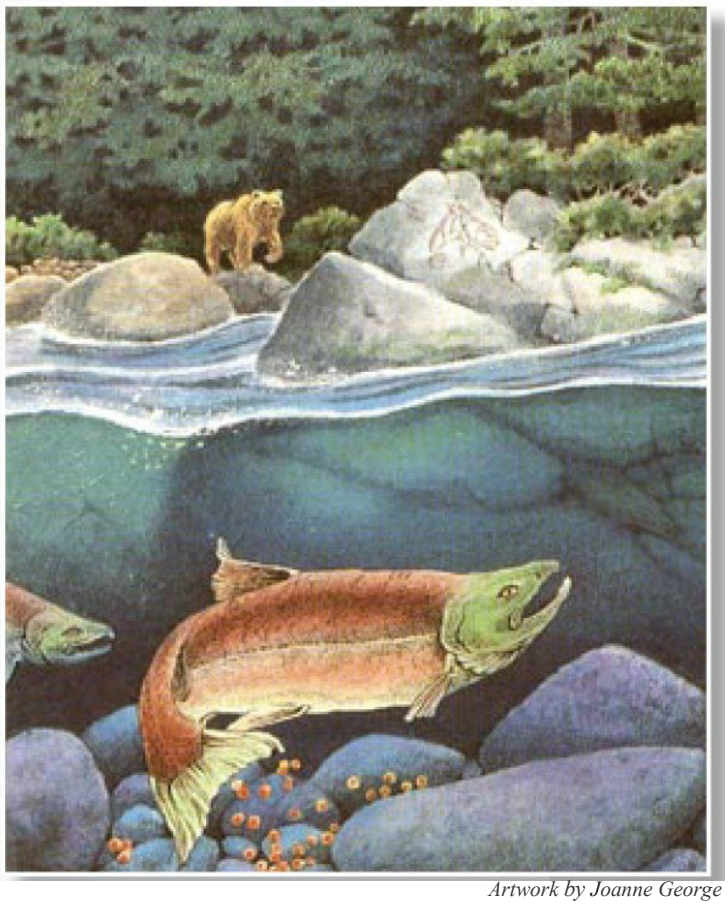
Moving Prevention Upstream

A Plan to Implement a Comprehensive Approach to Substance Abuse Prevention in Alaska

Alaska's SPF SIG Strategic Plan

Developed by the SPF SIG Project Staff in partnership with the SPF SIG Advisory Council



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Abbreviations & Acronyms

AASB: Association of Alaska School Boards

ABDR: Alaska Birth Defects Registry

ABADE: Alaska Bureau of Alcohol and Drug Enforcement

ADAM: Arrestee Drug Abuse Monitoring

AKVDRS: Alaska Violent Death Reporting System

AHSO: Alaska Highway Safety Office

AK AIMS: Alaska Automated Information Management System

AK FACE: Alaska Fatality Assessment and Control Evaluation

APSIN: Alaska Public Safety Information Network

ASAP: Alcohol Safety Action Program

ASB: Alaska School Board

ATR: Alaska Trauma Registry

ATV: All Terrain Vehicles

BRFSS: Behavioral Risk Factors Surveillance System

BVS: Bureau of Vital Statistics

CADCA: Community Anti-Drug Coalition of America

CAPT WRET: Center for Applied Prevention Technology Western Regional Expert Team

CBHRS: Center for Behavioral Research and Services

CDR: Child Death Review

CFR: Child Fatality Review

CLI: Community Level Instruments (part of National Cross Site Evaluation)

CPS: Child Protective Services

CSAP: Center for Substance Abuse Prevention

CSR: Client Status Review

DEA: Drug Enforcement Agency

DHSS: Department of Health and Social Services

DJJ: Division of Juvenile Justice

DOC: Department of Corrections

DOL: Department of Labor

DSDS: Division of Senior and Disability Services

DSM IV: Diagnostic and Statistical Manual of Mental Disorders

DUI: Driving Under the Influence

EBI: Evidence Based Intervention

ED(D): Emergency Department (Data)

EMS: Emergency Medical Services

FARS: Fatality Analysis Reporting System

FAS: Fetal Alcohol Syndrome

FASD: Fetal Alcohol Spectrum Disorders

GLI: Grantee Level Instruments (part of National Cross Site Evaluation)

GPRA: Government Performance Results Act

HIV: Human Immunodeficiency Virus

HDD: Hospital Discharge Data

IC &RC: International Certification & Reciprocity Consortium

JOMIS: Juvenile Offender Management Information System

KABB: Knowledge, Attitudes, Beliefs & Behaviors

MAPP: Mobilizing Action through Partnerships and Planning

MCA: Minor Consuming Alcohol

MIMR: Maternal Infant Mortality Review

MOA: Memorandum of Agreement

MH(BH)SIP: Mental Health (Behavioral Health) Statistics Improvement Program

MRT: Prevention Management Reporting and Training System

NCADD: National Council on Alcoholism and Drug Dependence

NCHS: National Center for Health Statistics

NHTSA: National Highway Traffic Safety Administration

NOMS: National Outcomes Measures

NSDUH: National Survey on Drug Use and Health

ORCA: Online Resources for the Children of Alaska

PEC: Proposal Evaluation Committee

PLI: Participant-Level Instrument (part of National Cross Site Evaluation)

PRAMS: Pregnancy Risk Assessment Monitoring System

RFP: Request for Proposals

RPMS: Rural Patient Management System

SAMHSA: Substance Abuse & Mental Health Services Administration

SBIRT: Screening, Brief Intervention, Referral and Treatment

SEARHC: South East Alaska Regional Health Corporation

SAPT: Substance Abuse Prevention & Treatment [Block Grant]

SAPST: Substance Abuse Prevention Specialist Training

SEOW: Substance Abuse Epidemiologic Outcomes Workgroup

SEW: State Epidemiology Workgroup

SPF SIG: Strategic Prevention Framework State Incentive Grant

SPF TIG: Strategic Prevention Framework Tribal Incentive Grant

TA: Technical Assistance

TCC: Tanana Chiefs Conference

TEDS: Treatment Episodes Data System

TTC: Trust Training Cooperative

UAA: University of Alaska Anchorage

UCR: Uniform Crime Report

URS: Uniformed Reporting System

USCG: United States Coast Guard

WCFH: Women's Children's and Family Health

YKHC: Yukon Kuskokwim Health Corporation

YRBS: Youth Risk Behavior Survey

Alaska's Demographics

- ✓ Land area = 571,951 square miles (about 16.1% of the US land area)
- ✓ Population Density = 1.1 persons per square mile of land
- ✓ 65.6% of population is urban; 34.4% rural
- ✓ Total population = 692,314
- ✓ Alaska is the 47th most populous state—only North Dakota, Vermont, Wyoming and the District of Columbia have less population
- ✓ 51% of the population is male; 49% is female
- ✓ 70.43% of the population is white; 16.16% is Alaska Native/American Indian; 3.8% African American; and 4.81% Asian or Pacific Islander/Hawaiian
- ✓ 5% of the population is of Hispanic origin
- ✓ 32% of the population is between 0-19 years of age; 41.4% between 20-49 years of age; and 26.6% 50+

Alaska, as the 49th state to join the union of the United States, is not only a young state, but unique in many ways. Alaska has a large land mass and small population; with a population density of only 1.1 person per square mile of land.[1] Many communities in Alaska are not connected by a road system: planes, boats, snow machines and other forms of transportation are the norm in most of rural and remote Alaska, and indeed, Alaska itself is not connected to the other 48 states. There are 149 incorporated cities and only 19 have populations of 2,500 or more.

There are 229 federally recognized Alaska Native Tribes and 12 Alaska Native Regional Corporations representing Alaska Natives and their interests. Each Alaska Native Regional Corporation includes parallel Alaska Native Health Corporations serving Alaska Native beneficiaries.

Active duty military and their dependents equal 58,346 or 8.4% of the total population in 2009. The Army represents 54% of the Alaska military presence; the Air Force 36%; and the Coast Guard 9%.

[1] All demographic data is from the State of Alaska, Department of Labor, *Alaska Population Overview: 2009 Estimates*

Recognizing Alaska's unique qualities is critical to the success of developing and implementing strategies to meet the social, health and economic needs of this diverse and disperse population. Building a comprehensive behavioral health system of care that includes promotion, prevention, early intervention, treatment and recovery for all mental health and substance use conditions is the focus for the Alaska Division of Behavioral Health. Building a strong foundation and infrastructure for a comprehensive system of care for substance use, abuse and dependency is the focus of the Alaska Strategic Prevention Framework State Incentive Grant (SPF SIG); forming a strong, holistic and sustainable community-based system of care.

Assessment of Need

The more you learn, the more acutely aware you become of your ignorance.[2]

~ Peter M. Senge ~

Assessing the Problem (Epidemiological Profile)

In 2006 the State of Alaska received funding from the Center for Substance Abuse Prevention (CSAP) for the development, implementation and maintenance of a Substance Abuse Epidemiologic Outcomes Workgroup (SEOW). The purpose of this group was to collect and review data on the consumption of alcohol, illicit drugs, and tobacco and consequences closely associated to use of these substances and publish an annual state-level epidemiologic profile for Alaska. Over those three years, the SEOW maintained and improved its ability to identify key data constructs for each type of substance use; captured data from new sources for review and inclusion into the State Epidemiologic Profile (See Appendix A—Potential Alaska Substance Use, Abuse, Dependency, Treatment Data Sources and Associate Data Indicators); and published a 5-year summary for each of Alaska's six economic regions.

Through the Strategic Prevention Framework State Incentive Grant (SPF SIG), awarded in July 2009, Alaska was able to continue the State's substance use data collection and analysis efforts through the State Epidemiology Workgroup (SEW). As part of the SPF SIG process and requirements, the Alaska SEW continues to function as a collective of statistical and prevention program experts that utilize a clear, systematic approach to

[2] Peter M. Senge. The Fifth Discipline: The Art & Practice of the Learning Organization. 1990.

evaluate surveillance information and new scientifically valid evidence related to substance use and its consequences.

Having a broad scope of state-level data across multiple professional disciplines pertaining to alcohol, illicit drug, tobacco use and consequences, it was necessary for the SEW to identify a data-driven, scientific methodology to determine prevention priorities. The process included the review of all potential substance-related constructs or indicators; an assessment of issues impacting the past, present, and future quality of the data used for the indicators; and determining the overall data relevance to the three types of substance use in order to rank substance-related prevention constructs.

Over the 5-year period of the SPF SIG, the SEW will continue to be responsible for 1) on-going review of substance-related consumption, consequence, and influences data summaries that best describe substance use, abuse, dependency and treatment in Alaska; 2) identifying measures for data development to improve substance-related surveillance for future SPF activities; and 3) providing direction and advice on format and content of an annual report titled "State Epidemiologic Profile on Substance Use, Abuse, and Dependency."

Framework for Selecting Potential Indicators

The importance of having a comprehensive and integrated compilation of data across disciplines is the foundation for determining key constructs that truly show the impact of alcohol, illicit drug use, and tobacco in Alaska. Figure 1 provides an overview of the undertaken by the SEW and Advisory Council to develop a data-driven process. The first and most critical step in data assessment and prioritization is a discovery process to identify known as well as new data resources to expand our understanding and clarify underlying issues related to substance use (consumption) and contributing to the consequence(s) of substance use.

In order to gather the potential indicators, three workgroups were established. The first two workgroups focused on gathering and reviewing consumption and consequence indicators. A third subcommittee, focusing on influences that impact and lead to substance use consumption and consequences was organized, thus covering the three over-arching constructs represented by the SPF diagram (Figure 2).

Figure 1. Overview of the Epidemiological Workgroup Process for Data Assessment and Prioritization Procedures

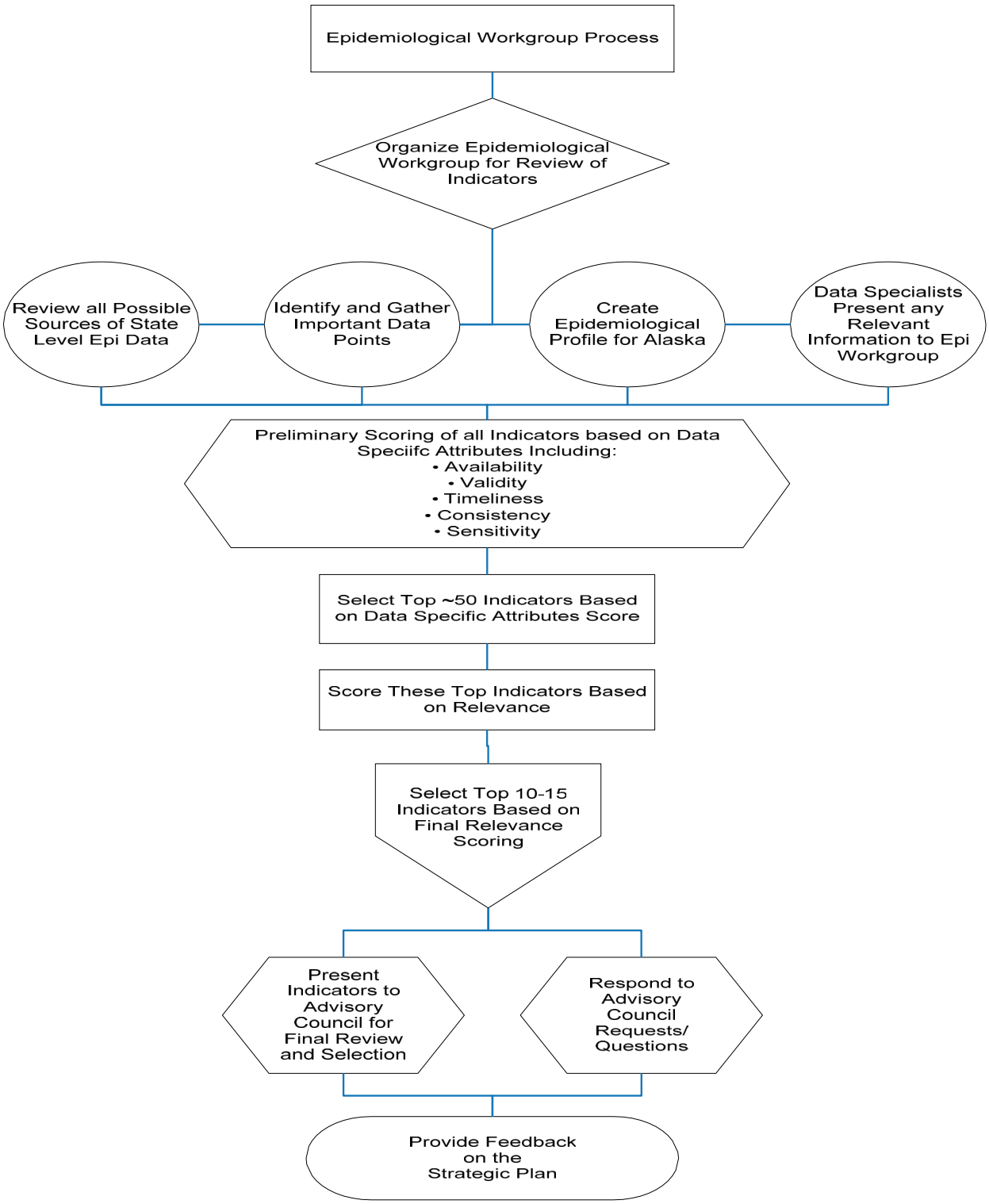
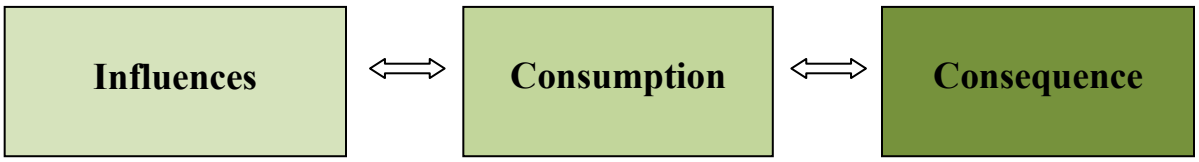


Figure 2. SPF SIG Diagram showing the relationship between substance use problems



For the purpose of these workgroups, consumption refers to alcohol, illicit drugs, and tobacco consumption patterns such as any lifetime, current or episodic use. For example, key constructs for consumption must detail drinking behavior (i.e., lifetime, initial age, daily/monthly habits) or describe the prevalence of other behavioral risk factors (i.e., driving after drinking, sexual activity while under the influence of alcohol or illicit drugs). Economic data regarding sales, transport, and geographic restrictions for purchase and/or possession is also used to conceptualize consumer patterns and the extent of the problem.

Similarly, for the purpose of these workgroups, consequences of substance use included mortality, morbidity, and other undesirable events such as social problems, unprotected sex, violence, motor vehicle crash, physical dependency, and psychological addiction. Alcohol-induced mortality, drug-induced mortality, and tobacco use related mortality are examples of constructs pertaining to consequences of substance use.

Finally, an influences subcommittee formed to gather information regarding potential indicators for the influences surrounding substance use. Influences can include family and community environments prior to, during, and following substance use. This construct focuses on extensive research that demonstrates a strong association between life domain influences and substance consumption and consequence issues. Factors such as parental modeling, interpersonal interaction, and psychosocial and socioeconomic factors contribute to substance use and other risk-taking behaviors. Understanding influences is critical to developing a clear strategic plan and prevention outcome measures. Thus, the influences subcommittee was an integral part of the SEW process, and the members were tasked, to: 1) identify and prioritize the factors that influence substance use and abuse, and 2) identify existing and recommend new indicators to monitor over time. Information on influences that had strong association with substance use consumption or consequences were noted and presented to the advisory group for inclusion in their deliberation. During this initial stage, influences were limited to youth/adolescent conditions. See Appendix B for an overview of the influences subcommittee.

SEW members self-assigned to one or more of these three subcommittees based on professional experience—either being directly responsible for collection and analysis of targeted data or being highly familiar with data collection processes and analysis. Subcommittees were tasked with reviewing potential data sources and data indicators (results of their work is presented in Appendix A); or contacting appropriate source agencies/organizations familiar with the data and requesting updated analysis reports or data subsets for analysis by SEW support staff. The subcommittees were also tasked with identifying any new information not previously available or excluded due to quality issues. Data providers not currently members of the SEW were invited to scheduled meetings to describe their data collection process(es), analysis practices, and any trends and patterns.

In addition to identification of potential data resources, the Alaska Epidemiological Profile data directory (originally developed 2006 by the SEOW) was updated to function as a roadmap for future SEW and research needs. The revised directory entries included:

- Time span; initiation of surveillance
- Consistency of data collection
- Data definitions
- Population specificity
- Long-term retention plan for data
- Short-term "snapshot"
- Barriers/restrictions to data access

Selecting Potential Indicators for Review

Building on the extensive groundwork from the SEOW (the original State Epidemiology Outcomes Workgroup subsequently renamed the SEW), measures of each construct and potential sources of data were reviewed and updated. Even though the Influences Workgroup was active throughout the data indicators compilation process, only consumption and consequences indicators were included in the original Profile, in accordance with the directions provided by SAMSHA. A summary of the major indicators and their associated datasets are listed in Table 1. Please see Appendix A for a complete listing of indicators which were considered by the SEW.

Table 1. Major Measures of Alcohol, Illicit Drug, and Tobacco Use, Abuse and Dependency

Alcohol/Illicit Drug/Tobacco Use/Consumption	**Youth, Adult, Both**	**Data Source***
Age of first use	Youth	YRBS
Binge drinking	Both	YRBS, BRFSS
Tobacco sales		Tobacco Sales
Alcohol sales	Both	Alcohol Sales
Communities with restricted alcohol sales		AK ABAD
Alcohol use/abuse/dependence	Both	NSDUH, YRBS, BRFSS
Marijuana/drug use/abuse/dependence	Both	NSDUH
Tobacco Use	Both	YRBS, BRFSS
Driver of/Passenger in motor vehicle after drinking	Both	YRBS, BRFSS
Alcohol/Illicit Drug/Tobacco Consequence	**Youth, Adult, Both**	**Data Source***
Minor consuming, possession, sales and manufacturing arrests/convictions	Both	DJJ, UCR
Referrals to DJJ for alcohol/drug treatment	Youth	DJJ
DUI	Both	DJJ, Courts
Fatal motor vehicle crashes	Both	FARS
Driver positive for alcohol/drugs	Both	FARS
Alcohol/drug manufacture/possession/sales arrests	Both	UCR
Unintentional injury	Both	ATR, AK FACE, HDD
Hospitalization for alcohol/drug	Both	HDD
Suicide	Both	BVS, AK VDRS
Homicide	Both	BVS, AK VDRS
Undetermined cause of death related to alcohol/drugs	Both	BVS, AK VDRS
Occupational death related to alcohol/drugs	Both	AK FACE
Firearm injuries	Both	Epi
Firearm deaths	Both	BVS, AK VDRS
Alcohol/drug/tobacco related mortality	Both	BVS, NCHS
Poisoning	Both	AK PCP
Prenatal exposure	Both	PRAMS, ABDR, MCH
Arrests for crimes have high correlation to alcohol/drugs	Both	UCR

**See List of Abbreviation & Acronyms (page vi)*

Data Assessment Process and Data Prioritization for Substance Use and Consequences Indicators

The SEW developed a three-step procedure to assess data availability and quality in order to select indicators of greatest need and importance. Step One eliminated any dataset without sufficient scope, i.e., the ability to generalize information for Alaska's population for at least 5 years. Step Two evaluated the data relevance and usefulness in order to measure change within at-risk populations. These first two processes provided a refined and robust set of information for statewide prioritization in Step Three. The third and final step also utilized a three-tiered process to determine the order relative to its ability to foster long-term change and improve the physical and mental health of Alaska's citizens.

Step One: Data Availability and Quality Evaluation

Each indicator within a dataset was scored on a scale of 0 to 2 (Table 2a) for each of five data quality factors: availability, validity, timeliness, consistency, and sensitivity (Table 2b). The sum of these 5 scores, which ranged from 0 to 10, were then averaged across all of the SEW members. A high score indicated datasets the SEW believed provided the highest quality information regarding each of the substance use constructs. Low scores indicated the group did not believe that indicator could be successfully used to track consumption and consequence issues in the state.

Table 2a. Scoring Scale for Phase One: Data Quality

0	Absence of desired quality
1	Lack of quality
2	High level of quality

Table 2b. Data Indicator Quality Scoring Criteria

Availability	• The data is readily available and accessible. The measure must be available in disaggregated form at the age/gender/race level. • The data is available through 2008. • The data is currently available for past 5 years or from 2004-2008.
Validity	• The measure must meet basic criteria for validity. There must be research-based evidence that the indicator accurately measures the specific construct and yields a true snapshot of the phenomenon at the time of the assessment.

	• The indicator provides a true representation of what is actually occurring in our population (state-level).
Timeliness	• The information is available in a reasonable amount of time. • There are no sporadic delays for getting the information. • The information can be analyzed in a reasonable amount of time.
Consistency	• The method or means of collecting and organizing data should be relatively unchanged over time, such that the method of measurement is the same from time i to i+1. Alternatively, if the method of measure has changed, sound data should exist that determine and allow adjustment for differences resulting from data collection changes. • The question are asked the same way over a period of years • The indicators are collected the same way over a period of time.
Sensitivity	• The measures are sufficiently sensitive to detect change over time that might be associated with changes in alcohol, illicit drug, or tobacco use. • If collected, this information will we see a change over the five-year period of our grant in the indicator.

