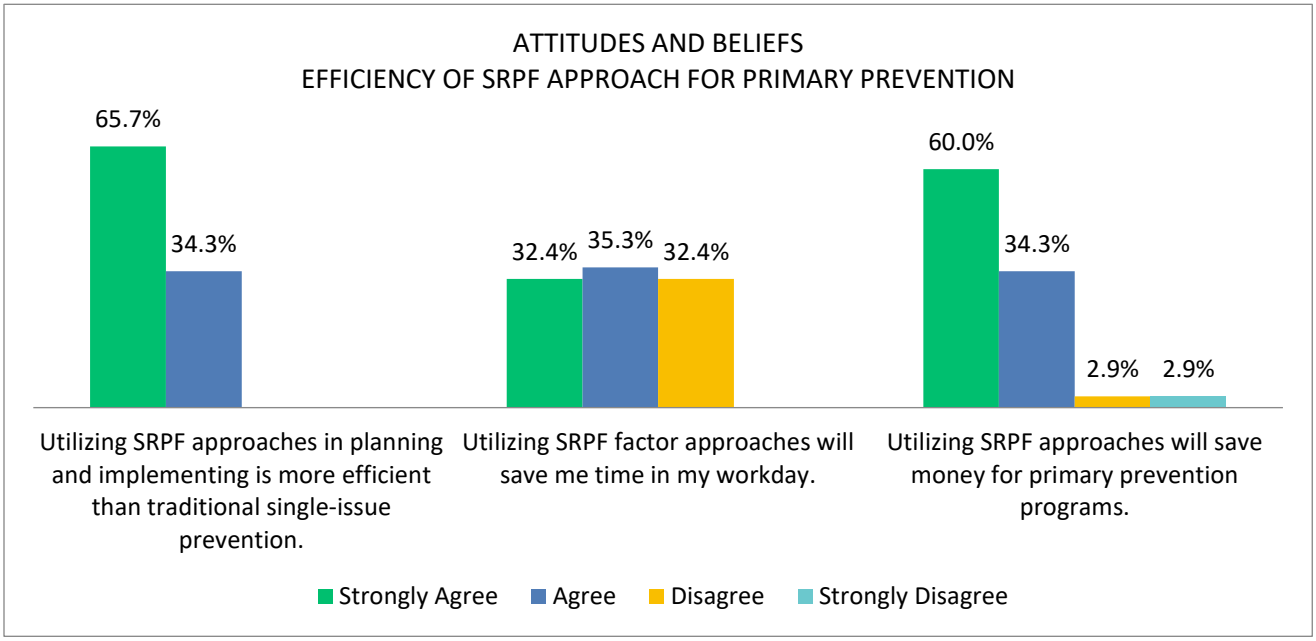


Attitudes and Beliefs About SRPF Approaches

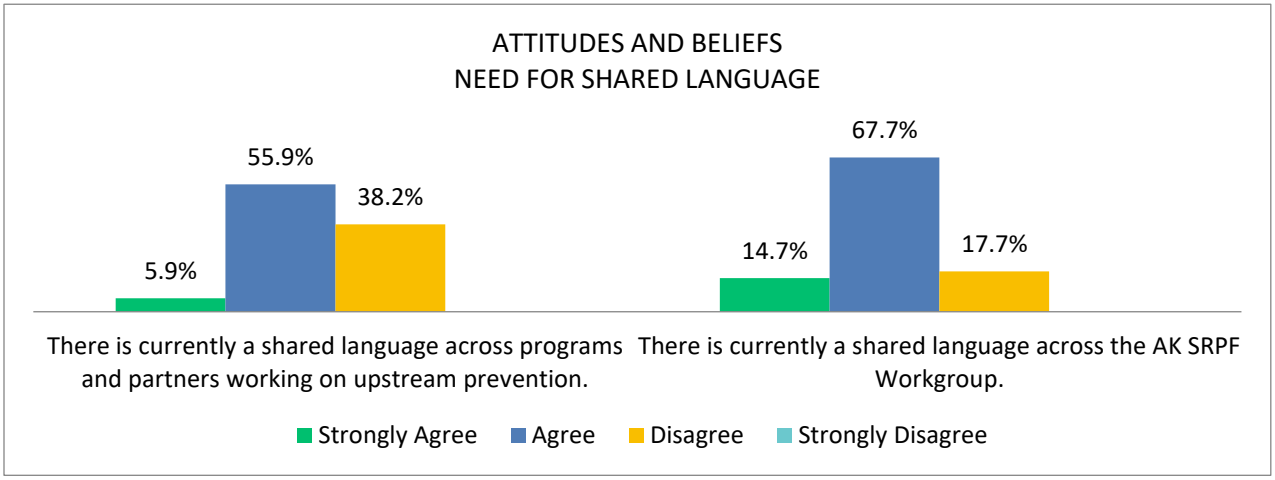
Across both surveys and those interviewed, individuals are strongly in support of SRPF approaches, upstream approaches, and their impact on primary prevention. All those surveyed agreed or strongly agreed that "Primary prevention is important to my work," "Quality of life outcomes are interconnected and share root causes," and "Multi-sector interventions that positively and equitably impact the social determinants of health are important." One interviewee noted, "*I think everyone would agree that we all understand the need of aligning work around shared risk and protective factors."*



Partners were also in agreement that "Approaching primary prevention by focusing on multi-sector interventions is feasible." However, 23% disagreed with the statement that "There is a strong foundation for Alaska to implement SRPF approaches across the state." Part of this could be owed to the fact that Alaska is a big state with very different communities from one side to the other. As one interviewee stated, "*The idea of a statewide plan to this work is cute, but if you actually want to create a comprehensive plan that is going to apply to Alaskans, it needs to be regional…. The reality of life in rural Alaska is so vastly different from the reality of life in urban Alaska, that it is, it's just two different worlds*.

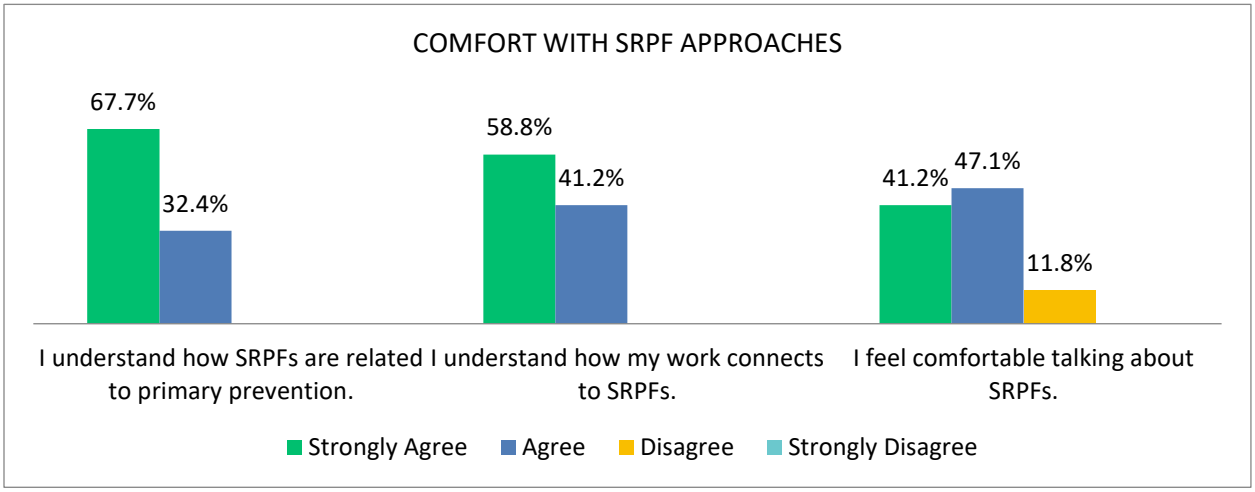


The majority of those surveyed agreed-strongly agreed that "Utilizing SRPF approaches in planning and implementing is more efficient than traditional single-issue prevention" and that "Utilizing SRPF approaches will save money for primary prevention programs." However, there was some disagreement (32%) as to such an approach saving them time in their workday.

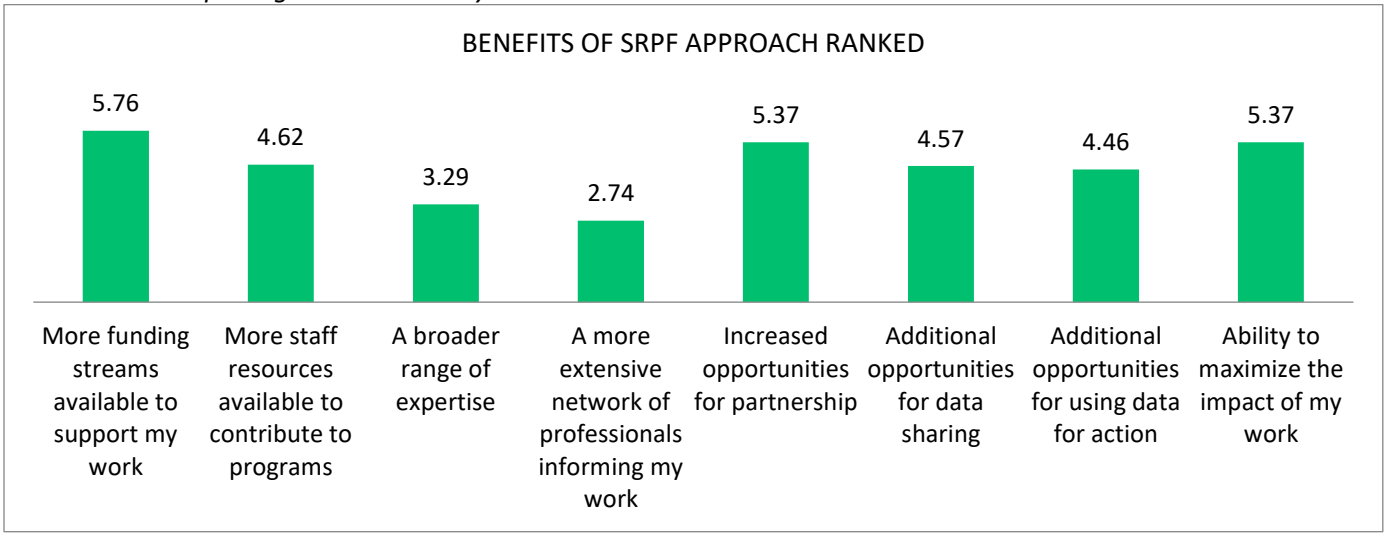


When it came to language, there was less agreement. When asked if "there is currently a shared language across programs and partners working on upstream prevention" 55% agreed and 38% disagreed. When asked if "There is currently a shared language across the AK SRPF Workgroup." 67% agreed and 17% disagreed. The image seems to be there is a common language around SRPFs among those within the AK SRPF Workgroup. One interviewee noted "*I sometimes I feel overwhelmed trying to grasp the shared risk and protective factors and explain the science, but fortunately, there's people in our state who are experts and really do keep on top of that.*"

