

# **The Nebraska Substance Abuse Prevention Strategic Plan**

by

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Nebraska Governor's Office

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# Introduction

In October of 2006 the Nebraska Department of Health and Human Services (NDHHS) received a Strategic Prevention Framework State Incentive Grant (SPF SIG) from the Center for Substance Abuse Prevention in the Substance Abuse and Mental Health Services Administration (SAMHSA). There are three overarching goals of the project, which include:

- Prevent the onset and reduce the progression of substance abuse, including underage drinking;
- Reduce substance abuse related problems in communities; and
- Build prevention capacities and infrastructure at the state/tribal and community levels.

One of the major requirements of the SPF SIG is to develop a state substance abuse prevention plan using the Strategic Prevention Framework (SPF) model. SPF is an outcomes-based prevention model that focuses on the substance abuse consequences and consumption patterns that need to be changed. The SPF model also uses a public health approach that focuses on achieving positive health outcomes for the entire population, rather than a sub-set of individuals.

The five steps of the SPF model are shown on page four. Each of the steps is briefly described below and in more detail throughout the plan.

Step 1:           Assessment – Collect data to determine needs and identify resources and readiness to address both needs and service gaps.

Step 2:           Capacity – Mobilize and build capacity (e.g., financial and organizational) by engaging stakeholders to address identified needs.

Step 3:           Planning – Develop a comprehensive strategic plan that includes the state's vision and substance abuse prevention priorities, including essential training and educational activities and the allocation of resources to community coalitions.

Step 4:           Implementation – Build infrastructure and capacity to support the implementation of policies, programs, and practices at the community level.

Step 5:           Evaluation – Measure the changes in the state's targeted priority consequences and consumption patterns and the overall effectiveness of the state strategic plan.

## Strategic Prevention Framework



Cultural competence and sustainability are at the center of the model and these concepts must be addressed at every step of the process. At the state and regional levels, the prevention system infrastructure that supports community work must be ingrained with the ideals of cultural competence and inclusion. At the local level, it is critical to recognize that every community is composed of subgroups with unique and complex cultural needs and that these diverse groups must be included in every facet of prevention planning. At the state, regional, and community levels, sustainability – the process of ensuring adaptive and effective systems that achieve and maintain desired long-term results – requires that adaptable, effective prevention systems demonstrate organizational capacity and benefit from the commitment of key stakeholders who leverage both financial and non-financial support. Both cultural competency and sustainability issues will be discussed in greater detail below.

# Assessment

The assessment component is divided into four sections. The first section will describe the process and the data elements that were used to develop the epidemiological profile, along with a summary of the findings. The second section will examine substance abuse related systems (capacity and infrastructure). The third section will explain the criteria and rationale for determining the state's substance abuse prevention priorities. The final section will describe those priorities.

## Nebraska Substance Abuse Epidemiology Workgroup

The Nebraska Substance Abuse Epidemiology Workgroup (NSAEW), formed in March 2007, is a workgroup of administrators, epidemiologists, and key decision makers who collaborate to make decisions regarding the collection and reporting of data related to substance use, consequences of substance abuse, and factors that contribute to substance abuse in the state of Nebraska. Work completed by the NSAEW has and will continue to guide decision making around substance abuse prevention in the state, including decisions made by the Nebraska Partners in Prevention (NePiP), the Governor's Advisory Council for substance abuse prevention.

The NSAEW is made up of 24 members, 20 of whom are important stakeholders to the Nebraska Substance Abuse Prevention Program and four whom are Substance Abuse Prevention Program staff. Organizations represented within the NSAEW include:

- Native American Tribal Representatives;
- Nebraska Crime Commission;
- Nebraska Department of Correctional Services;
- Nebraska Department of Education;
- Nebraska Local Public Health Departments;
- Nebraska Office of Highway Safety;
- Nebraska Substance Abuse Regional Prevention Centers;
- University of Nebraska-Lincoln;
- University of Nebraska Medical Center;
- Non-profit organizations; and
- Divisions/programs within the Nebraska Department of Health and Human Services including maternal and child health, behavioral health, tobacco prevention, epidemiology, and minority health.

A complete list of members and participating organizations is included in Appendix A.

The initial NSAEW meeting was held on March 20, 2007, in Lincoln, Nebraska. To help new members get acquainted with the SPF SIG Program and to set the stage for future meetings, staff from the Pacific Institute for Research and Evaluation (PIRE) and the Southwest Center for the Application of Prevention Technologies (Southwest CAPT) attended and presented at the meeting. Between March and October 2007, NSAEW met eight times, averaging one meeting per month.

The initial tasks of NSAEW have included creating an epidemiological profile of substance abuse in Nebraska and establishing a set of criteria to facilitate the selection of the state substance abuse prevention priorities. NSAEW will remain active throughout the SPF SIG Program and will continue to enhance substance abuse data collection, analysis, and reporting.

## **Assessing the Problem (Epidemiological Profile)**

This section describes the step-by-step process used by NSAEW to identify data sources, constructs, and indicators used in profiling substance abuse in the state as well as a summary of the findings from the substance abuse epidemiological profile report, entitled "Substance Abuse and Associated Consequences in Nebraska, an Epidemiological Profile."

### **Purposes of the Epidemiological Profile**

During the initial planning stages of the epidemiological profile report, NSAEW identified two primary purposes of the report, which included (1) to report data that will help facilitate the assessment phase of the SPF SIG Program and (2) provide information to stakeholders and decision makers that will assist with planning and garner support for substance abuse prevention beyond SPF SIG.

### **Substance Abuse Data Sources Within Nebraska**

Prior to the initial NSAEW meeting, Nebraska Substance Abuse Prevention Program staff completed an inventory of data sources within Nebraska to determine which sources contained information on substance abuse. The inventory identified 63 sources which were either exclusive to substance abuse or contained some information on substance abuse.

### **Identifying Constructs**

The initial work of NSAEW consisted of identifying data constructs to include in the epidemiological profile. At the initial meeting, the group reviewed substance abuse data sources available within Nebraska and began discussions to hone in on the data constructs to include in the report. The following constructs were agreed upon by the workgroup during the first couple of meetings:

- Consequence constructs (where available):
  - Mortality;
  - Medical care;
  - Motor vehicle crashes;
  - Legal consequences (arrests, convictions, probation, incarceration, parole);
  - Smoking-related fires;
  - Impaired driving; and
  - Dependence, abuse, and treatment.
  
- Consumption constructs (where available):
  - Lifetime use;
  - Early initial use;
  - Current use;
  - Excessive use;
  - Sales; and
  - Use among pregnant women and women of childbearing age.

### **Selecting Indicators**

Once the data constructs were selected, NSAEW members spent several meetings reviewing and selecting indicators to include in the report and eventually in the prioritization process. The following items were considered when reviewing indicators:

- Data quality;
- State level availability;
- National comparison;
- Trend availability;
- Future collection; and
- Sample size or number of cases for demographic reporting.

The group determined that it was particularly important to select indicators that were comparable to the nation as a whole and those where trend data were available.

To begin the indicator selection process, NSAEW identified more than 100 indicators that were available at the state level and were from quality data sources for which future collection was planned. To allow all members an equal voice in narrowing the final set of indicators, NSAEW members completed an on-line survey to rate each of the indicators on a five-point rating scale ranging from “not at all important” to “extremely important.” In addition to rating indicators, the survey also asked members to rate the proposed constructs, demographic groups, and specific illicit drugs on their overall importance to the report. The survey was open for two weeks and was completed by 17 of 20 members (excluding staff from the State Substance Abuse Prevention Program).

After considerable discussion, indicator scores were calculated using four components, including: (1) the original indicator score from the survey (which included a combination of the mean score, the percentage reporting that they felt the indicator was extremely important, and the percentage reporting that they felt the indicator was important or extremely important); (2) construct score from the survey; (3) national comparison available; and (4) trend data available. The final indicator score was based on a maximum of 10 points, with half coming from the original indicator score, and one-sixth coming from each of the three additional components.

NSAEW did not reach a clear consensus on which indicators to include in the report and which to exclude from the report. As a result, NSAEW chose to include nearly all indicators in the report but to focus more heavily on those with higher scores, while concentrating less on indicators with lower scores. As a result, to aid in the prioritization process, some indicators were presented in detail (i.e., trends, national, and demographic comparisons) while others were limited to just an overall percent, number of cases, or rate to provide greater context to the subject. In all, 19 data sources containing information on Nebraska residents were included in the epidemiological profile report.

Due to the number of indicators and data sources included in the epidemiological profile report, NSAEW decided to use only a subset of indicators for the prioritization process, discussed in further detail, below. The remaining indicators, although not selected as potential priorities, proved to be valuable in helping to score potential priority indicators (primarily in scoring the economic/social impact).

### **Demographic Reporting**

Early in the report development process, NSAEW chose to focus the report on state level data as opposed to regional or local level data. However, to enhance the value of the report and its usability by various audiences, NSAEW chose to break down findings, where available, by age, gender, urban/rural, and race/ethnicity.

### **Summary of Findings from the Epidemiology Profile Report, entitled "Substance Abuse and Associated Consequences in Nebraska, an Epidemiological Profile"**

In Nebraska, substance abuse continues to be a problem, placing an enormous strain on the health care system, the criminal justice system, and the substance abuse treatment system. The following is a summary of alcohol, tobacco, and illicit drug use and associated consequences in Nebraska. The full epidemiological report, completed in December of 2007, can be obtained online at <http://www.dhhs.ne.gov/puh/oph/saprev.htm> or by calling (402) 471-2353.

## **Alcohol Summary**

### ***Consequences of Alcohol Use in Nebraska***

#### *Alcohol use is a major contributor to death and medical care*

- Alcohol use killed an estimated 392 Nebraska residents in 2004, and shortened the life of those who died by an average of 28.5 years between 2002 and 2004.
- In 2003, there were 4,948 hospitalizations among Nebraska residents in which an alcohol-attributable condition was listed on the hospitalization record.

#### *Alcohol use is common in motor-vehicle crashes*

- More than one-third (34.1%) of all fatal motor vehicle crashes in 2006 involved alcohol, killing 86 individuals in 77 alcohol-involved fatal crashes.
- In 2006, alcohol-related motor vehicle crashes in Nebraska cost an estimated 130.6 million dollars when counting wage and productivity losses, medical expenses, administrative expenses, motor vehicle damage, and employer costs.

#### *Alcohol impaired driving is particularly high in Nebraska*

- In 2005, high school students in Nebraska were 1.7 times more likely than high school students nationally to drive after drinking in the past month, 17.3 percent and 9.9 percent, respectively (Figure 1).
- In 2006, adults in Nebraska were also 1.7 times more likely than their national counterparts to report alcohol impaired driving in the past month, 4.2 percent and 2.5 percent, respectively (Figure 1).

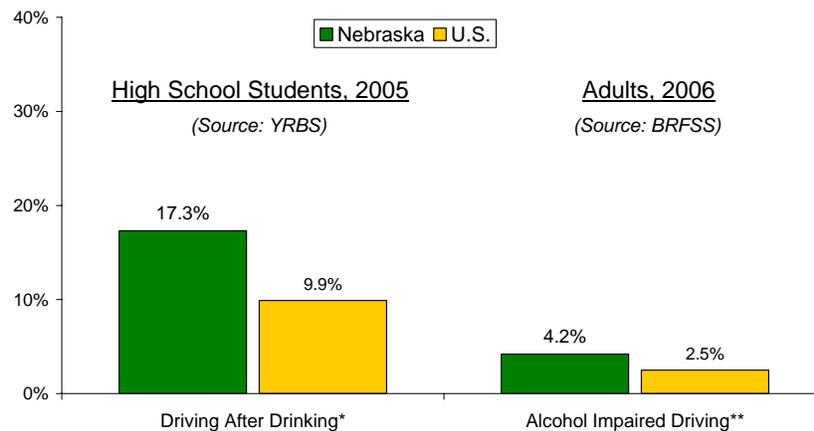
#### *Alcohol use places a tremendous strain on the criminal justice system*

- In 2006, there were 13,075 arrests for DUI among adults in Nebraska, making it the leading arrest offense among adults in Nebraska, accounting for about 1 in every 6 arrests (17.0%).
- Of all adults sentenced to probation in Nebraska during 2006, more than half (55.3%) were sentenced for DUI, a substantial increase since 2000 (37.6%).
- Incarceration for DUI has increased from less than 50 each year during the 1990s to more than 100 each year since 2000, with 129 individuals being incarcerated for DUI in 2006.
- In 2006, there were an additional 12,714 arrests for non-DUI alcohol-related crime in Nebraska (e.g., public intoxication, minor in possession, purchasing for a minor, selling to a minor), making it the second leading arrest offense category in 2006.

#### *Alcohol is the primary drug of choice in substance abuse treatment admissions*

- In 2006, alcohol was listed as the primary drug of choice during 7 in every 10 substance abuse treatment admissions (70.9%) in Nebraska, and was listed as one of the top three drugs of choice during 86.0 percent of all admissions.

**Figure 1: Past Month Alcohol Impaired Driving, Nebraska and U.S., among High School Students and Adults (18 and older)**



\*Students who drove a car or other vehicle when drinking alcohol during the 30 days preceding the survey; Source: Youth Risk Behavior Survey  
 \*\*Adults 18 and older who drove after having had perhaps too much to drink during the 30 days preceding the survey; Source: Behavioral Risk Factor Surveillance System

### ***Alcohol Use in Nebraska***

*Alcohol is the most commonly used substance among youth and adults*

- In 2005, more than 2 in every 5 Nebraska high school students (42.9%), and estimated 43,000 students, drank alcohol during the past month.
- In 2006, nearly 3 in every 5 Nebraska adults (58.5%) drank alcohol in the past month, a relatively stable percentage over the past 15-years.

*Binge drinking is particularly high*

- Binge drinking among Nebraska residents was higher than residents nationally across the three data sources presented in the epidemiological report that contained information on self-reported binge drinking (although the difference for high school students was non-significant), suggesting Nebraska residents are more likely than residents nationally to binge drink (Figure 2).

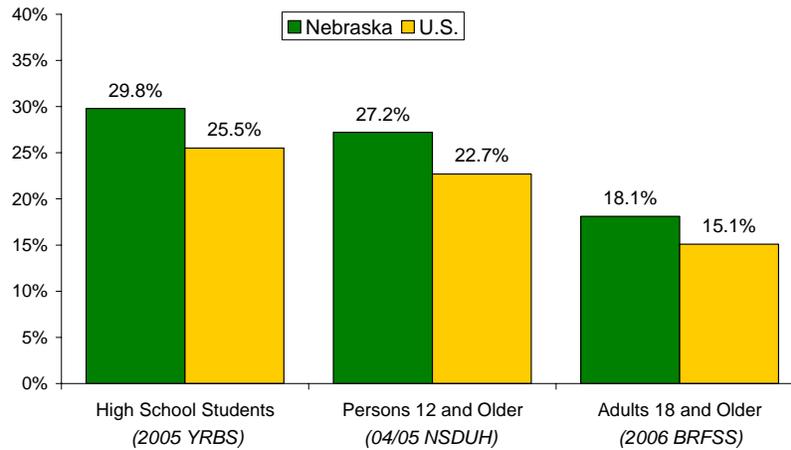
*Alcohol use among women of childbearing age is higher than the nation*

- In 2006, Nebraska women of childbearing age (18-44 years old) were more likely than their national counterparts to report binge drinking (19.0% and 14.8%, respectively). Furthermore, according to the PRAMS, 57.9 percent of women in Nebraska who delivered a child in 2002 reported drinking during the three-months prior to pregnancy, which was higher than the 47.5 percent of women nationally.

*Alcohol is a commonly sold product*

- In 2004, 49.2 million gallons of alcoholic beverages were sold at the wholesaler level in Nebraska, containing an estimated 3.2 million gallons of pure (ethanol) alcohol, an average of 2.26 gallons of pure alcohol sold per Nebraska resident 14 and older.

**Figure 2: Binge Drinking among Nebraska Residents compared to Residents Nationally\*;** according to the YRBS, NSDUH, and BRFSS



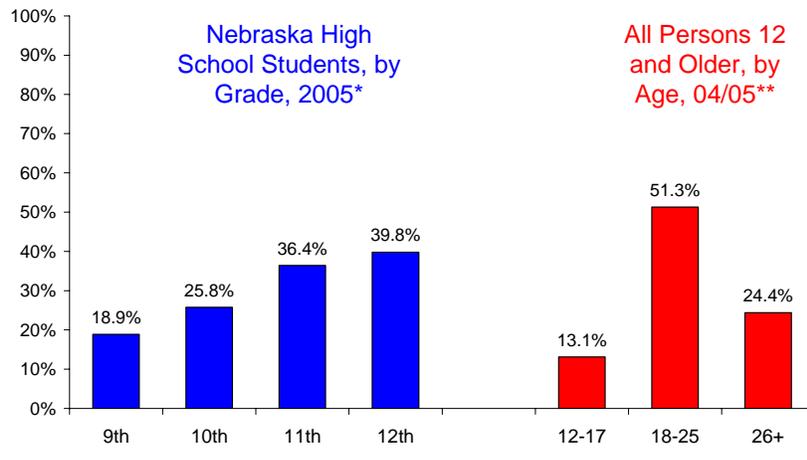
\*The BRFSS definition consists of five or more drinks for men and four or more drinks for women on one occasion during the past month while the YRBS & NSDUH consist of five or more drinks for both genders. Note: YRBS=Youth Risk Behavior Survey; NSDUH=National Survey on Drug Use and Health; BRFSS=Behavioral Risk Factor Surveillance System

## Demographic Differences: Alcohol

### Differences by Age

- Residents in their late teens and early 20's were most likely to binge drink (Figure 3), to drive after drinking, to die or be injured in an alcohol-involved crash, to be arrested for DUI or other alcohol offenses, and to receive treatment for substance abuse.

**Figure 3: Binge Drinking among Nebraska Residents, by Age,** according to the 2005 YRBS and the 2004/2005 NSDUH



\*Students reporting 5+ drinks of alcohol in a row on one or more of the 30 days preceding the survey, Source: 2005 Youth Risk Behavior Survey

\*\*Percentage of persons who report having five or more drinks on at least one occasion during the 30 days preceding the survey, Source: 2004/2005 National Survey on Drug Use and Health

### Differences by Gender

- Men were more likely than women to binge drink, to drive after drinking, to die or be injured in an alcohol-involved crash, to die from an alcohol-related death, to be arrested for DUI or other alcohol offenses, and to receive treatment for substance abuse. However, male and female high school students reported a similar percentage for current alcohol use while males had a slightly but not significantly higher percentage for binge drinking.

