Ohio Strategic Prevention Framework

Strategic Plan

February 14, 2011

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Acronyms Used By The Alcohol and other Drug Abuse Prevention Field-

	Acronym	*Translation*
1.	**ADAMHS**	Alcohol, Drug Addiction and Mental Health Services
2.	**ADAPAO**	Alcohol and Drug Abuse Prevention Association of Ohio
3.	**ADAS**	Alcohol and Drug Addiction Services
4.	**AOD**	Alcohol and Other Drugs
5.	**ASI**	Addiction Studies Institute
6.	**ATOD**	Alcohol, Tobacco and Other Drugs
7.	**ARBD**	Alcohol Related Birth Defects
8.	**ARND**	Alcohol Related Neurodevelopmental Disorder
9.	**BRFSS**	Behavioral Risk Factor Surveillance System
10.	**CADCA**	Community Anti-Drug Coalitions of America
11.	**CAPT**	Center for Application of Prevention Technology
12.	**CDC**	Center for Disease Control and prevention
13.	**CEPP**	County Epidemiological Prevention Profile
14.	**CEWG**	Community Epidemiology Workgroup
15.	**CMH**	Community Mental Health
16.	**COA**	Children of Alcoholics
17.	**COSAP**	Children of Substance Abusing Parents
18.	**CSAP**	Center for Substance Abuse Prevention
19.	**DODD**	Department of Developmental Disabilities
20.	**DEA**	Drug Enforcement Administration
21.	**EBP**	Evidence Based Prevention Practice

	Acronym	*Translation*
22.	**EPP**	Expert Prevention Panel
23.	**EUDL**	Enforcing Underage Drinking Laws Initiative
24.	**FAS**	Fetal Alcohol Syndrome
25.	**FASD**	Fetal Alcohol Spectrum Disorder
26.	**FCFC**	Family and Children First Council
27.	**FFY**	Federal Fiscal Year
28.	**GFA**	Guidance for Applicants
29.	**HIDTA**	High Intensity Drug Trafficking Area
30.	**HRY**	High Risk Youth
31.	**IOM**	Institute of Medicine
32.	**IPP**	Improving Prevention Practices
33.	**MACSIS**	Multi-Agency Community Services Information System
34.	**NASADAD**	National Association of State Alcohol and Drug Abuse Directors
35.	**NCADD**	National Council on Alcoholism and Drug Dependence
36.	**NCADI**	National Clearinghouse for Alcohol and Drug Information
37.	**NSDUH**	National Survey on Drug Use and Health
38.	**NIMH**	National Institute of Mental Health
39.	**NIAAA**	National Institute on Alcoholism and Alcohol Abuse
40.	**NIDA**	National Institute on Drug Abuse
41.	**NIH**	National Institutes of Health
42.	**NOMS**	National Outcome Measures
43.	**NPN**	National Prevention Network
44.	**NREP**	National Registry of Effective Programs

	Acronym	*Translation*
45.	**OACBHA**	Ohio Association of County Behavioral Health Authorities
46.	**OCBHP**	Ohio Council of Behavioral Healthcare Providers
47.	**OCDPB**	Ohio Chemical Dependency Professionals Board
48.	**OCPS**	Ohio Certified Prevention Specialist
49.	**ODADAS**	Ohio Department of Alcohol and Drug Addiction Services
50.	**ODA**	Ohio Department of Aging
51.	**ODE**	Ohio Department of Education
52.	**ODH**	Ohio Department of Health
53.	**ODJFS**	Ohio Department of Job and Family Services
54.	**ODMH**	Ohio Department of Mental Health
55.	**ODPS**	Ohio Department of Public Safety
56.	**ODRC**	Ohio Department of Rehabilitation and Corrections
57.	**ODYS**	Ohio Department of Youth Services
58.	**OFCFC**	Ohio Family and Children First Council
59.	**ONG**	Ohio National Guard
60.	**OSAM**	Ohio Substance Abuse Monitoring Network
61.	**OTCM**	Over the Counter Medications
62.	**PDFA**	Partnership for a Drug Free America
63.	**PIPAR**	Prevention Investment Planning and Reporting
64.	**SAMHSA**	Substance Abuse Mental Health Services Administration
65.	**SAPST**	Substance Abuse Prevention Specialist Training
66.	**SAPT**	Substance Abuse Prevention and Treatment (Block Grant)
67.	**SEOW**	State Epidemiological Workgroup

	Acronym	*Translation*
68.	**SEPP**	State Epidemiological Prevention Profile
69.	**SFY**	State Fiscal Year
70.	**SPF**	Strategic Prevention Framework
71.	**SPF-SIG**	Strategic Prevention Framework State Incentive Grant
72.	**SSA**	Single State Agency
73.	**TA**	Technical Assistance
74.	**UDETC**	Underage Drinking Enforcement Training Center
75.	**UMADAOP**	Urban Minority Alcoholism and Drug Abuse Outreach Program
76.	**WFD**	Work Force Development
77.	**YLP**	Youth-Led Prevention
78.	**YRBS**	Youth Risk Behavior Survey
79.	**YRBSS**	Youth Risk Behavioral Surveillance
80.	**YTS**	Youth Tobacco Survey

ASSESSMENT

I. Assessing Substance Use and Related Consequences

Ohio has identified several indicators of substance use (consumption) and consequences resulting from substance use in the epidemiological data profiles. Consumption indicators include age of initiation, lifetime use, current use, and high-risk use. Consequences of use include mortality and morbidity data, measures of abuse and addictive disorders, and crime related indicators.

Several measures of mortality and morbidity which demonstrate ties to substance use are currently of concern within Ohio. Syphilis and Chlamydia rates have been on a steady climb for both adolescents and adults in Ohio since 2006. Similarly, the HIV incidence within Ohio increased at a rate of 9.4 per 100,000 population between 2006 and 2008. While stable, the infant mortality rate within Ohio remained above the US average every year between 2003 and 2008. Finally, Ohio's poverty rate has been rising steadily since 2001.

There are some direct consequences of alcohol, tobacco and other drugs (ATOD) consumption that are of concern for Ohio residents. Approximately 4 to 5% of the motor vehicle crashes within Ohio between 2001 and 2008 were alcohol related. During this time period, alcohol accounted for 3,969 deaths on Ohio's roadways. According to the NSDUH, Ohio's alcohol abuse or dependence rate has remained above the national average since 2005-2006. Similarly, the illicit drug abuse or dependence rate has remained above the US average since 2005-2006. Ohio's rate of unintentional drug deaths has also been rising since 2004.

In addition, mental health issues also remain of concern for Ohio residents. The National Survey on Drug Use and Health (NSDUH) reports that Ohio has remained above the national average for major depression among individuals aged 12+ since 2004-2005. While several external factors can influence the prevalence of mental health conditions, a decrease in ATOD use could significantly reduce such problems for Ohio residents.

Contextual indicators from the Research Triangle Institute study that measure community instability and family-related factors (e.g., teen-birth rate, divorce, and child-abuse or neglect) comprised another set of measures used for the Ohio epidemiological profile. While the relationship between such indicators and ATOD consumption is at times inconsistent, Sanchez, Dunteman, Kuo, Yu, and Bray (2001) suggested that the above demographic and contextual measures should be monitored closely in an effort to evaluate the impact of ATOD use on Ohio's population.

Several state departments provided data regarding ATOD consumption within Ohio. In addition, state and federal surveys were reviewed as possible data sources for the State Epidemiological Outcomes Workgroup (SEOW)'s role in the Strategic Prevention Framework State Incentive Grant (SPF-SIG). The purpose of the federal State Epidemiological Outcomes Workgroup (SEOW) initiative is to provide states and communities with data needed for planning,

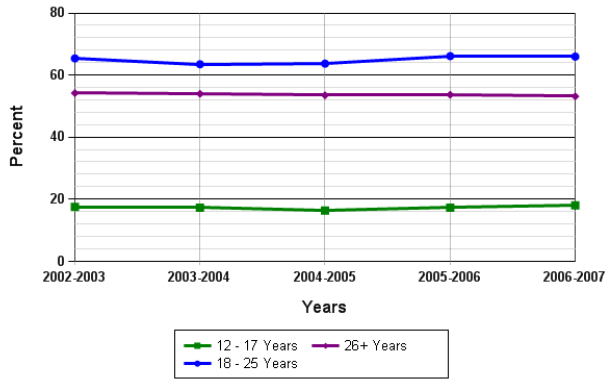
monitoring and evaluation purposes. SEOW is responsible for the collection, analysis, and reporting of substance use incidence, prevalence and related data and National Outcome Measures (NOMs). The NOMs are a set of domains and measures which SAMHSA will use to meet all its statutory and Congressional reporting requirements. Substance abuse NOMs are drawn from many types of data including: substance use incidence and prevalence, related consequence data, and program process and output data. The SEOW is a critical component to enabling Ohio to report on NOMs and to address the Strategic Prevention Framework State Incentive Grant (SPF/SIG).The SPF/SIG provides a data-driven planning framework to assist in developing comprehensive plans to prevent substance abuse and reduce problems associated with substance abuse. Indicators that met the SEOW inclusion criteria were categorized broadly by ATOD consumption and the consequences associated with alcohol, tobacco, or illicit drug use.

The following is a detailed description of the alcohol, tobacco and other drug consumption and related problems within Ohio. Throughout the data collection and analysis process, US Census data was used as a standard for establishing rates and comparing groups of interest.

Alcohol Consumption

Alcohol is the most commonly abused substance in both Ohio and the US. According to the National Survey on Drug Use and Health (NSDUH), current alcohol use is most common among young adults between the ages of 18 and 25. Within Ohio, young adults between the ages of 18 and 25 ranked above all other age groups for alcohol use in past month (Figure 1), binge alcohol use (Figures 2 and 2a), heavy drinking among adults (Figure 3), and alcohol abuse or dependence. In addition, young adults in Ohio presented a high national ranking in alcohol abuse or dependence (Figure 4). Finally, Ohio was above the national average in alcohol use in past month, binge alcohol use, and heavy drinking among adults. Therefore, the data suggests that a focus upon alcohol consumption by young adults between the ages of 18 and 25 could potentially reduce alcohol consumption and, in turn, alcohol-related consequences within this age group.

Figure 1: Alcohol Use in Past Month, by Age in Ohio



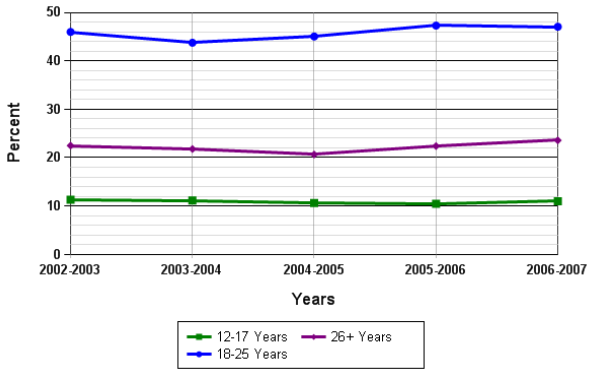
Within developed countries, alcohol use accounts for approximately 9% of years of life lost worldwide. Approximately 100,000 deaths each year in the U.S. are attributed to alcohol misuse. Among Ohio residents aged 12+, members of the 18 to 25 age group remained above other groups in current alcohol use across all years examined here. In 2005-2006, close to 2/3 of Ohio residents between the ages of 18 and 25 had used alcohol within the past month.

Variable Definition Figure 1: Percent of persons aged 12 and older reporting any use of alcohol within the past 30 days.

Data Sources: National Survey on Drug Use and Health (NSDUH).

Thomson, S. J., Westlake, S., Rahman, T. M., Cowan, M. L., Majeed, A., Maxwell, J. D., & Kang, J. Y. (2008). Chronic liver disease-An increasing problem: A study of hospital admission and mortality rates in England, 1979-2005, with particular reference to alcoholic liver disease. Alcohol & Alcoholism, 43(4), 416-42

Figure 2: Binge Alcohol Use in Past Month, by Age in Ohio



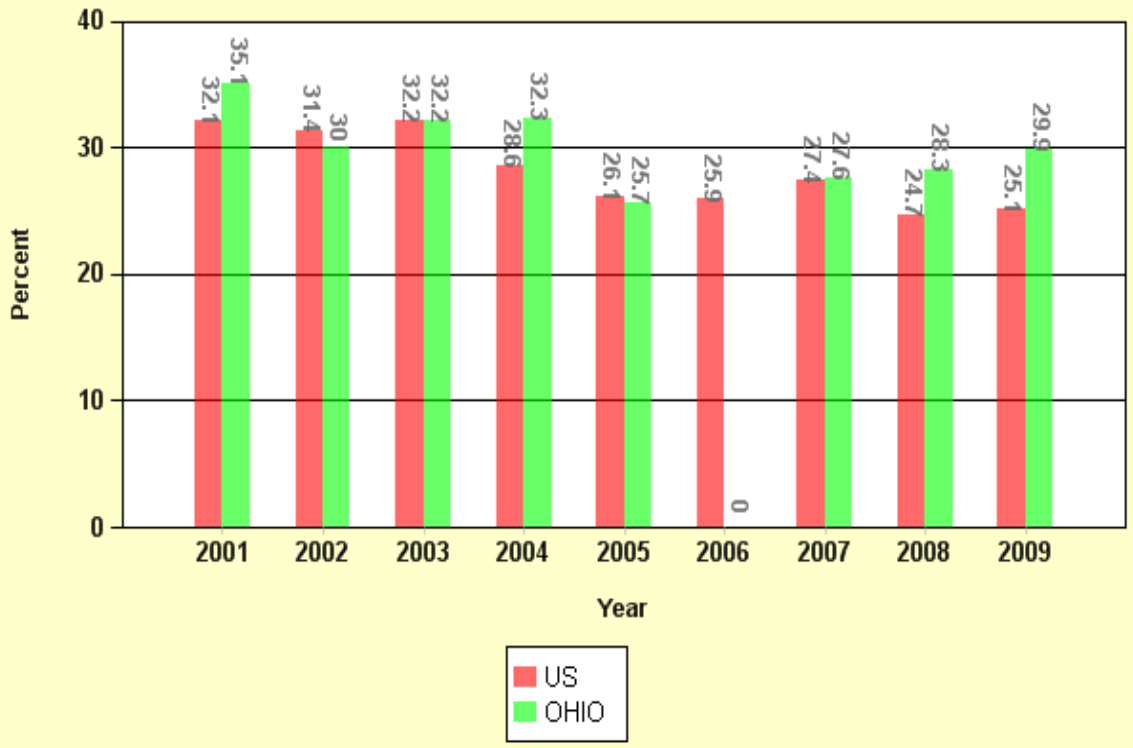
Binge drinking, as indicated by consumption of five drinks or more within a short time span, is often related to injuries, motor vehicle crashes, violence, fetal alcohol syndrome, chronic liver disease, and a number of other chronic and acute conditions. Men are more likely than women to participate in binge drinking, and the prevalence of binge drinking has been shown to decline with age.

Variable Definition Figure 2: Percent of persons aged 12 and older reporting having five or more drinks on at least one occasion within the past 30 days.

Data Sources: National Survey on Drug Use and Health (NSDUH)
Morbidity and Mortality Weekly Report (MMWR), 2008; 57(49); 1333. Quickstats: Percentage of adults aged =18 years who consumed five or more alcoholic drinks in 1 day at least once in the preceding year, by sex and age group--National Health Interview Survey, United States, 2007. From http://www.cdc.gov/mmWR/preview/mmwrhtml/mm5749a6.htm.

Figure 2a: Binge Drinking among Persons Aged 18 to 24

Ohio vs. US

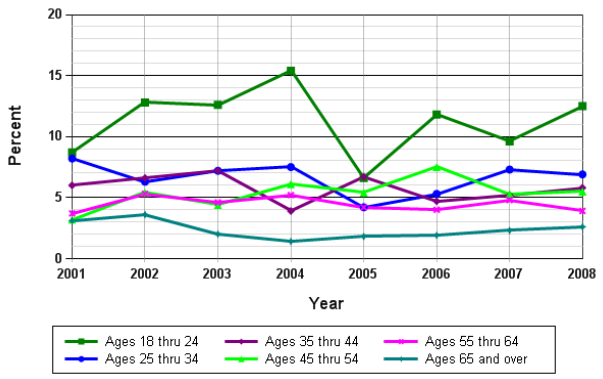


Binge drinking, as indicated by consumption of five drinks or more within a short time span, is often related to injuries, motor vehicle crashes, violence, fetal alcohol syndrome, chronic liver disease, and a number of other chronic and acute conditions. Men are more likely than women to participate in binge drinking, and the prevalence of binge drinking declines with age. Definition: Percent of persons aged 18 and older reporting having five or more drinks on at least one occasion within the past 30 days.

Data Sources: Behavioral Risk Factor Surveillance System

Morbidity and Mortality Weekly Report (MMWR), 2008; 57(49); 1333. Quickstats: Percentage of adults aged =18 years who consumed five or more alcoholic drinks in 1 day at least once in the preceding year, by sex and age group--National Health Interview Survey, United States, 2007. From http://www.cdc.gov/mmWR/preview/mmwrhtml/mm5749a6.htm.

Figure 3: Heavy Drinking among Adults, by Age in Ohio



Heavy use of alcohol pertains to a pattern of regular use at levels that exceed U.S. Dietary Guidelines. It is associated with heightened levels of mortality. Heavy drinkers are at increased risk for a variety of adverse health outcomes, including alcohol abuse and dependence. Within Ohio, the rate of heavy drinking among 18 to 25 year old residents remained at or above other age groups throughout all years examined here.

