ADVANCING ACCESS TO MENTAL HEALTH SERVICES THROUGH SINGLE-SESSION INTERVENTIONS

SESSION TWO

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***slide content is human-created, with some formatting guidance by Claude*

Today's agenda:

1

A guiding framework for SSI implementation

Why SSI implementation is hard, and how COM-B helps us diagnose where to push.

2

SSIs in Pennsylvania

Two-year pilot of Single Session Consultation (SSC) across 5 publicly funded clinics in rural PA counties

3

SSIs in Montana

Statewide deployment of Project YES (a digital SSI platform) with youth, parent, provider, and school partners

*We will close (2) and (3) with **lessons for implementers** across settings*

Single-session interventions aim to create meaningful change within the first (and often last) encounter with support.

50-80% Of people in need of mental health care cannot access any treatment

10-20 Sessions in most evidence-based mental health intervention protocols

1 Modal number of sessions accessed (among those who access care at all), per US national insurance reimbursement data

50%+ Of people who start mental health services drop out before completion

SSIs can be effective—but effectiveness is insufficient for impact.

Across hundreds of clinical trials, single-session interventions (SSIs) shown promise to improve both **mental health outcomes** and **service seeking** in youth and adults.

But SSIs can only bridge gaps in care systems if they **consistently reach people** whom they stand to benefit.

COM-B: a helpful behavior change framework for SSI deployment

Whether the target 'behavior' is delivering an SSI, completing one, or referring to one, **3 conditions must be met:**

C Capability

Do I know what SSIs are?

Do I know how to deliver/use an SSI?

May be promoted via: training/education, streamlined workflows, boosting people's confidence to deliver/use SSIs, reducing friction

O Opportunity

Does my environment allow me to deliver/use an SSI?

Is it easy for me to deliver/use an SSI?

May be promoted via: removing regulatory burden; reimbursement pathways; permissions to use; integration into help-seeking pathways

M Motivation

Do I want to deliver/use an SSI?

Do I believe an SSI will help?

May be promoted via: supporting positive expectancies; reinforcements for using or delivering SSIs; visible benefits of SSIs

Case examples: State-level SSI implementation

PENNSYLVANIA

Single Session Consultation

Provider-delivered, clinic-based SSI on waitlists

Setting	5 publicly funded clinics, rural North Central PA
Population	Medicaid-eligible, age 14+, all presenting concerns
Delivery	Clinician-led, in person or telehealth
Partner agencies	PA Office of Mental Health and Substance Use, Community Care Behavioral Health, BHARP
Stage	Ending 2-year pilot; pursuing lasting sustainment strategies

MONTANA

Project YES (Youth Empowerment & Support)

Youth-facing, digital, self-guided, as-needed

Setting	Schools, primary care, outpatient waitlists, community (statewide)
Population	Adolescents 13–19 in Montana, any concern, anonymous
Delivery	Web-based SSIs, no provider required
Partner agencies	Frontier Psychiatry, Montana Pediatrics, Department of Behavioral Health, Koko
Stage	Co-designed Project YES platform and implementation toolkit; statewide implementation underway

CASE EXAMPLE I

Pennsylvania: Single Session Consultation

A multi-level, systemic deployment of provider-led SSIs to people on waitlists at publicly-funded clinics

Goodness-of-fit of an SSI-based solution

What gaps in care might SSIs bridge?

- **Long waitlists at rural community clinics**

Members often waited *months*; many dropped out before their first session; others got worse before treatment began

- **Outpatient regulations assume ongoing care**

Treatment plans and records standards designed for episodes, not single encounters, and require overwhelming up-front administrative work

- **Drop-out is the norm, not the exception**

The one session many people get is not structured to help on its own

Our pilot

- **Single Session Consultation (SSC)**

Structured, evidence-based, one encounter; offered as its own service upon waitlist placement

- **Targeted state waivers from OMHSAS**

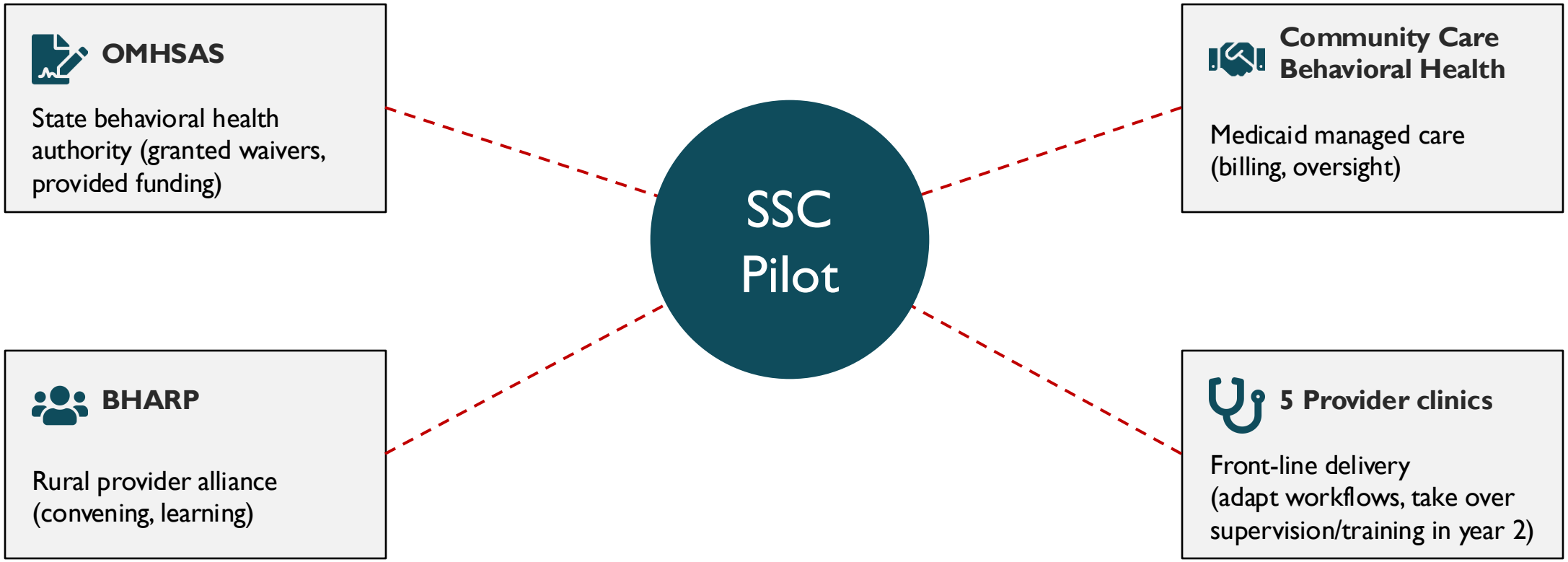
Temporary, narrow flexibility on treatment plan and records rules for SSC only

- **Five clinics, North Central PA**

Implementation and evaluation initiative co-led by Community Care Behavioral Health, BHARP, and the Lab for Scalable Mental Health

The SSC was deployed by a *system*, not an individual or a clinic

Lab for Scalable Mental Health *(Dr. Schleider, Dr. Szkody) served as partner for SSC training, technical implementation support, and evaluation*



How COM-B guided our PA implementation plan

Capability

Built capability via training and consultation

Clinical training, administrative scripts for intake staff, EMR-integrated SSC materials, learning binders, and ongoing consultation with the developer.

Opportunity

Created opportunity via waivers to alter regulatory environment

OMHSAS granted narrow, time-limited waivers from treatment-planning and records rules (55 Pa. Code §5200.31, §5200.41), only for SSC, only during the pilot period

Motivation

Sustained providers' motivation via visible SSC outcomes, learning collaboratives

Monthly data reports to OMHSAS. Quarterly learning collaboratives. Client feedback shared back to clinicians, including pre/post symptom changes from their own caseloads.