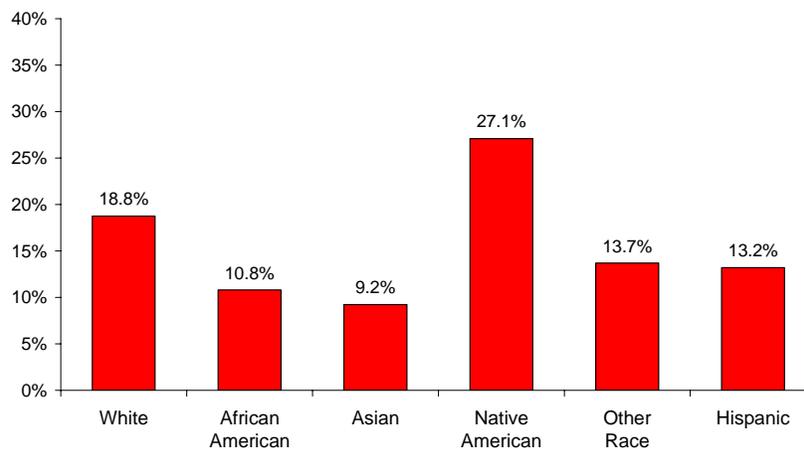
### *Differences by Urban/Rural*

- While current alcohol use and binge drinking were relatively similar across urban/rural counties, residents of rural counties reported the highest percentage for alcohol impaired driving.

### *Differences by Race/Ethnicity*

- Native Americans reported the highest percentage for binge drinking among adults; however, due to the small number of survey respondents the percentage was not significantly higher than the percentage for Whites (Figure 4). However, Native Americans were the most likely racial and ethnic group to die from chronic liver disease as well as from alcohol-related death overall.

**Figure 4: Binge Drinking (age-adjusted) among Nebraska Adults\* by Race/Ethnicity, 2004-2006 combined**



\*Percentage of adults 18 and older who report having five or more drinks on at least one occasion during the 30 days preceding the survey

Note: Racial categories include non-Hispanics, Hispanics can be of any race

Source: Nebraska BRFSS and Minority Oversample BRFSS Combined

## ***Tobacco Summary***

### ***Consequences of Tobacco Use in Nebraska***

#### *Cigarette smoking is a major contributor to death and medical care*

- Smoking killed an estimated 2,115 Nebraska residents in 2004, accounting for about 1 in every 7 deaths (14.4%).
- In 2003, an estimated 8,517 smoking-related hospitalizations occurred among Nebraska residents.

#### *Cigarette smoking causes fires*

- In 2005, there were at least 54 structure fires in Nebraska that were determined to have resulted from cigarette smoking, killing three people and costing an estimated \$601,470 in property and content loss.

## ***Tobacco Use in Nebraska***

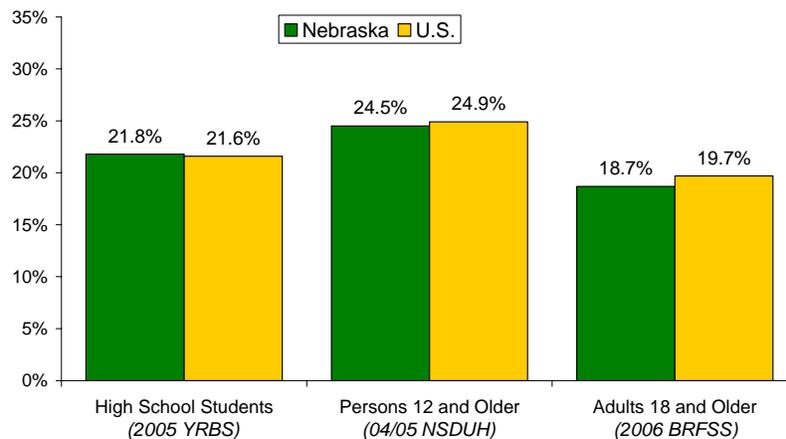
### *Tobacco use is common among youth and adults*

- In 2005, nearly 3 in every 10 Nebraska high school students (28.0%), used tobacco (cigarettes, cigars, or smokeless tobacco) during the past month, while 28.9 percent of all persons 12 and older reported past month tobacco use.

### *Cigarette smoking is the most common form of tobacco use*

- In 2005, more than 1 in every 5 Nebraska high school students smoked cigarettes during the past month (21.8%) while nearly 1 in every 5 adults (18.7%) reported smoking in 2006 (Figure 5).
- Cigarette smoking among Nebraska residents was similar to residents nationally across the three data sources presented in this report that contain information on self-reported cigarette smoking (Figure 5).
- Since the early 1990s, cigarette smoking appears to have declined among high school students and remained relatively stable among adults.
- According the Pregnancy Risk Assessment Monitoring System (PRAMS), Nebraska women who delivered a child in 2002 were more likely than their national counterparts to report smoking during the three-months prior to pregnancy (27.4% and 23.2%, respectively), but were equally likely to smoke during the last three months and immediately following their pregnancy.

**Figure 5: Current Cigarette Smoking\* among Nebraska Residents compared to Residents Nationally; according to the YRBS, NSDUH, and BRFSS**



\*The BRFSS asks respondents to report if they currently use cigarettes while the YRBS and NSDUH ask about past month cigarette smoking.  
Note: YRBS=Youth Risk Behavior Survey; NSDUH=National Survey on Drug Use and Health; BRFSS=Behavioral Risk Factor Surveillance System

### *Cigarettes are commonly sold products in Nebraska*

- In 2006, 104.7 million packs of cigarettes were sold at the wholesaler level in Nebraska, for an average of 59.5 packs sold per Nebraska resident.

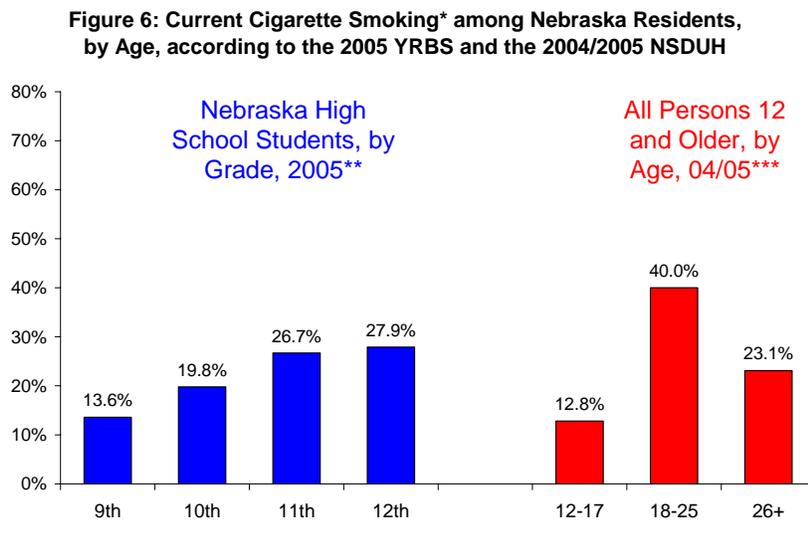
*Although less common than smoking, smokeless tobacco use remains common*

- In 2005, nearly 1 in every 11 Nebraska high school students used smokeless tobacco during the past month (8.7%) while about 1 in every 22 adults (4.5%) reported past month use in 2004.
- Smokeless tobacco use among residents in Nebraska was similar to residents nationally.
- Since the early 1990s, smokeless tobacco use appears to have declined among high school students and remained relatively stable among adults.

## ***Demographic Differences***

### *Differences by age*

- Residents in their late teens (Figure 6) and early 20s were the most likely to use tobacco products; although, as a result of the long latency period for health consequences from cigarette smoking, residents 65 and older were the most likely to die or be hospitalized as a result of cigarette smoking.



\*Self-reported cigarette smoking during the 30 days preceding the survey

\*\*Source: 2005 Youth Risk Behavior Survey

\*\*\*Source: 2004/2005 National Survey on Drug Use and Health

### *Differences by gender*

- Males and females in Nebraska reported similar percentages for current cigarette smoking, among youth and adults; however, men were more likely than women to die or be hospitalized from cigarette smoking.
- Unlike cigarette smoking, males in Nebraska, compared to females, had a much higher percentage for smokeless tobacco use.

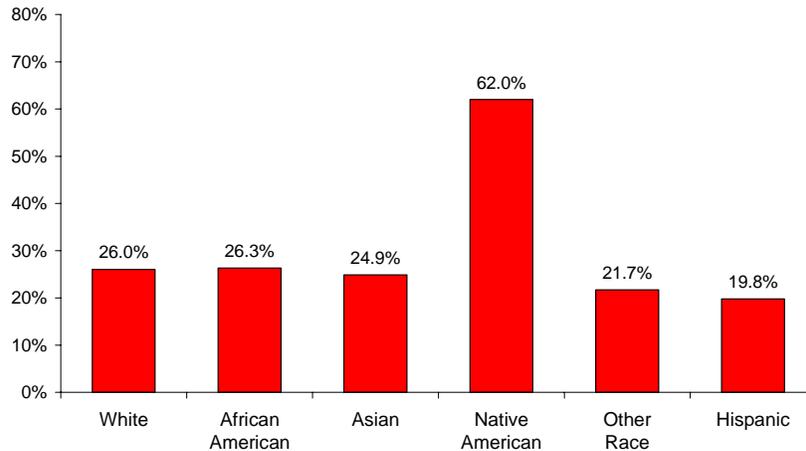
### *Differences by urban/rural*

- Among Nebraska adults, cigarette smoking varied little by urban/rural while smokeless tobacco use was most common in rural Nebraska counties.

### *Differences by race/ethnicity*

- Native American adults reported the highest percentage for current cigarette smoking at 62.0% (age-adjusted) compared to African Americans and Whites at 26 percent (the next highest groups), Figure 7.

**Figure 7: Current Cigarette Smoking (age-adjusted) among Nebraska Adults\* by Race/Ethnicity, 2004-2006 combined**



\*Adults 18 and older who report smoking 100+ cigarettes in their life and now smoke everyday or some days  
Note: Racial categories include non-Hispanics, Hispanics can be of any race  
Source: Nebraska BRFSS and Minority Oversample BRFSS Combined

## **Illicit Drugs Summary**

### ***Consequences of Illicit Drug Use in Nebraska***

#### *Drug use is a contributor to death and medical care*

- Drug use was directly responsible for killing 61 Nebraska residents in 2004, and shortened the life of those who died by an average of 33.3 years between 2002 and 2004.
- In 2003, there were 2,887 hospitalizations among Nebraska residents in which a drug-attributable condition was listed on the hospitalization record.

#### *Drug use places a tremendous strain on the criminal justice system*

- In 2006, there were 10,502 arrests for possession or sales/manufacturing of illicit drugs in Nebraska, making it the third most common arrest offense, accounting for 1 in every 9 arrests (11.3%). However, possession accounted for the majority of these arrests (9,386 arrests, 89.4%).
- During the combined years of 2004/2005, law enforcement drug recognition experts (DREs) examined 18,003 drivers for impairment by non-alcoholic substances.
- In 2006, there were 895 adults sentenced to probation for a drug offense in Nebraska, accounting for about 1 in every 17 adults sentenced to probation (5.9%).
- Incarceration for drug offenses has increased 20-fold over the past 25 years, from 60 incarcerations in 1980 to 488 in 1990, to 812 in 2000, to 1,171 in 2006.

*Treatment admissions for drug use are common*

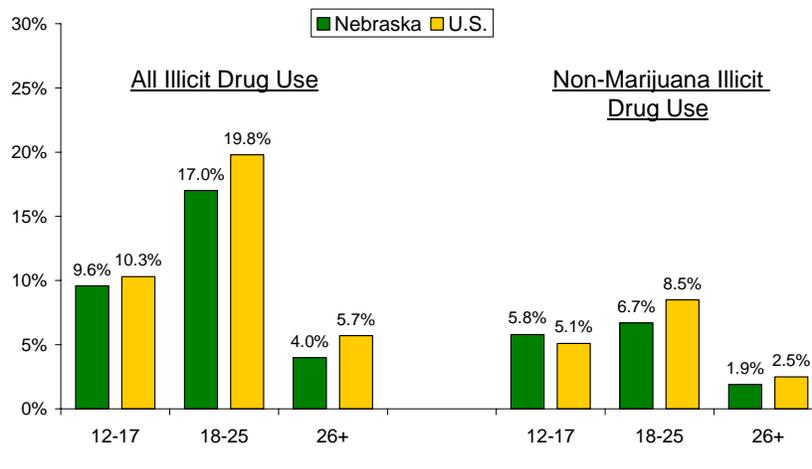
- In 2006, there were 6,493 substance abuse treatment admissions in Nebraska in which a non-alcoholic drug was listed at the primary drug of choice, accounting for 3 in 10 admissions (28.6%).

***Illicit Drug Use in Nebraska***

*Drug use is common among youth and adults in Nebraska*

- In 2005, more than one-third of Nebraska high school students (36.5%), an estimated 37,000 students, reported using illicit drugs during their lifetime.
- During the combined years of 2004 and 2005, about 1 in every 15 Nebraska residents 12 and older (6.5%) reported using illicit drugs in the past month, while about 1 in every 33 (3.0%) reported using non-marijuana illicit drugs. Figure 8 provides a breakdown of illicit drug use by age for all persons 12 and older.

**Figure 8: Illicit Drug Use in Past Month\* among Persons 12 and Older, Nebraska and U.S., by Age, 2004-2005 Combined**



\*Persons 12 and older reporting any illicit drug use (including nonmedical use of psychotherapeutics) during the 30 days preceding the survey  
Source: National Survey on Drug Use and Health (NSDUH)

*Marijuana use is the most common illicit drug*

- In 2005, about 1 in every 6 Nebraska high school students (17.5%) reported using marijuana in the past month (Figure 9).
- During the combined years of 2004 and 2005, about 1 in every 11 (9.1%) persons 12 and older reported past year marijuana use while 5.0 percent reported past month use (Figure 10).
- According to the DEA, marijuana is the most prevalent illicit drug in Nebraska. In Nebraska, marijuana is common in drug-related crimes, accounting for three-fourths of all drug possession arrests in 2006. It was the most common substance found in

drivers who were caught driving under the influence of drugs in 2004/2005 and in 2006 more than half of all new prison inmates in Nebraska reported using marijuana during the five years prior to their incarceration.

#### *Cocaine use remains a commonly used illicit drug*

- In 2005, about 1 in every 30 Nebraska high school students (3.3%) reported using cocaine in the past month, an increase from the less than 2.0 percent in the early 1990s (Figure 9).
- During the combined years of 2004 and 2005, about 1 in every 45 (2.2%) persons 12 and older reported past year cocaine use, a similar percentage to all persons nationally (2.3%), Figure 10.
- According to the DEA, cocaine is available at both the wholesale and retail level in Nebraska, with crack cocaine being more of a problem in the large urban centers of the state. In Nebraska, cocaine appears to be relatively common in drug-related crimes. It is a commonly used drug among newly incarcerated prison inmates (in 2006 one-fourth of all new prison inmates in Nebraska reported using cocaine during the five years prior their incarceration) and it was the third most commonly reported illicit drug during substance abuse treatment admissions in 2006.

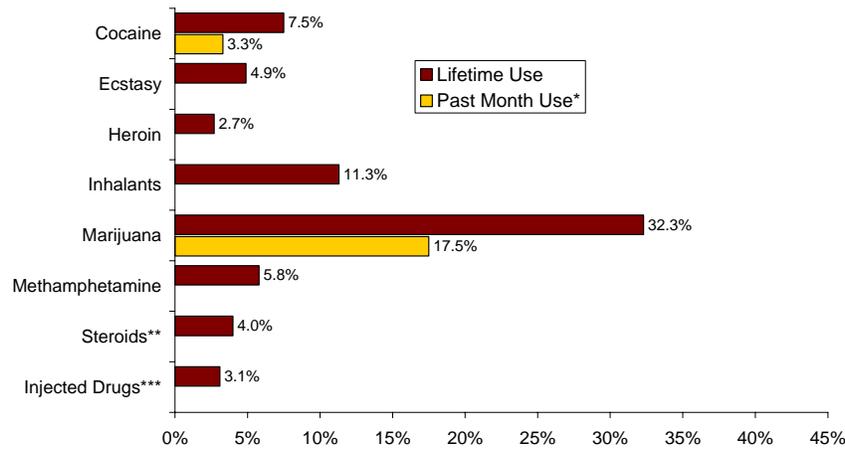
#### *Methamphetamine use is high in Nebraska*

- In 2005, about 1 in every 17 Nebraska high school students (5.8%) reported using methamphetamine (meth) during their lifetime (5.8%), Figure 9.
- During the combined years of 2002-2004, about 1 in every 77 (1.3%) persons 12 and older reported past year meth use, a percentage that was higher than the nation (0.6%), Figure 10.
- According to the DEA, meth is the greatest drug threat to the state, and is available in almost every community. In Nebraska, meth (although not always reported independent of other drugs) appears to be relatively common in drug-related crimes. It is the second most commonly used drug (to marijuana) among newly incarcerated prison inmates (in 2006, two-fifths of all new prison inmates in Nebraska reported using meth during the five years prior their incarceration), and when examining the primary drugs of choice, meth was the most commonly reported illicit drug during substance abuse treatment admissions in 2006.

#### *Prescription drug use is a growing problem nationally*

- During 2004 and 2005 combined, about 1 in every 25 (4.0%) persons 12 and older reported non-medical use of pain relievers during the past year (Figure 10).
- According to the DEA, OxyContin®, hydrocodone, and codeine-based cough syrups continue to be a problem in Nebraska. They also suggest that "pharming" parties are becoming popular among high school students nationally, where controlled pharmaceuticals are traded and abused.

**Figure 9: Lifetime and Past Month Illicit Drug Use among Nebraska High School Students, by Drug Type, 2005**



\*Past month use only asked for cocaine and marijuana  
 \*\*Includes steroid pills or shots taken without a doctor's prescription  
 \*\*\*Includes using a needle to inject illegal drugs into the body  
 Source: Nebraska Youth Risk Behavior Survey (YRBS)

## ***Demographic Differences***

### *Differences by age:*

- Residents in their late teens and early 20's were most likely to use drugs (Figure 8), to be hospitalized for drug use, to be arrested for drug possession, and to receive treatment for substance abuse.

### *Differences by gender:*

- Among Nebraska high school students, drug use varied little by gender, with male students tending to have slightly higher percentages than female students; however, the differences were largely non-significant. Although drug-attributable death and hospitalization rates were similar for males and females in Nebraska, males were more likely to experience legal consequences for drug-related crimes as well as to be admitted into substance abuse treatment.

### *Differences by urban/rural and race/ethnicity:*

- These data were largely unavailable for this report.

## **Substance Use in Nebraska: Comparing Alcohol, Tobacco, and Illicit Drugs**

### ***Consequences of Substance Use in Nebraska***

#### *Substance abuse is a major contributor to death and medical care*

- In 2004, there were an estimated 392 alcohol-related deaths, an estimated 2,115 smoking-related deaths, and 61 deaths in which drugs were listed as the primary cause of death.