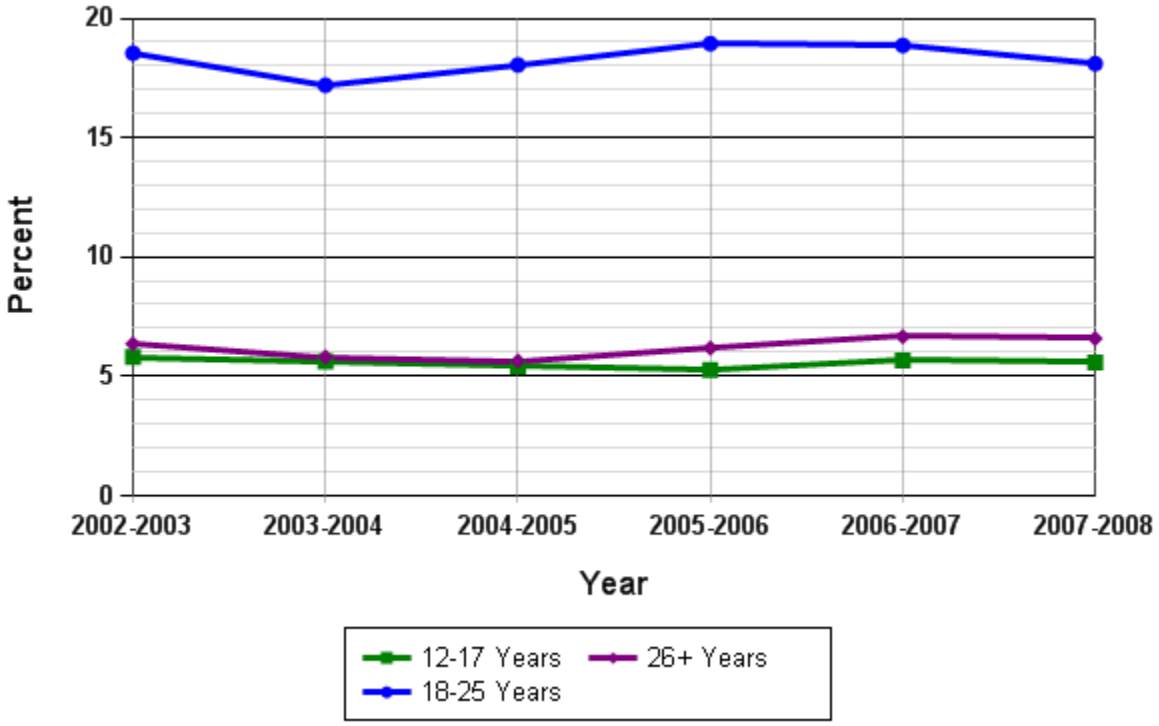
Variable Definition Figure 3: Percent of women aged 18 and older reporting average daily alcohol consumption greater than one drink per day Percent of men aged 18 and older reporting average daily alcohol consumption greater than two drinks per day.

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC)

Alcohol Consequences

As demonstrated below, young adults in Ohio are consistently presenting high rates of alcohol abuse and dependence (Figure 4). Ohio also presented a high national ranking in alcohol abuse or dependence. Combined with the apparent gap in services within this age group (See figures 5 and 5a), it is evident that this population deserves significant attention.

Figure 4: Alcohol Abuse or Dependence in Past Year among Persons Aged 12+



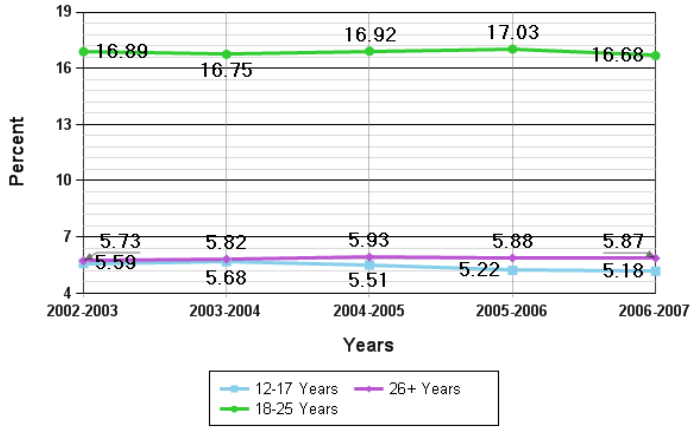
Abuse and dependence are clinical terms used to characterize patterns of alcohol use associated with significant social, psychological, and physical problems for the user and/or others that may be negatively impacted by the user.

Variable Definition Figure 4: Percent of persons aged 12 and older meeting DSM-IV criteria for alcohol abuse or dependence

Data Sources: National Survey on Drug Use and Health (NSDUH)

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association.

Figure 5: Needing but Not Receiving Treatment for Alcohol Use, by Age in US

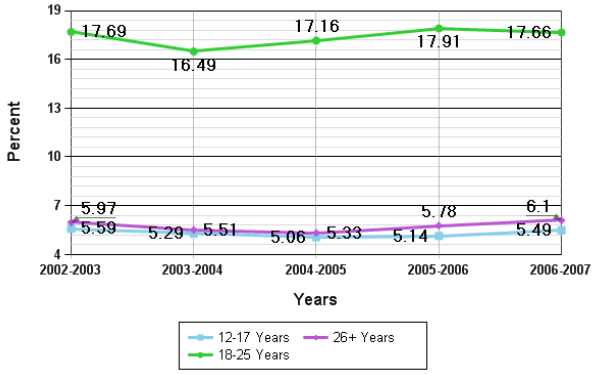


As can be seen here, the nationwide treatment gap for alcoholism is more prevalent among individuals between the ages of 18 and 25, and remains relatively stable over time. Given that Ohio's rate of alcohol abuse or dependence has remained above the national average for the past six years, with a slight decline in 2003-2004, the treatment gap for alcoholism among members of the 18 to 25 year old age group is viewed as a high priority within the state.

Variable Definition Figure 5: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for alcohol, but not receiving treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

Data Source: National Survey on Drug Use and Health (NSDUH)

Figure 5a:Needing but Not Receiving Treatment for Alcohol Use, by Age in Ohio



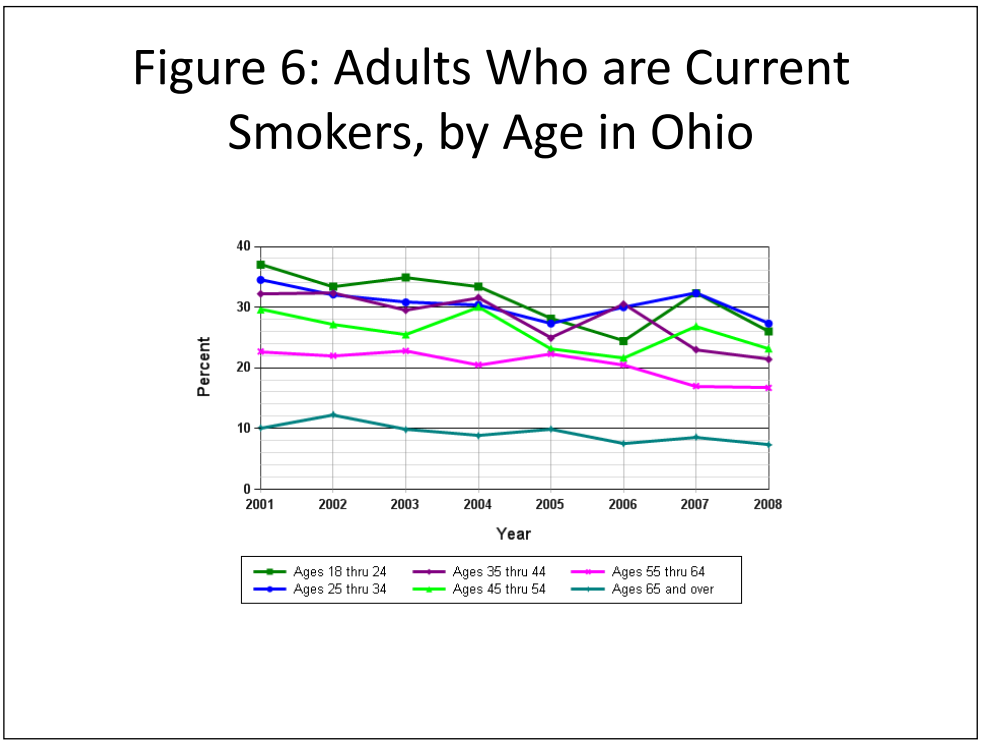
As can be seen here, the treatment gap for alcoholism within Ohio is more prevalent among individuals between the ages of 18 and 25, and remains relatively stable over time. In addition, Ohio's rate of alcohol abuse or dependence within this age group has remained above the national average for the past six years, with a slight decline in 2003-2004. Therefore, the treatment gap for alcoholism among members of the 18 to 25 year old age group is viewed as a high priority within the state.

Variable Definition Figure 5a: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for alcohol, but not receiving treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

Data Source: National Survey on Drug Use and Health (NSDUH)

Tobacco Consumption

More than 400,000 deaths each year are attributed to cigarette smoking, making it the leading preventable cause of death in the United States. Despite recent efforts to reduce tobacco sales through increased taxes and statewide media campaigns, tobacco consumption continues to be of concern within the state of Ohio. While Ohio's cigarette sales rate has declined significantly since 2001, cigarette consumption rates remain above the national average. Young adults within Ohio report high rates of current cigarette (See Figure 7) and current smokeless tobacco consumption. In addition, the percent of high school students who reported smoking a whole cigarette before age 13 remained at or above the national average between 1999 and 2007. Current smokers are highly prevalent among young adults (Figure 6).



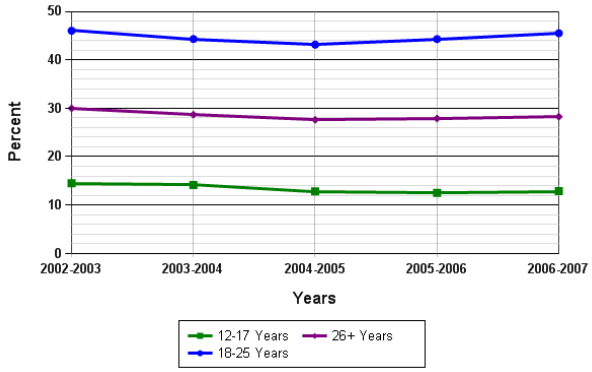
Within Ohio, current smoking is highly prevalent among individuals between the ages of 18 and 34. This trend continued despite a decline among 18 to 24 year olds since 2001. Smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease. The decrease in daily use of cigarettes during the early 2000's has slowed, and figures have remained relatively stable since 2004.

Variable Definition Figure 6: Percent of adults aged 18 and older who report smoking 100 or more cigarettes in their lifetime and also now smoke cigarettes every day or on "some days".

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC) at http://www.thecommunityguide.org/tobacco/index.html.

National Center for Health Statistics Health, United States, 2008 With Chartbook Hyattsville, MD: 2009. From http://www.cdc.gov/nchs/data/hus/hus08.pdf#063.

Figure 7:Cigarette Use in Past Month, by Age in Ohio



Smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease. More than 400,000 deaths each year are attributed to cigarette smoking, making it the leading preventable cause of death in the United States. Within Ohio, current smoking is highly prevalent among individuals between the ages of 18 and 25, with Ohio numbers remaining approximately 5% above the US average. According to NSDUH, this trend has remained relatively stable since 2002-2003.

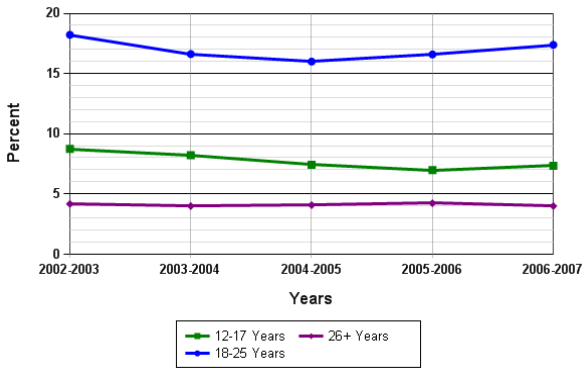
Variable Definition Figure 7: Percent of persons aged 12 and older reporting smoking a cigarette on one or more days within the past 30 days

Data Source: National Survey on Drug Use and Health (NSDUH)

Illicit Drug Consumption

Within Ohio, the illicit drug data were similar to those related to alcohol consumption and related consequences. Specifically, the marijuana (See Figure 8) and cocaine (Figure 9) consumption rates among young adults between the ages of 18 and 25 remained above other age groups. In addition, young adults demonstrated high rates of non-medical use of pain relievers (See Figure 10). Therefore, the limited amount of available data on this topic does demonstrate a need for increased prevention efforts among young adults in Ohio.

Figure 8: Marijuana Use in Past Month, by Age in Ohio

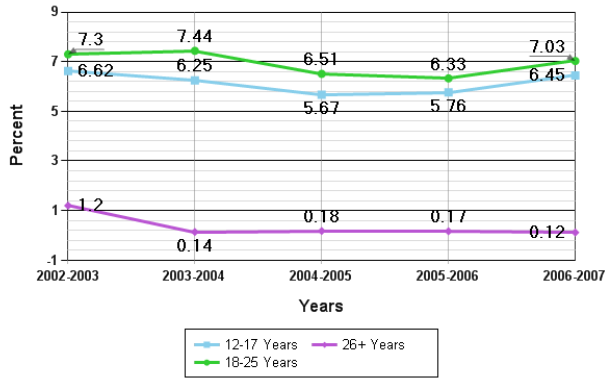


The use of marijuana can produce adverse physical, mental, emotional, and behavioral changes, and can be addictive. Health risks include respiratory illnesses, memory impairment, and weakening of the immune system. Of all illicit drugs within Ohio, marijuana had the highest rate of past year dependence in 2007. Marijuana use among 18 to 25 year olds has been on the rise since 2004-2005, and current marijuana use is more prevalent within this age group than young adolescents or adults.

Variable Definition Figure 8: Percent of persons aged 12 and older reporting any use of marijuana within the past 30 days.

Data Sources: National Survey on Drug Use and Health (NSDUH)
http://oas.samhsa.gov/nsduh/2k7nsduh/2k7results.cfm#Ch

Figure 8a: First Use of Marijuana, by Age in Ohio

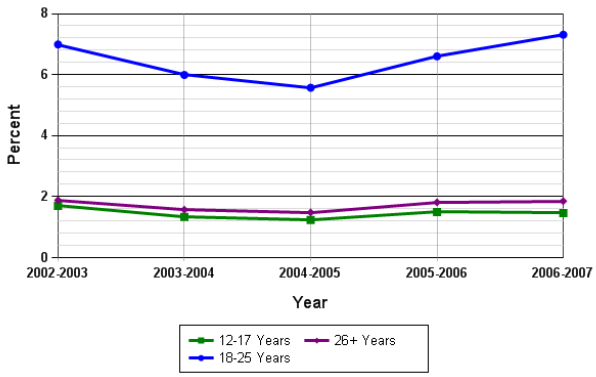


Initiation of marijuana use at young ages, especially in pre-adolescence, has been linked to more intense and problematic levels of use of marijuana and other illicit drugs in adolescence and adulthood. Early initiation of use may also present a direct, negative effect upon physical health in adulthood.

Variable DefinitionFigure 8a: *Average annual rate* = $100*\{[X_1 \div (0.5 * X_1 + X_2)] \div 2\}$, where X_1 is the number of marijuana initiates in past 24 months and X_2 is the number of persons who never used marijuana. Both of the computation components, X_1 and X_2, are based on a survey-weighted hierarchical Bayes estimation approach. Note that the age group is based on a respondent's age at the time of the interview, not his or her age at first use.

Data Sources: National Survey on Drug Use and Health (NSDUH)
Ellickson, P. L., D'Amico, E. J., Collins, R. L., & Klein, D. J. (2005). Marijuana use and later problems: When frequency of recent use explains age of initiation effects (and when it does not). Substance Use & Misuse, 40, 343-359.

Figure 9: Cocaine Use in Past Year, by Age in Ohio



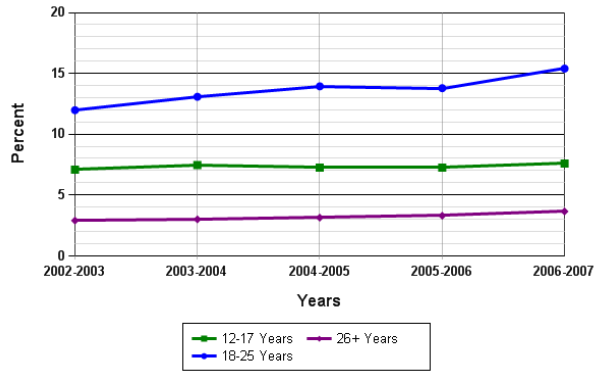
Cocaine use can result in serious negative health consequences and the substance is highly addictive. Physical symptoms may include chest pain, nausea, blurred vision, fever, muscle spasms, convulsions, coma and death. Within Ohio, cocaine use in the past year is on the rise among 18 to 25 year olds, who remain above other age groups for all years examined here.

Variable Definition Figure 9: Percentage of respondents who reported using cocaine within the past year.

Data Sources: National Survey on Drug Use and Health (NSDUH)

U.S. Drug Enforcement Administration (2009). Cocaine. Retrieved 10/28/09 from http://www.justice.gov/dea/concern/meth.html.
Drug Enforcement Administration, U. S. Department of Justice. (2005). Drugs of Abuse. Retrieved 10/28/09 from www.dea.gov.

