

## **Abstract**

The Utah Strategic Prevention Framework Partnership for Success (SPF PFS) Project in Utah utilizes a science based, proven to be effective system called the Strategic Prevention Framework (SPF) to deploy prevention services in Utah for underage drinking and prescription drug abuse prevention. The SPF drives communities and the state to effective prevention programming and strategies that meet unique community needs. Utah's goal is to continue the efforts of our SPF grant in enhancing our capacity, assessing, planning, implementing and evaluating our prevention efforts, specifically underage drinking and prescription drug abuse.

Measurable goals and objectives were established by considering Utah's population, need, culture and ethnic makeup. Our overarching goal is to decrease 30 day alcohol use by 30% and decrease prescription drug abuse by 30%. Utah's population is approximately 2.8 million. The racial makeup is over 90% white and ethnicity is 13% Hispanic. Our state has an estimated number of 54,000 underage drinkers a year. Furthermore, nearly 9% of students through 12<sup>th</sup> grade have used alcohol in the past 30 days, nearly half of them report alcohol is easy to get, and 6.6% report heavy (binge) drinking. SPF PFS will reach the general population, approximately 630,000 students, with environmental and universal programs and strategies. Indicated programs will reach 10,000 students annually, selective programs will reach 40,000 students, delivered mostly through the school system. In the lifetime of the project, we aim to reach 3,000,000 in a universal population, 200,000 selective and 50,000 with indicated services.

Previous SAMHSA/CSAP Grants have improved Utah's prevention system in the strategic process to the point where the state and communities follow the Strategic Prevention Framework and utilize best practice programs and strategies. The state has the same Prevention Network system that was used with the State Incentive Cooperative Agreement (SICA) grant, with enhancements. During SICA, the enhancement was using more evidence based programming and prioritizing. With SPF SIG, Utah enhanced the Prevention Network by incorporating the SPF process and building capacity through local coalitions. With SPF PFS, Utah plans to enhance the system with a stress on sustainability – sustainability of the system, the programming and the desired outcomes.

The communities are tied to performance measures and a rigorous ongoing evaluation will immediately begin at the start of this project that includes process and outcome data. Because the Utah system is inherently connected, existing resources will be easily leveraged in these communities, and the provider network has agreed to participate.

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## **Section A: Statement of Need**

### **A.1.**

Utah's population has been growing rapidly. Between 2000 and 2010, Utah's population grew by 24%. In 2012, the state of Utah had a projected population of approximately 2,855,287 according to the United States Census Bureau. Utah is one of the youngest states in the nation, with over 31% of the population under the age of 18 (vs. 24% for the nation), and only 9% of the population over the age 65 (vs. 13% for the nation). One contributor is the fact that Utah often leads in the nation in birthrate. In terms of race, the vast majority of Utah's population is White (92%), with small percentages reporting Asian (2.2%), multi-racial (2.2%), American Indian (1.5%), Black (1.3%) and Pacific Islander/Native Hawaiian (1%). In terms of ethnicity, 13% of the state's population identified as Hispanic/Latino in 2012. Educationally, over 90% of Utahns have received a high school diploma (or equivalent), and 30% of residents over the age of 25 have a bachelor's degree or higher. Utah enjoys relatively low unemployment (6.5% vs. 8.7% [total unemployed]) and poverty rates compared to the nation (11.4% vs. 14.3%), as well as a higher than average median household income (\$57,783 vs. \$52,762). However, because of Utah families are larger than average, per capita income in Utah trails that of the nation (\$23,650 vs. \$27,915).

Geographically, Utah is a diverse state noted for its beautiful snowcapped mountains and salt flats in the north, while one can find red rock deserts 350 miles to the south. The state is divided into 29 counties which are organized into 13 local substance abuse authorities (LSAAs) who are tasked with prevention planning and implementation. In 2010, four counties were considered urban, 12 rural, and 13 were considered frontier status. Seventy-five percent of the state's population resides in the four northern "Wasatch Front" counties of Utah, Salt Lake, Davis and Weber (which comprise only 5% of the state's land mass). This dense population distribution ranks Utah in the top ten most urbanized states in the U.S. (#8 in 2010).

Key Stakeholders include the Utah Prevention Advisory Council (UPAC), the State Epidemiological Outcomes Workgroup (SEOW), the Division of Substance Abuse and Mental Health (DSAMH), and Utah Prevention Network which is a component group of the Utah Association of Counties. Through the Strategic Prevention Framework State Incentive Grant (SPF SIG), these groups effectively collaborated and impacted the prioritized issues of Alcohol Related Motor Vehicle Crashes and Prescription Drug Morbidity and Mortality. UPAC is a consortium that brings together other state agencies within Utah with the focus of substance abuse prevention. The SEOW reports the data to UPAC, DSAMH and the Utah Prevention Network. That data from SEOW drives decisions on prevention priorities and needs. With these stakeholders DSAMH is confident that Utah could build the needed infrastructure to complete the Strategic Prevention Framework Partnership for Success (SPF PFS) grant.

## A.2.

A set of indicators related to underage drinking were compiled to create a snapshot regarding underage drinking across the state at the regional level. Included in the snapshot were two indicators of underage alcohol use (past 30 day use and binge drinking among 10<sup>th</sup> and 12<sup>th</sup> graders combined), as well as three risk/causal factor indicators related to underage alcohol use (perceived risk of alcohol use, peer disapproval of alcohol use and parental disapproval of alcohol use among grades 6, 8, 10 and 12 combined). All of these data were collected through the Utah Student Risk and Prevention Health (SHARP) survey, which is administered on a biennial basis statewide to youth in grades 6, 8, 10 and 12. The most recent data available from the SHARP survey are for 2011<sup>1</sup>, and data from the two most recent surveys were included in the snapshot. Specifically, the two measures of alcohol use included were: a) the percentage of youth who indicated any past 30 day use of alcohol, and b) the percentage of youth who indicated binge drinking (5 or more drinks in a row) at least once in the past 2 weeks. The three risk/causal factor indicators were: a) the percentage of youth who indicated moderate or great risk when asked, “How much do you think people risk harming themselves (physically or in other ways) if they take one or two drinks of an alcoholic beverage nearly every day?,” b) the percentage of youth who indicated wrong or very wrong when asked, “How wrong do you feel it is for someone your age to drink beer, wine or hard liquor regularly?,” and c) the percentage of youth who indicated wrong or very wrong when asked, “How wrong do your parents feel it is for you to drink beer, wine or hard liquor regularly?”