- In 2003, there were 4,948 alcohol-attributable hospitalizations, an estimated 8,517 smoking-related hospitalizations and 2,887 drug-attributable hospitalizations.

*Substance abuse places a tremendous strain on the criminal justice system*

- In 2006, there were 13,409 arrests for DUI, 12,714 arrests for non-DUI alcohol-related crime, and 10,502 arrests for possession or sales/manufacturing of illicit drugs in Nebraska. These were the top three arrest offenses in 2006 and together accounted for 2 in every 5 arrests (39.4%).
- Of all adults sentenced to probation in Nebraska during 2006, more than half (55.3%) were sentenced for DUI, a substantial increase since 2000 (37.6%), while about 1 in every 17 were sentenced for a drug-related offense (5.9%), a stable trend since 2000 (5.4%).
- Incarcerations for drug offenses and DUI have both increased over the past 20 years; however, the increase for drug offenses was much more dramatic (see illicit drug summary above).

*Alcohol is the primary drug of choice in substance abuse treatment admissions*

- In 2006, alcohol was listed as the primary drug of choice during 7 in every 10 substance abuse treatment admissions (70.9%) in Nebraska, followed by methamphetamine (12.5%), marijuana (9.1%), and cocaine (4.7%).

***Substance Use in Nebraska***

*Substance use is common in Nebraska with alcohol being the substance of choice*

- In 2005, more than 2 in every 5 Nebraska high school students (42.9%) drank alcohol during the past month, about 1 in every 5 smoked cigarettes (21.8%), and approximately 1 in every 6 used marijuana (17.5%).
- During 2004 and 2005 combined, more than half of all persons 12 and older in Nebraska drank alcohol in the past month (55.6%) while more than one-quarter of all persons binge drank (27.2%). In comparison, about one-quarter (24.5%) smoked cigarettes and approximately 1 in 15 used illicit drugs (6.5%), Figure 10.

*Compared to the U.S., alcohol and meth use are high while smoking is similar*

- Compared to residents nationally, binge drinking among Nebraska residents 12 and older was higher, cigarette smoking was nearly identical, and meth use was higher although drug use overall tended to be slightly lower (Figure 10).

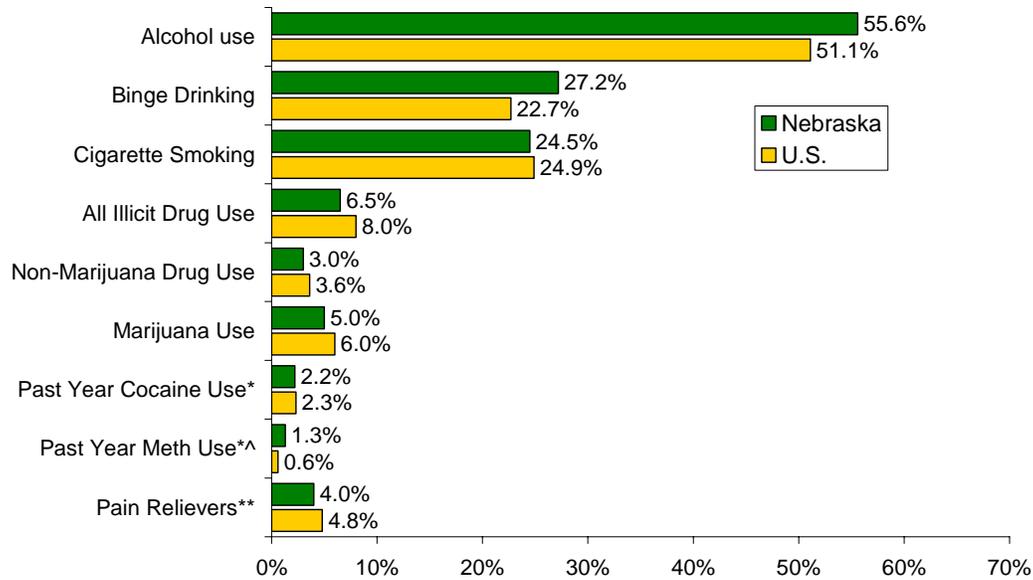
*Over the past 15 years, substance use changed positively and negatively among youth*

- Alcohol use (including binge drinking) and cigarette smoking among Nebraska high school students declined since the early 1990s, but remained stable among adults during the same time period.
- In contrast, marijuana use among Nebraska high school students increased since the early 1990s; however, more recent estimates of use among all persons 12 and

older, between 2002 and 2005, were stable and may have begun to decline (although the decline was non-significant).

- Overall, non-marijuana illicit drug use among all persons 12 and older in Nebraska remained virtually unchanged between 2002 and 2005.

**Figure 10: Past Month Substance Use among Persons 12 and Older, Nebraska and U.S., by Substance Type, 2004-2005 Combined**



\*Past month estimates for cocaine and methamphetamine use were unavailable  
 ^Estimate represents data from 2002-2004 combined, 04-05 estimate was unavailable  
 \*\*Includes only non-medical use of prescription pain relievers (excluding over-the-counter drugs)  
 Source: National Survey on Drug Use and Health (NSDUH)

## Assessing the Systems (Capacity and Infrastructure)

Nebraska’s substance abuse prevention services are carried out by a broad range of state, tribal, regional and local agencies and organizations. For example, there are at least eight state agencies or divisions of state agencies that provide grants or other support to communities engaged in substance abuse prevention activities. Historically, these efforts have largely been fragmented and uncoordinated.

Communication and coordination has increased somewhat among state agencies and between state agencies, regional agencies and communities as a result of the State Incentive Cooperative Agreement (SICA) grant program, which ended on September 30, 2007. For example, the Division of Behavioral Health and the Nebraska Department of Education began to work much more closely to organize the work done by each agency on the Safe and Drug Free Schools and Communities grant. In another example, coalitions funded through the Department of Highway Safety and through SICA were encouraged to collaborate with one another in order to achieve shared outcomes.

There are also many other instances where a variety of state agencies and divisions are engaged in collaborative substance abuse prevention activities. For example, the Division of Behavioral Health is responsible for managing and administering the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The vast majority of the block grant prevention funds are distributed to the six regional behavioral health offices. The offices are required to spend at least 50 percent of Block Grant dollars to fund community coalitions that utilize the SPF model. In addition, Block Grant dollars pay for a regional prevention coordinator to serve each office.

The behavioral health regions have been in operation since 1974, providing services to the state's 93 counties. While the regions originally were involved chiefly in direct service provision (with a primary focus on strategies aimed at changing the behavior of individuals, and implemented almost exclusively without adequate assessment in order to determine need), that approach took a dramatic about-face with the launch of SICA. As a result of SICA, regions were required to transition away from direct service and towards providing training and technical assistance to community coalitions. In addition, starting in 2003, the regions were required to begin developing regional strategic plans for substance abuse prevention, following a planning model similar to SPF. They are now being required to adhere to the SPF model exactly. As a result of this work, the SPF model has been successfully infused into the work of the regions, which have now been charged with providing SPF training and technical assistance to communities (the details of the SPF training and technical assistance plan are provided in the section on State and Community-Level Activities).

In order to more accurately align state resources with federal grant dollars, in January 2007, the Division of Public Health (DPH) began managing and administering the SICA grant program, the Governor's Portion of the Safe and Drug Free Schools and Communities grant program (DFSC), and the SPF SIG program. These programs were formerly administered by the Division of Behavioral Health which continues to administer SAPT. While this transition was a necessary move for the state, it effectively split NDHHS' substance abuse prevention program between two divisions where one was formerly in charge. Although this change led to some staff turnover and loss of institutional knowledge, it has improved the collaboration between the state and the behavioral health regions concerning the delivery of community-based training and technical assistance needs (this collaboration is discussed more fully under the Capacity section).

While, as mentioned above, there is a need for increased coordination among state agencies to effectively address substance abuse prevention (addressed in greater detail in the Potential Gaps and Challenges section, below), the fact that so many state agencies and/or divisions of state agencies are actively engaged in substance abuse prevention activities is an indicator of the commitment of the state to address the issue. Additional state agencies and divisions involved in funding substance abuse prevention or related prevention activities include:

- **Tobacco Free Nebraska (TFN):** TFN is the state's comprehensive tobacco control program that targets youth prevention, cessation, eliminating secondhand smoke exposure, and disparities related to tobacco use and its effects among different population groups. The TFN program supports partnering community coalitions across the state, each of which are dedicated to reducing tobacco use among young people, eliminating exposure to secondhand smoke, and promoting tobacco cessation among adults and youth. Currently, nine coalitions are funded through TFN, with awards totaling \$1.4 million annually.
- **Nebraska Department of Education (NDE):** The NDE administers the State Education Agency portion of the U.S. Department of Education's Safe and Drug Free Schools and Communities program. This program provides \$1.25 million in funding for local school districts to establish, operate, and improve local programs of school drug and violence prevention and early intervention.
- **Nebraska Office of Highway Safety (NOHS):** This division of the Nebraska Department of Motor Vehicles is responsible for administering federal highway safety funds for the development and implementation of effective strategies to reduce the state's traffic-related injury and fatality rates. Alcohol is one of NOHS's five key priority traffic safety areas, and NOHS provides grant funding to political subdivisions and nonprofit organizations in priority counties for the reduction of fatal and serious injury crashes in the areas of occupant protection, youth, alcohol and/or speed. NOHS also administers the Office of Juvenile Justice & Delinquency Prevention's Enforcing Underage Drinking Law Grant funding, which targets Nebraska counties utilizing a community coalition model that focuses attention on the local enforcement of underage drinking laws as well as advocacy for public policy initiatives that support environmental strategies that are effective in reducing underage alcohol access and availability. NOHS receives approximately \$360,000 annually that is passed through to communities.
- **Nebraska Commission on Law Enforcement and Criminal Justice (a.k.a. Crime Commission):** Coordinates the development of juvenile justice initiatives and projects by administering state and federal grant funds to juvenile justice and delinquency prevention programs throughout Nebraska. Funding for these programs totals approximately \$3.2 million. The Crime Commission is also responsible for compiling and reporting adult and juvenile crime statistics for the entire state, and provides planning assistance to communities in developing and providing community-based juvenile services including substance abuse and delinquency prevention.
- **U.S. Attorney's Office:** The Office's Law Enforcement Community Coordination (LECC) Unit works to coordinate and support the efforts of law enforcement, criminal justice and community-based organizations and initiatives targeting reductions of drug and violent crime issues. LECC efforts include training, program development and facilitation, project assistance, and grants. Current areas of involvement for the LECC include: Project Safe Neighborhoods, the Weed and Seed program, sanctions-based drug demand reduction, and the Nebraska initiatives of the Midwest High Intensity Drug Trafficking Areas (HIDTA).

Another resource that is available to the state, regions, and communities is the recently expanded public health system. Prior to 2001, a total of 16 local public health departments covered only 22 of the state's 93 counties. The vast majority of these departments were small and severely underfunded. In 2001, legislation was enacted that provided dedicated state funds through the Tobacco Settlement Fund to create regional health departments across the state. By 2004, every county in Nebraska was covered by a local health department. These new health departments have expertise in planning and evaluating prevention programs and can serve as an important resource to community coalitions.

In response to SICA, a statewide advisory council, the Nebraska Partners in Prevention (NePiP), was formed in 2004. It was composed of representatives from key state agencies that administer substance abuse prevention funding and resources. Through collaborative partnerships, NePiP supported the development of state, regional, and community prevention-related capacity and infrastructure to conduct assessment, mobilization, planning, implementation, and evaluation processes. Under SICA, NePiP also piloted the implementation of tools to assist in prevention infrastructure assessment and planning, effective substance abuse prevention planning, and the selection of locally and culturally-appropriate evidence-based strategies.

Chaired by the Lieutenant Governor, NePiP currently includes 23 key stakeholders that continue to mobilize substance abuse prevention efforts at the state, regional, and community levels. NePiP includes representatives from the Department of Health and Human Services, the Department of Education, the State Office of Highway Safety, the State Legislature, the Nebraska Commission on Indian Affairs, the Nebraska Crime Commission, the Drug Enforcement Administration, the University of Nebraska, the U.S. Attorney's Office, and SAMHSA. (A complete list of the current NePiP members is included in Appendix B.) NePiP and its various workgroups and subcommittees has provided a means for state-level stakeholders to talk to each other (sometimes for the first time), learn from each other, and work together towards common substance abuse prevention goals. NePiP served as the advisory council for SICA and will continue to act in that capacity throughout the SPF SIG, providing leadership and oversight of the program. NePiP was responsible for making the final decision on state priorities with regard to SPF SIG, and will determine which community coalitions are awarded SPF SIG funds.

The SICA grant provided funding to 15 community coalitions across the state. Each coalition was required to identify desired substance abuse prevention outcomes based on identified risk and protective factors, and to implement evidence-based strategies in order to achieve those outcomes. Throughout the SICA process, the behavioral health regions were charged with the task of assisting funded coalitions to develop and implement comprehensive substance abuse prevention plans. SICA communities have clearly demonstrated the capacity to: (1) collect needs, resource and community readiness data; (2) engage in strategic planning for prevention using logic models; (3)

implement action plans; (4) measure and report data on the effectiveness of implemented strategies, and to modify prevention plans based on evaluation data; (5) engage in culturally competent and inclusive processes; and (6) develop and implement plans to enhance local prevention systems in order to sustain desired outcomes into the future.

Data capacity at the local level has also been enhanced through the Nebraska Risk and Protection Factor Student Survey. This biannual survey which is managed by the state SPF SIG staff was initially conducted in 2003. By 2007, about 175 schools and over 40,000 public and nonpublic students in grades 6, 8, 10, and 12 were participating in the survey. The survey results can be used by communities in prevention planning and future surveys that will be conducted in 2009 and 2011 will allow many of the SPF SIG funded communities to monitor and evaluate their progress.

The state used SICA funding to lay a strong foundation that supports the development of collaborative partnerships at the state, regional, and community levels. These partnerships will continue to support the creation of strong, sustainable systems of community-based substance abuse prevention. As a result of all of this experience, Nebraska is in an ideal position to implement the SPF SIG program.

### **Potential Gaps and Challenges**

One of the significant challenges of substance abuse prevention efforts is to assure that appropriate coordination and communication exists at the state, regional and community levels. As mentioned earlier, state agencies have begun to work more effectively together as a result of SICA, and through the collaborative process of NePiP. In addition, since the DPH began administering the SICA and SPF SIG programs, communication between DPH and the Division of Behavioral Health has been very open. This has resulted in both informal and formal meetings between staff of the two divisions that have increased mutual knowledge about prevention-related activities. Also, representatives from the Division of Behavioral Health serve on the NSAEW, and both divisions have representatives on NePiP.

Prior to receiving the SPF SIG, data collection efforts were conducted in isolation, with no central collection, analysis, or reporting. The overall effect has been a system of prevention that is disconnected. A particular challenge is that without a centralized system, the state's capacity to effectively and efficiently collect, analyze and report on data generated by SPF SIG grant recipients (as well as other grantees involved in substance abuse prevention and related issues) is substantially reduced. The NSAEW is now in place to analyze data, and a new online community level data collection and reporting system should be in place in about nine months. This system will allow all community coalitions to report data and information into a centralized repository.

Some challenges and gaps still exist in communities engaged in substance abuse prevention planning. For example, there has been some turnover among key staff and community leaders at the local level. Some communities have overcome this problem by effectively nurturing new leadership, but others are suffering from stagnating planning processes and low morale among remaining coalition members. Another challenge is that the capacity to conduct local evaluation needs to be strengthened. Finally, successfully developing the capacity to achieve sustainable outcomes over the long term remains a concern at the community level. To illustrate, it is apparent that several SICA coalitions that did not achieve sustainable outcomes by the end of that grant are hoping to achieve continued viability through SPF SIG funding.

Another challenge is that the biannual Risk and Protective Factor Student Survey is still not implemented in all communities. In fact, Nebraska's two largest public school districts (Lincoln Public and Omaha Public) have never participated. As a result, it will be a challenge to accurately measure the progress of SPF SIG strategies across the state. Furthermore, the survey only provides data for middle and high school students. Accurate local level risk and protective factor data for other age groups is often not available. Finally, local capacity to effectively conduct both process and outcome evaluation needs to be enhanced in some areas of the state.

## **Criteria and Rationale for SPF SIG Priorities**

After selecting the indicators and data sources to include in the epidemiological profile report, NSAEW began the process of identifying the indicators and criteria that should be used to determine the potential SPF SIG priorities. With the exception of two indicators related to alcohol-involved motor vehicle crashes, NSAEW decided to limit the indicators for the prioritization process to those on substance use and impaired driving. This approach was selected because the NSAEW felt that funded communities would have more control over changing substance use behaviors rather than the consequences (or outcomes) of these behaviors, and in-turn changes in behaviors would have a positive impact on multiple consequences of use. However, individuals scoring the potential priorities were encouraged to review data on the consequences of substance abuse to better score the economic/social impact of each indicator.

Forty-four indicators were chosen as potential priorities to score, with 10 being specific to tobacco, 13 to alcohol, and 21 to illicit drugs. Table 1 contains the 44 indicators along with their prioritization scores in descending order.

After selecting the indicators to score, NSAEW began to determine the criteria that should be used to identify SPF SIG priorities. The first step in the process was to review the criteria that had been used in other states. After considerable discussion, the Workgroup recommended that the following six criteria be used to establish the SPF SIG priorities:

- **Magnitude/Size of the Problem:** Shows the percentage of the population involved;
- **Comparison with National Ranking:** Compares Nebraska data with national data;
- **Historical Trends:** Indicates whether the problem is an isolated event, and whether the problem is getting better or worse;
- **Economic/Social Impact:** Reflects the impact on productivity of the workforce, the health of the population, crime rates, and the number of children and adolescents;
- **Preventability/Changeability:** Indicates whether the problem can be influenced at the community level in the next five years through prevention strategies and whether there are evidence-based programs, policies, and practices available that can significantly impact the problem;
- **Readiness/Political Will:** Reflects the awareness, interest, and political support or lack of clear political opposition at both the state and community levels.

After selecting the six criteria, the NSAEW determined that each should have an equal weight in the overall indicator score. As a result, half of the score would be based on objective scoring, while the other half would be based on more subjective scoring. The next step was to develop a rating scale so that the high priorities could be identified. The rating scale for each criterion is shown below.

1. Magnitude/Size of the Problem:
  - 1 = 0 – 4 percent of the population;
  - 2 = 5 – 9 percent of the population;
  - 3 = 10 – 14 percent of the population;
  - 4 = 15 – 24 percent of the population;
  - 5 = 25 percent+ of the population;
  - NA = not applicable.
2. Comparison with National Rankings:
  - 1 = significantly better than national rank;
  - 2 = slightly better than national rank;
  - 3 = same as national rank;
  - 4 = slightly worse than national rank;
  - 5 = significantly worse than national rank;
  - NA = not applicable.