Figure 10: Non-Medical Use of Pain Relievers in Past Year, by Age in Ohio



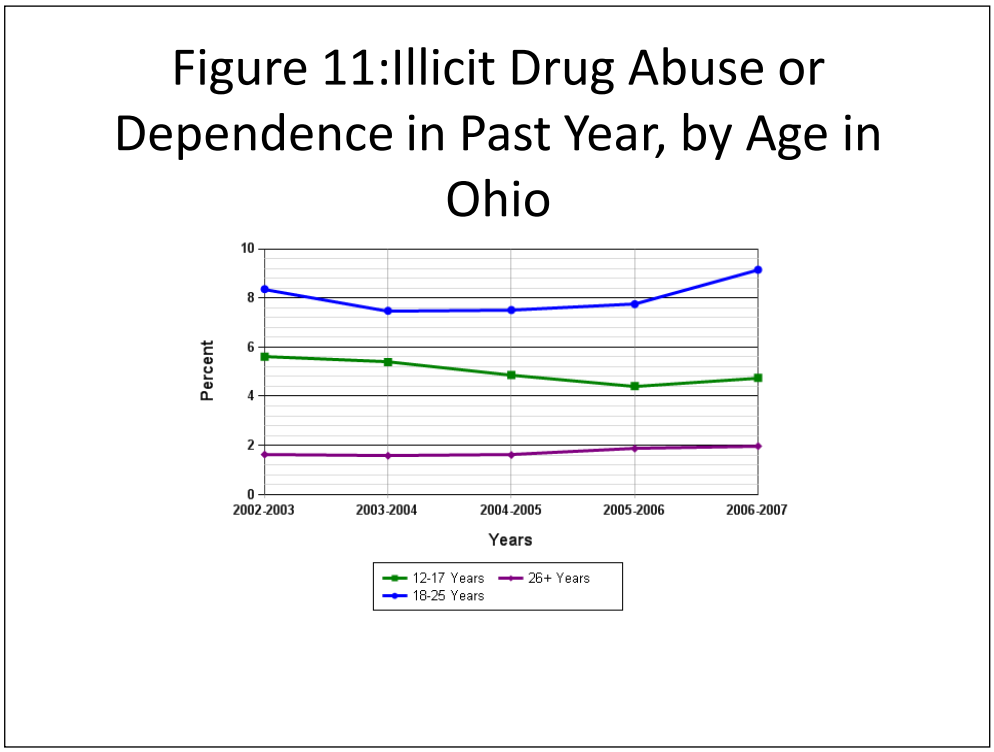
The abuse of several classes of prescription drugs, including pain relievers, depressants and stimulants, is currently on the rise both within Ohio and nationwide. Within Ohio, the non-medical use of pain relievers among 18 to 25 year olds has maintained a steady climb since 2002, and remained above other age groups for all years examined here. The long-term use or abuse of prescription drugs is more common among individuals with a history of alcoholism, and carries threats of addiction, dependence and withdrawal. Without proper treatment and observation, withdrawal from depressants and opioids can be fatal.

Variable Definition Figure 10: Abusable legal products include prescription drugs (pain relievers, tranquilizers, stimulants, and sedatives) and inhalants (amyl nitrate, cleaning fluids, gasoline, paint, and glue).

Data Sources: National Survey on Drug Use and Health (NSDUH)

McCabe, S. E., Cranford, J. A., & Boyd, C. J. (2006). The relationship between past-year drinking behaviors and nonmedical use of prescription drugs: Prevalence of co-occurrence in a national sample. Drug and Alcohol Dependence, 84, 281-288.
McCabe, S. E., West, B. T., Morales, M., Cranford, J. A., & Boyd, C. J. (2007). Does early onset of non-medical use of prescription drugs predict subsequent prescription drug abuse and dependence?: Results from a national study. Addiction, 102, 1920-1930.

Illicit Drug Consequences



Abuse and dependence are clinical terms used to characterize patterns of drug use associated with significant social, psychological, and physical problems for the user and/or others who may be negatively impacted by the user. When compared with other age groups, individuals between the ages of 18 and 25 demonstrate the highest drug abuse and dependence rates within Ohio. With the exception of a slight decrease between 2002 and 2007 for individuals aged 12-17, the rates of abuse and dependence have not changed significantly in recent years.

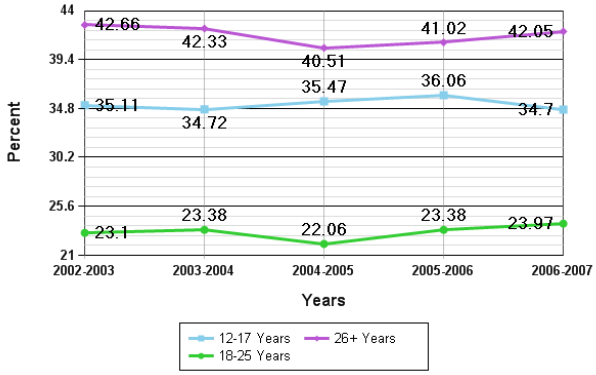
Variable Definition Figure 11: Percent of persons aged 12 and older meeting DSM-IV criteria for drug abuse or dependence

Data Sources: National Survey on Drug Use and Health (NSDUH:http://oas.samhsa.gov/nsduh/2k7nsduh/2k7results.cfm#Ch7)

Causal Factors

Alter, Lohrmann and Greene (2006) recently reported that past month marijuana use is negatively correlated with perceived harm from marijuana use, particularly among young adults. Therefore, as perceived risk of marijuana use (See Figure 12) increases, the likelihood of use and first use decreases. Similar results have been found in relation to cigarette use (Halpern-Felsher, et al., 2004, See Figure 13) and binge drinking (See Figure 14).

Figure 12: Perception of Great Risk of Smoking Marijuana Once a Month, by Age in Ohio

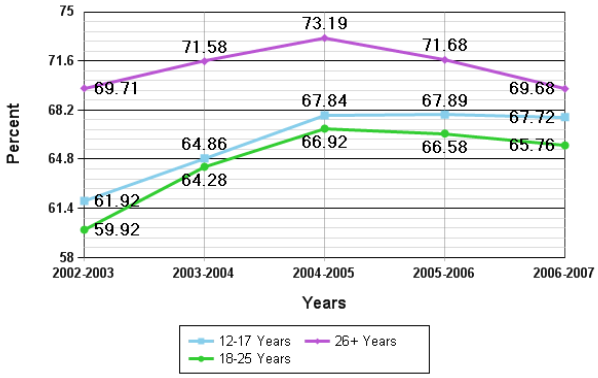


Variable Definition Figure 12: Response categories for the Perception of Risk questions include "No risk," "Slight risk," "Moderate risk," and "Great risk." The estimates in this table correspond to persons reporting "Great risk." Respondents with unknown Perception of Risk data were excluded.

Data Sources: National Survey on Drug Use and Health (NSDUH)

Alter, R. J., Lohrmann, D. K., & Greene, R. (2006). Substitution of marijuana for alcohol: The role of perceived access and harm. Journal of Drug Education, 36(4), 335-355.

Figure 13: Perceived Risk of Smoking One or More Packs of Cigarettes per Day, by Age in Ohio



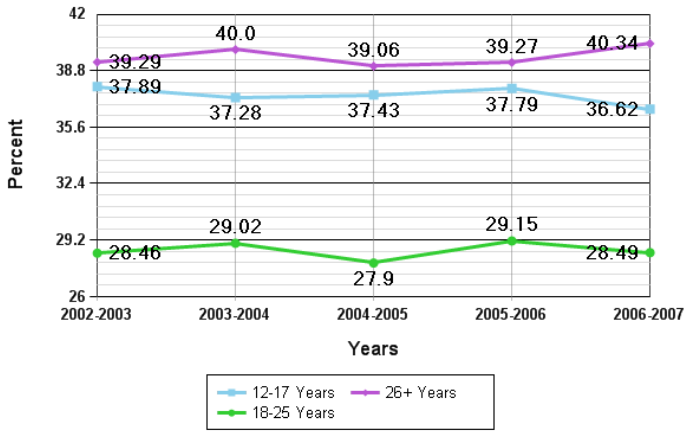
Halpern-Felsher, et al. (2004) suggested that adolescents' beliefs regarding their risk of developing an illness related to smoking had a direct impact upon their intentions to smoke or avoid smoking in the future. Similarly, Weinstein, Marcus, and Moser (2005) found that current smokers tended to underestimate their likelikhood of developing a chronic illness as a result of smoking.

Variable Definition Figure 13: Response categories for the Perception of Risk questions include "No risk," "Slight risk," "Moderate risk," and "Great risk." The estimates in this table correspond to persons reporting "Great risk." Respondents with unknown Perception of Risk data were excluded.

Data Sources: National Survey on Drug Use and Health (NSDUH)

Halpern-Felsher, B. L., Biehl, M., Kropp, R. Y., & Rubinstein, M. L. (2004). Perceived risks and benefits of smoking: Differences among adolescents with different smoking experiences and intentions. Preventative Medicine, 39, 559-567.
Weinstein, N. D., Marcus, S. E., & Moser, R. P. (2005). Smokers' unrealistic optimism about their risk. Tobacco Control, 14, 55-59.

Figure 14: Perception of Great Risk of Binge Drinking, by Age in Ohio



Binge drinking, as indicated by consumption of five drinks or more within a short time span, is strongly associated with injuries, motor vehicle crashes, violence, fetal alcohol syndrome, chronic liver disease, and a number of other chronic and acute conditions. Men are more likely than women to participate in binge drinking, and the prevalence of binge drinking declines with age.

Variable Definition Figure 14: A higher perceived risk is associated with a lower prevalence in binge drinking.

Data Sources: National Survey on Drug Use and Health (NSDUH)
Morbidity and Mortality Weekly Report (MMWR), 2008; 57(49); 1333. Quickstats: Percentage of adults aged =18 years who consumed five or more alcoholic drinks in 1 day at least once in the preceding year, by sex and age group--National Health Interview Survey, United States, 2007. From http://www.cdc.gov/mmWR/preview/mmwrhtml/mm5749a6.htm.

Data Limitations

NSDUH Data

State-level estimates for most states are based on relatively small samples. Although augmented by model-based estimation procedures, estimates for specific age groups have relatively low precision (i.e., large confidence intervals). The estimates are provided directly by SAMHSA and raw data that could be used for alternative calculations (e.g., demographic subgroups) are not available. The estimates are subject to bias due to self-report and non-response (refusal/no answer).

BRFSS Data

BRFSS is a telephone survey subject to potential bias due to self-report, non-coverage (households without phones), and non-response (refusal/no answer). Estimates for subgroups may have relatively low precision (i.e., large confidence intervals), due to small sample size.

YRBSS Data

As of 2005, weighted representative samples were available for only 40 states. Not all states participate, and some participating states do not provide representative samples. YRBSS is a school-based survey, so students who have dropped out of school are not represented. It is also subject to bias due to self-report, non-coverage (refusal by selected schools to participate), and non-response (refusal/no answer). Estimates for subgroups may have relatively low precision (i.e., large confidence intervals). The Youth Risk Behavior Surveillance System (YRBSS) and Youth Tobacco Survey (YTS) were primary sources for data regarding consumption rates and related consequences among school age children and adolescents within Ohio and the US. The substantial sample sizes for these studies allowed SEOW to include comparisons across gender, race, and grade level. SEOW reviewed the data, and did see some trends related to race. SEOW then presented this data to the SPF-SIG committee, which reviewed all YRBSS and YTS-related graphs. After a close evaluation of the data at the federal and state levels, the SPF-SIG committee suggested that due to the youth sample, the trends related to these indicators could not be tied to a particular drug across the lifespan. As this is a primary goal of the SPF, the YRBSS and YTS data were no longer viewed as secondary to NSDUH and ODH data, which included all age groups.

ODH Mortality/Morbidity Data

Because data collection and analysis at the county and state levels generally require 1 to 2 years, there may be a lag of several years between changes in behavior and population mortality. The stability of this indicator is directly related to the size of the population in which these deaths occur. Therefore, this indicator may be unstable for less populated states and counties that have low numbers of annual deaths, especially when used for demographic subgroups. There also is variability in the procedures used within and across each state to determine cause of death. In addition, trend data regarding alcohol and drug-related mortality and morbidity were gathered from the Ohio Department of Health (ODH), analyzed, and presented to the SPF-SIG committee. After a close evaluation of the data at the state and county levels, the SPF-SIG committee

determined that the trends related to these indicators could not be tied to a particular drug at the regional or state levels.

Uniform Crime Reports
Reported violent crimes are reported under the total number of actual violent crimes. No information on the perpetrator is available to determine if they have been drinking or to disaggregate these data by demographic subgroups. Estimates of the percentage of crimes attributable to alcohol are derived primarily from self-reports of incarcerated perpetrators of the crimes. The percentage actually attributable to alcohol may vary across geographic units. Although most police departments do report UCR data, there are a few jurisdictions each year for which data are not provided. The data regarding ATOD-related crime, mortality, and morbidity indicators were analyzed and graphed by members of SEOW. Specifically, the uniform crime reports were grouped according to violent and property crimes, and trend data were presented according to crime rate per 100,000 population.

Taking the above limitations into account, the data demonstrated the need for a focus upon the state's young adult population. Recently, individuals aged 18 to 25 within Ohio are consistently showing higher rates of use when compared with other age groups. While other demographic categories, such as race/ethnicity, school type and gender, do demonstrate between-group differences, the consumption data shown here are the only available state-level data which are relevant to ATOD use across the lifespan. The SPF-SIG aims to provide data-driven, community-level change across the lifespan. In addition, the SPF-SIG committee suggested that reducing ATOD consumption among young adults within Ohio would, in turn, reduce the impact of ATOD-related mortality and morbidity within the target population. Therefore, the members of ODADAS and the SPF-SIG Committee agreed that implementing change within the 18 to 25 age group was relevant to the current needs of Ohio's population.

County Level Data Collection
Several factors were considered in the review of the Board and Prevention Provider's current capacity to collect, analyze and report on data, including the consistency and accuracy of data collected in the past, current funding and staffing capacity and research facilities or universities within a particular Board areas and/or region. There are only a few areas across the State, mostly urban, that possess an abundance of resources that enable them to more effectively assess their community needs, plan for services and evaluate what has been implemented. All Boards and Prevention Providers currently utilize the Prevention Investment Planning and Reporting (PIPAR) System for data entry and as a tool for responding to state and federal reporting requirements. They also have the ability to compile this data into standardized reports to track the provision of services to meet their needs. Some of the larger, more urban areas possess the human and financial resources that have allowed them to conduct data collection via surveys and focus groups to monitor prevention efforts in their area.

However, the majority do not currently have the funds or the capacity to create new programs necessary to perform continuous data analysis regarding the unique consumption patterns of the 18-25 age group. Some of the smaller rural areas have utilized local universities and/or depended on other community member's expertise to assist in their data collection efforts. There are varying levels of capacity across the five regions of the state. Based on past

performance, current staffing and data collection, and the young adult population within each Board area, it is estimated that 28 of Ohio's 50 Boards could collect and analyze data at a level crucial to the maintenance of the SPF SIG. In addition, the 29 federally funded drug free community coalitions, as a requirement from the Office of National Drug Control Policy – are required semi-annually to collect and report on data for their community-specific initiatives through the Coalition Online Management and Evaluation Tool (COMET).

Although the Alcohol Drug Addiction Mental Health Services/Alcohol Drug Addiction Services (ADAMHS/ADAS) Boards have been transitioning to more data-centered approaches, many of them have not yet received training in SAMHSA's Strategic Prevention Framework (SPF), and tend to have limited experience in using public health approaches to achieve population change.

Data Monitoring

As mentioned above, SEOW has made extensive efforts to collect, display and describe data from other state departments relevant to ATOD consumption and consequences. Similar efforts have been made at the county level, with mixed results. ODADAS maintains a close relationship with the regional Alcohol and Drug Addiction Services (ADAS), Community Mental Health (CMH), and Alcohol, Drug Addiction and Mental Health Services (ADAMHS) boards within Ohio. Each board will be an asset to ODADAS in assessing their communities' ability to collect, analyze and report data. ODADAS is currently conducting a survey with both board members and Ohio's Family and Children First members to assess existing data collection processes. In addition, SEOW is currently collecting and analyzing data provided by the Hospital Council of Northwest Ohio. This county level consumption and consequence data can provide information regarding trends within the counties of Ohio's northwestern region, and could potentially be valuable to several SPF-SIG sub-grantees. Upon receiving reports from the county boards through survey data, the state SEOW will review the data for relevance to current National outcome measures (NOMs), and run appropriate analyses. Upon completion, the appropriate figures will be reported to SAMHSA. Finally, the SPF-SIG Program Manager/Project Coordinator, SEOW, trainers and evaluators will all work together closely with county board members to assure valid and reliable data collection and reporting.

Prioritization Process

An Expert Prevention Panel (EPP) was originally convened in an effort to support the ongoing efforts of Ohio's Prevention SIG project by providing technical oversight and expertise regarding emerging research and evaluation as these apply to Ohio's efforts. As this group was already working toward similar goals, they were asked to serve as Ohio's State Epidemiological Outcome Workgroup (SEOW).

This group was comprised of the following individuals:

Dr. David Andrews, The Ohio State University
Dr. Robert Carlson, Epidemiologist, Wright State University
Dr. Zili Sloboda, Epidemiologist, University of Akron
Dr. Robert Suefert, Miami University
Dr. Randi Love, The Ohio State University
Dr. Donald Wagner, University of Cincinnati

Dr. Dennis Moore, Wright State University
Dr. Molly Laflin, Bowling Green State University
Dr. Lesli Johnson, Ohio University
Dr. Robert Indian, Epidemiologist, Ohio Department of Health
Dr. Anu Sharma, Central Center for the Application of Prevention Technologies (CCAPT)

The SPF-SIG Project aims to provide data-driven, community-level change across the lifespan. ODADAS staff and the SPF-SIG Committee agreed that the processes aimed at implementing change must be evidence-based, and data must be collected using reliable and valid measures.