Capability: SSC training, consultation, and technical support

PILOT YEAR 1:

Kick-Off Meeting
Introduction to the SSC initiative, program model, goals, and engagement structure across all five participating clinics

Initial Administrative Consultation
Agency-specific planning to embed SSC into workflows, streamline EMR processes

Initial Clinical Training
Group-based didactic training (1.5 hours) plus individual practice and feedback sessions for all 25 clinical staff (1 hour per clinician)

Ongoing Clinical Consultation
Bi-monthly agency-specific consultation for the first two months, transitioning to monthly support for the remaining four, plus support for supervisors to train others moving ahead

Ongoing Admin. Consultation
Same cadence as clinical track — troubleshooting workflow integration and supporting implementation success.

Learning Collaboratives & Monthly Reporting
Two cross-agency learning sessions, focus-group planning, and a final written report on feasibility and acceptability.

PILOT YEAR 2:
Continued learning collaboratives and monthly reporting of implementation and clinical outcomes; clinical oversight transitioned from our lab to clinics/providers

Opportunity: Modifying Regulatory Environment (waivers)

OMHSAS granted temporary, time-limited waivers for specific operational steps (typically required for all new patients):

- **55 Pa. Code §5200.31 -** Treatment planning requirements
- **55 Pa. Code §5200.41(a)(3–7) -** Records requirements

Waiver Parameters

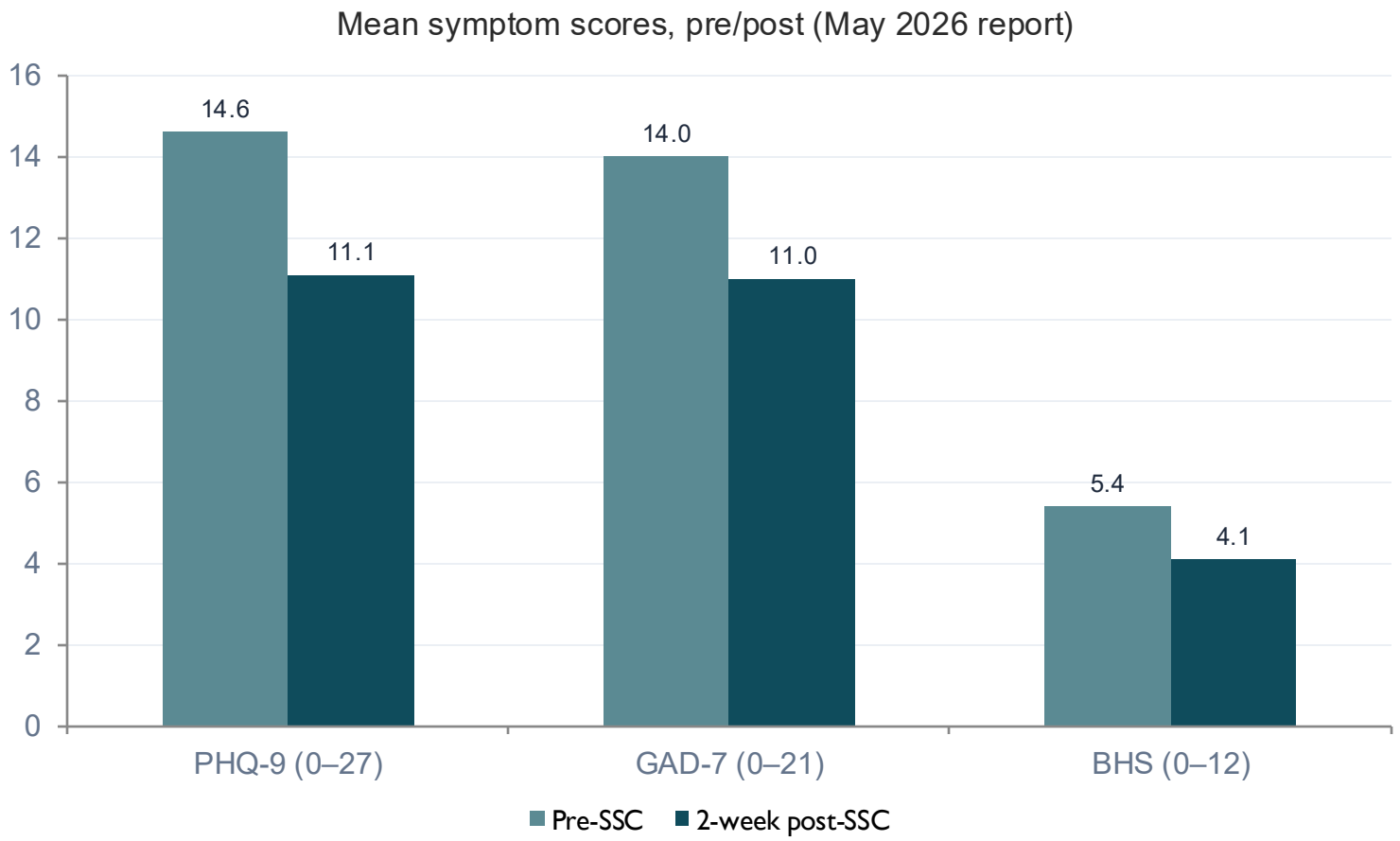
- Applies only during the SSC encounter
- Standard rules resume if member enters ongoing care
- Delivered only in licensed outpatient sites (including approved school satellites)
- Delivered only by qualified MH professionals/workers

Approval timeline

- **Initial pilot approved** (December 2023)
  12-month window with waivers
- **First extension** (December 2024)
  Additional 12 months requested and approved
- **Second extension** (December 2025)
  6 more months, initiated by OMHSAS to expand data collection and SSC delivery
- ***Permanent waiver decision pending***
  Recommendation in development based on pilot results

Motivation: Assessing & sharing key outcomes across stakeholders

Clinical SSC Outcomes: *Pre vs. 2-week post symptom scores to date (N = 181)*



Clinical Results Summary

- **Depression (PHQ-9)**

14.6 → 11.1 [3.5-point average drop; **significant** within-group]

- **Anxiety (GAD-7)**

14.0 → 11.0, [3.0-point average drop; **significant** within-group]

- **Hopelessness (BHS)**

5.4 → 4.1 [immediate post-session drop; **significant** within-group]

Satisfaction (mean 17/20) and therapeutic alliance (mean 37/40) were high.
SSC was highly acceptable to clients.

Motivation: Assessing & sharing key outcomes across stakeholders

SSC Written Client Feedback, Post-SSC

> *I came in today feeling drained and out of focus and am now leaving with hope and a positive attitude, like I'm on my way for a positive journey to better myself and my life.*

> *I really enjoyed this and feel much better after talking and working through a plan.*

> *I think this is a great idea. It's going to help people in crisis like me. It's going to save lives.*