At the end of Step One, SEW members scored 253 data indicators. After discussion, the group determined that indicators with an average score of 8 or higher with a standard deviation of 2 or less met a minimum level of quality for the SPF process. The subcommittee members incorporated a standard deviation into the evaluation process to assess whether the scoring for a particular indicator shared a consensus view. A total of 72 indicators met these scoring criteria and moved forward to Step Two.

It is important to note that decisions at this stage were based primarily on professional experience of state data managers and other professionals who work with the data on a regularly basis. Examples of measures that scored well at this point, and which were moved forward for future consideration in Step Two, included "Percent of youth reporting lifetime alcohol use" from the YRBS and "Percent of population reporting 30-day alcohol use" from any of the YRBS, BRFSS or NSDUH datasets. High scoring consequence indicators included the "Number/rate per 100,000 of alcohol induced deaths" and the "Number/rate per 100,000 of chronic liver disease /cirrhosis deaths",

both from the Bureau of Vital Statistics. These measures were deemed to have a high level of Availability, Validity, Timeliness, Consistency, and Sensitivity.

Step Two: Data Relevance

Following the completion of Step One, the 72 indicators were evaluated for their relevancy to substance use, abuse, dependency, and treatment. During this phase, individual indicators were scored as low, medium, or high (1, 2, or 3) (Table 3a), based on four relevance factors: severity, magnitude, cultural sensitivity, and changeability (Table 3b).

Table 3a. Scoring Scale for Phase Two-Data Relevance

1	Low level of relevance or mostly lacking
2	Moderate level of relevance
3	High level of relevance factor

Table 3b. Data Relevance Scoring Criteria

Severity	▮ The measure must examine the potential impact or level of outcomes on individuals or society that are associated with substance abuse. ▮ How serious is the nature/extent of outcomes associated with substance abuse compared to those of other problems? ▮ The measures are available to quantify severity, such as Years of Potential Life Lost, Quality-Adjusted Life Years, or Disability-Adjusted Life Years.
Magnitude	▮ The measures are described in terms of absolute number (e.g., total number of cases, frequency of occurrence (e.g., percents), or rates (e.g., number of cases per some standard unit). ▮ Incidence and prevalence rates are adjusted for population variations (per 100,000 people).
Cultural Sensitivity	▮ Assessment of cultural sensitivity addresses the difference of the individual, family, or community culture and values and understanding the range of dynamics that result from the interaction of people from different cultures. ▮ The measures can be broken down into individual

	components like race, gender, community of residence, or ethnicity.
Changeability	▮ Assessment of the changeability of substance abuse problems should focus on the feasibility to prevent or control the problem or the consequence(s). ▮ Potential change can be measureable in 5 years. ▮ There are opportunities that may affect present or future burden of the measure. ▮ There is scientific evidence about effectiveness of interventions.

Scores for each indicator were placed into the following equation:

Relevance Score = (Severity + Magnitude + Cultural Sensitivity) x Changeability

This scoring system was adopted and modified from the Wyoming SPF and was similar to the Centers for Disease Control and Prevention's "Guide for Establishing Public Health Priorities."

Summary of Data Findings

In order for the SEW to score relevance, an extensive review of the state epidemiological data was conducted, which will be review here.

While trends of alcohol consumption vary among age groups, gender and race, the consequences of alcohol abuse are severe in Alaska. Deaths due to alcohol and alcohol-related injuries in Alaska are one of the highest rates in the nation. While no less significant, drug-induced deaths are overshadowed 3:2 by alcohol-induced deaths. In 2008, males experienced 1.5 times more alcohol-induced deaths than females (Table 4a). Alaska Natives experience the highest rate of alcohol-induced death, 4.4 times greater than Whites (Table 4a). Trends among Native males are consistently higher than White males, where rates are 3x to 6x greater among youth and young adults. Similarly, Native females are consistently higher than White females and have rates higher than Native males between the ages of 25-44. (Table 4b).

Table 4a. Trends in Alcohol-Induced Deaths of Alaskan Residents, by Race and Gender, Age-Adjusted, Alaska BVS, 2000-2008

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	US 1999-2007
Native	69.1	56.7	66.4	70.9	65.4	56.0	60.7	50.7	69.5	65.2	--
White	7.8	12.8	14.1	11.8	14.0	9.4	13.7	17.7	13.4	14.9	--
Female	11.5	11.6	13.1	13.4	10.3	14.0	14.5	16.4	18.2	17.5	11.7
Male	19.3	26.1	28.9	25.9	32.1	17.5	24.7	26.1	23.8	26.7	3.8
Total (AK)	15.6	18.7	20.8	19.8	21.1	15.7	19.5	21.4	21.1	22.2	
Total (Nationwide)	7.1	7.0	7.0	6.9	7.0	7.0	7.0	7.0	7.3	--	7.7

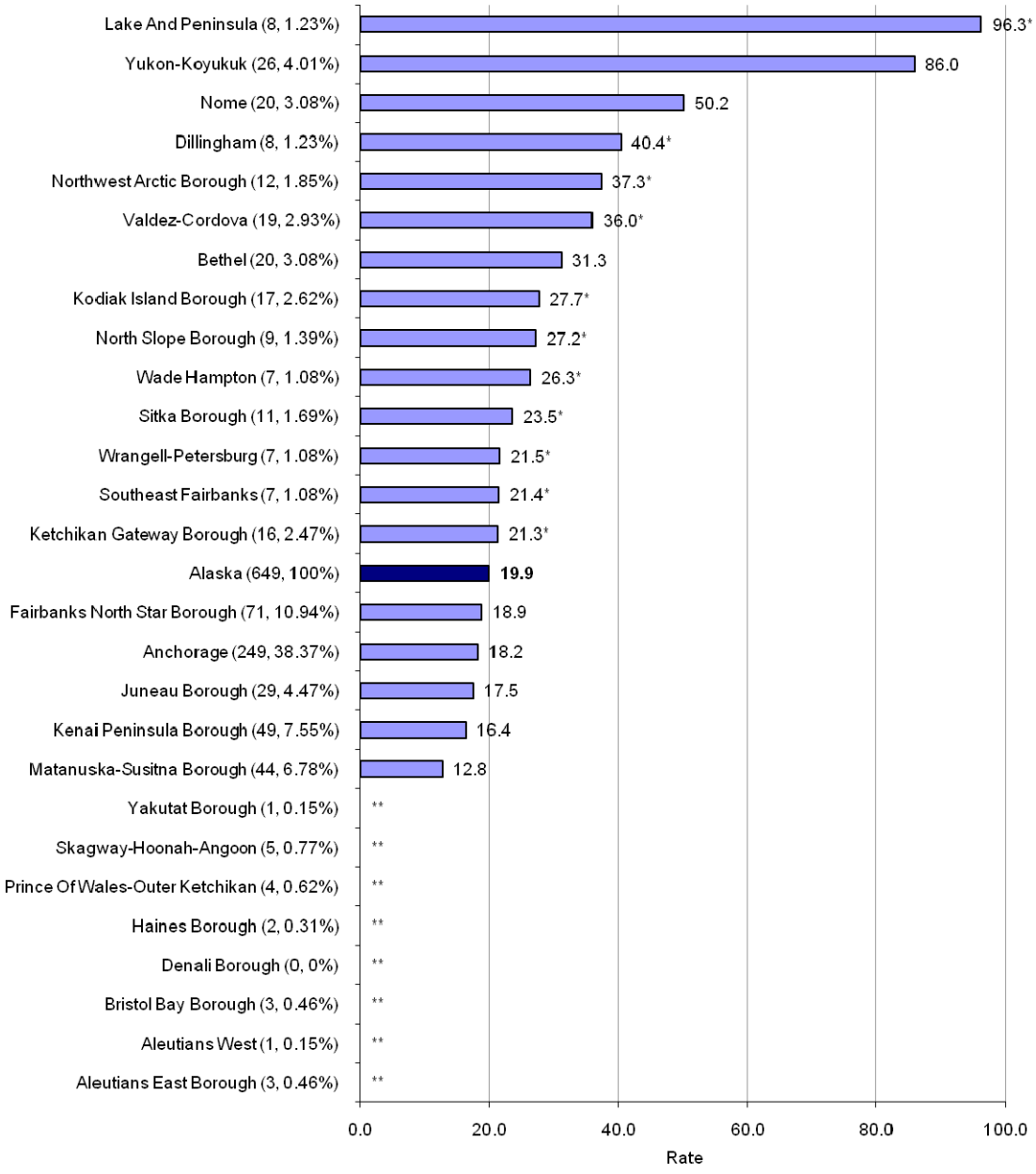
Table 4b. Trends in Alcohol-Induced Deaths of Alaskan Residents, by Age, Race and Gender, Age-Adjusted, Alaska BVS, 1999-2008

		0-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Native	Female	**	5.9*	44.7	103.9	123.6	107.3	63.1*	**	**
	Male	**	17.4*	36.3	99.6	138.6	169.6	117.1	94.6*	**
	Total	**	11.9	40.5	101.8	131.0	137.5	88.5	66.7*	**
White	Female	**	**	2.0*	11.0	14.6	17.7	14.2*	14.0*	**
	Male	**	1.8*	2.1*	17.1	40.7	47.8	51.9	38.0*	**
	Total	**	1.8*	3.9*	27.4	53.6	62.6	64.9	54.6	**
Total	Female	**	1.5*	9.2	24.7	28.2	29.0	22.2	17.7*	**
	Male	**	5.1	7.4	28.3	50.8	60.2	59.8	45.8	**
	Total	**	3.4	8.3	26.6	40.0	45.6	41.2	30.3	17.2*

*Rates calculated with should be interpreted with caution.
**Rates ≤ 5 observations were not calculated.

In 2008, approximately one of every 10 Native deaths was an alcohol induced death. Highest rates were found in rural Alaska (Figure 3). Causes of alcohol-induced death included alcohol psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, alcohol induced chronic liver disease, cirrhosis, and alcohol poisoning.

Figure 3. Alcohol Induced Death and Rates by Borough/Census Area, 2004-2008



*Rates calculated with should be interpreted with caution.
**Rates ≤ 5 observations were not calculated.

Alaska's alcohol-related problems mirror issues encountered in other states—domestic/family violence, intentional and unintentional injury, motor vehicle crash, mental illness, crime, poverty, and unemployment. Unintentional injury remains the third leading cause of death and is highly associated with alcohol use. In 2008, unintentional injury deaths among Alaska Natives were nearly twice the rate of the

overall state (96.9 per 100,000 Alaska Natives vs. 54.9 per 100,000 persons, respectively). Alcohol abuse also contributed significantly to the rate of serious non-fatal injury. Of the hospitalizations due to injury reported to the Alaska Trauma Registry (ATR), nearly 25% of all hospitalized injury patients were suspected or proven alcohol-related injuries. The rate of males hospitalized for injuries associated with alcohol use (at the time the injury occurred) was nearly double that of females (Table 5). Of these hospitalizations, the highest rates were among Alaska Natives (59%) followed by Whites (33%). This information should be considered an under ascertainment of injuries associated with alcohol since injury resulting from someone else's alcohol involvement is not reportable to the registry.

Table 5. Hospitalized Injury Associated with Alcohol Use, Alaska Residents, by Race and Ethnicity, ATR 2004-2008

	Number of Recordable Injuries	Number of Suspected or Proven Alcohol Use by Patient At Time of Injury	Percent of Recordable Injuries by Race
Asian / Pacific Islander	607	53	8.7%
Black	570	98	16.9%
Hispanic	356	62	17.4%
American Indian/ Alaska Native	8,632	3,635	42.1%
White	13,506	2,058	15.2%
Unknown	994	187	18.8%
Total	24,665	6,093	24.7%

In contrast, Alaska showed an overall decrease of alcohol-related crashes over time, of which a 24% decrease in fatalities and a 26% decrease in fatal crashes were identified between 2007 and 2008. The percent of alcohol-related fatal crashes (41%) remained steady. Survivability of motor vehicle crashes may be attributable to prevention education (BRFSS and YRBS rates for reporting driving after drinking and YRBS rates for riding as a passenger with a driver that had been drinking were static or slightly declined; both were lower than the national averages) and to significantly improved technology and seatbelt use by vehicle occupants. However, these rates do not reflect alternative modes of transportation commonly used in Alaska (snow machine, all-terrain vehicle, boat, etc.) and should be interpreted with caution.

The report of current alcohol use, heavy drinking, and binge drinking among adults in Alaska have historically been higher than the national averages. The percent of alcohol use reported by females and percent of binge alcohol use by males were consistently higher than national averages (Table 6a).

Table 6a. Trends in Alcohol Use Among Adults, by Gender, Alaska BRFSS

		2005	2006	2007	2008	2009	U.S. 2009
Female	% Binge Alcohol Use	9.7	11.9	12.5	9.8	12.4	10.6
	% Current Alcohol Use	52.0	52.7	47.1	59.0	52.4	46.3
	% Heavy Alcohol Use	4.2	3.8	6.4	4.8	6.5	4.1
Male	% Binge Alcohol Use	24.9	21.3	25.4	22.1	22.9	21.0
	% Current Alcohol Use	66.8	64.1	62.0	60.7	57.7	61.2
	% Heavy Alcohol Use	5.9	7.8	6.4	6.8	5.9	5.8

In contrast, only the report of alcohol use among youth did not vary significantly, staying at or below national averages (Table 6b).

Table 6b. Trends in Alcohol Use Among Youth, by Gender, Alaska YRBS

		1995	1999	2003	2007	2009	U.S. 2009
Female	% Current Drinking	44.6	--	37.4	39.2	32.9	42.9
	% Binge Alcohol Use	27.2	32.6	23.4	23.9	19.9	23.4
Male	% Current Drinking	50.1	--	39.6	40.0	33.5	40.8
	% Binge Alcohol Use	35.0	35.1	29.1	27.3	23.3	25.0

However, in 2009, the Alaska YRBS included an analysis comparing participants from traditional and alternative schools. Survey results from alternative high school students reported current alcohol use and binge drinking at significantly higher rates. Findings suggest that youth attending alternative high schools demonstrate higher risk behaviors.

Alcohol use is associated with other high risk behaviors including abuse of other substances, sexual activity, self-harm and other behaviors resulting in injury, delinquency, and criminal behavior in the majority of cases. Intentional self-harm (suicide) is also closely associated with alcohol use, drug abuse, or both. Suicide rates in Alaska are one of the highest in the nation (Table 7). Males successfully completed a suicidal act four times greater than females. Suicide is a leading cause of death among Alaska Natives, where highest rates are found among Native males and in communities in northern Alaska. From 2004-2008, 43% of suicides had either proven or suspected alcohol intoxication preceding the event, of which one-third had a known alcohol dependency or problem. The highest suicide rates were among Alaska Native males ages 20-29 years (150 per 100,000 persons) and Alaska Native females ages 15-19 and 35-39 years (50 per 100,000 persons).

Table 7. Death from Intentional Self-Harm, Alaska 2004-2008

Assigned Manner of Death	AKVDRS							NVDRS[2]
	2004	2005	2006	2007	2008	2004–2008		2007
	Number of Deaths by Year (Rate per 100,000 persons)[†]					Number (%)	Average (Rate)	Number (Rate)
Intentional self harm (suicide)	154 (23.3)	138 (20.6)	134 (19.8)	148 (21.7)	166 (24.2)	740 (65)	148 (21.9)	9,245 (11.6)
Undetermined intent	21 (3.2)	16 (2.4)	20 (3.0)	32 (4.7)	69 (10.1)	158 (14)	32 (4.7)	2,404 (3.0)

The impact of alcohol on a developing fetus is of concern. While infant mortality rates have not significantly changed (Table 8), SAMHSA estimates the prevalence of FASD at about 100 per 10,000 live births. Brain damage and other consequences can occur when alcohol crosses the placenta, impacting the fetus. The result may be mild to severe cognitive impairment, mental retardation, social and emotional problems, learning disabilities, visual impairment, neurobehavioral problems and other structural birth defects.

Table 8. Infant Mortality Rates per 1,000 births, by Year, BVS, Alaska 2000-2008

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Neonatal Mortality Rate	3.5	3.8	2.0	3.3	3.5	2.0	3.8	3.0	2.2
Post-neonatal Mortality Rate	3.2	4.5	3.6	3.8	3.2	2.8	3.2	3.3	3.7
Total Infant Deaths	6.7	8.3	5.6	7.0	6.7	5.7	7.0	6.2	5.9

Although other etiologies may lead to similar clinical presentations, prenatal alcohol exposure is by definition the only cause of Fetal Alcohol Syndrome (FAS). Alcohol-related birth defects are most severe among Alaska Natives (Table 9).

Table 9. FAS by Select Birth Characteristics, Alaska 1996-2002

	Number	Rate[1]
Maternal Race		
Hispanic	24	53.3
Native American, Alaska Native	812	478.0
White	132	29.2
Maternal Age		
15 - 19 years	138	179.0
20 – 29 years	475	125.2
30 – 39 years	321	145.1
40 – 45 years	21	111.1

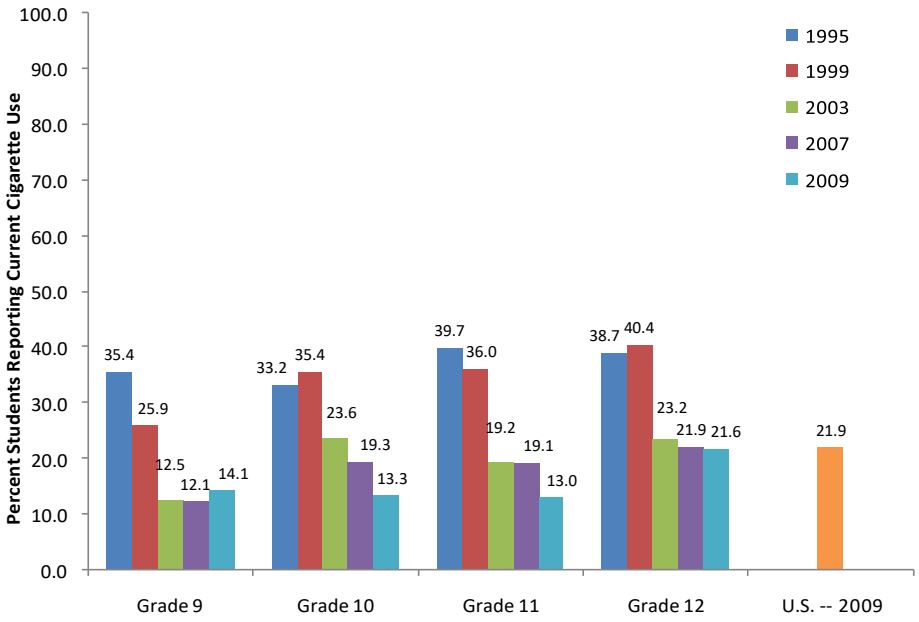
[1] Rate per 10,000 live births.

Maternal use of tobacco is also associated with low-birth weight, premature births, and infant death. Data on adult and youth smoking habits is largely provided by the BRFSS and the YRBS, respectively, and national averages are available for most recent year comparison. As present in Table 10 and Figure 4, cigarette tobacco use remains prevalent but showed an overall reduction indicating that control and prevention initiatives are impacting populations at risk. In contrast, data collected by the Alaska YRBS survey comparing traditional and alternative high schools indicate, once again, that youth attending alternative high schools are demonstrating higher risk behavior for tobacco use.

Table 10. Trends in Cigarette Use Among Adults, BRFSS, Alaska 2003-2009

	2003	2004	2005	2006	2007	2008	2009	US 2009
% Current Cigarette Use	26.2	24.8	24.9	24.0	22.2	21.5	20.6	17.9
% Daily Cigarette Use	19.3	16.4	18.8	16.2	15.6	15.1	14.6	12.9

Figure 4. Trends in Cigarette Use Among Youth, YRBS, Alaska 2003-2009



Alaska's current drugs of choice (excluding tobacco) are alcohol, marijuana, cocaine, methamphetamine, and pharmaceuticals according to the Annual Drug Report by the Alaska Bureau of Alcohol and Drug Enforcement (ABADE). Areas of growing interest, as seen by law enforcement officials, are 1) methamphetamine use and manufacture; and 2) pharmaceutical (hydrocodone and oxycontin/oxycodone) abuse and "club" drugs. Yet, the reported use among youth in Alaska remains low except for alcohol (Table 11).

Table 11. Comparison of Alcohol, Cigarette, and Illicit Drug Use Among Youth, by Gender, Alaska YRBS

		1995	1999	2003	2007	2009
Female	**% Ever Drank Alcohol**	**80.7**	**--**	**75.3**	**73.9**	**67.8**
	% Current Drinking	44.6	--	37.4	39.2	32.9
	% Current Cigarette Use	36.5	35.8	20.2	19.7	17.1
	% Current Smokeless Tobacco Use				7.3	7.4
	% Ever Used Cocaine	6.4	8.4	5.2	6.6	7.1
	% Ever Used Inhalants	20.9	15.7	10.4	16.7	10.6
	% Current Marijuana Use	24.9	27.4	21.2	18.9	19
	% Ever Used Heroin	--	2.7	0.7	0.9	2.3
	% Ever Used Methamphetamines	--	10.5	4.8	4.3	2.8
	% Ever Used Ecstasy	--	--	4.8	8	6.4
	% Ever Used Injection Drugs	1.5	2.1	1	0.9	2
	% Ever Used Steroids	3.3	3.6	2.6	2.8	--
Male	**% Ever Drank Alcohol**	**79.6**	**--**	**74.6**	**73.4**	**65.4**
	% Current Drinking	50.1	--	39.6	40	33.5
	% Current Cigarette Use	36.4	31.1	18.4	15.9	14.2
	% Current Smokeless Tobacco Use				13.5	19.3
	% Ever Used Cocaine	9.7	8.5	7.7	8.7	7.4
	% Ever Used Inhalants	23.4	13.1	9.9	12.3	8.7
	% Current Marijuana Use	32.1	32.8	25.9	22	26
	% Ever Used Heroin	--	4.6	2.8	2.4	3.6
	% Ever Used Methamphetamines	--	10.5	6.7	4.9	3.8
	% Ever Used Ecstasy	--	--	7.4	7.1	7.3
	% Ever Used Injection Drugs	2.3	4.4	2.2	3.3	2.1
	% Ever Used Steroids	4.4	5.9	4.2	3.7	--

Results of Step Two

After a complete review of Alaska's data, the 26 highest scoring indicators moved forward to Step Three, the final Advisory Council selection. These 26 indicators were selected based on receiving a consensus score of 16 or higher based on the criteria described above. The score of 16 indicated that the severity, magnitude, cultural sensitivity, and changeability of the indicators were sufficient to merit a review by the Advisory Council.

In order to facilitate prioritization, these 26 indicators were grouped into eleven substance abuse constructs, based on natural groupings of the indicators into the indicated constructs. The resulting matrix of eleven substance abuse constructs and their associated indicators were then presented to the Alaska SPF SIG Advisory Council for final prioritization (see Table 12).

