OKLAHOMA STRATEGIC PLAN

for the Prevention of Mental, Emotional, and Behavioral Disorders

OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Foreword

In July 2009, the *Oklahoma Department of Mental Health and Substance Abuse Services* (ODMHSAS) was awarded a Strategic Prevention Framework State Incentive Grant (SPF SIG) by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). One of the central requirements of the SPF SIG is to develop a state substance abuse prevention plan using the Strategic Prevention Framework (SPF) model.

While the *Oklahoma Strategic Plan for the Prevention of Mental, Emotional, and Behavioral Disorders* will act as the state's roadmap for its SPF SIG initiatives, it is intended for a larger purpose, encompassing Oklahoma's vision for building a strong prevention infrastructure for a broad array of related mental, emotional, and behavioral disorders. The *Plan* reflects statewide input from community representatives and experts in substance abuse and related fields who participated in the planning process. The *Plan* provides clear direction and common ground for future endeavors addressing the prevention of substance abuse, the prevention of mental illness, and mental health promotion.

The commitment and cooperation of those involved in the planning process for the *Oklahoma Strategic Plan* is unprecedented. It speaks to the gravity of mental, emotional, and behavioral disorder issues in our communities. Oklahoma's *Strategic Plan* provides the opportunity to initiate collective action among diverse groups and restore and strengthen our youth, families, and communities.

Terri White

Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services

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I. Background

STATE INFRASTRUCTURE COOPERATIVE AGREEMENT (SICA)

A state substance abuse prevention plan was developed in 2005 as a result of Oklahoma's previous infrastructure cooperative agreement with SAMHSA/CSAP known as the State Incentive Cooperative Agreement, or SICA. Several significant improvements in the state's prevention service delivery system were made as a result of this past assessment and planning effort, including the adoption of a SPF-based community workplan utilized by providers, development of the Oklahoma Prevention Needs Assessment survey, and a commitment to fund evidence-based prevention practices.

Like SICA, the SPF SIG is an infrastructure cooperative agreement aimed at changing the way that prevention is implemented in Oklahoma. SAMHSA conceived the SPF as a process through which all state prevention resources may be aligned and performance of the substance abuse prevention portion of the SAPT Block Grant organized and managed. Oklahoma will use its SPF SIG funding to develop an infrastructure that supports bringing together multiple funding streams from multiple sources with the common goal of creating and sustaining a community- and evidence-based approach to substance abuse and mental illness prevention and mental health promotion.

MISSION

The mission of this *Strategic Plan* is to implement and sustain comprehensive, statewide prevention efforts that are evidence-based and accountable to the state's citizens, encourage the collaboration of multiple agencies and organizations, and enhance the capacity of communities to provide an effective and comprehensive system of prevention services reflective of community needs and resources.

VISION

The *Strategic Plan* provides a vision of a future for Oklahoma in which every citizen is provided the opportunity to achieve a state of health and well-being free from the scourge of mental, emotional, and behavioral disorders.

GOALS

1. Prevent the onset and prevent/reduce the problems associated with the use of alcohol, tobacco, and other drugs across the lifespan as identified and measured using epidemiological data.

2. Prevent the onset and prevent/reduce the problems associated with mental and emotional disorders as identified and measured using epidemiological data.

3. Use the SPF process to create prevention-capable communities where individuals, families, schools, workplaces, communities, and the state have the capacity and infrastructure to prevent substance abuse and mental illness.

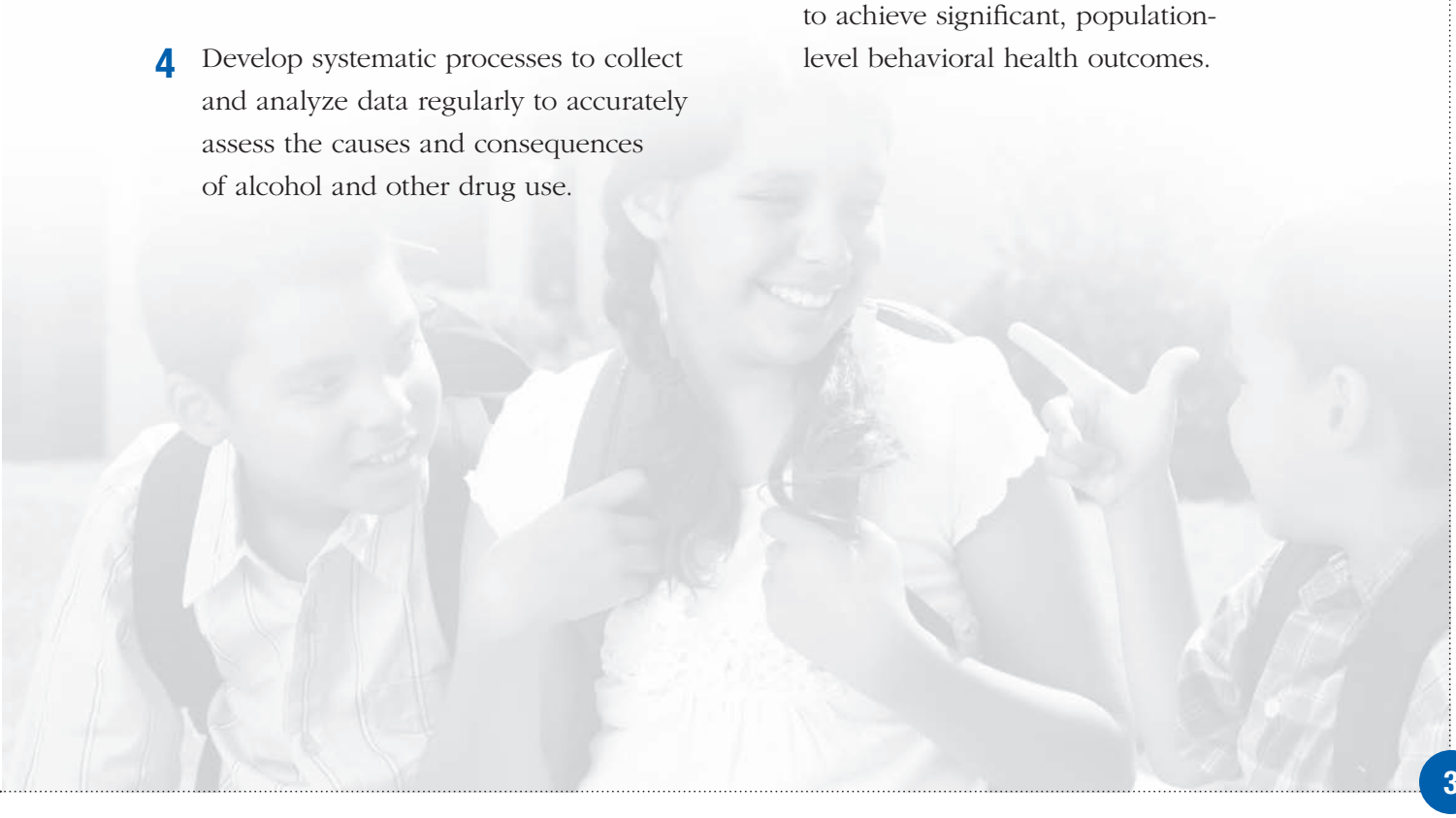
4. Develop systematic processes to collect and analyze data regularly to accurately assess the causes and consequences of alcohol and other drug use.

5. Develop data-driven decision methods to use prevention resources effectively.

6. Increase the use of prevention services that are evidence-based, implemented with fidelity, and evaluated for effectiveness.

7. Increase the capacity of prevention providers to meet the behavioral health prevention needs of diverse individuals and communities in a timely, culturally competent manner.

8. Actively seek opportunities to collaborate and coordinate prevention efforts and resources across sectors to achieve significant, population-level behavioral health outcomes.



PREVENTION PRIORITIES

SPF SIG PRIORITIES

CONSTRUCT	INDICATOR/MEASURE
Underage Drinking	• Percent of students in grades 9-12 who reported driving when they had been drinking • Percent of students in grades 9-12 who reported riding in a car driven by someone who had been drinking • Percent of students in grades 9-12 reporting having five or more drinks on at least one occasion in the past 30 days • Percent of students in grades 9-12 reporting any use of alcohol in the past 30 days • Percentage of fatal crashes with an alcohol-impaired driver
Nonmedical Use of Prescription Drugs	• Non-medical use of prescription pain relievers in the past month among persons aged 12 and older • Opioid Overdose Deaths per 100,000 population

REGIONAL BLOCK GRANT/STATE FUNDED PRIORITIES

CONSTRUCT	INDICATOR/MEASURE
Underage Drinking	• Current, 30-day alcohol use among youth under age 21 • Current, 30-day binge drinking among youth under age 21 • Current, 30-day drinking and driving among youth under age 21
Binge Drinking	• Current, 30-day binge drinking among adults age 18 and older
Inhalant Use	• Current, 30-day inhalant use among 6, 8, 10, and 12 graders • Lifetime, any inhalant use among 6, 8, 10, and 12 graders
Nonmedical Use of Prescription Drugs	• Past year use of pain relievers among adults age 18-25 • Past year use of prescription drugs among 6, 8, 10, and 12 graders

REGIONAL BLOCK GRANT/STATE FUNDED PRIORITIES *(continued)*

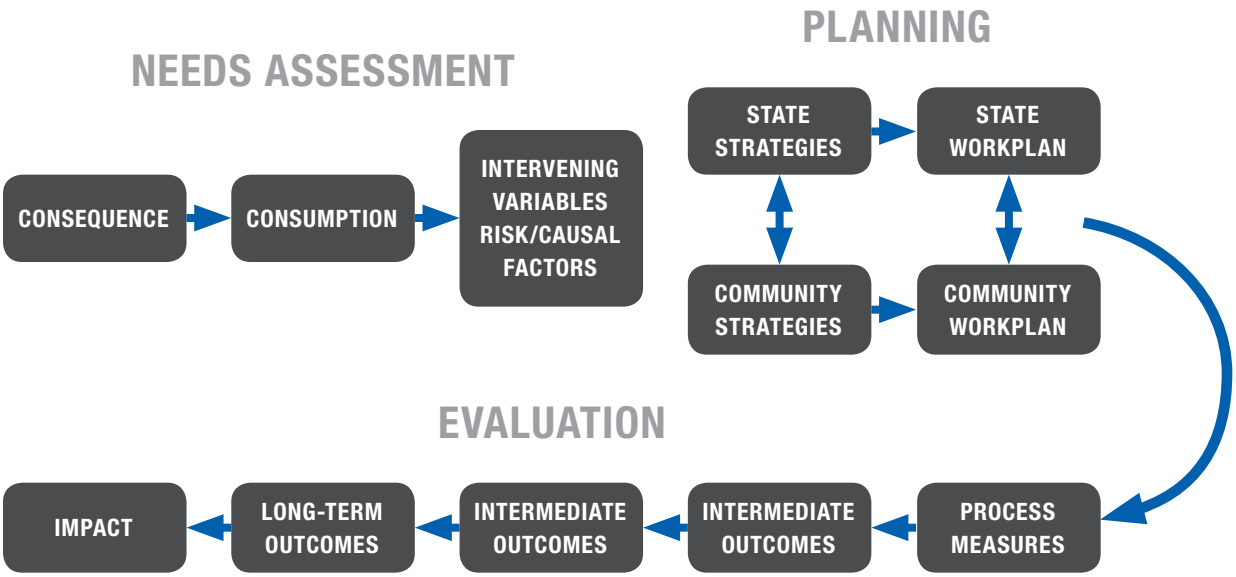
CONSTRUCT	INDICATOR/MEASURE
Methamphetamine Use	• Past year methamphetamine use among adults age 18-25 • Current, 30-day methamphetamine use among 6, 8, 10 and 12 graders
Alcohol Use During Pregnancy	• Any alcohol use in last 3 months of pregnancy • Any alcohol use during pregnancy
Marijuana Use	• Current 30-day marijuana use among 6, 8, 10 and 12 graders • Lifetime, any marijuana use among 6, 8, 10 and 12 graders

Suicide Prevention

1. Promote awareness that suicide is a public health problem that is preventable.
2. Develop broad-based support for suicide prevention.
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
4. Develop and implement community-based suicide prevention programs.
5. Promote efforts to reduce access to lethal means and methods of self-harm.
6. Develop and promote effective clinical and professional practices.
7. Increase access to and community linkages with mental health and substance abuse services.
8. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
9. Promote and support research on suicide and suicide prevention.
10. Improve and expand suicide surveillance systems.
11. Provide support for survivors of suicide.

OKLAHOMA LOGIC MODEL

To prevent the onset and prevent/reduce the problems associated with the use of alcohol, tobacco, and other drugs across the lifespan, Oklahoma will work from a theory of change that is supported through research. Research has shown changing population behavior requires targeting resources to issues influencing that behavior (intervening variables, or risk or causal factors). Once these issues have been identified, a comprehensive set of state and community evidence-based strategies can be selected and employed. It also is important to evaluate the effectiveness of the state and community efforts at each phase through process, immediate, intermediate, and long-term outcome data collection.



THEORETICAL MODEL

Conceptual and theoretical approaches to prevention rest on a number of assumptions. First, prevention is viewed as a proactive process by which conditions that promote well-being are created. Prevention activities empower individuals and communities to meet the challenges of life events and transitions by creating conditions and reinforcing individual and collective behaviors that lead to healthy communities and lifestyles.

Second, prevention requires multiple processes on multiple levels to protect, enhance, and restore the health and well-being of communities and the state. State departments and community organizations may emphasize a number of different processes in seeking to realize the goals of the *Oklahoma Strategic Plan*—all with very little overlap or duplication. Although their focus on and approach to prevention may differ—as mandated by funding and regulatory sources—they may share similar processes and elements, such as needs assessment activities and the development and nurturing of community collaboratives, which can be strengthened through communication and coordination.

Third, prevention is based on the understanding that there are risk and protective factors that vary among individuals, age groups, racial and ethnic groups, communities, and geographic areas. Theories, models, and data that allow for the explanation and understanding of risk and protective factors at several levels of social aggregation—community, school, peers, family, and the individual's characteristics—provide a rational approach to designing prevention strategies and programs. The Hawkins and Catalano risk and protective factors model is the conceptual approach currently practiced within the Oklahoma State Department of Mental Health and Substance Abuse Services and provides the framework for conceptualizing prevention efforts within the *Oklahoma Strategic Plan*.

Risk factors exist in clusters rather than in isolation. For example, children who suffer abuse or neglect frequently are found in single-parent families of low socioeconomic status living in disadvantaged neighborhoods inundated

with violence, drug use, and crime. Research has shown that multiple risk factors have a synergistic effect (i.e., the interactions between these risk factors have a greater effect than any single risk factor produces alone). Therefore, the more risk factors a child is exposed to, the greater the likelihood that he or she will, for example, use drugs, become violent, or engage in criminal behavior.

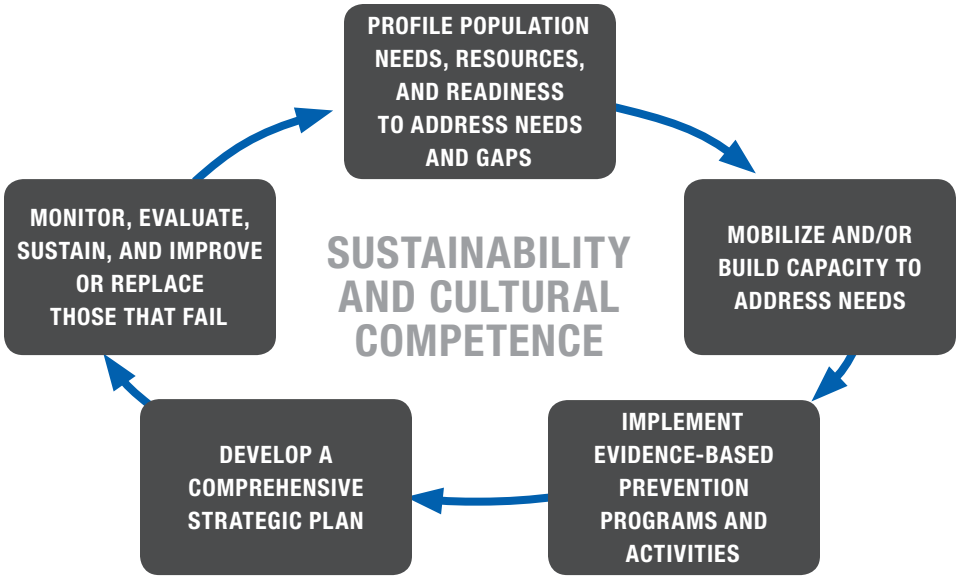
However, Oklahoma understands that achieving significant, population-based behavior change requires more than just making a positive impact on the underlying conditions (i.e., risk and protective factors); it requires significant and measurable reductions in the *causal* factors related to mental, emotional, and behavioral disorders.

The idea of multiple influences affecting behavioral outcomes is evident in the causal factor research conducted by the Pacific Institute for Research and Evaluation (PIRE). PIRE has identified seven causal factors or areas of intervention that can make drug using behaviors—and therefore the profusion of health, social, and economic problems related to drug use—more or less likely to occur.

Economic availability (accessibility according to price), *retail availability* (accessibility from retail sources), and *social availability* (accessibility from nonretail sources, such as family and friends) are key areas of influence, since without availability there can be no substance use and no associated problems. *Promotion*—alcohol and tobacco manufacturers' and retailers' attempts to increase demand through the advertising and promotion of their products—is another identified causal factor. *Community norms* regarding the acceptability of high-risk behaviors, including substance use, may be codified into concrete expressions such as public policies, laws, and regulations. In addition to directly defining undesired illegal substance use, these community norms can affect other areas of intervention (e.g., availability and promotion), shaping both demand and supply. The degree to which laws and regulations limit availability, regulate promotion, or reduce undesired use is directly related to their enforcement. Finally, individual characteristics—ge-

netics, values, attitudes, and social associations—also contribute to individual substance use decisions.