Among the most valuable benefits that a SRPF approach would bring, "More funding streams available to support my work" "Increased opportunities for partnership" and "Ability to maximize the impact of my work" were at the top. "A more extensive network of professionals informing my work" was the least valuable benefit. This sentiment was strong with the interviews as well. People understand the value that SRPFs can bring to their work and the impact it can have at a population level. "*I think that finally, the state and other*

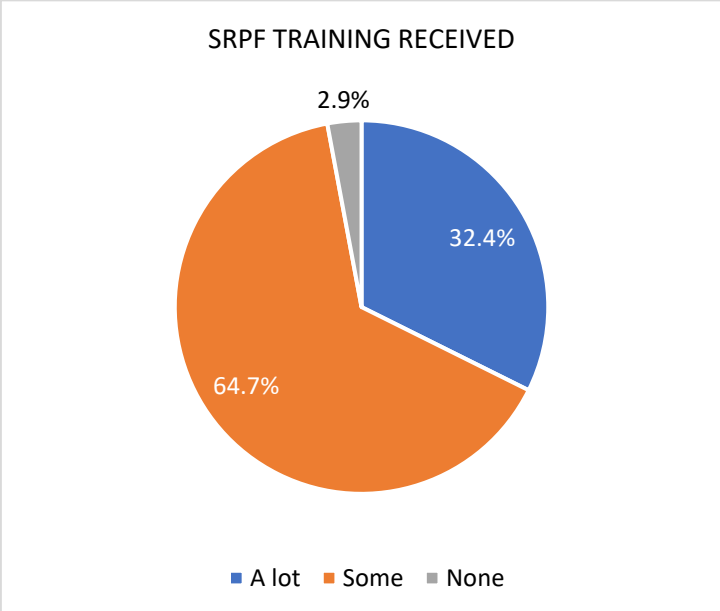


entities are saying, yes, this is important. And they are investing time, resources, contractors, (etc.) to those that are exploring work in this way."



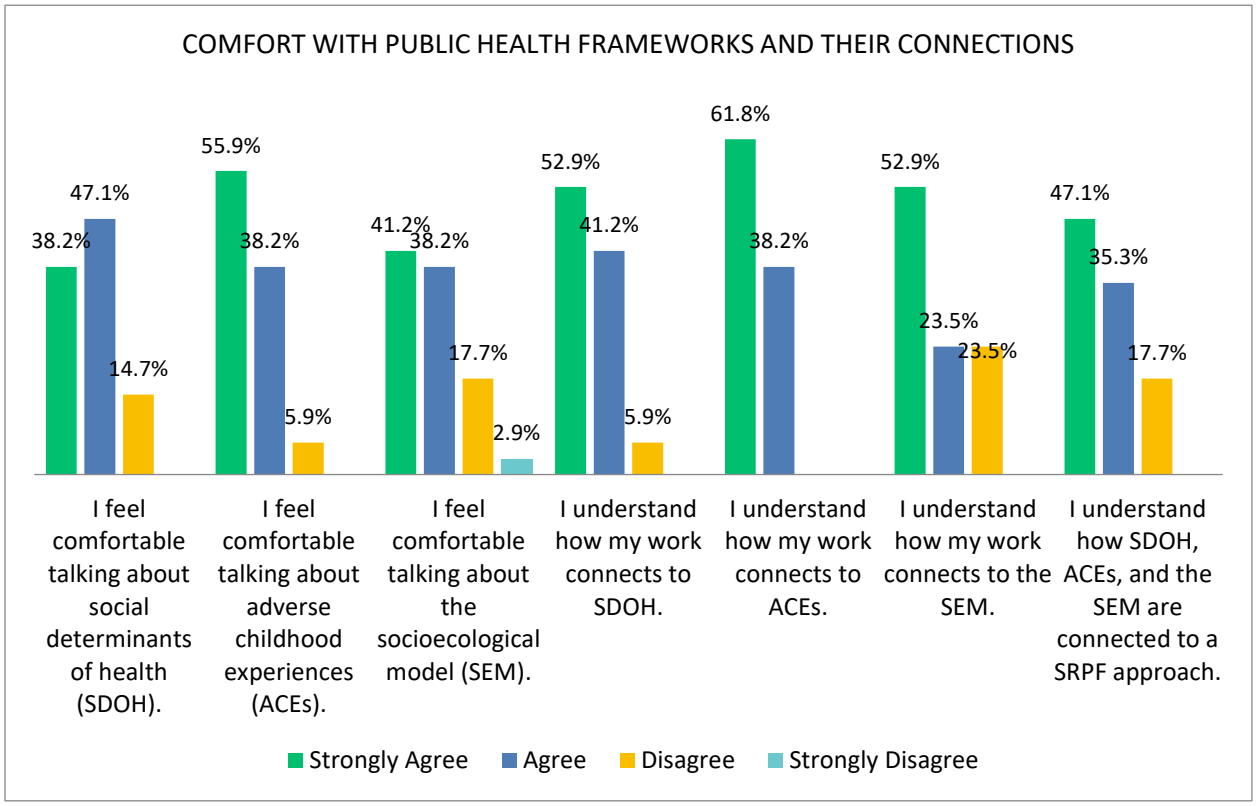
From both those surveyed and interviewed there is an image that Alaska is well prepared and trained in upstream prevention strategies and SRPF approaches. Out of those that responded to the survey, only 3% indicated that they haven't received training around shared risk and protective factors. When asked about the type of training that they have received around this work, respondents had a variety of answers from academic, didactic presentations to basic training at state conferences. Many indicated that they have "been around since the very beginning." This champion workforce is a common theme among Alaska's SRPF work and will be looked at more closely in the resources section.

The survey also examined how comfortable individuals are with SRPF approaches in their work. All respondents agreed or strongly agreed that they "understand how SRPFs are related to primary prevention" and that they "understand how (their) work connects to SRPFs." The only disagreement was at 12% about feeling "comfortable talking about SRPFs." People are well educated and bought into the work of SRPFs. This comfort could be a response that this work is well grounded in Alaska. In interviews, the theme that "this isn't new work" continued to come up. "*In the beginning it was just a holistic approach to looking at adolescents and their contexts, and what are we going to do about them. This immediately became what we call today, shared factors."*



There is slightly less comfort around individuals connecting SRPFs to other public health approaches/frameworks. While not a substantial amount, there was some disagreement (21% disagree-strongly disagree) in feeling comfortable talking about the socioecological model (SEM) and 23% disagreed that they understand how their work connects to the SEM. This gap in terminology clearly doesn't deter the upstream work taking place in Alaska. Many of the interviewees talked about using different language for

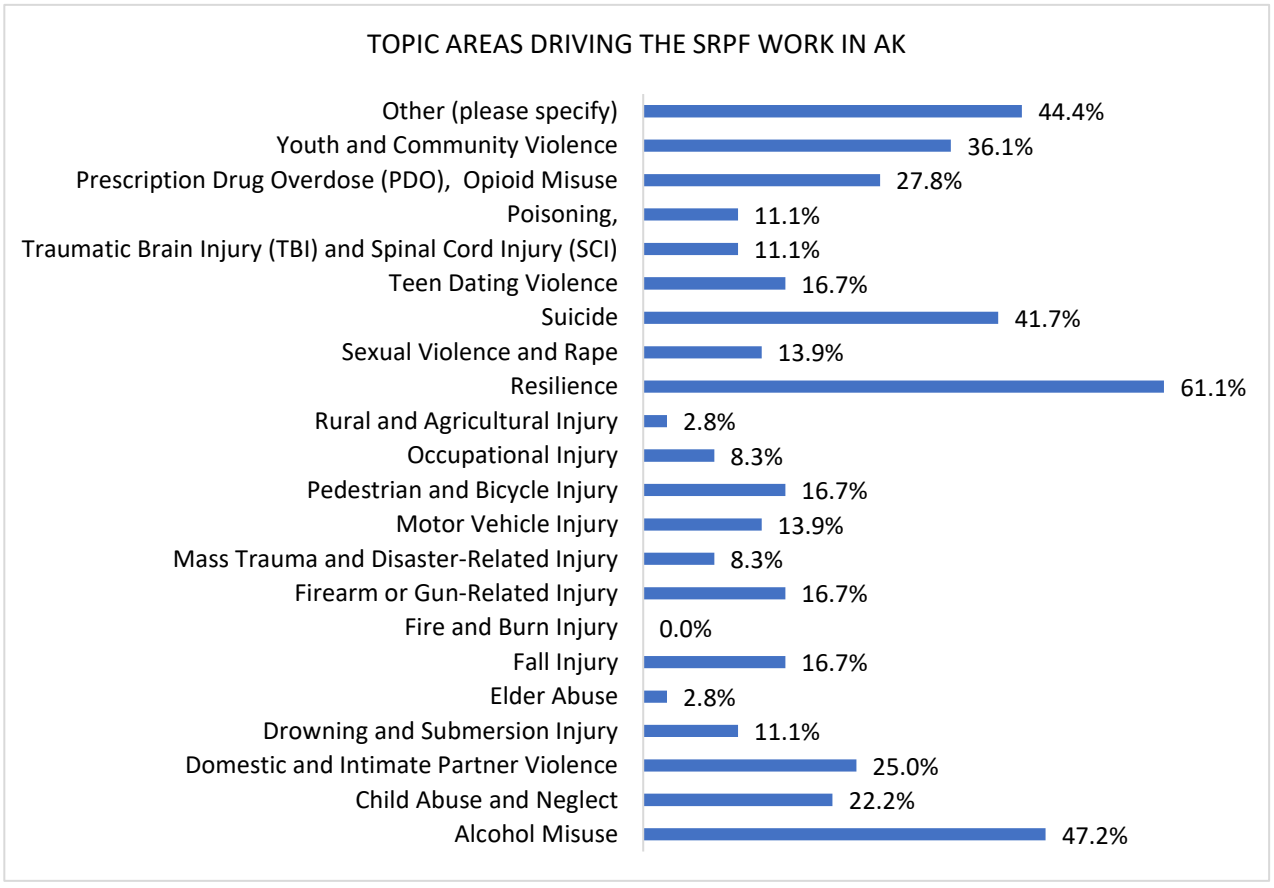
different partners and the advantages of that. As one individual put I, "*One of the things I appreciate about public health is, it's very scientifically based and that's good. But sometimes that language can get in the way of people grasping it and understanding it in a way that's meaningful to them."* Another individual noted, "*I have found that you can use the word, protective factors, assets, youth development, resiliency, and sometimes you're talking about the same thing. It just depends on who your audience is. When I'm talking to a doc, I'm going to use medical terms like protective factors, because they know about that related to heart disease. If I'm talking to a mental health clinician, I may use the term resiliency, because that seems to be the word that the mental health field glommed onto about a decade or so ago. If I'm talking to moms and dads, and they're not technical, then sometimes this assets framework works really well for them. So I changed my language… So this concept of shared factors to me is just, it's a repackage a bit. The difference being that the shared factors work is interested in risk and protective factors."*