In 2011, alcohol use rates for 10<sup>th</sup> and 12<sup>th</sup> graders (combined) in Utah were 13.9% for past 30 day use, and 10% for binge drinking. This data demonstrates Utah is certainly not immune to problems regarding underage drinking. Alcohol is still the most widely used substance among youth. For example, among high school youth, 30 day use rates for alcohol, marijuana, and cigarettes were 13.9%, 8.8%, and 6.1% respectively. Additionally, a recent analysis of alcohol use data revealed that while Utah youth who drink alcohol are more likely to binge. Based on 2011 data, nationally, about 55% of 12<sup>th</sup> graders who drank alcohol in the past 30 days also engaged in binge drinking in the past two weeks. In Utah, about 72% of 12<sup>th</sup> graders reporting 30 day alcohol use also indicated binge drinking. High binge drinking rates among 30 day alcohol users held for 8<sup>th</sup> (84.9%) and 10<sup>th</sup> (72.7%) graders in Utah as well. These data suggest that a very high percentage of Utah youth who do drink are doing so in a relatively high risk manner.

In addition to the profile for underage drinking, a profile of indicators related to prescription drug misuse among 12-25 year olds was developed to provide a snapshot of the regions and state. Included in the prescription drug snapshot were two indicators of youth non-medical prescription drug use (past 30 day use of prescription narcotics and sedatives among 10<sup>th</sup> and 12<sup>th</sup> graders combined), three consequence indicators related to prescription drug use (methadone emergency

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<sup>1</sup>Data for the 2013 SHARP survey was collected in February and March of 2013, but is not yet available.

department [ED] encounters, “other” narcotic ED encounters, and drug poisoning deaths), and two indicators of past year non-medical prescription pain reliever use (among 12-17 and 18-25 year olds, respectively). Specifically, the two youth prescription drug use indicators were collected via the Utah SHARP survey, and represent the percentage of youth who indicated using: a) “narcotic prescription drugs (such as Oxycontin, methadone, morphine, codeine, Demerol, Vicodin, Percocet),” and b) “prescription sedatives including barbituates or sleeping pills (such as phenobarbital, Tuinal, Seconal, Ambien, Lunesta, or Sonata), “without a doctor telling you to take them.” The three consequence indicators were obtained through the Utah Department of Health’s Indicator Based Information System<sup>2</sup> (IBIS), a web portal to health related data for the state of Utah. Included in the snapshot are the (age-adjusted) rate and number of: a) methadone ED encounters (any diagnosis with ICD 9 code 965.02), b) other narcotic ED encounters (any diagnosis with ICD 9 code: 965.09), and c) drug poisoning deaths (primary cause of death with ICD 10 codes X40-X44, X46, X60-X64, X66, Y10-Y14, Y16). Finally, the two state level indicators of past year non-medical prescription pain reliever use were obtained via the National Survey on Drug Use and Health (NSDUH).

Past year non-medical pain reliever use rates in Utah were 5.6% for 12-17 year olds and 3.2% for 18-25 year olds, respectively. Data regarding youth 30 day non-medical sedative use suggest Utah youth use sedatives at a higher rate than the nation (2.7% for Utah 12<sup>th</sup> graders vs. 1.7% for the nation in 2011). Utah’s youth 30 day use rates for sedatives is also higher than chewing tobacco use rates (2.1% for Utah all grades vs. 1.3% for chewing tobacco use). Utah has consistently had a substantially higher rate of drug poisoning deaths than the nation since 2000. From 2000 to 2007, the rate ratio for drug poisoning deaths (Utah vs. the U.S.) ranged from a low of 1.35 (in 2001) to 1.76 (in 2005). In 2007, the most recent year of data available through the Center for Substance Abuse Prevention funded State Epidemiological Data System (SEDS), the crude rate of drug poisoning deaths in Utah was approximately 19.7 per 100,000 population vs. 12.0 per 100,000 population for the U.S. Unfortunately, national data for ED encounters are not readily available for comparison, but in looking at the Utah ED encounter data related to prescription drug misuse, the data are worrisome. Over 3,000 ED encounters were recorded for methadone and other narcotics overdoses between 2008 and 2010 in Utah.

The SHARP Survey is designed to assess Utah students’ involvement in a specific set of problem behaviors, as well as exposure to risk and protective factors that predict problem behaviors in adolescents. The SHARP surveys 6th, 8th, 10th, and 12th grade students on a biennial basis, with participation of more than 40,000 students enrolled in Utah public schools for both 2009 and 2011. The table below presents sample sizes by region/district and for the state for both high school students (10<sup>th</sup> and 12<sup>th</sup> grades combined) and for all grades combined.

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<sup>2</sup> <http://ibis.health.utah.gov/>

| <b>District</b>      | <b>High School (Grades 10 and 12)</b> |              | <b>All Grades</b> |              |
|----------------------|---------------------------------------|--------------|-------------------|--------------|
|                      | <b>2009</b>                           | <b>2011</b>  | <b>2009</b>       | <b>2011</b>  |
| Bear River           | 1871                                  | 2346         | 5340              | 5943         |
| Central              | 914                                   | 1142         | 2589              | 2710         |
| Davis                | 756                                   | 2047         | 1782              | 5025         |
| Four Corners         | 725                                   | 685          | 1619              | 1537         |
| Northeastern         | 278                                   | 478          | 1059              | 1468         |
| Salt Lake County     | 4796                                  | 5237         | 12181             | 13014        |
| San Juan             | 130                                   | 112          | 353               | 277          |
| Southwest            | 1570                                  | 1577         | 3438              | 3625         |
| Summit               | 486                                   | 538          | 1277              | 1367         |
| Tooele               | 922                                   | 1248         | 2578              | 3011         |
| Utah County          | 2229                                  | 3144         | 4581              | 6367         |
| Wasatch              | 343                                   | 428          | 874               | 1013         |
| Weber                | 1247                                  | 1701         | 3160              | 4350         |
| <i>State of Utah</i> | <i>16267</i>                          | <i>20683</i> | <i>40831</i>      | <i>49707</i> |

### A.3.

Utah was a SPF SIG recipient in 2006. The SPF SIG helped build a foundation for an improved prevention system, just as the State Incentive Cooperative Agreement (SICA) grant and State Incentive Grant – Enhanced (SIG-E) did previously. Utah aims to enhance the prevention infrastructure and sustain those enhancements. During the SPF SIG, Utah was able to develop better relationships and communication between other state agencies. This improved communication allowed the state agencies to collaborate and blend funding to address the prioritized prevention issues.