Oklahoma's commitment to the risk and protective factor model is in alignment with PIRE's causal factor model, which represents a public health approach to prevention and emphasizes prevention effects at the community level. Oklahoma appreciates that communities are complex systems with complicated and shifting interactions among and between their parts, and recognizes that preventing mental, emotional, and behavioral disorders requires a comprehensive, systematic approach based on a clear understanding of each contributing causal factor and the relationship between those factors. Knowing how—and where—to effectively intervene is essential to achieving population outcomes.



The SPF model also employs a public health approach that focuses on achieving population outcomes. In instituting the SPF process, Oklahoma is transitioning from a focus on services to individuals or small groups of consumers to population-based approaches that view community wellbeing as the unit of outcome measurement, and from agency-centered services to

coordinated, multisector systems approaches that use evidence-based practices to achieve and change.

ODMHSAS and its state- and community-level partners are committed to implementing the five steps of the SPF process to enhance state and community prevention system accountability, capacity, and effectiveness. This dynamic, systematic process to build infrastructure and capacity and achieve results provides a logical framework that addresses five key steps:

1. Assessment of substance abuse and related problems, resources and gaps, contextual conditions, and readiness to act through data collection and analysis

2. Mobilization of stakeholders and financial/organizational capacity building at state and community levels to address the priority issues identified in the assessment process

3. Development of a comprehensive strategic plan that aligns resources with locally, culturally, and developmentally appropriate strategies that have been documented to be effective in addressing the state's/community's identified priority issues

4. Implementation of state/local strategic plan that identifies timelines, processes, activities, and responsibilities

5. Ongoing evaluation and monitoring of progress toward achieving outcomes, making adjustments as needed to ensure continuous improvement.

The SPF is an iterative process in which each step tests the validity of conclusions drawn in previous steps—sometimes requiring revisions to earlier assumptions. Oklahoma will continually assess new information. Initially the focus will be on substance abuse-specific data relative to the SPF SIG priorities, but over time the state plans to expand its assessment to include

related prevention areas such as child abuse, domestic violence, and suicide. Based on data analysis findings, the state will mobilize new stakeholders and partners, as appropriate; continue to build capacity to deal with broader and more complex issues; plan and implement new or expanded initiatives; and evaluate progress in building system capacity and achieving identified outcomes at the state and local levels.

The SPF includes interwoven emphases on cultural competence and sustainable systems and outcomes. It is essential to recognize that every Oklahoma community is composed of subgroups with unique and complex cultural needs, and to include these diverse populations in every facet of prevention planning. Oklahoma also will work to develop the organizational capacity and stakeholder commitment needed to create an adaptive and effective prevention system that can achieve and maintain the desired long-term results, resulting in a dynamic and sustainable prevention system.

Because the *Oklahoma Department of Mental Health and Substance Abuse Services* is responsible for providing services to Oklahomans who are affected by mental illness as well as substance abuse, the infrastructure built by the Department using its SPF SIG funding will provide a foundation for the prevention of the myriad mental, emotional, and behavioral disorders, many of which share the same risk and causal factors and could benefit from shared interventions using proven, evidence-based practices and expanded community-based services.

The *Oklahoma Strategic Plan for the Prevention of Mental, Emotional, and Behavioral Disorders* supports Oklahoma's broadened focus on multisector prevention systems development, affording the state expanded opportunities for multiagency cooperative interventions using shared strategies to serve the same or similar populations or to target mutual outcomes, and encourages the application of systems theory and knowledge to design and evaluate comprehensive prevention initiatives.

II. Assessment

ASSESSING THE PROBLEM

Epidemiology, the science of public health, provides vital information about disorders that threaten the health and well-being of populations. Epidemiological data identify problems, help determine what areas and who are affected by the problems—knowledge that is essential for effective intervention—and measure the success of interventions aimed at preventing or reducing these problems. Engagement in a thoughtful planning process that includes careful assessments of needs, resources, capacity, readiness, and contextual conditions—prior to selecting strategies—is essential to successful prevention efforts.

This data focus—collection, analysis, and use—is entrenched in each step of the SPF and continually informs the process. The formal assessment of contextual conditions, needs, resources, readiness, and capacity is used to identify priority issues in Step 1. In Step 2, data are shared to generate awareness, spur mobilization, and leverage resources. In Step 3, assessment data are used to drive the development of a strategic plan and guide the selection of evidence-based strategies. Data are used in Step 4 to inform (and, if necessary, revise) the implementation plan. And finally, data are collected to monitor progress toward outcomes, and findings are used to make adjustments and develop sustainable prevention efforts.

The Oklahoma State Epidemiological Outcomes Workgroup (SEOW) is a multidisciplinary workgroup whose members are connected to key decision-making and resource allocation bodies in the state. This workgroup, funded through a Federal grant from SAMHSA/CSAP, was established by ODMHSAS in 2006 and is patterned after the National Institute on Drug Abuse (NIDA) community epidemiological workgroup. Oklahoma's SEOW is charged with improving prevention assessment, planning, implementation, and monitoring efforts through data collection and analysis that accurately assesses the causes and consequences of the use of alcohol, tobacco, and other drugs and drives decisions concerning the effective and efficient use of prevention resources throughout the state.

To study the nature and extent of the problem of alcohol, tobacco, and other drug use in Oklahoma, the state's SEOW utilized the CSAP model of consumption and consequence constructs and indicators. Table 1 provides a complete listing of alcohol, tobacco, and illicit and prescription drug consumption and consequence constructs. For each construct, one or more identifiable indicators (measures) were used to quantify consumption and substance-related consequences. Unlike the underlying constructs, these indicators are precisely defined and determined by specific data sources. Thus, while "alcohol-related mortality" is a relevant construct for monitoring trends of an important consequence of use, it does not provide a precise definition of how this construct can be measured. However, a number of indicators do provide specific measures of this construct (e.g., annual incidence rate of deaths attributable to alcohol-related chronic liver disease, suicide, homicide, or crash fatalities). A list of constructs and indicators for alcohol and illicit drug consumption and consequences appear in the epidemiological data tables on pages 54–59.

CSAP recommendations were not available for prescription drugs, so Oklahoma used the same data sources CSAP recommended for the other constructs and indicators.

TABLE 1. ALCOHOL, TOBACCO, ILLICIT DRUGS, AND PRESCRIPTION DRUG CONSUMPTION AND CONSEQUENCE CONSTRUCTS

	ALCOHOL	TOBACCO	ILLICIT DRUGS	PRESCRIPTION DRUGS
CONSUMPTION	• Current use • Current binge drinking • Heavy drinking • Age of initial use • Drinking and driving • Alcohol use during pregnancy • Apparent per capita alcohol	• Current use • Age of initial use • use during pregnancy • cigarette use consumption per capita	• Current use • Lifetime use • Age of initial use	• Current use
CONSEQUENCE	• Alcohol-related mortality • Alcohol-related motor vehicle crashes • Alcohol-related Crime • Dependence or abuse	• Tobacco-related mortality	• Illicit drug-related mortality • Illicit drug-related crime • Dependence or abuse	• Prescription opiate-related mortality

The SEOW required data indicators for each substance to be readily available and accessible, with the measure available in disaggregated form at the State or lower geographic level. The method or means of collecting and organizing the data also had to be consistent over time; if for any reason the method of measurement had changed, reliable data had to be available to allow adjustment for differences resulting from data collection changes. In addition, research-based evidence had to support that the indicator accurately measured the specific construct and yielded a true representation of the phenomenon at the time of assessment, with data collected—preferably on an annual, or at minimum, a biennial basis—for the preceding 3 to 5 years. And each indicator had to be sufficiently sensitive to detect change over time that might be associated with changes in alcohol, tobacco, or illicit drug use.

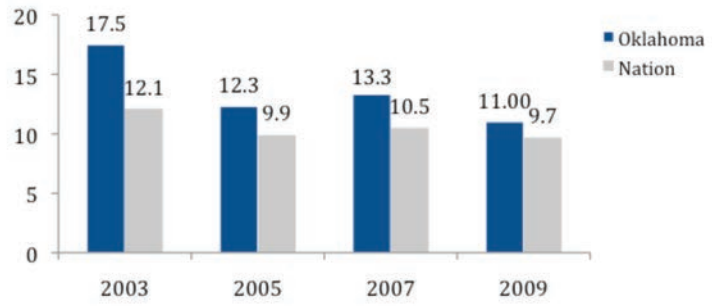
ALCOHOL CONSUMPTION

According to Oklahoma's Youth Risk Behavior Survey (YRBS), in 2009, 39.0 percent of students in grades 9–12 reported current alcohol consumption. That percentage is consistent with data collected by the National Survey on Drug Use and Health (NSDUH) for the population aged 12 and older, which showed 42.5 percent of respondents were current drinkers in 2007. NSDUH and YRBS data also showed between 21 and 28 percent of adolescents were binge drinkers at the time of the surveys. Although youth binge drinking is on the decline, with the exception of 2009, Oklahoma has been consistently above the national average for this behavior according to the YRBS. NSDUH data from 2007 indicated 37.4 percent of 18- to 25-year-olds and 9.0 percent of 12- to 17-year-olds were binge drinkers. The 2009 YRBS showed 19.4 percent of Oklahoma students in grades 9–12 reported early initiation of alcohol; a continued indication of a steady decline in that behavior since the 2003 YRBS report of 26.8 percent.

While adolescent drinking and driving is trending downward, Oklahoma continues to have percentages higher than the national average. In 2003, Oklahoma's percentage of adolescent drunk driving was 17.5 percent, which was 45 percent higher than the national average. This dropped to 11.0 per-

cent in 2009, which was 13 percent higher than the national average of 9.7 percent.[1]

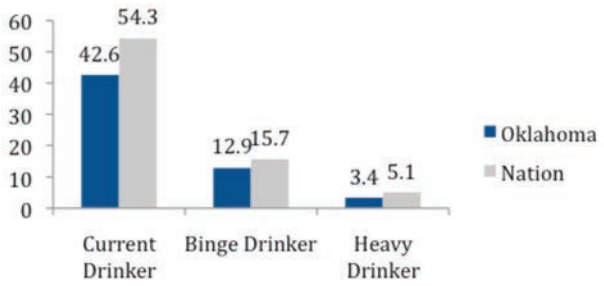
FIGURE 1. YRBS 2003–2007 PERCENTAGE OF STUDENTS IN GRADES 9–12 WHO REPORTED DRIVING WHEN THEY HAD BEEN DRINKING



Indicators from the 2009 Behavioral Risk Factor Surveillance System (BRFSS) show Oklahoma is lower than the national average in current alcohol consumption, heavy consumption, and binge drinking among adults. In 2009, 42.6 percent of Oklahoma adults reported current alcohol consumption, which was 27 percent lower than the national average of 54.3 percent.[2]

Although lower than the national average, NSDUH data indicates Oklahoma's percentage of binge drinking among persons 12 and older has increased from 2003-2007. The percentage was 19.01 in 2003 and 21.2 in 2007.[3]

FIGURE 2. BRFSS 2009 ALCOHOL CONSUMPTION CATEGORIES

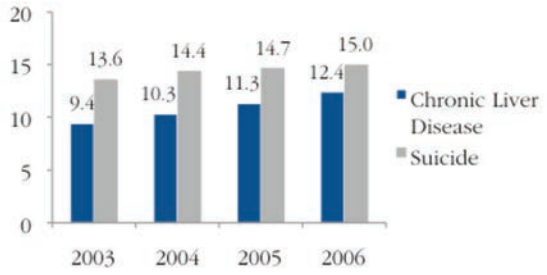


Data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS) show that alcohol use among pregnant women has been climbing in Oklahoma since 2003, when 2.5 percent of pregnant women had consumed alcohol during the last 3 months of their pregnancy. In 2007, the percentage had increased to 4.8 percent of pregnant women.[4]

ALCOHOL CONSEQUENCES

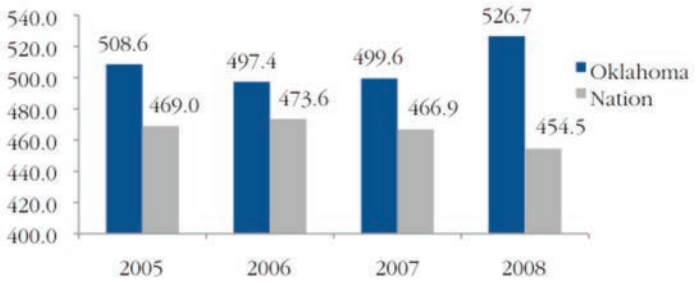
Oklahoma is consistently above the national average in alcohol-related mortality. Long-term alcohol consumption is associated with chronic liver disease. The relationship between alcohol use and suicide is also well documented, according to CSAP. Both chronic liver deaths and suicide deaths have been on the rise in Oklahoma since 2003.[5,6,7]

FIGURE 3. 2003–2006 NATIONAL VITAL STATISTICS SYSTEM (NVSS) OKLAHOMA CHRONIC LIVER DISEASE AND SUICIDE MORTALITY DATA DEATHS PER 100,000



According to the Uniform Crime Reports (UCR), Oklahoma has also been consistently above the national average in crimes related to alcohol use which include aggravated assaults, sexual assaults, and robberies. Since 2003, there has been an 18.1 percent increase.[8]

FIGURE 4. 2005–2008 UCR NUMBER OF VIOLENT CRIMES REPORTED TO POLICE PER 100,000 POPULATION



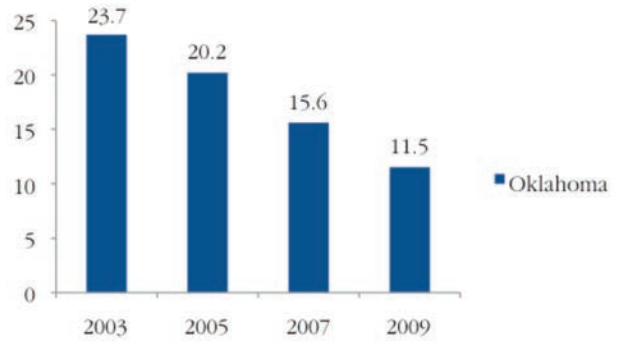
Fatality Analysis Reporting System (FARS) data show that Oklahoma has maintained a steady rate of fatal crashes involving an alcohol-impaired driver. In 2003, Oklahoma's alcohol-impaired driver fatality rate was 31.3 percent, and in 2008, that figure remained relatively stable at 31.6 percent. National percentages for those years were 30.3 and 31.4, respectively.[9]

TOBACCO CONSUMPTION

According to the 2007 NSDUH, 30.6 percent of Oklahomans aged 12 and older were current cigarette smokers, which was above the national average of 24.2 percent. Data from the 2009 BRFSS also showed Oklahomans' daily cigarette smoking exceeding that of the United States population as a whole, at 25.4 percent vs. 17.9 percent, respectively.[2,3]

The YRBS shows indicators in tobacco use among adolescents have been falling in Oklahoma since 2003, with students who smoked their first cigarette before the age of 13 decreasing by half since that year.[1]

FIGURE 5. YRBS 2003–2009 PERCENTAGE OF STUDENTS IN GRADES 9–12 WHO REPORTED SMOKING A WHOLE CIGARETTE FOR THE FIRST TIME BEFORE THE AGE OF 13.



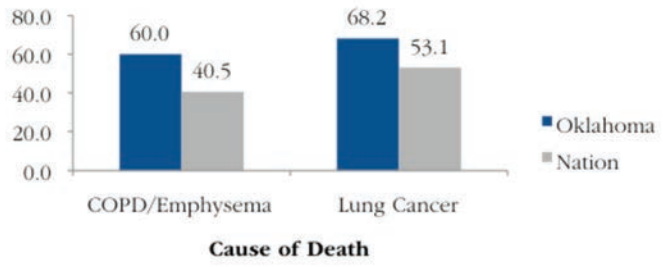
Smoking among pregnant women is climbing in Oklahoma according to PRAMS. In 2003, 16.2 percent of pregnant women reported they had smoked during the last 3 months of their pregnancy; in 2007, the most recent PRAMS for which data are currently available, the percentage of pregnant women

who smoked during the last 3 months of pregnancy had jumped to 21.3.[4]

TOBACCO CONSEQUENCES

National Vital Statistics System (NVSS) data show deaths from both chronic obstructive pulmonary disease (COPD) and emphysema for Oklahoma are above the national average.[10]

FIGURE 6. NVSS 2006 COPD/EMPHYSEMA AND LUNG CANCER DEATHS PER 100,000



ILLICIT DRUG CONSUMPTION

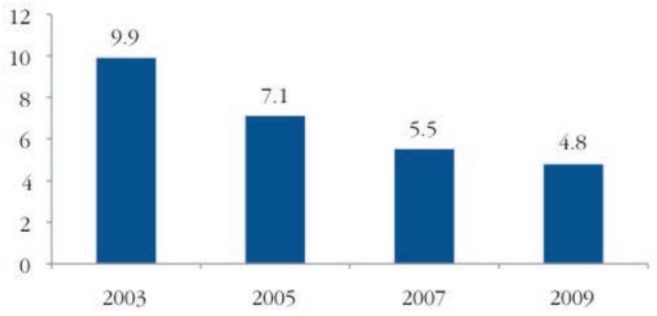
The YRBS shows daily marijuana use for high school students in grades 9–12 is decreasing; 22.0 percent were daily users in 2003, while just 15.9 percent reported this behavior in 2007.[1]

According to NSDUH, Oklahoma has been consistently above the national average among persons aged 12 and older reporting the use of any illicit drug other than marijuana. The percentages were 4.1 in 2004 and 4.6 in 2007. The national percentages for those same years were 3.4 and 3.7, respectively.[3]

Although still above the national average, youth methamphetamine use continues to decline in Oklahoma according to the YRBS. Since 2003, the percentage of youth methamphetamine users has dropped by half.[1]