Table 12. Matrix of Constructs and Indicators Identified by Epidemiology Workgroup

Consumption/Consequence Constructs	***Data Indicator***
Substance Related Mortality	▮ Number/rate per 100,000 of drug-induced deaths ▮ Number/rate per 100,000 of alcohol-induced deaths
Infant Mortality	▮ Neonatal mortality rate per 1,000 live births ▮ Post-neonatal mortality rate per 1,000 live births
Adult Tobacco Use	▮ % reporting daily cigarette use ▮ % reporting current cigarette use
Youth Tobacco Use	▮ % reporting 30-Day frequent cigarette use ▮ % reporting 30-Day heavy cigarette use ▮ % reporting 30-day cigarette use on school property ▮ % reporting first cigarette before age 13 ▮ % reporting 30-day cigar use
Youth Smokeless Tobacco Use	▮ % reporting past 30-day smokeless tobacco use ▮ % reporting past 30-day smokeless tobacco use on school property
Adult Binge Drinking	▮ % reporting past 30-day binge alcohol use
Youth Binge Drinking	▮ % reporting past 30-day binge alcohol use
Youth Alcohol Use	▮ % first alcohol before age 13 ▮ % past 30-day consume alcohol on school property ▮ % alcohol or drug use before last sexual intercourse
Drinking and Driving	▮ [Number / rate per 100,000] of motor vehicle deaths involving alcohol-impaired drivers ▮ [Number / %] of all fatal motor vehicle crashes

	involving an alcohol-impaired driver ▮ % of youth reporting as passenger with a driver under the influence of alcohol past 30 days ▮ % reporting past 30-day driving under the influence of alcohol ▮ % of adults reporting "too much to drink" before driving
Methamphetamine	▮ Number of federal drug seizures - methamphetamine
Marijuana Use	▮ % reporting marijuana before age 13 ▮ % reporting past 30-day marijuana use

Step Three: Final Assessment and Prioritization

The final prioritization process occurred at a 2-day in person meeting including participation by Project staff, DBH Prevention staff, Advisory Council members, and SEW and Evidence Based Intervention Workgroup members. The Alaska SPF SIG Advisory Council and other participants were asked to evaluate the 26 indicators put forward by the SEW, and to determine which substance abuse constructs would become priorities for Alaska. Meeting participants utilized a three-tiered approach (see Figure 5). This two-day activity resulted in the identification of one overarching consumption priority area viewed as vital to the state of Alaska: **Alcohol Abuse**.

Figure 5. Three-tiered Prioritization Process

The first tier of the Alaska prioritization process involved a review of the results submitted to the council by the Epidemiology Workgroup. These results included a matrix of eleven substance abuse constructs and their associated indicators (see Table 12). Participants received an in-depth presentation by the SPF SIG Epidemiologist of each construct and associated indicators selected by the Epidemiology Workgroup;

some of which were presented in the previous "Summary of Data Findings" section. Meeting participants were allotted time to ask a variety of questions about the data and their sources; about other additional constructs viewed as a priority for Alaska that were not identified by the Epidemiology Workgroup; as well as questions about gaps in data collection efforts within the state.

At the end of Day One, participants ranked their top five priority areas through an anonymous ballot based on their interpretation of the presented epidemiological data. All members identified their top five priority areas and ranked (prioritized) them from one to five. To determine the top five ranked areas, rankings were assigned a weighted points value (1st Priority = 5; 2nd Priority = 4; 3rd Priority = 3; 4th Priority = 2; and 5th Priority = 1). New priority areas identified by members under "other" were grouped into overarching constructs and point values assigned in the same manner. A total score, a mean score, and a count of total votes for each of the constructs were then calculated to determine the highest priority areas, based on the information provided in Day One. This served as a means to narrow the focus of the discussion for Day Two and to allow members to add constructs that they identified as major substance-related concerns for Alaska.

Table 13. Results of Day One Priority Ranking Process

Constructs	***Consumption***	***Consequence***	***Total Score***	***Mean*****	***Total Votes***
Youth Alcohol Use	x		101	3.5	29
Substance-related Mortality		x	62	2.6	24
Youth Binge Drinking	x		62	3.4	18
Suicide*		x	54	3.4	16
Interpersonal Violence*		x	52	3.7	14
Adult Binge Drinking	x		49	2.5	20
Drinking and Driving		x	38	2.9	13
Sexual Assault*		x	20	4.0	5
Adult Alcohol Use*	x		17	2.8	6
Youth Tobacco Use	x		15	2.1	7
Methamphetamine	x		14	2.3	6
Child Abuse*		x	13	3.3	4
Trauma*		x	10	5.0	2
Prescription Drug Use*	x		9	3.0	3
Infant Mortality		x	5	1.3	4

Youth Drug Use*	x		5	2.5	2
Youth Marijuana Use*	x		4	1.3	3
Co-occurring Disorders*	x		4	4.0	1
Youth Smokeless Tobacco Use	x		3	1.5	2
Heroin*	x		1	1.0	1
Adult Tobacco Use	x		0	NA	0

**Denotes constructs added by council members on Day One.*
***The higher the mean score the higher the overall ranking within the votes submitted.*

The second tier of the prioritization process began with reviewing the results of the Day One ranking (See Table 13). Special attention was placed on the five constructs with the highest mean score based on votes, namely:

1. *Youth Alcohol Use*
2. *Substance-related Mortality*
3. *Youth Binge Drinking*
4. *Suicide*
5. *Interpersonal Violence*

These priority areas, as well as others deemed important, were discussed with regard to the knowledge-based impact criteria outlined by SAMHSA (Table 14).

While the focus of Day Two discussions were on the constructs and data related to the consumption patterns and consequences of substance abuse, important influences were also addressed. To provide the members with additional context around the issue of substance abuse and its related consequences, the influences subcommittee of the Epidemiology Workgroup provided an overview of their work. Their findings identified substance use risk and protective factors and the availability of data related to these factors in Alaska.

Table 14. Knowledge-based Impact Criteria

Capacity and Resources	Capacity/resources may include the availability of human, institutional, or financial resources (e.g., number of agencies that can provide resources and expertise, the level of commitment of community groups, possibility of continued funding, etc.) as well as the commitment of these resources.
Preventability and	Assessment of the preventability/changeability of substance abuse problems may focus on the opportunities that may affect

Changeability	present or future burden, feasibility to prevent or control the problem or its consequences, scientific evidence about effectiveness of interventions to change the problem, and application of knowledge about effectiveness of interventions to the current context.
Readiness and Political Will	Assessment of readiness/political will may include a focus on the current levels of awareness, concern, and interest at the public, political, and organizational levels to support addressing a particular issue. It may also include a focus on the public/political level of acceptability and support associated with addressing the issue.

Based on further group discussion following Day One, members asked to reconsider the previous day's vote, and to identify their new top five priority areas. Only constructs scoring more than 10 points during Tier One ranking were included in the Tier Two rankings. Similar to Day One, priority areas were ranked from one to five during the Tier Two ranking process, also incorporating into their rankings considerations of the knowledge-based impact criteria. With regard to calculation, the same process from Tier One was used to derive a total score, mean, and number of votes. No new constructs emerged during the Tier Two prioritization process; however, results from Tier Two suggested a change in thinking among members as reflected in the top constructs chosen (Table 15). Specifically, Adult Binge Drinking was broadened to Adult Alcohol Abuse, which includes both binge and heavy drinking.

Table 15. Ranking of Constructs for Prioritization

Constructs	***Consumption***	***Consequence***	***Total Score***	***Mean****	***Total Votes***
Youth Alcohol Use	x		105	4.2	25
Interpersonal Violence		x	87	3.2	27
Youth Binge Drinking	x		59	3.5	17
Suicide		x	56	2.8	20
Adult Alcohol Abuse	x		36	2.2	14
Substance Mortality		x	31	2.6	14
Sexual Assault		x	31	3.1	10
Child Abuse		x	27	3.0	9
Drinking and Driving		x	21	3.0	7
Adult Binge Drinking	x		18	2.3	8
Youth Illicit Drug Use	x		8	2.7	3

Alcohol Related Assault		x	2	2.0	1
Youth Tobacco Use	x		1	1.0	1
Methamphetamine Use	x		1	1.0	1

Final Consensus of Priority Selection of Substance Abuse Construct

The third tier of the substance abuse prioritization process included the council and workgroup members and project staff integrating the ranking results and discussions from all proceedings during Day One and Two to determine a final focus area for Alaska Advisory Council. The top five ranking constructs, *Youth Alcohol Use, Interpersonal Violence*, *Youth Binge Drinking, Suicide, and Adult Alcohol Abuse (including binge and heavy drinking),* were discussed at length for the purpose of coming to a consensus vote of the priority area(s) including the previously detailed scoring on relevance and associated factors of significance (e.g., suicide rates, alcohol abuse while operating a motorized vehicle, adult modeling impacting youth behavior.)

Through a consensus vote, it was determined that the advisory members viewed **alcohol consumption as the priority concern, including both youth alcohol use (e.g., lifetime, current, heavy and binge drinking) and adult alcohol abuse (e.g., heavy and binge drinking**.) In addition, the members agreed on a set of consequences associated with alcohol abuse in Alaska that should be targeted by reducing alcohol consumption. These include interpersonal violence (as defined as child abuse, domestic violence, partner violence, and sexual assault), suicide, and alcohol-related mortality.

Assessing the Systems (Capacity and Infrastructure)

Alaska has a long-standing system of promotion, prevention and early intervention services across disciplines including substance use, fetal alcohol syndrome, mental health, tobacco, obesity and other health conditions, child abuse, domestic violence, suicide and other critical social and health conditions. Prevention work occurs in our departments of health and social services, education and early development, public safety, transportation/highway traffic safety, and environmental conservation.

State Level Prevention System in Place

Within the Department of Health and Social Services, two primary divisions manage prevention programs related to substance use/abuse: Public Health manages all tobacco prevention programs across the state; and Behavioral Health manages all alcohol and other drugs prevention programs. These two divisions work in close

partnership to achieve positive change at the community level. Both divisions embrace the SPF concepts of data driven decision-making; community planning and community readiness; and focusing attention on measureable outcomes at both the program level and the population level. While the Division of Behavioral Health uses the Strategic Prevention Framework model of community mobilization/planning, the Division of Public Health is using the Mobilizing Action through Partnerships and Planning (MAPP) framework. The two models for community planning are very similar, with the same desired outcome and both models can provide the infrastructure communities need to move their health and wellness agendas forward. The Division of Public Health is playing a significant role in the Alaska SPF SIG process: our SEW Epidemiologist is from Public Health, Section of Epidemiology; we have Public Health representation on our Advisory Council; and significant representation on our Epidemiology Workgroup.

In addition, the strength of our SPF SIG Advisory Council is the broad, multidisciplinary, cross-department representation and commitment to developing an Alaska plan to prevent the consequences of alcohol use across our state. Representation from the Department of Health and Social Services comes from public health, juvenile justice, child welfare and behavioral health; other state department representation includes the Departments of Corrections; Transportation/Highway Traffic Safety; Education & Early Development; and Public Safety including the Alcohol Beverage Control Board, Alaska State Troopers, and the Council on Domestic Violence and Sexual Assault. We have representation from the Alaska Native Health Board, the Alaska Native Tribal Health Consortium and our two (2) SPF TIGs (Cook Inlet Tribal Council and Tanana Chiefs Conference); a member of our Alaska State Senate and our Alaska House of Representatives; the Alaska Mental Health Trust Authority; community partners including the Alaska Network on Domestic Violence and Sexual Assault; Alaska Family Services; United Way of Anchorage; the Alaska National Guard Drug Demand Reduction Program; the Advisory Board on Alcoholism & Drug Abuse, the University of Alaska Anchorage; and the Office of the Governor. The attendance and commitment of each and every one of these partners has been extraordinary.

The memberships of the Epidemiology Workgroup and the Evidence Based Interventions Workgroup represent the same level of cross-department and multidisciplinary partnerships as the Advisory Council. The energy and synergy developing through the current SPF SIG efforts is powerful and, we believe, sustainable. See Appendix C for a list of all Advisory Council and Workgroup members.

The state level prevention infrastructure for substance use/abuse prevention resides mainly in the Division of Behavioral Health (DBH), except of tobacco prevention.

Within DBH, there are four primary sections: treatment and recovery, program integrity, policy and planning and prevention and early intervention services. Prevention section staff include a Section manager, two Program Managers (Alcohol Safety Action Program and Tobacco Enforcement/Synar), five (5) program coordinators, a project assistant, a CSAP Prevention Fellow and 21 direct service staff working specifically for the ASAP and therapeutic court projects. The Prevention section has a general budget of almost $11 million dollars in state general fund, federal and alcohol tax dollars. These dollars provide community-based grant funding across Alaska to over 70 agencies, including non-profit organizations, school districts, tribal governments and/or health corporations, local village/municipal governments and for profit contractors. In addition to our DBH grantees, there is a close partnership with other department grantees utilizing prevention strategies, as well as Alaska's seven (7) federal Drug Free Community grantees.

Alaska has significant ability and will to implement the SPF SIG work at both the state and community level. Beginning in state fiscal year 2007, when the Strategic Prevention Framework was first introduced by SAMHSA, Alaska embraced the framework and immediately began implementing the 5-step process into its existing community prevention grant programs (funded with state general fund dollars, alcohol tax dollars and SAPT Block Grant prevention dollars). Numerous trainings have been held on the SPF steps primarily through the annual Prevention grantee meeting; telephonic/webinar training; and through a large community coalition-building training held in September 2009 with CADCA.

Grantee quarterly reports are designed to address all 5-steps of the SPF; the Request for Proposals and continuation applications are organized to have applicants/grantees respond to their intent and/or progress in addressing each of the 5- steps; and the Performance Based Funding Review/Assessment is organized to assess progress on each of the SPF steps. Presentations have been given on the Strategic Prevention Framework at statewide conferences such as the Alaska Health Summit, the Rural Providers Conference and the School on Addictions. DBH maintains active communication with our state's Advisory Board on Alcoholism and Drug Abuse, the Alaska Behavioral Health Directors Association, the Mental Health Trust Authority and the Alaska Addiction Professionals Association.

Community Level Prevention System in Place

The Alaska prevention provider community is well informed about the Strategic Prevention Framework, trained in the 5-steps and how each step is defined; many providers have been implementing/practicing the SPF process for the past four state

fiscal years. During the September 2010 Annual Prevention Grantee meeting, the SPF SIG project director, the chairs of each SPF SIG workgroup and the evaluator provided a 90-minute plenary session to outline the progress made, the data review outcomes and the state's priority consumption and consequence selections. They understand the process, the purpose and the intended outcome of the Alaska SPF SIG to develop a stronger behavioral health prevention infrastructure and increased capacity for conducting prevention and producing better results for all of Alaska.

The State of Alaska Division of Behavioral Health has been utilizing the Strategic Prevention Framework model since 2007. All current DBH Comprehensive Prevention grantees have received training in all 5-steps of the model. Grant funds currently available through the Governor's Domestic Violence and Sexual Assault initiative are soliciting innovative community based approaches to domestic violence and sexual assault prevention and early intervention that will use the 5-step SFP model of assessment, capacity building, planning, implementation and evaluation. Providers across Alaska (urban and rural) are well versed and well trained in the SPF model.

In addition, our Public Health partners have been using the "MAPP" model of planning—Mobilizing Action through Partnerships and Planning. Nine (9) specific communities have received MAPP training and are utilizing this method of community assessment and mobilization. The MAPP model is very similar to the Strategic Prevention Framework and those communities using MAPP can easily integrate their process into the SPF planning process.

Other communities that have a formalized level of readiness are the Alaska Drug Free Community Grantees. Currently we have seven (7) active DFC grantees and a number of other communities who were past DFC grantees and have maintained their readiness level.

Potentially, there are many Alaska regions/communities that have a significant level of readiness to undertake the level of rigor the SPF process requires and the ability to show changeability at the regional/community level.

Alaska has a well-defined and well functioning Alaska Native health care system through the Alaska Native Medical Center, the Alaska Native Health Board, and the Alaska Native Tribal Health Consortium. The Alaska Tribal Health System is a compact among 21 tribes and tribal organizations authorizing them and Native health organizations to operate health and health-related programs; it was formed October 1, 1994.

Having a strong system of care is a significant task considering the size of the state, the small population density, the lack of connection between and among communities, and the vast cultural diversity. And, for this reason, there continue to be gaps in services and 'holes' in our safety net. Part of this struggle is that Alaska too often ranks number one in areas identified as "rotten outcomes."[3] Child abuse, domestic violence, sexual assault, suicide, alcohol use are a few of the outcomes we struggle to improve. There is a constant pull between funding social and health services or funding roads and pipelines; between funding rural programs or urban programs; and between promotion/prevention approaches or treatment/recovery programs. As in all states, there are not enough resources to fund adequately everything needed and compromises are made.

A new concern that has recently become apparent is the impact from the elimination of federal Safe and Drug Free Schools funding. While Alaska's share of this funding has always been small, it did provide a focus and intent that Alaska's schools have a role in preventing alcohol and drug use among our young people. Without the federal dollars and mandate for state school districts to assume a portion of this task, there is concern that a valuable partner will be minimized at best, or lost altogether. In a recent publication from the Alaska Department of Education and Early Development, "Alaska School Health & Safety Plan, October 2010," alcohol and other drugs are only mentioned minimally —tobacco, teen pregnancy, bullying & violence, and physical health all receive more attention and greater focus. While we recognize the interconnectedness of all social risk factors, it is unfortunately that alcohol, our number one "drug of choice" among Alaska youth, does not receive equal attention with other factors. The Department of Education and Early Development and the local school districts have been active partners in our substance use prevention work—it would be a great loss if their role and responsibilities to this issue are reduced.

One significant challenge Alaska will face is the capacity of some local communities (primarily rural and remote communities) to collect, analyze and report on local data.

Through the State Epidemiology Workgroup, and the diverse, competent and committed membership, Alaska has greatly increased its ability to collect, analyze and utilize broad substance use data. We have, for the first time, a comprehensive collection of substance use data for Alaska—cross discipline, cross department, and statewide.

[3] Lisbeth B. Schorr. Within our Reach: Breaking the Cycle of Disadvantage. 1988.

Criteria and Rationale for SPF SIG Priorities

In conducting this data collection, review and analysis a number of issues came to the forefront in our discussions: alcohol is a readily available and acceptable product, and consequences related to youth consumption and over-consumption by adults are significant. Due to the extreme weather, isolated communities, and lack of mobility, consequences for Alaskans who drink heavily are more severe than in other locales. For example: individuals who drink to excess, go outside and pass out, will most likely die due to exposure to extreme weather; whole communities accept the use and abuse of alcohol as a community 'norm;' youth raised in homes/communities where alcohol is regularly misused are more likely to become problem drinkers; lack of road systems and community isolation impede enforcement of alcohol laws; and extended cold and dark during winter months lead to more depression and mental health concerns where alcohol is used to self-medicate.

During the assessment process, two issues that ranked particularly high in concern, but had less data documenting a direct association with alcohol use/abuse were suicide and interpersonal violence. Alaska has consistently been in the top 5 ranking (and often number 1) among states in areas of suicide, domestic violence and sexual assault. While anecdotal data indicates a strong relationship between alcohol use, suicide, domestic violence and sexual assault, data is not consistently and reliably collected to provide clear data-driven associations. For example, Alaska data indicates that approximately 46% of all suicides involved alcohol; but less than ½ of all suicide deaths had toxicology screens requested and only 2/3 of those were completed.[4] If policies required toxicology screens for all suicides, would the data suggest a stronger correlation?

The same is true for both domestic violence and sexual assault—when law enforcement and/or medical providers are involved in these issues, alcohol and/or drug use data is not always collected leaving a gap in knowledge about the use of alcohol by the perpetrator and/or victim and its relationship to the violence. In September, 2010, the University of Alaska Anchorage Justice Center released the findings from the 2010 Alaska Victimization Survey, indicating that alcohol or drug use BY THE VICTIM, was present 26.8% of the time in the lifetime estimates of sexual violence incidents. While it is exciting to have this new data, there is little data on alcohol/drug use of the perpetrator or toxicology or arrest data that can give more specific information about the relationship of alcohol to interpersonal violence. These gaps in data are a top priority of the SEW and its ongoing tasks.

[4] Alaska Injury Prevention Center. Alaska Suicide Follow-back Study Final Report. 2007.

Even with the lack of consistent and reliable data, suicide, domestic violence and sexual assault rose to the top of Alaska's priority consequences due to the devastating numbers and the current political will to address these issues. The Alaska Governor and many members of the State Legislature, as well as Alaska Native leadership and health care/social service providers have all indicated these three issues as critical to the overall health and well-being of Alaskans and Alaska communities. In state fiscal year 2010, Governor Sean Parnell established an initiative to eliminate domestic violence and sexual assault within a decade; equal attention is being paid to our ever increasing rates of suicide, especially among young Alaska Native males, many who also indulge in heavy and binge drinking.

While Alaska-specific data may be limited in connecting the impact of family/interpersonal violence, sexual assault, and suicide to alcohol usage, there is clear and convincing research that shows the relationship between adverse childhood experiences such as witnessing domestic violence, child physical abuse or sexual assault and living in a home with extensive alcohol use and a greater risk for that child to exhibit adult behaviors that mirror their childhood experiences or that impact their overall health and well-being in adulthood. [5] For these reasons, suicide and interpersonal violence **related to alcohol consumption** are among our priority consequences.

The other four top consequence priorities all have more direct links to the use of alcohol, with clear data documenting the need for attention: alcohol-related mortality; driving under the influence; minor consuming alcohol citations; and alcohol-related crashes and collisions. At this time, there are good sources of data collection (over time) for these consequences, except for alcohol-related crashes and collisions in off-road situations. The Alaska Highway Traffic Safety Office has excellent and reliable data for our road system, but in Alaska, many of the crashes and collisions that involve alcohol are All Terrain Vehicles (ATV), snow machines, and boats. This also is a data gap we will continue to explore and find ways to better capture the impact of these crashes and collisions in the overall picture of alcohol-related motor vehicle incidents.

Description of SPF SIG Priorities

Based on the results of this three-tiered process, the Alaska SPF SIG Advisory Council determined that alcohol consumption is the primary concern. Group members made preliminary decisions regarding the target population, consumption patterns,

[5] Vincent J. Felitti, MD. The Origins of Addiction: Evidence from the Adverse Childhood Experiences Study. 2004.

consequences, and overarching areas of concern related to alcohol abuse in Alaska. These are noted below:

Population: Youth (12-20 years of age); Adult (21-44 years of age)

Focus Areas: 1) Youth alcohol use (lifetime, current, binge, and heavy); and
2) Adults alcohol abuse (heavy and binge)

Consequence: Intentional injuries (either as the perpetrator or victim)

1) Interpersonal violence (domestic violence/sexual assault);
2) Intentional self-harm (suicide);
3) alcohol-related mortality;
4) Driving under the influence of alcohol;
5) Minor consuming alcohol citations; and
6) Alcohol crashes/collision.

Additional areas of concern identified through the data analysis included disproportionality among Alaska Native people, and higher risk among students attending Alaska's Alternative High Schools. In 2009, the Alaska Department of Education and Early Development, in partnership with the Department of Health and Social Services conducted its first ever Youth Risk Behavior Survey (YRBS) among Alaska's Alternative High Schools, schools that primarily serve at-risk youth who have failed in traditional high school settings. The results of this survey showed significantly higher risk for alcohol and other drug use, suicidal thoughts, relationship violence, and risky sexual behavior. See Appendix E.