3. Historical Trend:
  - 1 = significant improvement over the past five to ten years;
  - 2 = some improvement in the past five to ten years;
  - 3 = stable over the past five to ten years;
  - 4 = some deterioration (worsening) over the past five to ten years;
  - 5 = rapid deterioration (worsening) over the past five to ten years;
  - NA = not applicable.
  
4. Economic/Social Impact:
  - 1 = low impact on productivity, health care expenditures, crime and arrest rates, and the number of children and adolescents involved;
  - 2 = below average impact on productivity, health care expenditures, crime and arrest rates, and the number of children and adolescents involved;
  - 3 = average impact on productivity, health care expenditures, crime and arrest rates, and the number of children and adolescents involved;
  - 4 = above average impact on productivity, health care expenditures, crime and arrest rates, and the number of children and adolescents involved;
  - 5 = high impact on productivity, health care expenditures, crime and arrest rates, and the number of children and adolescents involved;
  - NA = not applicable.
  
5. Preventability/Changeability:
  - 1 = very unlikely that the problem can be changed at the community level through evidence-based programs, policies, and practices;
  - 2 = somewhat unlikely that the problem can be changed at the community level through evidence-based programs, policies, and practices;
  - 3 = neither unlikely nor likely that the problem can be changed at the community level through evidence-based programs, policies, and practices;
  - 4 = somewhat likely that the problem can be changed at the community level through evidence-based programs, policies, and practices;
  - 5 = very likely that the problem can be changed at the community level through evidence-based programs, policies, and practices;
  - NA = not applicable.
  
6. Readiness/Political Will:
  - 1 = there is very little willingness among state and community leaders and advocates to move forward on this problem;
  - 2 = *<not labeled>*;
  - 3 = there is some willingness among state and/or community leaders and advocates to move forward on this problem;
  - 4 = *<not labeled>*;
  - 5 = there is strong willingness among state and community leaders and advocates to move forward on this problem;
  - NA = not applicable.

Because the first three criteria could be scored objectively, staff from the Nebraska Substance Abuse Prevention Program was directed to rank the criteria for each of the 44 indicators that had been selected by the NSAEW. Since the bi-directional rating scale labels for 'comparison with national rankings' and 'historical trend' were somewhat ambiguous, the following methods were used during the scoring process:

- For scoring national comparisons, the categories of significantly better than the national rank (value of one) and significantly worse than the national rank (value of five) were selected when the Nebraska value was statistically better or worse than the national value, where  $p < 0.05$ . The categories of slightly better (value of two) and slightly worse (value of four) were selected when the Nebraska value was not statistically different from the nation but was greater than 10 percent above or below the national value. The category of same was selected when the Nebraska value was not statistically different from the nation and the difference between the Nebraska and national value was less than 10 percent.
- For scoring the historical trend, the trend line was observed to determine if it was moving in a positive linear direction (increasing), a negative linear direction (decreasing), or if it remained stable or changed inconsistently from year to year. If the trend was determined to be moving in a positive or negative linear direction (generally occurring when the most recent three or more data points were moving in the same direction), the first and last data points were tested in a similar manner to those described in the national comparison testing above. However, it should be noted that the Youth Risk Behavior Survey had only two recent data points available for analysis (data between 1995 and 2001 were unweighted due to a low response rate). As a result, the 2003 and 2005 data points were compared to one another to determine a change in trend.

The next step was to have every member of the NSAEW rank the remaining three criteria using an online survey. The survey was completed by 22 individuals, including all active members of NSAEW as well as staff from the Nebraska Substance Abuse Prevention Program. Table 1 shows the scores for all of the 44 indicators for each criterion along with the total score in descending order.

Following the completion of the online survey, a total score was calculated for each indicator using the average score across the six criteria. With a maximum of 5 points possible, scores ranged between 4.40 for "driving after drinking or riding with a driver who had been drinking among high school students" to 2.68 for "marijuana use in past month among all persons 12 and older."

Indicators of alcohol use and impaired driving ranked highest, with the top eight indicators being alcohol-related, 9 of the top 10 being alcohol-related and 11 of the top 15 being alcohol-related. Of the top 10 indicators, three were specific to alcohol

impaired driving (ranking 1<sup>st</sup>, 5<sup>th</sup>, and 10<sup>th</sup>), three were specific to binge drinking (2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup>), and three were specific to overall alcohol use (6<sup>th</sup>, 7<sup>th</sup>, and 8<sup>th</sup>).

Following alcohol, indicators of tobacco use ranked next highest. The top tobacco indicator, "current tobacco use among high school students," had a score of 3.70 and ranked 9<sup>th</sup> out of the 44 indicators that were scored. Tobacco use had one of the top 10 and three of the top 15 indicators, with one specific to overall tobacco use (ranked 9<sup>th</sup>) and two specific to cigarette smoking (ranked 11<sup>th</sup> and 13<sup>th</sup>). Indicators specific to tobacco use overall and cigarette smoking tended to rank relatively high while indicators specific to smokeless tobacco use ranked in the bottom one-third of all indicators.

Indicators of illicit drug use tended to be mixed with indicators of tobacco use; however, the top drug use indicator fell slightly below the top tobacco use indicator. The top drug use indicator, "methamphetamine use in the past year among 18-25 year olds," had a score of 3.63 and ranked 14<sup>th</sup> out of the 44 indicators. Drug use had no indicators ranked in the top 10 and one ranked in the top 15. Of the drug use indicators, methamphetamine ranked highest (14<sup>th</sup>, 16<sup>th</sup>, and 23<sup>rd</sup>), followed by indicators of illicit drug use overall (top indicator ranked 18<sup>th</sup>), marijuana use (top indicator ranked 26<sup>th</sup>), cocaine use (top indicator ranked 29<sup>th</sup>), and nonmedical use of pain relievers (top indicator ranked 40<sup>th</sup>).

In the next step, the members of the NSAEW met to discuss the scores and develop their recommendations for the SPF SIG priorities to NePiP. During the discussion, there was a consensus that it was important to target various age groups and allow community coalitions to determine which state priorities should be addressed in their communities. With regard to alcohol consumption, the NSAEW determined that community coalitions should continue their efforts to reduce underage drinking and also begin to reduce alcohol use in other age groups.

There was also considerable discussion about illicit drug use, particularly for methamphetamine and marijuana. Even though the documented use rate was relatively low when compared to alcohol and tobacco, the impact of methamphetamine and marijuana have a ripple effect throughout the state (e.g., long-term health care costs, costs to the criminal justice system, lost productivity, crime rates, schools and foster care, etc). While it was recognized that both of these drug problems require policy changes at the state level, long-term success cannot be achieved unless these problems are also addressed at the community level.

Members of NSAEW felt that it was not necessary to fund tobacco prevention activities using SPF SIG dollars since there was already a state level tobacco prevention program (Tobacco Free Nebraska). As a result, specific tobacco prevention priorities were not discussed nor recommended by the group.

After the discussion, the NSAEW recommended that the following priorities should be sent to NePiP for its consideration and final approval:

- Prevent alcohol use among persons 17 and younger;
- Reduce binge drinking among 18-25 year olds;
- Reduce alcohol impaired driving across all age groups;
- Reduce the use of methamphetamine among persons 12 and older; and
- Reduce the use of marijuana among persons 12 and older.

## **Description of the SPF SIG Priorities**

At a meeting on October 31, 2007, NePiP considered the recommendations from the NSAEW. After considerable discussion, NePiP decided that Nebraska's SPF SIG should focus exclusively on the three alcohol-related priorities identified by the NSAEW. The three priorities that were chosen were:

- **Prevent alcohol use among persons 17 and younger;**
- **Reduce binge drinking among 18-25 year olds;**
- **Reduce alcohol impaired driving across all age groups.**

Each community coalition will not be required to address all three priorities, but they must justify which priorities will be addressed based on the assessment process.

During the discussion that preceded the selection of the three priorities, several members indicated that a list of five priorities encompassing both alcohol and illicit drugs would provide a broader range of options for communities working to address substance abuse problems. A longer list of priorities would also provide an opportunity to impact several substance abuse problems across the state. However, NePiP members also identified some major disadvantages of a larger number of priorities, including:

- SPF SIG funds may be spread too thinly to have a significant impact on any one issue;
- It would be more difficult and costly to evaluate the effectiveness of local policies, programs, and practices;
- Many communities lack the expertise and resources to address multiple problems simultaneously;
- It is more difficult for the state and the regional prevention coordinators to provide adequate technical assistance on numerous priorities that cover several substance abuse areas.

Since many of Nebraska's community coalitions have focused on underage drinking either through the State Incentive Cooperative Agreement or other grants such as Safe and Drug Free Schools and Communities or the Substance Abuse Prevention and Treatment Block Grant, there is already considerable experience in this arena at the

local level. Coalitions that have worked on alcohol use prevention in the past can be resources to coalitions new to this focus area. NePiP members also pointed out that reducing binge drinking among 18-25 year olds and decreasing drinking and driving across all age groups were both natural extensions of existing work already being done in many Nebraska communities.

**Table 1**

**NSAEW Indicator Prioritization Scoring – Scores in Descending Order for all Indicators**

Indicator	Magnitude	Magnitude Score	Comparison Score	Trend Score	Economic/Social	Preventable/Changeable	Readiness/Political Will	Total Score
Driving after drinking or riding with a driver who had been drinking among high school students <sup>1</sup>	37.4%	5	5	3	4.73	4.48	4.19	4.40
Binge drinking among 18-25 year olds <sup>2</sup>	51.3%	5	5	3	4.23	4.19	4.05	4.25
Binge drinking among high school students <sup>1</sup>	29.8%	5	4	3	4.23	4.45	4.45	4.19
Binge Drinking among all persons 12 and older <sup>2</sup>	27.2%	5	5	3	4.23	3.90	3.79	4.15
Driving after drinking among high school students <sup>1</sup>	17.3%	4	5	2	4.73	4.43	4.43	4.10
Current alcohol use among all persons 12 and older <sup>2</sup>	55.6%	5	5	3	3.23	3.64	3.37	3.87
Current alcohol use among 18-25 year olds <sup>2</sup>	71.3%	5	5	3	3.23	3.76	3.10	3.85
Current alcohol use among high school students <sup>1</sup>	42.9%	5	3	3	3.23	4.32	4.10	3.78
Current tobacco use among high school students <sup>1</sup>	28.0%	5	3	3	3.45	4.21	3.55	3.70
Alcohol impaired driving among 18-24 year olds <sup>3</sup>	7.2%	2	4	3	4.73	4.18	4.19	3.68
Current cigarette smoking among high school students <sup>1</sup>	21.8%	4	3	3	4.05	4.10	3.95	3.68
Alcohol impaired driving among all adults 18 and older <sup>3</sup>	4.2%	1	5	3	4.73	4.00	4.14	3.65

Indicator	Magnitude	Magnitude Score	Comparison Score	Trend Score	Economic/Social	Preventable/Changeable	Readiness/Political Will	Total Score
Current cigarette smoking among 18-25 year olds <sup>2</sup>	40.0%	5	3	3	4.05	3.60	3.20	3.64
Methamphetamine use in past year among 18-25 year olds <sup>2</sup>	2.9%	1	5	NA	4.50	3.76	3.90	3.63^^
Percentage of motor vehicle fatalities in which alcohol was involved <sup>4</sup>	32.0%	5	1^	3	4.73	4.00	4.00	3.62
Methamphetamine use in past year among all persons 12 and older	1.3%	1	5	NA	4.50	3.70	3.86	3.61^^
Current tobacco use among all persons 12 and older <sup>2</sup>	28.9%	5	3	3	3.45	3.62	3.30	3.56
Lifetime Illicit Drug Use among High School Students <sup>1</sup>	36.5%	5	1	3	4.23	4.10	4.05	3.56
Percentage of motor vehicle injuries in which alcohol was involved <sup>4</sup>	7.3%	2	NA	3	4.73	4.00	3.95	3.54^^
Lifetime Illicit Drug Use Other than Marijuana among High School Students <sup>1</sup>	18.1%	4	2	3	4.32	4.10	3.80	3.54
Current cigarette smoking among all persons 12 and older <sup>2</sup>	24.5%	4	3	3	4.05	3.67	3.47	3.53
Current tobacco use among 18-25 year olds <sup>2</sup>	45.5%	5	3	3	3.45	3.62	3.05	3.52
Lifetime Methamphetamine Use among High School Students <sup>1</sup>	5.8%	2	3	3	4.50	3.95	4.19	3.44
Illicit Drug Use in Past Month among 18-25 year olds <sup>2</sup>	17.0%	4	2	3	4.23	3.70	3.45	3.40
Lifetime cigarette smoking among high school students <sup>1</sup>	53.4%	5	3	1	4.05	3.75	3.30	3.35
Marijuana use in past month among high school students <sup>1</sup>	17.5%	4	2	3	3.41	3.95	3.74	3.35

Indicator	Magnitude	Magnitude Score	Comparison Score	Trend Score	Economic/Social	Preventable/Changeable	Readiness/Political Will	Total Score
Lifetime alcohol use among high school students <sup>1</sup>	73.2%	5	3	1	3.23	3.86	3.50	3.27
Lifetime marijuana use among high school students <sup>1</sup>	32.3%	5	1	3	3.41	3.75	3.37	3.26
Cocaine use in past year among 18-25 years old <sup>2</sup>	7.2%	2	3	4	3.68	3.48	3.26	3.24
Lifetime cocaine use among high school students <sup>1</sup>	7.5%	2	3	3	3.68	4.00	3.53	3.20
Cocaine use in past month among high school students <sup>1</sup>	3.3%	1	3	4	3.68	3.86	3.58	3.19
Current smokeless tobacco use among 18-24 year olds <sup>5</sup>	7.7%	2	4	3	3.27	3.40	2.63	3.05
Marijuana use in past month among 18-25 year olds <sup>2</sup>	14.7%	3	2	3	3.41	3.43	3.26	3.02
Illicit drug use other than marijuana in past month among 18-25 year olds <sup>2</sup>	6.7%	2	2	2	4.32	3.62	3.60	2.92
Cocaine use in past year among all persons 12 and older <sup>2</sup>	2.2%	1	3	3	3.68	3.52	3.30	2.92
Current smokeless tobacco use among all adults 18 and older <sup>5</sup>	4.5%	1	4	3	3.27	3.48	2.60	2.89
Illicit Drug Use in Past Month among all Persons 12 and Older <sup>2</sup>	6.5%	2	2	2	4.23	3.57	3.48	2.88
Marijuana use in past year among 18-25 year olds <sup>2</sup>	23.1%	4	1	2	3.41	3.52	3.28	2.87
Current smokeless tobacco use among high school students <sup>1</sup>	8.7%	2	3	2	3.27	3.89	3.00	2.86
Non-medical use of pain relievers in past year among all persons 12 & older <sup>2</sup>	4.0%	1	2	3	3.55	3.81	3.42	2.80

Indicator	Magnitude	Magnitude Score	Comparison Score	Trend Score	Economic/Social	Preventable/Changeable	Readiness/Political Will	Total Score
Non-medical use of pain relievers in past year among 18-25 year olds <sup>2</sup>	9.6%	2	1	3	3.55	3.62	3.30	2.75
Illicit drug use other than marijuana in past month among persons 12 and older <sup>2</sup>	3.0%	1	2	2	4.32	3.57	3.48	2.73
Marijuana use in past year among all persons 12 and older <sup>2</sup>	9.1%	2	2	2	3.41	3.43	3.30	2.69
Marijuana use in past month among all persons 12 and older <sup>2</sup>	5.0%	2	2	2	3.41	3.43	3.25	2.68

*^National comparison based on 2005 estimates for NE and U.S. from the National Highway Traffic Safety Administration*

*^^Based on only five scoring criteria due to unavailable information*

- 1) 2005 Youth Risk Behavior Survey (YRBS)
- 2) 2004/2005 (combined) National Survey on Drug Use and Health (NSDUH)
- 3) 2006 Behavioral Risk Factor Surveillance System (BRFSS)
- 4) 2006 Nebraska Department of Roads
- 5) 2004 Behavioral Risk Factor Surveillance System (BRFSS), note measures were not collected in 2005 and 2006

# Capacity Building

The mission of Nebraska's SPF SIG program is to nurture the development of sustainable, coordinated, and data-driven prevention systems at the state, tribal, regional, and local levels. To be successful, these prevention systems must involve partnerships of agencies, organizations, and individuals that are committed to decreasing substance abuse through a collaborative and coordinated process of: (1) comprehensive planning for and evaluation of outcomes; (2) promoting evidence-based strategies; (3) allocating resources; and (4) enhancing workforce skills and knowledge.

## Areas Needing Strengthening

Although Nebraska has made considerable progress in developing substance abuse prevention capacity and infrastructure, some areas must be strengthened. Nebraska must improve the coordination of substance abuse prevention funding, planning, and strategy implementation at the state level. In the past, the lack of coordination could be attributed to "silo" funding streams and different prevention approaches among state agencies. However, Nebraska plans to overcome this obstacle by (1) using the SPF SIG five-step model to set state priorities across the diverse array of agencies funding substance abuse prevention activities, (2) distributing funds to communities based on the NSAEW's epidemiological profile, and (3) using a common evaluation approach regardless of the funding source. In essence, the results of the state's epidemiological profile developed under SPF SIG will be used as a guide for distributing funds for substance abuse prevention initiatives regardless of whether they are funded under the Block Grant, the SPF SIG, or other grant programs. By adopting the SPF model as a uniform requirement across state agencies engaged in substance abuse prevention, "silos" can be eliminated and coordination of efforts will be greatly enhanced.

As part of the coordination process, it is critical for the state to involve the six behavioral health regions as active partners. Regional staff can be instrumental in providing training and technical assistance to community coalitions because they have the best understanding of local issues and problems – they know the communities first-hand because they live near them and regularly work with them. While, as mentioned above, the state's ultimate goal is that all communities receiving substance abuse prevention funding from state agencies be required to implement the SPF, the process has begun through a partnership between the Division of Public Health and the Division of Behavioral Health. As a result of coordinated planning between the two divisions, an agreement has been reached whereby communities that receive either Block Grant dollars (which are funneled through the regions) or SPF SIG funding must apply the SPF model.

In order to ensure that the SPF planning model is adhered to, the regional prevention coordinators and state prevention staff within the two divisions are working with the

Southwest Center for the Application of Prevention Technologies (Southwest CAPT) and an independent consultant to develop a statewide SPF education and training program that can be used in all communities that receive the aforementioned prevention funds. By ultimately requiring all communities to use the SPF model, and by providing effective statewide training and technical assistance in the use of the model, greater progress can be achieved in reducing substance abuse and related health consequences across the state. The next section (State and Community-Level Activities) provides a more complete description of the involvement of regional staff in providing training and technical assistance to both SPF SIG communities and other coalitions engaged in substance abuse prevention planning.