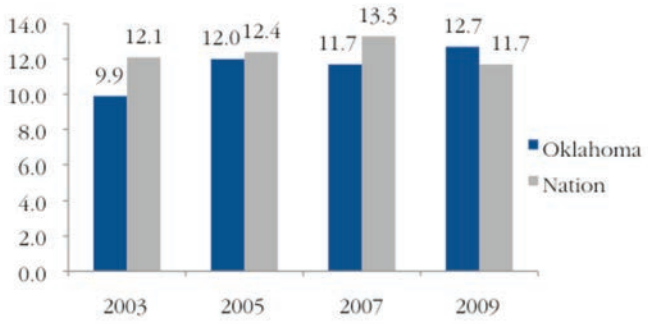
The YRBS also shows Oklahoma exceeds the national average in cocaine, ecstasy, steroid, and inhalant use. Although above the national average, cocaine use in Oklahoma has dropped from 9.2 percent in 2003 to 7.4 percent in 2009.[1]

FIGURE 7. YRBS 2003-2009 PERCENTAGE OF OKLAHOMA STUDENTS IN GRADES 9–12 WHO REPORTED EVER USING METHAMPHETAMINES



Although initially below the national average in years 2003–2007, adolescent use of inhalants is on a steady ascent. In 2009, 12.7 percent of Oklahoma adolescents reported inhalant use, surpassing the national average of 11.7 percent.[1]

FIGURE 8. 2003-2009 YRBS PERCENT OF STUDENTS IN GRADES 9–12 WHO REPORTED EVER USING ANY FORM OF INHALANT



ILLICIT DRUG CONSEQUENCES

The latest NVSS data show that Oklahoma exceeds the Nation in number of deaths due to drug-related behavior. In 2006, the rate per 100,000 was 17.3 for Oklahoma and 12.8 for the United States as a whole.[5]

The number of drug-related crimes (larceny, burglary, motor vehicle theft) in Oklahoma also outstrips that of the Nation; in 2008, Oklahoma reported 3,442.4 per 100,000 compared to the national rate of 3,212.5 per 100,000. However, Oklahoma's 2008 rate does represent a decline for the state, which reported drug-related crimes of 4042.0 per 100,000 in 2005.[8]

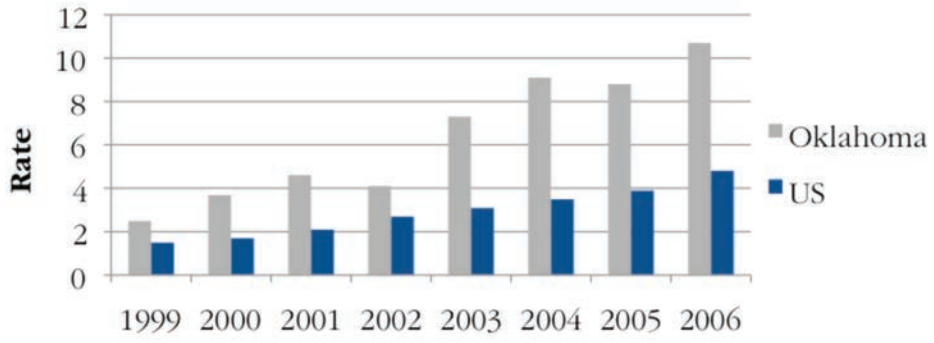
PRESCRIPTION DRUG CONSUMPTION

According to data from the 2007 NSDUH, Oklahomans aged 12 and older exceeded the national average for the consumption of painkillers for non-medical use by 232 percent. This is a 22 percent increase since 2004.[3]

PRESCRIPTION DRUG CONSEQUENCES

Although hospital inpatient discharge data were not indicators used in scoring, they were presented to the State Epidemiological Outcomes Workgroup (SEOW) due to the paucity of indicators regarding prescription drugs. Oklahoma hospital data associated with opiates have shown a 91 percent increase since 2003. Although this is a general category for opiates, for all practical purposes, heroin is the only illicit opiate taken into account.[11]

FIGURE 9. NVSS 1999-2006 OPIOID OVERDOSE DEATHS PER 100,000 POPULATION



NVSS data show there has been a 328 percent increase in opiate-related deaths in Oklahoma since 1999. In 2006, Oklahoma ranked 4th in the Nation

for opiate overdose deaths, exceeding the national average by 123 percent.[12]

MENTAL AND EMOTIONAL DISORDERS

The Oklahoma SEOW intends to expand its scope to collect and analyze epidemiological data on the nature and extent of mental illness and related indicators in the state. The broadening of the SEOW's scope of work is critical for Oklahoma to gain more understanding about opportunities for mental illness prevention and mental health promotion within the state. In addition, developing research supports the connection between mental and emotional disorders, their causal factors, and other behavioral health problems, including substance abuse. Therefore, it is imperative that Oklahoma apply the same assessment standards integral to the SPF process for the prevention of mental and emotional disorders as has been done for substance abuse.

Mental disorders (brain dysfunction disorders) account for 25 percent of disability in the United States. About 22 percent of the U.S. adult population has one or more diagnosable disorders in a given year. Oklahoma currently ranks number one in the Nation for the prevalence of these disorders in adults.[13]

Mental illness can influence the onset, progression, and outcome of other illnesses. Anxiety, impulse control, and mood disorders often correlate with health risk behaviors such as substance abuse, tobacco use, and physical injury. Depression is a risk factor for such chronic illnesses as hypertension, cardiovascular disease, and diabetes. Mental illness and depression also increase the risk for suicide. Oklahoma has consistently had a higher number of suicide deaths compared to the rest of the Nation. In Oklahoma, suicide is the most common manner of violent death. The first quarter of 2010 has yielded a sharp increase in calls to Oklahoma's suicide prevention hotline. In 2009, for example, there were 833 calls during the first quarter. In the first quarter of 2010 there has been a 53.0 percent increase, with 1,272 clients having called the hotline.[14]

From 2004–2007, the rate of suicide was 14.4 per 100,000 according to the Oklahoma Violent Death Reporting System (OVDRS). Data from OVDRS also show that suicide was the third-leading cause of death among 15- to 24-year-olds in 2007. The suicide rate reported by Oklahoma for this population was 13.5 percent higher than the national rate among the corresponding age group. And in fact, among all ages, Oklahoma's reported suicide rate is higher than the national average. In 2006, Oklahoma's rate per 100,000 was 15.0, compared to the national average of 10.9. Seventy-eight percent of suicides were males. Depression was the leading circumstance associated with suicide. Forty-six percent of suicides were the result of a depressed mood. Substance use also played a role in suicides according to OVDRS. Thirty percent of persons tested had a positive blood alcohol test, and 88 percent tested positive for other drugs.[15]

In 2007, NSDUH reported that 14.0 percent of Oklahomans aged 18 and older suffered from serious psychological distress. Table 2 shows several mental health indicators for which Oklahoma had some of the highest percentages in the Nation in 2006–2007. In addition, results from the 2009 BRFSS show 20.7 percent of Oklahoma adults had between 1 and 13 mentally unhealthy days in the last month, and 13.7 percent had between 14 and 30 such days.[3]

TABLE 2. NSDUH, 2006–2007 ANNUAL AVERAGES

Mental Health Indicator	Percent
Serious psychological distress in the past year (age 18 and older)	14.0
Serious psychological distress in the past year (age 26 and older)	13.2
Persons having at least one major depressive episode in the past year (age 18 and older)	9.1
Persons having at least one major depressive episode in the past year (age 18–25)	10.5
Persons having at least one major depressive episode in the past year (age 26 and older)	8.9

ODMHSAS reported 34,132 persons received ODMHSAS-funded mental health services for fiscal year 2004. In 2009, that number increased to 52,226. In 2009, the top three reasons clients sought services were emotional maladjustment/disturbance (38.9 percent), substance abuse disorders (29.0 percent), and depressive disorders (7.0 percent). The top drug of choice was alcohol. The age groups of clients that had the highest percentages of service were 25–34 (23.5 percent) and 35–44 (21.0 percent). The gender breakdown of clientele was virtually the same. Of the clients who were given a substance abuse screening, 57.0 percent tested positive.[16]

The number of children with serious emotional disturbance (SED) receiving ODMHSAS-funded mental health services increased 76 percent over a 5-year period, from 2,254 in 2004 to 3,959 in 2009. Persons with serious mental illness (SMI) receiving ODMHSAS-funded mental health services increased from 25,492 in 2004 to 38,222 in 2009—an increase of approximately 50 percent.[16]

Data from the YRBS show that, in 2009, 28.2 percent of students felt sad or hopeless everyday day for 2 weeks or more in a row to the extent that they stopped doing some usual activities during the past 12 months; this was slightly higher than the national average of 26.1 percent.[1] Oklahoma Systems of Care, a comprehensive spectrum of mental health and other support services for adolescents and their families with a serious emotional disturbance, has experienced a 73 percent increase in enrolled clients since fiscal year 2006—jumping from 456 in 2006 to 787 in 2010. The majority of clients are white, male, and diagnosed with conduct disorders.[17]

POPULATIONS OF NOTE

American Indian

In 2000, the American Indian and Alas¬ka Native (AI/AN) popula¬tion in Oklahoma was 266,801, comprising 8 percent of the state's total population and ranking Oklahoma second among all states for AI/AN population. Alcohol and tobacco consumption is a significant problem in this population.

According to data from the 2009 BRFSS, 14.2 percent of AI/AN adults reported binge drink¬ing, and 4.0 percent reported heavy drinking; both percentages exceed those reported by any other race. Smoking consumption was also highest among this group according to the BRFSS. In 2009, 31.9 percent AI/ANs reported current smoking compared to all other races (25.0 percent).

Data from the Okla¬homa State Bureau of Investiga¬tion (OSBI) show Oklahoma's AI/AN population had substantially greater alcohol-related arrests (i.e., driving under the influence, liquor law violations and drunkenness) at 44 percent; lower drug law violation arrests (i.e., all drug arrests reported as sale/manufacturing and possession) at 8 percent; and lower index crime arrests (i.e., mur¬der, rape, robbery, aggravated as¬sault, burglary, larceny, and motor vehicle theft) at 10 percent, compared to all races combined (29 percent, 14 percent, and 13 percent, respectively).

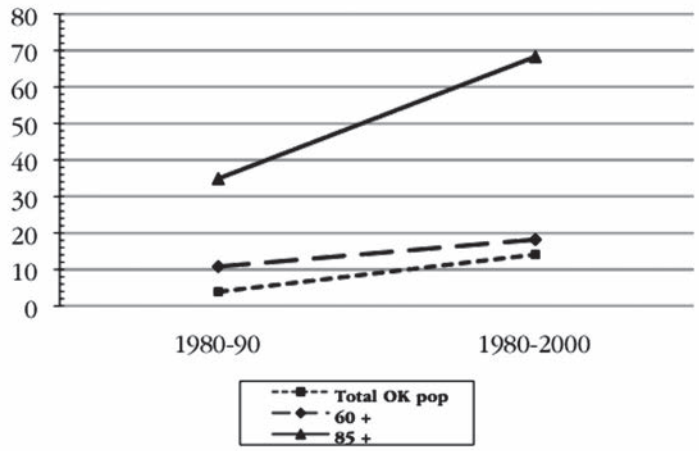
From fiscal years (FYs) 2001–2008, Oklahoma's AI/AN population had consistently high rates of per¬sons served in substance abuse treatment facilities compared to Whites and people of all races combined.[18]

Older Adults

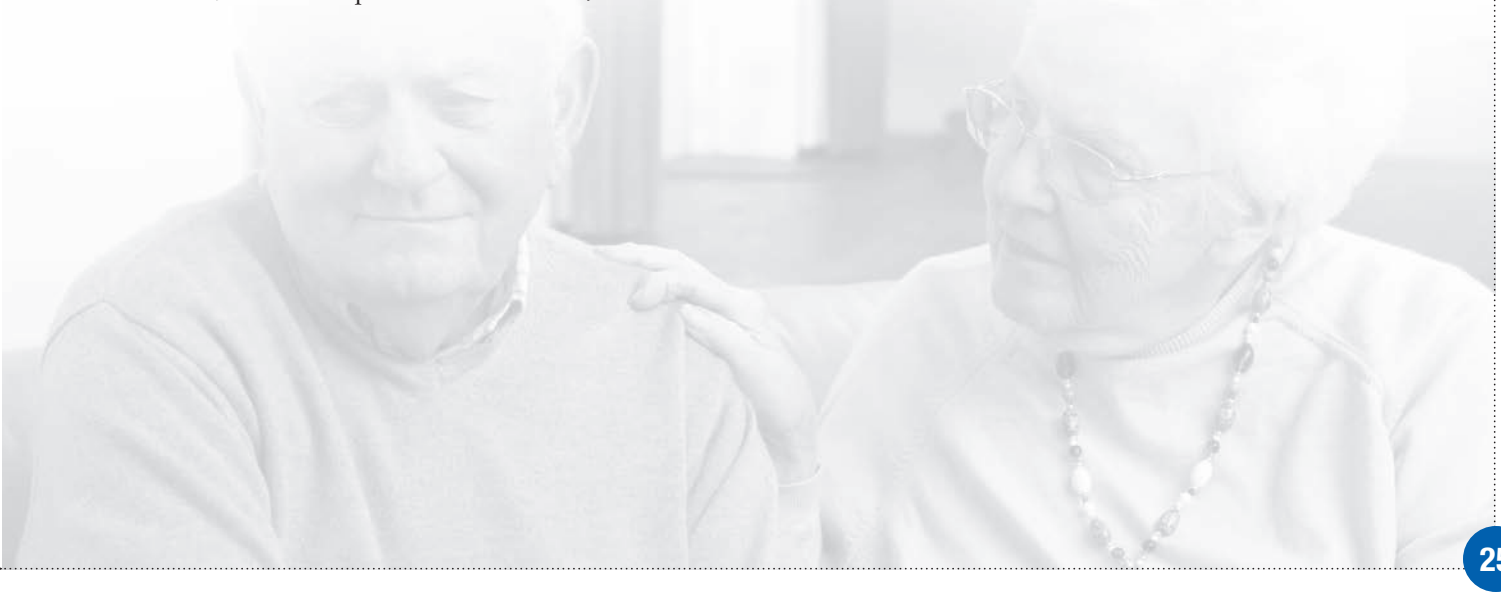
Older Oklahomans, aged 65 and above, are the fastest growing segment of the state's population. In 2006, Oklahoma had the 19th-highest number of persons aged 65 and over, with 475,637 individuals falling into this category (U.S. Census Bureau, 2006). The population ages 60 and older increased by 18.2 percent from 1980 to 2000. This is substantially higher than the national average of 12.4 percent. In 2000, Oklahoma ranked 13th in terms of the percentage of the total population 60 years and older .This high growth rate among senior citizens outpaced Oklahoma's overall growth rate of 14 percent for the same period. The very old (85 years and older) experienced the most notable growth rate of 61 percent from 1980 to 2000. It is estimated that while Oklahoma's total population will grow at a relatively slow pace (10.2 percent), those 65 years and over will increase by over 60 percent between

2007 and 2030. Further, the state's population ages 85 years and older is expected to increase by 50 percent during the same time period (U.S. Census Bureau, 2006).[13]

FIGURE 10. PERCENT GROWTH 1980–1990, 1980–2000



According to Oklahoma's 2009 BRFSS, 78.8 percent of persons aged 65–74 said that they always or usually received social and emotional support. This was down from 2005, when the percent was 83.1. Conversely, this among persons aged 75 and older, 77.6 percent always or usually received support in 2005 and 78.4 percent did in 2009.[3]



Another significant characteristic within the state's older populations is grandparents raising grandchildren. Approximately 43,000 older Oklahomans are responsible for their grandchildren; of these, 16,200 have been responsible for the care of their grandchildren 5 years or longer. Grandparents living with grandchildren under 18 years of age for the population 30 years and over households are shown in the following table.[13]

Household types	United States	Oklahoma
Total households 30+ years	158,881,037	1,915,455
Grandparents living with grandchildren under 18	5,771,671	67,194
Grandparents responsible for their grandchildren	2,426,730	39,279
Grandparents responsible for their grandchildren 5 years or more	933,408	14,714

Source: U.S. Census 2000

Veterans and Military Families

In Oklahoma, 12.5 percent (333,358) of the state's citizens are veterans, with 20.7 percent having served in the Gulf War, 35.1 percent having served in Vietnam Conflict, 12.7 percent having served in the Korean War, and 13 percent having served in World War II. The American Forces News Services reports that over 47,000 individuals based in Oklahoma are active in military operations and 24,500 have been deployed since American troops entered Afghanistan (www.usmilitary.about.com. 2008). In addition to other mental health disorders, 20 percent of returning veterans suffer posttraumatic stress disorder.[13]

According to the OVDRS, 23 percent of suicide deaths between 2004 and 2007 were veterans, which represented 76 percent of all violent deaths among veterans.[15] In addition, a comparison of mortality between Operation Enduring Freedom/Operation Iraqi Freedom Veterans and the general U.S. population (adjusted for age, sex, race, and calendar year) showed evidence of a 21 percent excess of suicides among veterans through 2007. Although the

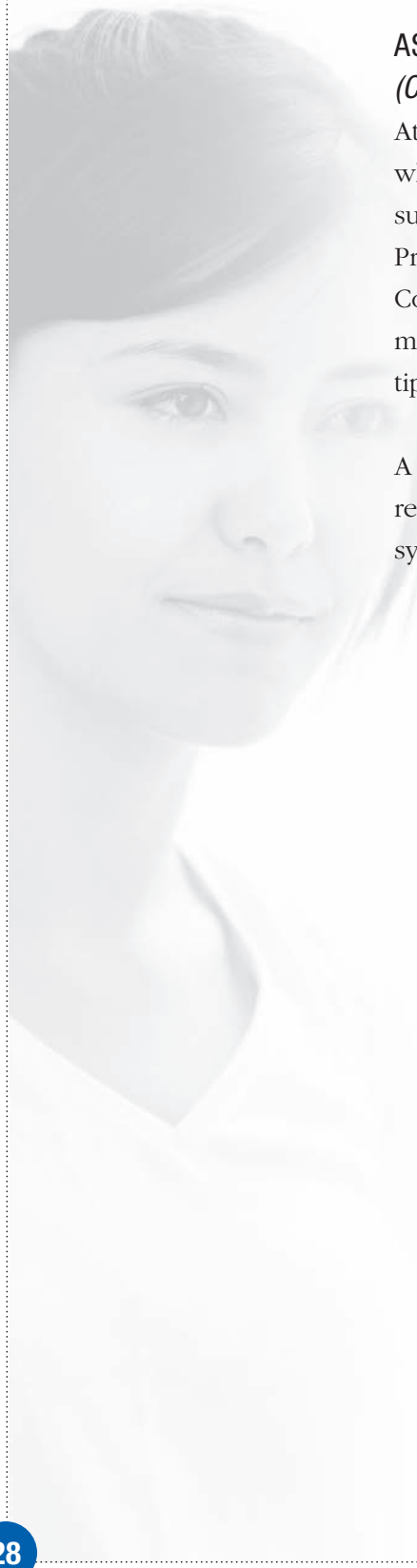
evidence is preliminary, it suggests decreased suicide rates since 2006 among veterans of both sexes aged 18–29 who have used Veterans Health Administration (VHA) health care services relative to veterans in the same age group who have not. This decrease in rates translates to approximately 250 lives per year. Finally, more than 60 percent of suicides among users of VHA services include patients with a known diagnosis of a mental health condition.[19]

Incarcerated Women

According to the Oklahoma Depart¬ment of Corrections (ODOC), Okla¬homa leads the Nation in the rate of female offender incarceration at 131 per 100,000 population, a significant departure from the national average of 69 per 100,000 popula¬tion. As of 2006, 2,213 women were incarcerated in the State of Oklahoma, and the state's female inmate population is growing more rapidly than its male inmate population. Analogous to this rise in incarcerated females is a rise in incarcerated female drug use (i.e., both personal use and drug-related crimes).