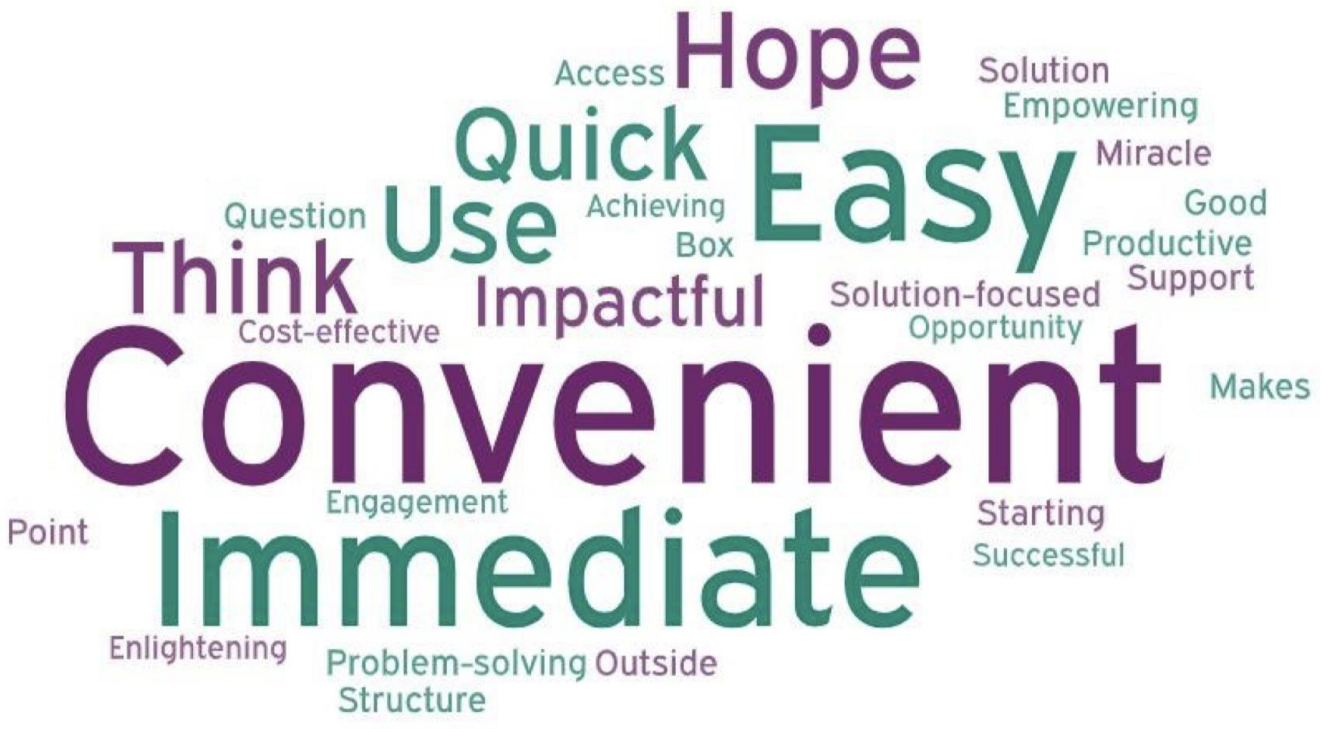
Motivation: Assessing & sharing key outcomes across stakeholders

SSC Clinician (n = 6) and Administrator (n = 6) Focus Group Feedback

> *I felt hope and felt the client leave the office with hope, like I was achieving something with a client that I don't always get.*

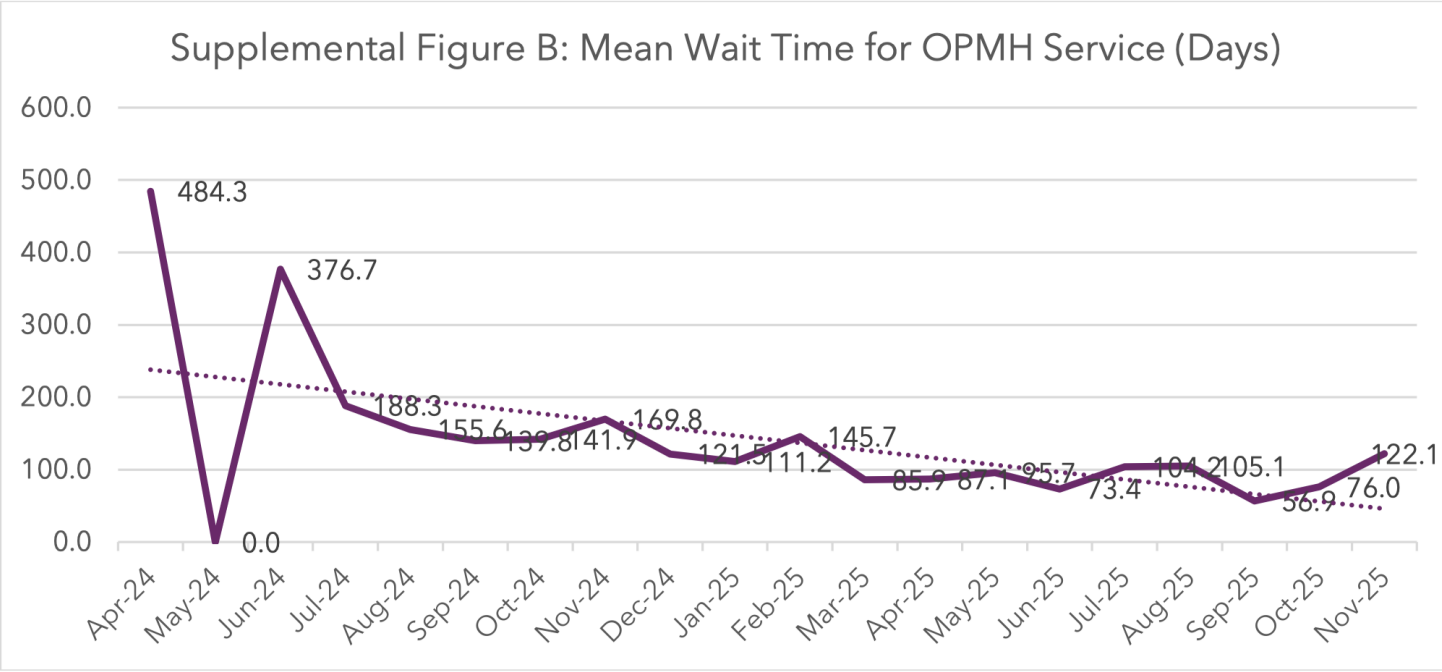
> *We could strike while the iron is hot…*
>
> *…It worked well to get right into [needs] without paperwork, assessments, or ROI.*

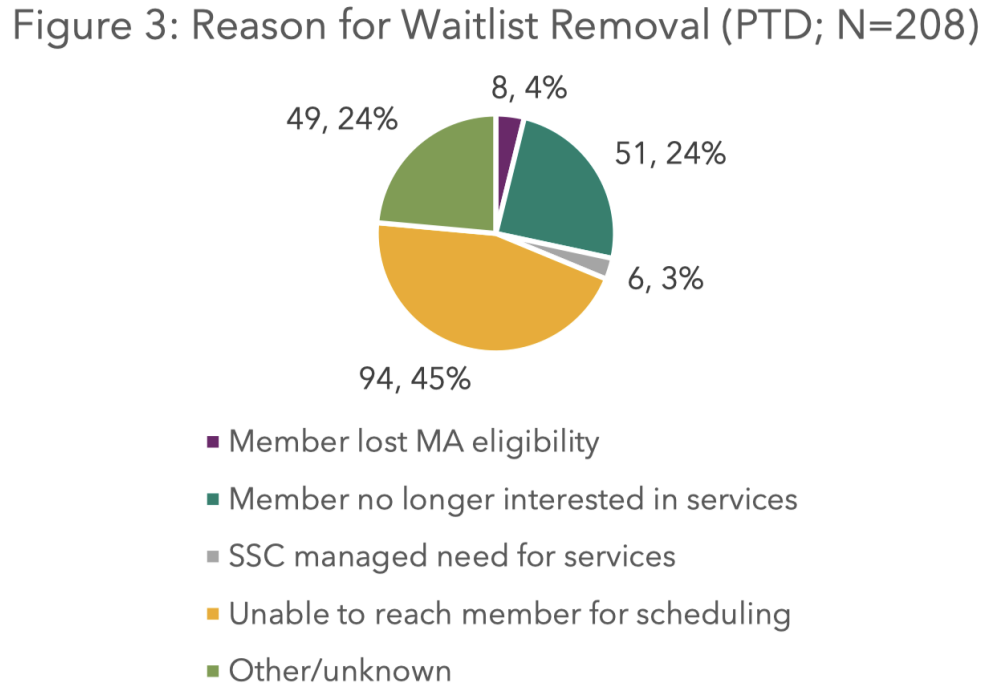
> *I've wondered if the name 'single session' hinders people from engaging – only come in once and done. Do we call it outpatient therapy express?*