State level capacity must also be strengthened through the development of an online and centralized data collection and reporting system for both block grant and SPF SIG funded grantees. This reporting system, currently under development, will allow communities and regions to report on their goals and objectives, evidence-based strategies, National Outcome Measures (NOMs), and other data that are needed to evaluate the effectiveness of substance abuse prevention strategies. Not only will this reporting system aid in the evaluation of individual coalitions, it will allow State staff and researchers an opportunity to plan for future projects by allowing them to identify areas of the state that are receiving funding and/or lacking funding, areas that have been particularly successful or unsuccessful, and the types of strategies that are being implemented in different regions of the state.

Another area that needs improvement is the timely delivery of new and existing substance abuse data. To accomplish this, Nebraska is taking the first step in moving toward that goal by developing an interactive data web site that will provide a mechanism for users to download the most currently available data. This web site is intended to enhance awareness, planning, and decision-making by:

1. Providing easily accessible and up-to-date data on substance abuse for use by public health, media, and policymakers;
2. Providing data across a variety of demographic subgroups to enhance planning at the state, regional, and local levels; and
3. Providing a model for other public health programs within NDHHS that want to make their data accessible online.

In addition, state, regional and local level capacity to engage in effective evaluation of substance abuse prevention initiatives must be enhanced. Under SICA, Nebraska relied on local evaluators and the Research Triangle Institute (RTI) to conduct the evaluation. However, the effectiveness of local evaluators varied substantially, such that the quality of local evaluations ranged across the board. During the implementation of the SPF SIG, RTI will work much more closely with local evaluators to ensure both a standardization of evaluation processes and greater synergy between local evaluation efforts and the statewide evaluation. By the end of the SPF SIG program, the goal is to have developed

a team of local evaluators that have expertise in evaluating the outcomes of evidence-based substance abuse prevention strategies and policies implemented by community coalitions, and whose experience can be leveraged by both SPF SIG and other coalitions working on substance abuse prevention throughout the state. This team will be responsible for providing training and technical assistance to the regions and coalitions in order to build their capacity around evaluation, with the ultimate intention of ensuring that all communities are capable of engaging in effective evaluation of substance abuse prevention initiatives.

Finally, a major challenge is to identify the unique needs and circumstances of racial/ethnic minority populations. Because data are often not available or are very limited, it can be quite difficult to identify these needs. As a result of these data limitations, the state plans to continue to do targeted outreach to representatives from minority communities and to include individuals from these communities on SPF SIG funded coalitions. The state also plans to seek input from these groups to better understand any unique risk and protective factors within these populations, the strategies that would be most effective in addressing priority substance abuse problems, as well as innovative assessment methods that might be used to effectively collect data about these populations in the future.

## **State and Community-Level Activities**

One of the critical elements of the substance abuse prevention infrastructure is a skilled and knowledgeable workforce. In order to develop a competent workforce that is capable of understanding and using the SPF model, it is essential to provide training and technical assistance (T/TA) at the state, regional and local levels.

### **The Nebraska Approach to Training and Technical Assistance**

**State Level:** Under SICA, NePiP created a Workforce Development Leadership Team (WFDLT). This subcommittee will be reconvened under SPF SIG to provide leadership and vision for the creation of a coordinated Nebraska workforce development strategic plan for prevention that meets needs across the spectrum of agencies, organizations and entities with a stake in prevention. In addition, the WFDLT will lead the effort that integrates workforce development planning with other prevention planning.

The first step in planning for workforce development is to assess the existing substance abuse prevention workforce. To accomplish this goal, the WFDLT (under SICA) developed and implemented an online substance abuse prevention workforce assessment. Under the SPF SIG, this survey will be implemented annually. The intent of the survey is to provide necessary information about the composition of the workforce, what their knowledge, skills, and activities consist of, as well as training needs. This information will be used to develop and revise the state's workforce development strategic plan.

The survey is intended to reach as many individuals as possible whose work intersects with substance abuse prevention, including: school personnel, law enforcement officers, health care workers, tribal representatives, state agency staff, community coalitions, advocacy groups, and, of course, substance abuse prevention professionals. The data analysis will include cross-tabulations that will provide useful information about each of the specific professional categories mentioned above. This information will be used by the WFDLT to develop appropriate strategies to meet the needs and resources of Nebraska's diverse substance abuse prevention workforce.

**Regional and Community Level:** Based on the experience under SICA, community coalitions benefit enormously from hands-on, face-to-face training and technical assistance that takes them through every step of the prevention planning process. When this assistance is bolstered by the provision of specific tools for assessment and planning, communities demonstrate significantly increased capacity to engage in effective planning. This approach to capacity development will be sustained and enhanced under the SPF SIG program. These training and technical assistance activities must be continually monitored and remain flexible because communities will progress through the SPF model at different speeds.

To meet immediate SPF SIG training and technical assistance needs, a partnership was formed between the state and the six regional prevention centers in the spring of 2007. This approach to capacity building uses a train-the-trainer model whereby the Regional Prevention Coordinators (RPCs) are responsible for providing educational materials, training, and technical assistance to communities to support successful implementation of the SPF process.

This approach has several advantages. First, RPCs have the best understanding of the needs and circumstances of local communities within their regions. Second, the experience gained by the RPCs through the SPF SIG project can be used in training other (non SPF SIG) communities that are interested in addressing substance abuse and related problems. For example, at least half of the Block Grant funds that are allocated to the regions must be used to fund substance abuse prevention programs and policies at the community level. Using the SPF model for all communities should lead to a more consistent training approach throughout the state.

Finally, by creating a collaborative state/regional partnership, an opportunity is created to develop uniform, statewide training and technical assistance materials and methodologies for use with communities engaged in substance abuse prevention planning. Because of the partnership, a system of accountability is cultivated whereby the regions are responsible for assuring a degree of standardization in terms of T/TA content, while simultaneously being allowed the flexibility to mold content to specific local needs.

In May 2007, SPF SIG staff and the RPCs began meeting to determine the skills and competencies that are needed to educate communities in assessment, capacity building, planning, implementation, evaluation, cultural competency, and sustainability. A consultant (previously employed as the Southwest CAPT's Nebraska Liaison from May 2002 to May 2006, and who developed training materials for the SICA subrecipients) was hired to facilitate the meetings and begin working with the group to develop the tools and materials that are needed. During these discussions, the group identified the following six major steps in the process:

- 1) Participate in an online SPF course;
- 2) Identify areas of the SPF model where additional training is needed by T/TA providers;
- 3) Develop tools and materials that can be used by the RPCs in order to provide SPF training and technical assistance to communities;
- 4) Organize regional and/or statewide workshops to present information about the SPF model and the state's prevention priorities to communities;
- 5) Identify subject matter experts (e.g., cultural competency) that can be used to provide additional support to the RPCs; and
- 6) Develop a web-based system to facilitate the sharing of training and technical assistance information and tools among T/TA providers.

Because there was considerable variation in the level of understanding of the SPF model among state and regional staff, the entire group participated in a six-week online facilitated course offered by the Southwest Prevention Center entitled "Program Planning Using Strategic Prevention Framework (SPF)." After completing the online course, the participants met to identify the broad areas of the SPF model where additional training was needed.

The meeting was facilitated by an outside consultant with assistance by the Nebraska Liaison from the Southwest CAPT. During the meeting, a small training team was formed to determine the training tools and materials that will be needed by the RPCs as they work with the community coalitions during the three phases of Nebraska's SPF SIG for community coalitions: (1) the application phase, (2) the planning phase, and (3) the implementation phase. With input from the larger group, the training team identified six key training and technical needs for Nebraska's T/TA providers:

➤ Assessment:

Build community capacity to use data to bring people together and motivate them to effectively prioritize community needs.

- Capacity:  
Assist coalition members to nurture local leadership.
- Implementation:  
Work effectively with communities to help them understand that the SPF is a dynamic process that requires constant revisiting (e.g., evaluation results may dictate a change in strategies, a new implementation plan).
- Evaluation:  
Help communities use evaluation to bring people together and motivate them to effectively meet priority community needs.
- Cultural Competency:  
Assist communities to establish an open, supportive environment wherein cultural competency and diversity issues are effectively addressed at each stage of the SPF.
- Sustainability:  
Define sustainability in terms that build a strong community understanding of what sustainability means, and find simple, applicable and usable tools that will allow community members to be successful in achieving sustainable outcomes.

In September, the training team determined that training and technical assistance materials would have to be developed in order to assist communities preparing to compete for SPF funding – the first phase of the SPF SIG process for Nebraska communities. Together, these materials would form a “Planning to Plan” Guide for use by the RPCs in helping to lead potential SPF SIG communities successfully through the application process.

A second workshop that was held in October provided coaching to RPCs on effective methods of T/TA for communities as they prepare to compete for the SPF Request for Applications (RFA). Staff from the Southwest Prevention Center and Southwest CAPT presented information on the four topic areas identified by the RPCs as most critical for building the capacity of communities during the SPF SIG application phase. These areas were assessment, evaluation, cultural competency and sustainability.

The goal of the October workshop was to increase the capacity of the Regional Prevention Centers to assist communities in preparing to compete for SPF SIG funding. The three training objectives were: (1) establish a baseline of knowledge within the four content areas to be addressed; (2) develop questions around the four content areas to assist in the development of the "Planning to Plan" Guide for communities competing for SPF SIG funding; and (3) identify the next steps for implementation of the "Planning to Plan" process.

The next steps are for the RPCs and SPF SIG staff to work on developing useful materials to assist community coalitions during the SPF SIG application and planning phases. In the area of assessment, for example, communities should identify how they intend to approach the assessment process (e.g., what data sources and collection methods will be used to collect and analyze both quantitative and qualitative data). During the planning phase, successful grantees will analyze local data, identify the major factors contributing to substance use and abuse, determine which priorities will be addressed based on the data analysis, and ultimately select evidence-based strategies to impact those priorities.

## **Role of the NSAEW**

The NSAEW will continue to have an integral role in the remaining years of the SPF SIG program. One of the functions of the Workgroup is to identify and prioritize substance abuse data gaps, including missing or incomplete data, availability of data, and utilization of data. While the following list is a major step toward identifying and prioritizing data gaps within the state, it is intended to be the initial step in an evolving discussion of data and their overall importance to substance abuse prevention in the State. The following data gaps were identified by the NSAEW and included in the epidemiological profile report (in no particular order of importance):

- Lack of representative data on Nebraska youth, resulting from a lack of participation in school-based surveys.
- Under-representation from specific target groups, including but not limited to, rural communities, racial and ethnic minorities, individuals of low socio-economic status, and individuals who are institutionalized (for both crime and mental illness).
- Limited data at the regional, county, and community levels.
- Limited demographic data on self-reported illicit drug use among adults. The National Survey on Drug Use and Health is the only state source containing self-reported data on illicit drug use among adults, and for adults, demographics are limited to two age groups (18-25 and 26 and older).
- Incomplete data on substance abuse among college students in Nebraska, attending both two and four year institutions.
- Limited surveillance to identify new and emerging drugs (e.g., Nebraska does not have a state-operated medical examiner data system).
- Inconsistent categories for illicit drug type are used across data systems.
- Incomplete hospital discharge data.
- Inconsistent alcohol and drug testing of patients at Nebraska trauma centers.
- Limited data linkage within the legal and health care systems.
- Low capacities to collect, analyze, and utilize data at the community level.

- Limited data from schools, worksites, health care, and law enforcement regarding substance abuse prevention efforts within their organizations.

The NSAEW will identify the most serious data gaps and develop strategies to alleviate them. In addition to addressing the data gaps, the NSAEW will focus on specific projects. For example, one of its first projects is to develop in-depth reports on the substance abuse prevention priorities. These reports will include an expanded analysis of regional differences as well as provide information on contributing factors that are related to a specific substance abuse problem (e.g., attitudes, policies, access, enforcement).

In addition, the NSAEW will help develop a community assessment guidance document that will help community coalitions collect, interpret, and use local data for planning. Parallel to this document, each funded community will receive a county profile of substance abuse problems and issues designed to assist community coalitions in data analysis and overall planning efforts. The profiles will not contain every potential data source, but they should stimulate both discussion around key issues and further data collection efforts.

A third major project is to provide regular updates to the epidemiology profile. These updates will be used to monitor progress in addressing the priority problem areas and to identify emerging issues that need to be addressed. This process for updating the profile will be similar to the initial profile. Key databases will be analyzed to identify new problems and observe whether there have been changes in the substance abuse trends.

A fourth major project will be the development of a strategic plan with specific action steps to encourage greater participation in school-based surveys. In both the Youth Risk Behavior Factor Survey (YRBS) and the Nebraska Risk and Protective Factor Student Survey (NRPFS) fewer schools participated in the 2007 than in 2005, although the number of students responding to the NRPFS increased substantially during the 2007 administration because more larger schools chose to participate in the survey. Although these surveys are critical to the development of substance abuse strategies and policies for middle and high school students, many school officials believe that the surveys take too much time away from academics and there is limited interest among the students. They also contend that the surveys are repetitive and redundant and that over-surveying students may lead to less authentic responses.

A final major project is to create an interactive substance abuse data web site for the State of Nebraska, which will serve as a substance abuse data repository (noted above under 'areas needing strengthening'). This web site would enhance access to current data and provide more complete information across various demographic sub-groups (e.g., urban/rural). This interactive web site would allow community, regional, and state policymakers to obtain information to help them make more informed decisions about the substance abuse burden as well as strategies and policies to address the problems.

# Planning

This section describes the mechanism for distributing SPF SIG resources. It contains the following components: (1) the state planning model; (2) a description of community-based activities; (3) the allocation approach; and (4) the implications of the allocation approach.

## 1. The State Planning Model

Nebraska will use a competitive RFA process for distributing funds to meet the high priority substance abuse problems identified in the Assessment section. A competitive process was selected for several reasons, including:

- Nebraska already has several established coalitions that are addressing alcohol-related substance abuse problems, especially underage drinking.
- Another factor is that Nebraska lacks sufficient local data to identify the highest risk areas.
- Nebraska is making a strong effort to encourage all communities to engage in substance abuse prevention through training and technical assistance provided by regional prevention coordinators.
- A final reason for using a competitive RFA process is related to state rules and regulations. Because the grant awards will exceed \$50,000, a competitive process is required.

A competitive RFA process will be used to determine which coalitions will be awarded funds. Although some variation exists, there is strong evidence to suggest that major problems exist in all of the state's six behavioral health regions. As a result, SPF SIG funding will support at least one community coalition in each of Nebraska's six behavioral health regions (see Appendix C for a map of the regions). Failure to fund at least one coalition in each region could dramatically set-back existing efforts to unify all regions in using the SPF model to address substance abuse prevention within funded communities.

As will be described in substantially more detail in the remainder of this section, Nebraska was unable to determine that any particular region of the state or any particular subpopulation was either particularly "high need" or "low need." As a result, SPF SIG application review criteria will be based on balancing community capacity to implement the SPF process against available resources already accessible at the community level (see the section on Allocation Approach for additional details of the review process).

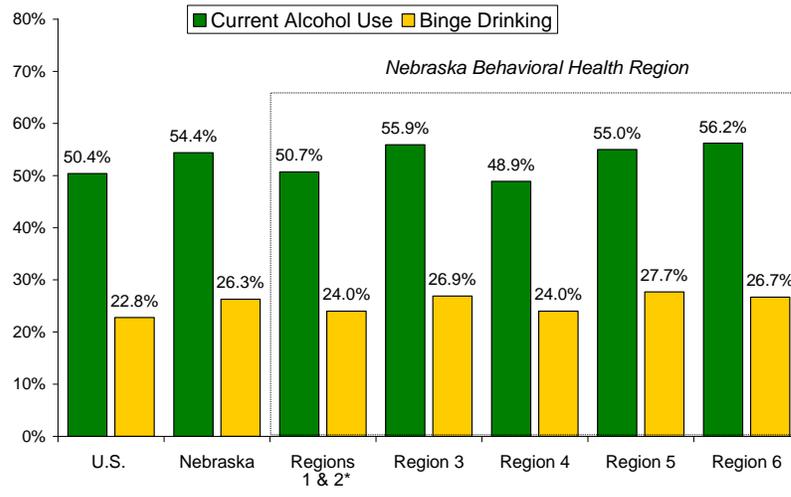
To better understand the differences in Nebraska for alcohol use, binge drinking, and alcohol impaired driving across Nebraska's six Behavioral Health Regions, data

were analyzed using four data sources. These data sources included the Youth Risk Behavior Survey (YRBS), the Nebraska Risk and Protective Factor Survey (NRPFS), the Behavioral Risk Factor Surveillance System (BRFSS), and the National Survey on Drug Use and Health (NSDUH).

While it would have been desirable to analyze these data at a county or community level, the data did not allow for this type of analysis. In fact, analysis at the behavioral health region level was questionable for the YRBS and NRPFS, in particular. The YRBS is designed to generate representative state level data, but not necessarily representative regional data. As a result, differences by region should be viewed with caution, especially for region six (encompassing the state’s largest city, Omaha) which had a low school response rate. The NRPFS is a census sample with a relatively low overall response rate. As a result, these data only represent the schools, school districts, and communities who chose to participate in the survey, but do not represent all students at the state and regional level. Participation among schools in the Lincoln and Omaha Metropolitan areas was poor for the NRPFS and as a result these data consist mainly of students from small urban and rural communities.

After examining differences across the four data sources, it was determined that alcohol use, binge drinking, and alcohol impaired driving are important public health issues across the entire State of Nebraska. According to data from the 2002-2004 NSDUH, alcohol use and binge drinking varied slightly across the six Nebraska Behavioral Health Regions; however, none of the regions differed significantly from the state as a whole nor did they differ significantly from one another (Figure 11). When comparing regions to the nation, all regions were above the national average for binge drinking.