From 2001 to 2007, the number of female prison admissions per year increased by 136 (12 percent). Of the total female prison admissions during this time, 5,308 (61 percent) were White; 2,141 (24 percent) were Black; 998 (11 percent) were American Indian or Alaska Native; and 274 (3 percent) were Hispanic.

According to the Bureau of Jus¬tice Statistics (2002), 52 percent of the Nation's female inmates were dependent on drugs or alcohol. Of all the offenses listed for incarcerated women between 2001 and 2007 in Oklahoma, ap¬proximately 70 percent were associated with a controlled substance (i.e., a drug or chemical substance whose possession and use are controlled by law), alco¬hol, or both.[18]



ASSESSING THE CURRENT PREVENTION SYSTEM
(Capacity and Infrastructure)

At the state level, prevention services are managed through ODMHSAS, which is the Single State Authority (SSA) responsible for publicly funded substance abuse and mental illness prevention services. The ODMHSAS Prevention Services Division is led by Commissioner Terri White, Deputy Commissioner Steven Buck and Division Director Jessica Hawkins, with a management team and staff of 16 full-time equivalents funded through multiple state and Federal sources.

A number of different governing groups guide and inform the strategic direction of the state's substance abuse and mental health prevention service system:

- The Prevention Services Division is monitored and overseen by the agency's Governing Board.
- The Oklahoma Prevention Leadership Collaborative (OPLC), developed in 2010, is expected to serve as a guiding council on state prevention priorities and coordination among state agencies related to prevention services.
- The ODMHSAS Prevention Services Division staffs three statewide committees charged with setting priorities on significant state prevention initiatives, including the Governor's Task Force on the Prevention of Underage Drinking, the Oklahoma Suicide Prevention Council, and the Oklahoma Crystal Darkness Collaborative (focusing on the prevention of methamphetamine use).
- The SEOW was convened to collect and report on substance abuse consumption and consequence data to help identify and monitor state priorities for ODMHSAS and other agencies. The Oklahoma SEOW intends to expand its scope to analyze other behavioral and physical health data as a service to other state agencies using a data-driven prioritization process.

- The Oklahoma Prevention Policy Alliance is a nonprofit advocacy organization comprised of state- and local-level prevention supporters who advance state and municipal prevention-related policy agendas.
- The Behavioral Health Development Team (BHDT) is a subcommittee of the State Advisory Team for Oklahoma's Systems of Care initiative. The membership of the BHDT includes a designee for each member of the Partnership Board, which includes all eight child-serving agencies (ODMHSAS, Department of Human Services, Department of Rehabilitative Services, Office of Juvenile Affairs, Oklahoma Commission on Children and Youth, State Department of Education, Oklahoma Health Care Authority, and Oklahoma State Department of Health). The BHDT's primary focus is on researching options for developing the needed infrastructure and services for Systems of Care. The team develops recommendations for the Partnership for Children's Behavioral Health Board (PCBH), and creates specific implementation plans based on the decisions and guidance of the PCBH Board. Recently, the BHDT has adopted a strategic plan that includes behavioral prevention priorities, including community-based prevention approaches (through Oklahoma's Area Prevention Resource Centers) and suicide prevention.

The Area Prevention Resource Centers (APRCs), which are funded by state-appropriated funds and the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant administered by SAMHSA, are the backbone of Oklahoma's prevention service system. There are 17 regional APRCs serving all 77 counties in Oklahoma. APRC Directors convene quarterly with ODMHSAS staff at the Oklahoma Prevention Network meetings. APRC staff are certified prevention specialists and receive regular training on evidence-based prevention strategies and principles, including the SPF. APRCs develop, in partnership with community coalitions, community-level prevention workplans based on the SPF and aligned with state prevention priorities. Services are focused on achieving sustainable, population-level outcomes. APRC staff are charged with implementing community-level workplans in collaboration with community coalitions and building local-level prevention capacity. Services

provided and guided by the APRCs are evaluated at the local level. A contract with the University of Oklahoma's College of Public Health, to provide training and technical assistance on evaluation as well as overall Block Grant evaluation services, is slated to commence in 2010.

The ODMHSAS Prevention Services Division administers 2much2lose (2m2l), which is the overarching moniker of Oklahoma's underage drinking prevention initiative funded by the Office of Juvenile Justice and Delinquency Prevention's Enforcing Underage Drinking Laws Block Grant program. 2m2l represents an array of efforts, including a youth leadership development program and underage drinking law enforcement activities. Regional 2m2l Coordinators provide training and technical assistance to local 2m2l youth chapters and law enforcement throughout the state on best practice strategies for underage drinking prevention. There is a 10-member state 2m2l Youth Council that advises ODMHSAS on local and state youth training, as well as two regional cross-jurisdictional law enforcement task forces that implement high visibility underage drinking operations throughout the year.

The ODMHSAS Prevention Services Division also manages a number of other Federal and state substance abuse prevention grant programs, including the Oklahoma Partnership Initiative funded by the Administration on Children and Families to provide prevention services to children in substance abusing families; the Oklahoma Methamphetamine Prevention Initiative funded by SAMHSA/CSAP to implement evidence-based meth prevention interventions in high-risk communities; a responsible beverage sales and service training program and underage/high-risk drinking law enforcement effort funded by a Justice Assistance Grant from the Oklahoma District Attorneys Council; and administration of a program to prevent youth tobacco retail sales to minors funded by the Oklahoma Tobacco Settlement Endowment Trust. Finally, ODMHSAS Prevention Services Division has a professional on staff to develop a statewide infrastructure for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services and advise on advances in state and Federal health reform as it relates to the prevention of mental, emotional, and behavioral disorders.

In addition to substance abuse prevention, ODMHSAS Prevention Services Division operates two mental health promotion initiatives. The Oklahoma Youth Suicide Prevention Initiative is funded by the SAMHSA Center for Mental Health to implement state and local strategies such as training, screening, and community capacity building to prevent suicide and develop prepared communities. Second, the Mental Health First Aid training program supports a network of trainers throughout the state to increase community knowledge of mental illness, identify warning signs, and administer effective help when signs are recognized.

Oklahoma continues to work toward a collaborative substance abuse prevention system that ensures the use of evidence-based programs and policies and demonstrates accountability among partners. The ODMHSAS Prevention Services Division partners with a number of other agencies to coordinate and implement prevention services. These agencies include, but are not limited to, those shown in the following table.

Agency
Cherokee Nation Behavioral Health Services
Oklahoma State Department of Education
Oklahoma State Department of Health
Oklahoma Department of Public Safety/Highway Safety Office
Office of Faith-based Initiatives
Office of Juvenile Affairs
Oklahoma Bureau of Narcotics and Dangerous Drugs
Oklahoma Commission on Children and Youth
Oklahoma Health Care Authority
Oklahoma Institute for Child Advocacy
Oklahoma National Guard
Oklahoma State Regents for Higher Education
Oklahoma State Parent-Teacher Association

CRITERIA AND RATIONALE FOR SPF SIG PRIORITIES

In July 2009, Oklahoma received a 5-year Strategic Prevention Framework State Incentive Grant from SAMHSA/CSAP. The ODMHSAS Prevention Services Division administers the Oklahoma SPF SIG project. The purpose of the SPF SIG funding is for states to build the infrastructure necessary to prevent the onset and reduce the progression of substance abuse and related problems, as well as build prevention capacity and infrastructure at the state and community levels. The following describes the processes by which the state determined substance abuse-specific priorities for the 5-year SPF SIG initiative. The same process will be applied utilizing the infrastructure developed via the SPF SIG to determine prevention priorities related to mental and emotional disorders.

On March 26, 2010, Oklahoma held its SPF SIG kickoff meeting in Oklahoma City, with members of CSAP present. At that meeting, the SEOW discussed the existence and purpose of the Oklahoma Tobacco Settlement Endowment Trust. Oklahoma is the only state in the Nation that has constitutionally protected the majority of its Master Settlement Agreement (MSA) funds in an endowment to ensure a growing funding source. Earnings have increased each year from a low of $650K in FY 2002 to a high of $18M in FY 2010. Given this large, dedicated funding stream, which ensures that funds will be available for tobacco prevention for many generations to come, the State Tobacco Control Program endorsed the omission of tobacco issues from consideration by the SEOW in favor of Oklahoma using its SPF SIG funding to support other substance-related issues currently receiving less financial support in the state.

The SEOW was tasked with analyzing the state epidemiological data to determine problem or emerging alcohol and other drug consumption and consequence patterns. The SEOW decided to categorize indicators into one of three substance categories: alcohol, illicit drugs, and prescription drugs.

CSAP provides an excellent list of indicators, solid reasoning for selecting these indicators, and equally sound explanations for the exclusion of certain indicators. On its Web site, https://www.epidcc.samhsa.gov/background/criteria.asp, CSAP fully details why each indicator was selected or rejected. It was CSAP's sound logic that convinced the SEOW to use its recommendation of indicators for evaluating each substance.

1. **National source.** The measure must be available from a centralized, national data source.

2. **Availability at state level.** The measure must be available in disaggregated form at the state (or lower geographic) level.

3. **Validity.** There must be research-based evidence that the data accurately measure the specific construct and yield a true snapshot of the phenomenon at the time of assessment. These criteria are used to eliminate measures that look at face value as if they assess a particular construct, but are in fact poor or unproven proxy measures and thus do not accurately reflect the construct. Because OPNA is conducted using a convenience sample, the SEOW voted not to include these data in the process since such data would not be a valid measure of consumption and consequence at the state level.

4. **Trend.** The measure should be available for the past 3 to 5 years, preferably on an annual basis, but no less than a biennial basis. This enables the state to determine not only the level of an indicator but also its trends.

5. **Consistency.** The measure must be consistent (i.e., 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 time i+1). Alternatively, if the method of measurement has changed, sound studies or data should exist that determine and allow adjustment for differences resulting from data collection changes.

6. **Sensitivity.** For monitoring, the measure must be sufficiently sensitive to detect change over time.

To prioritize each of the three substance categories for the State of Oklahoma, a set of consumption and consequence indicators for each substance type was identified (see pages 54–60), and an index score was computed for each substance based on the indicator data available to allow prioritization of each substance category as follows:

1. A ratio comparing Oklahoma to the United States was calculated based on either the percentage of use or rate of incidence for each year of available data for each consumption and consequence indicator.

2. The ratios were summed for all of the consumption indicators and divided by the number of data points to calculate an average of the consumption ratios.

3. A ratio average was calculated across the consequence indicators for the substance category. The consequence ratio average was then multiplied by 2 due to CSAP's history of placing an emphasis on consequence data.

4. The ratio averages for consequence data and consumption data for each substance were added together for the ratio score for each substance.

Next, time trends were analyzed to create a trend index for each substance category, increasing the sensitivity of substance index scores to current trends. Because a general trend could have overlapping confidence intervals—which may or may not represent a statistically significant trend—Oklahoma felt the best way to control for this across all data sources was to conduct a regression analysis for each indicator rather than look for a general trend. If a statistically significant increase was found, the indicator was assigned a +1, if a statistically significant decrease was noted, the indicator received a -1. If a significant trend was not found, then the indicator scored a 0. The scores

for each substance were then divided by the total number of indicators, and consequence data were multiplied by 2 and added to the consumption score to create a trend index score for each substance.

To calculate the total index score for each substance category, the time-trend data and the ratio data were added together.

An example of the calculation of the substance category scoring method can be found on pages 61–62 of the appendix.

Substance Consumption = $\frac{\text{Oklahoma Indicator}}{\text{National Indicator}}$ **=a**

Substance Consequence = $\frac{\text{Oklahoma Indicator}}{\text{National Indicator}}$ **Ratio (*2)** **= b**

$\frac{a+b}{\text{data points of substance}}$ **=c**

Substance Consumption = Linear Regression of Time Trend of Indicator **= x (which is +1 increase, 0 no change, -1 decrease)**

Substance Consequence= Linear Regression of Time Trend of Indicator **= y (which is +1 increase, 0 no change, -1 decrease)**

$\frac{x+y\ (2)}{\text{data points of substance}}$ **=z**

Substance Score = C+Z

Following are the results of this process:

- Prescription drugs (9.44)
- Alcohol (3.54)
- Illicit drugs (2.75).

On May 26, 2010, the SEOW discussed the two priorities that had scored the highest in the process—prescription drug misuse and alcohol use. The

SEOW coordinator had reexamined the indicators comprising each score. Although consequence data were not found to be age related (e.g., no matter the age of the individual, drinking increased the likelihood of involvement in violent crime), findings from this examination for the alcohol score clearly illustrated that the consumption indicators that were above the national average were all youth related:

- Percent of students in grades 9–12 reporting any use of alcohol in the past 30 days
- Percent of students in grades 9-12 reporting having five or more drinks on at least one occasion in the past 30 days
- Percent of students in grades 9–12 who reported riding in a car driven by someone who had been drinking
- Percent of students in grades 9–12 who reported driving when they had been drinking.

As a result, the SEOW elected to focus on underage rather than adult drinking. The nonmedical use of prescription drugs—which scored nearly threefold higher than alcohol—also was chosen by the SEOW as a priority issue that should be addressed by Oklahoma through its SPF SIG.

On June 22, 2010, the SEOW coordinator briefly discussed the state's epidemiological data and the data prioritization process at a meeting of the OPLC. The OPLC, which acts as the state's SPF SIG Advisory Committee, is the state-level Collaborative established to promote the coordinated planning, implementation, and evaluation of quality prevention services for children, youth, and families at the state and local levels, with a particular focus on the prevention of mental, emotional, and behavioral health disorders, related problems (e.g., alcohol and other drug use), and contributing risk factors.

The OPLC's membership, as directed by the Oklahoma Secretary of Health and Commissioner of Mental Health and Substance Abuse Services, includes not only the representation CSAP requires of the SPF SIG advisory council,

but a range of prevention representatives from across sectors (e.g., injury prevention, child abuse prevention), as well as membership from the state PTA and tribal governments—specifically those concerned with behavioral health. The group represents a broad array of connected issues. Since the different problem areas (e.g., substance abuse, suicide, child abuse, etc.) share risk factors, collaboration between OPLC members offers significant potential for shared interventions. It is the OPLC's responsibility to determine whether there is an investment Oklahoma can make as a state to achieve population outcomes.

The responsibilities of the Council include, but are not limited to: identifying opportunities for coordination and collaboration on prevention initiatives serving the same populations, using common strategies, or aiming to achieve similar goals or outcomes; promoting the implementation of best practices for prevention at the state and local levels; and serving, as requested, in an advisory role on required state and Federal grant programs. Currently, the OPLC is focused on the SPF SIG funded by SAMHSA and administered by ODMHSAS. Collaborative members will advise on important decisions related to this cooperative agreement throughout the duration of the project.

Therefore, on July 13, 2010, a subgroup of the SEOW presented the workgroup's findings and recommendations to the OPLC. The SPF SIG project director, the SEOW coordinator, and the SPF SIG evaluator provided an overview of the entire SEOW prioritization process; Donald Baker, Ph.D., of the University of Oklahoma Anne and Henry Zarrow School of Social Work, presented the SEOW's findings on underage drinking; and Scott Schaeffer, R.Ph., of DABAT Oklahoma Poison Control Center, presented the SEOW's findings on nonmedical prescription drug use.