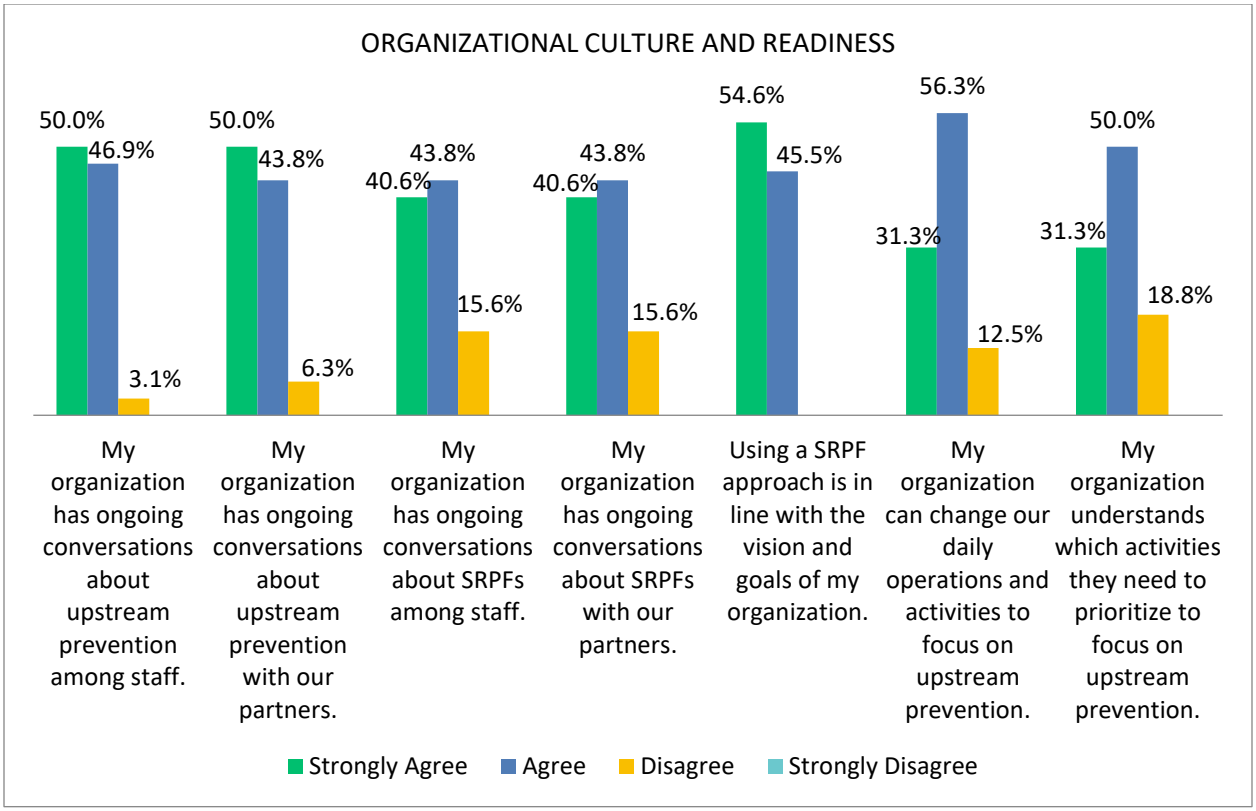


Alaska's Current Work With SRPFs

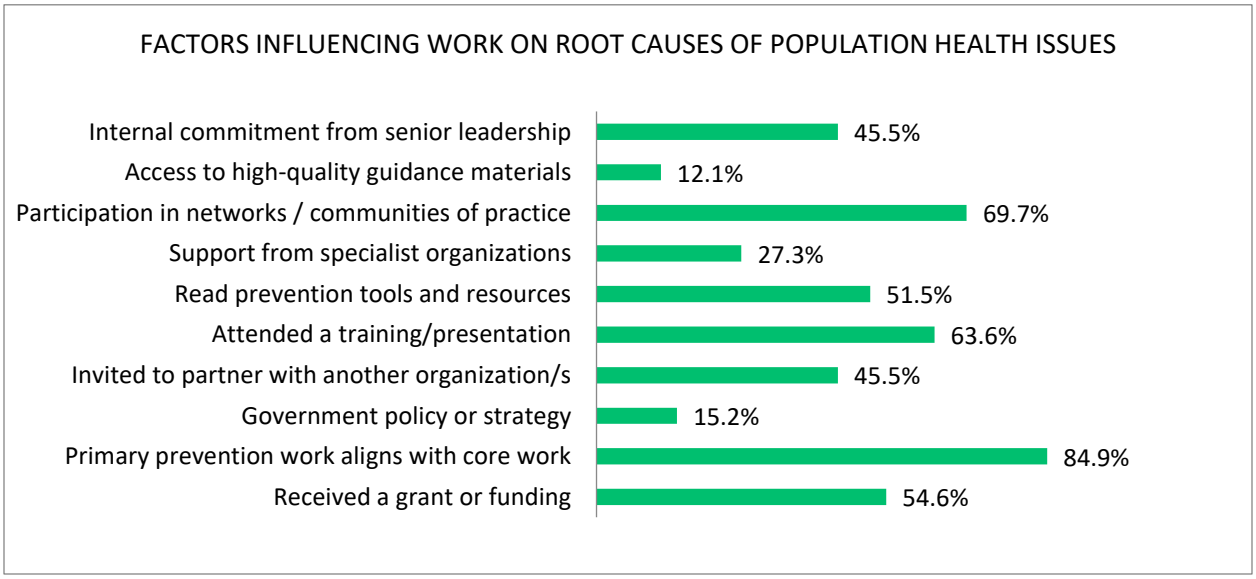
There is a substantial amount of work around SRPFs and upstream prevention in Alaska. Much of this work stems from youth development and wellness promotion. Upstream prevention and SRPF work connects with many partners. Half of those surveyed strongly agreed that their "organization has ongoing conversations about upstream prevention among staff" as well as their partners. This sentiment was felt among those interviewed as well, "*the true focus and goal direction for my organization is upstream prevention work and wellness promotion."* There was not as strong of an agreement with organizations "having ongoing conversations about SRPFs with staff and partners," however the majority still indicated that these conversations were taking place.

The overwhelming majority of survey respondents strongly agreed that using a SRPF approach is in line with the vision and goals of their organization. This was also in-line with the interview responses *"I think anybody working in prevention who's been doing it for more than five years will tell you that prevention is the long game, it's generational work."*





This response about "the long game" leads into a larger theme that presented itself in both interviews and survey responses. It's clear from those interviewed and surveyed that there has been a significant amount of work that has gone into understanding, researching, evaluating and concentrating prevention efforts on youth development. When it comes to connecting their work with concepts, the majority of survey respondents indicated that they are most comfortable connecting their work to ACEs. From interviews there is a clear understanding around the importance of the data in AK and connecting that to shared population health outcomes for adolescents.



Alaska's most widely used youth surveys (Youth Risk Behavior Survey (YRBS) and the School Climate Connectedness Survey (SCCS) reflect the growing interest in measuring the shared factors that impact adolescent behavior. The development and expansion of these data sets seem to have set the landscape for how professionals think about outcomes connected to SRPFs. Which has in many ways paid off for AK, as one interviewee put it "*if you can measure it, then people want to do something about it."*

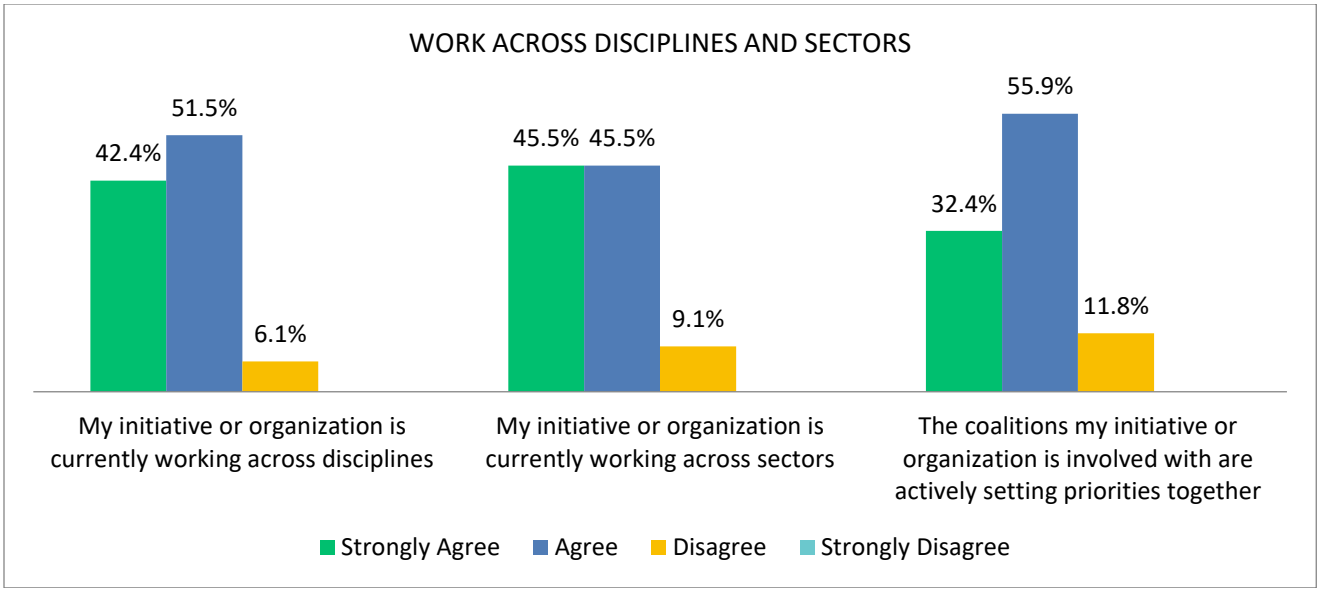
The development of adolescent adversity indexes, based on questions from the YRBS and the SCCS, have provided for Alaska both risk factor and protective factor data. There has also been data analysis around the patterns of risk and protective factors among Alaskan children over extended amounts of time. This type of rich data analysis has provided for Alaska a strong base for SRPF work, rooted in adolescent health outcomes.