In an effort to identify valid data-driven indicators of alcohol and other drug consumption within Ohio, the SPF-SIG committee met over several months and reviewed the data. The goal of the committee was to thoroughly review and discuss available consumption and consequence data, and reach a consensus among committee members regarding the SPF-SIG priorities.

Continuing the work of the State Epidemiological Outcome Workgroup (SEOW) is vital to Ohio's ability to target scarce resources, assess the cost/benefit of current and proposed programs and policies, and wisely invest new resources. The SEOW began collecting and analyzing consumption and consequence data at the state and county levels in 2006. In an effort to identify relevant indicators of ATOD consumption and related consequences, SEOW members reviewed the processes and current data of prior SEOW cohorts to identify instruments and indicators relevant to SAMHSA's required NOMs. Next, SEOW members assessed a social indicator modeling study completed in 2001 by members of The Ohio State University College of Social Work. SEOW members reviewed 40 indicators from this study, and chose several indicators deemed relevant to ATOD consumption within Ohio. These findings were then presented to the Interagency Prevention Panel (IPP), and approved for inclusion in the SEOW dataset. SEOW also consulted other state departments in an effort to gather data relevant to the project. Several State departments contributed to the effort, including the Ohio Department of Health, Ohio Department of Development, Ohio Department of Public Safety, and the Ohio Department of Job and Family Services. SEOW collected population data from the US Census Bureau, and used the results to calculate age-adjusted rates for several indicators of ATOD-related morbidity and mortality.

In addition to the social indicator modeling study, the members of SEOW gathered data from several nationwide and state-level surveys relevant to ATOD consumption and consequences. Some surveys which were included in the dataset are listed below:

- National Survey on Drug Use and Health (NSDUH)
- Youth Tobacco Survey (YTS)
- Youth Risk Behavior Surveillance System (YRBSS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- The Substance Abuse Mental Health Services Administration's State Epidemiological Data Set (SEDS)

Upon collection, the data were placed into manageable files and graphed for display on Ohio's SEOW website. The website design team displayed trends via line graphs, allowing the

workgroup members to monitor change over time, while comparing rates of counties and state-level consumption and consequences. County data were also displayed by region, assisting in the comparison of any particular county to counties with similar populations.

Criteria and Rationale for the SPF-SIG Priorities

Social indicator data are key components of a comprehensive needs assessment process (Fiorentine, 1994) in part because they are objective and easily obtained (and updated) without the costs or barriers associated with conducting surveys. Social indicators also can be useful tools for defining high-risk groups for community-based prevention interventions (Feinleib, 1998). Additionally, information contained in social indicators often cannot be captured reliably through a survey. The indicators to be included will be drawn from the 13 risk factors and their 40 associated social indicators shown through a three year project conducted by the SAMHSA-funded Six-State Consortium to have strong correlations with rates of adolescent substance abuse and risk factors measured through surveys. Given the relatively low cost of collecting social indicators as compared to survey data, a number of states have used such data as an important part of systems that can inform effective preventive programming (University of Arizona College of Public Health, 2003).

Because the use of social indicator data by itself has limitations (Cagle and Banks, 1986; Gruenwald, 1997; Morgenstern, 1998), additional information about needs, resources, and readiness will come from a mixture of new and existing survey data. Ohio historically has implemented a large variety of surveys both statewide and in local communities and the needs and resource assessments made use of the substantial information already collected. Prevalence indicators were extracted from national and state survey data sets including but not be limited to the following: U.S. Census Bureau data, National Survey on Drug Use and Health data and sub-state regional estimates, Youth Risk Behavior Surveillance Survey (YRBSS), Behavior Risk Factor Surveillance Survey and ODADAS' SFY 2006-2007 Budget Survey. ODADAS also utilized the Behavioral Health Module data, the component of the client information system that contains sociodemographic data and data elements used to respond to NOMs and MACSIS prevention data.

Prior to meeting with the SPF-SIG committee to choose the focus of the SPF-SIG project at the state level, members of the SEOW workgroup and ODADAS collected data regarding several consumption and consequence indicators at the national, state and county levels. These indicators provided SEOW with a comprehensive picture of alcohol, tobacco and other drug consumption and related issues within Ohio. Several of the indicators came from state and nationwide school surveys directly related to ATOD consumption, and overseen by the Center for Disease Control. Among these surveys, the Youth Risk Behavior Surveillance Survey (YRBSS) was chosen due to its extensive coverage of alcohol, tobacco and other drug consumption among high school students. In addition, the YRBSS also addresses risk behaviors which can contribute to increase in mortality and morbidity among young adults of high school age. Finally, the YRBSS has been conducted within Ohio since 1992. For these reasons, the YRBSS is an excellent resource for the SEOW and other groups wishing to depict ATOD consumption and consequences at the state level. YRBSS indicators and data which are relevant to SEOW and the SPF-SIG are presented in a series of tables below.

The data did not reveal apparent consumption trends in relation to school type or grade level within Ohio. The Youth Tobacco Survey (YTS), which collects similar consumption data from students grades 6 through 12, has often yielded results in conflict with the YRBSS. In addition, as YRBSS data does not view consumption across the lifespan, it was considered inadequate as a primary data source for SPF-SIG. Therefore, the SEOW workgroup sought to supplement YRBSS data with other nationwide data sources relevant to ATOD consumption.

The Behavioral Risk Factor Surveillance System (BRFSS) was also a source for SEOW data regarding ATOD consumption at the state level. Through the Ohio Department of Health, Ohio has provided state-level data to the BRFSS phone survey since 1984. Of the several BRFSS indicators which are collected on a yearly basis, SEOW members decided to collect and analyze trend data regarding binge drinking, current drinking and heavy drinking among adults and adults who are current smokers.

While the Center for Disease Control surveys have been primary to the SEOW dataset, survey data and administrative data from ODADAS sister agencies have also served as data sources for the state and county-level mortality and morbidity indicators. Memorandums of Understanding were developed with administrative data source organizations to facilitate annual updates of the compendium. This process allowed the state and county profiles to be updated annually where data was available. ODADAS, ADAMHS/ADAS Boards and Providers are also working to address the prevention needs of existing, new, emerging and hard to reach populations in culturally competent and relevant ways. Ohio has significant African American, Somali, Latino, Asian, Appalachian and Amish population groups. In an effort to assess the needs of Ohio's large cultural population groups, the SEOW has gathered mortality and morbidity data available. As Ohio's increasingly diverse population grows, the ongoing need for data as it relates to various population groups is critical to building capacity within Ohio's communities. As Ohio continues to engage its diverse populations, we recognize the value and importance of cultural competence as an essential thread to be woven throughout Ohio's SPF SIG project and how vital it is for successful project implementation.

As Ohio's increasingly diverse population grows, the ongoing need for AOD providers to be adequately trained remains to be a priority for the state. Cultural and linguistic competence is fundamental to evidence-based prevention and is critical to meeting the diverse needs of all Ohioans. ODADAS recognizes the need to be more inclusive in engaging Ohio's culturally diverse populations in prevention planning, coalition participation, and access to services; however, there is no formal or comprehensive approach to ensure that all components and levels of the Ohio prevention system are providing culturally appropriate prevention services, ensuring that prevention protocols and administration is culturally relevant and optimizing inclusion of these disparate populations in the system.

Through a technical assistance request to CSAP ODADAS is currently working with Dr. Edwin Nichols to develop a draft Cultural Competence State Plan with its partners to be implemented in the prevention system at the State (ODADAS) and county levels (county boards, coalitions, and funded prevention providers). The development and implementation of this cultural competence plan will inform the successful implementation of Ohio's SPF SIG project. It will assist SPF SIG project staff as they work to make sure cultural competence is a common thread throughout

the project and ultimately build the skills and capacity of the AOD prevention workforce as they continue to engage Ohio's diverse populations.

The SPF-SIG Committee was established in March of 2010. ODADAS presented the SEOW data to the committee, and began discussions to build a consensus among committee members regarding Ohio's SPF-SIG priorities. The Committee requested and received additional data and reconvened on April 9, 2010. Small groups consisting of at least one board representative, one provider, and one "other" representative reviewed the data received and presented on the SEOW website, and identified the need to focus on 18-25 year olds. The following questions were addressed within the discussion:

1. What evidence-based policies, programs and practices exist that have strong evidence of reaching this audience and having an impact?
2. Accessibility of the young adult population within Ohio: How do we reach them?
    a. Comparing young people who are employed vs. young people who are college students-many young people fit into both categories. It is necessary to have sufficient access to both groups when considering comparisons.
    b. Some young people continue to live at home while "working their way" through college at a nearby college; others live at residential campuses, but some of these are employed. Factors that influence youth who live on residential campuses (whether they work part-time or not) are different from factors that influence youth who live at home and commute to college.
3. If the strategies for reaching this audience will need to rely heavily on media campaigns, is there evidence that even strong media campaigns can make a difference with this age group?

The groups discussed and posted their suggestions for the larger group and further discussed to establish consensus.

The committee clarified the following points:

1. Cultural competence is worked into every process of the SPF. The state will be responsible for providing training to sub-recipient grantees on cultural competence as part of the state level plan
2. Sub-recipients must identify and understand the sub-populations within the 18 to 25 year old age group (ethnic groups, college vs. non-college, employed vs. non-employed, living with parents vs. living on their own, rural vs. urban, etc.).
3. The focus would be placed upon an age group. The communities will select alcohol and or other drugs based upon their data.
4. Working with sub-recipient grantees is an important step toward thoroughly incorporating cultural competence beyond a surface level within the SPF process.
5. Choosing the priority of 18 to 25 year olds would allow the 16 to 20 year old age group to be addressed if the communities identified the need, as work with 16 and 17 year olds could affect data on 18 to 19 year olds over time, and the university/college freshmen could be addressed if that was the need within the community.

6. The project needs to remain focused on infrastructure and capacity development rather than the strategies and programs.

With this clarification, the SPF-SIG Committee came to a consensus on the priority of the SPF-SIG project: 18 to 25 year olds consumption of alcohol and other drugs.

The decision to focus on 18-25 year old consumption of alcohol and other drugs as the priority for Ohio's SPF-SIG project is strongly supported by the National Survey on Drug Use and Health (NSDUH) data, which consistently demonstrated high levels of use within this age group across several substances. However, there are several indicators of both ATOD consumption and related consequences which are not directly addressed by the NSDUH data. Ohio recognizes that we have data collection gaps in the state prevention infrastructure. The consumption and consequences indicators in which we have limited data are shown in the table below.

Data Gaps, Ages 18 to 25	
Consumption	Consequences
Current Heroin Use	FASD
Current MDMA Use	Unemployment Rate
Current Cocaine Use	Poverty Rate
Current Illegal Injection Drug Use	Homicide
Current Inhalant Use	Suicide
Current Steroid Use	Alcohol-related Motor Vehicle Crashes
	Persons Living with HIV/AIDS

II. ASSESSING THE SYSTEMS

Current State Infrastructure

The Single State Authority (SSA) in Ohio overseeing alcohol and other drug prevention and treatment efforts is the Ohio Department of Alcohol and Drug Addiction Services (ODADAS). ODADAS has been serving Ohio citizens with a comprehensive approach to alcohol and other drug (AOD) addiction treatment and prevention since its inception in 1989. ODADAS, one of 23 cabinet-level agencies in the executive branch of the State government, is responsible for the administration and oversight of the prevention portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. ODADAS has the distinction of being one of the few cabinet-level state AOD departments in the country. Ohio recognizes the importance of addressing alcohol and drug abuse by maintaining ODADAS as a separate agency for maximum visibility.

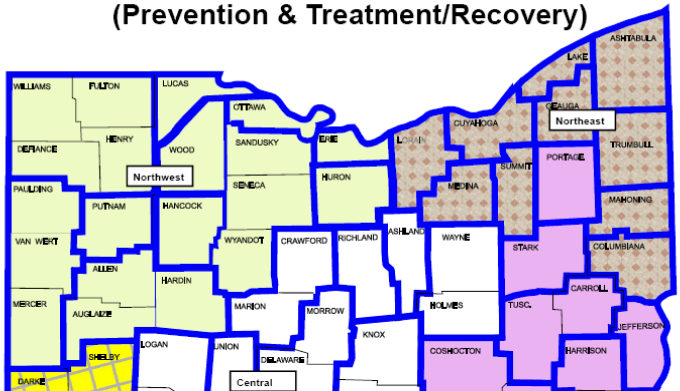
ODADAS' mission is to provide statewide leadership in establishing a high quality addiction, prevention, treatment and recovery services system of care that is effective, accessible and valued by all Ohioans. The vision is an addiction-free Ohio that promotes health, safety, and economic opportunity. ODADAS plans, initiates and coordinates an extensive system of services designed to prevent abuse and treat Ohio's addicted populations.

Ohio has a relatively unique approach to its alcohol and other drug (AOD) services. The Department, by statute Amended Substitute House Bill 317 (Am. Sub. H.B. 317), coordinates the alcohol and other drug services of state departments, the criminal justice system, law enforcement, the legislature, local programs and treatment/prevention professionals. When House Bill 317 was signed into law, it also mandated that counties create a board to oversee alcohol and other drug prevention and treatment at the local level. Ohio's publicly funded system for AOD services are state supervised and administered at the county level by ADAMHS/ADAS boards. ODADAS allocates federal and state funding to combined county level ADAMHS Boards or stand alone ADAS Boards. As units of local government, these boards determine local needs, plan and contract for services, monitor local provider agencies and issue provider payment. ADAMHS/ADAS Boards do not provide direct services. Ohio now has a total of fifty county boards, (three Alcohol Drug Addiction Services [ADAS] Boards and forty-seven Alcohol Drug Addiction Mental Health Services [ADAMHS] Boards).

The Department has 106 full-time staff with expert knowledge, values and skills in the prevention and treatment of alcohol and other drug use, abuse and addiction. Contracts with state colleges and universities and nationally recognized consultants assist with research and evaluation activities. ODADAS is organized into divisions representing the key administrative and programmatic functions of the Department.

Prevention is a priority in Ohio and the Division of Prevention Services supports a regional structure that allows for a more collaborative and consistent prevention system. The Division consists of the Chief, Prevention Manager, SPF SIG Prevention Manager/Project Coordinator, 5 Regional Prevention Coordinators and the CSAP Fellow. The five Regional Prevention Coordinators serve the statewide system by providing technical assistance, oversight, networking, and other prevention resource support. A primary focus for the Regional Coordinators, as subject matter experts (SME), is to assist in fostering relationships with county ADAMHS/ADAS Boards and local prevention providers to increase capacity to reduce barriers and address needs and gaps in services. The SPF SIG Prevention Manager/Project Coordinator will be working closely with the Regional Coordinators to provide training, technical assistance and support to local ADAMHS/ADAS Boards sub-recipient communities to develop capacity as they implement the SPF process.

ODADAS
ADAMHS/ADAS Board Regions
(Prevention & Treatment/Recovery)



The majority of the Department's funding for Prevention comes from the SAPT Block Grant prevention set aside in the amount of $17,442,755.. ODADAS also administers the Enforcing Underage Drinking Laws (EUDL) grant $350,000 from the Office of Juvenile Justice and Delinquency Prevention. Before this year, 2010, the Department also administered the U.S. Department of Education Governor's Portion of the Safe and Drug Free Schools and Communities Act funds in the amount of $2.1 million.

Ohio's publicly funded system, for AOD services, is state supervised and administered at the county level by ADAMHS/ADAS boards. ODADAS allocates federal and state funding to combined county level ADAMHS Boards or stand alone ADAS Boards. As units of local government, these boards determine local needs, plan and contract for services, monitor local provider agencies and issue provider payment. ADAMHS/ADAS Boards do not provide direct services.

ODADAS was formed with the passage of Amended Substitute House Bill 317 which brought together alcohol prevention and treatment efforts administered by the Ohio Department of Health and the Ohio Department of Mental Health and also established the Governor's Advisory Council on Alcohol and Drug Addiction Services (GAC). The purpose of the GAC is to review the development of the comprehensive statewide plan for alcohol and drug addiction services, revisions of the plan, and other actions taken by the Department and shall act as an Advisory Council to the Director of ODADAS. The GAC is comprised of representatives of key state departments involved in alcohol and other drug prevention and treatment, local prevention and treatment providers, county drug and alcohol board directors and representatives of state organizations addressing alcohol and other drug issues. GAC members are appointed by the Governor for a two year term. State departments and offices represented include:

Ohio Department of Education
Ohio Department of Commerce/Liquor Control
Office of Criminal Justice Services
Ohio Department of Rehabilitation and Correction
Ohio Department of Health
Ohio Department of Mental Health
Office of the Attorney General
Ohio National Guard

Ohio Department of Public Safety
Ohio Department of Youth Services
Ohio Department of Alcohol and Drug Addiction Services (non-voting)

The GAC has five standing committees (Medicaid and Finance, Outcome, Rules and Policy, Planning and SPF-SIG) that meet as necessary to advise and make recommendations that will assist the Department in addressing its priorities and accomplishing its strategic goals. The various agencies on the GAC, participating in the SPF SIG subcommittee, are committed to taking prevention to the next level with the aid of SPF SIG resources.