Motivation: Assessing & sharing key outcomes across stakeholders

Trends in outpatient mental health waitlist length: *632 members tracked project-to-date*





Motivation: Assessing & sharing key outcomes across stakeholders

Claims data trends from pre- to post-SSC deployment *(90 days before and after)*

Increases *in case management (19.5% to 23.2%), outpatient mental health (31.7% to 46.3%) and crisis services (6.1% to 9.8%),*

Decreases *in outpatient mental health evaluation (17.1% to 0%), inpatient hospital (12.2% to 2.4%), outpatient mental health medication management (26.8% to 23.2%), and consultation (4.9% to 1.2%)*

Table 1. Behavioral Health Service Claims in the 90 Days Before and After SSC (N=82)

Service	90 Days Prior to SSC n (%)	90 Days After SSC n (%)
Case Management (Mental Health)	16 (19.5)	19 (23.2)
Consultation	4 (4.9)	1 (1.2)
Peer Support Services (Mental Health; CPS)	6 (7.3)	8 (9.8)
Crisis	5 (6.1)	8 (9.8)
D&A Certified Recovery Specialist	1 (1.2)	--
D&A Intensive Outpatient	--	1 (1.2)
Outpatient Mental Health Evaluation	14 (17.1)	--
Intensive Behavioral Health Service (IBHS)	2 (2.4)	1 (1.2)
Integrated Care Wellness Center (ICWC)	2 (2.4)	2 (2.4)
Inpatient Hospital	10 (12.2)	2 (2.4)
Outpatient Mental Health Medication Management	22 (26.8)	19 (23.2)
Non-Hospital Withdrawal Management	2 (2.4)	1 (1.2)
Non-Hospital Rehab	2 (2.4)	1 (1.2)
Outpatient D&A Clinic	3 (3.7)	2 (2.4)
Outpatient Mental Health	26 (31.7)	38 (46.3)
Psychiatric Rehabilitation	1 (1.2)	1 (1.2)
Telehealth	3 (3.7)	4 (4.9)

Project status and sustainment plans

4 of 5

participating clinics submitted waiver requests for the 6-month extension (*they want to continue SSC delivery*)

Sustained adoption after two years is a strong positive signal!

Next steps

1. **Complete the final 6-month extension**
   Pilot continues through October 2026
2. **Submit recommendation to OMHSAS, publish results**
   Build the case for permanent waivers to the state
3. **Scale beyond the pilot region**
   Codify what worked for expansion

Take-aways for system leaders & implementers

State partnership is key in the face of regulatory roadblocks

OMHSAS's willingness to grant narrow, temporary waivers made the pilot possible. Clinician hesitancy is ***much*** easier to modify than state regulations

Show results back to clinicians and agency leadership, fast and frequently

Monthly data reports and learning collaboratives turned a new, unfamiliar model into a demonstrably useful part of the regular workflow

Sustainment within regulatory constraints requires multi-level approach

Training, waivers, and continued feedback were all key to 80% 2-year sustainment rate

CASE EXAMPLE 2

Montana: Adapting & Implementing Project YES statewide

A government-nonprofit-industry-academic partnership to scale free, anonymous, digital SSIs for teens

Goodness-of-fit of Project YES to Montana's youth mental healthcare gap

The gap in Montana

51 of 56

Montana counties designated as mental health professional shortage areas

43%

of Montana youth report persistent feelings of sadness or hopelessness

~2.7×

Montana youth are more likely to die by suicide than U.S. peers (CDC)

Why Project YES fits

Project YES offers free, anonymous, evidence-based SSIs designed to be completed in one sitting, on any internet-connected device.

1. **Circumvents Montana's biggest access barriers**

   Free, anonymous, web-based; no insurance, no appointment, no providers, no transportation needed, no parental gatekeeping, no stigma. Meets rural youth where they are.

2. **Exceptionally brief, low/no barrier to entry**

   Self-guided single-session interventions deliver evidence-based skills immediately, combating challenges of early attrition/dropout from traditional treatments; requires less commitment, more approachable to teens unsure about help-seeking

3. **Backed by evidence**

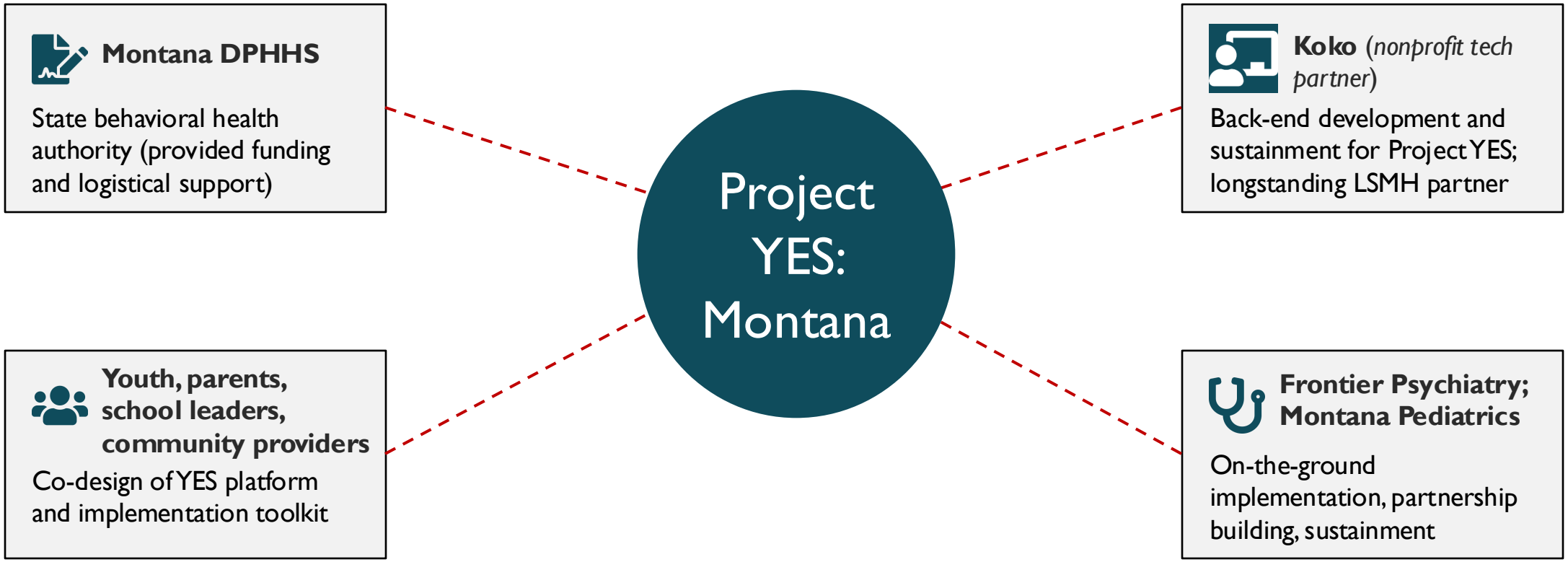
   RCT with ~2,500 teens showed reduced depression, hopelessness, anxiety, and restrictive eating at 3 months. Pre/post data from 5,500+ youth show gains in hope and agency.