Another success of the SPF SIG grant was the implementation of the SPF process and use of local coalitions. The areas that engaged local key leaders and community members were able to go through the five step process. If coalitions used the SPF, their assessment and capacity was greater than areas that didn't have functioning coalitions.

Utah discovered during the SPF SIG that the local areas that received adequate training and technical assistance were far more successful in addressing the priorities and ultimately sustaining the infrastructure that they built than their counterparts that didn't request TA or attend provided trainings. With inadequate capacity at the state level adequate monitoring, face to face training and TA for some of these areas was unavailable. These areas have higher rates of substance abuse and other negative behavioral health/ brain disorder related outcomes.

The gaps that surfaced were a local communities' ability to have a functioning coalition. Without a functioning coalition the community struggled to have one or two people complete the assessment and ultimately build the necessary capacity. Factors that played into coalitions' functioning were issues such as engaging key leaders, how to do a complete assessment, understanding the SPF at a local level, understanding how long an assessment can take, and understanding how to build capacity. A lesson learned from SPF was clear outcomes regarding a coalitions role in assessment and capacity. In more successful areas of the state, local coalitions served as the entity that collected the information for the assessment of the community (data, capacity and resources).

In addition, while Utah has developed a prevention system that reaches throughout the state, the gap is in how the SPF process is actually rolled out in each of the different communities. Without additional monitoring, technical assistance, training and coaching/guidance, SPF outcomes show us areas default to non-evidence based prevention strategies, such as scare tactics and one-time events.

During the SPF SIG it was also noted that the data collection system is not sufficient for anything other than collecting data for the SAPT Block Grant application. Utah collects the minimum required. However when pushed by policy makers for additional information and outcomes outside of that data, Utah has been unable to respond.

Since the priority issues for Utah during the SPF SIG were Prescription Drug Morbidity and Mortality and Alcohol Related Motor Vehicle Crashes, it was identified that our data collection related to prescription drugs was insufficient. Utah collects the following data: consumption data for youth in the biennial Student Health and Risk Prevention survey; adult consumption data is collected by the Behavioral Risk Factor Surveillance System, only if the questions are submitted, sponsored and approved by the Department of Health. This has been inconsistent; death data is collected by the Office of the Medical Examiner but can be classified in at least four different ways; and Emergency Room Data – if the intake/triage assessment is complete. Utah could definitely enhance the data collection surrounding Prescription Drug abuse.

A.4.

In 2006, the State Epidemiology/Outcomes Workgroup (SEOW) was established. This workgroup continues to meet regularly and reviews the most current data and data sources to keep our prevention system up to date on prevention related indicators. This workgroup is comprised of Ph.D. level evaluators, epidemiologist and prevention specialists. We contract with Bach-Harrison LLC to act as consultants to the SEOW group. Bach Harrison provides expertise in research services, program evaluation, survey administration, data management systems, and web-based services to government agencies and to community-based and private organizations. Five Ph.D. level staff from Bach Harrison worked with the SEOW in collecting, analyzing and

reporting indicators. A website was developed that provides easy access and comparable county level archival indicators that were used to determine the high need areas for the project.

The SEOW will be enhanced by engaging additional stakeholders to participate and provide access to clean data. One hurdle the SEOW will also address is obtaining and maintaining local level data on the priority issues. Statewide there are data available, but it may not be reported down to the community level. At the minimum we have state level data, followed by the Local Substance Abuse Authority areas, counties, school district (depending on data), and municipalities and cities. When there isn't consistent reporting or collecting of data at the sub-state level, we have gaps. The SEOW will look at ways to minimize this gap.

In addition, the SEOW will continue to incorporate other behavioral health factors and indicators into the SEOW work. The SEOW worked on prioritizing mental health risk factors related to suicide in 2012.

## **Section B: Proposed Approach**

### **B.1.**

Utah has modeled its prevention system after SAMHSA's Strategic Initiative 1 and with the goals of the SPF PFS program. Utah adopted the SPF process for all SAPT and other federal money that comes to the state for substance abuse prevention. The SPF is required through all contracts and is monitored on an ongoing basis including data collection, reports, and at least one face to face visit with each provider. In addition, the goals of the SPF PFS match with the priorities set 7 years ago in Utah. It is Utah's goal to build a foundation that will enhance the delivery of services at the local level, which will lead to a decrease in the consumption rates of underage drinking and prescription drug abuse.

Utah's Underage Drinking Prevention Workgroup, established in 2005, made a goal to eliminate underage drinking in Utah. Our purpose of the SPF PFS project is to mobilize and organize efforts in our high need areas to assist the state in its underage drinking prevention goal. The SPF PFS will allow us to work on our goal to reduce alcohol consumption among 12 – 20 years old and reduce rates of risk factors that predict increased likelihood of alcohol consumption. The SPF PFS objectives are to reduce by a statistically significant amount the 30 day use rates and related risk factors in Utah.

In 2007, the Prescription Drug Abuse workgroup was established with the goal of reducing the number of overdose deaths related to prescription pain medication in the state. The workgroup developed a media campaign and has also worked with local agencies in efforts to raise awareness, increase knowledge and change perceptions of risk. The SPF PFS will allow the state to continue to support and address the goals of impacting the risk factors related to prescription drug abuse. Utah proposes to see a change in the 30 day use rates of both youth and adults of prescription medication used non-medically and identified risk factors.

The Division of Substance Abuse and Mental Health took quick attention to SAMHSA's Strategic Prevention Initiative #1 and immediately sought training and assistance from our SAPT project officer and attended federally sponsored meetings and conferences to learn how to implement the initiative in our state. Since then, our office coordinated with the mental health team and has since released state level grant money that was developed using the 3 steps of SAMHSA's initiative. We've since found that our coalitions throughout the state have accepted these goals and initiatives readily and are quick to include all behavioral health promotion and prevention of illness associated with behavioral health issues in their coalitions processes. With some additional capacity and assistance, these local coalitions will flourish in their role and relationship with SAMHSA's initiative 1.