Below are Alaska data specific to youth alcohol consumption and adult heavy and binge drinking:

Youth Alcohol Consumption Priorities

Table 16. Trends in Alcohol Use Among Youth, by Gender, Alaska YRBS

		1995	1999	2003	2007	2009	U.S. 2007	U.S. 2009
Female	% Ever Drank Alcohol	80.7	--	75.3	73.9	67.8	75.0	74.2
	% Alcohol Before 13	34.1	29.7	20.4	16.3	16.0	20.0	18.1

	% Current Drinking	44.6	--	37.4	39.2	32.9	44.6	42.9
	% Binge Alcohol Use	27.2	32.6	23.4	23.9	19.9	24.1	23.4
	% Drank Alcohol or Used Drugs Before Last Sexual Intercourse	21.6	--	22.5	21.5	15.2	17.7	17.1
	% Ever Drank Alcohol	80.7	--	75.3	73.9	67.8	75.0	74.2
Male	% Ever Drank Alcohol	79.6	--	74.6	73.4	65.4	74.3	70.8
	% Alcohol Before 13	39.1	37.1	25.6	24.0	17.6	27.4	23.7
	% Current Drinking	50.1	--	39.6	40.0	33.5	44.7	40.8
	% Binge Alcohol Use	35.0	35.1	29.1	27.3	23.3	27.8	25.0
	% Drank Alcohol or Used Drugs Before Last Sexual Intercourse	31.3	--	27.8	22.9	18.6	27.5	25.9
	% Ever Drank Alcohol	79.6	--	74.6	73.4	65.4	74.3	70.8

- Binge Drinking (5+ drinks in a couple of hours) in the past 30 days.
  - Since 1995, binge drinking among high school students has declined substantially among all groups, including males and females, white and Alaska Native people, as well as in all age groups, from roughly 31% of the student population to 21.7% of the population in 2009. This is slightly below the national average.
    - Alaskan High School Students: 21.7%
    - Alaskan Alternative High School Students: 42.7%
    - National Sample: 24.2%

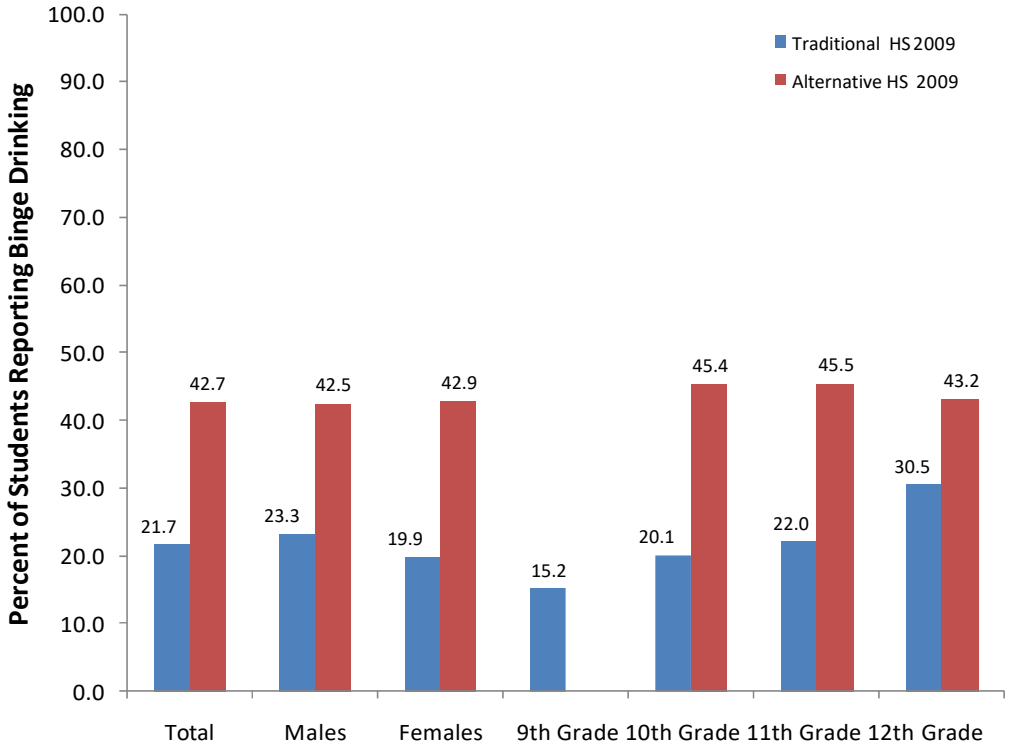
- 30-day alcohol use
  - 30-day alcohol use has also declined in all high school demographic groups since 1995, from 47% reporting current use down to 33.2% in 2009. This proportion is well below the national average.
    - Alaskan High School Students: 33.2%
    - Alaskan Alternative High School Students: 57.0%
    - National Sample: 41.8%

- First Alcohol use before age 13 years.

- Alcohol use before 13 years old has more than halved since 1995, dropping from 36.6% to 16.9%. This is less than the national average.
    - Alaskan High School Students: 16.9%
    - Alaskan Alternative High School Students: 31.3%
    - National Sample: 21.1%

- Alternative High Schools - While traditional schools have shown improvement in alcohol consumption, in 2009 alternative school students reported dramatic differences in consumption patterns compared to traditional schools:
    - 42.7% of alternative school students report binge drinking. This proportion is well above the national average.
    - 57.0% of alternative school students report 30-day alcohol use. This proportion is also well above the national average.
    - 3.4% of alternative school students report alcohol use on school property
    - 31.3% of alternative school students report drinking alcohol before age 13.

Figure 6: Trends in Youth Reporting Binge Drinking, Traditional vs. Alternative Schools, Alaska YRBS 2009



As part of the Epidemiology Workgroup, the influences subcommittee conducted an extensive review of literature, research and conclusions about the impact of risk and protective factors on the outcome of adolescent behavior. Research has identified specific factors that impact youth problem behaviors such as substance use, violence, suicide ideation and early sexual activity. Studies have found the more risk factors an adolescent has, the greater the likelihood of problem behavior. Conversely, youth with more protective factors and a resilient personality are better able to cope with risk factors and life challenges; they are less likely to be involved in problem behaviors and more likely to do well in school and in life. The influences subcommittee selected six (6) protective factors and six (6) risk factors as state priorities for the purposes of the SPF SIG process; those factors most relevant to Alaska youth. These factors are:

Protective Factors:

1. Family connectedness (attachment and bonding)
2. Connected to school
3. Positive connection to other adults
4. Engagement in meaningful activities
5. Life skills and social competence
6. Cultural identify

Risk Factors:

1. Death by suicide of a family member
2. Availability of alcohol/other drugs
3. Community norms and laws
4. Experience child abuse (physical, sexual) or other family violence
5. Early initiation of the problem behavior
6. Loss of cultural identity

The work of the influences subcommittee will continue as we move into the community engagement and will expand the work related to cultural identity, adult influences and the impact of suicide of a family member.

Adult Alcohol Consumption Priorities

Table 17. Trends in Alcohol Use Among Adults, by Age Group, Alaska BRFSS (using BRFSS age groups)

		2005	2006	2007	2008	2009	U.S. 2009
Ages 18 thru 24	% Binge Alcohol Use	N/A	19.2	14.4	13.6	11.7	19.5
	% Heavy Alcohol Use	7.5	5.9	5.2	1.8	3.5	6.2

- Binge drinking
  - While men and women in Alaska report binge drinking at rates that are just slightly higher than the national averages, men report this behavior nearly twice as frequently as women. White and Alaska Native people report the highest proportion of binge drinking, at 19.0% and 18.6%, respectively.
    - Alaska: 17.9%
    - National: 15.5%

- Heavy alcohol use
  - While the proportion of people reporting heavy use varies from year to year, most of the age, gender and race categories are similar to the national average, although Alaska is a little higher overall.
    - Alaska: 6.2%
    - National: 5.1%

Capacity Building

The social fabric of each community has its own distinct pattern. This system holds intractable problems in place and must be unfrozen to allow new behaviors and mind-sets to evolve. [6]

~ Richard Pascale, et.al. ~

The Alaska Strategic Prevention Framework State Incentive Grant is well timed, aligning with recent focus and progress to improve the overall behavioral health prevention framework, infrastructure and capacity. The Alaska Division of Behavioral Health was newly formed beginning in 2003—seven years later, we continue to define, refine and expand the meaning of a comprehensive behavioral health system of care incorporating promotion, prevention, early intervention, treatment and recovery for both substance use disorders and mental health issues and concerns. Key concepts that have guided our behavioral health integration include reducing silos, expanding partnerships and collaborations, community as the unit of change and progress (healthy communities promote healthy individuals), results accountability and measureable outcomes to show progress, and strength-based vs. deficit-based strategies for change.

[6] Richard Pascale, Jerry Sternin & Monique Sternin. The Power of Positive Deviance: How Unlikely Innovators Solve the World's Toughest Problems. 2010.

As we move forward with the SPF SIG priorities of reducing youth alcohol use and adult heavy and binge drinking we will continue to build, strengthen and improve our state's capacity for success.

Areas to Strengthen

In many respects, Alaska has a great deal of capacity—a strong state system of health, social service, community/economic development, education, and public safety programs. Alaska provides a large and well-defined "safety net" for many of its citizens. To reach our most remote communities we have a strong system of itinerate care including Public Health Nurses, Community & Behavioral Health Aides, public safety and school personnel.

One significant challenge Alaska will face is the capacity of some local communities (primarily rural and remote communities) to collect, analyze and report on local data. Because of the small population size of many rural and remote communities, data collection and analysis is difficult at best, in an effort to have data analysis that is meaningful. When your community population is 2,000 people or less, data is easily misinterpreted and skewed due to small numbers. In addition, in many communities local data is not collected regularly or it is collected at a regional level.

Western vs. traditional Alaska Native concepts of data and how it can/should be used also vary; due to years of being "over researched" by outside experts, professionals and academia many Alaska Native Tribes and villages have developed a dislike of researchers, evaluators and those putting Alaska Native traditions and existence under a microscope--all legitimate concerns and cautions. For this reason, it is critical that communities have full ownership and control over the process, the data, the decision-making and the implementation of their plans and strategies.

Another area of need and attention is to increase the capacity, training and professionalism of Alaska's prevention workforce.

State and Community-level Activities

The SPF SIG project staff and evaluation team will work closely with all selected community grantees to develop training, technical assistance and support that is culturally responsive and meets the needs of each individual community or region. It will be critical to provide training and support to fit within the community norms, beliefs and traditions. As will be discussed later in this plan, the state intends to fund a Community Prevention Support Team that will work with each individual grantee to

develop technical assistance and support plans that are individually designed to meet each grantees specific need. In addition, the Community Prevention Support Team will develop a process for ongoing regional prevention support, training and technical assistance; a process that can sustain regional expertise after the end of the SPF SIG grant.

The behavioral health and health care workforces in Alaska are not as robust as needed to tackle the enormous problems that face our state and our communities. Some of the problems lie within the lack of funding scenario, but more significant is the lack of trained prevention staff, the high turnover rates, especially in rural Alaska, and the need for more "insiders" working in the field, opposed to "outsiders" coming to Alaska for a short-term work experience.

There has been an unspoken, yet evident belief, that anyone can do prevention—no need for special training, certification, or expertise; the belief that prevention work is 'fluff' and not the hard work of changing beliefs, behaviors, norms and individual and community practices. Alaska is committed, through the SPF SIG project, to change these perceptions about behavioral health prevention. In 2010 'DBH began a prevention workforce initiative that includes a staff person assigned to lead this initiative (Natasha Pineda); a subcommittee of the SPF SIG Advisory Council that will focus on improving our state prevention workforce; partnerships with the Alaska Mental Health Trust Authority and the University of Alaska, Anchorage and Fairbanks to increase training/education opportunities; and our newly hired CSAP Prevention Fellow (Sherrie Wilson) will focus a majority of her efforts on the workforce development initiative.

A number of steps are already underway or in the planning stages including:

- An informal survey of our current DBH prevention grantees related to their level of education, prevention specific education, longevity in the field and interest in a prevention certification for Alaska.
- A partnership with the University of Alaska Fairbanks, Rural Human Services program—this partnership has been long standing and promoted the concept of "growing our own" and a "counselor in every village."
- A partnership with the University of Alaska Fairbanks, School of Social Work and their Distance BSW program, focusing on offering university-level programs through a well-designed distance program. This partnership is working to increase student's knowledge and understanding about behavioral health, prevention and community change.

- A partnership with the Alaska Mental Health Trust Authority and the University of Alaska Center for Human Development, through the Trust Training Cooperative (TTC). This project is aimed at increasing the leadership, management and supervisory skills of behavioral health providers in general. We are partnering with the TTC to develop a leadership program specifically for prevention staff/managers and possibly to assist in the development of a Prevention Specialist Certification program.

- Performing a review and analysis of the IC&RC's Certified Prevention Specialist program and steps Alaska will need to take to engage into an agreement with this national accreditation program—is this doable in Alaska, is there interest in certification, what will it take to establish a certification program?;

- Consulting with the Center for Applied Prevention Technology's Western Regional Expert Team (CAPT WRET), as the Substance Abuse Prevention Specialist Training (SAPST) is revised and redesigned to better meet the needs of today's workers and improved distance-delivery training methods;

- Establishing a process and timeline for all DBH Prevention staff to become certified as Prevention Specialists. We are in discussions with the state of Washington to possibly allow us to use their certification board as we move through our development stages.

Workforce development, expansion, and longevity are critical elements for Alaska to have adequate capacity in the field of behavioral health promotion, prevention and early development. In the area of SPF SIG capacity building, prevention workforce development is our top priority.

Finally, significant data gaps have been uncovered and the Epidemiology Workgroup will continue their efforts to remedy these identified gaps. Because of the diversity of the SPF SIG Advisory Council membership, and their ability to affect state policy, there is an opportunity to bring a positive focus on the need for these data gaps to be eliminated. Closing these data gaps will increase the state's ability to change the impact alcohol and other drugs have on the overall health and wellness of Alaska, its communities and its citizens.

Past Capacity Building Activities

During the first year of the SPF SIG project, Alaska has contributed significant efforts to statewide and community level prevention capacity building. First, at the state level, there has been a broad campaign to inform and educate partners, communities, and

interested individuals in the intent of the Strategic Prevention Framework, as well as how the State Incentive Grant will be used and the overall goals to:

- Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking;
- Reduce substance abuse-related problems in communities; and
- Build prevention capacity and infrastructure at the State and community levels.

Presentations have been made to the Alaska Health Summit, the Alaska Public Health Nurse's Conference, the Alaska Behavioral Health Director's Association, Behavioral Health Prevention Grantee meeting, the Alaska Legislative Health Caucus, and many other venues. All current Division of Behavioral Health Prevention Grantees have been educated about the five steps of the Strategic Prevention Framework through annual grantee meetings (beginning in fiscal year 2007 and continuing through this year's FY11 Annual Grantee meeting). In fiscal year 2010 DBH partnered with a number of substance use coalitions to present a 2-day CADCA workshop focused on building community coalitions and the use of the SPF to organize, assess, plan, implement and evaluate the important work of their community coalitions.

DBH recently completed a new Alaska SPF SIG web presence that will include information about the Strategic Prevention Framework, the ongoing SPF SIG activities and decisions of the Advisory Council, Epidemiology Workgroup and the Evidence Based Interventions Workgroup, as well as other sub-committee and staff activities. The site will include meeting minutes, publications, links to related state and federal websites and references and will be updated regularly to be as current and useable as possible. Once sub-recipient grant awards are made their information will be added, as well as their ongoing activities and accomplishments. To access the website go to: http://hss.state.ak.us/dbh/prevention/programs/spfsig/default.htm. The DHSS Winter Update newsletter featured an article on the state's Strategic Prevention Framework State Incentive Grant, the goals and accomplishments to date.

As a way to inform and engage the newly selected members of the SPF SIG Advisory Council, Epidemiology Workgroup, Evidence Based Intervention Workgroup and DBH Prevention staff, a daylong "kick-off" meeting was held for all members of the various SPF SIG workgroups, councils and staff on April 6, 2010. The meeting was held in Anchorage as a central location. Each member received a binder of information and resources that will continue to be used throughout the SPF SIG process, including the original Alaska Epidemiology Profile of Substance Use, Abuse and Dependency as well as a number of state and federal publications and data sources. Alyssa O'Hair, from the

CAPT West Regional Expert Team attended and provided a 2-hour overview of the SPF history, process and the requirements and expectations of the State Incentive Grant, including the roles and responsibilities of each Advisory Council and Workgroup.

In the afternoon of April 6 each group gathered individually to meet, discuss the information presented earlier in the day and to begin outlining next steps in the process. It was a very productive day and provided an invaluable opportunity for everyone to meet together, receive the same information, ask questions and begin detailing the work of each separate workgroup. The Epidemiology Workgroup continued meeting the following day for a 4-hour overview and discussion of the initial SEOW group and the 2009 Profile, as well as determining how the Epidemiology Workgroup would proceed, knowing their work was critical to initiating the work of the other groups and to select the state's priority substance use issues.

At this time, each of the Workgroups has a regular monthly meeting schedule:

- Advisory Council – 4th Friday of each month, 9:30-11:30 a.m.
- Epidemiology Workgroup – 2nd Wednesday of each month, 1:30-2:30 p.m.
- Evidence Based Interventions Workgroup – 3rd Tuesday of each month, 1:30-3:30 p.m.

An additional subcommittee of the Epidemiology Workgroup, the influences subcommittee, is exploring risk and protective factors that influence youth and adult alcohol use, with special attention to factors related to suicide and cultural factors (loss of culture, connection to culture, etc.). A subcommittee of the Advisory Council will work with Prevention staff on the issue of Prevention Workforce Development. As a critical issue for Alaska, there is a great deal of interest in exploring this topic across disciplines (education, child welfare, juvenile justice, public health and others)—recognizing the need for improved and consistent prevention training, competencies, prevention ethics, certification and cross-training to better provide services across social and health issues (removing disciplinary silos).

Additional training has been offered to increase knowledge and provide a foundation for the work of the Evidence Based Interventions Workgroup. Two webinars were held specifically for the EBI Workgroup, in partnership with the CAPT WRET: *An Overview of SAMHSA's Guidance Document on Identifying and Selecting Evidence Based Interventions* (June 15); and *Service to Science and the Role it Can Play in Evidence Based Interventions* (July 27). Both webinars were well attended by EBI Workgroup members, as well as Advisory Committee members.

In an effort to address the challenge of identifying traditional Alaska Native interventions with evidence to support their effectiveness DBH co-sponsored, with Alaska's two SPF Tribal Incentive Grants, a 1-1/2 day training, *Many Pathways to Follow: Tribal and Minority-based Practices.* Caroline Cruz, CAPT WRET Consultant, provided an overview of Oregon's model of reviewing tribal practices to determine if they have sufficient documented effectiveness to meet Oregon's evidence based intervention requirements. This training was offered to all members of the Evidence Based Interventions Workgroup and the Advisory Council, as well as DBH Prevention staff. The training provided a great opportunity to learn from a state that has already developed a process, hear their lessons learned and to work in partnership with Alaska's two Tribal SPF programs—Tanana Chiefs Conference and Cook Inlet Tribal Council.

Overall, Alaska is well grounded in the Strategic Prevention Framework and the intent, responsibilities and expected outcomes of the State Incentive Grant. During the coming months ongoing efforts will inform policy-makers, providers and the general public about the continuing activities and progress of the SPF SIG and its impact on Alaska's youth and adult alcohol consumption.

Role of the State Epidemiology Workgroup (SEW)

The State Epidemiology Workgroup began in 2006 through a CSAP-funded contract to all states currently not receiving a SPF State Incentive Grant. The purpose of the contract was to begin the data assessment process (Step 1) in preparation for a later SPF SIG state award. Initial efforts began as a partnership first between the DHSS Divisions of Behavioral Health and Public Health—identifying a current Public Health Epidemiologist who could assist and take the lead in the data gathering and analysis. The Workgroup itself was established following an internal DHSS meeting to identify where the state's data resided, who had the best knowledge and access to the needed data, as well as a selection of substance use program experts who could help identify what data would be useful and what issues needed to be addressed. The first Alaska Epidemiology Profile of Substance Use, Abuse and Dependency was completed in April 2008 and revised in January 2009.

While the 2009 version of the Epidemiology Profile was the one used for the current SPF SIG data analysis and priority setting exercise, new and updated data was added to the discussion, as it was available. The intent of the Workgroup is to revise the Profile annually, with updated data, as well as newly acquired data as a result of identifying and filling data gaps. A central depository of all information related to the Alaska

Strategic Prevention Framework State Incentive Grant is available via website at: http://www.hss.state.ak.us/dbh/prevention/programs/spfsig/default.htm.

All publications developed by the SEW, including the Alaska Epidemiology Profile, will be posted on this website and updated as new data is available. In addition, links will be added to other state data sources such as Division of Public Health sections of vital statistics, chronic disease prevention, epidemiology, the Alaska Highway Traffic Safety Office, Department of Public Safety and others. Staff are currently exploring ideas for developing a more interactive online version of the Epidemiology Profile, using a platform allowing more timely updates, and additional data, charts/graphs, and enhanced overall content. This approach will also allow for in-depth analysis behind a change or lack of change in certain trend lines.

Additional publications the SEW will complete in fiscal year 2011 are Regional Epidemiology Profiles for our six (6) Department of Labor regions—Northern, Interior, Anchorage/Matanuska-Susitna, Gulf Coast, Southwest, and Southeast (see Appendix D). Each profile will outline the data, analysis and critical issues identified for each region related to substance use. Each regional profile will mirror the larger statewide Epidemiology Profile, recognizing that some data sources are not readily available at the regional level.

The SEW has established a regular meeting schedule for the second Wednesday of each month at 1:30 p.m. Having regularly scheduled meeting times will provide a consistent opportunity for members to meet and discuss critical and emerging issues related to the state's substance use data. Emergent topics for the SEW are the identified data gaps in our 2009 Epidemiology Profile, with a particular emphasis on toxicology reports, alcohol and other drug related arrests and follow-up data on outcomes of these arrests; substance use data related to child abuse/neglect; domestic violence; sexual assault; and all forms of interpersonal violence; and better data showing the relationship alcohol and drugs have on Alaska's suicide deaths and attempts.

In addition, the SEW will identify emerging national issues and determine what Alaska data is available (or not available) to determine the impact locally; issues such as prescription drug use/ abuse; K2 Spice, a synthetic marijuana; and alcohol fortified energy drinks such as Four Loko. In preparation for Alaska's upcoming legislative session, and an apparent interest in preparing legislation regarding K2 and caffeine fortified alcohol, it is imperative that data is available to inform legislators and the legislative process to make sure Alaska's is making informed, data driven decisions and not just responding to national media attention.

It is clear that the work of the SEW will continue with data updates, revisions, and data gap analysis. As a diverse group the SEW will also provide a strong, multidisciplinary voice to educate and advocate for needed changes to our state's data collection systems, for Alaska to have strong, comprehensive data that can tell the "story" of substance use and its impact on individual citizens, families, communities and the state as a whole.

Planning

This business of skipping ahead to solutions is very tempting and very common. Much of our political discourse is about means and not ends, about actions and not results. It takes discipline and even a little courage to help a group of partners think about results indicators and causes, before they craft solutions. [7]

~ Mark Friedman ~

Through the ongoing work of the Project staff, Advisory Council, Epidemiology Workgroup and the Evidence Based Interventions Workgroup, Alaska has spent a significant amount of time developing a well-designed and thoughtful approach to how the Strategic Prevention Framework State Incentive Grant funds will be used both at the state level and the community level. Alaska sees the SPF SIG process and funding as a unique opportunity to refine and enhance our state's existing substance use prevention format and framework. It also is providing a more focused opportunity to work across disciplines. While the intent is always to work in partnership with all departments/ divisions impacted by alcohol and other drug use, it often takes a specific occurrence to motivate everyone to action. The SPF SIG has been such an occurrence.