4. **Built to complement, not replace, the existing healthcare system**

   Deployed with the MT Dept. of Public Health and local partners — fills the gap for the ~50% of teens with depression who currently receive no care.

Again, **Project YES was deployed by a *system***, not an individual

Lab for Scalable Mental Health *serves as 'umbrella' partner linking all four groups in evaluation and implementation effort*



3 groups = 3 sets of implementation challenges

Teens

Need to **find Project YES, **understand** what it is, **trust** it enough to try it, and **complete a session** on their own

Parents & caregivers

Need to **know enough about Project YES to **surface** it to their teen—and feel **comfortable and capable** to do so

Providers & schools

Need to **know when and how to **share** Project YES, within constraints of their systems

Each group has its own capability, opportunity, and motivation (COM) barriers to drive target behavior (B)

How COM-B guided our MT implementation plan

Capability

Built capability across all three groups via co-design

**Co-designed an adapted, Montana-specific Project YES platform with youth, so it made sense to them

**Built an implementation toolkit so parents and providers know when and how to share it, including scripts, FAQs, and short training videos

Opportunity

Created opportunity within trusted spaces

**Advisory boards (parents, school staff, clinicians) shaped a rollout that is running through schools, clinics, and counselor education programs statewide, with the approvals needed to operate inside each

Motivation

Surfaced YES benefit and applications clearly to motivate use

**Implementation toolkit names concrete situations where Project YES helps — and signals credibility (Montana-built, evidence-based, no data sold, free) right where each audience first encounters it.

With Youth: Codesigning a Montana-tailored Project YES platform

We conducted **online, asynchronous focus groups** with Montana teens to adapt Project YES for uptake in their state.

Method

76	adolescents living in Montana, ages 13–19, recruited via community partner organizations
8	asynchronous, anonymous focus group sessions over 4 weeks (FocusGroupIt.com)
100%	all participating teens endorsed having a history of unmet mental health needs
IRB Waiver	we obtained a **waiver of parent consent requirements** to allow teens to participate regardless of family involvement in their mental health journey

With Youth: Codesigning a Montana-tailored Project YES platform

Results *What did teens recommend?*

Session 1: Icebreaker
Have you ever used technology to get mental health information or support? Why or why not? What about that experience was helpful? What about that experience was challenging or unhelpful?
"Just recently I texted 988 for help in a situation with a friend and I have recently gone to YouTube for some breathing exercises"

- **Nearly all teens** had used technology to get mental health information or support.
- Teens used **many technologies** (e.g., relaxing music, apps, social media, websites, crisis helplines, chatbots)
- At times, tech felt **unreliable** or **untrustworthy** to teens. Data privacy and security were key concerns
- Other tech felt **overwhelming** or **hard to use**. Existing crisis helplines had long waits
- Teens stopped using tech that felt **impersonal**, **boring**, or "**addictive**"

With Youth: Codesigning a Montana-tailored Project YES platform

Results *What did teens recommend?*

Session 2: Learn about our website (teens shown this description and this image)	
What are some things you would like to know about our website [Project YES] before using it? What would make you MORE interested in trying a website like this, and why? What would make you LESS interested in trying a website like this, and why?	
"I would first ask if it would cost anything, and if it would provide specific coping skills for certain disorders/struggles"	*"I would also like to know how exactly my information is kept private and who reads the information"*

- Teens felt more interested if the website was:
  - **Clear** on purpose + creators
  - **Safe**: Made by experts, data protected
  - **Private**: No/minimal personal data required
  - **Personalized**: Tailored to individual needs/options to choose
  - **Easy/Quick**: Simple to use, low time commitment
  - **Free**: No hidden fees or ads, 100% free
  - **Human (vs. AI)**: Connected you to real people/resources

With Youth: Codesigning a Montana-tailored Project YES platform

Results *What did teens recommend?*

Session 6: Help us better respond to crisis (teens were shown this description)
[If user crisis detected] What do you think should happen? What do you think would help them most, and why? How would you feel if… this happened to you? Why would you feel this way? Talking about crisis experiences… are there words you like, or don't like, to be used? Why?
"I want the words to feel like they're talking to me, not about me"

- **All teens** wanted the site to respond to users in crisis
- Responses that are **supportive, private, actionable, clear**, and give teens **options/control** over what happens next would feel better
- Teens preferred **encouraging, non-judgmental, and de-stigmatizing** language ("help is available", "you're not alone")

With Youth: Codesigning a Montana-tailored Project YES platform

Results *What did teens recommend?*

Teens want referrals to be **low-cost**, **personalized** for them/their community, delivered or designed by **experts**, and **quickly-available**

Session 7: Help us refer to more resources		
What types of resources… would be most helpful to share with young people in Montana? What… would you want to know about a resource before recommending it to a friend? Why these resources and this information?		
"most montana teens struggle and it's hard to find a good resource thats affordable or fast to get access to help, free clothing and food resources like for example The Heart Locker in Kalispell Mt, as lots of teens in montana are homeless or don't have food and clothes"	*"Counseling is a term that many have a better reaction to because therapy can sometimes be scary to hear but I think it is important for people to know that they can get help from a professional"*	*"Resources to help with teens that have disabilities, not many people at resources i know of can handle mental health mixed with a disability"*

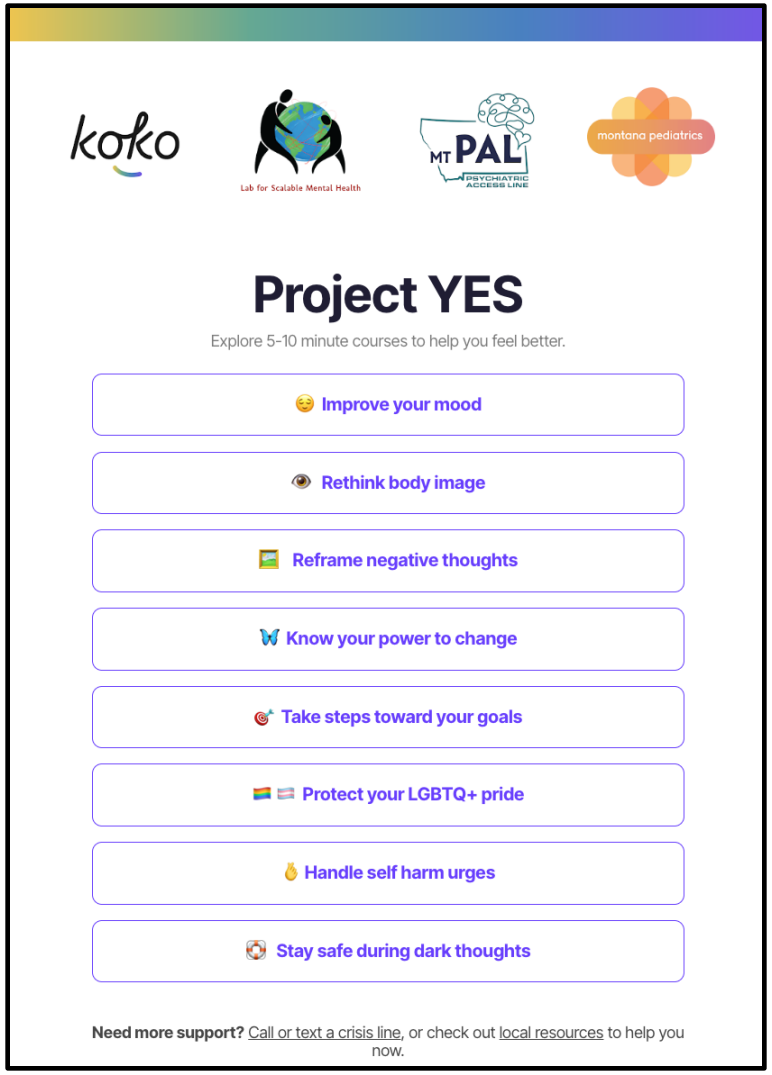
With Youth: Codesigning a Montana-tailored Project YES platform