DESCRIPTION OF SPF SIG PRIORITIES

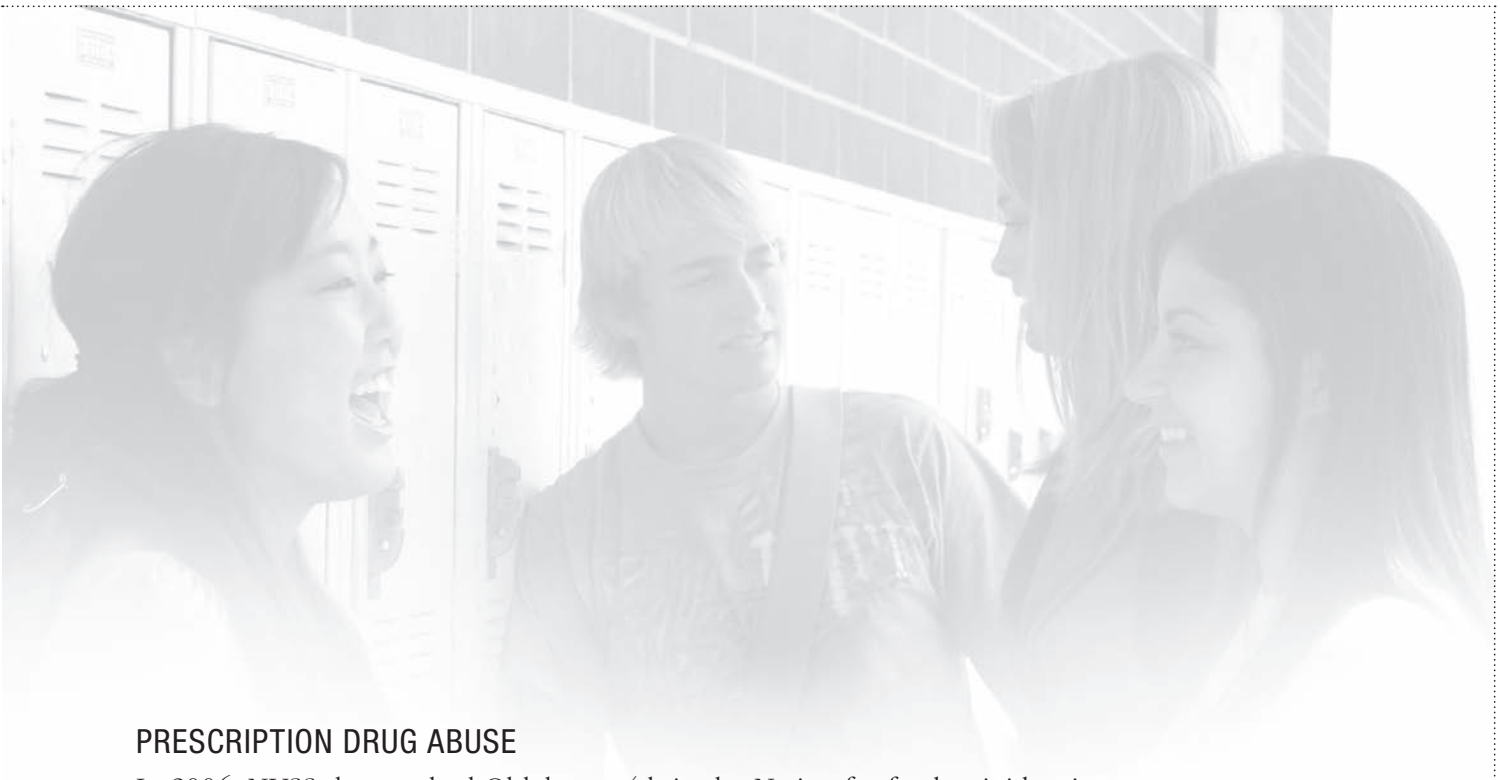
Based on the findings presented by the SEOW, the Collaborative endorsed that body's recommendations and selected two SPF SIG priorities: underage drinking and prescription drug abuse. Communities may choose one or

both of the two priorities based on their own local-level needs assessment performed during the first six months of funding using the same process by the SEOW.

UNDERAGE DRINKING

Oklahoma is consistently above the national average in alcohol-related mortality and crime. In 2009, 39.0 percent of students in grades 9–12 reported current alcohol consumption. That percentage is consistent with NSDUH's data for individuals 12 years and older who reported being a current drinker, which was 42.5 percent in 2007. Oklahoma's adolescent binge drinking also consistently exceeds the national average, with 2009 being the exception according to the YRBS. The SEOW was presented with additional information when examining the persistence of the problem with underage drinking. The YRBS showed that current alcohol use among 12th-grade students was over 45 percent for 2009. Although there has been a decline, nearly half of high school seniors are current drinkers, and over one-fourth of seniors reported binge drinking. In 2009, one quarter of 9th graders reported initiating alcohol use before age 13. Over one in five high school seniors had ridden in a car with someone who had been drinking, and 18.7 percent drove while drinking. Below are a sampling of possible indicators communities may choose using the same process that the SEOW undertook, based on their needs assessment findings:

- Past 30-day alcohol use
- Binge drinking in the past 30 days
- Age of first use of alcohol
- Riding in a car driven by someone who has been drinking
- Driving after drinking.



PRESCRIPTION DRUG ABUSE

In 2006, NVSS data ranked Oklahoma 4th in the Nation for fatal opioid poisonings, and in 2007, NSDUH data showed Oklahoma was 232 percent above the national average in consumption of painkillers for nonmedical use—a 22-percent increase since 2004. Oklahoma has experienced a 328-percent increase in opiate deaths since 1999. In 2006, Oklahoma's opiate-related death rate was 123 percent higher than the national average. Hospital data associated with opiates has shown a 91-percent increase since 2003 in opiate admissions.

Below is a partial list of possible indicators for prescription drug abuse communities may choose using the same process that the SEOW undertook, based on their needs assessment findings:

- Nonmedical use of prescription pain relievers in the past month
- Opioid overdose deaths
- Emergency room prescription drug abuse visits
- Hospital admissions for prescription drug abuse.

III. Capacity Building

AREAS NEEDING STRENGTHENING

While Oklahoma currently has an effective prevention system, there are areas that need strengthening. Primarily, the prevention system will benefit from gaining the ability to: 1) build and sustain coalitions, 2) enhance understanding of how to identify or adapt strategies for specific cultures, 3) increase the implementation of environmental strategies, and 4) build and sustain an evaluation system.

To identify areas for infrastructure improvement at both the state and community levels, ODMHSAS conducted an infrastructure needs assessment in July 2010. State and local agency leads, ODMHSAS staff, and community coalition members participated. Findings identified:

- Gaps in state and local partnerships,
- Workforce development needs, and
- The need for a comprehensive data warehouse with query capabilities.

Gaps in state and local partnerships included law enforcement, school boards, local education staff, universities, businesses, media, alcohol industry, health care providers, parents, and child care providers.

Workforce development needs included skills for coalition development and operations, engaging the community and reaching all sectors, strategic planning, using data for decision-making, evidence-based and environmental strategies, and sustainability planning.

STATE- AND COMMUNITY-LEVEL ACTIVITIES

Diverse capacity building activities are being considered and planned for both the state and local communities.

At the state level, Oklahoma government currently does not have a central location through which grant opportunities are filtered (e.g., suggesting which agencies should apply for specific funding opportunities as they be-

come available). The OPLC provides a potential venue for bringing together a broad group of prevention stakeholders to talk about how to blend funding, coordinate prevention services, discuss state priorities—where only agency priorities previously existed—without taking away from individual agency priorities, and come up with what the state can do to make a difference.

ODMHSAS staff or consultants trained in the SPF will be available to support the work and build the capacity of other state systems. Providing agencies this assistance through shared training opportunities and in-kind embedded SPF consultants could increase their buy-in to the process, making them more likely to infuse the SPF into their own work. If successful, this will create a common approach and language across systems.

In addition, other agencies are encouraged to use the SEOW as a tool to identify emerging issues and areas of need, including treatment. ODMHSAS has a strong connection with other workgroups that address suicide, tobacco, injury, maternal and child health, violence, and chronic disease; however, these groups are not regularly assessing need in common or coordinated ways at this time. By formally connecting these groups and allowing the SEOW to look at other areas (outside of substance abuse), the state will be helping the SEOW to build its capacity while also identifying meaningful opportunities for cross-sector coordination.

SPF SIG technical assistance and training will be provided to the APRCs by two state prevention field representatives, who also are responsible for monitoring the APRC contracts. These staff are trained preventionists, with a minimum of 5 years of direct prevention experience prior to their appointment as state field representatives.

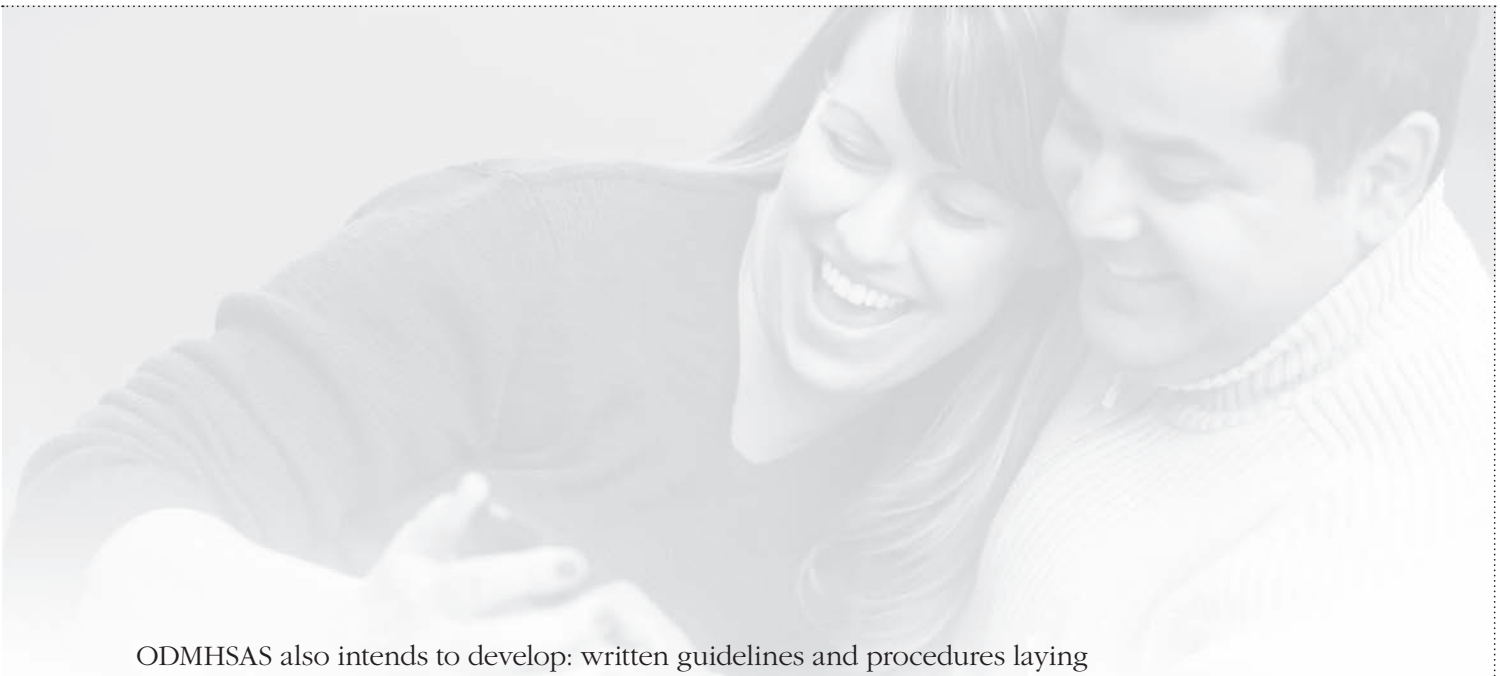
Training and technical assistance to community coalitions will be the responsibility of the APRCs. Through the SAPT Block Grant, the APRC staff are responsible for providing expert assistance to community coalitions and agencies. They are also trained and certified preventionists who are encour-

aged to implement strategies on behalf of the community, particularly if no coalition exists.

Oklahoma is going to use the Southwest Regional Expert Team (SWRET)—formerly the SW CAPT—for training and technical assistance needs for its SPF SIG efforts. The state will look outside for other sources if the SWRET is unable to provide technical assistance in an identified area, but only after confirming the lack of availability for such assistance through the SWRET.

The Oklahoma State Department of Health provides infrastructure support for Turning Point, a grassroots network of community coalitions throughout the state. The Turning Point coalitions are actively engaged in determining local-level public health needs and implementing solutions to improve community health. Many of Oklahoma's community coalitions currently partnered with APRCs and are implementing substance abuse prevention strategies. ODMHSAS and OSDH Turning Point have actively collaborated to coordinate efforts where possible. Increased collaboration will be necessary when rolling out the SPF SIG initiative as Oklahoma Turning Point also is continuing to make strides in building community capacity through public health planning frameworks similar to the SPF. ODMHSAS will include Turning Point regional staff in SPF staff meetings, coordinate SPF trainings at the state and community levels with Turning Point staff, and pursue agreements to streamline messaging and project requirements to avoid burdening coalitions potentially working on both SPF SIG and Turning Point projects.

ODMHSAS will convene an Evidence-Based Practices Workgroup consisting of at least five members, including local experts, community providers, state staff, and Advisory Council members. Although initially a SPF SIG-funded effort, Oklahoma plans to use the Workgroup to build its capacity in using evidence-based practices in all its mental, emotional, and behavioral health prevention initiatives.



ODMHSAS also intends to develop: written guidelines and procedures laying out principles and processes for the delivery of training and technical assistance from state staff to the APRCs and from the ARPCs to the coalitions/communities they serve; systems to assess/monitor the training and technical assistance needs of the APRCS and of coalitions; and processes for communities and the APRCs to request training and technical assistance.

ROLE OF THE SEOW

To assist the APRCs in developing their capacity to implement the SPF process, the SEOW coordinator's function will evolve as the SPF SIG initiative reaches the community-level to include a coaching role, providing technical assistance in needs assessment and data collection. Should the SEOW coordinator require support in this role, ODMHSAS will contract with additional resources to supply technical assistance to communities.

The SEOW also will review community workplans to ensure communities choose strategies that logically connect to their data, that the strategies they choose are evidence based, and that their plan's evaluation components test both their fidelity to process and the outcomes of the strategies they have chosen.

ODMHSAS will make the SEOW available as a tool for other state agencies, including treatment. It is the state's intention that the SEOW take on myriad issues related to—but outside the boundaries of—the state's identified priority issues (i.e., underage drinking and prescription drug abuse), looking at epi data not just for substance abuse, but also for mental, emotional, and behavioral disorders sharing contributing risk factors. In this role, the SEOW will both build its capacity and assist Oklahoma in its planning, implementation, and evaluation of quality prevention services for children, youth, and families at the state and local levels.

Each of the agencies represented on the SEOW brings with them all available data on the populations they serve. Despite this influx of data, the SEOW is still experiencing data gaps. To address these gaps, the SEOW has established a workgroup whose task it is to examine the lack of data at the State and sub-state for certain special populations, including Native Americans, veterans, older populations, and individuals with mental health issues, among others. The SEOW's work on gaps in the state's data across populations also will include the areas identified below.

Oklahoma Prevention Needs Assessment Survey (OPNAS)—Randomize, Weight, Disaggregate Racial Data, and Add Tribal Affiliation

Although the state will make the OPNAS available to all schools—so that any school choosing to participate may do so—the SEOW also will randomize and weight OPNAS data from a selected sample. Previously, the state has faced opposition to using these data beyond a community level; the OPNAS is a powerful instrument, and randomizing and weighting these data will help validate survey results, making them comparable across counties and therefore allowing them to be used in a greater capacity.

The SEOW may disaggregate data to classify "American Indian" as its own racial category within the OPNAS responses, and to further disaggregate these data by specific tribal affiliation. Oklahoma has the second-largest American

Indian population of any state, and having racial data for this group would be invaluable in developing culturally competent prevention programs, practices, and policies, and providing culturally appropriate and sensitive services to Native populations.

Combining existing school surveys—YRBS, OPNAS, and YTS.

Currently, Oklahoma administers the YRBS and the Youth Tobacco Survey (YTS) in schools in odd-numbered years, and the OPNAS in even-numbered years. Although the YTS and YRBS are administered in the same year, administration efforts are not combined. School participation is challenging as a result of increasing school burden. To decrease the burden on schools and increase the likelihood of participation in the state's school surveys, ODMHSAS plans to work with its SEOW to propose the coordination of the three surveys so that schools are solicited only once every 2 years instead of annually.

BRFSS Prescription Drugs and Illicit Drugs Modules

The BRFSS is a great source of alcohol and tobacco data, but currently does not collect data regarding illicit and prescription drug use. Its counterpart, the YRBS, does collect illicit drug information and in 2011 will collect prescription drug information. CSAP suggests using the BRFSS as a data source for indicators in alcohol and tobacco, but relies on the YRBS for data on specific drugs—yet the YRBS captures data only for high school students in grades 9–12. NSDUH captures data on illicit drugs, reporting all illicit drugs as a single category (not by individual drug, as is done by the YRBS), and also reports data on prescription drug use.

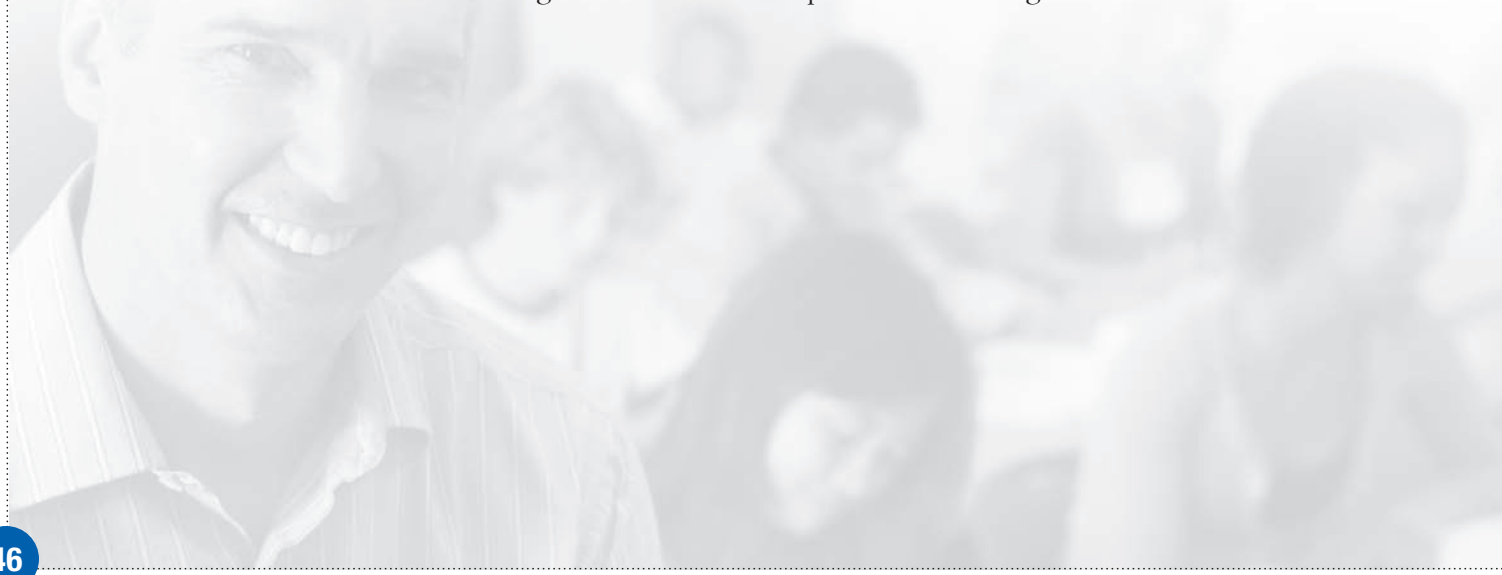
CSAP uses both the BRFSS and NSDUH to address indicators in alcohol and tobacco. Having both available for illicit drug use—and the BRFSS for specific drug use—would help further identify and address issues in the state.