State Planning Model

Following the 2-day meeting on August 2-3, to review the Epidemiology data and to decide on the consumption and consequence priorities for this project, the Advisory Council held three meetings to discuss and decide both the planning model, and the allocation plan for distributing SPF SIG community grants. The first teleconference meeting was held August 13, 2010. The meeting generated a robust discussion related to community capacity and readiness as a critical factor to consider in our planning model. Prior to the meeting the Advisory Council reviewed the SAMHSA Allocations Guidance Document and the five recommended models:

[7] Friedman, Mark. Trying Hard Is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities. 2005.

1. Equity Planning Model, allocating funds equally across areas of the state;
2. Highest Contributor Planning Model, allocating funds to those areas of the state with the highest number of cases to the state overall;
3. Highest Rate Planning Model, allocating funds to those areas of the state with the highest rates of incidence;
4. Hybrid Model, concentrates funding in areas defined by both numbers and rates; and
5. Stratified Planning Model, using an existing regional model of distribution.

Following a review of age and gender data related to the two priority consumption patterns (youth alcohol use, and adult heavy and binge drinking) and the associated consequence priorities, the discussion of the Advisory Council was to target funds at areas with the highest need or highest contribution. It was clear that the Advisory Council believed funding allocations should be somehow related to the areas of highest need/contribution; but at the same time with the ability to stratify the funding allocations to guarantee some equitable distribution between urban and rural areas of the state.

From this discussion came recognition of other issues that deserved consideration; just because an area has a high need or contribution to the priority issue, what if that community or region has low levels of readiness or mobilization? Because grantees will only have 4-years to do their assessments and provide interventions to their community, is this enough time to demonstrate changeability? If the selected communities/regions do not have a certain level of readiness are we setting ourselves and our communities up for failure? Or, by working with communities currently lacking "readiness" will we be adding to our state's capacity and infrastructure to better provide prevention interventions in the future? Clearly there are pros and cons for both scenarios and building increased capacity in communities that currently have low capacity is a focus of the SPF SIG process.

While the general feeling at the end of this first meeting was to utilize a stratified hybrid model, there were lingering issues that needed further discussion, such as the departments grant regulations related to single source grant awards and regional data patterns and trends. A second meeting was scheduled for August 27, where Project staff agreed to provide data/materials offering a more in-depth look at the priority data by regional patterns and trends. During the first meeting only age, gender and race data were reviewed.

During the second meeting, Jesse Metzger of the UAA Evaluation Team reviewed each section of regional data sent to Advisory Council members and highlighted noteworthy points/trends. An important consideration in Alaska is the difference between rates versus numbers: because of the small populations in rural Alaska and the larger populations in urban Alaska, data will consistently show high rates of social issues in rural areas (but small numbers) and low rates in urban Alaska (with high numbers). For example, in a community such as Anchorage, there are high numbers of youth consuming alcohol, but because of the larger population the overall rate of youth consumption is lower than in some rural communities.

Following this more in-depth discussion and review, it became evident the priority issues selected do not show a clear regional pattern of either high numbers or high rates. Such as, data related to adult alcohol abuse showed the Northern and Southwest regions with the highest percentage of overall adult alcohol use, but the lowest percentage of heavy and binge drinking. Heavy and binge drinking rates among adults were highest in the Southeast, Interior and Gulf Coast regions, yet overall alcohol consumption was higher in other areas. This pattern of variation across the state and across regions continued as the Advisory Council examined youth alcohol use, minor consuming citations, alcohol related mortality, and drinking and driving. This information caused the Advisory Council to pause and consider the critical factors for determining a funding model including community readiness, mobilization, and data indicating high rates/high numbers. The Advisory Council requested Project staff review the data again and develop some optional planning/funding scenarios for the Council to review and consider. A third meeting was schedule for September 13.

Prior to the Advisory Council meeting on September 13, Project staff prepared a number of documents for review showing regional data, age, gender and race trends for youth alcohol use and adult alcohol use and information on communities/regions that have some level of formalized "readiness." In addition, four optional scenarios for funding parameters and potential funding criteria were provided for review. The options provided were:

#1: One (1) grant available per region (using the DOL Regions: Northern, Interior, Southwest, Anchorage/Mat-Su, Gulf Coast and Southeast). Local data-driven decisions will determine which consumption priority they select. If youth alcohol consumption selected, coalitions must agree to work with area Alternative High Schools if available. A total of six (6) grant awards will be made.

#2: One (1) grant available per region, excluding areas being served by the two SPF Tribal Incentive Grants (TCC Interior Region and Anchorage). This option would allow Fairbanks North Star Borough, SE Fairbanks, Denali area and Mat-Su to still be eligible to apply. If youth alcohol consumption selected, coalitions must agree to work with area Alternative High Schools if available. A total of six (6) grant awards will be made.

#3: Four (4) total grants available; priority given to rural Alaska (with highest rates of alcohol-related crashes, alcohol induced deaths, Minor Consuming Alcohol charges, alcohol-related suicide and interpersonal violence). Regional priority would include Northern, Southwest, Southeast and Gulf Coast. If youth alcohol consumption selected, coalitions must agree to work with area Alternative High Schools if available.

#4: Four (4) to six (6) total grants: 2 or 3 urban and 2 or 3 rural. Urban numbers are highest for youth MCA charges (Anchorage, Fairbanks, Palmer) and DUI/Alcohol-related crashes for adult alcohol use (Anchorage, Fairbanks, Mat-Su, Kenai). Rural rates are highest for adult alcohol induced mortality/deaths and binge drinking (Northern, Southwest, Interior, Gulf Coast and Southeast). Alaska Natives have the highest rate of alcohol-induced deaths at 65.2 per 100,000 compared to Whites at 14.9 per 100,000. Suicide rates also are highest in Northern and Southwest regions of Alaska. If youth alcohol consumption selected, coalitions must agree to work with area Alternative High School if available.

Following another lively discussion, and a thorough review of the previous data, it was decided to select a modified version of Option 4. A total of six (6) grants will be awarded with a minimum of 2 urban and 2 rural grants being awarded. It was also decided, due to the exceptionally high incidence of alcohol use and other risky behaviors by youth attending Alaska's Alternative High Schools, including these programs will be required as part of the strategy for communities selecting youth alcohol use (if an Alternative High School is in their service area). Additional consideration was given to the DHSS grant regulations that require competitive funding be utilized unless one entity can be determined to be the only entity able to carry out the requirements of the grant.

In the final conclusion Alaska's selected funding allocation plan will be an **Equity Model**, whereby funding will be available to all parts of the State. Other funding parameters include:

- The first 6-9 months of funding will be for planning—completing steps 1-3 of the SPF (assessment of data; capacity assessment/building; development of strategic plan).
- Grants will be for 3.5 years, with potential 1 year extension depending on federal funding and a possible no-cost extension.
- Grantees are expected to be to community coalitions—not individuals agencies. Coalitions can be in various stages of development from informal to formal.
- Awards can be made to a single community, a sub-regional group of communities, or a region.
- A clear definition of "rural" will be established for these grant awards.
- A process for determining level of community readiness will be included in the grant review process.

As stated above, a major consideration of the final determination to utilize an Equity Allocation Model are the grant regulations for the Alaska Department of Health and Social Services that require competitive solicitation for grant funds unless it can be documented that only one applicant is capable of providing the requested service or one provider per region will be able or interested in providing the service. For the SPF SIG activities, it is anticipated that there will be a great deal of interest in and ability to provide the service/interventions required.

For this reason, the Alaska SPF SIG will issue a competitive Request for Proposals solicitation. In an effort to guarantee some level of equity between rural Alaska and urban Alaska the Advisory Council established a "minimum" number of proposals from each (2 rural and 2 urban: the remaining 2 awards can come from either rural Alaska or urban Alaska). The information used to frame this decision will be included in the request for proposals.

Community-Based Activities

In addition to the requirements noted above in "State Planning Model" the Request for Proposals (RFP) will highlight the following activities and grant requirements/expectations:

- Applicants will be required to address each of the priority consumption patterns—youth alcohol use and adult heavy and binge drinking. How the grantee determines to address these two consumption patterns (selection of strategies) will follow the completion, review and analysis of Steps 1-2, identifying the community-level risk and protective factors that are driving the harmful use of alcohol by youth and adults.

- Two indicators will be provided for each consumption pattern that applicants will track to determine change in the population measure;
    - Youth alcohol use: 30-day alcohol use; and binge drinking in past 30 days (data available through the YRBS)
    - Adult heavy and binge drinking: rate of binge drinking; and rate of heavy drinking (data available through the BRFSS)
- Based on the outcome of Steps 1-2, each applicant will select at least one priority consequence that results from the selected consumption pattern for their region/community. Applicants will identify one indicator that will be used to measure progress in improving the identified consequence.
- Following the completion of Steps 1-2 each applicant will develop a strategic plan, documenting their priority selections, based on local data, and identifying their planned strategies to reduce the risk factors and/or increase the protective factors. Applicants will be reminded that strategies should not be selected prior to completing Steps 1-2 of the SPF.
- Applicants will be required to choose strategies that will result in population-level change. This will necessitate the need for applicants to chose both environmental and individual-level strategies. As with all DHSS grant programs, applicants will be required to develop a logic model, identifying intervening variables associated with the selected priority; then select strategies that will appropriately address the identified issues.
- Applicants will receive guidance in the selection of evidence-based interventions from the Evidence Based Intervention (EBI) Workgroup. EB Interventions, as defined by the EBI Workgroup (they are currently developing a guidance document to meet the unique needs of Alaska) must be utilized. All proposed strategies/interventions will be reviewed by the EBI Workgroup to determine their compliance with the Alaska EBI Guidance Document.
- Any intervention/strategy proposed in the strategic plan, following the completion of Steps 1-2, must clearly indicate a plan for sustainability (especially those interventions that are not environmental) beyond the federal funding.
- All applicants will be required to develop a Memorandum of Agreement (MOA) with their local school district indicating the school district's willingness to participate in the bi-annual YRBS survey, either as a school selected for the random sample or as a voluntary participant beyond the selected sample. The

MOA must also indicate that the school district will share the YRBS results with the local coalition for the purpose of tracking changes in the identified indicators.

- As previously indicated, if the applicant selects youth alcohol use as their priority consumption pattern, and there is an Alternative High School in their service area, they will be required to include them in their defined strategy. In 2009, the Alaska Department's of Health and Social Services and Education and Early Development made a decision to conduct a separate YRBS survey among our state's Alternative High Schools. The traditional YRBS survey excludes Alternative High Schools. Not surprisingly the results showed significantly higher risk behaviors among students at the Alternative High Schools. For this reason we have decided that these programs will be deemed a priority for the SPF SIG funds focusing on youth alcohol use. See Appendix E for more detail.

- Funding will be available only to community or regional coalitions—funding will not be available to a single agency. Coalitions can be in various levels of development from an informal/developing coalition to a formalized/established coalition. The intent for these funds is to generate a regional/community effort to produce population level change; not to fund a single agency to work independently of appropriate and logical partners. Alcohol use does not occur in a vacuum and should not be addressed as such. While one agency may act as the funding agent for the coalition, the proposal must clearly state and document (through letters, MOA's or charters) that the proposed project is the result of a joint regional/community effort.

- Through the development of a statewide contract, all grantees will receive thorough training in the SPF process (Steps 1-5), Results Based Accountability, developing quality outcome measures, conducting local data collection efforts, selecting the 'right' environmental strategies, guidelines for using evidence based interventions, cultural responsiveness, and focusing on sustainability from the beginning. Once a contractor has been selected, a 3-day initial training will be developed and provided to all selected grantees within the first 60-days of the grant award. This training will be required and grantees will be asked to include travel to Anchorage for this meeting in their year one budget. Additional training, technical assistance and support services will be developed and offered through a variety of training methods (teleconference, webinars, site visits, etc.) by the Community Prevention Support Team; the team also will be available to work directly with each selected sub-recipient to address need unique to each grantee.

Allocation Approach

As previously discussed, State DHSS Grant and Contract Regulations will determine the methodology to award SFP SIG community funding. Grant funds will be available through a statewide competitive solicitation; everyone meeting minimum qualifications is eligible to apply. Minimum qualifications will include meeting state criteria for receiving grant funds (non-profit, tribal entity, school district, municipal government), application received by the identified deadline, and applicant is/or represents a coalition of regional/community members.

The Request for Proposals (RFP) is currently being drafted and will be finalized once the Alaska Strategic Plan has been approved. All competitive proposals are posted on the State's Online Public Notice page, the central location for public posting of State government solicitations and notices (http://notes3.state.ak.us/pn). RFPs are posted for six (6) weeks, providing ample time for community planning to occur, proposals to be developed, and MOAs/letters to be signed. Approximately two weeks following the release of the RFP, 2-3 pre-proposal teleconferences will be held to provide an overview of the grant expectations and to respond to questions potential applicants have or to clarify the RFP narrative. All questions and responses will be posted on the Online Public Notice page allowing all potential applicants to have the same information.

The RFP will be written to directly align with the priority consumption patterns and consequences determined by the SPF SIG Advisory Council. Applicants will have access to all State Epidemiology Profile data, including the process used to make the statewide selections. While the state's priorities will be clearly defined, the RFP will not ask applicants to select their priority issues until after they have completed their own substance use needs assessment. Once grantees have conducted their local needs assessment, they can determine which of the two (2) state consumption priorities rank highest locally. For some applicants they will be starting the SPF process at Step 1; for other communities, they will have already conducted their assessment of need and some will have completed Step 2. Because the SPF process has been utilized by some Alaska agencies since 2007, it is anticipated that proposals being submitted from coalitions/communities/groups will be at varying levels of readiness.

The goal is to fund six (6) proposals; a minimum of two (2) urban and two (2) rural. Attention to statewide regional distribution will be considered during the review process, to ensure adequate statewide allocation of SPF SIG funds through an Equity Model. Once proposals are received and deemed eligible, a Proposal Evaluation Committee (PEC) will review and score each proposal. The PEC will be a committee of

5-6 individuals including members of the Advisory Council, SEW and the EBI Workgroup. Project staff will review and score each proposal separately.

Scoring criteria will include a clear understanding of the RFP intent (to reduce youth alcohol use and/or adult heavy and binge drinking and their consequences); community readiness/mobilization to conduct the needs assessment, capacity building and prepare a strategic plan; the completeness of the coalition (are the right people at the table); a consideration and discussion of cultural responsiveness and sustainability; and a desire/confidence to see measureable change within the time limits of the grant award. Proposals should also include a discussion of how their new efforts will enhance and compliment current community change efforts.

Approximately $1.4 million will be available for community grant awards; individual grant award allocations may range from $150,000 to $350,000 per award depending on the size, population and location of the targeted service area. The intent is to provide enough funding to each region/community that significant progress can be made to begin "turning the curve" on the identified population indicators.

Once grantees have completed Steps 1-3 of the SPF, they will be required to submit their strategic plan to the Division of Behavioral Health for review and approval of the plan, including the selected strategies/interventions to address one of the two priority consumption patterns: 1) youth alcohol use; or 2) adult heavy and binge drinking. Each grantee may only address one priority consumption pattern; this will guarantee that each regional/community project will stay focused on one priority and not dilute their focus and efforts. Approval to begin implementation will only be given once project staff and the Proposal Evaluation Committee feel the plan ensures adherence and alignment to the state plan.

A selected sub-group from the EBI Workgroup will be involved in the review of each Strategic Plan to ensure the use of approved evidence based practices, policy or programs. As previously discussed, the EBI Workgroup is developing an Alaska EBI Guidance Document that each grantee will have access to; EBI Workgroup members will provide training to all grantees prior to the selection of strategies/interventions and will be available to respond to questions and requests for assistance by grantees.

Implications of Allocation Approach

By utilizing a statewide, competitive solicitation process a broad array of Alaska regions/communities will have access to SPF SIG funds to enhance prevention infrastructure and capacity. While community readiness to conduct the SPF assessment/planning/implementation and evaluation process will be considered

during the review process, all regions of Alaska will have access to these funds and have the opportunity to successfully compete for funds. A lack of community readiness will not be a determining factor in grantee selection, but will be assessed to determine the level of training and TA each grantee will need following the award of grant funds.

As noted, Alaska has a large land mass, but a small population. In addition, many of the unique characteristics of Alaska (extreme weather, lack of roads connecting rural communities, remoteness of many communities, cultural diversity, etc.) provide opportunities for innovative approaches to both decreasing risk factors and increasing protective factors. Because of smaller populations, focused efforts can often see results more quickly than in larger populations. Due to isolation and the remote nature of many regions/communities there is greater homogeneity than in large urban areas where diversity is more common. This homogeneity can promote greater success in implementing strategies to change community knowledge, attitudes, beliefs and behaviors. Conversely, it can create unique challenges to changing "traditional" knowledge, beliefs and behaviors.

By funding a limited number of proposals, resources will be more focused, will provide a blend of rural and urban projects, and will allow for more in-depth training, technical assistance and support to promote successful outcomes. This ability to develop a close working relationship with each grantee will promote better outcomes and ongoing sustainability.

Because DBH has made the choice to integrate the Strategic Prevention Framework model into all prevention funding, it will be important to coordinate and align SPF SIG grantees not only with the State SPF SIG Plan, but also to align them with other DBH prevention grantees receiving funding from state general funds, federal SAPTBG funds, and alcohol tax funds. The intent is that all DBH prevention grantees will be moving in a complimentary and comprehensive direction, enhancing the work of all partners, while also avoiding duplication of efforts. A general overview of SPF SIG Timelines and Milestones is included in Appendix F.

Implementation

Social fabric and successful communities elsewhere cannot be imported. What works somewhere else ends up as simply another program here, which might be useful but does not shift the fundamentals that we are after. [8]

~ Peter Block ~

Alaska's ability to build prevention infrastructure and capacity at the state level, and in turn promote prevention infrastructure and capacity at the community level will focus on four key strategies:

1. Enhance the Alaska prevention workforce;
2. Develop regional/community capacity to promote prevention principles and strategies;
3. Increase the understanding and use of community coalitions and environmental strategies to accomplish sustainable community change; and
4. Increase regional/community understanding and use of data to drive decision-making, implementation, evaluation and continuous quality improvement of strategies and interventions.

If the status of these four areas of behavioral health prevention improves, Alaska can make significant progress in reducing the use and abuse of alcohol and other drugs, and increase the overall health and wellness of the state, its communities, its families and its citizens.

To implement this statewide effort to improve the prevention workforce, a sub-committee of the SPF SIG Advisory Council has been established to focus specifically on workforce development issues. Committee members represent public health, juvenile justice, child welfare, domestic violence, education and behavioral health. A Prevention staff person and the CSAP Prevention Fellow will both be working on this strategy. In addition to the Prevention Workforce sub-committee, DBH has a strong partnership with the University of Alaska system of higher education. Specifically, the Trust Training Cooperative (http://trusttrainingcoop.org/); the Rural Human Services Program (http://www.uaf.edu/rhs/); and the Bachelor of Social Work Distance Delivery Cohort Program (http://www.uaf.edu/socwork/) are programs we have close working relationships. These programs offer unique opportunities for Alaska's diverse and isolated geography; allowing students to live and work in their home community (often in rural Alaska) and still obtain a higher education degree. Each of

[8] Peter Block. Community: The Structure of Belonging. 2008

these programs will play a key role in the Prevention Workforce Development agenda and the delivery of prevention training and certification.

Alaska currently does not have prevention specialist certification; part of the Prevention Workforce Development plan is to explore certification options, identify prevention competencies (aligning with the work of the CSAP Workforce project), and determine the best way prevention certification will work in all parts of Alaska. DBH staff members are in contact with the IC&RC certification organization, as well as communicating with states currently employing a Prevention Specialist Certification program.

Once the newly revised and designed Substance Abuse Prevention Specialist Training (SAPST) is ready for use, Alaska will incorporate this training program into its ongoing training/technical assistance and support work with grantees and community members striving to increase their promotion and prevention efforts at the local level. We anticipate the revised SAPST to include a significant web-based or distance delivery presence, allowing our rural and remote grantees easier access to training. The SAPS Training will be incorporated into our grantee training requirements once completed.

The second statewide implementation key strategy is to develop strong regional and local capacity regarding prevention knowledge, principles, concepts and a process for regional level training, technical assistance and support. One challenge Alaska faces is staff turnover among grantees, especially in the rural and remote communities. For this reason, it is important to have a clear process in place to assist new program coordinators and staff in gaining the knowledge they need to mange a state grant program, as well as understanding data, community readiness and capacity, planning, implementation, and program outcomes/evaluation; understanding the importance of a continuous quality improvement process. Over the past six years, the DBH Prevention section has established an annual grantee meeting, where training is offered. Webinars are also being used to provide training and skill-building. What is needed is either a centralized training/technical assistance contractor that is available to assist anyone who requests support or prevention support systems at the regional level.

To begin this process with the SPF SIG grantees, the intent is to award a statewide prevention training, technical assistance and support contract; a contractor with unique skills at understanding the SPF model, rural and remote Alaska, and the unique systems and challenges faced by Alaska communities in incorporating prevention principles and knowledge into their regional and community work. The first requirement of the Community Prevention Support Team contractor will be to establish a series of workshops/training for the SPF SIG grantees—a 3-day face-to-face training/meeting will be organized and required within the first 60-days of the grant awards. This training will provide all grantees with the same baseline information, an opportunity to meet as a cohort, and an opportunity to meet the contractors and develop individualized training plans for the future. In addition, contractors will be available to provide onsite training, technical assistance and support as needed and

requested. The initial training will include, but not be limited to, topics such as coalition building, development and use of logic models, using intervening variable to select appropriate strategies, identifying and selecting evidence based interventions, developing clear and measurable outcomes, and how to collect and use local data.

Once the initial training is complete, the next deliverable for the contractor will be to develop a "gold standard" for what training, technical assistance and support SPF SIG grantees will need to be successful in seeing indicator change in the targeted population. Additional training will be developed to be available through distance learning such as webinars or teleconferences. A regular schedule of available training opportunities will be established to meet the needs of SPF SIG grantees. The development of training will coordinate closely with the Prevention Workforce Development subcommittee to guarantee cohesion of both efforts.

In addition to developing training to meet the needs of the SPF SIG cohort as a whole, the Community Prevention Support Team will meet individually with each sub-recipient to determine training and TA needs specifically to meet the unique needs of each grantee. The needs of urban grantees will vary considerably from the needs of rural grantees. Communities new to the SPF process will need more assistance to understand the 5-step process than those grantees that have used the SPF model for a number of years. Each community will have unique challenges, environmental and political conditions, and risk and protective factors specific to their community/region. Each grantee will receive a combination of both generic training for the entire cohort, as well as specialist training, TA and support to meet their priority needs.

The final deliverable for the Community Prevention Support Team will be to meet with key individuals at the state, regional and local level to determine the best model for Alaska in terms of a Behavioral Health system of prevention training, TA and support for all grantees; a system that can be sustainable beyond the life of the SPF SIG project. Recommendations will be made by the contractor to the SPF SIG Advisory Council, based on feedback, information gathering and the best approach to reach all of Alaska's urban and rural communities.

The third key strategy for state implementation is to enhance and increase understanding, development and support of community coalition work. Currently, coalition work in Alaska is sporadic and varies on a continuum from very informal to formal. The definition of coalitions ranges from sharing letters of support between agencies to working together in a collaborative approach to solving critical social and health issues. In the words of Tom Wolff, "Coalitions are partnerships of the many sectors of a community which gather together collaboratively to solve the community's problems and guide the community's future." It is this definition that Alaska is working towards. This strategy is also closely tied to our Prevention Workforce Development plan.