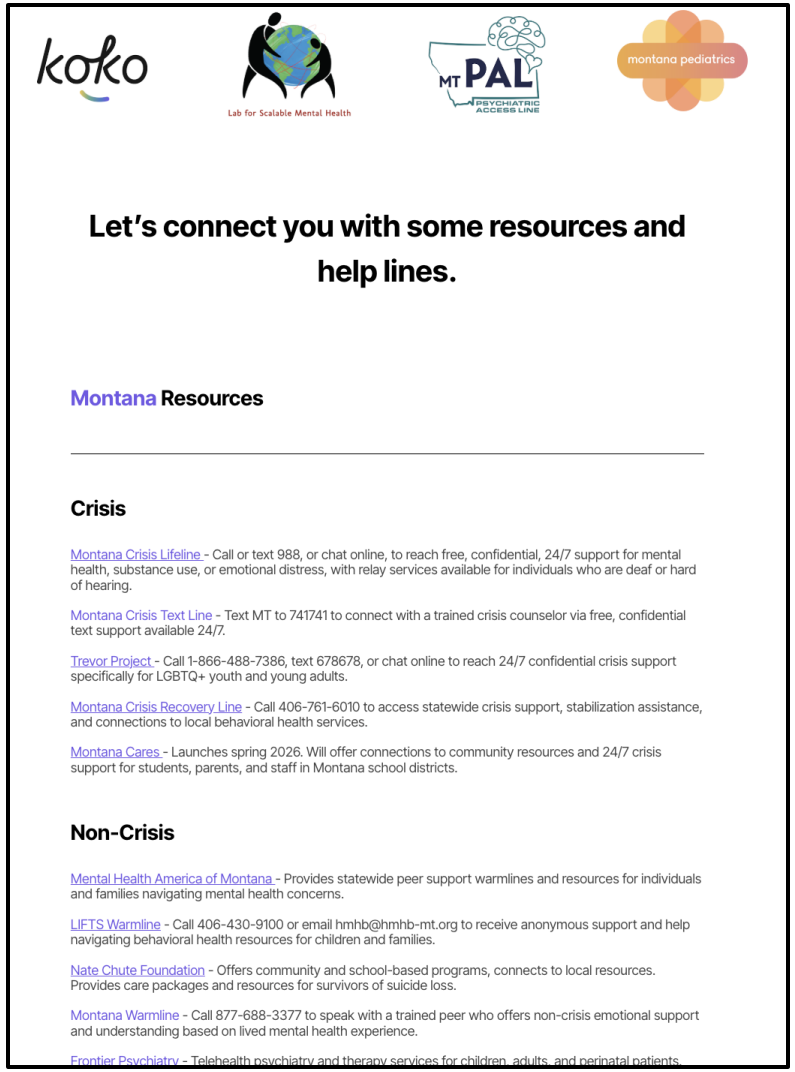
Results *What did teens recommend?*

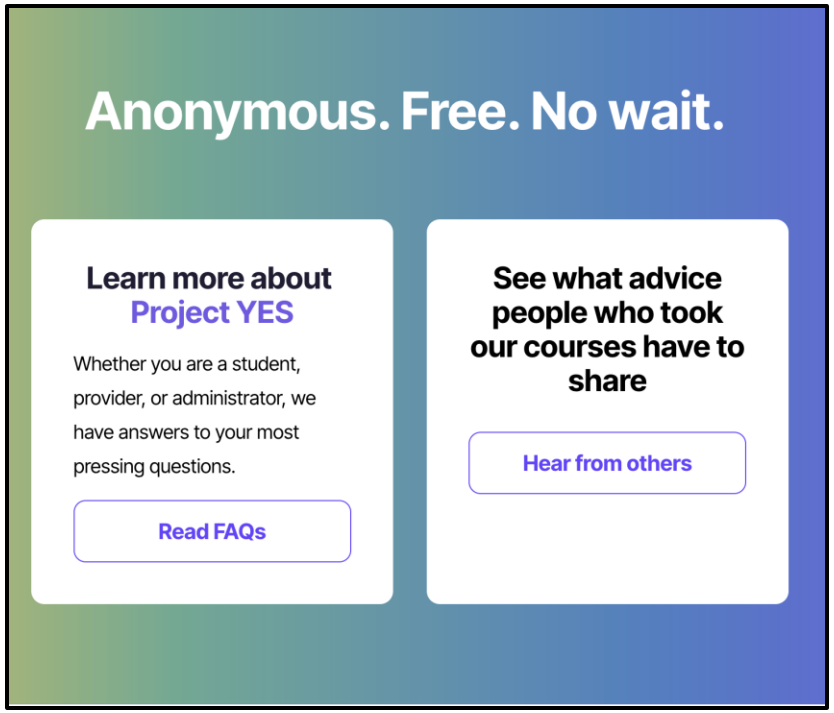
Session 8: Help us describe our website	
In your own words, how would you describe our website to others your age? What would you emphasize about our website to a friend? Why? How should young people find out about our website? Why?	
"I would emphasize that it is not super personal and not public to give them a sense of security and that it is for teens to show that it is not just about adult brains"	*"It 100% anonymous, because it's nice to be behind a screen sometimes"*

- For **others their age**, teens described the site as a **free, trusted, helpful, "safe" or non-judgmental, low-pressure, private** resource made for them
- For **friends**, teens emphasized our website has **lots of options** to choose from; it's **quick, free, private, helpful, made for you**, and **easy to use**
- Teens recommended sharing the website in **spaces where teens already spend time** (social media, from peers/friends, schools, community orgs)

The result: tryprojectyes.org/montana





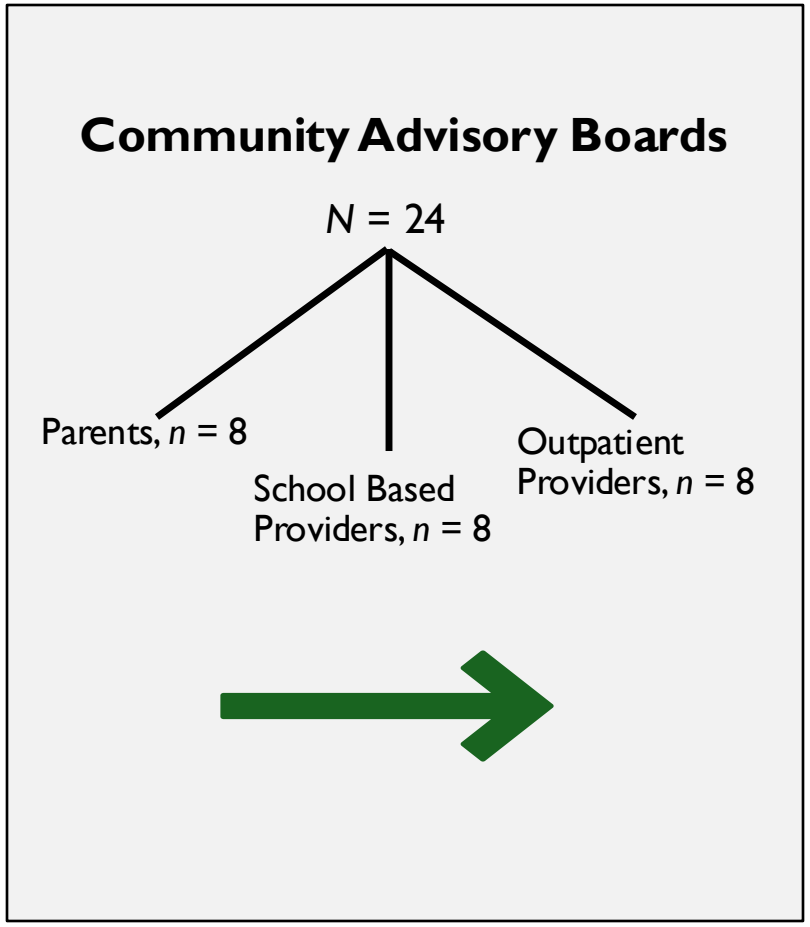


How is AI used in Project YES?