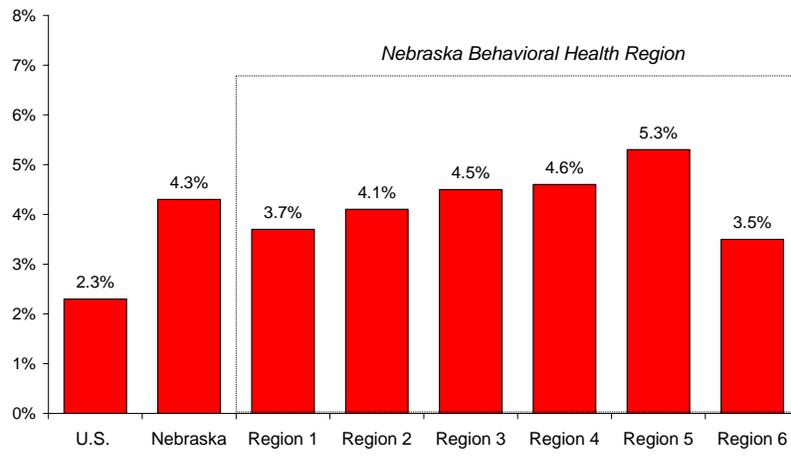
**Figure 11: Current Alcohol Use and Binge Drinking among Persons 12 and Older, by Nebraska Behavioral Health Region, 2002-2004 Combined**



\*Data were only available for regions one and two combined  
Source: National Survey on Drug Use and Health

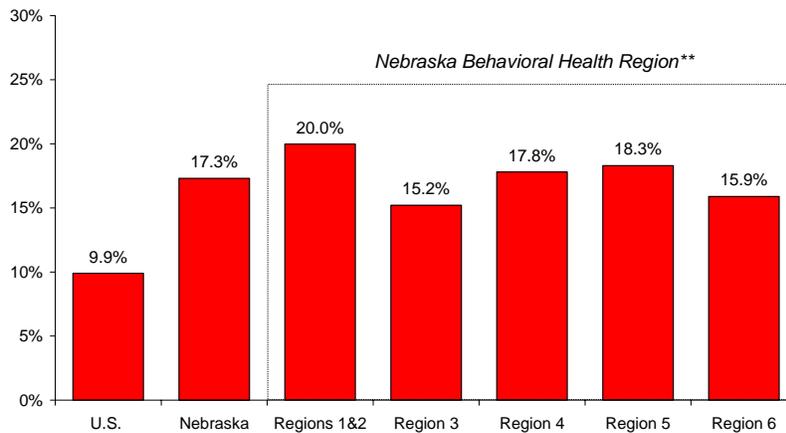
Alcohol impaired driving among high school students and adults (18 and older) in Nebraska did vary slightly by behavioral health region; however, none of the regions differed significantly from the state as a whole (Figures 12 and 13). Furthermore, none of the regions differed significantly from one another with the exception of region five (a largely rural region, geographically, that also encompasses the state's second largest city, Lincoln), which had a significantly higher percentage of adults reporting alcohol impaired driving than region six. When comparing regions to the nation, all regions were above the national average for high school students and adults reporting alcohol impaired driving.

**Figure 12: Alcohol Impaired Driving (Age-Adjusted) among Adults (18 and Older)\*, by Nebraska Behavioral Health Region, 02, 04, 06 Combined**



\*Percentage of adults 18 and older who report driving after having perhaps too much to drink during the 30 days preceding the survey  
 Source: Behavioral Risk Factor Surveillance System (BRFSS)

**Figure 13: Alcohol Impaired Driving among High School Students\*, by Nebraska Behavioral Health Region, 2005**



\*Students who drove a car or other vehicle when drinking alcohol during the 30 days preceding the survey  
 \*\*Data were not collected to represent sub-state regions and should be viewed with caution, especially region six due to a low school response rate  
 Source: Behavioral Risk Factor Surveillance System (BRFSS)

While some differences existed by region for specific data sources, these differences were inconsistent across all data sources. For example, compared to the state, Region Three had a significantly lower percentage of high school students (YRBS) and adults (BRFSS) reporting current alcohol use. In contrast, although the difference was non-significant, alcohol use among all persons 12 and older within region three fell just above the state average and was within 0.3 percent of the region demonstrating the highest alcohol use for this age group (region six).

For the 18-25 year old population in Nebraska, the BRFSS was the only data source available for comparing alcohol use by behavioral health region. Findings from the BRFSS suggest that current alcohol use and binge drinking may be highest in region five and lowest in region one. However, regional disparities found within this age group are not necessarily consistent with the findings for youth and all adults across the four surveys. In addition, the sample size for 18-25 year olds is considerably smaller than for all adults and there is growing concern among researchers about the influence that cell phones are having on the validity of landline based telephone surveys, such as the BRFSS, especially for young adults, both of which make the interpretation of the data more difficult.

Based on an extensive analysis of alcohol use, binge drinking, and alcohol impaired driving by Nebraska behavioral health region, we could not conclude that any one region of the State of Nebraska should be targeted for SPF SIG funding, nor could we conclude that any region be excluded or downgraded because it lacks a serious enough problem to warrant funding. As a result, we intend to invite all communities to apply and will base application scores on factors other than the state level data that were analyzed during the epidemiological profile and state planning processes.

For additional information on current alcohol use, binge drinking, and alcohol impaired driving by Nebraska behavioral health region, detailed results for the three priority areas can be seen in Appendix D of this plan.

## **2. Community-Based Activities**

Once community coalition grantees have been identified, SPF SIG funding will be used initially to support the planning activities necessary to apply the SPF model. In the first six to eight months, each coalition will be expected to work through the five steps of the SPF model beginning with assessment. During the planning phase, technical assistance will be primarily provided by the RPCs. However, SPF SIG staff will prepare local community data profiles that will include local substance abuse use and consequence data.

During the assessment phase, each community coalition will determine which priority(s) will be addressed. The selection of the priority(s) should be based on analysis of local data (e.g., magnitude of the problem, historic trends, comparison

with state and national data, etc.). The assessment process should also identify the major contributing factors that have influenced local substance abuse problems. In addition to analyzing local data, community coalitions must describe the process used to select priorities. For example, what process was used to obtain community input (e.g., town hall meeting, focus group interviews)? The needs assessment should also describe how the concepts of cultural competency and inclusion were woven into the assessment process. Finally, data gaps should be identified along with strategies to eliminate these gaps in the future.

In the capacity section of the plan, the mission and goals of the coalition should be described as well as the composition of its members. The description of coalition membership should also include the degree and manner in which key stakeholders have agreed to participate in the project, and how the coalition will leverage local resources to enhance the initiative.

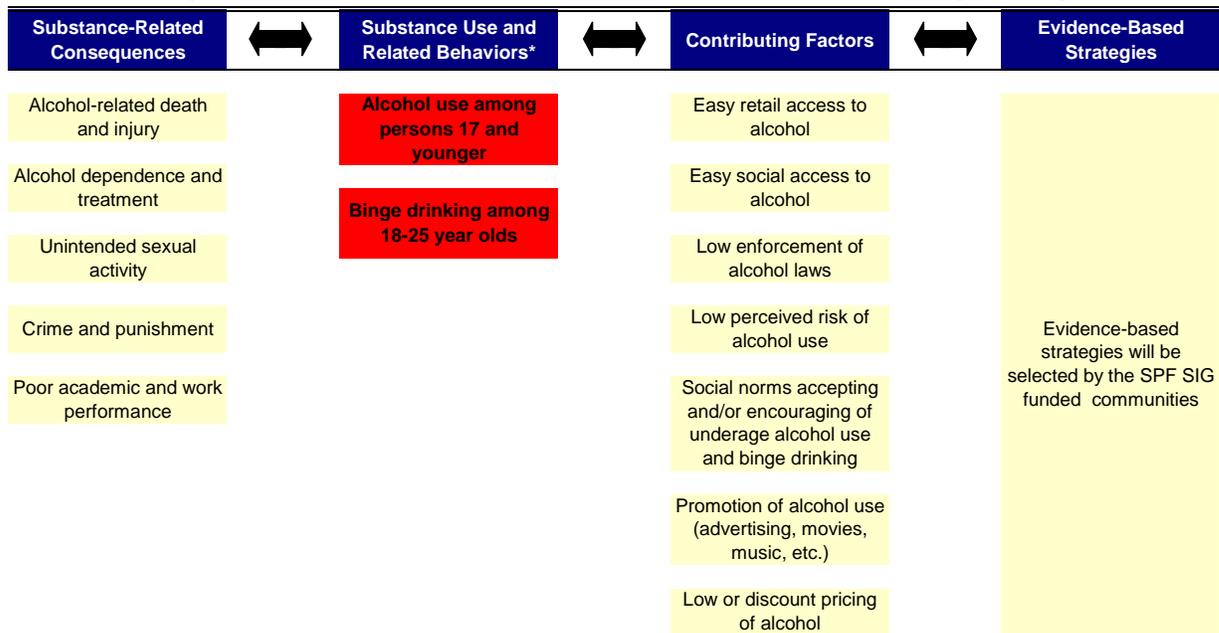
Finally, the coalition should address its capacity to mobilize stakeholders and use other human resources. For example, how will the coalition interact and collaborate with stakeholders not currently involved with the coalitions? The capacity section should also identify the processes that are in place or will be developed to help ensure that the people working within the local substance abuse prevention system will have the skills, abilities, and commitment to contribute to prevention goals (e.g., on the job learning, mentoring, technical assistance, training, continuing education, support/supervision).

In the planning section, community coalitions will develop logic models that identify the prevention priority(s), the various factors that contribute to the priority, and the proposed strategies that will be implemented (examples of logic models are shown on page 49). Selected strategies must be consistent with the problem areas identified in the needs assessment and must be evidence-based, such as the programs, practices, and policies contained in the National Registry of Evidence-Based Programs and Practices (NREPP). Finally, the planning section should describe the process that was used to select strategies, the identified target population(s), the geographic area or areas that will be covered, and whether the target population(s) had input into the decision-making process.

The implementation section should describe the capacity of the coalition to implement the prevention plan. If a coalition has experience with implementation, it should describe the lessons learned through that experience, how past policies, programs, and practices were made more culturally relevant, and how they were monitored and perhaps modified. Most importantly, the implementation section should lay out the specific steps and timeline that will be followed to carry out the coalition's substance abuse prevention plan.

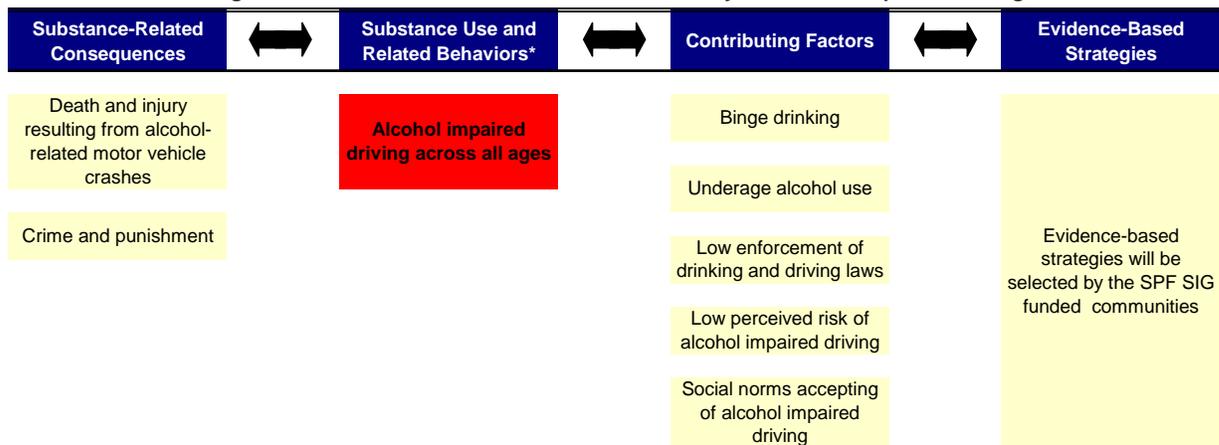
The evaluation section should describe the approach that will be used to conduct the evaluation. For example, what data will be used to measure the results (both outcome and process), what methods will be used to analyze the data, and how will the results be used and shared with the community? The evaluation plan should also address the effectiveness of the coalition and what changes may be needed to make the coalition more effective.

**Logic Model 1: Nebraska SPF SIG Prevention Priorities for Alcohol Use and Binge Drinking**



\*Red shading signifies state SPF SIG prevention priorities  
 Note: This model was adopted from the New Mexico SPF SIG logic model

**Logic Model 2: Nebraska SPF SIG Prevention Priority for Alcohol Impaired Driving**



\*Red shading signifies state SPF SIG prevention priorities  
 Note: This model was adopted from the New Mexico SPF SIG logic model

As part of the planning process, it is critical for each coalition to address both current capacity around cultural competency as well as its plans to integrate culturally competent processes into all five steps of the SPF. Coalitions will be asked to demonstrate an active commitment to cultural competency. The following questions related to cultural competency must be answered by each coalition:

- What are the unique cultural, racial/ethnic, and linguistic need patterns within the geographic area served by the coalition, and how does the coalition currently meet those needs?
- How does the coalition plan to enhance capacity to more effectively meet those needs in the future?
- What is the extent to which there is broad-based citizen participation, including those most affected by the consequences of substance abuse, in current substance abuse prevention efforts? How does the coalition plan to increase that participation?
- What is the extent to which coalition members represent the diversity of the community with respect to race, gender, geography, ethnicity and age? Is there adequate representation of both grassroots and agency perspectives?
- How will the coalition ensure that community prevention strategies are culturally competent (use past experience to illustrate, as appropriate)?
- What is the coalition's past experience engaging in culturally competent and inclusive assessment, capacity development (i.e., mobilization of stakeholders and other resources), planning, strategy implementation, and evaluation? How will the coalition increase cultural competence and inclusion within these areas in the future? Are there any lessons learned about cultural competence and inclusion?

The capacity to sustain desired prevention outcomes is also a key element of the planning process. Each coalition must describe its current capacity to sustain desired prevention outcomes and how it intends to expand its capacity in this area (specifically, each coalition must explain how it will build organizational and prevention system capacity, ensure strategy effectiveness, and foster community support). Also, if it is an experienced coalition, it should describe how existing prevention strategies have been sustained, and what approaches were most effective in achieving sustainability.

### **3. Allocation Approach**

Nebraska will allocate its funds to community coalitions through a competitive RFA process. Eligible applicants will be broad-based coalitions applying on behalf of one or more counties. A coalition is an organized group with strong leadership and multiple partners that has demonstrated capacity to engage in the five steps of the SPF Model.

Nebraska has almost \$9 million that will be awarded to community coalitions over the course of the SPF SIG program. After applications are submitted, they will be reviewed by SPF SIG staff and members of a grant review committee to be formed by NePiP. That committee will make its recommendations to NePiP, which is responsible for final approval of grant awards. Before implementation activities will be funded, each coalition must prepare a local strategic plan using the SPF model.

As mentioned above, this plan will use local quantitative and qualitative data to assess the needs of the population, examine current capacity to meet these needs, identify the state priorities that will be addressed at the local level, identify evidence-based strategies to implement in order to address the needs, and formulate an evaluation plan to determine the effectiveness of strategies. It is anticipated that most coalitions will be able to complete the plan in six to eight months because several community coalitions have prepared a somewhat similar plan for substance abuse prevention under SICA. For coalitions with more limited planning experience, the planning phase may take somewhat longer.

In order to distribute the funds more equally between rural and urban areas, one application will be funded in each of Nebraska's six behavioral health regions. In terms of eligibility, every applicant must demonstrate that they represent a broad-based coalition. A single organization (i.e., the coalition or its fiscal agent) must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements. Coalitions will not be required to have a 501(c)(3) non-profit status, but they must have a designated fiscal agent that is either a public entity or a 501(c)(3) to serve as the fiduciary for the grant. The fiscal agent must also be a member of the coalition.

By the time the application is submitted, the coalition must have representation from its targeted county(s) and include a minimum of one member/representative from at least eight of the following sectors:

- Youth (an individual 18 or under)
- Parents
- Business community
- Media
- School
- Youth-serving organization
- Law enforcement agencies
- Religious or fraternal organizations
- Civic and volunteer groups
- Healthcare professionals
- Local health department
- Representative that brings perspective on cultural diversity

- State, local, or tribal governmental agencies with expertise in the field of substance abuse (if applicable, the state authority with primary authority for substance abuse)

By the start of the implementation phase, all sectors must be represented on the coalition. Tribal applicants must also include representatives from at least eight of these sectors or their functional equivalents. Tribal applicants must be tribal councils or coalitions applying under an approved tribal resolution.

It is possible for a coalition to represent multiple communities and counties. Coalitions representing multiple counties must have representatives from each county to ensure that the views and perspectives are represented. Because this is a collaborative approach, counties with two or more coalitions are encouraged to work together to submit a single application. Although tribes are encouraged to work together, separate applications will be considered from each tribe. To the extent possible, the grants that are funded will represent the diversity of the state's population.

The number of successful grant recipients is projected to be between 12 and 18. After the recipients have been selected, the initial planning grant awards will range between \$40,000 and \$60,000. Once plans are approved, annual grant awards for implementation activities are likely to range between \$100,000 and \$150,000, depending on the scope of activities and the number of subpopulations that have been targeted.

#### **4. Implications of the Allocation Approach**

The major implication of the allocation approach is to change the substance abuse priorities in a positive way (i.e., reduce underage drinking for those 17 and under, decrease binge drinking rates for those between the ages of 18 and 25, and reduce the number of people who are drinking and driving) at the population level. In Nebraska it is likely that major changes at the community level will produce significant changes at the state level because of the relatively small population base.

Nebraska has the capacity to support community grantees and achieve positive outcomes. As previously mentioned, the Division of Public Health (DPH) prevention program staff, working with the NSAEW, will develop community data profiles to assist communities in the assessment process. The state also funds the Risk and Protective Factor Student Survey every two years. Data from the 2007 survey will be available to communities early next year to assist them in identifying the major risk and protective factors that impact one or more of the state priorities.

Training and technical assistance will be provided mainly by the RPCs. Currently, the RPCs, SPF SIG staff, as well as a consultant and representatives from the Southwest

CAPT, are in the process of developing appropriate educational tools and materials to assist communities in the application of the SPF model. These were described in detail in the Capacity section under State and Community Level Activities.

Special emphasis will be placed on assessment, coalition building, evidence-based strategies, evaluation, cultural competency, and sustainability. DPH prevention program staff and the RPCs are becoming knowledgeable about evidence-based strategies. A subcommittee under NePiP will also review the community grant applications to assure that evidence-based strategies are proposed and that they are appropriate based on the culture of the area.

The state and the regions will use other resources to address the priority problems. It is anticipated that funds from the Substance Abuse Prevention and Treatment Block Grant will help support several of the communities that are eventually funded through the SPF SIG project. Grant funds from the Safe and Drug Free Schools and Communities will be available on a competitive basis in early 2008. It is also very likely that some of the communities funded under SPF SIG will receive grant awards from the Safe and Drug Free Schools and Communities Program.

Finally, there are four state prevention program staff that are assigned to work specifically on the SPF SIG program, including the project director, an epidemiologist, a program manager, and an administrative assistant. That is, of course, in addition to the hundreds of hours that will be devoted to this project by NePiP members at quarterly meetings as well as on various workgroups and subcommittees, including the continued work hours of NSAEW members. It is also anticipated that a full-time data position will be filled to support the Substance Abuse Prevention and Treatment Block Grant; this individual will also be designated to provide support to the epidemiologist on SPF SIG related activities.

# Implementation

As mentioned in the Capacity section, Nebraska's approach to the SPF process is two-pronged, involving: (1) the development and implementation of effective prevention systems at all levels; and (2) focusing on achieving desired substance abuse prevention outcomes through the implementation of evidence-based strategies. This section describes the approach Nebraska will take in the implementation of activities at the state and regional level directed at systems level change, as well as the implementation of systems enhancement plans and SPF SIG policies, programs and practices at the community level.