In research from the Wyoming SPF SIG, a critical element for successful community work and problem solving is the development of quality leadership. "All communities

have assets that can be tapped for collaborative problem solving, although it is often primarily through local leadership that the potential for effective action becomes reality. Consequently, leadership development is emerging as a center of attention within the field of health promotion."[9] This presents a logical reason and solution for increasing community level coalitions and collaborative work. While Alaska has a few excellent examples of community coalition work, including seven (7) current Drug Free Community grantees, the more common coalition structure is informal and at times inconsistent. The development of quality community leadership, in conjunction with the overall Prevention Workforce Development efforts will play a critical role in increasing the number and quality of successful community anti-drug coalitions in Alaska.

Two years ago, DBH and the Mat-Su Substance Abuse Coalition co-sponsored a two-day training opportunity by the Community Anti-Drug Coalitions of America (CADCA). This training provided over 200 participants with the building blocks of quality coalition knowledge, skills and practical application to their own communities. In an effort to continue this work through the SPF SIG, funding for local grants will be available only to community or regional coalitions not to single agencies. While the RFP definition of a coalition will allow for those in the development phase, training, TA and support will also be available to all grantees to assist in their coalition growth and development.

The final SPF SIG key strategy is to increase regional/community understanding and use of data to drive decision-making, implementation, evaluation and continuous quality improvement of prevention strategies and interventions. Alaska's goal is to embed the core principles of the Strategic Prevention Framework into the daily work and decision-making of all regional/community-level grantees. From current experiences with community-level grantees, it is clear they have acquired *knowledge* about the steps of the SPF, but many have been unable to incorporate that knowledge into *changed behavior*. Grantees understand they are required implement an assessment of their local data, needs and capacity. However, some struggle to use that information to drive their decision-making, the selection of their strategies and the structure of their evaluation.

Through the SPF SIG community funding process, grantees will need to demonstrate both their knowledge of the steps AND their implementation and follow-through in using this process. By supporting and challenging SPF grantees to a high standard of fidelity to the framework, it is anticipated the outcomes and performance will generate greater success and improvement in the overall community health and wellness. It is also expected the lessons learned will be incorporated beyond the SPF funded grantees to the larger statewide process.

[9] Jerome Evans, Pamela Tindall, and Jeffery Linkenbach. Developing Community Leadership in Wyoming's Strategic Prevention Framework State Incentive Grant Initiative. August 2010.

If grantees begin to see and experience population level change resulting from their actions, this success will breed greater success. On the other side, if grantees do not see change occurring from their actions, using the lessons being taught from the failure can also breed success (if they listen to and learn from their less than successful efforts). Data is useful in multiple ways if it is truly understood.

Alaska is using the SPF SIG to engage, mobilize and expand its comprehensive promotion and prevention efforts to reduce substance use and its tragic consequences. The implementation process will promote and build a strong prevention infrastructure, as well as increase capacity to engage in behavioral health promotion and prevention across disciplines, communities and regions.

Evaluation

Results Accountability uses three common sense performance measures: How much did we do? How well did we do it? And, is anyone better off?[10]

~ Mark Friedman ~

To complement the State of Alaska's existing infrastructure and capabilities, DBH has contracted with the Center for Behavioral Health Research and Services (CBHRS) at the University of Alaska Anchorage. CBHRS has a long history of successful statewide and community-based collaborations on mental health and substance abuse related evaluation projects. More specifically, CBHRS served as the independent evaluator for several SAMHSA-funded state grants, as well as community-based grants. Through these and other projects, CBHRS has acquired the knowledge and skills needed to collect, analyze, and report on data from sources such as Medicaid, Youth Risk Behavior Surveillance System, Behavioral Risk Factor Surveillance System, Treatment Episode Data Set, and National Outcome Measures. Working as *independent* evaluators, the CBHRS team works closely and collaboratively with project staff and community entities; this approach provides many benefits for project implementation and evaluation at the community level. As CBHRS has extensive experience in assisting in the collection and utilization of the above data sources, the independent evaluation and cross-site evaluation will be a smooth and seamless process.

[10] Mark Friedman. Trying Hard Is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities. 2005.

Alaska's Target for Change

The Alaska SPF SIG has selected two primary target areas for changes in alcohol consumption: (1) adult binge and heavy drinking; and (2) underage drinking. Several alcohol-related consequences were also determined as priorities for change. These include alcohol-related suicide, alcohol-induced mortality, driving under the influence (DUI) arrests, and alcohol-related collisions resulting in an injury or fatality.

Evaluation Questions

a. Outcome Evaluation

The outcome evaluation will consist of both quantitative and qualitative components and will answer the following four questions:

1) What was the effect of the SPF SIG project on the proportion of adults reporting binge and heavy drinking, or the proportion of those 12 to 20 years old reporting alcohol consumption?
2) What impact has the SPF SIG had on reducing alcohol-related consequences of importance to the state of Alaska, that include, depending on sub-grantee interventions, alcohol-related suicides, alcohol-induced mortality, DUI arrests, and alcohol-related collisions resulting in an injury or fatality?
3) What program/contextual factors were associated with outcomes?
4) What individual factors were associated with outcomes?

b. Process Evaluation

The process evaluation will be primarily qualitative and will measure the extent to which proposed tasks and activities were achieved. For the Alaska SPF SIG, process evaluation will answer four (4) questions. These questions will be addressed on both a state-wide (grantee) level and a community (sub-grantee) level.

1) How closely did implementation match the plan?
2) What types of deviation from the plan occurred?
3) What led to any deviations from the plan?
4) What impact did the deviations have on the intervention and evaluation?

Evaluation Strategy

a. Overview of Surveillance, Monitoring, and Evaluation Activities

Through this project, the State and CBHRS commit to collect all necessary data for the Grantee Level Instruments (GLIs), Infrastructure and Implementation Surveys, and Community Level Instruments (CLIs), including the Community Partner Activities and Intervention Strategies Surveys. In addition, data for the National Outcomes Measures (NOMs), as listed in Table 19, will be collected as appropriate to the content of the sub-grantee awards, at the State, Community, and Program level. If local communities engage in program activity, the Participant-Level Instrument (PLI) data will be collected and reported. The corresponding data elements for all of these data sources will be collected in a format consistent with SAMHSA's reporting requirements (i.e., Prevention Management Reporting and Training System [MRT] web-based data entry system).

The ongoing monitoring and evaluation of the Alaska SPF SIG project will assess program effectiveness and service delivery quality, encourage needed improvement, and promote the sustainability of effective programs.

b. State-Level Surveillance, Monitoring, and Evaluation Activities

State-Level Outcome Evaluation

National Outcome Measures. State-level outcome measures will include all of the National Outcome Measures (NOMs) listed in Table 18. Most of the state-level NOMs will be pre-populated by SAMHSA using a variety of national data sources including NSDUH, FARS, UCR and NCES. Therefore, the local evaluation team will not need to provide these data directly. The data for three additional NOMs will be gathered and aggregated from the CLIs. These NOMs are: 1) number of persons served, by age, gender, race, and ethnicity, 2) total number of evidence-based programs and strategies employed, and 3) service costs per participant,. The evaluation team will work closely with the Project Director and the communities to ensure that the aggregate information is available in a timely manner for the reporting of state-level NOMs.

Table 18. National Outcome Measures by State and Community Level Data Source

National Outcome Measures (NOMs)	State-Level Data Source	Community-Level Data Source
Abstinence from Drug Use/Alcohol Abuse		
30-day Substance Use (nonuse/reduction in use)	Pre-Populated	YRBS / BRFSS
Age of First Substance Use	Pre-Populated	YRBS

Perception of Disapproval/Attitude	Pre-Populated	YRBS
Perceived Risk/Harm of Use	Pre-Populated	YRBS
Increased/Retained Employment or Return to/Stay in School		
Perception of Workplace Policy	Pre-Populated	N/A
Substance Abuse-Related Suspensions and Expulsions	Pre-Populated	Alaska School Boards(ASB)
School Attendance and Enrollment	Pre-Populated	ASB
Decreased Criminal Justice Involvement		
Alcohol-Related Car Crashes and Injuries	Pre-Populated	Alaska Highway Safety Office (AHSO)
Alcohol and Drug-Related Crime	Pre-Populated	UCR / AHSO
Increased Access to Services (Service Capacity)		
Number of Persons Served by Age, Gender, Race, and Ethnicity	Cross-Site CLI	Cross-Site CLI
Increased Retention in Service Programs – Substance Abuse		
Total Number of Evidence-Based Programs and Strategies Employed	Cross-Site CLI	Cross-Site CLI
Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message	Pre-Populated	Cross-Site CLI / PLI / NSDUH
Increased Social Support/Social Connectedness		
Family Communication Around Drug Use	Pre-Populated	NSDUH
Cost-Effectiveness of Services (Average Cost)		
Services Provided Within Cost Bands (Universal, Selective, and Indicated)	Cross-Site CLI	Cross-Site CLI
Use of Evidence-Based Practices		
Total Number of Evidence-Based Programs and Strategies Employed	Cross-Site CLI	Cross-Site CLI

Additional Outcome Measures. In addition to the NOMs, the Alaska SPF SIG may also track four additional outcome measures listed in Table 19, depending on the specific nature and focus of the community-level interventions. With regards to alcohol consumption among adults and youth, data regarding binge and heavy alcohol use may be collected both from the Youth Risk Behavior Survey (YRBS), as well as the Behavioral Risk Factor Surveillance System (BRFSS). Alcohol consequence indicators may include alcohol-induced deaths and alcohol-related suicides, data for which will come from the Bureau of Vital Statistics (BVS) and the Alaska Violent Death Reporting System (AKVDRS), respectively. The evaluation team has been active with the State Epidemiology Workgroup (SEW) as well as in communication with many of the state data analysts; thus, acquiring and compiling data from the BVS, AKVDRS, and the YRBS/BRFSS systems will be efficient.

Table 19. Outcome Measures in Addition to the National Outcome Measures

Outcome Measures	**State Level Data Source**	**Community Level Data Source**
Consumption		
Binge Alcohol Use	YRBS/BRFSS	YRBS/BRFSS
Heavy Alcohol Use	YRBS/BRFSS	YRBS/BRFSS
Consequences		
Alcohol-Induced Deaths	BVS	BVS
Alcohol-Related Suicides	AK Violent Death Reporting System	AKVDRS

Finally, the influences subcommittee has been active in Alaska since the inception of the SEOW identifying and documenting statewide risk and protective factors related to substance use. As a result of this group's work, additional measures will also be tracked at both the state and community level. Decisions about which risk and protective factors will be of interest to the Alaska SPF SIG will not be made until the grantee communities have been selected, their assessment completed, and their strategies selected. Examples of potential measures include questions from YRBS, such as whether students have a positive connection to at least one adult or whether students are involved in volunteer or helping activities. The Association of Alaska School Boards (AASB) administers a School Climate and Connectedness Survey, from which risk and protective factor questions may be monitored over the course of the grant period.

Strategy and Expected Changes. The state-level outcomes evaluation for Alaska will attempt to assess whether rates of alcohol use and abuse, as well as adverse consequences related to alcohol use, decline over the grant period at the state level. Several factors lead us to conclude that using comparison groups (i.e. unfunded communities) to assess changes in outcomes among funded communities would be impractical in Alaska and possibly even inappropriate. These include the vastness of the Alaskan landscape; the large distances between communities; the regional, ethnic and culture differences between communities; the large relative differences in community sizes; and limited ability to collect certain outcome information in rural, unfunded communities. Instead, the Alaska outcome evaluation will use baseline measures to assess change over the 5-year grant period.

State-level baseline data as well as ongoing data collection for years 2011 through 2015 will be readily available from all of the relevant data sources including the Bureau of Vital Statistics (VBS), Alaska Violent Death Reporting System (AKVDRS), Alaska School Boards (ASB), Alaska Highway Safety Office (AHSO0, Youth Risk Behavior Survey (YRBS), and the Behavior Risk Factors Surveillance System (BRFSS). These data will provide reasonably solid estimates upon which to base an evaluation of change over time. It should be noted, however, that the sample size of certain outcomes, such as suicide, may be too small to make a definitive claim as to the direct effect of the SPF SIG on any observed changes (or lack thereof) in these measures. Analytical methods will include aggregated descriptive frequencies over time, and potentially mixed models regression to account for the correlation of responses within communities.

Challenges Facing the Outcomes Evaluation. A primary concern that was considered throughout the Epidemiology Workgroup's deliberations, and now during evaluation planning, has been the timeliness of some of the data sources. Delays in obtaining current data from these sources may impact the ability to report outcome results in a timely fashion. To address this challenge, the evaluation team will work closely with the state analysts to generate data relevant to the evaluation as promptly as is possible.

Although the team has indicated they will assess the change in the outcome measures over the 5 year SPF SIG grant period, the implementation of the strategies/ interventions will not likely begin until the end of year 2. It is possible the intended behavior, policy or practice change may require a longer period of implementation in order to be effective. This leaves only 3 years between the beginning of the implementation and the actual outcomes assessment. While there is concern that the grant period may be too short to observe the long-term effects at the state or even

community level, through sustainability efforts it is intended the results/outcomes will continue to be evident long after the federal funding has ended.

An additional concern is whether change at the state level will be detectable given the heterogeneity of the communities in Alaska, heterogeneity of implemented programs and interventions, relatively small size of the SPF SIG funded communities, cyclical trends that may overwhelm the observed effects of SPF SIG interventions, small sample size or timeframe to detect change. These are complex issues that all states face equally. The state-level outcomes evaluation will be more affected by these limitations than the community-level outcomes evaluation; however, even at the community level many of the same concerns remain.

State-Level Process Evaluation

At the state level, a primary source of process information will come from the Grantee Level Implementation and Infrastructure Instruments (GLIs) which will be conducted to fulfill national cross-site evaluation requirements. CBHRS will work with the SPF SIG Project Director and other relevant community members to ensure that these surveys are completed adequately and submitted in a timely manner through the Prevention Management Reporting and Training System (MRT). These instruments will provide insight into the fidelity by which the Alaska SPF SIG adheres to the five-step SPF process.

Information gathered through this process evaluation will allow for an assessment of overall progress and the fidelity to the SPF process in Alaska. In addition to the two GLIs, CBHRS will conduct a qualitative process evaluation on an annual basis throughout the grant period. Table 20 provides a list of State and Sub-Grantee process evaluation instruments. On an annual basis, CBHRS will submit a written report of results. Results will also be shared with all project partners/grantees and discussed during annual grantee meetings. This process evaluation will consist of the following major components:

1) *Key Informant Interviews* to be conducted with members of the SPF Advisory Council, Epidemiology Workgroup, and Evidence-Based Interventions Workgroup
2) *Focus groups* to be conducted with regional community groups involved in this project. Focus groups were used in evaluating the first SIG project and can be successfully used to obtain data about a range of opinions. The main reason for using this method is that attitudes and perceptions are usually not developed in

isolation, but through interactions with other people. Focus group representation will be diverse in gender, age, geography, culture and race, and where possible, will include at least one leader from each major community represented in the project.

3) *Participant Observation Notes* will be maintained by CBHRS staff throughout the grant period
4) M*eeting minutes* of all relative groups and committees will be monitored and reviewed by CBHRS staff throughout the grant period

Table 20. Process Evaluation Instruments

State	Sub-Grantee
• GLI – Infrastructure Survey • GLI – Implementation Survey • Participant Observation Notes • Key Informant Interviews • Meeting Minutes	• CLI – Community Partner Activities • CLI – Intervention Strategies • Participant Observation Notes • Key Informant Interviews • Meeting Minutes

c. Community-Level Surveillance, Monitoring, and Evaluation Activities

Outcome Evaluation

Similar to the state-level outcomes evaluation, the community-level outcome evaluation will assess whether rates of alcohol use and abuse and the adverse consequences related to alcohol use decline within each of the funded communities over the 5-year grant period. Community-level outcome evaluation will include several of the NOMs in Table 18. The selection of other specific outcome measures will be based on which community strategies are chosen. These may include any or all of the indicators in Tables 18 and 19 listed for community evaluation.

Community-level baseline data, as well as ongoing data collection, will be readily available from BVS, AKVDRS, ASB, and AHSO. Funded communities will be strongly encourage to participate in the YRBS and make at least aggregated community level data available and possibly even respondent-level data. The state will work closely with each community to assist in this decision-making process. This data will provide baseline and follow-up measures for several of the consumption indicators listed in Tables 18 and 19. This will also ensure adequate representation of Alaska Native people from the more rural funded communities. A recent change to the Alaska BRFSS

will allow for regional breakdowns of BRFSS responses, based on six sub-divisions used by the Alaska Department of Labor and Workforce Development (generally defined by groups of counties). Depending on the communities funded, these sub-regions could provide at the community-level a slightly more refined way to assess change over time than the aggregated state-level data.

Process Evaluation

At the community level, a primary source of process information will come from the Community-Level Instruments (CLIs). Data from these instruments will provide answers to the process-related questions regarding how closely the implementation matched the plan and how much any deviations might have affected the interventions. As stated previously, focus groups will be conducted with regional community members involved in the project.

In an effort to increase the quality and utility of sub-grantee data, before any data collection is started, all funded communities will be thoroughly trained on how to implement any required evaluation tools, such as the CLI survey instruments. In addition, grantees will be trained on how to properly manage data in regards to confidentiality. In collaboration, CBHRS and DBH will provide ongoing evaluation feedback to grantees/community programs, developing a process for continuous quality improvement of programs and encouraging grantees to use data/outcome measures for purposes of program improvement. As part of the regional technical assistance visits, CBHRS will provide communities with technical assistance to learn how to conduct local process evaluations that will contribute to the overall statewide process evaluation findings.

Data Collection and Reporting

a. Sub-recipient Collection of NOMs and Cross-Site Evaluation Data

Two factors are important with respect to data collection within Alaska. One relates to the wide range of cultural differences across the state. Because of this diversity, sub-grantees with experience serving the specific (regional) populations will be responsible for their own data collection and for demonstrating cultural competency. Another factor is the communication challenges that exist in remote areas of the state. Some of the regions of the state in which the greatest need exists for the SPF SIG may not have Internet access, and phone communication can at times be severely limited. DBH and

CBHRS staff will work with grantees on an individual basis to identify barriers and find solutions to data collection issues.

Beginning with regional technical assistance visits to be conducted during the first year of the community-funded project period, DBH and CBHRS staff will ensure that adequate evaluation and data collection capacity exists at the community level. Project staff, the Epidemiology Workgroup, and the SPF Advisory Council will provide recommendations to grantees on what resource may be required to conduct such activities.

This capacity will be accomplished in a variety of ways. Trainings and extensive technical assistance related to the collection of the needed data elements, such as needs assessments for the SPF process, will be provided to community evaluators by CBHRS. Training will then be provided to all grantees on how to submit required data to the DBH central office (e.g., frequency, format). In addition to informatics capacity required for sufficient community data collection and evaluation, designation of adequate funding to conduct related activities is essential.

Project data will be managed mostly in hard-copy format. If local communities choose to provide programs as part of their sub-grantee funding, PLIs will be required. In this case, protocols will be developed on how to minimize the potential for breach of confidentiality (e.g., use of coded identifiers as opposed to names on hard copy data and restricted access) and to maximize data accuracy (e.g., fewer persons entering data, data entered on a regular basis to avoid "entry fatigue" and possibility for errors).

b. Reporting of Results to State and CSAP

All project data will be analyzed by CBHRS in partnership with the DBH Policy and Planning Section staff (in close consultation with Epidemiology Workgroup partners) on a regular basis. One of the prime functions of the Epidemiology Workgroup will be to provide interpretation of project data and make preliminary policy and programmatic recommendations to the SPF Advisory Group and Project Manager. Written annual reports on SPF SIG progress will be provided and discussed at annual sub-grantee meetings, along with process and outcome evaluation results.

Cultural Competency of the Evaluation Methods and Instruments

DBH recognizes the importance of demonstrating cultural competence in evaluation methods and corresponding instruments. This was a primary consideration in selecting

CBHRS to serve as project evaluators given their extensive experience in working with diverse populations (with particular emphasis on working with Alaska Native populations). DBH and CBHRS will provide SPF SIG staff refresher training in the area of cultural competence and thoroughly explore values of specific communities which may result in slight variations of the evaluation methods so that the best process and outcome data can be collected.

The outcome measures that have been chosen, as well as the NOMs, primarily come from well-established national data sources and should be appropriate for use across most cultures and regions. For example, the BRFSS and YRBS have been administered for many years and are considered appropriate for most groups. In Alaska, BRFSS uses complex sampling techniques to ensure representation of those living in rural areas as well as across the various demographic subgroups. Other data sources, such as the BVS and AKVDRS, are surveillance systems which simply collect basic information on events in the state, and should be representative of statewide trends. Relative to the process evaluation, the evaluation team will ensure that all of the surveys, key informant interviews, focus groups and participant level instruments are administered in a way that is representative of the gender, age, and cultural groups that make up the state of Alaska.

Cultural Competence

Cultural competency emphasizes the idea of ***effectively*** operating in different cultural contexts.
Knowledge, sensitivity, and awareness do not include this concept.
This is beyond awareness or sensitivity.[11]

~ Marva Benjamin ~

When we address the issue of culture, everyone describes and defines it through their own lens; culture can be described by race, ethnicity, location, life style and many other critical elements. Everyone has a unique "culture" that defines them and their perspectives. Father Michael Oleska, a Russian Orthodox Priest in Alaska, says that "talking about your own culture is one of the most difficult things to do, because your culture is the air you breathe." Mohandas Gandhi stated that "a nation's culture resides

[11] Marva Benjamin. Georgetown Technical Assistance Center for Children with Mental Health.

in the hearts and in the soul of its people." And, Marcus Garvey believes that "a people without the knowledge of their past history, origin and culture is like a tree without roots." All of these are true, making a discussion about culture challenging, vast, and debatable from many perspectives.

The ideas of cultural knowledge, awareness, sensitivity, competency or responsiveness all have some level of sameness, but qualities of difference as well. Within the state of Alaska the notion of being "culturally competent" often becomes a discussion of white vs. Alaska Native populations—but, it is much more than this simple discussion. Alaska has a vast diversity of cultures including 229 federally recognized Alaska Native tribes, Filipinos, Asians, African Americans and many other races and ethnicities. We have a strong military culture; a culture of independence (the Alaska way); urban and rural cultures; youth, adult and senior/Elder cultures; religious cultures, and cultures of different sexual orientation.

Being competent in all cultures that exist in Alaska (or anywhere) is impossible; but being culturally knowledgeable, aware and sensitive should equal a strong sense of cultural responsiveness. Alaska is committed to the goal that everyone working in Alaska on behavioral health projects funded through federal or state dollars is *responsive* to cultural diversity across Alaska.

As a purveyor of both prevention philosophy and funding, Alaska's goal is to guarantee that all community-based programs keep their eyes and minds open to the enormous diversity that exists in their region, their community, and within their identified target population. Coalitions, programs and providers must be aware, knowledgeable, and sensitive to the needs and uniqueness of each culture within their service/target community. And, finally, grantee's needs and opportunities to develop strategies strengthen interventions and approaches that are responsive to the diverse cultural composition of their community.

From the state perspective, there is a commitment to providing cultural awareness training and resource materials as well as technical assistance and support to all grantees.

One critical issue Alaska faces is the concept of "evidence based interventions" and supporting community providers in understanding how to utilize evidence based principles and concepts, without missing the unique needs of Alaska's culture and communities. Local learning and behavior change "is shaped by social context" and knowledge that is "conventionally delivered like pizza (neat boxes with toppings of concepts, theories, best practices, and war stories) is consumed by the brain but not

metabolized into action."[12] Traditional Alaska Native practices and interventions are vastly different, but equally valid, from western practices and interventions, yet documenting "evidence" for these traditional practices is challenging.