The SPF-SIG Committee is a multi-disciplinary assembly chosen to represent Ohio's wide range of diversity, including the various unique racial and ethnic populations as well as geographical areas unique to Ohio. The Committee's roles are to oversee the implementation of the SPF-SIG, work in collaboration with the SEOW and the ODADAS Evidence Based Practice workgroup (EBP), develop timelines for the completion of the SPF strategic plan, and to approve the strategic plan. The Ohio SPF-SIG Committee will act as a guiding body for the SPF-SIG and ensure that the framework set forth in the strategic plan is implemented. The members of the SPF-SIG committee include representatives from the following:

Ohio Department of Alcohol and Drug Addiction Services
Ohio Department of Education
Ohio Department of Mental Health
Ohio Department of Health
Ohio Department of Rehabilitation and Corrections
Ohio Department of Public Safety
Governor's Office of Faith Based Initiatives
Urban Minority Alcohol and Drug Abuse Outreach Programs
Center for Substance Abuse Prevention
Ohio National Guard
Community Prevention Providers
Institutes of Higher Education
ADAMHS/ADAS Boards

Capacity for State Level Implementation

The work of the GAC has enhanced collaboration and communication across the member agencies. The efforts of these key stakeholder agencies, their available resources and how each agency will support SPF implementation is discussed below.

The Ohio Departments of Education, Health, Mental Health, Public Safety and Rehabilitation and Corrections will be integral in the implementation of the SPF SIG. The existing collaboration at the state level around community coalitions, data collection/sharing and behavioral health will help promote natural linkages at the community level and opportunities for capacity building. Once communities identify their priority within the 18-25 year old population, each entity will have the opportunity to play a role. The Department of Education provides assistance to those communities who choose to impact the age group by working with high school students. Mental Health provides assistance to those who choose to look at the overlap of mental health and substance abuse disorders, and Health will continue their work with data collection/sharing and the partnership with the SEOW. Public Safety is also a partner in data sharing, and their Investigative Unit has the potential to play a large role in working with SPF SIG sub-recipients as they implement environmental strategies focusing on alcohol permits, compliance checks and other enforcement policies. As Ohio focuses its efforts on 18-25 year old consumption of alcohol and other drugs Ohio Department of Rehabilitation and Corrections will also serve as a data resource to assess not only how many 18-25 year olds are currently

incarcerated, but also to help locate the re-entry population in an effort to provide prevention services to them.

The Ohio Departments of Commerce and Job and Family Services will also provide SEOW with annual data regarding the per capita sales of hard liquor within both the state and Ohio's individual counties and with county and state-level data regarding poverty and unemployment rates, children in poverty, and child abuse and neglect rates. All of these indicators are directly related to substance abuse, and can be used to monitor the effect of the SPF-SIG process within Ohio's communities.

The Governor's Office of Faith Based Community Initiatives (GOFBCI) supports nonprofits and community organizations through capacity building activities and training. Their involvement along with the Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP) Federation will assist in fostering relationships with the faith based and minority communities. The UMADAOPS will play a significant role with Ohio's SPF SIG project because of the culturally relevant evidence based and promising practices programming they provide in African-American and Latino communities. As sub-recipient communities work to infuse cultural competence throughout the implementation of the SPF process these partners will provide resources through education, training and technical assistance that will strengthen communities and help to ensure sustainability after funding has ended. Drug Free Action Alliance will assist the implementation of the SPF process as subject matter experts in the areas of coalition building and underage drinking. Their expertise will benefit both the SPF SIG Committee and the SPF SIG sub-recipients.

ODADAS works closely with the Ohio National Guard (ONG) Drug Demand Reduction Program (DDR). A part of Ohio's SPF SIG project will be a requirement for all sub-recipients to have a member of the ONG (if there is a base in their area) as a member of their community coalition. The ONG will assist sub-recipient communities in finding a representative and continue to be a key partner and subject matter expert in assisting communities to address the needs of the military population.

Central State University (CSU) and Ohio University (OU) will serve as resources and subject matter experts regarding the 18-25 year old targeted population for the SPF project. Not only will they be able to provide demographics and statistics on the target population but CSU as a historically black university can offer a cultural perspective and knowledge base that can be utilized as a resource for Ohio's training team to ensure the delivery of culturally appropriate training for this target population as well. OU's implementation of the Coalition Advocating Responsible Drinking Decisions (CARDD) has had success in implementing environmental strategies with the SPF SIG identified priority population (18-25 year olds) and this will prove to be a valuable resource to sub-recipient communities as they move through the SPF process.

Ohio University is also a member of the Network Addressing Collegiate Alcohol and Other Drug Issues. This Network is a national organization that proactively addresses the issues of alcohol, other drugs, and violence in order to promote healthy campus environments through self-regulatory initiatives, information dissemination, and technical assistance. As a member of this group, OU has the ability to access resources across the nation related to substance abuse

prevention efforts with college age youth. The Network Addressing Collegiate Alcohol and Other Drug Issues., also has begun to develop relationships with the state representatives from the National Prevention Network (NPN) to strengthen their efforts nationally. The Ohio Coordinator for the Network is also a member of the SPF SIG Committee and will play an integral role in helping the sub-recipient communities gain access to information related to the priority population.

With the creation of the ODADAS Office of Workforce Development and Cultural Competence, strengthening of training resources and development of the prevention workforce are being addressed through the provision of training, workshops and conferences for Ohio's AOD professionals. WFDCC also works closely with the Ohio Credentialing Board (OCB) to enhance the credentialing process to ensure it is realistic, achievable and reflects the core competencies needed by the prevention workforce. As of October 2009, Ohio has 423 Registered Applicants (RA), 111 Ohio Certified Prevention Specialist I, and 246 Ohio Certified Prevention Specialist II.

Through workforce development and partnerships throughout the state level modeling relationships and offering assistance at the community level, Ohio is ready to successfully implement the SPF-SIG.

Barriers/Economic Gaps

Ohio has a significant need for an enhanced prevention infrastructure to increase its capacity to implement, sustain and improve substance abuse prevention services at both the state and community levels. Recent budget reductions have impacted the progress the state has made in building AOD prevention capacity. The Department faced reduction in state funds in SFY 2008 and 2009. In February 2008, ODADAS reduced costs by approximately $2.7 million and $1.1 million in SFY 09, for a total General Revenue Fund (GRF) reduction of $3.8 million. In September 2008, the GRF funds for ODADAS were reduced an additional 4.75%, or $2,050,016 for the remainder of SFY 2009. Additionally, the loss of the Governor's portion of the Federal Safe and Drug Free Schools and Communities Act funds in the amount of $2.1 million, resulted in a loss of 60 programs that will not be funded across the state.

Based on the experience of past collaborative efforts, one gap in the current state level infrastructure is the lack of ongoing, timely and effective communication with collaborative partners. Multi-directional communication between the state, SPF-SIG Committee, sub-recipient communities, collaborative partners, project staff and workgroups is the key to successful implementation of this project. Several communication strategies have been identified to address this barrier, including developing a user-friendly web-page specific to the Ohio SPF-SIG project on the ODADAS website, quarterly electronic newsletters, on-line prevention training and events calendar, quarterly SPF-SIG Committee meetings, on-site sub-recipient visits and providing SPF process training and coaching to support communities in their efforts. Utilizing these strategies will help us to address the gaps in our current state level infrastructure.

ODADAS recognizes there is limited cultural representation for many of our coalitions. The focus of the SPF process to incorporate cultural competence throughout all phases will assist in

addressing this issue through increasing community awareness and a requirement to ensure coalition membership represents the sub-populations within the 18 to 25 year old age group (ethnic groups, college vs. non-college, employed vs. non-employed, living with parents vs. living on their own, rural vs. urban, etc.) of the community selected by the sub-recipients.

The inconsistent structure of community level prevention planning, with 50 ADAMHS/ADAS Boards across the state, may also act as a barrier within our system. Currently there is no one model or method utilized by all 50 ADAMHS/ADAS Boards. To begin the standardization of state and community level prevention planning and implementation a multi-level capacity building model will begin with an initial training phase to prepare the state partners, ODADAS project management staff, regional prevention coordinators ADAMHS/ADAS Board, and sub-recipient communities to carry out the work of Ohio's SPF SIG. Specific topics will include: the SPF five-step process, prevention research, theories, evidence-based approaches, leadership, systems development, coalition development, sustainability, cultural and linguistic competence and accessing AOD prevention through technology.

Workforce development is a challenge for prevention in Ohio and may impact the implementation of the SPF-SIG. Recruitment is a significant problem for AOD professional because of a lack of standardized education pathways and retention is a concern because of the rate of turnover for prevention professionals. Due to the economic times and limited dollars available for training and continuing education our workforce does not always have the opportunity to access resources to remain current on prevention practices. This coupled with the aging workforce in prevention provides unique circumstances when looking at workforce development issues.

The SPF SIG will provide the opportunity for Ohio's AOD prevention system to address identified needs and gaps in services.

County Level Infrastructure

ODADAS and ADAMHS/ADAS Boards share a partnership in running Ohio's alcohol and other drug prevention and treatment system. Across the state, a full continuum of AOD services is provided by 360 providers with 900 programs offering prevention, treatment and recovery support services. In October 2006, Prevention Standards were implemented in the state of Ohio requiring all agencies providing direct prevention services to be certified. To date ODADAS has 193 certified prevention agencies. This system will be utilized to implement the SFP-SIG.

Ohio's publicly funded system for AOD services are state supervised and administered at the county level by ADAMHS/ADAS boards. ODADAS allocates federal and state funding to combined county level ADAMHS Boards or stand alone ADAS Boards. As units of local government, these boards determine local needs, plan and contract for services, monitor local provider agencies and issue provider payment. ADAMHS/ADAS Boards do not provide direct services. ODADAS allocates a portion of the SAPT Block Grant funds to the ADAMHS/ADAS Boards on a per capita/needs basis. Some boards also receive local funding through property tax levies. ADAMHS/ADAS Boards are required by Ohio law to prepare and submit to ODADAS and/or ODMH a plan for the provision of alcohol, drug addiction and mental health services in its service area. These plans are reviewed in collaboration by both Departments. Federal

requirements that are attached to state block grant dollars regarding allocations and priority populations also influence community planning. In essence the community plan helps to guide the AOD services for county ADAMHS/ADAS Boards.

County Prevention System Effectiveness

Ohio's alcohol and other drug abuse system is built on the understanding that communities are most knowledgeable of their own needs. The ADAMHS/ADAS Boards system provides the structure for planned response to community needs, however each area varies in resources and capacity. Although ADAMHS/ADAS Boards are required by Ohio law to prepare and submit to ODADAS and/or ODMH a plan for the provision of alcohol, drug addiction and mental health services in its service area there is not a standardized process for local assessment and planning that use multi-sector community system approaches to plan and implement courses of action. Utilizing the SPF model will assist counties in having a more standardized process. Although the implementation and outcomes may look different in varying counties, the SPF process utilized will be consistent. The community plans will help ADAMHS/ADAS Boards and their partner coalitions determine if Ohio SPF SIG project priorities are in line with the current service needs of their area.

The SPF SIG will provide the opportunity for Ohio to further develop its substance abuse prevention infrastructure in partnership with other state and community organizations. This opportunity will result in the capacity for Ohio's AOD prevention system to enhance data driven planning, increase use of evidence based programs, policies and practices, heighten cultural competence, increase focus on sustainability, and address identified needs and gaps in services.

County Capacity to Implement the SPF

Ohio's community prevention infrastructure consists of a partnership where ADAMHS/ADAS Boards and AOD Providers work together as a collaborative system to assess community needs, plan and coordinate AOD prevention services that maximize resources on the local level. Because provider agencies are local, they have a better understanding of their communities' needs and of prevention programs, strategies, and services that are culturally appropriate for specific populations. In essence, they guide the process of how prevention services are implemented in the various communities across the state. Ohio historically has placed value on planning, outcomes, and research in the field of prevention and in turn ODADAS has assisted the Board and Provider infrastructure to increase their capacity regarding the core components of the SPF.

ADAMHS/ADAS Boards will be expected to identify a primary partner coalition with whom to submit the application. ADAMHS/ADAS Boards are encouraged to partner with an existing federally funded Drug Free Community Coalition (DFCC) if feasible for this project. If a federally funded DFCC exists in the Board area and is not chosen as a partner, the Board must provide rationale for their selection. It is the expectation that sub-recipients will work with existing AOD Community Coalitions or with AOD prevention providers to develop a new AOD Community Coalition to engage community sectors in the SPF process.

It will be expected that if there are multiple coalitions in the community to be served, the strength of the other coalitions be considered as potential to support the selected coalition.

Although one coalition will be selected for the SPF project, members from other coalitions could serve on the selected coalition to strengthen the ability to respond to the selected community.

Each of the sub-recipient communities will convene a local planning team comprised of 5-7 representatives from the 12 sectors of the community wheel to attend a five day training. This group will serve as the nucleus of the community planning team and will recruit additional community team members as the planning process moves forward. This group must include a ADAMHS/ADAS Board representative and an AOD prevention professional. This five day training will provide basic information on each step of the SPF to build an understanding of the process to prepare the group to engage members.

Sub-recipients will utilize SPF principles and guidelines to develop a comprehensive plan for an infrastructure that supports the implementation of the most effective, culturally and linguistically competent, and sustainable alcohol and other drug prevention programs, policies, and strategies. Sub recipients are required to follow the SPF model or they will not be funded.

Although the UMADAOPS of Ohio have been discussed in previous sections of the strategic plan, it is important to note that for over twenty years the UMADAOPs of Ohio have provided programming with the belief that substance abuse is best prevented and treated when the cultural dynamics of a group are addressed and included as part of the process. The UMADAOP Federation (comprised of the Executive Directors of 12 independent UMADAOP agencies) requested training from Central Regional Expert Team (RET) on the SPF in September 2009. Central RET provided a series of trainings to the UMADAOP Federation on the SPF process and the UMADAOP Federation completed the SPF training in May 2010. As sub-recipient communities begin moving through the phases of the SPF the UMADAOPs are available as a resource to provide culturally competent training and to assist communities to begin to think differently about how to effectively address the issues of substance abuse prevention in Ohio's African American and Latino populations. In addition UMADAOPs of Ohio convene an annual statewide conference to provide culturally competent training to Ohio's workforce to effectively address the issues of substance abuse prevention, treatment and recovery services that affect Ohio's African and Hispanic/Latino diverse populations.

As mentioned previously, Ohio has a rich history of coalition development. The Statewide Prevention Coalition Association (SPCA), the Ohio Center for Coalition Excellence and the Ohio College Initiative to Reduce High Risk Drinking all serve as additional community resources to assist sub-recipients in building community capacity. These three initiatives provide training, technical assistance and support to communities in their efforts to impact community norms; access and availability of alcohol, tobacco and other drugs; media messages; and policy enforcement issues on the local level. The focus of these groups are to help local communities increase capacity, increase use of environmental prevention strategies on a local level and foster drug free lifestyles.

SPCA, the Ohio Center for Coalition Excellence and the Ohio College Initiative to Reduce High Risk Drinking, all under Drug Free Action Alliance, have been essential to building community level capacity and expertise in Ohio. SPF SIG sub-recipients will have an opportunity to attend SPCA meetings to receive training resources and network with other coalitions throughout the

state. Through the Ohio Center for Coalition Excellence they will have the opportunity to attend trainings provided by national and state experts that will assist coalitions, strengthen their development and increase the impact within their community. This existing prevention infrastructure will prove to be a valuable resource for SPF SIG sub-recipient communities.

County Capacity to Collect, Analyze and Report Data

Several factors were considered in the review of the ADAMHS/ADAS Board and Prevention Provider's current capacity to collect, analyze and report on data, including the consistency and accuracy of data collected in the past, current funding and staffing capacity, and research facilities or universities within a particular Board areas and/or region. There are only a few areas across the State, mostly urban, that possess an abundance of resources that enable them to more effectively assess their community needs, plan for services and evaluate what has been implemented. Ohio does not currently have consistent statewide county level data available. The ADAMHS/ADAS Boards have differing levels of capacity based on access to resources, including monetary, technology and human.

The utilization of the Risk Tables to indicate community levels of risk focuses on statewide data available broken into regions. This allows each Board area to have a beginning for comparison. The Boards can also provide any additional data the community may have to indicate need specific to their target.

The sub-recipient grantees will be required to develop means of prevention data collection as part of the SPF process in order to develop their evaluation processes and to explore collection of data needed at the state and national levels. Each Board will be required to develop a Prevention Data Committee that is sustainable beyond the life of the grant.

The web based SPF-SIG application is in development. In the initial phase it will provide means to enter their GFA through a web portal, and submit quarterly progress as needed. This system is planned to develop into an expenditure reimbursement system. There will be discussion regarding the opportunity to collect outcome information utilizing this system however with the MRT, CLI and PLI system expectations in place it may not be reasonable to add another reporting process which may be duplicative.

All Boards and Prevention Providers currently utilize Ohio's Prevention Investment Planning and Reporting (PIPAR) System for data entry and as a tool for responding to state and federal reporting requirements. This same technology will be utilized for the collection of SPF SIG data. Both the PIPAR and newly developed SPF SIG application will enable sub-recipients to prepare standardized reports and extract data for customized reports.

Some of the larger more urban areas possess the human and financial resources that have allowed them to conduct data collection via surveys and focus groups to monitor prevention efforts in their area. However, the majority do not currently have the funds or the capacity to create new programs necessary to perform continuous data analysis regarding the unique consumption patterns of the 18-25 age groups. Some of the smaller rural areas have utilized local universities and/or depended on other community member's expertise to assist in their data collection efforts. There are varying levels of capacity across the five regions of the state.

Based on past performance, current staffing and data collection, and the young adult population within each Board area, it is estimated that 28 of Ohio's 50 Boards could collect and analyze data at a level crucial to the maintenance of the SPF SIG.

III. Criteria and Rationale for SPF SIG Priorities

Prioritization Process

Through a facilitated discussion, the SPF-SIG committee voted to focus Ohio's efforts on reducing alcohol and other drug consumption among young adults between the ages of 18 and 25. This priority was chosen through a consensus process following data presentations, a series of meeting's, discussions and personal reviews of the current data by members of the committee. At the ADAMHS/ADAS Board level, substance abuse related consequences data which displayed a direct relationship with young adults, such as needing but not receiving treatment, were factors in the final decision. The criteria and weighting process used to determine the State's areas of critical need are explained below.