The majority of respondents to the survey indicated that they are currently working on impacting more than one population-level health or quality-of-life outcome. When asked what population-level health or quality-of-life outcomes individuals are focused on, the majority of responses related back, in some way to adolescents. Included in this list was:

- Youth suicide and substance use
- Educating teens on how to help a peer at risk of suicide, teaching daycare workers about access
- Wellbeing and thriving across the lifespan- with focuses on young people and older people
- Healthy Families & Relationships
- ACEs
- Tobacco use with teen and tweens (at the community level)
- Breastfeeding is a tool to improve family bonding and reduce family violence
- Reduce maternal substance use & therefore decrease incidence of prenatal exposure/neurodevelopmental disorders in babies
- Site-based mentoring opportunities that look at key outcomes tied to academic success and healthy lifestyles as well as character and leadership development
- Healthy Relationships: The importance of youth having 3-5 supportive adults in their lives and how that relates to increased Mental Health
- Teen Sexual Health and long term positive healthier outcomes
- Improving youth friendly clinics, providing health literacy curriculum, training on motivational interviewing
- Teen suicide and teen substance use
- Adolescent substance use disorders; youth mental health; adolescent substance misuse

It's clear through both the interviews and surveys that there is a strong drive for primary prevention work. The top motivating factors to work focused on root causes of population health issues included that "primary prevention work aligns with our organization's/my core work" and "attended a training/presentation."

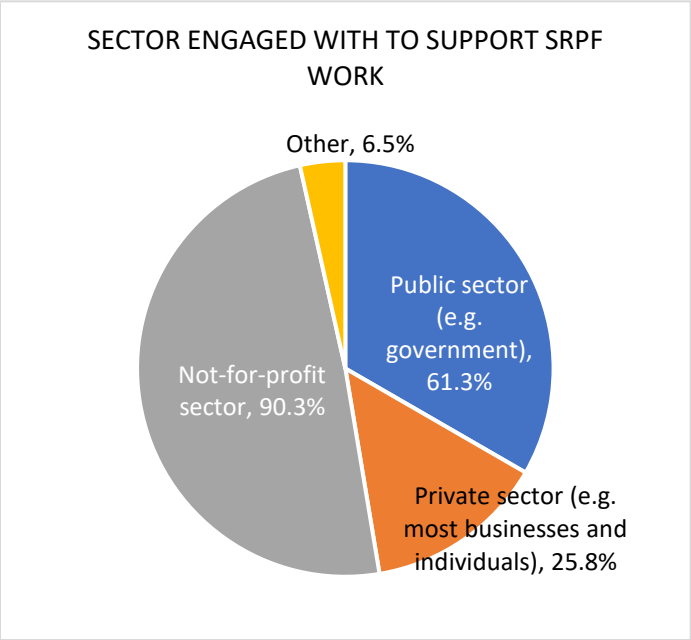
"Participation in networks and communities of practice," was also a core motivator for organization work focused on root causes of population health. This driver of work will be discussed further in the resources section of this report.



A SRPF approach requires working across disciplines and sectors. When asked about their work across disciplines and sectors, the majority of survey respondents indicated that they are currently involved in such work. Most strongly agreed (32%) to agreed (56%) that the coalitions they are involved with are actively setting priorities together, another critical piece to SRPF work. Interviews helped in demonstrating how cross-walking "upstream prevention language" between sectors and disciplines can help with this priority setting. One interviewee noted, "*One of my organization's established values is strength-based, so that influences our emphasis on priorities with partners. What are the strengths we can build as opposed to focusing on what are the fires we're trying to put out."*

In fact, many of the common goals and priorities among partners interviewed focused on this "strength-based" outlook. The vision of "thriving" was a consistent theme around upstream prevention work in Alaska. How can we support thriving communities? What can we do to increase strength-based assets or protective factors at a population level? As one partner commented, "*Even if we mitigate and avoid risks, that doesn't equal health. So, what we really want is to make sure that the assets and strengths and characteristics are there to ensure health… and mitigate risk."*

Among the sectors, partners seem to engage the most with the non-profit sector. However, there were a few "non-traditional" partners that individuals noted as working with on upstream prevention. Among those listed included: hospitals, fire departments, tribal community leaders, park departments, local business, transportation, the faith community, the military, afterschool programs, juvenile justice programs, etc. One area of work that was brought up in the interviews was collaborating with legislature and policy makers. Many of the interviewees expressed that while there is always more work that can be done, there has been a decent amount of work around educating legislature about upstream prevention and SRPFs. "*It's important that we continue policy and systems advocacy. So that when we're looking at trying to figure out what do we want to see changed in local or state laws or funding, this is top of mind."*



When asked about where individuals currently see SRPF approaches driving the work in Alaska, alcohol misuse, resiliency, wellness/wellbeing, suicide, mental health, and youth/community violence came to the top.

When asked "Who do you see leading the work on SRPFs in the State of Alaska" the majority of responses were "the Center for Safe Alaskans." This was also true from the interviews. While individuals agree and see that there are many voices impacting and carrying the work- the majority of people indicated that the biggest driver behind SRPF work is the Center for Safe Alaskans. Indeed, some seem to think that the SRPF workgroup currently "resides" in the Center for Safe Alaskans.

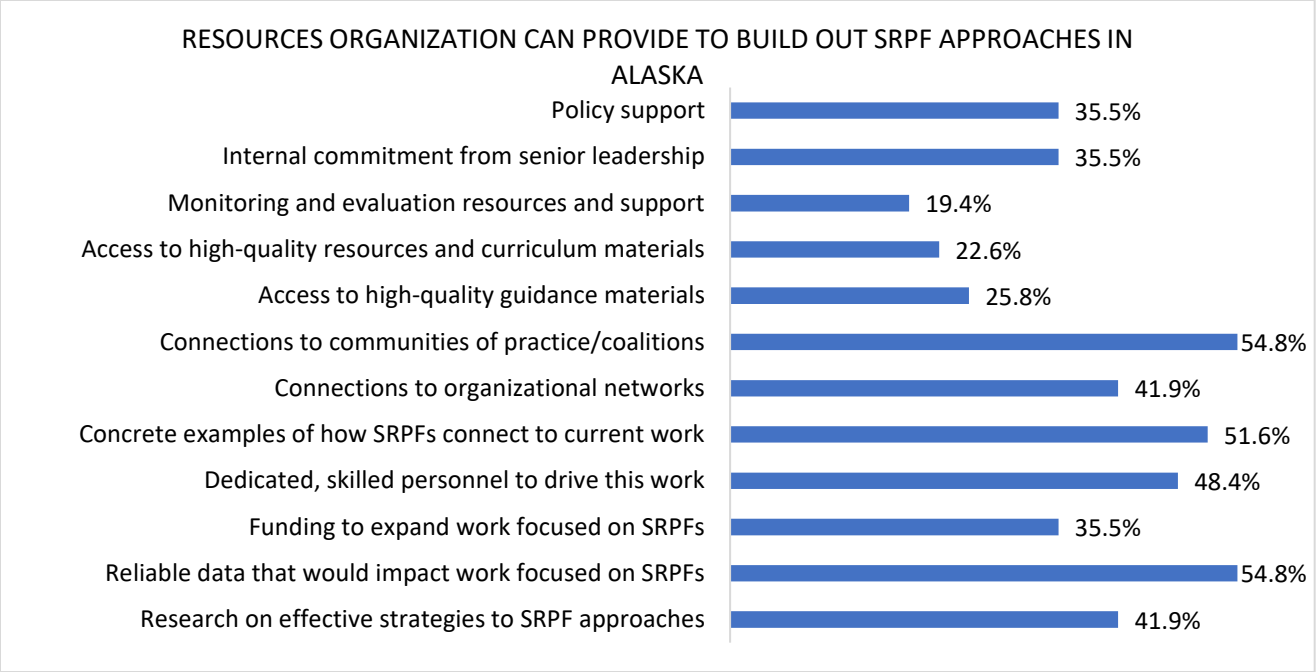
At the same time there seems to be some dissonance as to whether there should be one driver to such a collaborative approach. The workgroup seems to be an attempt to spread the work across disciplines, sectors and organizations across Alaska- however this also brings about its own challenges. There are barriers and resources to approaching the work in the way it currently exists. These will be examined more closely in the next two sections.

Overall, the SRPF workgroup is identified as a collaborative group of people who believe strongly in this work. One partner noted, "*I see this community of practice being a place to connect and collaborate. A place to share our work with each other, where we have thoughtfully used the SRPF lens to plan and implement activities or funding. I see it as a place to connect and collaborate and share. But, it may need to be more tangible."*

Resources

A few themes around resources exist for Alaska to expand SRPF work. When asked about what resources organizations could provide to help with building out shared risk and protective factors approaches to primary prevention in the State of Alaska, "Reliable data that would impact or help work focused on shared risk and protective factors" "Connections to communities of practice/coalitions" and "Dedicated, skilled personnel to drive this work" rose to the top.

Through both the surveys and interviews, it is clear that there is a strong foundation of work and networks of individuals doing upstream prevention work in Alaska. These communities of practice are an important resource.



When asked about communities of practice they are currently involved with interviewees noted several examples:

- "*We are currently partnering with Tobacco Prevention and Control Unit to pilot (in 2 communities) the "Communities that Care" framework to impact youth tobacco use and injury and violence outcomes."*
- *"Currently, I am participating in a number of state level discussion/work groups that have a focus on SRPF. For example, HA2030, ASVIPP, and Pathways Steering Committee. SRPF approaches have also been a consideration in the development of AASB's Trauma Framework for Schools and corresponding documents."*
- *"Most recently our prevention team has been highly involved in social justice work with partners. For example, we've been very focused on efforts seeking to decolonize our local city. This is in an effort to make our town a more equitable place for all people"*

As discussed in the previous section, the SRPF Workgroup is a huge resource in moving this work forward and helps to provide a network of collaboration. However, The SRPF Workgroup is not the only coalition working at a state-wide level to improve population level health outcomes. Both survey responses and interviews discussed the Wellness Coalition and The Alliance as influential communities of practice in Alaska. While all three groups have some technical differences, they also have a few overlapping areas of work. Through interviews it was difficult to maintain exactly where the differences stop, and the similarities begin. However there appears to be some work happening in better aligning priorities among the 3 state-wide groups. As one interviewee summed up, "*I am not afraid of redundancy. Some things need to duplicate, you know, there are some conversations, some talking points, some messaging, some priority issue areas that need to be addressed in multiple ways. It's not like I never want us ever doing the same thing, but I think if we're not doing it intentionally, that's what's going to confuse people*." This idea will be discussed more in the barriers section.