In an effort to improve Alaska's ability to be culturally responsive in rural and remote communities and among our Alaska Native and other minority populations, while also honoring the concept of evidenced based interventions, Alaska co-hosted training with Caroline Cruz of Oregon on defining evidence for traditional interventions. In partnership with Alaska's two Tribal SPF projects (Tanana Chiefs Conference and Cook Inlet Tribal Corp.) and the CAPT West Expert Team, Alaska hosted a one and a half day training titled "Many Pathways to Follow: Tribal and Minority Based Practices." The training is based on the experience of Oregon State, in meeting the needs of state legislation requiring a certain percentage of state funded grantees to be evidence based programs. Like Alaska, many of their providers were tribal organizations, using traditional interventions, not western evidence based interventions. This training was a first step in beginning the development of an Alaska-specific guidance document identifying how to best define and "credential" traditional/culture specific programs as meeting the standard of evidence based. It is anticipated, this product will not be realized early in the SPF SIG process, but will develop over time.

Being culturally responsive is a way of life in Alaska; it is more than just an item to be checked off a to-do-list. While it is a challenge to always pay attention and 'see' the diversity within the state and its communities, it is a critical element of making progress to improve the health and wellness of Alaska's citizens, families, communities and the state-as-a-whole; it is critical to be responsive to everyone.

[12] Richard Pascale, Jerry Sternin & Monique Sternin. The Power of Positive Deviance: How Unlikely Innovators Solve the World's Toughest Problems. 2010.

Prevention Sustainability

Lasting change happens when people see for themselves that a different way of life is more fulfilling than their present one. [13]

~ Eknath Easwaran ~

Sustainability is a continuing challenge in the field of social and health services and especially in the work of promotion and prevention. It is especially challenging when there is an infusion of one-time money. No matter how careful the plan and focus on building a sustainable system; most strategies, interventions and actions require resources (usually money) to be successful. With careful and thoughtful decision-making, clear expectations up front, and a plan for incorporating strategies into existing service delivery systems, sustainability can be promoted and planned for over time.

Taking lessons from a $29 million 5-year federal grant Alaska received in 2000, planning for sustainability begins now; not later in the grant cycle. Sustainability must be planned for and promoted at the beginning of any project. Other lessons learned include:

- Employ strategies that are not dependent on infrastructures requiring ongoing resources;
- Identify strategies/interventions that can be built into existing systems/infrastructures;
- The use of environmental strategies (changing practices, policy's and knowledge/behaviors) promote long-term change, without requiring long-term resources and infrastructures;
- When awarding regional/community-based grant funds, request sustainability plans at the beginning and include sustainability updates as part of the regular grantee reporting system; and
- Develop and provide training and technical assistance to grantees on sustainability planning and how to select strategies/interventions that require limited resources beyond the grant period.

[13] Eknath Easwaran. The Compassionate Universe: The Power of the Individual to Heal the Environments. 1993.

As discussed in the Planning section, coalitions receiving SPF SIG funding will be required to utilize at least one environmental strategy as part of their implementation plan. Language in the Request for Proposals will encourage applicants to select strategies, interventions and most importantly, outcomes that will be sustainable beyond the length of the grant award, to utilize environmental strategies as one of their key approaches, and to outline sustainability plans for all successful outcomes accomplished over the funding period.

In terms of sustainability at the state level, the primary goal is to enhance, promote and build the current Alaska prevention infrastructure and capacity. Each state strategy is sustainable beyond the life of the federal SPF SIG project: enhance and improve the current prevention system in Alaska; and utilize actions to increase the prevention capacity and the quality of prevention work in Alaska. If the approach is successful, the identified enhancements will become part of the existing behavioral health prevention system, creating a strong infrastructure, increased community readiness and enhanced community capacity.

Appendices

Potential Alaska Substance Abuse, Dependency, Treatment and Data Sources and Associate Data Indicators

Potential Data Sources

Division of Behavioral Health (internal):

- AK AIMS – client status review (CSR); Alaska Screening Tool; Client Episode Data; DSM IV
- Medicaid Claims data
- Quarterly grantee reports (prevention and treatment)
- Synar tobacco sales enforcement data
- Alcohol Safety Action Program data (DUI/MC assessments and monitoring data)
- Alcohol Drug Information Schools data
- FASD diagnostic data
- FAS Knowledge, Attitudes, Beliefs & Behaviors (KABB) Survey
- MH(BH)SIP data

Division of Behavioral Health (external):

- National Survey on Drug Use and Health (NSDUH)
- Uniformed Reporting System (URS)
- Treatment Episodes Data System (TEDS)
- Fatality Analysis Reporting System (FARS)
- Alcohol and tobacco sales data (revenue)
- Rural Patient Management System (RPMS)—Indian Health Services

Division of Public Health:

- Youth Risk Behavior Survey (YRBS) - Behavioral Risk Factors Survey System (BRFSS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Alaska Birth Defects Registry/Fetal Alcohol Syndrome Surveillance
- Hospital Discharge data—pre-hospitalization/EMS
- Poison Control (inhalants, drugs, alcohol)
- Alaska Trauma Registry (inpatient) (ATR)
- Alaska Violent Death Registry (AK VDRS)
- Maternal Infant Mortality Review (MIMR)
- Child Death/Fatality Review data (CDR/ CFR)
- Vital Statistics (ICD-10 coding, birth certificate information, etc.)

Alaska Court System:

- Two reporting systems—Legacy (rural) and Courtview (urban)
- Number of people charged with alcohol/drug-related crimes
- Charge of conviction
- Therapeutic Court data
- Number prosecuted for substance abuse-related crimes (Prosecutor's office)
- Justice Center (UAA)—ADAM Report; number ordered to alcohol assessment
- Judicial Council

Department of Corrections:

- Number of Title 47 holds (involuntary/protective holds)—can also get this from hospitals and contract community jails. Cannot separate between mental health and substance abuse holds.
- Number of Trust beneficiaries receiving services in DOC
- Women's treatment needs study
- Sex offender data
- Inmate Profile study (2003)
- Three (3) intensive therapeutic services (data rich) in Arizona, Wildwood and Hiland Mountain Correctional Centers
- Jail diversion data

Department of Public Safety:

- APSIN data
- Number of DUI's
- Alcohol/drug-related arrests

Department of Education and Early Development:

- School Report Cards
- Graduation rates
- School/Student Profiles (every other year)
- Suspensions, Expulsions and Truancy related to alcohol, tobacco, drugs and violence (since 1999)

Division of Juvenile Justice:

- Juvenile Offender Management Information System (JOMIS), since 2002
- DSM IV diagnoses
- Number of youth attending substance abuse classes/treatment
- Number of alcohol/drug related offenses (by community, demographics)

Office of Children's Services:

- Online Resources for the Children of Alaska (ORCA)
- Number of CPS cases involving Substance Abuse
- Child Advocacy Center data

Miscellaneous Data Sources:

- Veteran's Administration Information
- Veteran's Centers
- Vocational Rehabilitation – services by diagnosis
- Private treatment provider's – both in Alaska and outside
- National Council on Alcoholism and Drug Dependence (NCADD) -- # of referrals to outside providers
- Alaska Action Research Committee
- State Suicide Prevention Council/Vital Statistics
- National Co-Morbidity Study
- Anchorage Municipality data sets—safe cities; detox; substance abuse arrests, etc.
- GPRA
- Alaska Injury Prevention Center (Suicide Follow-back Study)
- Drunk Driving (Random Survey)
- National Highway Traffic Safety Administration (DUIs, Underage Drinking, etc.)
- Crisis Lines – Careline Crisis Intervention (Fairbanks) and Providence (Anchorage)
- Hospital discharge data – statewide
- Screening, Brief Intervention, Referral and Treatment (SBIRT) – Cook Inlet Tribal Council and Southcentral Foundation
- Agency specific client services and outcome data (Akeela, SEARHC, YKHC, etc.)
- Head Start data
- School Climate & Connectedness Survey (Association of Alaska School Boards)
- Grading Grown-ups (Association of Alaska School Boards)
- Profiles of Student Life -- since 1995 by schools (Association of Alaska School Boards)
- Domestic Violence Program data
- University of Alaska (CHSW, Justice Center, Center for Human Development, Institute for Circumpolar Health, Center for Substance Abuse)

Potential Data Indicators

ALCOHOL CONSUMPTION INDICATORS	
Percent of youth lifetime alcohol use	**YRBS**
Percent reporting 30-Day alcohol use	**YRBS BRFSS NSDUH**
Percent of youth first alcohol before age 13	**YRBS**
Percent of youth alcohol on school property	**YRBS**
Percent of youth age of first use of alcohol	**YRBS**
Percent reporting binge alcohol use	**YRBS BRFSS NSDUH**
Percent of youth alcohol or drug use before last sexual intercourse	**YRBS**
Percent reporting alcohol dependency or abuse	**NSDUH**
Percent reporting need of alcohol treatment during the past year	**NSDUH**
Percent of adults reporting heavy alcohol use	**BRFSS**
Percent of adults reporting "too much to drink" before driving	**BRFSS**
Percent of youth alcohol use during pregnancy	**PRAMS, BVS**
Percent of youth alcohol use before pregnancy	**PRAMS**
Percent of adults reporting daily alcohol use by an adult	**BRFSS**
Number of case sales	**DOR**
Per capita consumption of all beverages	**AEDS**
Per capita consumption of ethanol	**AEDS**
Number of communities with alcohol restrictions	**AEDS**
Number of alcohol distribution centers	**AEDS**
Number of sales of alcohol to minors	**Alcohol Board**
Quantity of alcohol transported to rural Alaska	**DOR**
Seized amounts of alcohol illegally transported/sold (bootlegged)	**DO Public Safety**
ILLICIT DRUG CONSUMPTION INDICATORS	
Percent of youth reporting lifetime cocaine use	**YRBS**
Percent of youth reporting lifetime inhalant use	**YRBS**

Percent reporting 30-day marijuana use	**YRBS NSDUH**
Percent of youth reporting marijuana before age 13	**YRBS**
Percent of youth reporting lifetime heroin use	**YRBS**
Percent of youth reporting lifetime methamphetamine use	**YRBS**
Percent of youth reporting lifetime ecstasy use	**YRBS**
Percent of youth reporting lifetime injecting drugs	**YRBS**
Percent of youth reporting lifetime steroid use	**YRBS**
Percent reporting 30-day any illicit drug use other than marijuana	**NSDUH**
Percent reporting drug dependency or abuse	**NSDUH**
Percent reporting need drug treatment in the past year	**NSDUH**
Percent reporting lifetime injecting drugs for adults	**NSDUH**
Percent of youth reporting lifetime marijuana use	**YRBS**
Percent reporting illicit drug use during pregnancy	**PRAMS**
Daily drug use for Alaska	
Driving under the influence of illicit drugs	
Drug related personnel actions	
Percent reporting 30-Day inhalant use	**NOT in YRBS**

TOBACCO CONSUMPTION INDICATORS	
Percent of youth reporting lifetime cigarette use	**YRBS**
Percent of youth reporting first cigarette before age 13	**YRBS**
Percent of youth reporting 30-Day cigarette use	**YRBS BRFSS NSDUH**
Percent reporting daily cigarette use	**YRBS BRFSS**
Percent of youth reporting 30-Day frequent cigarette use	**YRBS**
Percent of youth reporting cigarette use on school property	**YRBS**
Percent of youth reporting 30-Day cigar use	**YRBS**
Percent of youth reporting 30-Day smokeless tobacco use	**YRBS**
Percent of youth reporting smokeless tobacco use on school property	**YRBS**
Percent of youth reporting smoker who have tried to quit	**YRBS**
Percent of youth reporting 30-Day heavy cigarette use	**YRBS**
Percent of youth reporting prescription use	**YRBS**
Percent reporting lifetime cigarette use	**BRFSS**
Percent reporting 30-Day tobacco use	**NSDUH**

Percent reporting cigarette use during pregnancy	**PRAMS, BVS**
Percent reporting cigarette use before pregnancy	**PRAMS**
Number of cigarette sales per capita	**SETD**
Number of sales of smokeless tobacco	
Number of sales of nicotine replacement products	
Percent reporting greater than 100 cigarettes smoked	**ATS**
Percent reporting age of first use of cigarettes	**ATS**
Percent reporting cigarettes per day smoked	**ATS**
Percent reporting 30-Day smoking frequency assessment	**ATS**
Percent reporting cigarettes per day smoked	**ATS**
Number of clean indoor air acts initiated and passed in Alaska	**Public Health**

Traditional Vs Alternative Schools	
Percentage of Youth Reporting Lifetime Use of Alcohol	**YRBS**
Percentage of Youth Reporting Alcohol Use Before Age 13	**YRBS**
Percent of Youth Reporting Current Alcohol Use	**YRBS**
Percent of Youth Reporting Current Binge Drinking	**YRBS**
Percentage of Students Who Used Chewing Tobacco, snuff, or Dip on One or More of the Past 30 Days	**YRBS**
Percentage of Students Who Smoked a Whole Cigarette for the First Time Before Age 13 Years	**YRBS**
Percentage of Students Who Smoked Cigarettes on 20 or More of the Past 30 Days	**YRBS**
Percent of Youth Reporting Lifetime Marijuana Use	**YRBS**
Percent of Youth Reporting Marijuana Use Before Age 13	**YRBS**
Percent of Youth Reporting Current Marijuana Use	**YRBS**
Percent of Youth Reporting Lifetime Heroin Use	**YRBS**
Percent of Youth Reporting Lifetime Methamphetamine Use	**YRBS**
Percent of Youth Reporting Lifetime Ecstasy Use	**YRBS**
Percent of Youth Reporting Lifetime Cocaine Use	**YRBS**
Percent of Youth Reporting Current Cocaine Use	**YRBS**
Percentage of students who were offered, sold, or given an illegal drug by someone on school property during the past 12 months	**YRBS**
Percentage of students who used marijuana on school property one or more times during the past 30 days	**YRBS**

CONSEQUENCE INDICATORS	
Number/rate per 100,000 of alcohol induced deaths	**BVS**
Number/rate per 100,000 of chronic liver disease / cirrhosis deaths	**BVS**
Number/rate per 100,000 of vehicle and traffic deaths	**BVS**
Number/rate per 100,000 of deaths due to motor vehicle crashes among children aged 14 and younger	**BVS**
Number/rate per 100,000 of injuries due to motor vehicle crashes among children aged 14 and younger	**ATR**
Number/rate per 100,000 of unintentional injury death	**BVS**
Number/rate per 100,000 of intentional injury death (homicide, suicide)	**BVS**
Number/rate of infant death (under 1 year of age) per 1,000 live births	**BVS**
Number/rate per 100,000 of homicide deaths	**BVS**
Number/rate per 100,000 of suicide deaths	**BVS**
Number/rate per 100,000 of undetermined deaths	**BVS**
Number/rate per 100,000 of smoking attributable death	**BVS**
Number/rate per 100,000 of lung cancer deaths	**BVS**
Number/rate per 100,000 of chronic lower respiratory diseases	**BVS**
Number/rate per 100,000 of cardiovascular deaths	**BVS**
Number/rate per 100,000 of drugs Induced death	**BVS**
Number/rate per 100,000 of viral hepatitis death	**BVS**
Number/rate per 100,000 of HIV deaths	**BVS**
Number/rate per 100,000 of malnutrition deaths	**BVS**
Number/rate per 100,000 of accidental firearm deaths	**BVS**
Rate of unintentional injuries	**ATR**
Number of hospitalized injuries associated with alcohol	**ATR**
Number of hospitalized injuries associated with drug use	**ATR**
Number/rate of alcohol related school suspensions	**ADEED**
Number/rate of alcohol related school expulsions	**ADEED**
Percent reporting driving under the influence of alcohol	**YRBS BRFSS**
Percent of youth reporting as passenger with a driver under the influence of alcohol	**YRBS**
Number/rate of deaths due to alcohol-related motor vehicle crashes	**FARS**
Number of deaths due motor vehicle crashes	**FARS**
Number of fatal motor vehicle crashes	**FARS**

Number/rate per 100,000 of alcohol related fatal motor vehicle crashes	**FARS**
Number/rate per 100,000 of alcohol related vehicle deaths	**FARS**
Number/rate per 100,000 of deaths caused by motor vehicle accidents (inc. pedestrians)	**FARS**
Percent of alcohol involved drivers in fatal crashes	**FARS**
Number/percentage of injury crashes that are alcohol-related	**DOT**
Number/percentage of non-fatal injuries that are alcohol-related	**DOT**
Percentage of property damage that is alcohol-related	**DOT**
Number of non-fatal injuries caused by motor vehicle crashes	**DOT**
Number of DUI arrests	**UCR**
Number of state/municipal/community liquor laws	**UCR**
Number of arrests for drunkenness	**UCR**
Percent of persons aged 12 and older meeting DSM_IV criteria for alcohol abuse or dependence	**TEDS**
Number of persons receiving treatment for alcohol dependency or alcohol-related & drug dependence disorders from state funded treatment facilities	**TEDS**
Percent of live births weighing less than 2,500 g.	**BVS**
Percent of singleton births weighing less than 2,500 g.	**BVS**
Percent of births weighing less than 1,500 g.	**BVS**
Percent of singleton births weighting less than 1,500 g.	**BVS**
Percent of adults reporting that they have been told they currently have asthma	**BRFSS**
Percent of adults reporting that ever been told they have asthma	**BRFSS**
Number of federal drug seizures - marijuana	**DEA**
Number of federal drug seizures - cocaine	**DEA**
Number of federal drug seizures - methamphetamine	**DEA**
DEA drug violation arrests	**DEA**
Number of EMS medical response - drug overdose	**EMS**
Number of EMS medical response - alcohol	**EMS**
Number of reported AIDs cases 13 years of age and older and annual rates per 100,000	**HIV**
Number of reported AIDs cases and annual rates per 100,001	**HIV**
Number of alcoholic psychoses diagnoses	**HDD**
Number of alcoholic dependence diagnoses	**HDD**

Number of alcohol related injuries	**HDD,ED**
Number of illicit drug related psychosis diagnoses	**HDD,ED**
Number of illicit drug related dependence diagnoses	**HDD,ED**
Number of illicit drug related injuries in ER populations	**ED**
Number of FASD - Alaska Birth Defects Registry	**ABDR**
Number of alcohol related arrests and seizures	**ABADE**
Number of controlled substance arrests/charges - cocaine	**ABADE**
Number of controlled substance seizures/purchases - cocaine	**ABADE**
Number of controlled substance arrests/charges - marijuana	**ABADE**
Number of controlled substance seizures/purchases - marijuana	**ABADE**
Number of controlled substance arrests/charges - methamphetamine	**ABADE**
Number of controlled substance seizures/purchases - methamphetamine	**ABADE**
Number of controlled substance seizures/purchases - clandestine labs	**ABADE**
Number/rate per 100,000 of drug related vehicle deaths	**FARS**
Number of recreational boating accidents per year	**USCG**
Number of recreational boating injuries per year	**USCG**
Number of recreational boating injuries with alcohol involvement	**USCG**
Number of recreational boating accidents with alcohol involvement	**USCG**
Number of recreational boating accidents with drug involvement	**USCG**
Number of fatal recreational boating accidents per year	**USCG**
Number of fatal recreational boating accidents with alcohol involvement	**USCG**
Number of fatal recreational boating accidents with drug involvement	**USCG**
Number of murder, manslaughter reported	**UCR**
Number of domestic violence incidents reported	**UCR**
Number of domestic violence arrests	**UCR**
Number of drug violations arrests	**UCR**
Number of controlled substance seizures/purchase - crack cocaine	**UCR**
Number of AST cocaine seizures	**UCR**
Number of AST cocaine cases	**UCR**
Number of controlled substance seizures/purchase - hashish	**UCR**

Number of controlled substance seizures/purchase - sinsemilla plants	**UCR**
Number of controlled substance seizures/purchase - marijuana plants	**UCR**
Number of controlled substance seizures/purchase - ditchweed/wild plants	**UCR**
Number of AST marijuana seizure	**UCR**
Number of AST marijuana cases	**UCR**
Number of AST hashish seizure	**UCR**
Number of AST hashish cases	**UCR**
Number of AST methamphetamine seizure	**UCR**
Number of AST methamphetamine cases	**UCR**
Number of AST clandestine labs seizures	**ASB**
Number of Alaska K12 alcohol related expulsions	**ASB**
Number of Alaska K12 alcohol related suspensions	**ASB**
Number of Alaska K12 drug related expulsions	**ASB**
Number of Alaska K12 drug related suspensions	**DPS**
Number of meth clandestine labs seizures	**DPS**
Number of federal drug seizures - labs – DEA, State, local	**ABADE**
Number of treatment facilities in Alaska	**AKAIMS**
Number of treatment beds funded by Alaska	**AKAIMS**
Number of referral of treatment for illicit drugs	**AKAIMS**
Number of referral of treatment for alcohol	**AKAIMS**
Number of referred treatment completion for illicit drugs	**AKAIMS**
Number of referred treatment completion for alcohol	**AKAIMS**
Number of court ordered compliance with treatment for alcohol	**ASAP**
Number of court ordered compliance with treatment for illicit drugs	**ASAP**
Number of alcoholic psychoses diagnoses - Tribal	**RPMS**
Number of alcoholic dependence diagnoses - Tribal	**RPMS**
Number of alcohol related injuries in ER populations - Tribal	**RPMS**
Number of illicit drug related psychosis diagnoses - Tribal	**RPMS**
Number of illicit drug related dependence diagnoses - Tribal	**RPMS**
Number of illicit drug related injuries in ER populations - Tribal	**RPMS**
Number of Medicaid paid treatment for alcohol	**Medicaid**
Number of Medicaid paid treatment for drug use	**Medicaid**
Occupational fatalities associated with alcohol use	**AKFACE**
Occupational Fatalities Associated with Drug Use	**AKFACE**
Violent Death Associated with Substance Abuse	**VDRS**

OTHER CONSUMPTION OR CONSEQUENCE ASSOCIATED INDICATORS	
Number/rate per 100,000 of ten leading causes of mortality in AK	**BVS**
Number/rate per 100,000 of all death in Alaska	**BVS**
Number/rate per 100,000 of child deaths (under 18 years of age)	**BVS**
Number of adoptions of children with public child welfare agency involvement	**BVS**
Number/rate of teen births 18-19:	**BVS**
Number/rate of teen births 15-19:	**BVS**
Number/rate of teen births 15-17:	**KC, BVS**
Neonatal mortality rate per 1,000 live births	**BVS, WCFH**
Post-neonatal mortality rate per 1,000 live births	**BVS, WCFH**
Perinatal mortality rate per 1,000 live births plus fetal deaths	**BVS, WCFH**
Number of violent crimes reported	**DCI, UCR**
Number of property crimes reported	**DCI, UCR**
Number of larcenies reported	**DCI, UCR**
Number of rapes reported	**DCI, UCR**
Number of burglaries reported	**DCI, UCR**
Number of motor vehicle thefts reported	**DCI, UCR**
Number of murder, manslaughter reported	**DCI, UCR**
Number of robberies reported	**DCI, UCR**
Number of aggravated assaults reported	**DCI, UCR**
Number of rapes arrests	**DCI, UCR**
Number of robberies arrests	**DCI, UCR**
Number of aggravated assaults arrests	**DCI, UCR**