## State and Regional Level Implementation Activities

Nebraska Partners in Prevention (NePiP) will be responsible for monitoring and evaluating the statewide substance abuse prevention system. This means that NePiP must develop benchmarks for state-level systems change, track whether or not the state achieves those benchmarks, and determine how implementation processes can be modified in order to more successfully achieve desired system-wide outcomes. Furthermore, NePiP must implement, monitor, evaluate, and modify on an as-needed basis, its workforce development plan (a detailed description of the early phases of that plan is provided in the Capacity section under The Nebraska Approach to Training and Technical Assistance).

SPF SIG staff will be responsible for monitoring key performance measures related to community-level implementation of SPF SIG plans. Staff will also receive and evaluate quarterly coalition reports, make regular site visits to communities, and work with the coalitions to make necessary adjustments in the contract.

However, all of the major decisions that contributed to or flow from this strategic plan that will affect communities (e.g., selection of state priorities, community grant awards, determination of evidence-based strategies) will be made by NePiP. NePiP will receive regular updates from SPF SIG staff as well as representatives from funded community coalitions so that it can monitor progress throughout the project. In addition, a subcommittee under NePiP will define and continually evaluate the degree to which implemented programs, practices, and policies are evidence-based, and to assure that strategies are implemented in a culturally appropriate manner.

As previously discussed, a joint state-Regional Prevention Coordinator training and technical assistance workgroup is in the process of developing a plan to assist communities throughout the planning and implementation phases of the project. Workforce competencies will be continually evaluated so that appropriate training and education will be available. SPF SIG staff and the RPCs will assess the training and education needs of communities so that resources match the needs of communities. In

addition to materials and tools, regional and state-level workshops will be held throughout the grant period to keep regional and SPF SIG staff as well as community representatives up-to-date on current policies and trends.

## **Community Level Implementation Activities**

One of the first steps to facilitating effective implementation at the local level is to organize relevant local data so that coalitions focus on a data-driven process. All coalitions will also be required to hire a local evaluator to assist them in the assessment process as well as the evaluation component.

During the development of community-level plans, it is critical to ensure that relevant and appropriate policies, practices, and programs are selected. As the local coalition plans are developed, NePiP will form a subcommittee to review each coalition's selected strategies to determine not only if they are evidence-based, but also if they are culturally relevant and inclusive to the area. The subcommittee will also review the process that each coalition undertakes to select strategies, and whether input was received from those people in the community who will be most affected by them. In addition, one SPF SIG staff person will be assigned to each coalition so that there is a consistent point of contact. Staff will also attend at least two coalition meetings per year to monitor and become more familiar with the coalition's activities.

The manner in which cultural competency will be addressed is illustrated in great detail in the sections on Planning (above) and Cross-Cutting Components and Challenges. The manner in which sustainability will be addressed is also outlined in the later section on Cross-Cutting Components and Challenges.

## **State Support for Community Grantees**

The state, collaborating with the RPCs, will assure that appropriate technical assistance as well as tools and materials are available to all grant recipients. Special emphasis will be given to assessment, coalition building and effectiveness, evaluation, cultural competency, and sustainability.

Training and technical assistance will be provided throughout the process. It will begin during the application process with information workshops provided by SPF SIG staff and the RPCs. The RPCs will also provide training and technical assistance to individual communities during the planning and implementation phases.

The approach during the planning phase has been described in detail in the Planning section. RPCs and SPF SIG staff are already developing a comprehensive SPF training and education plan (described in detail in the Capacity section). This plan will be completed in advance of the grant awards, which are expected to be approved in late March or early April, 2008.

Although every community coalition that is funded under SPF SIG will receive training and technical assistance on all phases of the SPF model, each coalition member will also complete a Workforce Prevention Survey to determine the current capacity and effectiveness of the coalition. The survey will also identify the knowledge, skills, and activities of the coalition members. The results of these surveys will allow SPF SIG staff and the RPCs, along with the Southwest CAPT, to develop more specific training modules and technical assistance materials to meet the specific needs of each coalition. The survey will be conducted on a regular basis to assess the progress and to identify future training and technical assistance needs.

The survey is one mechanism to ensure that training is successful. All formal training and educational workshops will also be evaluated by the participants using a standard questionnaire. Ultimately, SPF SIG process data from coalitions will provide information enabling the state to assess how well grantees actually performed the SPF tasks in the field.

Finally, SPF SIG staff will ensure that duplicative regional anti-drug coalition infrastructures are not funded. It is anticipated that those community coalitions that receive funding will have experience (e.g., previous SICA grantees) and have sufficient resources and capacity to be successful (e.g., Drug Free Communities coalitions funded by ONDCP and administered through CSAP). Based on SPF SIG staff experience and a close working relationship with the RPCs, the state will be able to avoid funding duplicative anti-drug coalitions.

# Evaluation

This section will briefly describe the state-level surveillance, monitoring, and evaluation activities. It will also describe the approach for tracking process and outcome measures as well as the changes that are expected. Finally, a description will be provided about how the community coalitions will collect and submit data for the National Outcomes Measures.

## 1. State-Level Surveillance, Monitoring, Tracking, and Evaluation Activities

At the state level, Research Triangle Institute (RTI) will conduct the monitoring and evaluation activities using a variety of information sources. These sources will include collecting information from the state advisory committees, local coalition members, state and national survey data, key informant interviews, and site visits. The evaluation will include both process and outcome measures.

### Process Evaluation

The process evaluation will assess the extent to which state-level SPF SIG milestones/activities under assessment, capacity building, planning, and implementation have been completed. For example, the evaluation will examine the following questions and issues:

- How closely did the state execute the plan and meet its timelines?
- What process was used by the Nebraska Substance Abuse Epidemiology Workgroup to develop the state epidemiology profile and determine the priorities that were recommended to NePiP?
- What process was used by NePiP to establish the final state priorities and approve the allocation of resources?
- How effective was the training and technical assistance provided to the community coalitions by the RPCs and state staff?
- How did the state address cultural competence in the epidemiological profile, the strategic plan, the RFA, and in the training and technical assistance?

### Outcome Evaluation

The outcome evaluation will focus on the following two areas: (1) changes that resulted from the implementation of evidence-based strategies (e.g., policy changes, attitude changes) and (2) changes in the prevention priorities. While the focus of the outcome evaluation will be to monitor changes in SPF SIG funded communities, state level changes will also be monitored. For the state level evaluation, changes in state prevention priorities will be measured using state-level data obtained from national and state surveillance systems.

## **2. Local-Level Surveillance, Monitoring, Tracking, and Evaluation Activities**

At the local level, RTI in conjunction with local evaluators will conduct the monitoring and evaluation of coalition activities using a variety of information sources. These sources will include collecting information from local coalition members, collecting and analyzing data from local surveys and databases as well as state and national data sources that contain community level data, key informant interviews, and site visits. The evaluation will include both process and outcome measures.

### **Process Evaluation**

The process evaluation will assess the extent to which local-level SPF SIG milestones/activities under assessment, capacity building, planning, and implementation of the coalition strategic plans have been completed. For example, the evaluation will examine the following questions and issues:

- What processes were used by the coalition to complete the assessment phase, choose the community level prevention priorities, and establish the community level strategic plan?
- How were the specific strategies identified and chosen?
- What changes were made in the strategies over time and how were these decisions made?
- What was the involvement of people in the community who were not members of the coalition?
- How did the coalition consider and include cultural competence factors in the development and implementation of their strategies?
- How closely did the coalition execute the plan and meet its timelines?

### **Outcome Evaluation**

The outcome evaluation will focus on the following two areas: (1) changes that resulted from the implementation of evidence-based strategies (e.g., policy changes, attitude changes) and (2) changes in the prevention priorities. For community-level evaluation, data will be obtained from ongoing community level surveys, such as the Nebraska Risk and Protective Factor Student Survey (NRPFS), which was described in previous sections of this plan. In addition, community level data will be obtained from point-in-time data collection projects as well as state surveillance systems that contain community level data.

To aid in interpreting changes in the underage drinking, binge drinking, and alcohol impaired driving at the community level, rates within SPF SIG funded communities will be compared to nonfunded communities within the state.

## **Local Evaluators**

Finally, although RTI will conduct the state evaluation and track key changes in the state priorities at the local level, each community coalition will also have a local evaluator. The role of the local evaluator is to assist the coalition in developing a local evaluation plan and to ensure that the appropriate data are collected and submitted to the state and RTI. It is expected that RTI will work closely with the local evaluators to assure consistency in both the evaluation approach and reporting.

### **3. Expectations for Change**

Because of enhanced capacity at the state and local levels and the application of the SPF process, there should be significant improvements in the rates of underage drinking for people 17 and under, the rates of binge drinking for people 18 to 25, and the rates of alcohol impaired driving for people of all ages within SPF SIG funded communities. This change will occur because community coalitions assessed their needs, identified the major contributing factors, and selected and implemented the appropriate evidence-based policies, programs, and practices.

At the state level, change will be dependent on a number of factors, including how many communities select specific prevention priorities and the size of the communities relative to the state as a whole. While state level change in the three priority areas is desired, it is not the focus of the SPF SIG evaluation, but rather a potential benefit of successful change within SPF SIG funded communities.

### **4. Collection and Submission of National Outcomes Measures (NOMs)**

Appropriate National Outcome Measures (NOMs) will be collected by all community coalitions and submitted into a centralized state data system that is currently under development. The local evaluator for each coalition will be responsible for submitting the data into this automated internet-based reporting and data collection system. State staff will then compile the data and submit them to SAMHSA/CSAP.

# Cross-Cutting Components and Challenges

This section will address: (1) how a focus on cultural competency will be woven into every step of the SPF at the state and community levels; (2) the issue of underage drinking in Nebraska; (3) the manner in which sustainability of SPF SIG efforts will be achieved; (4) the challenges encountered in applying a need-based allocation process; and (5) the challenges that are anticipated during the implementation of this state plan.

## 1. Ensuring the Inclusion of Cultural Competence

Cultural competence, which implies “the understanding and appreciation of cultural differences and similarities within and between groups” (CSAP, 1994), is a central tenet of the SPF. As such, cultural competence must be infused within all stages of SPF planning and implementation at the state, regional, and community levels. Under the leadership of its statewide advisory council, Nebraska Partners in Prevention (NePiP), Nebraska is committed to ensuring cultural competence and inclusion throughout the state, regional, and community prevention systems. NePiP defines cultural competence as:

- A set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals, and enables that system, agency or those professionals to work effectively in cross-cultural situations.

NePiP has determined that inclusion is a critical companion piece to cultural competence, and defines inclusion as:

- The practice of intentionally working to ensure the right of all of a community’s diverse populations to participate fully and equally in decision-making, policy development, and implementation of programs, policies, and practices.

NePiP’s Cultural Competence Subcommittee is charged with ensuring that all SPF SIG tools, practices and processes are inclusive, appropriate, and culturally responsive to all of Nebraska’s diverse populations. The goals of the subcommittee are to: (1) promote cultural competency through common language and understanding throughout all SPF SIG practices and processes; (2) ensure a commitment to cultural competency throughout all SPF SIG practices and processes; and (3) develop processes and systems to engage all Nebraskans, including hard-to-reach populations, as active participants in implementing SPF SIG policies and activities at the state and local levels.

The Cultural Competence Subcommittee will undertake a comprehensive review of all SPF SIG tools, policies and practices developed and approved by NePIP and its work groups in order to ensure that they are culturally-responsive and appropriate for serving the needs of all of the State's citizens – including hard-to-reach populations and regardless of race, ethnicity, geography, age, gender, orientation, or religion. The federal Office of Minority Health's Cultural and Linguistically Appropriate Services (CLAS) frameworks and standards for institutionalization will be applied throughout all of the SPF SIG practices and processes.

The state will ensure that RPCs receive any needed training and technical assistance to ensure they are prepared to effectively assist communities to implement the SPF in a manner that is culturally competent and inclusive. SPF SIG staff and RPCs will, in turn, provide training and technical assistance to communities to assist them in developing core competencies in the essential elements of culturally and linguistically-appropriate services. The Cultural Competency Subcommittee of NePIP will oversee the creation of assessment and monitoring systems to ensure continuous improvement in the CLAS standards core competencies at the state, regional, and community prevention system levels.

Cultural competency and inclusion are built into every component of Nebraska SPF SIG planning methods. During the process of assessing readiness for engaging in social change, Nebraska SPF SIG communities will be required to be inclusive of all populations, and to include examination of attitudes towards sub-populations as part of their assessment process. In addition, they will be required to assess and prioritize issues related to cultural competency and inclusion within their community partnerships, and to develop a plan to address those issues. Specifically, coalitions receiving SPF SIG funding will have to develop and implement plans to achieve the following cultural competency capacities (adapted from CADCA's Capacity Primer):

- The capacity to ensure that coalition members represent the diversity of the community served, with respect to race, gender, geography, ethnicity, and age;
- The capacity to ensure broad-based citizen participation – including the participation of those most affected by the consequences of substance abuse – throughout the SPF process;
- The capacity to meet the unique cultural, racial/ethnic, and linguistic need patterns within the geographic area served; and
- The capacity to ensure that all community prevention strategies are culturally competent and inclusive.

## **2. Underage Drinking**

As one of the state's three priorities, underage drinking is likely to be addressed by several SPF SIG community coalitions for three primary reasons. First, as described

in the NSAEW profile, underage drinking is a huge problem in Nebraska, and is recognized as such by communities across the state (research has documented that underage drinking is associated with virtually every other youth risk behavior); second, many of Nebraska's substance abuse prevention coalitions (and certainly the vast majority of coalitions funded through SICA) already have extensive experience addressing the underage drinking problem. In all likelihood, several of these coalitions will be funded through SPF SIG, and as a result will have the opportunity to expand their work in this area. Finally, many of Nebraska's substance abuse prevention coalitions have collected good local data through the Nebraska Risk and Protective Factor Student Survey (NRPFS) related to underage drinking that will enhance the evaluation process.

### **3. Sustainability Efforts**

Nebraska defines sustainability as "the process of ensuring an adaptive and effective system that achieves and maintains desired long-term results." A substance abuse prevention system is composed of those individuals that have a stake in successful prevention outcomes, and those agencies, institutions, and organizations whose mission includes substance abuse prevention. Nebraska is committed to developing, enhancing and maintaining effective, coordinated prevention systems at the state, regional, and local levels. Once established, these systems will provide the infrastructure to support data-driven strategic planning for prevention whereby local needs, readiness and resources are assessed, and evidence-based strategies are selected, implemented, and evaluated in order to achieve population level positive outcomes.

A commitment to sustainability at the state level means that the various partners that make up NePiP are committed to working together to develop strong, effective, coordinated and adaptable prevention partnerships. These partnerships will cooperatively initiate prevention capacity building and infrastructure development activities in order to strengthen the statewide prevention system, for it is this statewide system that provides the foundation for regional and local level prevention work. If positive substance abuse prevention outcomes are to be sustained within communities, they must be supported by effective systems from the grassroots level on up.

Sustainability at the state level means that NePiP (including the work of the NSAEW and NePiP's other workgroups and subcommittees) will continue long past the end of SPF SIG funding. In order to achieve this end, Nebraska will use SPF SIG as a vehicle to strengthen its existing prevention system. Strengthening the system entails focusing on the three "keys" to sustainability (adapted from the CAPT Sustainability Course, 2007): (1) building organizational capacity; (2) strengthening commitment to substance abuse prevention among key allies and champions by nurturing collective ownership in both the problems of substance use and abuse, as

well as in the solutions to those problems; and (3) demonstrating effectiveness by successfully supporting regional and community entities in order to achieve positive population level changes in substance use and abuse over the long term.

Part of building organizational capacity involves the coordinated leveraging of resources from the variety of state agencies engaged in substance abuse prevention work (e.g., the Department of Health and Human Services, the Department of Highway Safety, the Department of Education). Within the Department of Health and Human Services, for example, various substance abuse resources (i.e., SPF SIG, Substance Abuse Prevention and Treatment Block Grant, Safe and Drug Free Schools and Communities Grant Program) will be directed in a coordinated fashion to communities in order to address state priorities. And, coordination between agencies means that agencies will work together to ensure that data collection, funding streams, and targeted prevention initiatives are synchronized and working in harmony to achieve desired outcomes.

In order to nurture a sense of collective ownership in substance abuse prevention activities at the state level, key allies and champions must be identified and their support must be cultivated. NePiP, the NSAEW, and other NePiP workgroups already include strong representation from key infrastructure partners within a variety of sectors (e.g., law enforcement, public safety, education, public health and behavioral health). However, in order to strengthen and broaden that foundation, NePiP will conduct outreach to additional state-level entities, with a particular focus on those whose mission includes prevention for populations whose needs are not currently addressed by existing partners.

NePiP will continue to support the development of regional and community prevention systems that include a broad cross section of representatives from core infrastructure partners. In addition, the training and technical assistance provided to SPF SIG grantees will follow the model laid out in the CAPT Sustainability Course. SPF SIG grantees will be required to develop sustainability plans as part of their overall strategic plans for prevention that address the “keys” to sustainability laid out in that course as they apply to communities:

- Organizational capacity: all of the organizations and agencies delivering the strategies must have the structures and capacity to develop the administrative functions related to the effective implementation of the strategies, secure adequate resources, and acquire appropriate expertise.
- Effectiveness: the organizations and agencies must have the capacity to demonstrate that they have reached the target population with effective strategies that have been tracked through careful evaluation.

- Community support: the organizations and agencies also need the capacity to develop positive relationships among key stakeholders, identify and nurture leaders and champions, and build a collective ownership among those who have a stake in sustaining the outcomes of a preventive intervention.

#### 4. Challenges

There were two challenges encountered in applying a “need-based” allocation approach. The first challenge relates to the quality and availability of data at the community level. As previously discussed in the Planning section, Nebraska lacks sufficient data to make meaningful comparisons between communities or counties. As a result, it was difficult to pinpoint the specific communities or counties that have the greatest substance abuse problems. For this reason and others that were discussed in the Planning section, community coalitions will be funded using a competitive RFA approach.

A second challenge was to establish the state priorities. The Nebraska Substance Abuse Epidemiology Workgroup (NSAEW) recommended five state priorities to NePiP. Three of the priorities related to alcohol use and abuse, one related to methamphetamine, and one to marijuana. However, through this data-driven process it was difficult to rank the two illicit drugs as priorities because use of those substances is significantly less than that for alcohol or tobacco. At the NePiP meeting at which NSAEW recommendations were considered and the state’s priorities were selected, some members initially supported including methamphetamine and marijuana because of the impact the use and abuse of these substances has on families, the criminal justice system, and the economy. Although the possibility of including these two issues as priorities was strongly considered, eventually there was unanimous consent to focus exclusively on the three alcohol-related problems, instead.

Some challenges are also anticipated during the implementation phase of the project. The major challenge is likely to be the coordination of resources at the regional and state levels throughout the process. For example, training and technical assistance will need to be provided to several communities that cover a wide geographic area, and to coalitions with varying levels of capacity, working, in turn, in communities with varying levels of readiness for prevention. Although the RPCs will be responsible for providing most of the training and technical assistance, SPF SIG staff must ensure that training is timely and consistent across the state, and that it adequately meets local needs.