Among the new and emerging research, resources, and tools that individuals use to guide the development and implementation of shared risk and protective factor approaches, many pointed to data sources. And again, many of these data sources were connected to adolescent health. These included:

- AK YRBS data relating risk factors to protective factors.
- CASEL - Collaborative for Social and Emotional Learning data, strategies and practices;
- AASB School Climate and Connectedness Survey data, and strategies;
- Applying an epidemiological approach to the interaction of risk and protective factor to adolescent problem behaviors.
- Population level health outcomes relevant to IPV/TDV and SA are monitored annually through CDVSA, DASHBOARD

There are strong advocates for expanding data and outcomes connected with adolescents, which is a very valuable resource. As one interviewee stated, "*The story may be very similar, but legislators need to hear one thing and business, people need to hear another and clinicians need to hear another. Being able to have the resources so that you can weave that story together with outcome data that resonates with each, really makes it much more powerful."*

Adding to the resources is the strong sense of buy-in and cultural understanding related to SRPF work in Alaska. This was particularly brought up in the interviews. There is a strong feeling that Alaska provides a unique opportunity for this work to resonate, given both its structure and cultural underpinnings. "*I think there is a lot of ability for individuals to impact things here. I think because it hasn't gotten so established and bureaucratic that, that people can just be like, 'oh yeah, I think I'll do that'. Then they added it. So yeah, I do think it is in part an Alaska thing."* SRPF work is steeped in the grassroots work of community resilience building. In Alaska this has a significant weight. As one interviewee noted, *"I often hear 'well the science is telling us…' And I just feel like responding 'Well, this is all actually traditional knowledge that our indigenous peoples have known."*

There are also those in Alaska who have been working on SRPF resources, upstream approaches and "on the ground" for years. This groundswell of support has manifested in different ways. For one, there are those who were in the forefront of this work, that are now in leadership positions. This provides for internal champions around funding and policy changes. As one interviewee noted, "*When people have ownership, it makes a difference. So you had a whole bunch of people that had fire and brimstone in their hearts back in the nineties. And now, some of them moved up into the ranks of different places of power. I think that's a big reason why work is moving forward."* This also adds to the consistency of messaging and number of advocates that can carry the message. "*This conversation has been happening in some ways, for many, many years. So it's like this stuff is not new. Just a 'yeah this sounds great, let's do it!' The buy in is already there."*

Funding for SRPF work and upstream prevention in AK is fairly spread out. SAMHSA, Drug Free Communities, the United Away, Division of Health, Behavioral Health, AK Highway Safety Office, State Farm Companies Foundation and Block Grants are just a few of the funding sources mentioned to help fund this work. A few interviewees noted that they "try to embed SRPF upstream work into our grants." There is a lot of disparate funding sources connected to AK SRPF work. This can be a good thing, in that there is always some opportunity or source that might help expand the work when another's funding goes dry.

Barriers

By and large the biggest barrier to expanding SRPF work is adequate funding. As one interviewee noted, "*The level of support from funders to use a shared factors approach varies. For some the case has to be made much more strongly. Others are already on board and promoting a shared factors approach. But many come with*

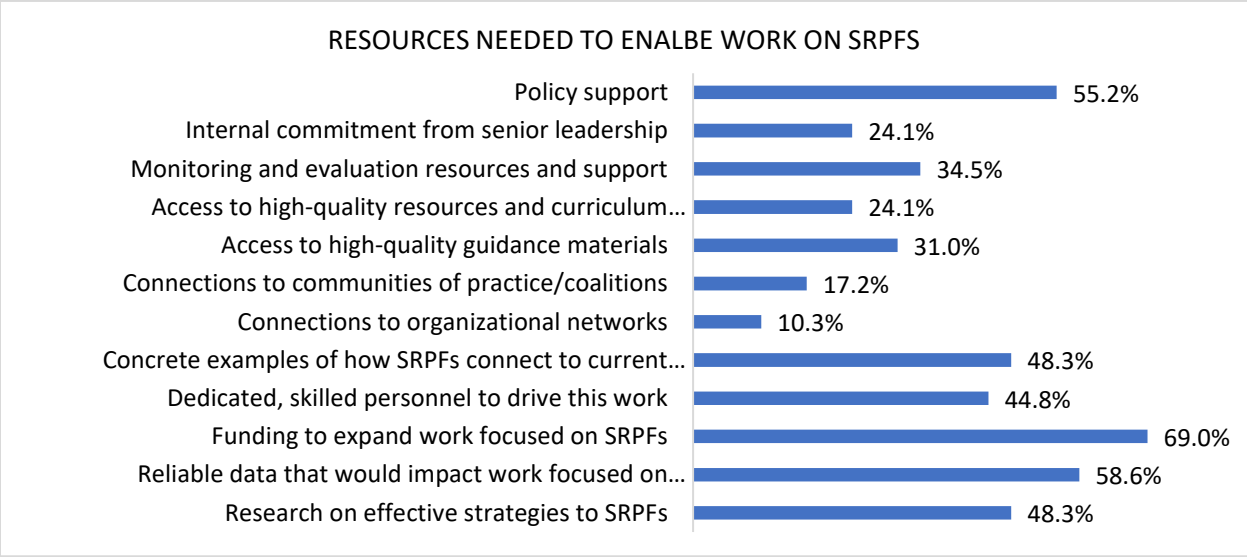
issue specific, non-shared factors requirements that often impede ability to focus resources on shared factors work." When asked what organizations need more of to enable their organization's work on shared risk and protective factors, funding was the top concern. When asked what tensions and difficulties they experience in expanding work that focuses on shared risk and protective factors, "limited funding available for upstream prevention work" was again on top.

This is especially true for those who work in state government and/or are state government grantees. As one interviewee noted, "*There have been very limited state and federal dollars available to support primary prevention programming, especially policy and practices at the outer layers of the SEM."*

Other difficulties that were noted around funding work that focuses on upstream approaches to prevention included:

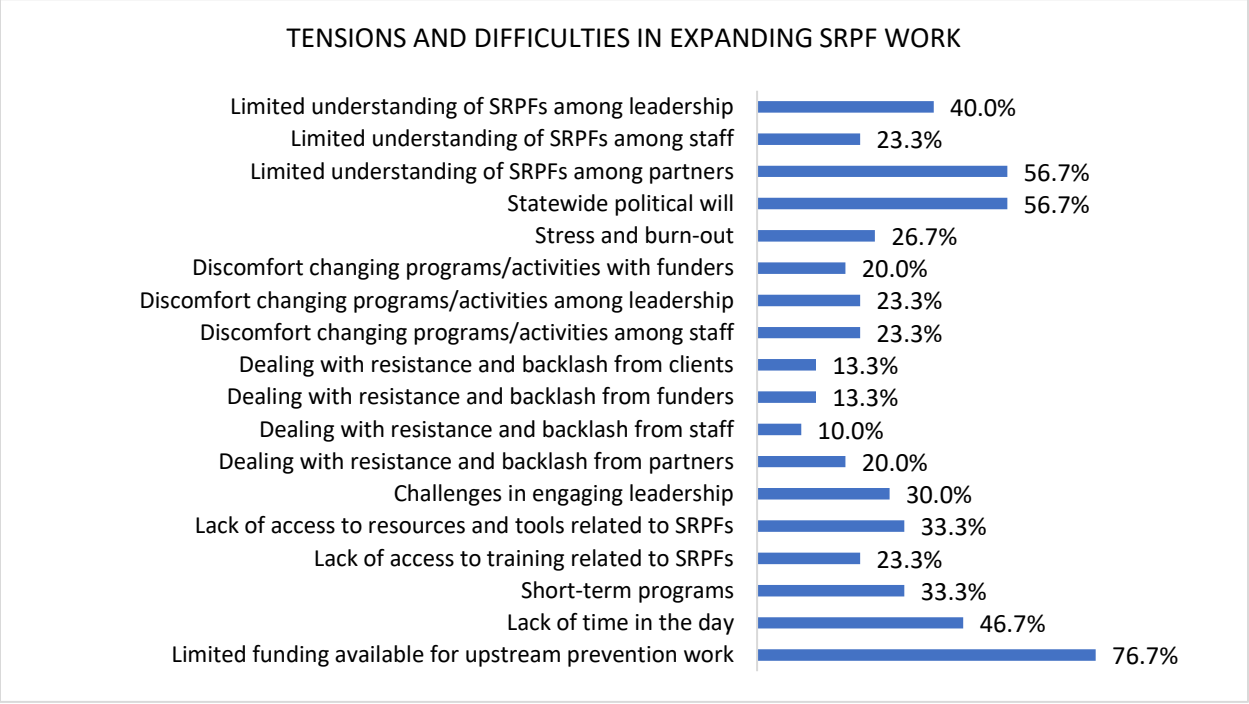
- Connecting with those working in housing
- Finding adequate funding for cross-sector collaboration in community coalitions
- *"Funding amount is small and reporting requirements are burdensome"*
- Funding for additional staff would be beneficial
- School Administration by and large still do not understand how upstream approaches impact academic achievement
- How to introduce this concept of a shared approach to partners outside of the health focused organization
- "*There is a lot to be done for the over 21 demographic that could still be considered upstream. Many founders see upstream as youth work."*

One theme that continued to come up in interviews as a barrier to both funding SRPF work and moving the SRPF work forward was the idea that "upstream work means youth work." As one interviewee put it, *"There's also probably an underlying bias that you don't really need to care about protective factors with adults, because if they didn't have them as kids they're out of luck. Or it's, it's riper for youth. The impact is bigger."* The idea that "upstream prevention" starts at an individual level, with youth, was a continued point of reasoning from many. "*You know, it makes sense for it to be youth focused because it's upstream and just by nature, this is when habits are forming that will impact adult populations."*
Part of this reasoning seems to stem from the lack of adult data out there to support shared population outcomes. Population level changes take time. "*I wouldn't expect anyone I work with to have trouble understanding the concept, but I have heard secondhand 'that we don't have as much adult data' or 'data-driven strategies for best practice with adults.' Obviously, that's a challenge."*



Reliable data that would impact or help work focused on shared risk and protective factors was one of the top things survey respondents noted as needing more of to enable their organization's work on shared risk and protective factors. "*The YRBS survey is the biggest data source that's being mined for this kind of information and as well as literature reviews. But the over 18, and especially over 25, there's not much happening for SRPF data."* Individuals interviewed described the need for data indicators among adult SRPF outcomes to placate funders, administration, and some leadership.