Prevalence

Rate per 100,000 population was the standard measure for mortality and morbidity indicators, while consumption indicators were measured by percent. As SEOW relies strictly upon secondary data, the ways in which data are displayed are often not of our control. As previously stated, the majority of age-specific consumption data were collected from either the National Survey on Drug Use and Health (NSDUH) or the Behavioral Risk Factor Surveillance System. Therefore, consumption data is often presented in the form of percent of the total population. Such estimates are based upon weighted survey results.

Severity

Demographic categories such as age, gender, race and school year were included within this measure, and committee members were asked to identify areas of impact which were of interest to them. The committee members reviewed the SEOW website data for approximately two weeks, and reconvened to discuss their findings. The members of the committee agreed that many consumption indicators were of high severity for Ohio residents between the ages of 18 and 25, suggesting that alcohol and other drug consumption rates were of significant concern for this population. Specifically, binge alcohol use, alcohol abuse or dependence, and non-medical use of pain relievers were areas of concern within this population.

National Ranking

This measure was used as a tool for comparing Ohio consumption rates against those of other states, and the national average. Maintaining current data on national ranking was viewed as pertinent to the prioritization process. If Ohio's consumption rate was ranked particularly high among other states, particularly within a specific demographic or subpopulation, the weight of that subgroup was increased within the prioritization process. For example, this process revealed that Ohio's young adult population, between the ages of 18 and 25, was almost double the national average in 2008.

Trend over Time

Whenever possible, consumption data collected by Ohio's SEOW were gathered and displayed focusing on the past five to seven years, in order to demonstrate a trend. This method allowed SEOW members and others to visualize how long a particular issue had impacted members of a community. In addition, collecting data in this way allowed SEOW members to compare a community's trends over time with those of larger populations. Finally, trend data was collected to compare the consumption rates of subgroups within Ohio.

An ODADAS internal review of the SEOW data suggested that trend data should be weighted highest among all criteria when identifying prevention priorities for the State's SPF-SIG. After examining the available consumption and consequence data, members of the SPF-SIG committee agreed upon the importance of trend data, particularly when applied to consumption data.

Consumption Indicators for Individuals Ages 18 to 25 (NSDUH Data, 2007-2008)			
	Ohio Value (Percent)	Ohio's National Ranking	Compared to National Average
Illicit Drug Use in Past Month	19.62%	25th	Below
Marijuana Use in Past Year	28.74%	**19th**	Above
Marijuana Use in Past Month	16.84%	**16th**	Above
First Use of Marijuana	7.00%	22nd	Above
Illicit Drug Use Other than Marijuana in Past Month	7.87%	26th	Below
Cocaine Use in Past Year	5.83%	29th	Below
Nonmedical Use of Pain Relievers in Past Year	15.11%	**9th**	Above
Alcohol Use in Past Month	64.48%	22nd	Above
Binge Alcohol Use in Past Month	46.75%	**15th**	Above
Tobacco Product Use in Past Month	51.04%	**4th**	Above
Cigarette Use in Past Month	43.24%	**4th**	Above

Consequences Indicators Among Individuals Aged 18 to 25 (NSDUH Data, 2007-2008)			
	Ohio Value (Percent)	Ohio's National Ranking	Compared to National Average
Alcohol Dependence or Abuse in Past Year	18.10%	20th	Above
Alcohol Dependence in Past Year	7.70%	**19th**	Above
Illicit Drug Abuse or Dependence in Past Year	8.65%	**16th**	Above

Illicit Drug Dependence in Past Year	6.20%	**8th**	Above
Alcohol or Illicit Drug Dependence or Abuse in Past Year	22.13%	**19th**	Above
Needing but Not Receiving Treatment for Illicit Drug Use in Past Year	8.36%	**11th**	Above
Needing but Not Receiving Treatment for Alcohol Use in Past Year	16.92%	25th	Above

Perceptions of Great Risk Among Individuals Aged 18 to 25 (NSDUH Data, 2007-2008) Please Note: The higher the ranking, the better (opposite of consumption indicators)			
Indicator	Ohio Value (Percent)	Ohio's National Ranking	Compared to National Average
Perceptions of Great Risk of Smoking Marijuana Once a Month	22.01%	**33rd**	Below
Perceptions of Great Risk of Having 5 or More Alcoholic Drinks Once or Twice a Week	27.74%	**37th**	Below
Perceptions of Great Risk of Smoking One or More Packs of Cigarettes per Day	65.02	**44th**	Below

IV. Description of SPF SIG Priorities

SPF SIG Priorities

The SPF-SIG Committee made the decision to focus efforts on 18-25 year old consumption of alcohol and other drugs as the priority for Ohio's SPF-SIG project. This focus would allow communities to choose the specific substances which presented the greatest impact among the lives of young adults within their area. This decision was strongly supported by age-specific, state level consumption data provided by both the National Survey on Drug Use and Heath (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS), which demonstrated both increased consumption levels and insufficient prevention services among young adults within Ohio.

Determination of Priority

The SPF-SIG Committee met regularly over a period of two months to help define SPF-SIG priorities for the state of Ohio, and confirm the variables and related data used to measure these priorities over time. Upon discussion of the data presented by the Ohio SEOW, the SPF-SIG

committee members chose to focus the state-level SPF-SIG efforts upon reducing alcohol, and other drug consumption among individuals between the ages of 18 and 25. This decision was strongly supported by the National Survey on Drug Use and Health (NSDUH) and Behavioral Risk Factor Surveillance System (BRFSS) data, which consistently demonstrated high levels of use within this age group across several substances.

Several criteria were chosen to compare and contrast substance abuse-related problems at the state level. Trend data, which demonstrated relationships over time, was seen as a primary focus. Specifically, state and federal data were compared over time to identify potential problem areas within Ohio. In addition, such trend data demonstrated the magnitude of a consumption problem within the state, in comparison with the national average. At the county level, SEOW compared county and state rates for mortality and morbidity indicators. In addition, counties were grouped by region and compared with similar counties through regional data, to provide a more accurate picture. ATOD consumption and consequence data also suggested that young adults in Ohio were in need of additional prevention planning and services. In 2006, unintentional poisoning exceeded motor vehicle traffic crashes as the leading cause of unintentional injury in Ohio. This trend continued in 2007, alongside the increasing rate of nonmedical use of pain relievers. Finally, between-group comparisons were viewed as a method for tracking changes over time within demographic categories

Using these criteria, ODADAS asked the SPF-SIG committee members to identify the consumption and consequence indicators which would become the priorities of the SPF-SIG. After spending a week reviewing relevant social indicator and survey data, the SPF-SIG committee reconvened, discussed several options, and voted to focus upon AOD consumption within the 18-25 age groups. The demographics within Ohio were in striking support of this decision. In 2008, the United States Census Bureau estimated that 1,081,734 of Ohio residents were between the ages of 18 and 24. At almost double the national average, the size of this population, coupled with its high rates of drug and alcohol consumption in recent years, presents a significant problem for providers of alcohol and drug treatment services within Ohio.

CAPACITY BUILDING

I. Areas in Need of Strengthening

Although Ohio has a well established prevention system, there is a need for an enhanced prevention infrastructure to increase the capacity to implement, sustain and improve substance abuse prevention services at both the state and community levels. Through the SPF SIG, the prevention system will have access to further training and technical assistance. Areas to be strengthened include: enhanced cultural competence, communication, collecting and analyzing data and workforce development.

Cultural Competency

ODADAS recognizes the need to be more inclusive in engaging Ohio's culturally diverse populations in prevention planning, coalition participation, and access to services; however, there is no formal or comprehensive approach to ensure that all components and levels of the Ohio

prevention system are providing culturally appropriate prevention services, ensuring that prevention protocols and administration is culturally relevant and optimizing inclusion of these disparate populations in the system. ODADAS has requested CSAP technical assistance to develop a draft Cultural Competence State Plan with its partners to be implemented in the prevention system at the State (ODADAS) and substate levels (county boards, coalitions, and funded prevention providers). ODADAS has also inquired about other States and what has been done to implement cultural competency in their prevention systems at the State and substate levels. ODADAS has requested examples of agency cultural competence organizational assessments, and recommendations on how coalitions can attract community representatives from currently underrepresented diverse populations.

In many of Ohio's communities with high poverty rates and large minority populations there is a huge saturation of access points leading to increased vulnerability of minority youth. It is imperative that communities understand the risk this places on these youth and how to address the issue to decrease the risk.

The UMADAOPS will play a significant role with Ohio's SPF SIG project as subject matter experts in the area of cultural competence. The culturally relevant evidence based and promising practices programming they provide in African-American and Latino communities will be integral resources for communities. As sub-recipient communities work to infuse cultural competence throughout the implementation of the SPF process these partners will also provide resources through education, training and technical assistance that will strengthen communities and help to ensure sustainability after funding has ended.

Communication

In order for the AOD prevention system to function seamlessly there needs to be effective and efficient means of communication from the top to the bottom and from the bottom to the top. Multi-directional communication between the state, ADAMHS/ADAS Boards, and AOD Providers in the community is critical to ensure the effective planning and implementation of prevention services across the state. Due to the nature of the SPF process the Department is confident that this system of communication will improve.

Data Collection

Several factors were considered in the review of the Board and Prevention Provider's capacity to collect, analyze and report on data, including the consistency and accuracy of data collected in the past, current funding and staffing capacity and research facilities or universities within a particular Board areas and/or region. There are only a few areas across the State, mostly urban that possess an abundance of resources that enable them to more effectively assess their community needs, plan for services and evaluate what has been implemented.

All Boards and Prevention Providers currently utilize Ohio's Prevention Investment Planning and Reporting (PIPAR) System for data entry and as a tool for responding to state and federal reporting requirements. They also have the ability to compile this data into standardized reports to track the provision of services to meet their needs. Some of the larger more urban areas possess the human and financial resources that have allowed them to conduct data collection via surveys and focus groups to monitor prevention efforts in their area.

ADAMHS/ADAS Boards are moving toward more data-driven planning and are using outcome management, but continue to struggle with evaluation methods due to cost, lack of mechanization and the limited utilization of continuous quality improvement. The majority do not currently have the funds or the capacity to create new programs necessary to perform continuous data analysis regarding the unique consumption patterns of the 18-25 age group. Some of the smaller rural areas have utilized local universities and/or depended on other community member's expertise to assist in their data collection efforts. There are varying levels of capacity across the five regions of the state. Based on past performance, current staffing and data collection, and the young adult population within each Board area, it is estimated that 28 of Ohio's 50 Boards could collect and analyze data at a level crucial to the maintenance of the SPF SIG. Although the ADAMHS/ADAS Boards have been transitioning to more data-centered approaches, many of them have not yet received training in SAMHSA's Strategic Prevention Framework (SPF), and tend to have limited experience in using public health approaches to achieve population change.

Technical assistance on the sources, collection and use of community-specific data will be provided by SPF SIG project staff, contracted evaluators and trainers during the assessment phase of the SPF. Sub-recipient communities will have on-line access to the epidemiological profiles and the statewide needs assessment. The SPF Evaluation team will also provide technical assistance to the sub-recipient communities as they move through the assessment phase and develop their community strategic plan.

Workforce Development

Like many communities across the nation, Ohio has experienced budgetary reductions, loss of staff, and reduction of available services. As mentioned earlier the Workforce Development Project identified recruitment and retention as significant issues for the AOD workforce. Recruitment is a significant problem for AOD professionals because of a lack of standardized education pathways. Retention is a concern because of the rate of turnover for prevention professionals. Because of the economic times and limited dollars available for training and continuing education our workforce does not always have the opportunity to access resources to assist in staying current on prevention practices. This coupled with the aging workforce in prevention provides unique circumstances when looking at workforce development issues.

II. State and Community Level Capacity Building Activities

Training/Technical Assistance

To develop capacity at the state level all stakeholders involved in the initiative, ODADAS staff, SPF-SIG Committee, EBP, etc. will receive training on the SPF-SIG process provided by CSAP's Central Regional Expert Team. This training will be the foundation the SPF SIG Prevention Manager/Project Coordinator, Global Insight (the SPF SIG training team) and the Regional Prevention Coordinators utilize to strengthen existing stakeholder relationships and will support the system as we move forward. The Central RET will serve as a resource for the state and provide technical assistance as needed. The utilization of the SPF process will also increase system capacity by ensuring state and local resources are targeted to AOD prevention services that have been demonstrated to be effective.

To develop capacity at the community level, Ohio will utilize training, technical assistance and coaching to provide intense ongoing support to the sub-recipient communities for the duration of the project. This work will help to lay a solid foundation for the sub-recipient communities, to mobilize, promote and/or enhance existing locally driven drug-free community coalitions to address community AOD needs. Ohio's SPF-SIG supports a broad view of AOD prevention by focusing on both risk and protective factors and developmental assets related to substance abuse prevention. Through the development of community strategic plans, communities will identify target priority areas, intervening variables and contributing factors to address. Sub-recipient communities will be expected to use the information gathered in their needs assessment to focus on environmental strategies in their implementation plan.

In addition to the training resources identified above we have utilized our partnership with Central RET to build a cadre of Substance Abuse Prevention Specialist Training (SAPST) trainers and will utilize these trainers to provide training to the communities. We will be working to strengthen capacity at the community level. Specific plans for community level capacity building include; ongoing training and technical assistance for the sub-recipients, coalition members and other community stakeholders, development of a community planning team, strengthening of relationships across systems at the local level and ongoing effective communication to maintain support for the project.

Those communities who do not receive a sub-recipient grant will be provided the opportunity to develop capacity through training and technical assistance as part of the state wide system development.

State Infrastructure

ODADAS is the state designated agency to administer public funds for alcohol and other drug addiction prevention, treatment and recovery services in Ohio. The SPF-SIG Project Staff is housed in the Division of Prevention Services, however contracts with state colleges and universities and nationally recognized consultants assist with research and evaluation activities.

The Division Chief, as the Project Director, will provide general project oversight and guidance for the SPF SIG grant. In addition, she will provide senior level leadership and management to ODADAS staff, contract evaluation and training staff, facilitate the EBP Workgroup meetings, and the SPF-SIG Committee. She will be responsible for the overall administration of, implementation of, and federal reporting for the grant. The Prevention Manager/Project Coordinator will be responsible for the day to day processes of the grant project and will support all programmatic reporting requirements. She will work with staff to coordinate project activities, trainings, and communications among internal staff, contractors, and sub-recipients. The Prevention Manager/Project Coordinator will provide oversight of the Regional Prevention Coordinators' intensive SPF SIG work with sub-recipients in the field and oversee the statewide implementation of the SPF-SIG. The Prevention Managers will also support the Project Director with additional duties as needed and assigned. The ODADAS project staff will attend all mandatory meetings and conferences. The Regional Prevention Coordinators will be trained in the SPF process in order to provide quality technical assistance at the local level. They will work

intensively with sub-recipients in the field and assist with training sub-recipients as well as conduct site visits with the Boards and Providers in their regions.

The Prevention Services staff has extensive experience providing technical assistance and fostering relationships with ADAMHS/ADAS Boards and prevention providers throughout the state of Ohio. The statewide system is further served by the Regional Prevention Coordinators through technical assistance, oversight, networking, and other prevention resource support. The Department contracts with Ohio University to provide the evaluation and Global Insight as the 8 person training team for the project. The expertise of the ODADAS staff along with the evaluation and training subject matter experts, will lead Ohio forward as we move through the SPF process at the state and community levels.

The Division of Planning, Outcomes, and Research Chief will serve as the SEOW liaison and provide senior level oversight for the research, data collection, and evaluation efforts. The Planning and Research Administrator will serve as the liaison between the department and evaluators. He will also be responsible for coordinating the state and local level data collection and analysis in cooperation with the contract evaluator. ODADAS staff from the divisions of Management Information and Fiscal services will also be a part of the SPF Project team as necessary.

The state will utilize the SPF SIG training team, the Regional Prevention Coordinators, the evaluation team and the expertise from the Central RET to build and strengthen the capacity at the state level. Specific plans for State level capacity building include; ongoing training for the SPF SIG Committee and the EBP workgroup, strengthening of relationships with our partner state agencies, development of Memorandums of Understanding with data collection entities for data sharing and ongoing communication to maintain support and to share progress toward achieving goals of the project.

Community Infrastructure/Sub-recipients

While Ohio has a rich history of coalitions spread across the state geographically, the coalitions do not represent the diverse cultural groups of the entire state. ODADAS currently funds 18 AOD coalitions in 16 counties. Ohio has a total of 88 community coalitions that address ATOD. The funding sources vary and include: 18 ODADAS funded coalitions; 17 Higher Education Coalitions, 8 of which are funded through ODADAS; 29 Drug Free Community Coalitions (including 3 mentor); and 1 Weed and Seed coalition. The coalitions have varying degrees of experience in collecting, analyzing and reporting on data and will be instrumental in our implementation of the SPF process. The 29 federally funded Drug Free Community Coalitions (DFCC), as a requirement from the Office of National Drug Control Policy – have been trained on the SPF and are using this framework for their specific communities – which may not be county-wide. The DFCC's as part of local communities can provide support to the SPF-SIG regions in partnership with SPF-SIG Project staff.