A second implementation challenge is for SPF SIG staff to assure that there is open communication and sharing of information between state and local evaluators and among local evaluators. Open communication channels should produce better evaluation results because issues and problems can be surfaced and addressed

immediately. In addition, an environment that fosters open communication has a greater potential to nurture cross-site learning through a free exchange of information between evaluators.

### **Timelines and Milestones**

A work plan that identifies the activities, responsibility, and timelines is shown below.

## SPF SIG Work Plan

Activities	Responsibility	Date of Completion
1. Application process <ul style="list-style-type: none"> <li>▪ Release of RFA</li> <li>▪ Grants submitted</li> <li>▪ Grants awarded</li> </ul>	SPF SIG staff Community coalitions NePiP	January 2008 March 2008 April 2008
2. Assessment <ul style="list-style-type: none"> <li>▪ Continuation of epi process</li> <li>▪ Prepare local data for community coalitions</li> <li>▪ Provide training and technical assistance on assessment</li> <li>▪ Analysis of community data, including contributing factors</li> </ul>	NSAEW NSAEW RPCs and SPF SIG staff  Community coalitions	Ongoing April 2008 April 2008 – December 2008  April 2008 – December 2008
3. Capacity <ul style="list-style-type: none"> <li>▪ NePiP continues to meet and engage key stakeholders across the state</li> <li>▪ Provide training and technical assistance to communities on SPF SIG process</li> <li>▪ Apply SPF process at community level</li> </ul>	NePiP  RPCs, SPF SIG staff  Community coalitions	Ongoing  April 2008 – December 2008  April 2008 – December 2008
4. Planning <ul style="list-style-type: none"> <li>▪ Provide training and technical assistance to communities regarding the selection of policies, programs, and practices</li> <li>▪ Develop local strategic plans using SPF process</li> <li>▪ Submit plans that include logic models, evidence-based strategies, and evaluation models to the Division of Public Health</li> <li>▪ Review and approve local plans</li> </ul>	RPCs and SPF SIG staff  Community coalitions  Community coalitions  SPF SIG staff and NePiP	April 2008 – December 2008  April 2008 – December 2008  September 2008 – December 2008  October 2008 – January 2009

## SPF SIG Work Plan

Activities	Responsibility	Date of Completion
5. Implementation <ul style="list-style-type: none"> <li>▪ Provide consultation and support to communities during the implementation of policies, programs, and practices</li> <li>▪ Provide ongoing coordination with the state and local evaluation team</li> <li>▪ Implement evidence-based strategies</li> </ul>	RPCs and SPF SIG staff  SPF SIG staff  Community coalitions	January 2009 – September 2011  April 2008 – October 2011  January 2009 – September 2011
6. Evaluation <ul style="list-style-type: none"> <li>▪ Provide ongoing coordination of state and local evaluation team</li> <li>▪ Collect state and local process evaluation data</li> <li>▪ Collect program, community, and state level NOMS data</li> <li>▪ Analyze community level evaluation data to examine the effectiveness of the local evidence-based strategies</li> <li>▪ Conduct Nebraska Risk and Protective Factor Student Survey</li> </ul>	SPF SIG staff  State and local evaluators  Community coalitions, SPF SIG staff, state and local evaluators State and local evaluators  SPF SIG staff	April 2008 – October 2011  January 2009 – September 2011  January 2009 – September 2011  January 2009 – September 2011  Fall of 2009 and 2011

## Appendix A

### Nebraska Substance Abuse Epidemiology Workgroup (NSAEW)

#### State Participants

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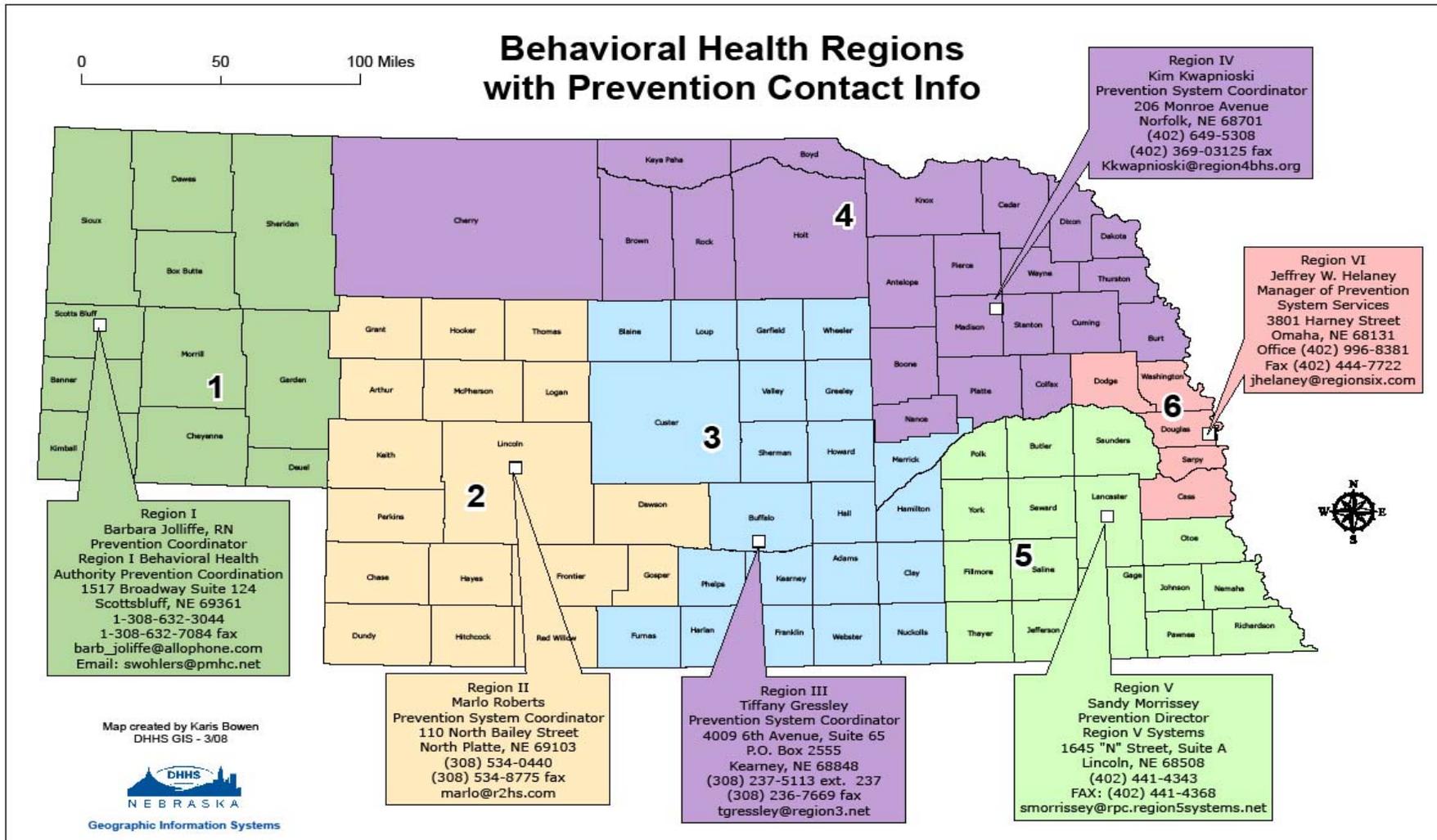
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# Appendix C



## Appendix D

Current Alcohol Use\* by Nebraska Behavioral Health Region

Region	High School Students (Grades 9-12), YRBS, 2005				Middle & HS Students**, NRPFS, 2005 (Grade-Adjusted)				Adults 18+, BRFSS, 04-06 (Age-Adjusted)				Persons 12 and Older, NSDUH, 02-04						
	Sample Size (n) <sup>a</sup>	% <sup>b</sup>	95% CI (low --- high) <sup>c</sup>		Diff From State <sup>d</sup>	Sample Size (n) <sup>a</sup>	AA % <sup>e</sup>	95% CI (low --- high) <sup>f</sup>		Diff From State <sup>f</sup>	Sample Size (n) <sup>a</sup>	% <sup>g</sup>	95% CI (low --- high) <sup>c</sup>		Diff From State <sup>d</sup>	Sample Size (n) <sup>h</sup>	% <sup>i</sup>	95% CI (low --- high) <sup>c</sup>	
<b>United States</b>	<b>13,235</b>	<b>43.3</b>	<b>(40.5 46.1)</b>	--	-	-	-	-	--	<b>981,254</b>	<b>53.6</b>	<b>(53.4 53.8)</b>	--	-	<b>50.4</b>	--	--	--	--
<b>Nebraska</b>	<b>3,587</b>	<b>42.9</b>	<b>(40.4 45.4)</b>	--	<b>26,310</b>	<b>24.1</b>	-	-	--	<b>24,878</b>	<b>59.0</b>	<b>(58.1 59.8)</b>	--	-	<b>54.4</b>	<b>(51.5 57.1)</b>	--	--	--
BH Region 1	429	43.7	(38.7 48.7)	NS	2,474	27.9	-	-	NA	4,039	53.1	(51.1 55.1)	-	-	50.7	(44.3 57.1)	NS	NS	
BH Region 2					1,698	23.2	-	-	NA	3,765	53.6	(51.5 55.7)	-	-					
BH Region 3	486	30.0	(24.1 35.8)	-	6,225	21.1	-	-	NA	4,492	55.1	(53.2 57.0)	-	-	55.9	(49.9 61.7)	NS	NS	
BH Region 4	938	43.0	(37.3 48.6)	NS	5,261	25.7	-	-	NA	3,222	57.6	(55.4 59.7)	NS	-	48.9	(43.1 54.7)	NS	NS	
BH Region 5	960	46.9	(43.0 50.9)	NS	4,469	25.3	-	-	NA	3,997	61.1	(59.3 62.9)	NS	-	55.0	(50.3 59.7)	NS	NS	
BH Region 6	774	45.1	(39.5 50.7)	NS	6,183	23.7	-	-	NA	5,196	61.6	(59.9 63.2)	+	-	56.2	(52.3 60.1)	NS	NS	

\*Consumed alcohol during the 30 days preceding the survey

\*\* Includes students from grades 6, 8, 10, and 12

<sup>a</sup> Non-weighted sample size by region

<sup>b</sup> Percentage weighted to reflect public high school students in grades 9-12

<sup>c</sup> 95% Confidence interval for the percentage (lower and upper confidence limits)

<sup>d</sup> Values represent "+" = behavioral health region percentage significantly higher than the state percentage (p < 0.05); "-" = BH region percentage significantly lower than the state percentage (p < 0.05); "NS" = BH region percentage not statistically different from the state percentage (p > 0.05); significant difference based on 95% confidence interval overlap

<sup>e</sup> Percentage was grade-adjusted to the 2005/2006 state population for all students in grades 6, 8, 10, and 12; however, data could not be weighted to represent all students statewide

<sup>f</sup> Because data do not represent all students statewide, confidence intervals were not calculated and subsequently region and state comparisons were unavailable

<sup>g</sup> Percentage weighted to reflect adults 18 and older, then age-adjusted to the 2000 U.S. population using five age categories (18-24, 25-34, 35-44, 45-64, 65+)

<sup>h</sup> Sample size unavailable within NSDUH publications

<sup>i</sup> Percentage weighted to reflect all persons 12 and older

Note: To improve estimates, behavioral health regions one and two were merged together within some data sources due to a small number of respondents by individual region

**Binge Drinking\* by Nebraska Behavioral Health Region**

Region	High School Students (Grades 9-12), YRBS, 2005				Middle & HS Students**, NRPFS, 2005 (Grade-Adjusted)				Adults 18+, BRFSS, 04-06 (Age-Adjusted)				Persons 12 and Older, NSDUH, 02-04			
	Sample Size (n) <sup>a</sup>	% <sup>b</sup>	95% CI (low -- high) <sup>c</sup>	Diff From State <sup>d</sup>	Sample Size (n) <sup>a</sup>	AA % <sup>e</sup>	95% CI (low -- high) <sup>f</sup>	Diff From State <sup>f</sup>	Sample Size (n) <sup>a</sup>	% <sup>g</sup>	95% CI (low -- high) <sup>c</sup>	Diff From State <sup>d</sup>	Sample Size (n) <sup>h</sup>	% <sup>i</sup>	95% CI (low -- high) <sup>c</sup>	Diff From State <sup>d</sup>
<b>United States</b>	<b>13,623</b>	<b>25.5</b>	<b>(23.3 27.8)</b>	--	-	-	- -	--	<b>973,333</b>	<b>14.3</b>	<b>(14.2 14.5)</b>	--	-	<b>22.8</b>	-- --	--
<b>Nebraska</b>	<b>3,683</b>	<b>29.8</b>	<b>(27.3 32.3)</b>	--	<b>25,412</b>	<b>14.5</b>	- -	--	<b>24,674</b>	<b>17.3</b>	<b>(16.6 18.1)</b>	--	-	<b>26.3</b>	<b>(24.3 28.5)</b>	--
BH Region 1	439	30.8	(24.6 36.9)	NS	2,367	17.8	- -	NA	4,006	15.0	(13.4 16.7)	NS	-	24.0	(20.1 28.2)	NS
BH Region 2					1,634	13.6	- -	NA	3,729	17.3	(15.6 19.2)	NS				
BH Region 3	503	20.5	(15.2 25.8)	-	6,047	12.1	- -	NA	4,455	16.5	(15.0 18.2)	NS	-	26.9	(23.2 30.9)	NS
BH Region 4	958	30.8	(25.5 36.0)	NS	5,072	15.7	- -	NA	3,199	18.1	(16.4 20.1)	NS	-	24.0	(20.4 28.2)	NS
BH Region 5	990	32.0	(28.1 35.8)	NS	4,332	15.5	- -	NA	3,965	19.4	(17.8 21.1)	NS	-	27.7	(24.5 31.1)	NS
BH Region 6	793	31.3	(25.6 37.1)	NS	5,960	13.8	- -	NA	5,156	16.6	(15.3 17.9)	NS	-	26.7	(23.9 29.8)	NS

\* Consumed five or more drinks of alcohol on at least one occasion during the 30 days preceding the survey; the NSDUH asks about the two-weeks preceding the survey

\*\* Includes students from grades 6, 8, 10, and 12

<sup>a</sup> Non-weighted sample size by region

<sup>b</sup> Percentage weighted to reflect public high school students in grades 9-12

<sup>c</sup> 95% Confidence interval for the percentage (lower and upper confidence limits)

<sup>d</sup> Values represent "+" = behavioral health region percentage significantly higher than the state percentage (p < 0.05); "-" = BH region percentage significantly lower than the state percentage (p < 0.05); "NS" = BH region percentage not statistically different from the state percentage (p > 0.05); significant difference based on 95% confidence interval overlap

<sup>e</sup> Percentage was grade-adjusted to the 2005/2006 state population for all students in grades 6, 8, 10, and 12; however, data could not be weighted to represent all students statewide

<sup>f</sup> Because data do not represent all students statewide, confidence intervals were not calculated and subsequently region and state comparisons were unavailable

<sup>g</sup> Percentage weighted to reflect adults 18 and older, then age-adjusted to the 2000 U.S. population using five age categories (18-24, 25-34, 35-44, 45-64, 65+)

<sup>h</sup> Sample size unavailable within NSDUH publications

<sup>i</sup> Percentage weighted to reflect all persons 12 and older

Note: To improve estimates, behavioral health regions one and two were merged together within some data sources due to a small number of respondents by individual region

**Alcohol Impaired Driving by Nebraska Behavioral Health Region**

Region	High School Students* (Grades 9-12), YRBS, 2005					Middle & HS Students**, NRPFS, 2005 (Grade-Adjusted)					Adults 18+***, BRFSS, 04-06 (Age-Adjusted)				
	Sample Size (n) <sup>a</sup>	% <sup>b</sup>	95% CI (low --- high) <sup>c</sup>		Diff From State <sup>d</sup>	Sample Size (n) <sup>a</sup>	AA % <sup>e</sup>	95% CI (low --- high) <sup>f</sup>		Diff From State <sup>f</sup>	Sample Size (n) <sup>a</sup>	% <sup>g</sup>	95% CI (low --- high) <sup>c</sup>		Diff From State <sup>d</sup>
<b>United States</b>	13,520	9.9	(8.9	10.9)	--	-	-	-	-	--	865,942	2.3	(2.2	2.4)	--
<b>Nebraska</b>	3,696	17.3	(15.2	19.5)	--	25,394	14.7	-	-	--	20,843	4.3	(3.9	4.7)	--
BH Region 1						2,436	17.0	-	-	NA	2,968	3.7	(2.6	5.3)	NS
BH Region 2	434	20.0	(15.0	24.9)	NS	1,650	17.7	-	-	NA	2,762	4.1	(3.0	5.5)	NS
BH Region 3	504	15.2	(10.9	19.6)	-	5,994	13.9	-	-	NA	3,582	4.5	(3.6	5.7)	NS
BH Region 4	965	17.8	(12.8	22.7)	NS	5,106	15.7	-	-	NA	2,746	4.6	(3.6	5.8)	NS
BH Region 5	998	18.3	(14.7	21.9)	NS	4,297	16.3	-	-	NA	3,795	5.3	(4.4	6.4)	NS
BH Region 6	795	15.9	(11.8	20.1)	NS	5,911	12.2	-	-	NA	4,865	3.5	(2.9	4.2)	NS

\* Drove a car or other vehicle when drinking alcohol during the 30 days preceding the survey

\*\* Drove a car, truck, or motorcycle after drinking alcohol during the one year preceding the survey; includes students from grades 6, 8, 10, and 12

\*\*\* Drove after having perhaps too much to drink during the 30 days preceding the survey

<sup>a</sup> Non-weighted sample size by region

<sup>b</sup> Percentage weighted to reflect public high school students in grades 9-12

<sup>c</sup> 95% Confidence interval for the percentage (lower and upper confidence limits)

<sup>d</sup> Values represent "+" = behavioral health region percentage significantly higher than the state percentage (p < 0.05); "-" = BH region percentage significantly lower than the state percentage (p < 0.05); "NS" = BH region percentage not statistically different from the state percentage (p > 0.05); significant difference based on 95% confidence interval overlap

<sup>e</sup> Percentage was grade-adjusted to the 2005/2006 state population for all students in grades 6, 8, 10, and 12; however, data could not be weighted to represent all students statewide

<sup>f</sup> Because data do not represent all students statewide, confidence intervals were not calculated and subsequently region and state comparisons were unavailable

<sup>g</sup> Percentage weighted to reflect adults 18+, then age-adjusted to the 2000 U.S. population using five age categories (18-24, 25-34, 35-44, 45-64, 65+)

Note: To improve estimates, behavioral health regions one and two were merged together within some data sources