Discussions around supporting shared data, evaluation methods and common outcomes were also common during the interviews. SRPF data (outside of adolescent data) is very spread out across Alaska. As one interview put it "*a weakness for years has been, an unwillingness by state and local entities to agree to some shared measures on these shared factors. I don't know if it's because they don't want to give up control or because they don't want people to have control over it. This of course gets in the way of fidelity. So not having shared measures are a real problem, and it's not in anybody's job description to be doing analysis. There may be data out there that could show impact."* Sharing evaluation methods and getting better statewide information around data that could impact SRPF outcomes is a large barrier for Alaska right now.



The lack of shared data leads to another barrier- identifying shared state SRPF outcomes when each group has different priorities. "*Sometimes some of my frustration with SRPF work for adults as I sit in meetings and everybody has their specific area. 'I work with falls for elderly, and this is what I do. And I don't look at the other areas.' You know, people just sometimes just keep their blinders on."* This frustration leads into another question that was commonly mentioned, what do some of these risk and protective factor approaches look like when you operationalize them?

There seems to be a feeling among interviewees that there are many directions that could be taken around SRPF work. Especially with the SRPF Workgroup, the challenge seems to be that the potential work that this group could do is so big and hard to prioritize. *"It seems like 'hey, we need to really figure out what this is.'*

And I think, sometimes that can get a little heady and it's not something that happens in a short timeframe. Especially when you are trying to figure out what measurable about this work."

When it comes to a state-wide approach, the SRPF Workgroup is clearly leading the charge. However, understanding who is leading the charge of priorities set by the SRPF Workgroup is harder to pin down. As discussed in the Attitudes and Beliefs section of this report, the Center for Safe Alaskans seems to be the main driver of the SRPF Workgroup currently. But in terms of carrying out the work and where this work is going, there seems to be more ambiguity. A common theme in the interviews was: how do we organize this thing that we are building?

"This stuff is what will really get work done. But who's going to lead each piece of it? I can show up to the meetings and support pieces of it and collaborate, but it's not like I can take on, a meaningful part of facilitation or doing the research that's needed. So, there's kind a vibe where people are like 'this is great, but who is going to move them into implementation.'" From interviews and surveys, it appears there are different people leading different parts of the SRPF work- the confusion comes in how it is all connected and the long-term plan for it.

Many noted the need for a champion, whose only job was coordinating SRPF work in the state. Others mentioned that, by nature, this work must stay collaborative. Added to this is the reality that this work has origins in many different sectors and has many different individuals steeped in it.

Another barrier to this workgroup and SRPF work in general, is the environment it exists in. As discussed in the Resources section of this report, there are currently 3 state-wide initiatives that are working on upstream prevention in some form. Overseen overlap of work and the impact on resources could potentially be a barrier. As one interview put it "*Okay who's doing what? One thing that stays in my mind is, how can we remain in each other's cosmos. If you have people over here saying, get engaged with this, and then you have somebody over here saying, get engaged with this and you have to choose, it's almost like, where do your loyalties lie?"* The lines in the work and who is working on what and how they overlap has yet to be clearly defined among these three coalitions. "*you try to avoid things getting turfy. You start doing this work. And then sometimes people are like, Hey, wait, you're doing this, we're trying to do this!"*

Adding to the barriers of expanding SRPF work is that of staff turnover and "one person doing the job of many." Lack of capacity was noted as one of the top barriers to SRPF work. These sentiments were felt within the interviews as well, especially when it came to carrying out work in the SRPF workgroup. "*A barrier could be that this is it's all volunteer basis. The people who go to these meetings are just volunteering their time because they're interested or see some advantage or some benefit*." However, it is hard to have momentum when there is staff change and funding change. "*When someone new takes it on, like you have to go back six months or a year to help them understand. (There is concern) that new people want to say 'oh no, we need a new work plan. Oh no, we need more meetings to build a new work plan.' I don't think we need that. Continuity would just be really helpful."*

When asked about what was missing from the work around SRPFs, two themes presented themselves "lack of rural representation" and "connecting the dots of racial equity work to SRPFs."

The lack of rural representation was presented in interviews as a fact that most of the representation on state-wide initiatives, such as the work the SRPF workgroup, comes from white-urban areas. The worry seems to be that this then develops a divide in how the work is seen and carried out. "*We definitely need think more intentionally about recruitment and what are we inviting people to do. What works in Anchorage doesn't resonate in small villages. I think the farther you radiate out from (urban areas), the less likely people*

are to know that there is even state-wide work happening. That it even exists, what it is. And honestly, why should they?"

There are many reasons and barriers for why this happens: grant processes are naturally restrictive, actual geographical barriers, colonization has developed systems of dividing that inequitably impacts native villages, etc. The answers on how to address these barriers are restrictive and difficult to obtain. As one interview stated, "*I think that there's just this messiness and this vulnerability that is required from leadership to take on reframing this work and reframing the systems in place."*

There seemed to be a theme among those interviewed that more work is needed in connecting the dots of racial equity work to SRPF approaches. "*We MUST start embedding SRPF into addressing the challenges in our state around equity and racism. All the components of living and dying in Alaska are indelibly attached to equity, intergenerational trauma and racism. Without this change in approach- focusing on the positive will never make a difference on the individual peer and community factors."* As we have seen throughout the report, for some partners, the upstream approach to prevention and connecting the dots is easier than to others.

The specific concept of equity also seems to not be as infused into the conversation around shared risk and protective factors approach. Especially when it comes to conversations with policy makers, funders, and state leaders. According to the survey, statewide political will (eg: for new policies and approaches) was one of the biggest tensions around expanding SRPF work. One interviewee summed up how lack of conversations about equity leads to lack of understanding around SRPF work. *"So, we have programs trying to partner on work. One group decides they want to address excessive alcohol use. And then we have another group that's really wants to focus on (SRPFs). Why can't we do both? Why can't we talk about the social determinants of health and how inequities, impact alcohol use. I think the tension is coming out of the fact that we have all been socialized into a white dominant norm. This makes our brains think either, or. So, either we're focusing on alcohol misuse or we're focusing on a shared factors approach. And by focusing on SRPF, we are somehow neglecting to talk about alcohol. I find this especially to be true when talking to policymakers."*

Final Thoughts

Alaska's work in SRPFs and upstream prevention is substantial. Partners are interested in the SRPF approach and see the value in it. Both those interviewed and surveyed indicated that this work is a priority to them. Alaska also has a deep history with SRPF work, especially as it relates to youth development. Numerous health agencies, school districts and community coalitions have developed new indicators to measure shared factors as they relate to adolescent development.

People understand the value that prevention through a SRPF approach can bring to their work and the impact it can have for Alaska – more funding streams, more opportunities, bigger impact. There is a strong foundation of work and networks of individuals doing upstream prevention work in Alaska. These communities of practice are an important resource. There are also true champions of this work throughout the state, those that have been doing this work for years.

The idea that "this isn't new work" or that "this is the same work we have been doing but with a new name" is an accepted knowledge within Alaska. The ability for partners to be able to crosswalk the different terminologies of upstream prevention for different audiences is very impactful. Many feel comfortable doing this and work has moved forward as a result.

Where Alaska may be lacking, is in the organization and prioritization of SRPF work. There are many stakeholders in this SRPF work, all with their own needs and outcomes. For a statewide approach to exist to this work, it might be beneficial for Alaska to take time to work on developing an infrastructure plan. One that outlines the outcomes they want to work on, who (explicitly) is leading each area of that work, how partners fit into that and who is convening the larger group (currently that seems to be Center for Safe Alaskans).

Taking time to prioritize outcomes might be a beneficial step. Currently the majority of work and to SRPFs seems to be centered around adolescent development are these the outcomes they want to work on or is it important to expand more into adult population level outcomes? There could be some value for Alaska to focus more on collecting, evaluating and connecting adult data to SRPF outcomes. It might also help to have an individual or group that is specifically, in charge of such a project. Currently population data related to SRPF outcomes is spread across divisions and areas in AK. Bringing those pieces together, might help with prioritizing which outcome they want to focus on first.

Through the surveys and interviews it is clear that everyone's time and resources are limited. Being very intentional about who is leading SRPF work and how partners fit into that work, might be beneficial. Prioritizing an area of work or outcomes and then piloting might be a good way to organize this work and would develop opportunities to work cooperatively. Organizing their infrastructure in this way may also make it possible for the SRPF Workgroup to connect with the other state-wide coalitions more strategically.

Many noted the need for a champion, whose only job was coordinating SRPF work in the state. Others mentioned that, by nature, this work must stay collaborative. Added to this is the reality that this work has origins in many different sectors and has many different individuals steeped in it. Currently Center for Safe Alaskans seems to be the biggest driver pushing the work forward. It might be helpful to have a strategic conversation about the overall vision for SRPF work in the state and who is doing what. While there is certainly some benefit in having one convener of the work, it also seems imperative that the work stay collaborative in nature.

Again, Alaska provides a unique opportunity for this work to resonate, given both its structure and cultural underpinnings. The buy-in to upstream work is there. There has also been a decent amount of training and convening around SRPF work. However, where training might help is examining what a state-wide SRPF approach looks like at operational levels, how to evaluate SRPF approaches, how other states are doing this work, examining funding opportunities in AK for this work, aligning research opportunities to expand Alaska's SRPF resources.

Partners indicated the need for research and resources showing how SRPF approaches connect to the communities/groups they work with. Partners need talking points about SRPF research that is "digestible" and easy to understand from a "non-public health" viewpoint. External partners want to know where a shared risk and protective factor framework has worked and how to integrate protective factors more routinely into models that focus more on risk.

Continuing the impactful work that has already been taking shape in Alaska means expanding the conversation. Engaging the public and rural partners with conversations about approaching prevention through an upstream lens (such as SRPF) is important. More targeted outreach to those that are not involved with SRPF but should be, is also an important step. Putting together an advocacy plan around the impact wellbeing can have on long term outcomes might also help move resources into this work.

What Survey respondents perceive as the next step for moving SRPF work forward in Alaska:

Selecting a narrow scope to focus initial efforts

More training and more promotion regarding it's use.