Project YES is not a chatbot or a program made by generative AI. Everything in Project YES has been pre-written by experts. We do use AI to review and find responses where someone says they may be in danger, or might hurt themselves or someone else. If this happens, we check in on that person privately and direct them to more resources right away.

With Parents & Providers: Codesigning the YES Implementation Toolkit

Method



Design Step	Activities
Step 1: Select Strategies	**Identify parents' and providers' perceived barriers & facilitators** to using Project YES
Step 2: Synthesize Feedback	**Synthesize insights** via rapid qualitative analysis; consolidate list of possible strategies for toolkit inclusion
Step 3: Incorporate Feedback	**Apply results to a wireframe**; present to Advisory Board, gather more feedback
Step 4: Build Prototype	**Develop a working prototype** of toolkit, based on Step 3 feedback
Step 5: Test & Refine Prototype	**Conduct in-vivo testing of the prototype** with advisory board members to guide refinements

With Parents & Providers: Codesigning the YES Implementation Toolkit

Results *What did parents & providers recommend?*

Overall thoughts, barriers, & facilitators

- Optimism about YES in Montana, *especially* given community-partnered approach
- Emphasized need for implementation tools designed specifically for them
- Highlighted anonymity, brevity, adaptability, interactivity as *facilitators* of youth/adult engagement
- Noted internet connectivity, risk management questions as *barriers* to adult engagement

Concerns

- Parents and providers both noted concerns/lack of clarity about risk/crisis response
- Toolkit resources must be *brief, easy to digest*, and *well-organized*
- Providers suggested short videos to support their use of both the toolkit and YES
- Parents suggested scripts for talking with their teens about mental health/YES

***The result*:** montana.projectyesguide.org

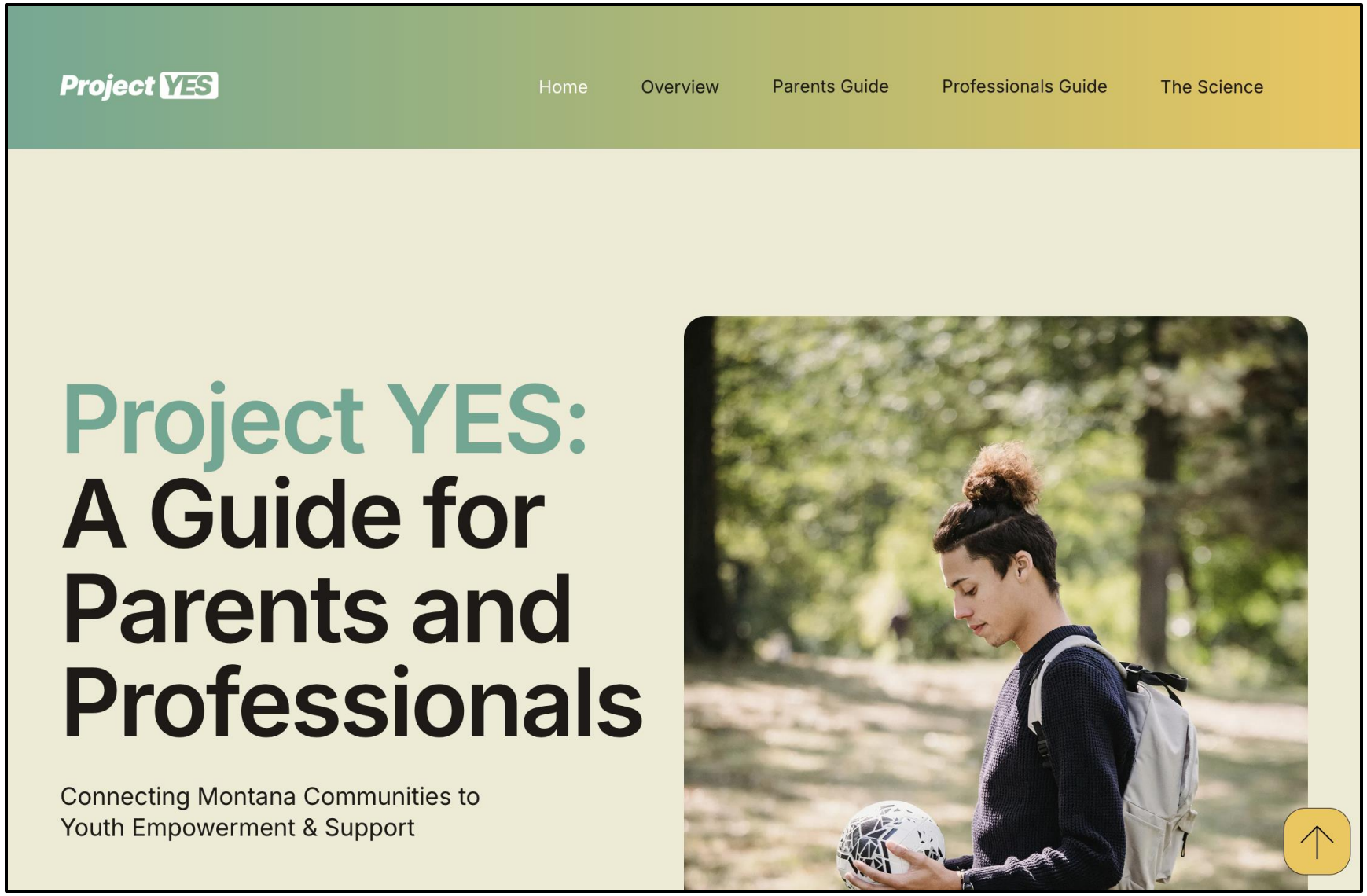
Toolkit highlights:

** **Setting-specific pages** (*primary care, schools, outpatient clinics, at home*)

** **Integration/engagement strategies** (*sample workflows, FAQs, marketing printouts*)

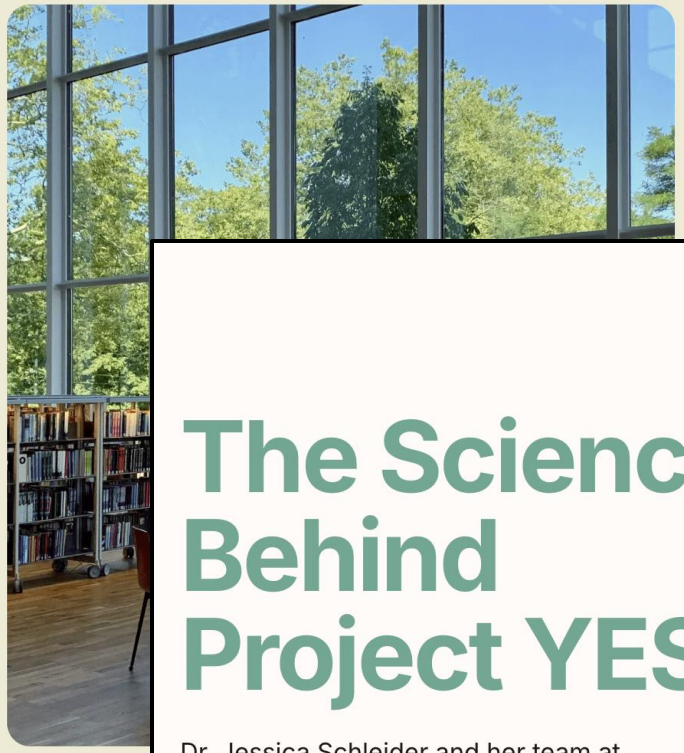
** **Additional resources** (*vetted mental health reading materials, option to contact YES team, guide to finding further support*)

** **Interactive tools** (*scripts for talking with teens, self-paced training materials, YES demo*)



The result: montana.projectyesguide.org

Overview



The Science Behind Project YES

Dr. Jessica Schleider and her team at Northwestern University have been designing and testing the activities behind Project YES with teens across the country since 2018.