ODADAS also supports the Statewide Prevention Coalition Association (SPCA), the Ohio Center for Coalition Excellence and the Ohio College Initiative to Reduce High Risk Drinking. SPCA provides venue for substance abuse prevention coalitions and other groups to advocate for policies related to substance abuse prevention. Both SPCA and the Ohio Center for Coalition

Excellence assist in working with coalitions in over 90 communities to build and enhance their local collaborative capacity to plan, implement, evaluate and sustain prevention strategies. These groups will continue to assist local communities increase their capacity to implement the phases of the SPF and to increase use of environmental prevention strategies to foster drug free lifestyles. Through these initiatives the Drug Free Action Alliance provides training, technical assistance and support to communities in their efforts to impact community norms; access and availability of alcohol, tobacco and other drugs; media messages; and policy enforcement issues on the local level.

Training and technical assistance will be continuous throughout the duration of Ohio's SPF to provide problem solving with communities and address the potential for staff changes at the state and community level. The Substance Abuse Prevention Specialist Training (SAPST) curriculum designed to provide both pre-service and in-service prevention professionals with up-to-date, evidence-based information was offered in Ohio in the spring of 2008. Through this and a SAPST TOT offered in 2009, Ohio now has 6 SAPST trainers who have assisted Central RET with training around the state and the Department is working on the possibility of providing the five day SAPST training at the annual Workforce Academy each year. In addition to the facilitation of the five day training, the six current SAPST trainers will also be utilized as we move through the phases of the SPF process. These trainers are a great resource and will be able to provide additional training and technical assistance to local communities. In addition, the UMADAOP's are available as a resource to provide culturally competent training to effectively address the issues of substance abuse prevention specifically as it relates to Ohio's African American and Latino populations. A professionally trained workforce is extremely important to the continuing improvement in substance abuse prevention services.

III. Role of the State Epidemiological Outcomes Workgroup

Role/Purpose

The purpose of the federal State Epidemiological Outcomes Workgroup (SEOW) initiative is to provide states and communities with data needed for planning, monitoring and evaluation purposes. The SEOW is responsible for the collection, analysis, and reporting of substance use incidence, prevalence and related data and National Outcome Measures (NOMs). The NOMs are a set of domains and measures which SAMHSA will use to meet all its statutory and Congressional reporting requirements. Substance abuse NOMs are drawn from many types of data including: substance use incidence and prevalence, related consequence data, and program process and output data. The SEOW is a critical component to enabling Ohio to report on NOMs and to address the Strategic Prevention Framework State Incentive Grant (SPF-SIG).The SPF-SIG provides a data-driven planning framework to assist in developing comprehensive plans to prevent substance abuse and reduce problems associated with substance abuse.

The SEOW has enabled the SPF-SIG committee to make valid, data-driven decisions during the identification of Ohio's SPF-SIG priorities.. The SEOW currently provides data at the national, state, regional and county levels and will continue to update data relevant to alcohol, tobacco, and other drug consumption and consequences. While the members of the SPF-SIG committee and the SEOW will continue to work to identify reliable and valid sources of secondary data, it is expected that the majority of consumption data at the state and national levels will be provided

by national surveys, such as the National Survey on Drug Use and Health (NSDUH), Behavioral Risk Surveillance System (BRFSS), and the Youth Risk Behavior Surveillance System (YRBSS). In addition, ODADAS will work to develop relationships with other data collection entities at the regional and county level as well as, Memorandums of Understanding (MOU's) with the Ohio Department of Health, Ohio Department of Job and Family Services, and the Ohio Department of Development regarding specific data needs. Such efforts will assist in providing the SEOW with age-specific consequence data at both the state and county level, whenever possible. As new data becomes available, it will be analyzed, graphed, and placed upon the SEOW website at www.odadas.state.oh.us/seow/.

Finally, the members of the SEOW will work in conjunction with the SPF-SIG evaluators to develop valid and reliable instruments for measuring consumption among 18 to 25 year old residents. Each instrument will be designed to meet the substance-specific needs and aims of the community in which it will be used.

Data Collection

Several state departments provided data regarding ATOD consumption within Ohio. In addition, state and federal surveys were reviewed as possible data sources for the State Epidemiological Outcomes Workgroup (SEOW)'s role in the Strategic Prevention Framework State Incentive Grant (SPF-SIG). The purpose of the federal State Epidemiological Outcomes Workgroup (SEOW) initiative is to provide states and communities with data needed for planning, monitoring and evaluation purposes. SEOW is responsible for the collection, analysis, and reporting of substance use incidence, prevalence and related data and National Outcome Measures (NOMs). The NOMs are a set of domains and measures which SAMHSA will use to meet all its statutory and Congressional reporting requirements. Substance abuse NOMs are drawn from many types of data including: substance use incidence and prevalence, related consequence data, and program process and output data. The SEOW is a critical component to enabling Ohio to report on NOMs and to address the Strategic Prevention Framework State Incentive Grant (SPF/SIG).The SPF/SIG provides a data-driven planning framework to assist in developing comprehensive plans to prevent substance abuse and reduce problems associated with substance abuse.

Indicators that met the SEOW inclusion criteria were categorized broadly by ATOD consumption and the consequences associated with alcohol, tobacco, or illicit drug use. Consumption indicators include age of initiation, lifetime use, current use, and high-risk use. Consequences of use include mortality and morbidity data, measures of abuse and addictive disorders, and crime related indicators. Contextual indicators from the RTI study that measure community instability and family-related factors (e.g., teen-birth rate, divorce, and child-abuse or neglect) comprised another set of measures used for the Ohio epidemiological profile. While the relationship between such indicators and ATOD consumption is at times inconsistent, Sanchez, Dunteman, Kuo, Yu, and Bray (2001) suggested that the above demographic and contextual measures should be monitored closely in an effort to evaluate the impact of ATOD use on Ohio's population.

SEOW has enabled the SPF/SIG committee to make valid, data-driven decisions during the prioritization of Ohio's SPF/SIG. Throughout the remaining years of the SPF/SIG grant, SEOW

will provide several services to both the state and counties which receive SPF/SIG funds. To begin, the SEOW will continue to update data relevant to alcohol, tobacco, and other drug consumption and consequences. SEOW currently provides data at the national, state, regional and county levels. While the members of the SPF/SIG committee and SEOW will continue to search for reliable and valid sources of secondary data, it is expected that the majority of consumption data at the state and national levels will be provided by national surveys, such as the National Survey on Drug Use and Health (NSDUH), Behavioral Risk Surveillance System (BRFSS), AND Youth Risk Behavior Surveillance System (YRBSS). In addition, SEOW will work to develop more specific data contracts with the Ohio Department of Health, Ohio Department of Job and Family Services, and the Ohio Department of Development. Such efforts will help to provide SEOW with age-specific consequence data at both the state and county level, whenever possible. As new data becomes available, it will be analyzed, graphed, and placed upon the SEOW website at www.odadas.state.oh.us/seow/.

While the Center for Disease Control surveys have been primary to the SEOW dataset, survey data and administrative data from ODADAS sister agencies have also served as data sources for the state and county-level mortality and morbidity indicators. Memorandums of Understanding were developed with administrative data source organizations to facilitate annual updates of the compendium. This process allowed the state and county profiles to be updated annually where data was available. ODADAS, ADAMHS/ADAS Boards and Providers are also working to address the prevention needs of existing, new, emerging and hard to reach populations in culturally competent and relevant ways. Ohio has significant African American, Somali, Latino, Asian, Appalachian and Amish population groups. In an effort to assess the needs of Ohio's large cultural population groups, the SEOW has gathered mortality and morbidity data available.

SEOW Membership Expansion

The Department is currently taking steps to increase the membership of the SEOW to include members of other state departments with a specific interest in data analysis and epidemiological research. In the future years of the SPF-SIG, ODADAS will continue to strengthen the work of the SEOW through these partnerships. In conjunction with the SPF-SIG committee, the SEOW will identify sources which could provide age-specific data that remains in line with the goals of the SPF-SIG. Furthermore, the SEOW will utilize existing relationships with fellow state agencies to acquire current, age-specific consumption and consequence data.

PLANNING

I. Planning Model

To allow sufficient funding for sub-recipients to successfully implement the SPF process, Ohio expects to fund between 10 – 15 applicants. Utilizing our local infrastructure responsible for system planning, ODADAS will allot funds through a competitive grant process. Applications will be made available to all ADAMHS/ADAS Boards, requiring that they demonstrate their need and ability to address the identified priority utilizing the SPF process.

II. Allocation Approach

Ohio will use a competitive Guidance for Applicants (GFA) grant process for distributing funds to address 18-25 year olds consumption of alcohol and other drugs. SPF-SIG funds will be awarded to approximately 10-15 sub-recipient communities.
The allocation model is a grant based model following the steps below:

- GFA developed, approved by CSAP, and sent via e-mail to all ADAMHS/ADAS Boards and posted on ODADAS website
- Bidder's conference held to share all relevant information pertaining to the SPF process and the grant submission
- ADAMHS/ADAS Boards work with selected prevention provider/coalition to develop and input the grant application into the ODADAS web based system
- Application reviewed by an internal review team
- Recommended applicants are presented to SPF SIG Committee for approval
- ODADAS Director approval and Notice of Award (NOA) is released

Funding Sub-recipients
Selection of sub-recipient grantees will occur based on the review criteria identified below:

*SPF SIG Grant Application Review	Available Points (100)
Project Abstract	15
Target Population	10
Statement of Need	10
Coalition Capacity	10
Implementation Plan	20
Sustainability	10
Data Collection	5
Connection to Community Prevention Plan	5
Budget	10
Budget Narrative	5

**See GFA attached (Appendix B)*
An additional five criteria were selected as priority measures to strengthen the selection of SPF-SIG grantees: Capacity to Collect Data, Level of Risk, Inclusion of Under-Represented Populations, Capacity to be Successful, and Sustainability.

The State considered *capacity to collect data* as a primary measure for sustainability throughout the SPF-SIG and years following the grant. As part of this capacity, the scorers will look for the community's plan to implement a readiness survey to gain understanding of the community's current population, and needs. In addition, community readiness would be demonstrated though a grantee's current capacity to implement change among young adults within their community. Specifically, the grantee is expected to demonstrate this knowledge through a well-defined plan of action to identify current resources within the community. Within this criterion, an applicant will not be judged based upon the amount or quality of the resources which their community currently possesses, rather on their ability to identify the resources and gaps in their identified community and their knowledge of the current situation.

The second criterion is *level of risk*. The reviewers will utilize risk charts prepared by the SEOW as a means of measuring this criterion. The reviewers will give additional weight to applicant communities if they are above the state average for consumption indicators and below the state average for perception of risk. Should the applicant identify two or more substances to address, the community's relation to the state average within the applicable risk charts will be given equal weight.

The scoring for level of risk will utilize the Risk Tables provided with the GFA. The Risk Tables were developed from National Survey on Drug Use and Health (NSDUH), data related to Ohio's priority. The ADAMHS/ADAS Boards are listed using the NSDUH regions for reporting data, with many Board areas combined to provide a sample large enough for valid comparison. We are using this data, recognizing Ohio does not currently have consistent statewide county level data available. We expect to develop our data collection capacity through this SPF-SIG opportunity. The scoring process for priority criterion, level of risk, allows 20 point for the area. With the state average identified in each chart, the reviewer will award 20 points if the substance focus selected is above the state average for consumption indicators or below the state average for perception of risk, and only 10 points if the substance focus selected is below the state average for consumption indicators or above the average for perception of risk. If an applicant chooses to focus on two substances, the total available points remains the same but split in half, leaving 10 points available for each substance's ranking. It is our hope to eventually move all areas of the state to at or below the state averages listed in the Risk Tables.

The third key criterion is inclusion of *under-represented populations.* Applicants will be scored on their compliance with the identification of a sub-target, within their target population and their ability to serve this population which is not typically served. Ohio's norms, values, beliefs and language are rooted in its ethnic heritage. They must demonstrate knowledge of their target population with regard to several characteristics, such as age, gender, race and ethnicity, an understanding of this population's needs related to the SPF project, discuss any history of serving this population and resources to gain further knowledge of this population and the planned outreach with this new population.

The fourth criterion is the *capacity to be successful*. This is defined as:

- how likely is an applicant's plan to succeed, both during the planning stages and over time,
- the identification of local barriers to their proposed plan, and development of specific plans to address each barrier,
- the description of local resources, collaboration between local groups and entities, and indicators of community buy-in

The fifth criterion is *sustainability.* Applicants will be able to receive additional points based on the strength of their sustainability plan showing how they will realistically maintain utilization of the SPF process to guide their prevention efforts beyond the grant period

These priority measures will be scored as follows:

Priority Measures Criteria	Available Points (100)
Capacity to Collect Data	20
**Level of Risk	20
Inclusion of Under-Represented Populations	20
Capacity to be Successful	20
Sustainability	20

***See risk tables attached (Appendix A)*

The applicant ADAMHS/ADAS Boards will work with their selected prevention provider/coalition to enter the grant application into the ODADAS web based system which will provide the mechanism to address all identified priorities. Once submitted into the ODADAS web based system all SPF SIG applications will be reviewed by an internal review team. ODADAS will fund 10-15 sub-recipients for this project. Once NOA's are approved sub-recipients will receive funds through a draw down process. Each sub-recipient will identify the amount of funding, expected to be within a range of $100,000-$150,000 over a 12 month period, to enable them to successfully implement their project. For the initial application they will submit a budget for the remaining 4 months of State Fiscal Year (SFY) 2011 and one for the 12 month period of SFY 2012.

III. Implications of the Planning Model/Allocation Approach

1).Ohio's allocation approach:

- Allows all areas of Ohio to apply for funds
- Introduces the SPF model to all ADAMHS/ADAS Boards in Ohio
- Recognizes high risk as well as readiness
- Requires inclusion of under-represented populations
- Strengthens and broadens collaboration on the state and local level
- Guides the current system toward a stronger outcome/data driven planning process and provides a standardized planning model across the state.

2).This allocation approach also empowers sub-recipient communities to address their priority areas and intervening variables in a way that best meets the needs of their community. Though the sub-recipient communities may identify similar priorities, the underlying factors that contribute most to them will vary between each sub-recipient. Each sub-recipient will need to tailor their strategic plan to fit their particular needs, capacities and readiness to determine what environmental strategies should be implemented based upon what they believe they have the power to change that will affect their goal. The sub-recipient outcomes are expected to demonstrate trends toward a decrease in consumption which relates to the state priority.

3). Because we are utilizing a GFA process, each year sub-recipient grantees will complete a new grant application and budget to identify what phases they will be working on, progress expected and the proposed budget. This state and local alignment begins to establish a structure to align with the Federal outcome focus.

IV. Community Based Activities

Community level activities will be carried out by sub-recipient ADAMHS/ADAS Boards and their respective AOD prevention providers. Once awarded, each selected ADAMHS/ADAS Board sub-recipient will be required to convene a local planning team comprised of 5-7 representatives from the 12 sectors of the community wheel. Two of the members must be an AOD prevention professional and an ADAMHS/ADAS Board representative. This group will serve as the nucleus of the local planning team and will recruit additional community team members as the planning process moves forward. This team will attend a five day training session that will provide basic information on each phase of the SPF to help build a foundational understanding of the process and prepare them to engage additional members. The Prevention Manager/Project Coordinator and Global Insight trainers along with the Regional Prevention Coordinators will also act as coaches working closely with communities throughout the SPF process.

Technical assistance on the sources, collection and use of community-specific data will be provided by ODADAS' project staff during the assessment phase of the SPF. Sub-recipient communities will have on-line access to the epidemiological profiles and the statewide needs assessment. The selection of their priority(s) should be based on analysis of local, state and national data. During the assessment phase, the sub-recipient communities will begin to identify strengths and weaknesses in the community

Following assessment, the capacity phase will provide the sub-recipient communities an opportunity to participate in extensive training around all the phases of the SPF process. Their identified community planning team will ensure that needed systems and levels of the community are engaged in the process. During this phase, the local planning team will mobilize stakeholders and garner support and "buy-in" in order to enhance current infrastructure or develop additional infrastructure based upon the needs of the community. Following the training, the community planning teams will possess the knowledge necessary to move forward with the additional phases of the SPF process. Increased coordination and collaboration among key stakeholders and on-going quality improvement will improve the state and sub-recipient community's ability to ensure the use of effective evidence-based prevention policies, programs, practices and strategies that are designed to address substance abuse and related problems.

During the planning phase of the SPF, ADAMHS/ADAS Boards and their selected AOD community coalition will participate in a standardized strategic planning process to ensure the provision of comprehensive, collaborative, culturally and linguistically competent evidence-based prevention efforts. Communities will ensure that these efforts are sustainable over time and meet community needs. They will utilize the knowledge they have acquired through years of community plan development and the training on the SPF process to develop a strategic plan for implementing the SPF process with the identified community and target population. They will build upon the data utilized in the assessment phase as they move through the process and develop their strategic plans. During this phase, the sub-recipient communities will begin to clarify strengths and challenges in the community along with the risk and protective factors and the intervening variables they will be addressing.

Technical assistance provided by the SPF SIG Prevention Manager/Project Coordinator, Regional Prevention Coordinators and Global Insight, will be instrumental in building community-level capacity and expertise. Sub-recipient communities will participate in semi-annual results and learning sessions throughout the SPF Initiative. These sessions will provide a venue for the sub-recipients to track successes and make process improvements, as necessary. These sessions will also provide opportunities for the sub-recipients to interact with one another and share lessons learned.

As the SPF SIG sub-recipient communities move into the implementation phase, SPF SIG resources will be used to continue to enhance community capacity to better understand and implement evidence-based prevention practices, policies, programs and strategies. Increased collaboration will engage communities and maximize and sustain resources. Each sub-recipient community will work with the Regional Prevention Coordinators and the evaluation team to select evidence-based environmental strategies based on identified needs and feasibility of implementation. The Prevention Manager/SPF-SIG Coordinator and the evaluation team along with the Regional Prevention Coordinators will provide technical assistance to the sub-recipients on how to modify evidence-based AOD prevention practices to address more diverse populations, and evaluate their efforts as needed. An evidence-based AOD prevention approach at any level (promising, effective, model or exemplary) will be accepted. The lower the level of evidence, the greater the evaluation burden of effort will be for the sub-recipient. The strategic plans developed by the sub-recipients will include strategies to sustain AOD prevention efforts and will be updated through continued technical assistance and training, with the Regional Prevention Coordinators and the SPF training team. Using the SPF process will increase system capacity by ensuring state and local resources are targeted to AOD prevention services that have been demonstrated to be effective.