Getting strategic communications and a legislative advocacy plan together to shift mental models of how wellbeing comes about and move resources into this work.

Researching surrogate indicators based on Alaska Native values

Continuing the "conversation" & going deeper

Statewide plan with specific evidence-based strategies to implement

Becoming more aware of ongoing work in Alaska using a SRPF lens. Looking for collaborations with each other, infusions of funding to support each other's projects, organizing research opportunities for interns to expand Alaska's SRPF resources.

This is survey is a good start:). Prioritizing an area of work and then seeking an opportunity to pilot the practice. I think it is unrealistic for all work to adapt this practice initially without opportunities to work cooperatively on a pilot project or two (state level).

If you would like to have this conversation, please contact me in a more appropriate forum.

More statewide coordination, more state grant funding tied to SRPF work, more targeted SRPF outreach to currently non-involved partners

Language crosswalk to develop shared language understanding- we don't need a shared language, just translation, SRPF matrix filled out across lifetime, not just youth, and with broader spectrum of factors to include equity and higher levels of SDOH and SEM.

reviewing the goals of HA2030 and sharing the best approaches for all levels of the socioecological Framework and creating a list of Policies and resolutions to pass for SFY21.

Commitment needed from State of Alaska.

solidifying concrete examples that are ALREADY happening

we have to have leadership and funding and dedicated staff to move this work forward. anything else is just talk.

Implementation of evidence-base interventions that increase the prevalence of known protective factors and research to discover additional positive influences.

Developing more clarity on what factors organizations are addressing and how we are/aren't aligned.

What survey respondents identified as additional learning and guidance that would benefit their organization to pursue a shared risk and protective factor approach:

Training/expertise on shifting mental models

Evaluation workshop identifying outcome measures

A "toolkit" of resources and materials

Moving beyond the theory and framework and into replicable strategies and partnerships to form a concrete upstream project that we could then solicit funding for.

Clear vocabulary across all our various groups about what SRPF is defining. Clear analysis of benefit of the approach (when possible), priority areas for SRPF within SOA

social marketing strategy aimed at community awareness

Shared evaluation measure across health concerns based on shared factors, published research showing connections like the early communities that care studies.

Risk Benefit Analysis- monetize the approach so folks understand the long term financial benefit.

concrete strategies to get folks to act out of their silos. SRPF sounds "good" but many especially leadership can not make the connection from concept to implementation

what protective factors are most important? what if that protective factor isn't enough to address ACES, SDOH?

Knowledge of advanced multivariate statistical techniques to better describe the multifactorial interactions among risk and protective factors upon problem behaviors.

Appendix A

Survey: Implementing a Shared Risk and Protective Factor Approach in Alaska

Alaska's Injury Prevention Unit within the Alaska Division of Public Health is partnering with Safe States Alliance to assess Alaska's readiness regarding their work with shared risk and protective factors (SRPF). Your perspective, along with thoughts from additional partners across the state, will provide both them and the AK SRPF Workgroup with a more complete understanding of opportunities for moving forward collectively.

The final product from the assessment will be a report that documents input from yourself and others, which will lead to trainings based on the patterns identified in the surveys. The goal of this process is to develop a framework to guide prevention initiatives in Alaska by gauging where partners stand in their understanding of and readiness to integrate dedicated activities to support a SRPF approach.

This survey should take *20 minutes* to complete.

The following terms (risk factors, protective factors and shared risk and protective factor approaches) will be heavily used throughout the survey. For clarity we are defining them as:

- **Risk factors**: Characteristics or situations that increase the probability that an individual will become a victim or perpetrator of violence, injuries and/or other health challenges.
- **Protective factors**: Characteristics or situations that mitigate the risk of an individual becoming a victim or perpetrator of violence, injuries and/or other health challenges.
- **Shared risk and protective factor approach:** Efforts to improve **multiple population health and quality-of-life outcomes** by **aligning diverse, multi-sector interventions** that positively and equitably impact the social determinants of health.

    - *The goal of a shared risk and protective factor approach is to address and impact **multiple population health or quality-of-life outcomes at the same time**. For example, instead of implementing a program to only reduce teen suicide, a SRPF approach would include an intervention that addresses teen suicide and at least one other outcome, such as substance abuse among teens.*

    - *A SRPF approach requires **aligning diverse sectors**. For example, a SRPF approaches can include working with a state department of transportation on reducing teen substance abuse as part of an effort to also reduce motor vehicle crashes involving teens.*

[Demographics]

Organization: [self identified]
Title: [self identified]
Location: [city]

Which of the following best describes your role in your organization?
- Management
- Program Staff
- Administrative/Support Staff
- Researcher
- Consultant
- Student
- Other

The organization you work for is in which of the following:
- Public sector (e.g. government)
- Private sector (e.g. most businesses and individuals)
- Not-for-profit sector
- Don't know
- Other

Please select the professional role that best describe your current job (please select up to 2)
- Coalition building
- Communications/Media
- Consulting
- Education
- Management
- Patient care/Direct health services
- Policy (e.g. education, advocacy, etc.)
- Program implementation/coordination
- Research
- Surveillance/Data analysis
- Teaching
- Other

In which of the following areas do you currently work or have expertise? (Please select all that apply)
- Alcohol Misuse
- Child Abuse and Neglect
- Domestic and Intimate Partner Violence
- Drowning and Submersion Injury
- Elder Abuse
- Fall Injury
- Fire and Burn Injury
- Firearm or Gun-Related Injury
- Mass Trauma and Disaster-Related Injury
- Motor Vehicle Injury
- Pedestrian and Bicycle Injury
- Occupational Injury
- Rural and Agricultural Injury
- Resilience
- Sexual Violence and Rape
- Suicide

Teen Dating Violence
Traumatic Brain Injury (TBI) and Spinal Cord Injury (SCI)
Poisoning,
Prescription Drug Overdose (PDO), Opioid Misuse
Youth and Community Violence
Other

Years in you have been working in the above areas?
>1 year
Between 1 and 2
Between 2 and 5
Between 5 and 10
Between 10 and 15
More than 15 years

I work primarily with:
Rural Areas
Populated Areas
Both

What age groups does your work address: (select all that apply)
0-9
10-19
20—29
30-59
60-79
80+

[Individual Attitudes and Beliefs]
We are interested in understanding your own attitudes and beliefs towards using shared risk and protective factors approaches for primary prevention.

Please note we define "primary prevention" as preventive measures that come before the onset of illness or injury and *before* the disease process begins. Examples might include immunization, altering risky behaviors, and banning substances known to be associated with a disease or health condition.

For each of the following statements, please rate your agreement (Strongly agree – Strongly disagree)

- Primary prevention is important to my work.
- Quality of life outcomes are interconnected and share root causes.
- Multi-sector interventions that positively and equitably impact the social determinants of health are important.

We are interested in understanding your attitudes and beliefs around the feasibility of using a SRPF approach for primary prevention. For each of the following statements, please rate your agreement (Strongly agree – Strongly disagree)

- Approaching primary prevention by focusing on multi-sector interventions is feasible.
- There is a strong foundation for Alaska to implement SRPF approaches across the state.

We are interested in understanding your attitudes and beliefs around the efficiency of using a SRPF approach to primary prevention. For each of the following statements, please rate your agreement (Strongly agree – Strongly disagree):

- Utilizing SRPF approaches in planning and implementing is more efficient than traditional single-issue prevention.
- Utilizing SRPF factor approaches will save me time in my workday.
- Utilizing SRPF approaches will save money for primary prevention programs.

We are interested in understanding your attitudes and beliefs about the need for a shared language around using a SRPF approach. For each of the following statements, please rate your agreement (Strongly agree – Strongly disagree):

- There is currently a shared language across programs and partners working on upstream prevention.
- There is currently a shared language across the AK SRPF Workgroup.

SRPF approaches have the potential to impact programs and the greater community. Which of the following benefits of a SRPF approach would be most valuable to your work? (Please rank from 1 - most important to 8- least important)

- More funding streams available to support my work
- More staff resources available to contribute to programs
- A broader range of expertise
- A more extensive network of professionals informing my work
- Increased opportunities for partnership
- Additional opportunities for data sharing
- Additional opportunities for using data for action
- Ability to maximize the impact of my work

[Individual Comfort/Skill Level]

How much training have you received around shared risk and protective factors? (a lot, some, none)

What type of training was received? [open ended]

We are interested in understanding how comfortable individuals are with SRPF approaches in their work. For each of the following statements, please rate your agreement (Strongly agree – Strongly disagree):

- I understand how SRPFs are related to primary prevention.
- I understand how my work connects to SRPFs.
- I feel comfortable talking about SRPFs.

We are interested in understanding how comfortable individuals are with public health approaches/frameworks and their connection with SRPFs. For each of the following statements, please rate your agreement (Strongly agree – Strongly disagree):

- I feel comfortable talking about social determinants of health (SDOH).
- I feel comfortable talking about adverse childhood experiences (ACEs).
- I feel comfortable talking about the socioecological model (SEM).
- I understand how my work connects to SDOH.
- I understand how my work connects to ACEs.
- I understand how my work connects to the SEM.
- I understand how SDOH, ACEs, and the SEM are connected to a SRPF approach.

[Your Organizational Readiness]

For each of the following statements, please rate your agreement (Strongly agree – Strongly disagree):

- My organization has ongoing conversations about upstream prevention among staff.
- My organization has ongoing conversations about upstream prevention with our partners.
- My organization has ongoing conversations about SRPFs among staff.
- My organization has ongoing conversations about SRPFs with our partners.
- Using a SRPF approach is in line with the vision and goals of my organization.
- My organization can change our daily operations and activities to focus on upstream prevention.
- My organization understands which activities they need to prioritize to focus on upstream prevention.

Which of the following factors have influenced you/your organization to focus on upstream prevention? Select all that apply.

- Received a grant or funding
- Primary prevention work aligns with our organization's/my core work
- Government policy or strategy
- Invited to partner with another organization/s
- Attended a training/presentation
- Read prevention tools and resources
- Support from specialist organizations
- Participation in networks / communities of practice
- Access to high-quality guidance materials
- Internal commitment from senior leadership
- We are currently not working on upstream prevention
- Other - Write In: _____

The goal of a shared risk and protective factor approach is to address and impact more than one population health or quality-of-life outcome at the same time. For example, instead of implementing a program to only reduce teen suicide, an SRPF approach would include implementing an intervention that addresses teen suicide and at least one other outcome, such as substance abuse among teens.

Is your organization currently working on impacting more than one population-level health or quality-of-life outcome?