#### B.2.a.

Since 2006, Utah's top two prevention priorities, driven by data, have been underage drinking and prescription drug abuse. The SEOW was instrumental in the identifying the priorities during the SPF SIG. Both prescription drug abuse and underage drinking have risen to the top of the priority list. While Utah's rates tend to fall at about half the national rates for most substance abuse consumption, prescription drugs don't follow that trend. After reviewing the Epidemiological report, a compilation of substance-related consequence and consumption data for the state of Utah, SEOW noted that prescription drug abuse among adults matched the national rate and our overdose death rate was higher than the national rate.

In addition, Utah is primed to address both priorities. With the SPF SIG, Utah addressed both priorities. Utah has a political climate that will support addressing both prescription drugs abuse and underage drinking.

#### B.2.b.

As noted, Utah's rates for most substance abuse indicators tend to fall at around half that of the national average. With prescription drug abuse/misuse, Utah matches the national rate. Prescription drug poisoning is the number one cause of injury death in Utah. After four years of seeing a decrease in drug poisoning deaths, 2011 showed a 4.2% increase from 2010. From 2008 to 2010, the U.S. age-adjusted rate of poisoning deaths from all causes was 13.5 per 100,000 persons. During this same time period, Utah's age-adjusted rate of poisoning deaths was significantly higher at 20.8 per 100,000 persons. Looking at SHARP data, the youth consumption rates for prescription drugs is remaining stable or decreasing. However, young adults, ages 18-25, appear to have the largest rate of prescription drug abuse.

Alcohol is still the number one abused substance by any age group in Utah. While Utah's trends mimic that of the national scene, slightly decreasing, it is of greater concern that our binge drinking rates among youth are higher than their national counterparts. Nationally, about 55% of 12th graders who drank alcohol in the past 30 days also engaged in binge drinking in the past two weeks, for Utah about 72% of 12th graders reporting 30 day alcohol use also indicated binge

drinking. A similar pattern of high binge drinking rates among 30 day alcohol users holds for 8th and 10th graders in Utah as well.

| Consequence/Indicator                          | Consumption Pattern(s)  |
|--|---|
| Underage Drinking, ages 12-20                  | <ul style="list-style-type: none"> <li>• 30 day use (SHARP and NSDUH)</li> <li>• Binge drinking (SHARP, BRFSS and NSDUH)</li> </ul> |
| Prescription Drug abuse and misuse, ages 12-25 | <ul style="list-style-type: none"> <li>• Treatment Needs data</li> <li>• 30 day drug use (SHARP, BRFSS, NSDUH)</li> </ul>           |

B.3.a.

Utah proposes building a foundation that will enhance the current delivery system at the local level. This will ultimately decrease the rates of underage drinking and prescription drug abuse within the priority areas across the State of Utah. Paramount to this foundation will be hiring Regional Prevention Directors whose priorities will match the priorities of this grant. The Regional Directors will monitor, assist, provide TA and support the local regions in their efforts to decrease in the priority issues at the local level. They will serve as a liaison and conduit for information between the state and LSAAs, and they will be an integral component of the monitoring to ensure fidelity to this project is adhered to. This proposal is a direct response to lessons learned from the previous SPF grant.

Utah’s current system, as noted previously, is made up of 13 Local Substance Abuse Authorities throughout the State. Within the 13 LSAAs, there is a Prevention Coordinator. DSAMH’s expectation is that the Prevention Coordinator in each LSAA will conduct the SPF process and identify what that LSAA, counties and cities need in addressing the priorities of this project.

Based on needs and capacity, DSAMH and the SEOW developed five (5) areas. Each of these areas will have a Regional Prevention Director to monitor and administer the SPF PFS. They will assist the Prevention Coordinator, coalition(s) and agencies in implementing each of the five steps of SPF and coordinating all selected strategies. The Regional Director will oversee all the environmental strategies, and enhancement of the system.

It is proposed that all indicated services of this project will be funded through a fee for service or a voucher system. Utah is looking to replicate the success of the Access To Recovery program in which the consumer receives a voucher for services and selects an approved provider for the services they feel they need. One option for dissemination of the vouchers is to collaborate with community agencies. This would include coordinating with Juvenile Courts, local school districts, Mental Health agencies, National Guard, and Health Clinics.

The agencies that collaborate with this project would have the ability to refer potential clients to services and provide those persons with vouchers for the services. The client would then be able to select which provider where they would want to receive the services.

#### B.3.b.

Utah has utilized data available through the SEOW and lessons learned from the SPF to divide the state into 5 broad regions, each with similar priority needs, capacity, and resources to address underage drinking and prescription drug abuse. Experience shows that due to the geographic and cultural issues in Utah, targeting a few high priority communities doesn't move the needle. We will continue to gather data, identify and define these regions so our prevention system can be mobilized and organized in a manner that we can continue to build on the successes of the SPF grant. Utah has considered geography, rates, indicators, factors, politics etc. in the development of the regions. The regions would consist of the following Local Substance Abuse Authority areas: 1, Northern Utah (Bear River, Weber, Davis, Tooele); 2, Salt Lake (Salt Lake County); 3, Central (Utah, Wasatch and Summit); 4, Eastern Utah (San Juan, Four Corners, Northeastern); 5, Southern Utah (Southwest and Central).

The high need areas throughout the state are dispersed within the five regions. These the high need areas were identified by an examination of the alcohol indicators. The data reveals that five areas had rates of alcohol use and levels of risk higher than the state average across all of the included indicators for both 2009 and 2011 (Four Corners, Salt Lake, Summit, Tooele and Weber). One additional area, Northeastern, was higher than the state on all of the indicators with the exception of one year (binge drinking in 2011). The data suggest that these six areas are relative high problem areas in the state. Moreover, Salt Lake and Weber are two of the largest areas in the state in terms of population, together comprising nearly 46% of the state's total population. When all six of the higher use/risk areas are considered, they comprise approximately 53% of the state's population. At first glance, trying to prioritize needs based on data is very confusing; however, based on the past evaluations of the SICA and SPF projects, it is clear that due to the diverse nature of our state geography and people, pooling data into five high need regions is the most effective and efficient manner to roll out science based 5 step prevention in our state.