Read more about some of the findings from these studies below.

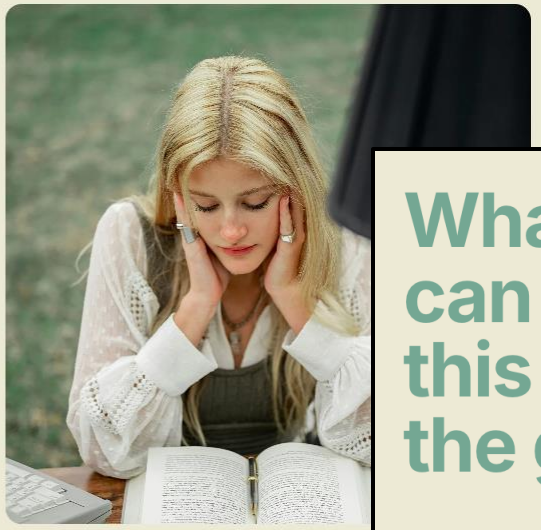
The result: montana.projectyesguide.org

Welcome to the Project YES Guide for Parents & Caregivers

Help your teen take charge of their mental health with a free, safe, and interactive platform of evidence-based mini courses they can complete on their own.

Here you'll find conversation starters, tips for guiding your teen, and even a demo to help you explore the platform yourself.

Project YES Starter Kit



What you can find in this part of the guide:

Click any section to go straight to what matters most to you.

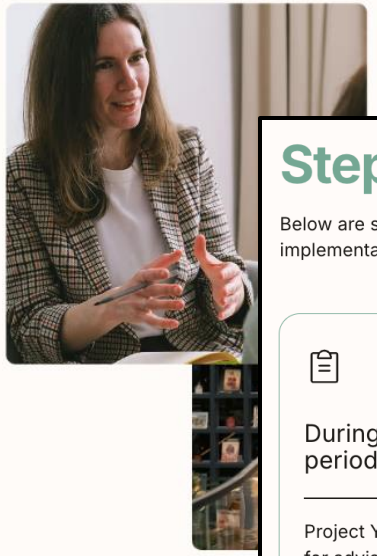
The result: montana.projectyesguide.org

Welcome to the Project YES Guide for Professionals

Support the teens you work with on their mental wellness journey through Project YES, a safe and engaging platform of evidence-based mental health mini courses that youth can access for free and complete independently.

Here you will find tools to help confidently guide teens in using Project YES, workflow tips and guides, and a full demo of the platform you can test yourself.

Project YES in Schools | Project YES in Clinics



Step-by-Step Integration of Project YES in Schools

Below are some simple ways Project YES can fit seamlessly into existing school workflows. Click on a setting to jump straight to more details and implementation ideas, or scroll to explore them all:

During classroom periods

Project YES is a great fit for advisory periods, health classes, and homeroom programming.

In the library

Students can complete Project YES on their own time from the library.

In the nurse's office

School nurses might be the first to catch mental health challenges. Project YES posters can be distributed to students who are struggling.

Extra resources for one-on-one support

Share Project YES as a resource for students who are in need of extra support.

During appointment downtime

Students may have downtime while they wait for an appointment with a school administrator or the counselor. Help them make the most of the downtime by sharing Project YES.

As a cool down activity

Many schools may already have space for students who need to be removed from the classroom. Help students regulate on their own.

Around the school reminders

Add Project YES premade posters to resource bulletins, upcoming events pages, or even just flyers in highly trafficked areas.

Download Our Ready-to-Print Project YES Flyer

The result: montana.projectyesguide.org

Welcome to the Project YES Guide for Professionals

Support the teens you work with on their mental wellness journey through Project YES, a safe and engaging platform of evidence-based mental health mini courses that youth can access for free and complete independently.

Here you will find tools to help confidently guide teens in using Project YES, workflow tips and guides, and a full demo of the platform you can test yourself.

Project YES in Schools | Project YES in Clinics

Step-by-Step Integration of Project YES in Clinics

Below are some simple ways Project YES can fit seamlessly into clinic workflows. Click on a setting for more details and tips, or scroll to explore them all:

In the Waiting Room

Offer tablets, posters, or QR codes so teens can start an activity while they wait.

Post Mental Health Screening

After a screening, especially if a teen shows mild-to-moderate concerns, you can introduce Project YES as an immediate support option.

For Waitlist or Referral Periods

Share Project YES, so families can have something safe and evidence-based to use while awaiting care.

Between Visits

Encourage teens to use Project YES as "mood-boosting" activities or coping practice until their next appointment.

During the Care Visit

Demonstrate the platform briefly in session and recommend one activity to try.

Within Clinic Materials

Add Project YES links or QR codes to your clinic website, after-visit summaries, or outreach handouts.

Posters & Signage: Think of these as general awareness tools. They're designed to catch attention in waiting rooms or hallways and spark curiosity. Posters often feature eye-catching visuals, simple taglines, and even youth or parent testimonials (e.g., *"Project YES helped me feel more in control"*). Their goal is to advertise that Project YES exists and make it feel relatable, safe, and inviting.

Statewide YES rollout: ongoing through 2027

1

Implementing advisory board & youth suggestions

Parents, school staff, clinicians, and youth shaped rollout strategy

2

School districts

Negotiating approvals to surface Project YES inside schools

3

Counselor education

Exploring whether trainings can be embedded in counselor education programs

4

Community channels

Our MT partners are introducing YES and the toolkit to local orgs, clinicians, and cultural spaces where teens already seek help

5

Online spaces

Deploying with Koko via digital platforms (e.g. social media)

Take-aways for system leaders & implementers

Co-design is <u>essential</u> for promoting *capability, opportunity,* and *motivation* in specific communities

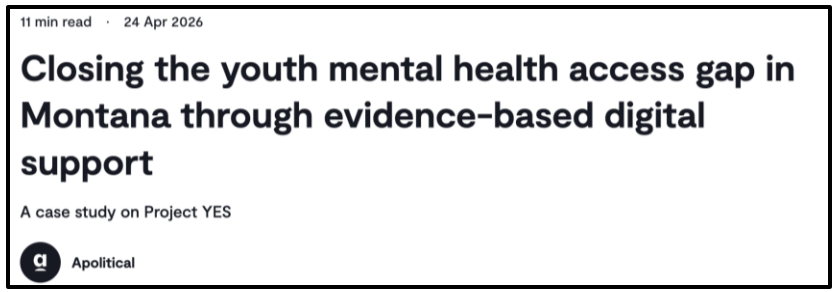
'Out-of-the-box' versions of Project YES and the implementation toolkit *could not have worked* in MT

Community-wide reach (*opportunity*) is <u>earned</u> via trust and partnership (*'free' is not enough to scale!*)

Even an anonymous, free, no-account-required platform requires community buy-in to scale in youth-facing settings

Different groups, different strategies

What motivates a teen to try Project YES is not what leads a parent or provider to share it. Separate tools and materials are needed to change behavior in different target groups



Read Apolitical's case study on Project YES in Montana ***here***

Thank you! *Questions?*

Session 3 *will support select participants in building an* ***SSI implementation plan*** *for their setting.*

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