College-Age Adult Data

Although the BRFSS includes college-aged individuals, participants are not selected based on college status, but as part of the population as a whole. The BRFSS is not designed to capture data on behaviors unique to college students that are important to understanding and serving this population. What is needed is a survey specific to college students, which collects data pertaining to alcohol, tobacco, and other drugs; attitudes toward substance use; and risk and protective factors affecting such use. Although some Oklahoma universities have conducted the CORE survey and/or the College Health Assessment in the past, the implementation of such surveys has been inconsistent. Through the SEOW, ODMHSAS plans to work with the state's colleges to collect data from this population on a regular basis, developing state and community competence in addressing the unique prevention needs of college students.

Low County Numbers

Oklahoma's rural nature is striking and challenging. Eighty-nine percent of cities in Oklahoma have fewer than 3,000 residents, and approximately one-half of Oklahoma's 77 counties have a population density of just 50 people per square mile. Valuable data obtained by national sources often are unstable or unreportable at such low population levels. Aggregation of data from multiple counties provides greater numbers and therefore greater stability; however, aggregated counties may have more differences than similarities. Addressing this issue will be a particular challenge for the SEOW.



Emergency Department Data

Data from overdose deaths do not properly capture the outcomes regarding substance abuse. Data from emergency departments would allow the SEOW to identify the broad and devastating health consequences associated with substance abuse.

Data Query System

Oklahoma's existing data system (ICIS) was created originally to address the National Outcome Measures (NOMs) identified for treatment, which focus on client-specific data collection. Although this system does not fit well with data collection for the population-based prevention NOMs, Oklahoma currently does not have an alternative for its prevention providers. To address this challenge, ODMHSAS will work with the University of Oklahoma College of Public Health—the state's Block Grant evaluator—to identify systems that would be more effective for collecting data relative to the prevention NOMs. A data query system that includes data collected from the OPNAS would be tremendously helpful to Oklahoma's providers, who rely heavily on the OPNAS to serve their communities and have expressed serious interest in acquiring a data query system to help with their efforts.

Prescription Drug Monitoring Program (PMP) Data

Currently, PMP data are housed within the Oklahoma Bureau of Narcotics and Dangerous Drugs. Legislation has placed significant restrictions on the ways this system may be accessed. In the course of understanding Oklahoma's issues with prescription drugs, this data source has been crucial, yet the SEOW's use of these data remains extremely limited, rendering critical data unavailable.

Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)

Research has shown that LGBTQ populations are at higher risks for certain substance abuse issues; however, data regarding these populations are unavailable in the state. Such data would prove valuable in understanding and addressing the needs of this population, and assisting communities and the state in developing culturally competent programs, practices, and policies.

IV. Planning

STATE PLANNING MODEL

The OPLC determined that no area was at higher risk than another for underage drinking, and that insufficient data were available to determine a "hotspot" for prescription drug abuse (and therefore justify selecting just one region for this priority issue).

FIGURE 11. ALCOHOL USE IN PAST MONTH AMONG PERSONS AGED 12 TO 20 IN OKLAHOMA, BY SUBSTATE REGION: PERCENTAGES, ANNUAL AVERAGES BASED ON 2006, 2007, AND 2008 NSDUHS

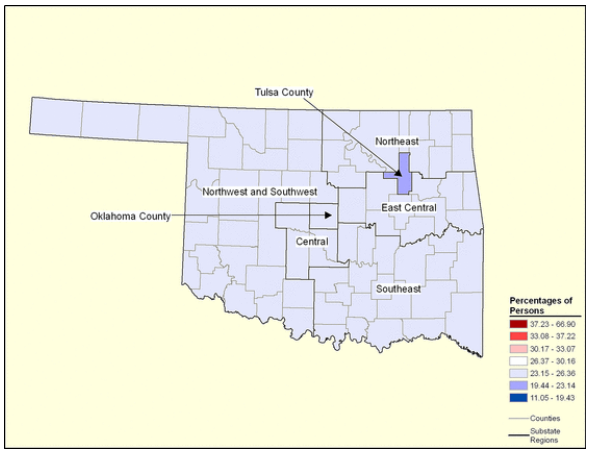


FIGURE 12. BINGE ALCOHOL USE IN PAST MONTH AMONG PERSONS AGED 12 TO 20 IN OKLAHOMA, BY SUBSTATE REGION: PERCENTAGES, ANNUAL AVERAGES BASED ON 2006, 2007, AND 2008 NSDUHS

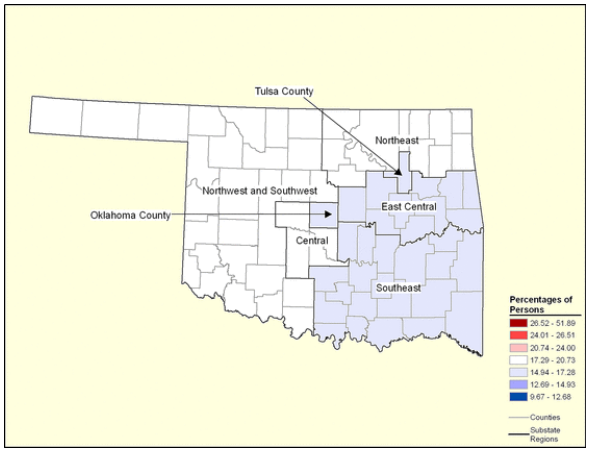
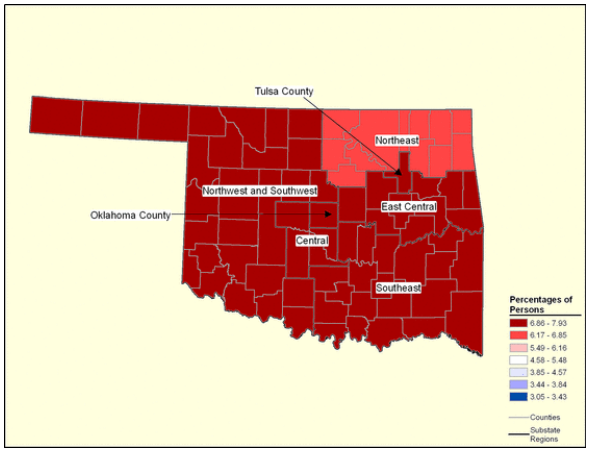


FIGURE 13. NONMEDICAL USE OF PAIN RELIEVERS IN PAST YEAR AMONG PERSONS AGED 12 OR OLDER IN OKLAHOMA, BY SUBSTATE REGION: PERCENTAGES, ANNUAL AVERAGES BASED ON 2006, 2007, AND 2008 NSDUHS



Therefore, Oklahoma is using a hybrid equity planning model, with allocation across the state based on both per capita and need. The model will allocate a baseline amount to each of the 17 APRCs for local needs and capacity assessment, prioritization, and plan development. Once the submitted plan is approved, the funding amount needed to implement that plan will be determined based on the strategies selected and population targeted.

There are a number of reasons that a statewide allocation through the APRC system makes sense. Since Oklahoma is primarily a rural state with only two large cities—Tulsa and Oklahoma City—the state will have adequate funds to make an impact on the prioritized issues statewide without sacrificing the prevention efforts in any region. In addition, by building capacity throughout the entire state, the SPF will be sustained well beyond the grant period.

The SPF SIG is an infrastructure cooperative agreement and the APRCs are the backbone of Oklahoma's prevention system. Therefore, ODMHSAS plans to use its SPF SIG to build the APRCs' capacity, with the intention of integrating the new infrastructure into the Block Grant when the SPF SIG has ended. Although the state plans to fund all 17 APRCs, because Cherokee

Nation—awarded its own SPF SIG in 2006—has saturated 2 of the regions (APRCs), ODMHSAS may give a larger share of the SPF SIG funding (after year 1) to the other 15.

The idea behind using an enhanced intervention site for prescription drug use comes from the literature (Stanford cardiac study) that suggests using a pilot site to test unproven (although theoretically promising) strategies for prescription drugs, not knowing whether or not those strategies will work. ODMHSAS plans to conduct a more intense evaluation of the enhanced site and compare the results to another site without the enhanced intervention. The purpose is to isolate an "experimental" strategy, try it in one community (the enhanced community), evaluate it, and then replicate it. This does not preclude other communities from choosing to focus on prescription drug abuse, but those sites will be limited to using the kinds of strategies currently used with alcohol and other drugs.

COMMUNITY-BASED ACTIVITIES

The APRCs are going to be required to conduct a thorough needs assessment at the regional level and will have to choose one or both of the state priorities and identify the priority community or communities with which they plan to work. Each APRC will be given the latitude to define community in its own way (e.g., county, city, etc.). The chosen community may or may not have an existing coalition, but if not, the APRC will be required to develop one. Different communities can be chosen by the same APRC, and different communities can have different priorities, even if they are chosen by the same APRC. If the APRC picks a community that has multiple coalitions, it will have to determine which of the coalitions the project will fit, recognizing that not all coalitions might want to engage as a SPF SIG-funded coalition. If Oklahoma identifies a hotspot in an area where a Drug-Free Community (DFC) coalition exists, the APRC will consider that coalition for funding, as it should any existing coalition in a designated hotspot.

To ensure that all SPF SIG funded interventions are evidence-based, ODMH-

SAS will convene an Evidence-Based Practices Workgroup, as mentioned previously. The Workgroup's role will be to utilize CSAP's guidance document and recommendations to clearly define criteria for Oklahoma to use when considering the implementation of certain prevention policies, practices, or programs. Oklahoma's Evidence-Based Practices Workgroup will consist of no fewer than five members representing local experts, community providers, state staff, and OPLC members. The Workgroup also will be responsible for reviewing community SPF SIG workplans and providing feedback and technical assistance to community providers and coalitions on the selection, potential adaptation, and fidelity of strategies that meet the defined evidence-based criteria.

ALLOCATION APPROACH

Oklahoma is using a hybrid equity model since statewide prevalence of underage drinking showed this need to be universal and insufficient data existed to justify choosing a hotspot for prescription drug abuse prevention. The state will fund each APRC directly.

The first year's funding will be divided equally among the 17 regions. First-year funding will be used to hire a full-time person in each region to work with the coalition, purchase equipment if needed (e.g., a computer), and to accommodate local travel (e.g., mileage).

APRCs are not expected to serve the entire region. Rather, each APRC will focus on the highest need at the community level as determined by the use of community-level data.

After the first year, the state will distribute money via a formula. Although this will be similar to what is used for the SAPT Block Grant (e.g., per capita, per region, with mileage for rural communities), the same formula will not be used because the SPF SIG communities chosen could be very different (e.g., a rural region could choose a high-population county and an urban area could choose a sparsely populated community). If needed, ODMHSAS

may also build in funding for lower capacity communities versus higher capacity communities.

Each community is expected to develop its own community action plan with support and guidance from the APRC. The plans must implement environmental strategies focused on population-level change.

IMPLICATIONS OF ALLOCATION APPROACH

Implications of the allocation approach include considering whether: 1) the smaller APRCs will be able to use as much money as they are allotted, 2) the larger metropolitan areas will receive adequate funds to complete the grant requirements, and 3) consumption and/or consequences can be reduced on

a state and local level. At the state level, ODMHSAS feels it is important each area receive enough money to build capacity so the APRCs are able to meet the requirements of the grant, but not so much so that there are funds left unspent. This consideration led to the selection of the allocation formula described above, which takes into account both per capita and need. By funding all APRCs, the entire state system is exposed to the approach, which provides the reasonable expectation for change on both the state and local levels.

As noted above, the Cherokee Nation of Oklahoma was previously awarded a SPF SIG cooperative agreement. Cherokee Nation funded a number of hub communities that conducted local-level needs assessments, selecting as priority issues underage drinking, prescription drugs, adult alcohol misuse, and methamphetamine use. The Tribal Jurisdictional Service Area (TJSA) is comprised of parts or all of 14 counties in northeastern Oklahoma. The same 14 counties in the TJSA are served by 4 APRCs. ODMHSAS has worked closely with Cherokee Nation at the state/tribal government and local levels to coordinate training, services, and community coalitions among and between service providers.

V. Implementation

TRAINING AND TECHNICAL ASSISTANCE SYSTEM

ODMHSAS has committed to the development and implementation of a workforce assessment survey. This survey will be conducted annually, statewide, and not confined to SPF SIG subrecipients.

In addition, the state field representatives will be aware of any training and technical assistance needed at the regional and community levels through their daily work with the APRCs. Although all communities will follow the five-step SPF process, individual communities may have unique strengths or areas for enhancements. The state field representatives will bring these needs forward in weekly meetings with ODMHSAS's Prevention Program Manager.

TRAINING PROCEDURES

Oklahoma's SPF SIG evaluator conducted statewide face-to-face interviews with state agency staff, community agencies and officials (e.g., mayors, tribal leaders), and community coalitions to identify skill development needs for the prevention workforce at both the state and community levels. At the state level, staff identified the need for a structured, graduated approach to prevention training (i.e., taking into account the training needs of both new and existing staff), as well as training in management and leadership skills, ways to merge government and faith community efforts, and methods for supporting common target populations (e.g., children, families, communities) through multiagency collaborative efforts. At the local level, coalitions/communities identified the need for assistance in conducting coalition operations; strategic planning; understanding data and evaluation; effectively using data for decision-making; understanding evidence-based strategies; grant writing; developing strategies for engaging community members, for changing norms, and for reaching all sectors of the community; and planning for sustainability.

Oklahoma will require a minimum of one onsite review annually, during which technical assistance needs for each community will be identified.

Findings from all of these approaches will be used to identify and provide trainings throughout the state. All of the SPF SIG training opportunities will be disseminated widely and open to tribes and other agency providers.

ODMHSAS is not going to fund coalitions directly. To avoid duplication of efforts, the state is using its existing system of APRCs, which already work with coalitions in their regions. Working from their knowledge of each community, the APRCs are aware of what programming and strategies are already in place. It is Oklahoma's goal that each of the communities use the SPF five-step process to identify needs, current strategies addressing those needs, and new and appropriate strategies to augment those already being used.

VI. Evaluation

SURVEILLANCE, MONITORING, AND EVALUATION ACTIVITIES

At the state level, ODMHSAS has identified Bach Harrison, L.L.C., as the Project Evaluator.

PROCESS EVALUATION

Oklahoma's SPF SIG evaluator will assess project implementation and overall state- and community-level progress using select process evaluation measures. Process information will be gathered through a variety of methods at both the state and community levels, including a review of existing documents and materials (e.g., the state and community SEOW data profiles and strategic plans, minutes from project meetings), participation and observations at project meetings, and interviews with project stakeholders.

OUTCOME EVALUATION

Oklahoma's evaluator also will assess outcomes at the state and community levels in two overarching areas: (1) prevention capacity, and (2) priority substance abuse problems.

To assess prevention capacity, Bach-Harrison will primarily use the stakeholder interviews (with state-level project members and community coalition members) discussed above to document changes in prevention infrastructure and capacity at the state and community levels (including coalitions' and member agencies' capacities). The interviews will be organized around the SPF steps and will place a particular emphasis on documenting and assessing project capacity-building activities and enhancements that correspond to the five steps (e.g., improvements in needs assessment and strategic planning capacities).

To assess the project's progress on preventing and reducing underage drinking and prescription drug abuse, Bach-Harrison will collect survey data annually and acquire archival data on an ongoing basis from a variety of state sources and publicly available national sources.

In addition to assessing changes in the priority outcomes, Oklahoma's SPF SIG evaluator will examine the intervening variables (causal factors) associated with these ultimate outcomes. The survey and archival data also will be sources of data for intervening variables.

TRACKING

The state's evaluator will track both process and outcome data. Process data will include demographics of the population served, number and type of strategies implemented, implementation of the SPF steps, facilitators of and barriers to project progress, and contextual factors that may affect project progress and outcomes. The SPF SIG evaluator will use ODMHSAS's system, ICIS, to collect process data. Oklahoma has used ICIS as its local reporting and monitoring system for the SAPT Block Grant and has satisfied all Federal reporting requirements without issue. As part of the cross-site evaluation, data will also be collected through the GLI, CLI, and fidelity instruments.

Outcome data for underage drinking will include past 30-day alcohol use, binge drinking in the past 30 days, age of first use of alcohol, riding in a car driven by someone who has been drinking, and driving after drinking. Outcome data for prescription drug abuse will include nonmedical use of prescription pain relievers in the past month, opioid overdose deaths, emergency room prescription drug abuse visits, and hospital admissions for prescription drug abuse.