| District             | Youth 30 Day Alcohol: % Used (High School) |              | Youth Binge Drinking: % Used (High School) |              | Youth Perceived Risk of Alcohol: % Moderate to Great Risk (All grades) |              | Youth Peer Disapproval: % Wrong or Very Wrong (All grades) |              | Youth Parental Disapproval: % Wrong or Very Wrong (All grades) |              |
|----------------------|--|--------------|--|--------------|--|--------------|--|--------------|--|--------------|
|                      | 2009                                       | 2011         | 2009                                       | 2011         | 2009   | 2011         | 2009   | 2011         | 2009   | 2011         |
| Bear River           | 9.5%                                       | 10.1%        | 6.2%                                       | 7.0%         | 84.3%  | 85.3%        | 91.1%  | 92.8%        | 96.7%  | 96.1%        |
| Central              | 14.4%                                      | 12.0%        | 10.9%                                      | 7.9%         | 82.6%  | 83.3%        | 89.3%  | 92.5%        | 95.8%  | 95.9%        |
| Davis                | 8.7%                                       | 13.0%        | 4.7%                                       | 9.7%         | 84.4%  | 85.3%        | 91.9%  | 90.5%        | 96.5%  | 94.8%        |
| Four Corners         | 21.5%                                      | 21.8%        | 14.2%                                      | 14.3%        | 72.4%  | 72.5%        | 82.0%  | 85.0%        | 92.1%  | 91.1%        |
| Northeastern         | 22.4%                                      | 14.8%        | 13.9%                                      | 9.7%         | 78.1%  | 76.3%        | 83.0%  | 89.4%        | 91.8%  | 91.7%        |
| Salt Lake County     | 20.4%                                      | 18.0%        | 12.7%                                      | 12.8%        | 76.1%  | 79.4%        | 84.1%  | 88.2%        | 92.9%  | 93.5%        |
| San Juan             | 11.0%                                      | 3.5%         | 8.7%                                       | 1.3%         | 78.8%  | 85.0%        | 92.8%  | 98.3%        | 98.0%  | 97.6%        |
| Southwest            | 12.3%                                      | 11.2%        | 8.8%                                       | 9.4%         | 81.8%  | 81.2%        | 89.5%  | 91.3%        | 96.2%  | 94.9%        |
| Summit               | 38.3%                                      | 28.6%        | 22.7%                                      | 20.6%        | 74.9%  | 77.7%        | 76.8%  | 83.3%        | 89.2%  | 90.7%        |
| Tooele               | 21.2%                                      | 20.4%        | 12.6%                                      | 13.6%        | 74.8%  | 75.9%        | 84.1%  | 87.9%        | 92.7%  | 93.0%        |
| Utah County          | 6.1%                                       | 6.8%         | 3.7%                                       | 5.4%         | 88.0%  | 87.1%        | 94.2%  | 94.4%        | 97.7%  | 97.3%        |
| Wasatch              | 20.9%                                      | 17.1%        | 15.2%                                      | 12.0%        | 76.1%  | 81.0%        | 86.8%  | 91.5%        | 94.1%  | 95.9%        |
| Weber                | 19.2%                                      | 16.3%        | 13.4%                                      | 10.9%        | 75.9%  | 77.5%        | 83.4%  | 88.1%        | 91.6%  | 93.7%        |
| <i>State of Utah</i> | <i>15.0%</i>                               | <i>13.9%</i> | <i>9.5%</i>                                | <i>10.0%</i> | <i>80.4%</i>   | <i>81.9%</i> | <i>87.8%</i>   | <i>90.4%</i> | <i>94.6%</i>   | <i>94.7%</i> |

Within Utah there is considerable variability across the areas regarding the data included in the prescription drug indicators. For youth non-medical prescription narcotic use, the Four Corners, Salt Lake, Summit, Tooele, and Wasatch areas were higher than the state for both 2009 and 2011. For youth non-medical sedative use, the Davis and Salt Lake areas were consistently higher than the state. In regards to the three mortality and morbidity indicators, the Four Corners, Salt Lake, Tooele and Weber areas were higher than the state on all three indicators. Moreover, these four areas were the only areas above the state rate for other narcotics ED encounters, and

accounted for four of the five areas that were above the state rate for drug poisoning deaths, indicating that they are certainly hot spots within the state for drug poisoning overdoses.

**Prescription Drugs Indicators**

| District         | Youth 30 Day Rx Narcotics : % Used (High School) |      | Youth 30 Day Rx Sedatives: % Used (High School) |      | Other Narcotics ED Encounters <sup>1</sup> (2008-2010) | Rate per 100,000 pop | Methodone ED Encounters <sup>2</sup> (2008-2010) | Rate per 100,000 pop | Drug Poisoning Deaths <sup>3</sup> (2009-2011) | Rate per 100,000 pop | Adult Past Year Rx Pain Killer Use (2010) | % Used 12-17 | Adult Past Year Rx Pain Killer Use (2010) | % Used 18-25 |
|------------------|--|------|---|------|--|----------------------|--|----------------------|--|----------------------|---|--------------|---|--------------|
|                  | 2009   | 2011 | 2009  | 2011 | Number   |                      | Number   |                      | Number   |                      |   |              |   |              |
| Bear River       | 2.2  | 1.8% | 2.3%  | 2.5% | 137  | 30.8                 | 10   | 2.8                  | 52   | 11.97                | n/a                                       | n/a          | n/a                                       |              |
| Central          | 2.5  | 1.8% | 2.5%  | 2.3% | 59   | 28.7                 | 14   | 6.3                  | 34   | 17.62                | n/a                                       | n/a          | n/a                                       |              |
| Davis            | 3.2  | 1.8% | 3.6%  | 3.3% | 258  | 30.3                 | 34   | 4.1                  | 109  | 13.1                 | n/a                                       | n/a          | n/a                                       |              |
| Four Corners     | 3.6  | 3.4% | 2.2%  | 2.4% | 64   | 54.0                 | 8  | 6.8                  | 37   | 33.37                | n/a                                       | n/a          | n/a                                       |              |
| Northeastern     | 2.1  | 2.7% | 2.4%  | 2.2% | 33   | 23.0                 | 6  | 4.2                  | 14   | 11.25                | n/a                                       | n/a          | n/a                                       |              |
| Salt Lake County | 3.1  | 2.0% | 4.1%  | 3.1% | 1058   | 36.1                 | 214  | 7.2                  | 532  | 17.72                | n/a                                       | n/a          | n/a                                       |              |
| San Juan         | 3.9  | 0.0% | 3.1%  | 5.1% | 4  | 10.2                 | 4  | 10.8                 | *  | *                    | n/a                                       | n/a          | n/a                                       |              |
| Southwest        | 2.4  | 0.9% | 3.7%  | 2.4% | 175  | 31.7                 | 65   | 12.2                 | 82   | 15.41                | n/a                                       | n/a          | n/a                                       |              |
| Summit           | 3.3  | 2.1% | 1.5%  | 2.1% | 10   | 8.9                  | 3  | 4.2                  | 18   | 16.18                | n/a                                       | n/a          | n/a                                       |              |
| Tooele           | 4.6  | 2.7% | 4.4%  | 2.7% | 80   | 50.9                 | 18   | 10.7                 | 28   | 17.28                | n/a                                       | n/a          | n/a                                       |              |
| Utah County      | 1.5  | 1.1% | 2.4%  | 1.7% | 420  | 31.5                 | 66   | 4.7                  | 217  | 16.57                | n/a                                       | n/a          | n/a                                       |              |
| Wasatch          | 3.6  | 2.5% | 4.2%  | 2.4% | 7  | 10.6                 | 3  | 5.1                  | 7*   | 10.15*               | n/a                                       | n/a          | n/a                                       |              |