Yes
No

Please share a brief, high-level description of what these population-level health or quality-of-life outcomes your organization is focused on. [open-ended]

A SRPF approach requires working across disciplines and sectors. SRPF approaches can include working with a state department of transportation on reducing teen substance abuse as part of an effort to also reduce motor vehicle crashes involving teens. For each of the following statements, please rate your agreement (Strongly agree – Strongly disagree):

- My initiative or organization is currently working across disciplines
- My initiative or organization is currently working across sectors
- The coalitions my initiative or organization is involved with are actively setting priorities together

SRPF approaches can also include working with businesses and non-profit organizations. What kind of "non-traditional" partners is your organization working with (leave blank if not applicable to you. [open ended]

[Resources and Support]

We would like to understand more about what resources and support are needed for Alaska to implement shared risk and protective factor approaches to primary prevention.

Please mark which of the following resources your organization could provide to help with building out shared risk and protective factors approaches to primary prevention in the State of Alaska.

- Research (or ability to provide research) on effective strategies relating to shared risk and protective factors approaches
- Reliable data that would impact or help work focused on shared risk and protective factors
- Funding to expand work focused on shared risk and protective factors
- Dedicated, skilled personnel to drive this work
- Concrete examples of how shared risk and protective factors currently connect to work you are doing
- Connections to organizational networks
- Connections to communities of practice/coalitions
- Access to high-quality guidance materials
- Access to high-quality resources and curriculum materials
- Monitoring and evaluation resources and support
- Internal commitment from senior leadership
- Policy support [e.g., insight, examples of successful policy concepts and language, connections with organizational, local, state, federal policy makers]
- Other - Write In: _____

Where are you experiencing support in funding work that focuses on upstream approaches to prevention? [open ended]

Where are you experiencing difficulties in funding work that focuses on upstream approaches to prevention? [open ended]

What new and emerging research, resources and tools do you use to guide the development and implementation of shared risk and protective factor approaches in your work? Please list these.

Which sector do you engage with the most when it comes to supporting work around SRPFs:

Public sector (e.g. government)
Private sector (e.g. most businesses and individuals)
Not-for-profit sector
Don't know
Other (describe)

Of the following topic areas, where do you see SRPF approaches driving the work, currently in Alaska?

Alcohol Misuse
Child Abuse and Neglect
Domestic and Intimate Partner Violence
Drowning and Submersion Injury
Elder Abuse
Fall Injury
Fire and Burn Injury
Firearm or Gun-Related Injury
Mental Health
Mass Trauma and Disaster-Related Injury
Motor Vehicle Injury

Pedestrian and Bicycle Injury
Occupational Injury
Resilience
Rural and Agricultural Injury
Sexual Violence and Rape
Suicide
Teen Dating Violence
Traumatic Brain Injury (TBI) and Spinal Cord Injury (SCI)
Tribal Health
Poisoning, Prescription Drug Overdose (PDO) and Opioid Misuse
Wellness/Wellbeing
Youth and Community Violence
Other

Who do you see leading the work on SRPFs in the State of Alaska? Please list any organizations or individuals that come to mind.

Who do you think is missing from the work on SRPFs in the State of Alaska? Please list any organizations or sectors that come to mind.

What additional learning and guidance would benefit you/your organization to pursue a shared risk and protective factor approach to your work? [open-ended]

What do you perceive as the next step for moving SRPF work forward in Alaska?

[Barriers]

What, if any, tensions and difficulties do you experience in expanding work that focuses on shared risk and protective factors? Select all that apply.

- Limited funding available for upstream prevention work
- Lack of time in the day
- Short-term programs
- Lack of access to training related to shared risk and protective factors
- Lack of access to resources and tools relating to shared risk and protective factors
- Challenges in engaging leadership
- Dealing with resistance and backlash from partners
- Dealing with resistance and backlash from staff
- Dealing with resistance and backlash from funders
- Dealing with resistance and backlash from clients
- Discomfort changing current programs or activities among staff
- Discomfort changing current programs or activities among leadership
- Discomfort changing current programs or activities with funders
- Stress and burn-out
- Statewide political will (e.g., for new policies and approaches)
- Limited understanding of shared risk and protective factors among partners
- Limited understanding of shared risk and protective factors among staff
- Limited understanding of shared risk and protective factors among leadership
- Other - Write In: _____

What do you need more of to enable your organization's work on shared risk and protective factors? Select all that apply.

- Research (or ability to provide research) on effective strategies relating to shared risk and protective factors approaches
- Reliable data that would impact or help work focused on shared risk and protective factors
- Funding to expand work focused on shared risk and protective factors
- Dedicated, skilled personnel to drive this work
- Concrete examples of how shared risk and protective factors currently connect to work you are doing
- Connections to organizational networks
- Connections to communities of practice/coalitions
- Access to high-quality guidance materials
- Access to high-quality resources and curriculum materials
- Monitoring and evaluation resources and support
- Internal commitment from senior leadership
- Policy support [e.g., insight, examples of successful policy concepts and language, connections with organizational, local, state, federal policy makers]
- Other - Write In: _____

Is there anything else you would like to share about SRPFs as they relate to Alaska?

Appendix B

Interview Guide: Culture of Shared Risk and Protective Factors

[One On One Interviews, 1 - 1.25 hour]

[Introductions]
Briefly introduce myself.

[Purpose of the interview]
Alaska's Injury Prevention Unit within the Alaska Division of Public Health is partnering with Safe States Alliance to assess Alaska's readiness regarding their work with shared risk and protective factors (SRPF). Your perspective, along with thoughts from additional partners across the state, will provide both them and the AK SRPF Workgroup with a more complete understanding of opportunities for moving forward collectively.

The final product from the assessment will be a report that documents input from yourself and others, which will lead to trainings based on the patterns identified in the surveys. The goal of this process is to develop a framework to guide prevention initiatives in Alaska by gauging where partners stand in their understanding of and readiness to integrate dedicated activities to support a SRPF approach.

In order to accurately capture all of your thoughts we are going to be recording this interview. We will not include individual names in any products, but because this is a small world and we're only speaking with a small number of individuals, we cannot promise that your words or thoughts will not be identifiable to some readers. If there is anything you are concerned about at any point, please let us know. Is that okay?

Do you have any questions before we get started?
We will start the recording NOW.

Before we begin, I would like to take a moment to define a few key terms

- **Risk factors**: Characteristics or situations that increase the probability that an individual will become a victim or perpetrator of violence, injuries and/or other health challenges.
- **Protective factors**: Characteristics or situations that mitigate the risk of an individual becoming a victim or perpetrator of violence, injuries and/or other health challenges.
- **Shared risk and protective factor approach:** Efforts to improve **multiple population health and quality-of-life outcomes** by **aligning diverse, multi-sector interventions** that positively and equitably impact the social determinants of health.

These terms will continue to be used in our interview, so please let me know if you need them defined again.

[Demographic]

For the first part of the discussion, I want to understand a little more about your organization and your role within it.

1. Can you tell me a little bit about your organization?
2. Can you tell me a little bit about the work you do with your organization?

[Organizational Readiness]

We define "primary prevention" as preventive measures that come *before* the onset of illness or injury and *before* the disease process begins. Examples might include immunization, altering risky behaviors, and banning substances known to be associated with a disease or health condition.

3. Does your organization engage in primary prevention?
4. What kind of activities or programs do you all have that are focused on primary prevention?
5. Does your organization work on population health outcomes (Rather than focusing on one person, these measures look at entire communities to understand trends and patterns that can impact health and quality of life. IE: Graduation rates, employment rates, income levels, prevalence of injuries and diseases, and rates of community violence)
    a. Can you please share what this look like?
    b. What has influenced your organization to focus on population health outcomes (funding, partners, champion at the organization, trainings)
6. The goal of a shared risk and protective factor approach is to address and impact more than one population health or quality-of-life outcome at the same time. Is your organization currently working on impacting more than one population-level health or quality-of-life outcome? (For example, instead of implementing a program to only reduce intimate partner violence among teens, a SRPF approach would include implementing an intervention that addresses teen suicide and at least one other outcome, such as substance abuse among teens.)
    a. Can you please share what this looks like?
    b. What partners are involved in this work?
7. Is your program or organization involved in any network of coalitions?
    a. Do any of these coalitions seek to promote or work on shared risk and protective factors?
    b. Do any of these coalitions include any "non-traditional" partners?
8. Does your organization work on or talk about SRPF approaches?
    a. How do you see work with shared risk and protective factors going forward in your organization?

[Individual Comfort/Understanding]

9. Do you use or refer to SRPFs in your work?
10. Do you feel comfortable talking about shared risk and protective factors to your partners, funders, staff and/or leadership?
11. Do you see value in developing primary prevention programing that focuses on shared risk and protective factors?
    a. Do you see value in using a shared risk and protective factor approach as it applies to **your own work?**
    b. Do you think it will save you money? Time?

[AK SRPF Landscape Gauge]

12. Who do you see driving the work around shared risk and protective factors in Alaska? (organization, topic area or individual)
13. Which topic area(s) do you see SRPF approaches being implemented or discussed the most? (ie: substance abuse, suicide, elder abuse, etc)

14. Who do you think is missing from the work on SRPFs in the State of Alaska?
15. What do you perceive as the next step for moving SRPF work forward in Alaska?

[Check in on time]

[Barriers & Resources]

We are clearly aware of that to implement any kind of change, there are barriers that can impede the work.

16. What are some things that you believe make SRPF type of work difficult?
    [Prompts: used if we haven't heard much about one of the following aspects]
    - Funding CDC vs non-CDC vs Partner funding; single funding source for multiple issues? blending multiple funding sources to address issues?)
    - Non-monetary resources
    - Skills of people [convening, connecting, data translation]
    - Knowledge [theoretical background/justification for working in this manner]
    - Interest [internal to org, larger org, community, or nationally]
    - Administrative structures [leadership, budget, operations]
    - Technology [ability to share information across different organizations]
    - Relationships [Friendships, informal connections]
    - Policy barriers [organizational, local, state, federal]
    - Partnerships
    - Internal (within SHD) and External (community, outside of state)
        - Behavioral health
        - Schools
        - Medicine
        - Social work
        - Law enforcement
17. Are you experiencing support in funding that focuses on upstream approaches to primary prevention?
18. What new and emerging research, resources and tools do you use to guide the development and implementation of shared risk and protective factor approaches in your work?
19. What additional learning and guidance would benefit you/your organization to pursue SRPF approaches with your work?

[Final Thoughts]

That is all the questions we have. Thank you so much for your time. Once we have completed the focus group, we will be drafting a report and we'll be sharing that with you for review. If we have additional questions as we go, is it ok to reach out to you?