EXPECTED CHANGE

Bach-Harrison will examine state and community measures to determine if the SPF SIG initiative is linked to an increase in prevention capacity and lower levels of underage drinking, prescription drug abuse, and targeted intervening variables. Due to the concentration of SPF resources in the selected communities, Oklahoma's evaluator anticipates that SPF effects on community-level outcomes will be more pronounced than state-level outcomes.

NOMS COLLECTION AND SUBMISSION

The state's evaluator will use ICIS to collect required NOMs, such as the number of persons served by age, gender, race, and ethnicity, and total number of evidence-based programs, policies, and practices. The evaluator will submit the data electronically twice a year through the CSAP Data Coordination and Consolidation Center Services Accountability and Monitoring System (DCCC-CSAMS).

VII. Cross-Cutting Components and Challenges

CULTURAL COMPETENCE

In their workplans, the APRCs will be required to indicate how they will be culturally competent, and to demonstrate inclusion of the coalitions with which they work. Evidence-based practices workgroup members will be responsible for confirming that the strategies match the community they expect to serve, identifying the modifications that can be made, and determining whether those are appropriate for the targeted population. Environmental approaches are more difficult to adapt and ensure they are culturally competent. ODMHSAS's tribal liaison—who is also the Systems of Care Cultural Competency Advisor—is written in-kind in SPF SIG to serve as the cultural competence advisor to the SPF.

The state does intend to contract for cultural competence training to the APRCs. ODMHSAS will purchase or examine tools for providers to help with their development in this area. One example already in use is Culture Vision, a Web-based tool for health care that advises providers on the backgrounds of different populations and general expectations for the different cultures in terms of health. Oklahoma will look into the viability of adding a prevention module to Culture Vision, and perhaps may be able to add individual tribes to the tool as well, since Oklahoma is home to 45 distinct tribes.

SUSTAINABILITY

Oklahoma's SAPT Block Grant is on a 5-year funding cycle. ODMHSAS is considering logistical revisions to its contracting methods that would help align the SPF SIG and the Block Grant, keeping the initiative within the same agency throughout the duration of the project. The review committee, which includes the SEOW, will review all bids, and annually or semiannually review community workplans, involving more experts in the process. The experts will be responsible for providing the technical assistance needed to develop the workplans (e.g., SEOW members will provide technical assistance on data collection and analysis).

Combining Block Grant and SPF SIG efforts will include, eventually, fully integrating the contracting and SPF processes, and ultimately aligning all prevention efforts with the SPF. The SPF will guide the approval of state and community strategies, with the review of community workplans asking: Is the strategy sustainable? How will it be sustained? If communities have to develop coalitions, how are the coalitions going to be sustained?

The state infrastructure assessment identified areas where Oklahoma will be making improvements for the long term. Because the state is able to budget the Block Grant for a longer time (than the SPF SIG), ODMHSAS will fund only those SPF initiatives that reasonably can be sustained by the Block Grant once the SPF SIG funding has ended.

Every community action plan will be required to include both an evaluation and a sustainability plan. Communities will receive training on these elements.

The state purposely developed both its SEOW and the OPLC to continue after the SPF SIG initiatives have been completed. As stated earlier, the OPLC was established to promote the coordinated planning, implementation, and evaluation of quality prevention services for children, youth, and families at the state and local levels. As the state's focus intensifies on mental, emotional, and behavioral health disorders as related problems, this council will broaden its focus on state prevention priorities and coordination among state agencies on prevention services. The same is true for the SEOW, which will continue to collect and analyze relevant state, tribal, and local data to guide substance use prevention planning, programming, and evaluation, but will be available to work on any mental, emotional, or behavioral disorder issue.

CHALLENGES

Needs-based Allocation

Oklahoma's data are not sufficient to justify on the allocation of funds on purely a needs-based process. As mentioned previously, underage drinking is prevalent statewide, and insufficient data are available to determine particular hotspots for the nonmedical use of prescription drugs. Communities wishing to address the latter issues will likely face some challenges concerning data. The literature on prescription drug use is limited, which will challenge communities to come up with strategies. A lot of data sources that include prescription drugs combine all drugs for singular reporting, rather than reporting on prescription drugs as a single class.

The state will have two cycles of prescription drug use data. OPNA collected prescription drug data in 2010 and YRBS will provide prescription drug use data in 2011. Communities currently have local-level comparison data from the OPNA that is unavailable at the state level.

Through its proposed enhanced intervention community, Oklahoma hopes to add prescription drug abuse prevention strategies to the Federal registry of effective and promising practices. If sufficient data surfaces from evaluation of the enhanced community demonstrating positive outcomes, those strategies may be considered for service-to-science submission.

Implementation of Plan

During the most recent Block Grant bidding cycle, Oklahoma designed a workplan template that aligns with the SPF, so the APRCs already are familiar with the process. The APRCs also are preventionists who can implement strategies if need be, in addition to providing technical assistance to coalitions. Under the upcoming bid, the state will hold the APRCs accountable for building organizational capacity within coalitions. This will be a challenge for the APRCs on two levels: many of the state's coalitions may not yet have the capacity to implement the SPF, and not all coalitions may want to engage in the SPF process.

One final challenge ODMHSAS expects to encounter in the planning process is communities' desire to jump straight to strategies after identifying their priority issues. Oklahoma communities understand why identifying priorities is necessary, but continue to require assistance to understand the importance of identifying intervening variables and targeting strategies to these risk or causal factors to have an impact on their identified problem behaviors.

Appendices

OPLC MEMBERSHIP

Member/Delegate Name	Affiliation
Secretary Terri White	Office of Governor
Pending Appointment	Senate Member
Representative Mark McCullough	House of Representatives Member
Steve Buck	Department of Mental Health & Substance Abuse Services
Kevin Ward	Department of Public Safety/Highway Safety Office
Dr. Lynn Mitchell	State Department of Health
Howard Hendrick	Department of Human Services
Michael Fogarty	Health Care Authority
Darrell Weaver	Oklahoma Bureau of Narcotics
Sandy Garrett	Oklahoma Department of Education
Lisa Smith	Oklahoma Commission on Children and Youth
Linda Terrell	Oklahoma Institute for Child Advocacy
Lt. Kerri Keck	Oklahoma National Guard
Stacy Potter	Community-level Prevention Provider
Dr. BJ Boyd	Tribal Behavioral Health
Jane Goble-Clark	Prevention Advisor
Sheila Groves	State PTA
Stacey Puckett	Oklahoma Chiefs of Police Association
Chancellor Glen Johnson	Higher Education
Robert E. Gene Christian	Office of Juvenile Affairs
Robin Jones	Office of Faith-Based Initiatives
Dr. Don Baker	Prevention Researcher

SEOW MEMBERSHIP

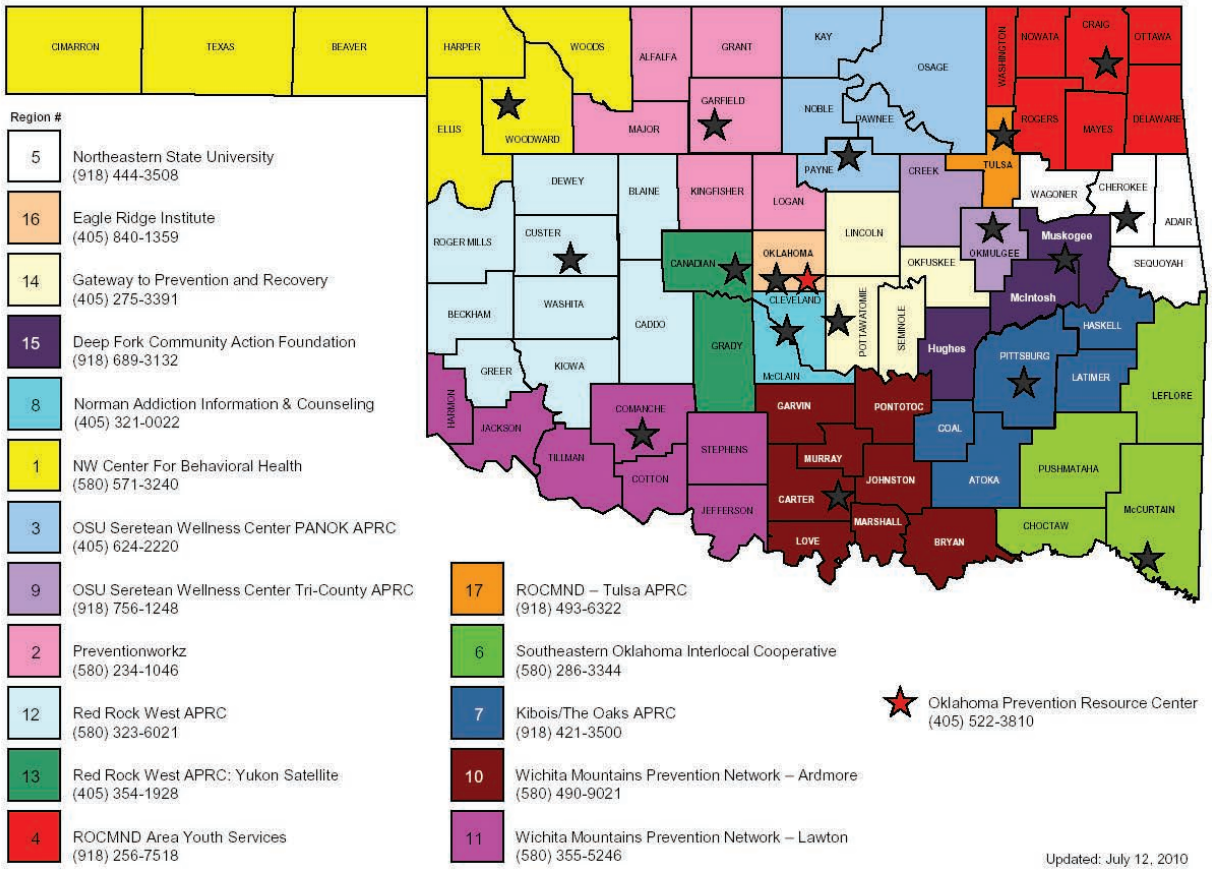
Member/Delegate Name	Affiliation
Anthony Kibble	Oklahoma Commission on Children and Youth
Leslie Ballinger	Southwest Regional Expert Team—Epidemiology Consultant
Cortney Yarholar	Oklahoma Department of Mental Health and Substance Abuse Services—Transformation Agency/Tribal Liaison
Connie Schlittler	Oklahoma Department of Human Services
David Wright	Oklahoma Department of Mental Health and Substance Abuse Services—Decision Support Services
Courtney Charish	Oklahoma Department of Corrections—Statistical Analyst
Stacey Puckett	Oklahoma Association of Police Chiefs
Dr. Misty Boyd	Cherokee Nation Behavioral Health Services
Patti Shook	Osage Nation Prevention Program
Captain Rusty Rhoades	Oklahoma Highway Patrol/Department of Public Safety
Derek Pate	Oklahoma State Department of Health—Health Care Information
Donald Baker	University of Oklahoma, Anne and Henry Zarrow School of Social Work—Director
Dough Matheny	Oklahoma State Department of Health, Department Tobacco Prevention Service—Chief
Dr. J.C. Smith	Oklahoma State Department of Education
Dr. Lee McGoodwin	Oklahoma Poison Control Center—Managing Director
Erin Meyer	Oklahoma Health Care Authority
Jamie Piatt	Oklahoma Department of Mental Health and Substance Abuse Services—Epidemiologist/SEOW Coordinator
Jessica Hawkins	Oklahoma Department of Mental Health and Substance Abuse Services—Prevention Services Director

SEOW MEMBERSHIP
(continued)

Member/Delegate Name	Affiliation
Young Onuorah	Oklahoma Department of Mental Health and Substance Abuse Services—Prevention Program Manager
Joyce Morris	Oklahoma State Department of Health Tobacco Use Prevention—State Assessment Coordinator
Scott Schaeffer	University of Oklahoma Health Sciences Center
John Hudgens	Oklahoma Department of Mental Health and Substance Abuse Services—Innovation Center Director
Sydney Martinez	Oklahoma Tribal Epidemiology Center
Captain Chin U Kim	Oklahoma Air National Guard—Drug Demand Reduction Administrator
Lisa Barnes	Wichita Mountain Prevention Network—Executive Director
Liz Langthorn	Oklahoma Department of Health—Injury Prevention
Dr. Barbara Masters	Oklahoma Veterans Affairs
Patty Martin	Bach Harrison LLC—Project Evaluator
Rashi Shukla	University of Central Oklahoma—Department of Sociology
Scott Schaeffer	Oklahoma Poison Control Center—Assistant Managing Director
Shannon Rios	Oklahoma Department of Human Services—Research Manager
Sheryll Brown	Oklahoma State Department of Health—Director of Violence Prevention Programs
Don Vogt	Oklahoma Bureau of Narcotics
Stephanie U'Ren	Oklahoma Department of Mental Health and Substance Abuse Services—Community Partnership Manager
Samuel McClendon	Oklahoma Department of Mental Health and Substance Abuse Services—Prevention Field Representative
Joy Hermansen	Oklahoma Department of Mental Health and Substance Abuse Services—Prevention Field Representative

REGIONAL NETWORK MAP

Area Prevention Resource Centers



EPIDEMIOLOGICAL DATA SOURCES

Alcohol Epidemiologic Data System (AEDS)

AEDS is responsible for maintaining, and extending an alcohol-related epidemiologic databank. AEDS also compiles the Alcohol Epidemiologic Data Directory which is a current listing of surveys and other relevant data suitable for epidemiologic research on alcohol.

Behavioral Risk Factor Surveillance Survey (BRFSS)

Established in 1984 by the Centers for Disease Control and Prevention (CDC), the Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors. Oklahoma has participated in BRFSS since 1995. This report focused on 2007 BRFSS data to give a current picture of substance use/abuse in Oklahoma. http://www.cdc.gov/brfss/about.htm

Bureau of Justice

The Bureau of Justice Statistics was first established on December 27, 1979 under the Justice Systems Improvement Act of 1979. The Bureau of Justice Statistics (BJS) is a component of the Office of Justice Programs in the U.S. Department of Justice.

Center for Disease Control and Prevention (CDC)

The CDC, a part of the U.S. Department of Health and Human Services, is the primary Federal agency for conducting and supporting public health activities in the United States. CDC's focus is not only on scientific excellence but also on the essential spirit that is CDC – to protect the health of all people. CDC keeps humanity at the forefront of its mission to ensure health protection through promotion, prevention, and preparedness.

Fatal Analysis Reporting System (FARS)

FARS contains data on all fatal traffic crashes within the 50 states, the District of Columbia, and Puerto Rico. The data system was conceived, designed, and developed by the National Center for Statistics and Analysis (NCSA) to assist the traffic safety community in identifying traffic safety problems, developing and implementing vehicle and driver countermeasures, and evaluating motor vehicle safety standards and highway safety initiatives.

National Survey on Drug Use and Health (NSDUH)

The National Survey on Drug Use and Health (NSDUH) provides annual data on drug use in the United States. The NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service and a part of the Department of Health and Human Services (DHHS). The survey provides yearly national and state-level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use. Other health-related questions also appear from year to year, including questions about mental health. The NSDUH findings were used to evaluate substance use/abuse from the age of 12. This survey is not a school based survey so it provides a different perspective than the YRBS for youth. https://nsduhweb.rti.org

National Vital Statistics System (NVSS)

The National Vital Statistics System is the oldest and most successful example of inter-governmental data sharing in Public Health and the shared relationships, standards, and procedures form the mechanism by which NCHS collects and disseminates the Nation's official vital statistics. These data are provided through contracts between NCHS and vital registration systems operated in the various jurisdictions legally responsible for the registration of vital events – births, deaths, marriages, divorces, and fetal deaths.

Oklahoma Bureau of Narcotics and Dangerous Drugs (OBN)

The Oklahoma State Bureau of Narcotics and Dangerous Drugs Control is a law enforcement agency with a goal of minimizing the abuse of controlled substances through law enforcement measures directed primarily at drug trafficking, illicit drug manufacturing, and major suppliers of illicit drugs.

Oklahoma Department of Corrections (ODOC)

Following the enacting of the Oklahoma Corrections Act of 1967, the new Department of Corrections was created on July 1, 1967. The ODOC is a network of facilities comprised of 17 institutions, seven Community Corrections Centers, and 15 Community Work Centers. The incarcerated women data was obtained from the ODOC.

Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)

The ODMHSAS was established in 1953 and continues to evolve to meet the needs of all Oklahomans. Collaborating with leaders from multiple state agencies, advocacy organizations, consumers and family members, providers, community leaders and elected officials, the way has been paved for meaningful mental health and substance abuse services transformation in Oklahoma. The ODMHSAS is responsible for providing services to Oklahomans who are affected by mental illness and substance abuse.

Oklahoma Prevention Needs Assessment Survey (OPNA)

The Oklahoma Prevention Needs Assessment is a paper/pencil survey administered in opposite years of the YRBS in schools to 6th, 8th, 10th and 12th grade students. The survey is designed to assess students' involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors. In 2008, 60,720 students were surveyed from 686 schools across 74 of Oklahoma's 77 counties.* The major limitation of this survey is that it is not a random sample; schools choose whether or not they participate, making it a convenience sample.

Oklahoma State Bureau of Investigation (OSBI)

The Oklahoma State Bureau of Investigation Uniform Crime Reporting (UCR) Program is part of a nationwide, cooperative statistical effort.

Oklahoma State Department of Health (OSDH)

The OSDH is a department of the government of Oklahoma responsible for protecting the health of all Oklahomans and providing other essential human services and through its system of local health services delivery, is ultimately responsible for protecting and improving the public's health status through strategies that focus on preventing disease. The OSDH serves as the primary public health protection agency in the state.

Oklahoma Tax Commission

Since 1931, the Oklahoma Tax Commission has held the responsibility of the collection and administration of taxes, licenses and fees that impact every Oklahoman. Under the direction of the state legislature, the Tax Commission manages not only the collection of taxes and fees, but also the distribution and apportionment of revenues to various state funds. The collected revenues fuel such state projects as education, transportation, recreation, social welfare and a myriad of other services.