|                      |     |          |          |          |      |      |     |     |       |       |          |          |
|----------------------|-----|----------|----------|----------|------|------|-----|-----|-------|-------|----------|----------|
| Weber                | 2.7 | 2.0<br>% | 2.9<br>% | 3.7<br>% | 310  | 46.4 | 51  | 7.5 | 141   | 20.82 | n/a      | n/a      |
| <i>State of Utah</i> | 2.7 | 1.7<br>% | 3.3<br>% | 2.8<br>% | 2615 | 34.2 | 496 | 6.4 | 1,273 | 16.65 | 5.6<br>% | 8.2<br>% |

\*Data are not suitable for publication or are unreliable due to small number of events.

<sup>1</sup>ICD 9 Code: 965.09

<sup>2</sup>ICD 9 Code: 965.02

<sup>3</sup>ICD 10 Codes: X40-X44, X46, X60-X64, X66, Y10-Y14, Y16

At first glance, trying to prioritize needs based on data is very confusing; however, based on the past evaluations of the SICA and SPF projects, it is clear that due to the diverse nature of our state geography and people, pooling data into five high need regions is the most effective and efficient manner to roll out science based 5 step prevention in our state.

### B.3.c.

We will document community level needs and baseline prevalence rates through information provided by the SEOW. The Epi Website will continue to track the baseline data at the LSAA level. Additional community level needs will be tracked by the Prevention coordinator and Regional Prevention Director.

The 2011 SHARP survey, 2011 overdose death report, and 2011 NSDUH report all make the baseline data for this project. Working with the local communities and the SEOW, Utah will identify additional baseline data specific to each community. During the assessment of the communities, items such as the functioning of the coalition, knowledge of SPF process and local capacity will have baseline data. This will allow Utah to demonstrate additional changes within the infrastructure and communities during the project period.

Each area will submit monthly reports to the Regional Prevention Director during the course of the project. These reports will collect process data as well as any challenges and accomplishments. These reports will assist the Regional Prevention Director and DSAMH in providing training, guidance and or technical assistance to the communities. An annual report will collect outcome data.

### B.3.d.

Throughout the grant project, the program manager and the Regional Prevention Directors (RPD) will work closely with the communities to track the available data. New SHARP data will be available in 2013 (baseline), 2015, 2017 and 2019 for monitoring community level changes. It is important to know that SHARP has been consistently administered since 2003 in Utah, providing the state with remarkable trend data. Data such as the injury, emergency room visits and deaths will be monitored on a yearly basis as available. If any local areas identify additional

local level data or indicators, that will be shared with the manager and director, as available, through quarterly reports.

The Regional Prevention Director will oversee and assist the local areas in submitting the data required by CSAP in a timely manner. In addition, the program manager will provide training and technical assistance as needed to the director and/or local communities on the data submissions. This assistance may come in the form of group training. Based on feedback during the SPF SIG, local areas preferred to do any federal reporting as a group to talk and discuss questions or challenges as entering the data.

#### B.3.e

Based on past experience, It is expected that if the local areas, with the guidance of a Regional LSAA Prevention Coordinator and Prevention Director, successfully go through the SPF process with a functioning coalition, the local areas will see a decrease in prescription drug misuse and/or underage drinking. If the local areas have a decrease in prescription drug misuse and/or underage drinking rates or numbers, the overall state rates will decrease.

The selection of local areas with higher rates and numbers will allow the state to impact the state rates more readily. Utah will include the areas with highest rates and numbers in the communities' selected. It is crucial that Utah doesn't just focus on the rates or the numbers of either of the priorities. Relying on one or the other may not enable Utah in reaching the goal of decreasing prescription drug misuse and underage drinking. For example, if Utah only focused on areas with the highest *rates*, the actual number of people that would ultimately need services may be small. This is the situation in Summit County; the 30 day alcohol use rate for grade 12 is 34.5% That is twice the state rate of 17%. However, the population of Summit County is smaller and that rate equates to approximately 60 students. In comparison, Salt Lake County's rate is 21.5%, but equates to more than 1600 students.

Utah will identify and work with communities with rates and numbers that will impact the state rates in a positive manner.

#### B.4.

Utah continues to build on the success of previous discretionary grants. The state has the same Prevention Network system that was used with the State Incentive Cooperative Agreement (SICA) grant, with enhancements. During SICA, the enhancement was using more evidence based programming and prioritizing. With SPF SIG, Utah enhanced the Prevention Network by incorporating the SPF process and building capacity through local coalitions. With SPF PFS, Utah plans to enhance the system with a stress on sustainability – sustainability of the system, the programming and the desired outcomes. With the proposed approach of using Regional Prevention Directors combined with utilizing the existing system, Utah is confident that the state's capacity to provide adequate support and guidance to the local communities to implement

the project will be enhanced. The Regional Prevention Directors will be able to guide the communities.

With the Regional Prevention Directors, the program manager, evaluator and SEOW analyst, the state will have resources to address the needs of the communities when they are identified. One role of the RPD is to guide the communities through the SPF process. It will be their responsibility to recognize the specific technical assistance or training needs of a community within their region. With the resources of the evaluator, SEOW analyst and program manager the training or coordination of training can be fulfilled.

The evaluator will provide assistance and support regarding assessment and evaluation to the local community. The SEOW analyst will provide links and access to available data as well as how to understand and interpret the data that the community is able to acquire. The program manager and RPD will assist the communities in capacity building, planning and implementation. Any Communities that Care training or coalition training needs can be address with the program manager.