Number of drug manufacture violations	**DCI, UCR**
Number of drug possession violations	**DCI, UCR**
Number of alcohol charges for juvenile offenders	**DJJ**
Number of drug charges for juvenile offenders	**DJJ**
Number of alcohol referrals for juvenile offenders	**DJJ**
Number of drug referrals for juvenile offenders	**DJJ**
Persons incarcerated in juvenile detention facilities: rate per 100,000	**DJJ**
Number of substantiated allegations of abuse	**DJJ, DOL**
Percentage of students who had sexual intercourse	**YRBS**
Percentage of students who had sexual intercourse before age 13	**YRBS**
Percentage of students who had sexual intercourse with four or more people during their life	**YRBS**
Percentage of students who had sexual intercourse with one or more people during the last three months	**YRBS**
Of students who had sexual intercourse, the percentage who used a condom pills during last sexual intercourse	**YRBS**
Of students who had sexual intercourse, the percentage who used birth control pills during last sexual intercourse	**YRBS**
Percentage of students who received grades mostly of D's and F's during the past 12 months	**YRBS**
Percentage of children in foster care maltreated by foster care provider	**OCS**
Number of children with substantiated allegations of abuse	**OCS**
Number of children reported as abused and neglected and referred for investigation per 251) 100,000 children in population,	**OCS**
Number of child abuse and neglect facilities	**OCS**
Number of children that witness DV	**OCS**
Number of children that are maltreated	**OCS, DSDS**
Rate of children per 100,000 population who received preventive services	**DHSS**
Number of offenses against family and children	**APSIN**
Percentage of high school dropouts	**ASB**

Missing Data:

Daily drug use for Alaska
Lifetime injecting drugs for adults
Percent of persons aged 16+ reporting driving after having smoked marijuana or using other illicit drugs in the past month
Percent of women reporting the use of illicit drugs during pregnancy
Number of single nighttime crashes per 100,000 population aged 16 and older
Number persons discharged from hospital ER for alcohol related injuries (as per ICD-10 codes) per 100,000 population
Alcohol related personnel actions per 100,000 employees
Drug-related personnel actions per 100,000 employees
Number of persons discharged from hospitals for conditions related to tobacco use (as per ICD-10 codes) per 100,000 population
Number of deaths from each specific cause that is at least fractionally attributable to tobacco, per 100,000 population aged 15+

Hierarchy of National and State-based Surveillance Data Pertaining to Alcohol, Illicit Drug, and Tobacco Use and Associate Substance Use Factors

National	Program Level	Data Description	Availability	Hierarchy
Alcohol Epidemiologic Data System, National Institute on Alcohol Abuse and Alcoholism, Division of Epidemiology and Prevention Research, National Institutes of Health.	National	Consumption data for alcohol	1999-2007 (annual)	Not applicable
Behavioral Risk Factor Surveillance System (BRFSS), CDC; National Survey on Drug use and Health (NSDUH), Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Alaska Behavioral Risk Factor Surveillance System (AKBRFSS), Division of Public Health, Alaska Department of Health and Social Services.	National National State-based	Consumption, consequence, and influences data for alcohol, illicit drug, tobacco	1999-2008 (annual)	AKBRFSS/BRFSS /NSDUH

National Center for Health Statistics (NCHS). Alaska Bureau of Vital Statistics (AKBVS), Division of Public Health, Alaska Department of Health and Social Services.	National State-based	Morbidity and mortality data	1999-2008 (annual)	AKBVS/NCHS
Fatality Analysis Reporting System, National Highway Traffic Safety Administration (NHTSA). Fatal Analysis Reporting System, Alaska Highway Safety Office (AHSO).	National State-based	Consequence data for motor vehicle accidents	1999-2008 (annual)	AHSO/NHTSA
Tobacco Tax Program, Tax Division Programs, Alaska Department of Revenue. Alaska Tobacco Facts, Section of Chronic Disease Prevention and Health Promotion, Division of Public Health, Alaska Department of Health and Social Services.	State-based State-based	Consumption and consequence data for tobacco use		

Youth Risk Behavior Survey (YRBS). National Survey on Drug use and Health (NSDUH), Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Alaska Youth Risk Behavior Survey (AKYRBS), Section of Chronic Disease Prevention and Health Promotion, Division of Public Health, Alaska Department of Health and Social Services.	National National State-based	Consumption, consequence, and influences data for alcohol, illicit drug, tobacco	1999-2009 (bi-annual)	AKYRBS/YRBS /NSDUH
Uniform Crime Reporting (UCR) Program, Criminal Records and Identification Bureau, Division of Statewide Services, Alaska Department of Public Safety.	National & State-based	Consequence data for alcohol and illicit drug	1999-2008 (annual)	Not applicable

Epidemiology Influences

Over the last several months the Epidemiology Influences Subgroup has been working diligently to revise and update the 2007 document Influences on Substance Use in Alaska. This document focuses on risk and protective factors influencing substance youth among adolescents under age 18.

The process the Influences Subgroup went through included the following: 1) Deciding to update the Influences on Substance Use in Alaska, 2) Refining the Cultural Identity risk and protective factor, 3) Utilizing "content experts" within and outside of the Influences Subgroup to determine which of the existing indicators the document would support, and 4) Updating the document Influences on Substance Use in Alaska document.

Listed below are the updated protective/risk factors and indicators we are using for each factor:

Protective Factors	Indicators
Family Support and Connection	• Percentage of parents who are connected and involved in their children's lives (by, sharing ideas or talking with them about things that matter; usually or always attend their events or activities; have met all or most of their friends; regularly eat meals with all family members.) NSCH AK 2007-2008 • Percentage of students talk with their parents, at least weekly about school YRBS 2009
Connection to School	• Percentage of students who attend a school they feel is respectful and fair. SCCS 2009 • Percentage of students who believe their teachers really care about them and give them a lot of encouragement. YRBS 2009
Positive Connection to *Other* Adults	• Percentage of youth who have a positive connection with two or more adults outside of their home. YRBS 2009
Engagement in Meaningful Activities	• Percentage of students that participate in one or more organized activities outside of school. Includes: clubs, lessons, volunteering, or helping activities one or more times per week. YRBS 2009 • Percentage of students who play on one or more sports teams in the past year. YRBS 2009
Social, Emotional & Employability Skills	• Percentage of students who feel they have "social, emotional & employability skills" SCCS 2009
Cultural Identity	Developmental Stage I* *Comment: This indicator continues to be in the developmental stages as the factor is more fully defined. The indicator may be more relevant at the local level vs. state level.*

Experienced Family Violence or Child Abuse (neglect, physical, sexual abuse)	• Percentage of mothers who report their child has (ever experienced), seen violence or physical abuse, in person. CUBS 2008 • Substantiated rate of Alaska children (ages 0-17) abused or neglected per 1,000 children OCS
Death by Suicide of a Family Member	Developmental Stage I* Comment: *This risk factor for adolescent substance use is being re-examined, the indicator will be selected based on this examination.*
Availability of Alcohol and Other Drugs	• Percentage of youth who got their alcohol from social sources (gave someone money to buy it or someone gave it to them).YRBS 2009 • Percentage of youth reporting it is easy (very or fairly) to get marijuana. NSDUH
Community Norms & Laws Related to Alcohol & Drug Use	Developmental Stage II* *Comment: This indicator continues to be in the developmental stages as the factor is more fully defined. The indicator may be more relevant at the local level vs. state level.*
Early Initiation of Substances	• Percentage of students that have used either tobacco, alcohol or marijuana beforethe age of 13. YRBS 2009
Loss of Cultural Identity	Developmental Stage I* *Comment: This indicator continues to be in the developmental stages as the factor is more fully defined. The indicator may be more relevant at the local level vs. state level.*

To ensure that we viewed these risk and protective factors holistically, the Influences Subgroup worked with a comprehensive list of data collection systems. Out of the nine data sets the workgroup used the following:

- **Alaska Childhood Understanding Behaviors Survey (CUBS): http://www.epi.alaska.gov/mchepi/cubs/default.stm**
- **National Survey of Children's Health (NSCH): http://www.nschdata.org/content/LearnAboutTheSurvey.aspx**
- **National Survey of Drug Use and Health (NSDUH): http://www.oas.samhsa.gov/nsduh.htm**
- **School Climate and Connectedness Survey (SCCS): http://www.alaskaice.org/material.php?matID=529**
    - **Youth Risk Behavior Survey (YRBS): http://www.hss.state.ak.us/dph/chronic/school/YRBS.htm**

Alaska Strategic Prevention Framework State Incentive Grant

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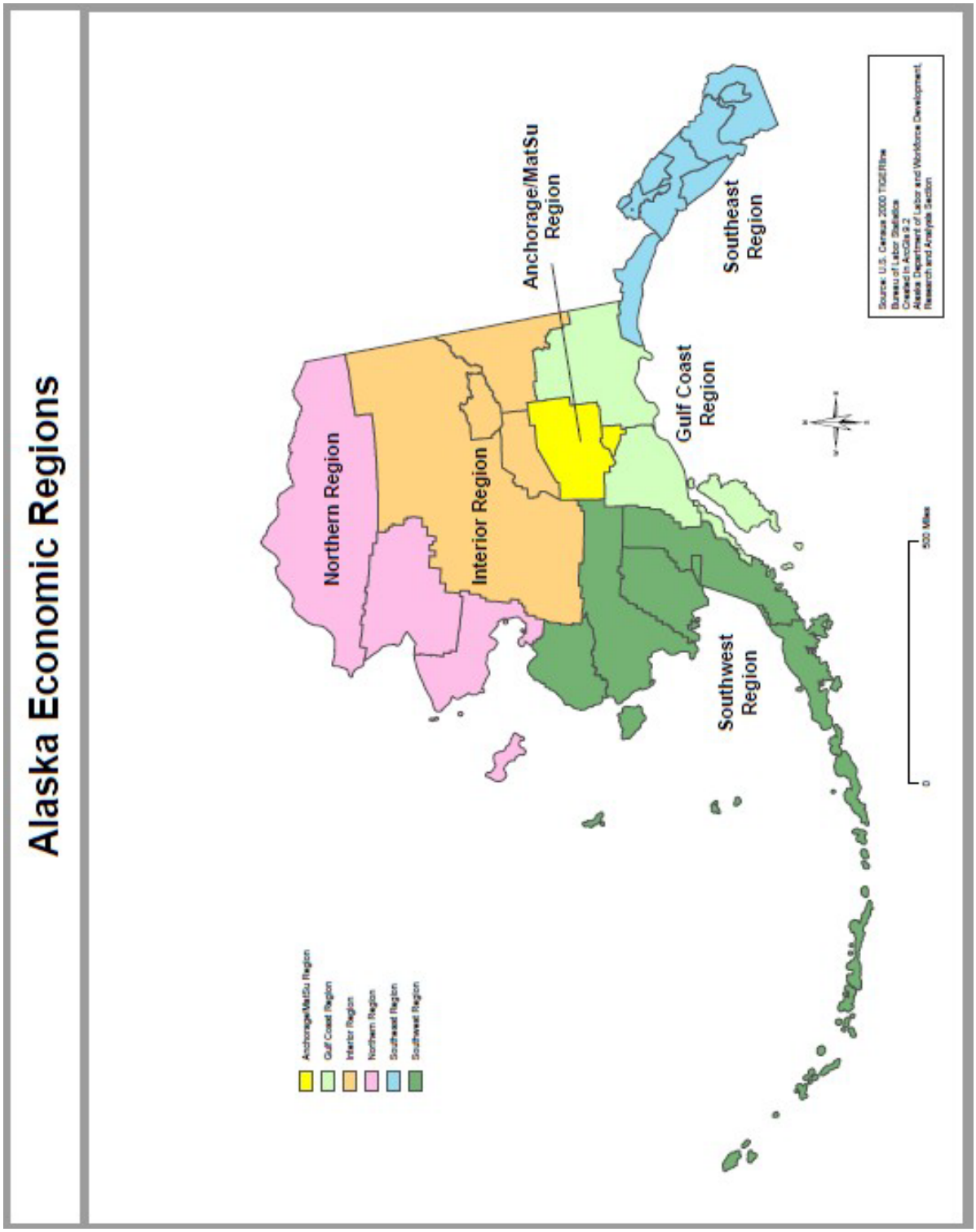
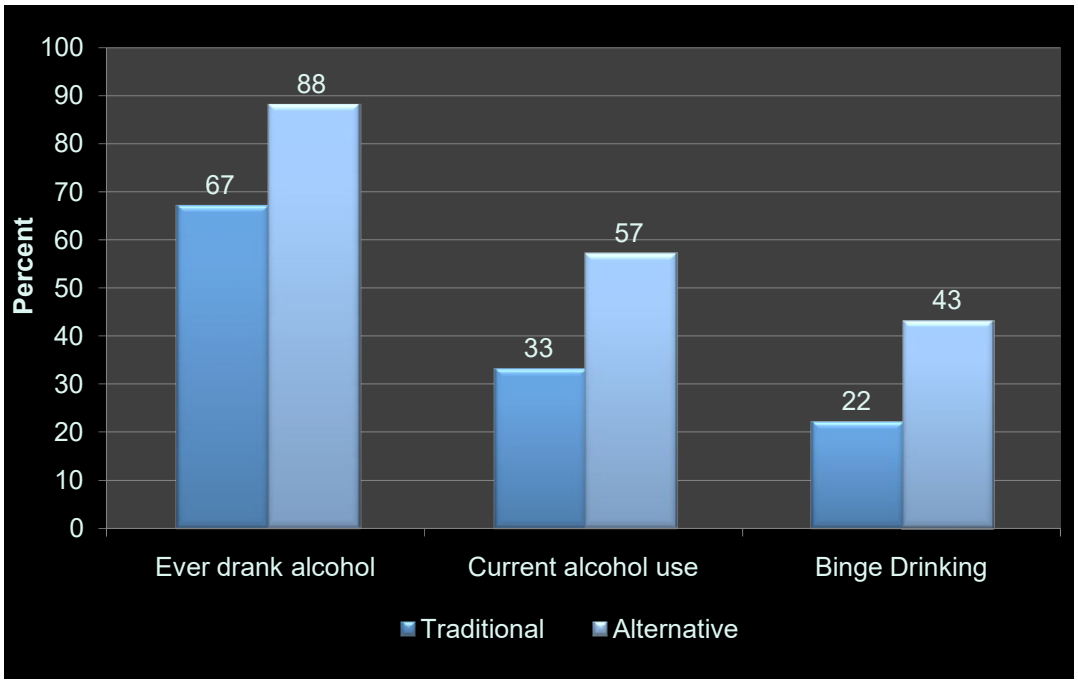

Alaska Economic Regions
Anchorage/MatSu Region
Southeast Region
Gulf Coast Region
Northern Region
Interior Region
Southwest Region
Source: U.S. Census 2000 TIGERline
Bureau of Labor Statistics
Created in ArcGIS 9.2
Alaska Department of Labor and Workforce Development,
Research and Analysis Section
Anchorage/MatSu Region
Gulf Coast Region
Interior Region
Northern Region
Southeast Region
Southwest Region

Traditional Vs. Alternative High School Data

Appendix E

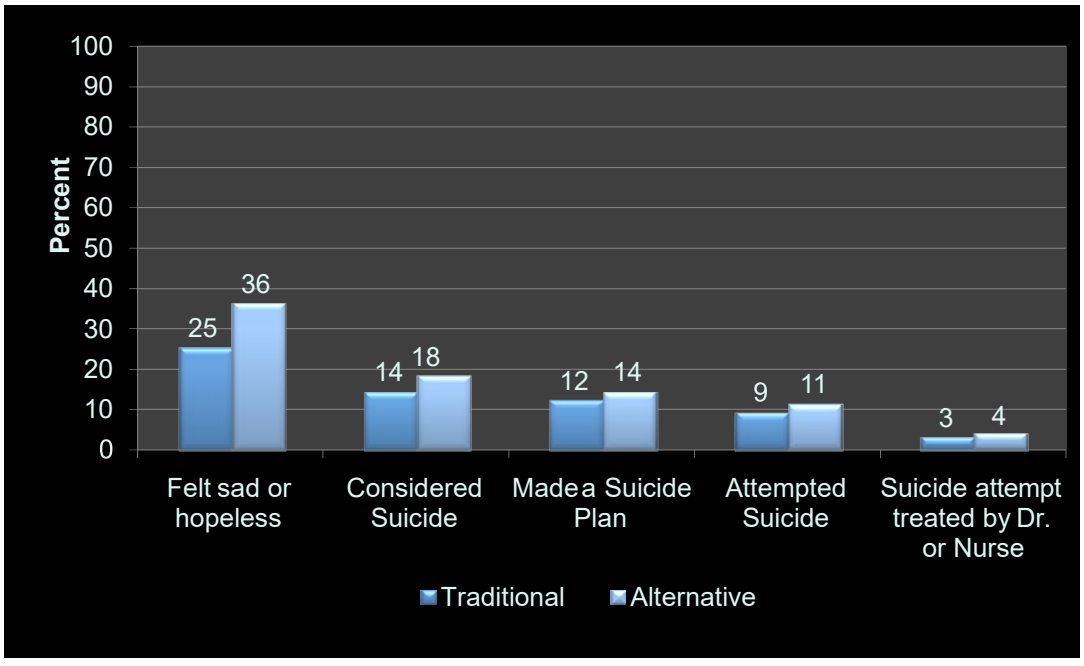
Alcohol Use

2009 Alaska Youth Risk Behavior Survey



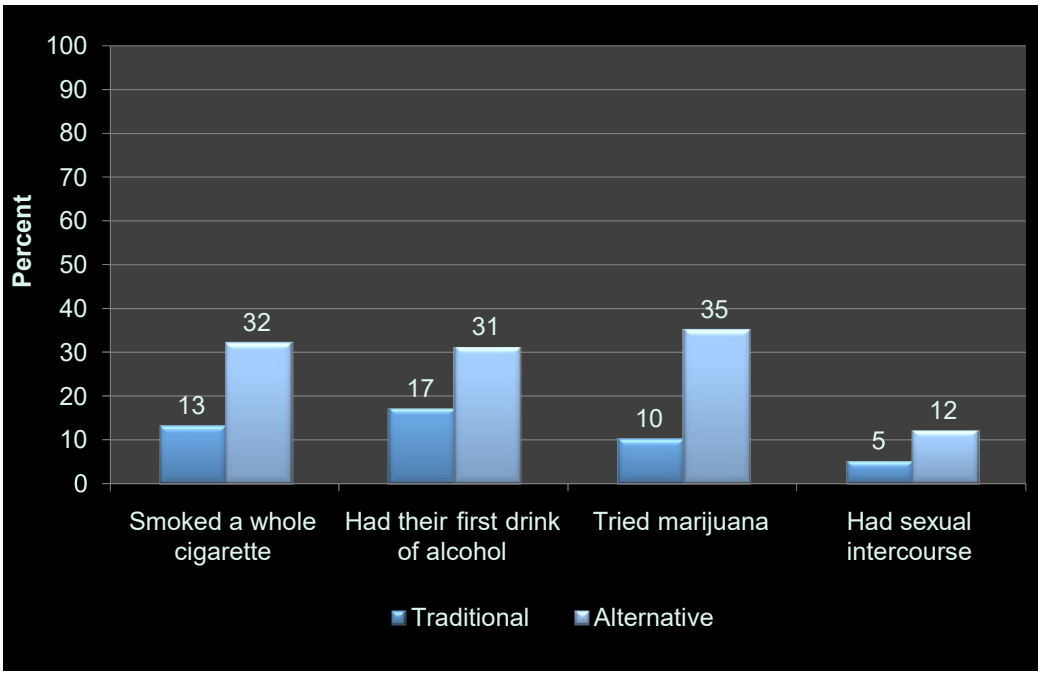
Suicide

2009 Alaska Youth Risk Behavior Survey



Before Age 13

2009 Alaska Youth Risk Behavior Survey



Alcohol Use by Students	Traditional High School	Alternative High School
Ever drank alcohol	67%	88%
Drank alcohol in the past month	33%	57%
Engaged in binge drinking during the past month	22%	43%

Before Age 13		
Had their first drink of alcohol	17%	31%

Consequences	Traditional High School	Alternative High School
Hit, slapped, or physically hurt by their boyfriend or girlfriend, during the past year	13%	21%
Forced to have sexual intercourse	10%	20%
Felt sad or hopeless	25%	36%
Seriously considered suicide	14%	18%
Attempted suicide during the past year	9%	11%

For additional information about the Alaska Youth Risk Behavior Survey Results, please visit:
www.hss.state.ak.us/dph/chronic/school/YRBSresults.htm

Alaska SPF SIG Timeline and Milestones

May 6-July 2, 2010: Epidemiology Workgroup met weekly to review Alaska's Substance Use Epidemiology Profile; updated data as needed, analyzed data, reviewed data availability and reliability, ranked and prioritized data.

July 6-16, 2010: Epidemiologist developed a report of the findings from the Workgroup, including data analysis; discussion of prioritizing methodology; identified challenges and issues to be considered in final decision-making process; and recommendations for selection of consumption/consequence priorities. Report submitted to Project Director for review.

July 23, 2010: Data review/analysis/recommendations report, from SEW sent to the Advisory Council and Evidence Based Workgroup for review prior to selection meeting August 2-3.

August 2-3, 2010: Face-to-Face meeting of the Advisory Council, Epidemiology Workgroup and the Evidence Based Workgroup to select priority substance use issues for Alaska's SPR SIG process.

August 4-September 15, 2010: Project staff and Advisory Council met, continued review of data and finalized Alaska's Planning and Allocation of Funds approach.

October-November, 2010: Project Staff drafted Alaska's Strategic Plan, with input from the SEW, EBI Workgroup, and the Project Evaluation Team.

November, 2010: Alaska's Strategic Plan distributed to Advisory Council, SEW, EBI Workgroup, Evaluation Team, and Prevention Staff for review, edit and approval prior to submitting final Plan to CSAP.

November, 2010: Federal Project Officer reviewed and submitted input on *Draft* Strategic Plan.

December, 2010: Project staff revised, edited and incorporated input from Federal Project Officer, Advisory Committee members and EBI and EPI Workgroup members.

January 11, 2011: *Moving Prevention Upstream: A Plan to Implement a Comprehensive Approach to Substance Abuse Prevention in Alaska,* Alaska's SPF SIG Strategic Plan submitted to CSAP Project Officer for final review and approval.

January, 2011: Once Strategic Plan submitted for final review/approval, Project staff to develop a draft Request for Proposal, using the framework of the draft plan.

January, 2011: Evidence Based Interventions Workgroup will complete first draft of Alaska's EBI Guidance Document for SPF SIG Grantees.

January, 2011: Development of Training and Technical Assistance Contract, solicit for interested contractors and award contract. Begin development of initial 3-day training for all SPF SIG grantees.

February, 2011: Upon receiving CSAP approval of the Alaska's Strategic Plan, the competitive Request for Proposals will be finalized and posted on the State's Public Notice website (http://notes4.state.ak.us/pn). Solicitation of community proposals will begin.

March 1, 2011: Funding to selected SPF SIG grantees begins.

March, 2011: Evidence Based Interventions Workgroup will complete final version of Alaska's EBI Guidance Document for SPF SIG Grantees. Work with contractor to develop training for grantees in using the document and selecting EB strategies.

March 29-31: Face-to-Face meeting/training for SPF SIG community grantees.

April-June, 2011: Project Staff and Training/TA Contractor(s) will develop and provide ongoing assistance to community grantees.

July 1, 2011: Year 2 of SPF SIG community grants begins.