Oklahoma Violent Death Reporting System (OKVDRS)

Oklahoma and 16 other states (Massachusetts, Maryland, New Jersey, Oregon, South Carolina, North Carolina, Virginia, Alaska, Colorado, Georgia, Wisconsin, Rhode Island, Kentucky, Utah, New Mexico and California) participate in the National Violent Death Reporting System. Violent deaths include homicides, suicides, deaths from legal intervention, unintentional firearm deaths, deaths of undetermined manner and deaths from acts of terrorism. Data for OKVDRS are collected from death certificates, medical examiner reports, police reports, supplemental homicide reports and crime labs. Standardized methodology and coding are used to collect the data and enter into a database that is housed at the Oklahoma State Department of Health (OSDH). The OSDH partners with the Oklahoma State Bureau of Investigation and the Oklahoma Medical Examiner's Office to collect the data.

Oklahoma Youth Tobacco Survey (OYTS)

Designed to provide comprehensive data for planning and evaluating progress toward reducing tobacco use among youth. Items measured as part of the OYTS survey include correlates of tobacco use such as demographics, minors' access to tobacco, and exposure to secondhand smoke. It provides data representative of Oklahoma middle school and high school youth's tobacco-related beliefs, attitudes and behaviors, and exposure to pro- and anti-tobacco influences such as curricula and media. The data can be compared to results from the National Youth Tobacco Survey and results from other states.

Pacific Institute for Research and Evaluation (PIRE)

PIRE is one of the Nation's preeminent independent, nonprofit organizations focusing on individual and social problems associated with the use of alcohol and other drugs. PIRE is dedicated to merging scientific knowledge and proven practice to create solutions that improve the health, safety, and well-being of individuals, communities, nations, and the world.

Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS was initiated in 1987 with a goal to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health.

Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC)

SAMMEC is an internet-based, computational application. SAMMEC calculates annual state- and national-level smoking-attributable deaths and years of potential life lost for adults and infants in the United States. The Adult application also calculates medical expenditures and productivity costs among adults. Likewise, Maternal and Child Health (MCH) SAMMEC estimates annual state- and national-level smoking-attributable deaths and years of potential life lost for infants.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (HHS), focuses attention, programs and funding on promoting a life in the community with jobs, homes and meaningful relationships with family and friends for people with or at risk for mental or substance use disorders. The Agency is achieving that vision through an action-oriented, measurable mission of building resilience and facilitating recovery.

The Uniform Crime Report (UCR)

The UCR was conceived, developed, and implemented by law enforcement for the express purpose of serving as a tool for operational and administrative purposes. Under the auspices of the International Association of Chiefs of Police, the UCR Program was developed in 1930. Prior to that date, no comprehensive system of crime information on a national scale existed. The Oklahoma State Bureau of Investigation assumed the statewide administration of the UCR Program on September 1, 1973. Statistical information was collected and compiled through the year 2007 with a comparative analysis of the years 2006 and 2005.

United States Census Bureau

The Census Bureau serves as the leading source of quality data about the Nation's people and economy. The bureau of the Commerce Department, responsible for taking the census, provides demographic information and analyses about the population of the United States. Census data was used for all Oklahoma demographics. http://www.census.gov/main/www/aboutus.html

Youth Risk Factor Behavioral Survey (YRBS)

The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health-risk behaviors among youth and young adults, including behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infections; unhealthy dietary behaviors; and physical inactivity. YRBSS includes a national school-based survey conducted by CDC and state and local school-based surveys conducted by state and local education and health agencies. Oklahoma has participated in the YRBS since 2003.

TIMELINES AND MILESTONES

Activity	Date	Agency Responsible
RFP released	January 2011	ODMHSAS
Proposals submitted	February 2011	APRC
Proposals reviewed and approved	February 2011	ODMHSAS
Awards made	March 2011	ODMHSAS
Start date	April 1, 2011	APRC
Subrecipient staff hired	May 1, 2011	APRC
Technical assistance on developing a workplan using the SPF model	May–November 2011	ODMHSAS
Workplans developed	May–November 2011	APRC
Workplans submitted	November 30, 2011	APRC
Workplans reviewed and approved	December 31, 2011	ODMHSAS
Implementation start date	January 1, 2012	APRC

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ALCOHOL CONSUMPTION

CONSTRUCT	MEASURE	SOURCE		YEAR 2003	2004	2005	2006	2007	2008
Current Use	Percentage of persons aged 12 and older reporting any use of alcohol in the past 30 days	NSDUH	OK	42.9	42.6	42.4	41.9	42.5	
			Nation	50.1	50.3	51.8	50.9	51.1	51.6
		Ratio		0.9	0.9	0.8	0.8	0.8	
	Percent of students in grades 9-12 reporting any use of alcohol in the past 30 days	YRBS	OK	47.8		40.5		43.1	
			Nation	44.9		43.3		44.7	
		Ratio		1.1		0.9		1.0	
	Percent of persons aged 18 and over reporting any use of alcohol in the past 30 days	BRFSS	OK	43.4	43.0	42.3	41.7	40.9	41.5
			Nation	59.4	57.1	56.2	55.4	54.8	54.4
		Ratio		0.7	0.8	0.8	0.8	0.7	0.8
Current Binge Drinking	Percent of persons aged 12 and older reporting having five or more drinks on at least one occasion in the past 30 days	NSDUH	OK	19.0	20.7	21.4	21.4	21.2	
			Nation	22.6	22.8	22.7	23.0	23.3	23.3
		Ratio		0.8	0.9	0.9	0.9	0.9	
	Percent of students in grades 9-12 reporting having five or more drinks on at least one occasion in the past 30 days	YRBS	OK	34.0		26.6		27.9	
			Nation	28.3		25.5		26.0	
		Ratio		1.2		1.0		1.1	
	Percent of persons aged 18 and older reporting having five or more drinks on at least one occasion in the past 30 days	BRFSS	OK	13.3	13.0	12.6	13.4	12.4	12.2
			Nation	16.5	15.1	14.4	15.4	15.8	15.6
		Ratio		0.8	0.9	0.9	0.9	0.8	0.8
HEAVY DRINKING	Percent of adults aged 18 and older reporting average daily alcohol consumption greater than 2 drinks (male) or greater than 1 drink (female) per day	BRFSS	OK	4.2	3.7	3.1	3.6	3.5	2.9
			Nation	5.8	4.9	4.9	4.9	5.2	5.1
		Ratio		0.7	0.8	0.6	0.7	0.7	0.6
AGE OF INITIAL USE	Percent of students in grades 9-12 who reported first using alcohol before age 13	YRBS	OK	26.8		25.2		23.3	
			Nation	27.8		25.6		23.8	
		Ratio		1.0		1.0		1.0	
DRINKING AND DRIVING	Percent of students in grades 9-12 who reported riding in a car driven by someone who had been drinking	YRBS	OK	30.6		25.8		26.8	
			Nation	30.2		28.5		29.1	
		Ratio		1.0		0.9		0.9	
	Percent of students in grades 9-12 who reported driving when they had been drinking	YRBS	OK	17.5		12.3		13.3	
			Nation	12.1		9.9		10.5	
		Ratio		1.4		1.2		1.3	
ALCOHOL USE DURING PREGNANCY	Alcohol use by pregnant women during last 3 months of pregnancy	PRAMS	OK	2.5	5.2	3.3	4.8	4.8	
APPARENT PER CAPITA ETHANOL CONSUMPTION	Total sales of ethanol (as estimated in gallons) in beer, wine, and spirits, per capita aged 14 and over	AEDS	OK	1.9	1.5	1.5	1.5	1.9	
			Nation	2.2	2.2	2.2	2.3	2.3	
		Rate Ratio		0.9	0.7	0.7	0.7	0.8	

ALCOHOL CONSEQUENCE

CONSTRUCT	MEASURE	SOURCE		YEAR 2003	2004	2005	2006	2007	2008
ALCOHOL-RELATED MORTALITY	Rate per 100,000 population of deaths from chronic liver disease	NVSS	OK	9.4	10.3	11.3	12.4		
			Nation	9.3	9.0	9.0	9.2		
		Ratio		1.0	1.1	1.3	1.3		
	Rate per 100,000 population of deaths from suicide	NVSS	OK	13.6	14.4	14.7	15.0		
			Nation	10.8	11.0	10.9	10.9		
		Ratio		1.3	1.3	1.3	1.4		
	Rate per 100,000 population of deaths from homicide	NVSS	OK	6.4	6.3	6.1	6.3		
			Nation	6.1	5.9	6.0	6.2		
		Ratio		1.0	1.1	1.0	1.0		
MOTOR VEHICLE CRASHES	Percentage of fatal crashes with an alcohol-impaired driver	FARS	OK	31.3	29.1	29.3	28.0	29.0	31.6
			Nation	30.3	30.4	31.1	31.4	31.5	31.4
		Ratio		1.0	1.0	0.9	0.9	0.9	1.0
CRIME	Number of violent crimes (aggravated assaults, sexual assaults, and robberies) reported to police per 100,000 population	UCR	OK			508.6	497.4	499.6	526.7
			Nation			469.0	473.6	466.9	454.5
		Ratio				1.1	1.1	1.1	1.2
DEPENDENCE OR ABUSE	Percent of persons aged 12 and older meeting DSM-IV criteria for alcohol abuse or dependence	NSDUH	OK	6.9	7.4	7.9	7.4	6.9	
			Nation	7.5	7.8	7.7	7.6	7.5	
		Ratio		0.9	0.9	1.0	1.0	0.9	

ILLICIT DRUG CONSUMPTION

CONSTRUCT	MEASURE	SOURCE		YEAR 2003	2004	2005	2006	2007	2008	2009
Current Use	Percent of persons aged 12 and older reporting any use of marijuana in the past 30 days	NSDUH	OK		5.6	5.2	5.3	5.2		
			Nation	6.2	6.1	6.0	6.0	5.8	6.1	
		Ratio			0.9	0.9	0.9	0.9		
	Percent of students in grades 9-12 reporting any use of marijuana in the past 30 days	YRBS	OK	22.0		18.7		15.9		17.2
			Nation	22.4		20.2		19.7		20.8
		Ratio		1.0		0.9		0.8		0.8
	Percent of persons aged 12 and older reporting use of any illicit drug other than marijuana in the past 30 days	NSDUH	OK		4.1	4.0	4.0	4.6		
			Nation	3.7	3.4	3.7	3.9	3.7	3.4	
		Ratio			1.2	1.1	1.0	1.2		
	Percent of students in grades 9-12 reporting the use of any form of cocaine in the past 30 days	YRBS	OK	3.4		2.6		3.0		2.3
			Nation	4.1		3.4		3.3		2.8
		Ratio		0.8		0.8		0.9		0.8
LIFETIME USE	Percent of students in grades 9-12 reporting any use of marijuana in their lifetime	YRBS	OK	42.5		39.3		33.2		31.9
			Nation	40.2		38.4		38.1		36.8
		Ratio		1.1		1.0		0.9		0.9
	Percent of students in grades 9-12 who reported the use of any form of cocaine in their lifetime	YRBS	OK	9.2		8.7		7.3		7.4
			Nation	8.7		7.6		7.2		6.4
		Ratio		1.1		1.1		1.0		1.2
	Percent of students in grades 9-12 who reported the use of any form of inhalation their lifetime	YRBS	OK	9.9		12.0		11.7		12.7
			Nation	12.1		12.4		13.3		11.7
		Ratio		0.8		1.0		0.9		1.1
	Percent of students in grades 9-12 who reported the use of heroin one or more times in their life	YRBS	OK	2.7		2.1		2.2		2.3
			Nation	3.3		2.4		2.3		2.5
		Ratio		0.8		0.9		1.0		0.9
	Percent of students in grades 9-12 who reported the use methamphetamines one or more times in their life	YRBS	OK	9.9		7.1		5.5		4.8
			Nation	7.6		6.2		4.4		4.1
		Ratio		1.3		1.1		1.3		1.2
	Percent of students in grades 9-12 who reported the use of ecstasy one or more times during their life	YRBS	OK	7.2		6.7		5.9		8.1
			Nation	11.1		6.3		5.8		6.7
		Ratio		0.6		1.1		1.0		1.2
	Percent of students in grades 9-12 who reported they took steroid pills or shots without a doctor's prescription one or more times during their life	YRBS	OK	4.8		3.7		4.7		5.3
			Nation	6.1		4.0		3.9		3.3
		Ratio		0.8		0.9		1.2		1.6
	Percentage of students in grades 9-12 who reported they used a needle to inject any illegal drug into their body one or more times during their life	YRBS	OK	2.4		2.0		2.1		1.7
			Nation	3.2		2.1		2.0		2.1
		Ratio		0.8		1.0		1.1		0.8
AGE OF INITIAL USE	Percent of students in grades 9-12 who reported first use of marijuana before age 13	YRBS	OK	11.1		9.4		8.1		7.3
			Nation	9.9		8.7		8.3		7.5
		Ratio		1.1		1.1		1.0		1.0

ILLICIT DRUG CONSEQUENCE

CONSTRUCT	MEASURE	SOURCE		YEAR 2003	2004	2005	2006	2007	2008
ILLICIT DRUG-RELATED MORTALITY	Number of deaths from drug related behavior per 100,000 population	NVSS	OK				17.3		
			Nation	9.9	10.5	11.3	12.8		
		Ratio					1.35		
CRIME	Number of property crimes (larceny, burglary, motor vehicle theft) reports to police per 100,000 population	UCR	OK			4042.0	3604.2	3526.4	3442.4
			Nation	3591.2	3514.1	3413.5	3334.5	3263.5	3212.5
		Ratio				1.18	1.08	1.08	1.07
DEPENDENCE OR ABUSE	Percent of persons aged 12 and over meeting DSM-IV criteria for drug abuse or dependence	NSDUH	OK		2.0	2.1	2.1	2.0	
			Nation	2.9	3.0	2.8	2.9	2.8	2.8
		Ratio			0.67	0.75	0.72	0.71	

NSDUH

Nonmedical Use of Prescription Pain Relievers in the Past Month among Persons Aged 12 or Older:

Year	Nation	Oklahoma	Ratio
2002	1.90%		
2003	2.00%		
2004	1.80%	5.71	3.17
2005	1.90%	5.84	3.07
2006	2.1%*	6.72	3.20
2007	2.10%	6.98	3.32

NVSS

Opioid Overdose Deaths per 100,000

	Oklahoma	US	Ratio
1999	2.5	1.5	1.6666667
2000	3.7	1.7	2.1764706
2001	4.6	2.1	2.1904762
2002	4.1	2.7	1.5185185
2003	7.3	3.1	2.3548387
2004	9.1	3.5	2.6
2005	8.8	3.9	2.2564103
2006	10.7	4.8	2.2291667

Formula Example—Scoring Analyses of the Prescription Drug Substance Category

PRESCRIPTION DRUG CONSUMPTION RATIO SCORE

CONSTRUCT	MEASURE	SOURCE		YEAR 2004	2005	2006	2007
Current Use	Nonmedical Use of Prescription Pain Relievers in the Past Month among Persons Aged 12 or Older	NSDUH	OK	5.7	5.8	6.7	7.0
			Nation	1.8	1.9	2.1	2.1
		Ratio		3.17	3.05	3.19	3.33

Total of all Ratios	12.74
Number of data points to divide ratio total by	4
Ratio score for consumption	**3.19**

PRESCRIPTION DRUG CONSEQUENCE RATIO SCORE

Opioid Overdose Deaths per 100,000

	Oklahoma	US	Ratio
1999	2.5	1.5	1.67
2000	3.7	1.7	2.18
2001	4.6	2.1	2.19
2002	4.1	2.7	1.52
2003	7.3	3.1	2.35
2004	9.1	3.5	2.60
2005	8.8	3.9	2.26
2006	10.7	4.8	2.23

Total of all Ratios	16.99
Number of data points to divide ratio total by	8
Ratio score for cosequence	2.12
Multiply consequence score by 2	**4.25**

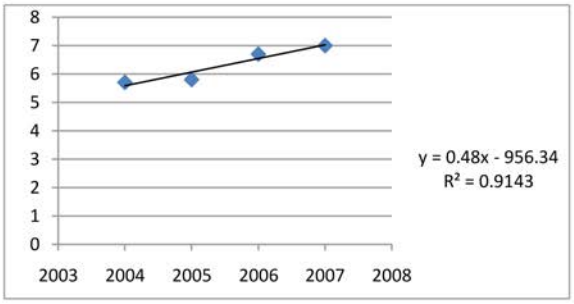
Ratio Total Score

Ratio score for consumption	3.19
Ratio score for consequence	4.25
	7.44

Formula Example—Scoring Analyses of the Prescription Drug Substance Category (Continued)

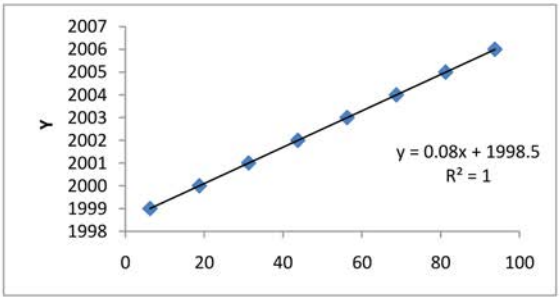
CONSUMPTION TIME ANALYSIS SCORE

Year	Percent
2004	5.7
2005	5.8
2006	6.7
2007	7.0



Degrees of Freedom	Critical Values		Significant
2	-0.950	0.950	N
		Score	0

CONSEQUENCE TIME ANALYSIS SCORE



Degrees of Freedom	Critical Values		Significant
6	-0.707	0.707	Y
		Score	1
	Multiply consequence score by 2		2

TOTAL TIME SCORE	**2**
TOTAL CONSUMPTION SCORE	**7.44**
TOTAL SCORE FOR PRESCRIPTION DRUGS	**9.44**