#### B.5.

Under the previous SPF grant, each high need area has established coalitions within its boundaries. These coalitions will be the foundation for this project and key to its success. The coalitions have been trained in the SPF process and while they are at different levels, assistance from the DSAMH allows each to progress throughout the SPF in the most efficient manner. The LSAA system in Utah allows a clear path to implementation of the SPF and the ongoing training and assistance needed.

These coalitions will use their existing systems for implementing the SPF process which includes implementation of each of the proposed activities. Each LSAA is under contract with the Division to include culturally competent care, language access services, and organization supports to address the needs of culturally diverse and disparate populations in their areas. One strength of Utah's system is the Local Authority Areas which allows local communities to hire their own staff, while still under the careful eye of the DSAMH to ensure the contracts are followed. During monitoring visits and in reports, a review of the structure of coalitions takes place to guarantee the coalitions and services match the composition of the community. The SPF PFS Project will be included in the regular site review process which includes ongoing monitoring of reports and process data submitted to the Division, an annual face to face monitoring visit, face to face follow up with LSAA administration and managers, and technical assistance and training plans developed. The SPF PFS will also include monitoring and visits from the SPF PFS evaluator/data expert, which will include attention to culturally appropriate involvement, instrument development, data collection, and evaluation implementation and reporting.

An example of how this is working in Utah is that in all target areas, changing demographics and community needs assessments tell us that there is an increasing need to provide services in Spanish. The Division will provide technical assistance and training to each subrecipient on how to best reach Spanish speaking populations and will link our providers with certified translation editors to ensure this growing population is provided meaningful prevention services.

A robust, effective, local prevention system includes inclusion of all cultural, ethnic, and socio-economic groups. All training from the DSAMH or its contractors includes modules on cultural competence and the strengths of diverse coalitions. One example is the National Substance Abuse Prevention Specialist Training which is required for all recipients of SAPT dollars.

However, we recognize our system is not perfect and under the SPF PFS grant, the Division will include ongoing assessments, monitoring, and technical assistance to the subrecipients in each of the 14 standards of the Culturally and Linguistically Appropriate Services in Health Care. We plan to fully utilize the expertise of CSAP staff and contractors to assist us in this area.

| Key Activities  | YEAR 1  |   |   |   | YEAR 2  |   |   |   | YEAR 3  |   |   |   | YEAR 4  |   |   |   | YEAR 5  |   |   |   | Responsible Parties                                |
|---|---------|---|---|---|---------|---|---|---|---------|---|---|---|---------|---|---|---|---------|---|---|---|--|
|   | Quarter |   |   |   | Quarter |   |   |   | Quarter |   |   |   | Quarter |   |   |   | Quarter |   |   |   |  |
|   | 1       | 2 | 3 | 4 | 1       | 2 | 3 | 4 | 1       | 2 | 3 | 4 | 1       | 2 | 3 | 4 | 1       | 2 | 3 | 4 |  |
| Hire Staff  | X       |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   | DSAMH  |
| Identify target communities                               | X       |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   | SEOW, UPAC   |
| application for Evaluator                                 | X       |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   | DSAMH  |
| Kick off  |         | X |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   | DSAMH  |
| Community plans submitted                                 |         | X |   |   |         | X |   |   |         | X |   |   |         | X |   |   |         | X |   |   | LSAA   |
| Contracts completed                                       |         | X |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   | DSAMH  |
| Evaluator hired   |         | X |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   | DSAMH  |
| Community Plans reviewed                                  |         | X |   |   |         | X |   |   |         | X |   |   |         | X |   |   |         | X |   |   | UPAC, SEOW, DSAMH                                  |
| Data system in place                                      |         | X |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   | DSAMH, SEOW  |
| Fidelity system in place                                  |         | X |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   | DSAMH, LSAA  |
| Quarter reports due                                       |         | X | X | X | X       | X | X | X | X       | X | X | X | X       | X | X | X | X       | X | X | X | DSAMH, Regional Dir.                               |
| meet with regions   |         | X | X | X | X       | X | X | X | X       | X | X | X | X       | X | X | X | X       | X | X | X | Regional Dir., LSAA                                |
| On site visit   |         |   |   | X |         |   |   | X |         |   |   | X |         |   |   | X |         |   |   | X | DSAMH  |
| Year end report   |         |   |   | X |         |   |   | X |         |   |   | X |         |   |   | X |         |   |   | X | DSAMH, Regional Dir.                               |
| Technical Assistance plan developed                       |         | X |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   | DSAMH, Regional Dir., LSAA, Communities, Evaluator |
| Technical Assistance plan reviewed, adjusted and deployed |         |   | X |   |         |   | X |   |         |   | X |   |         |   | X |   |         |   |   | X | Regional Dir., DSAMH, LSAA                         |
| Project End Report  |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   |   |         |   |   | X | DSAMH, Evaluator, Regional Dir, LSAA, Communities  |

#### B.7.

The Utah Prevention Advisory Council (UPAC) has been charged with overseeing the latest SPF Grant and will continue with the SPF PFS Grant. The UPAC is a workgroup of the Utah Substance Abuse Advisory Council, a statutory required council that acts as Utah's Drug Czar. Between executive committee meetings and the general membership meeting, UPAC meets monthly. The general membership, made up of 28 state program/agency managers and directors, meets every other month. The SPF PFS project manager and the SEOW chair will report to this group every meeting.

Utah organized a workgroup of prevention scientists and experts in 2008 to help determine what programs proposed to be implemented were evidence based. Later, using SAMHSA's Evidence Based Programming Guide as their main tool, this workgroup became the Utah Evidence Based Workgroup. This workgroup meets monthly or as needed in an ongoing effort to determine evidence base status of programs and to provide feedback to providers on how to evaluate the programs to determine effectiveness. All programs proposed for the SPF PFS will be required to be evidence based, as well as any prevention strategy.

The State Epidemiology Workgroup also started in 2005 under a grant from SAMHSA. It has thrived and became a critical component to the Utah Prevention System. The State has continued funding the SEOW helping to solidify its future. The SEOW was a critical component to this application and will be linked directly to the funded communities. In 2012, Utah was awarded an SEOW grant. Through that project, the SEOW developed an updated Epidemiological report, brief reports on both underage drinking and prescription drug abuse in Utah, and Community level epidemiological reports. The SPF PFS will continue to utilize the SEOW at both the state level and the community level. All SEOW functions will be greatly enhanced in the high need areas, data gaps will be filled, and each community will have a strong opportunity to develop an epidemiological data system in their area more sensitive and accurate for their unique make up. The SPF PFS project will allow the high need areas to be more effective at reaching out to diverse cultures and disparate groups in their area.