Many ADAMHS/ADAS Boards are moving toward more data-driven planning and are using outcome management, but others have struggled with evaluation methods due to cost, lack of mechanization and the limited utilization of continuous quality improvement. As part of the evaluation phase, SPF SIG resources will be used to provide training and technical assistance on program evaluation to sub-recipient communities. The evaluation team will provide process and outcome evaluation for the sub-recipient communities. They will also work closely with the sub-recipient community to make any modifications to the program, policy, strategy or practice to ensure that it is meeting the need of the target population and getting the results as evidenced in the research.

The sustainability of this initiative is based upon the purposeful involvement of the ADAMHS/ADAS Boards in the development of local plans that reflect the goals and cultural values of the participating communities. Continuation of the SPF process, beyond the grant period, will require community leaders and funders to recognize the local Strategic Plans are relevant to community needs. ODADAS will require that by year five, each sub-recipient county, along with their Regional Prevention Coordinator, work with an interested contiguous county to share the SPF process and lessons learned during the project period. This will enable Ohio to continue to expand the SPF process throughout the state. Local funding and commitment of resources will be sought prior to the end of the federal grant to increase the likelihood of continuation.

IMPLEMENTATION

I. Mechanism to Determine Training and Technical Assistance Needs

SPF-SIG Project Staff have extensive experience providing training, technical assistance and fostering relationships with ADAMHS/ADAS Boards and prevention providers throughout the state of Ohio. Five Regional Prevention Coordinators serve the statewide system by providing technical assistance, oversight, networking, and other prevention resource support on a local level. Ohio's ADAMHS/ADAS Boards and local AOD prevention providers know that if they have questions, concerns and/or training needs they should contact their Regional Coordinator. Since the current regional structure has enabled Ohio's AOD Providers to receive more coordinated and effective technical assistance from the Department, this same process will be followed for SPF-SIG.

In addition, Ohio has fifteen individuals trained in the SAPST curriculum. Five of the fifteen individuals have received further training as facilitators and will be utilized as we move through the phases of the SPF process. These trainers are a great resource and will be able to provide additional training and technical assistance to local communities. Similarly, the Executive Directors of the twelve Ohio UMADAOPs received training from Central RET on the SPF. The Directors were interested not only in learning about the phases of the SPF, but more importantly how cultural competency is integrated throughout the process. As mentioned in previous sections UMADAOP provides programming with the belief that substance abuse is best prevented and treated when the cultural dynamics of a group are addressed. The UMADAOPs can prove to be a local resource for sub-recipient communities as they move through the phases of the SPF and strive to implement culturally specific evidence based programming. Training and technical assistance will be continuous throughout the duration of Ohio's SPF to provide coaching and problem solving with communities as they move through the phases of the SPF process.

Logic Model

Each SPF sub-recipient will develop a logic model that outlines strategies, programs, policies and practices they will implement to achieve population level change. While community input will be sought as each community coalition designs its logic model, logic models will be developed in adherence to the SPF model's requirement that interventions are adopted based on assessed needs. Training and technical assistance needs may vary depending on the strategies determined necessary to achieve desired change. Each sub-recipient will submit its logic model, as a part of their strategic plan, to the EBP workgroup for feedback and approval. The workgroup will work with the SPF SIG project staff to ensure that training and technical assistance occurs as needed to ensure successful implementation of the logic model.

Capacity Assessment Tools

State capacity tools will be used to assess SPF SIG capacity building at the state level. The evaluation will include measures of individual stakeholder capacity for prevention system

change and measures of organizational capacity for prevention system change (e.g., expertise, staffing and other resources) that is targeted by the SPF SIG and the state strategic plan. Sub-recipient Capacity tools will be used to assess the impact of capacity building at the sub-recipient level. As at the state level, these tools will include measures of key stakeholder capacity for prevention system change and measures of organizational capacity for prevention system change that is targeted by the SPF SIG and the state and community strategic plans. Each sub-recipient will have received contact information regarding the following readiness assessments: CSAP Prevention Platform, Community Partner Institute Community Prevention Readiness Index,Tri-ethnic Center Community Readiness Model, Goodman and Wandersman Community Key Leader Survey and the Minnesota Institute of Public Health Community Readiness Survey and will have the opportunity to select the assessment best suited for their community. Outcome data to be collected at the community and program levels will be finalized in Step 1 of the SPF. Part of the requirement for this step is to specify the baseline data against which progress and outcomes of the SPF can be measured. At the state level, outcome data will be collected from the annual NSDUH. At the community level, the evaluator recognizes the need for a combination of data sources, in part because the sub-recipients are likely to implement a variety of evidence-based programs, policies and practices, focusing primarily on environmental strategies.

II. Procedures to Ensure Successful Training Implementation

The SPF SIG Prevention Manager/Project Coordinator will be responsible for the day to day processes of the grant project. She will coordinate project activities, trainings, and communications among internal staff, contractors, and sub-recipients. The SPF Prevention Manager/Project Coordinator will work with Global Insight, the contracted trainers for the SPF, to ensure that community training needs are met. Technical assistance needs will be addressed as deemed appropriate by the SPF SIG Prevention Manager/Project Coordinator, the Regional Prevention Coordinators, trainers and evaluation team.

The SPF SIG Prevention Manager/Project Coordinator and the Regional Prevention Coordinators will work intensively with sub-recipients in the field and assist with training sub-recipients as well as conduct site visits with the Boards and Providers in their regions.

ODADAS project staff, key stakeholders, trainers, evaluators, SPF-SIG Committee and EBP members are familiar with the culture and language of Ohio's communities in two distinct ways: 1. they represent the cultural, racial and ethnic diversity of the state population and 2. they live and share a personal history with individuals residing in Ohio's diverse counties. The combination of these resources will help to ensure inclusion of cultural competence in state and community level SPF steps.

All Project Staff have extensive experience providing technical assistance and fostering relationships with ADAMHS/ADAS Boards, and prevention providers, throughout the state of Ohio. ODADAS' regional structure has enabled the field to receive more coordinated and effective technical assistance from the Department. ODADAS Workforce Composition Report, denoting the percentage of women and minorities at ODADAS is much higher than the state as a whole, is evidence that key staff is reflective of the composition of the State of Ohio.

Global Insight has been in the training and professional speaking industry for close to 20 years. They have over 100 years of combined team experience with an extensive background in online training, coaching, consulting, assessment and evaluations. They have training and technical assistance experience in a variety of areas including; drug and alcohol, leadership, cultural competency, team building, empowerment, professional/personal development, community outreach and collaboration, quality assurance process improvement, marketing, project management, community needs assessments, capacity building, focus groups and strategic planning. They also have additional experience in research and the implementation of evidence based prevention strategies. James White Sr**.** is a senior, Master Training Management Consultant and Executive Coach. With more than 25 years of corporate, education, and government experience, White is committed to the training and development of individuals and organizations. Mr. White will work with ODADAS staff and sub-recipients to ensure the inclusion of cultural competence in state and community level SPF Steps.

Ohio's SPF Initiative evaluation activities will be conducted by Ohio University's George Voinovich School of Leadership and Public Affairs (GVS). Ohio University GVS has extensive experience conducting program evaluations to help expand the capacity of organizations at the local and state level and will work with experienced SPF SIG evaluators to ensure a strong evaluation component.

III. Cultural Competency

ODADAS, ADAMHS/ADAS Boards and Providers face challenges in addressing the prevention needs of new, emerging and under-represented populations in culturally competent and relevant ways. Ohio has significant African American, Somali, Latino, Asian, Appalachian and Amish population groups, and new immigrant and refugee populations from Asia and Northern Africa are increasing the number of languages and dialects spoken, stretching current capacity and dramatically boosting the demand for English as a Second Language services. In addition, the demographics of persons currently served by Ohio's AOD system do not necessarily reflect those of persons in need of services and strategies, but rather persons who are comfortable accessing services. Most professional conference and training events try to incorporate cultural competency components into all elements of planning and implementation. As Ohio's increasingly diverse population grows, the ongoing need for AOD providers to be adequately trained remains to be a priority for the state.

In September 2010, The Multiethnic Advocates for Cultural Competence, Inc. (MACC) unveiled a State of Ohio Cultural Competence Definition that was developed by various state departments including ODADAS. In the State of Ohio, cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities, and traditions of all Ohioans in order to develop policies to promote effective programs and services. This definition will begin to lay a foundation for building cultural competence not only for Ohio's SPF SIG project but in the state of Ohio as a whole. ODADAS understands that cultural and linguistic competence is fundamental to evidence-based prevention and is critical to meeting the diverse needs of all Ohioans.

ODADAS recognizes the need to be more inclusive in engaging Ohio's culturally diverse populations in prevention planning, coalition participation, and access to services; however, there is no formal or comprehensive approach to ensure that all components and levels of the Ohio prevention system are providing culturally appropriate prevention services, ensuring that prevention protocols and administration is culturally relevant and optimizing inclusion of these disparate populations in the system. ODADAS has requested CSAP technical assistance to develop a draft Cultural Competence State Plan with its partners to be implemented in the prevention system at the State (ODADAS) and sub-state levels (county boards, coalitions, and funded prevention providers).

Immediate, Short-Term Outcomes

● ODADAS will receive a draft cultural competency plan developed with ODADAS and its partners' input that includes benchmarks and timelines. The cultural competency plan will guide ODADAS, county boards, prevention providers and coalitions in building their workforce's cultural competence capacity to increase participation of underrepresented and underserved populations in the prevention system

● Recommendations will be provided on ways to incorporate cultural competence into key ODADAS documents (such as draft language will be included in GFAs that will address specific cultural competency requirements to receive ODADAS funding).

● ODADAS will receive recommendations on how coalitions can attract representation from currently underrepresented diverse populations in their communities

● ODADAS will receive a brief plan and guidance from CSAP and Consultant on how to implement the Cultural Competency plan

Intermediate Outcome:

● ODADAS will finalize and begin to implement a statewide cultural competency plan for the State and sub-state levels that includes measurable outcomes (18 to 20 months).

Long-term Outcome:

● Implementation of the final ODADAS Cultural Competency plan and its recommendations to enhance cultural competency within the prevention system will result in increased prevention workforce capacity in cultural competence and increased participation of underrepresented and underserved populations within the AOD prevention system (including community coalitions).

EVALUATION

I. Surveillance Monitoring and Evaluation Activities

Overall Plans for Managing Data

The SPF SIG evaluation team will conduct a process and outcome evaluation of Ohio SPF SIG to assess progress through the five steps of the SPF SIG framework, accomplishment of project activities, capacity building, and achievement of targeted outcomes. This data will be gathered through surveys, archival data, interviews and reports from the sub-recipient grantees. The evaluation will include analysis at the state, sub-recipient levels to assess effectiveness, ensure

quality of service delivery, identify successes and encourage needed improvements, and promote sustainability of effective programs. In addition, the SEOW will play an integral role in the surveillance and monitoring activities of the SPF SIG and the evaluators will work closely with them as well as the EBP Workgroup to insure fidelity of interventions at the sub-recipient level.

The SPF SIG evaluators will also collect and submit data, or provide guidance for this process where appropriate, on NOMS at all required levels (state, community). The evaluators will review quarterly the data to be reported to SAMHSA, evaluate current progress and use this information to assist ODADAS in assessing performance and determining what adjustments are needed.
The evaluation team will maintain the appropriate databases for storing the data that is collected, and utilize this data for state and local analysis.
ODADAS will explore the possibility of utilizing our current web based system to collect other SPF SIG data as appropriate. We will also use the MRT and any other data collection processes as required by CSAP.

Overview and Evaluation Questions

The evaluation team will implement an evaluation plan for conducting process evaluation at the state, sub-recipient, and program level, including measures, instruments, data collection, analysis, and reporting . Process data collection and analysis will help answer the process questions such as;

- How has the SPF SIG been implemented?
- To what extent has prevention capacity increased as a result of the SPF SIG?
- To what extent has consumption decreased among the 18-25 year old population?
- To what extent have the related causal factors (intervening variables, including NOMs) changed as a result of the SPF SIG?

Using Data for Feedback and Continuous Improvement

The evaluators will work closely with the EBP workgroup to review the sub-recipient strategic plans and provide feedback for ongoing training and technical assistance. They will also work with the SEOW reviewing data and identifying trends within the sub-recipient communities. The evaluators will provide information annually directly to the sub-recipient grantees to make adjustments as necessary. This will also help to inform the training team of changes in training needs and allow them to provide services.

II. Tracking Activities

The state will be tracking consumption data related to 18-25 year olds. The evaluators will monitor this through collaboration with the SEOW and other state partners and sub-recipient grantees.

Process Evaluation

The process surveys will include measures of reach (whether the right partners were involved); dosage (whether there was adequate dosage, including meetings and other activities, to achieve objectives); dynamics (including barriers to SPF process); and lessons learned (which can inform future SPF SIG activities). The surveys will also track progress through the five SPF steps. The

evaluation team will work to ensure that this tracking is coordinated with the SPF SIG cross-site data collection efforts, and does not duplicate those efforts.
Surveys will be conducted with key informants in organizations engaged in the SPF process within the 10-15 sub-recipient grantees. Similar to the state survey, measures will include: reach (whether the right partners were involved); dosage (whether there was adequate dosage to achieve objectives); dynamics (including barriers to SPF process, what training is needed to help implement the SPF process); and lessons learned (which can inform future SPF SIG activities).

Process Evaluation Components and Methods

To monitor SPF implementation, the evaluators will use a State SPF Checklist. The evaluator will collect data every six months in Years 1 through 5 from staff in ODADAS and selected SPF work groups. Data elements in the checklist will include: objectives, action steps related to each objective, types of deviations from the plan, and impacts of the deviations on achievement of objectives. The evaluators will analyze these data every six months, using as primary analyses a chronology of events, and frequency and contingency tables showing planned versus completed activities. Results will be shared within one month of data collection to document progress and inform decision-making.
Fidelity to the SPF-SIG framework will be assessed based on ratings of adherence by sub-recipients to core elements that have been identified for each SPF step. (For example, core elements within Step 1 include: Do those conducting the needs assessment have the requisite skills? Are data used to specify intervening variables?) The assessments will be conducted by one member of each of the following: The evaluation team, ODADAS, and the EBP Workgroup. The raters will be trained in how to make these assessments and inter-rater reliability will be calculated to assess concordance of ratings.
As sub-recipients select their evidence-based environmental strategies (SPF Step 4), the evaluators will provide them with Fidelity Worksheets in which they will be asked to document fidelity to the interventions they have selected and any adaptations that are planned. Should their plans for implementation deviate from the core elements of the interventions, they will be asked to justify the deviations. In each subsequent project year, the sub-recipients will be asked to complete additional Fidelity Worksheets, in which they document how the implementation has actually occurred. The evaluators will compare planned implementation to the standards for each intervention, and (in subsequent years) actual implementation to planned implementation. The results will be analyzed by the evaluator and ODADAS Project staff, and shared with the EBP Workgroup.
State level NOMS data are either pre-populated or aggregated from the sub-recipient community data. Community and program level NOMs are to be collected using archival data, community surveys and intervention level surveys. Ohio's PIPAR System already captures the required process-based community- and intervention-level NOMs including: number of persons served (by age, gender, race, and ethnicity) and number of evidence-based interventions. ODADAS will begin to explore the possibility of collecting other NOMs data through the PIPAR system.

III. Expected Change

Outcome Evaluation

It is the expectation the SPF SIG project will enable Ohio to have a statewide infrastructure with enhanced capacity to utilize data driven decision making to guide system development. Communities will utilize data driven decision making to guide strategy selection and develop local infrastructure to support effective AOD prevention efforts.

Assessment of Changes in Prevention Capacity

A primary aim of the evaluation will be to enhance State and sub-state capacity to collect, analyze, interpret, and use data to monitor their project/strategy outcomes. This change and the increased utilization of data will build capacity and assist the state and the communities in their ability to track consumption patterns ensuring needs are met in priority areas. The process of utilizing data to make data driven decisions regarding services will greatly strengthen service provision within the state.

Assessment of Changes in Priority Substance use Problems

It is expected that consumption patterns for targeted 18-25 year old populations will begin to be affected through the use of environmental strategies to address the target populations. Working with the SEOW we expect to demonstrate community level trends of decrease in consumption for selected substances.

IV. Sub-recipient Collection of NOMs Data

Sub-recipient grantees are required to report NOMS relevant to their priority programs, policies, and practices. The evaluators will work with ODADAS and other project partners to provide technical assistance and training to sub-recipients on NOMS reporting requirements. State level NOMS data are either pre-populated or aggregated from the sub-recipient community data. Community and program level NOMs are to be collected using archival data, community surveys and program level surveys. Ohio's PIPAR System captures the following process-based community- and program-level NOMS including: number of persons served (by age, gender, race, and ethnicity), number of evidence-based programs. ODADAS will begin to explore the possibility of collecting other NOMs data through the PIPAR system.

V. Cultural Competency of the Evaluation Methods and Instruments

Attention to the cultural competency of all evaluation instruments and methods will be emphasized and maintained as a priority through the project. Evaluation tools will be developed with specific relevance to the target audience. Implementation of evaluation strategies will be responsive to the diverse population targeted by each sub-recipient community.