#### B.8.

Each LSAA is under contract to ensure they implement culturally competent care and are monitored by DSAMH. Prevention providers are required to be certified in SAPT which includes developing prevention systems that include addressing issues of demographics, language, sexual identity and disabilities. In addition, a more thorough training is required for each staff member of the LSAA and their providers. The Division has a rigorous monitoring plan to address adherence to these contracts, followed by training and technical assistance when required.

The SPF PFS Project will enhance the accomplishments of the SPF in the aforementioned issues. Following the SPF, coalitions and providers address each of the five stages of the SPF with an

interest of cultural sensitivity. Our system now allows for cross training among providers which provides a rich experience of diversity and expertise. Such a system is deployed throughout the state which gives more opportunities for our providers to learn from diverse groups and populations. The DSAMH and the greater Department of Human Services takes addressing issues related to demographics, language, sexual identity and disability seriously and has hired staff and developed a system of training to reach all providers of services in Utah. For an example of the efforts by the DHS, see <http://diversity.hs.utah.gov/>.

## **Section C: Staff Management, and Relevant Experience**

### **C.1.**

The State of Utah DSAMH has been a part of the Strategic Prevention Framework State Incentive Grant (SPF SIG), the State Incentive Cooperative Agreement-Enhancement Grant (SPF E), and the original State Incentive Cooperative Agreement (SICA). All three of these recent grants were evaluated and success was achieved. All prevention staff and administrators included in this proposal implemented these grants are still on staff adding a wealth of knowledge and experience to the SPF PFS project. The Utah Department of Human Services requires that each employee attend and demonstrate competency in cultural issues and sensitivity. DSAMH acknowledges that becoming culturally competent requires ongoing education and an increase in collaboration with diverse agencies and populations.

### **C.2.**

- Craig L PoVey, M.S.W. will be the Project Director of the SPF PFS Project (10% FTE on this project). He is currently the Prevention Program Administrator. Mr. PoVey has held this position for 10 years. He has personally worked on or overseen the project for all the aforementioned grants. Prior to his current position, he worked in a local mental health/substance abuse community center for 12 years.
- Susannah Burt, B.S. is the lead staff for SAPST training and technical assistance leader for all providers. She was the Program Manager for the SPF SIG grant. Susannah has also coordinated the SIG-E and SICA grants at the local levels. She will be at 90% FTE for this project.
- All other support staff including budget and financial assistance will be provided in kind by the current DSAMH staff in those positions.
- Edward Ho, Ph.D. is our current SEOW data analyst through the SEOW project. (60% FTE on this project) We anticipate that Dr. Ho will remain as the SEOW data analyst for the SPF PFS project.

- We will select an evaluator for this project by October 30, 2013 to evaluate the project and provide ongoing training and technical assistance. Our procurement process does not allow us to announce an evaluator at this time. However, as an example of the experience and capability we expect, Bach Harrison LLC has won our bids for the SICA, SICA-E and SPF grants. Bach Harrison employs three Ph.D. psychologists along with masters and bachelor level support staff who work on evaluation projects. The staff has an in-depth knowledge of the prevention system in Utah and the issues involved in planning, implementing, and evaluating prevention programs throughout the state. In Utah, Bach Harrison conducted the evaluation of the CSAP funded SIG, SIG-E, SPF SIG grants, collects and manages data for the SEOW, and conducts the biannual student survey. Other large evaluation projects conducted by Bach Harrison include the Louisiana and Oklahoma SPF SIG and SPE grants, Drug Free Community grants, evaluation of the Utah Department of Corrections programs, evaluation of police department grants, and evaluation of school district Safe Schools Healthy Students and Middle School Grants. Through these and other evaluation projects, Bach Harrison staff members have gained considerable experience evaluating large, complex prevention projects and an in-depth knowledge of Utah's prevention system.

### C.3.

All DSAMH Staff, Mr. PoVey, and Ms. Burt, have worked at both the local level and state level on previous discretionary grants. This experience allows them to understand the challenges the communities may go through during the SPF process. All of these staff maintain cultural humility when dealing with the diverse populations. The DSAMH staff regularly seek out knowledge on the communities that the State serves.

The SEOW data analyst, Dr. Ho, has routinely demonstrated cultural competency in reporting and gathering data available for communities. Dr. Ho has produced ethnicity reports as requested by local communities highlighting specific issues within ethnicity and race in a community.

While none of the identified staff are multilingual, DSAMH has the resources to work with interpreters or native speakers for any of the communities and has bilingual staff who regularly assist all program managers in this regard.

## **Section D: Performance Assessment and Data**

### D.1.

The Utah DSAMH will meet the outcome data requirements for SPF-PFS through collaboration with the SEOW and the evaluation contractor(s). Currently, as a result of the substance abuse prevention data infrastructure developed through the SEOW (as part of the SPF SIG, SPF SPE, and SEOW grants received by the state), nearly all of the required state and community level outcome data measures (identified in Table 1 of the SPF-PFS RFA) are collected on a regular basis within the state. Moreover, through state level data sources, all of the applicable indicators

collected within the state are available at the planned sub-recipient level (state local substance abuse authorities/regions). Table XX below specifies which of the required indicators are available in Utah, the geographic levels at which the indicators are available, and the proposed data source. Indicators to be reported will be chosen for each SPF-PFS sub-recipient based on the priority(s) to be addressed and the interventions chosen. While only indicators that are logically relevant to each sub-recipient’s priority(s) and planned interventions will be collected, all of the indicators from the list that are identified as relevant will be collected for monitoring and evaluation purposes, and those data will concurrently be reported to CSAP. Because the data are available through the SEOW, there is no reliance on the sub-recipient agencies to collect and provide these data. As a result, no potential obstacles are foreseen in collecting and reporting these data.

| <b>Outcome Measure</b>  | <b>Utah Data Proposed Data Source</b> | <b>Levels Available</b>                      | <b>Data Availability</b> |
|---|---------------------------------------|--|--------------------------|
| 30 day alcohol use-Youth  | Utah SHARP                            | Sub-recipient (LSAA) by grade (6, 8, 10, 12) | Biennial (odd years)     |
| Binge drinking in past 2 weeks-Youth  | Utah SHARP                            | Sub-recipient (LSAA) by grade (6, 8, 10, 12) | Biennial (odd years)     |
| 30 day non-medical prescription narcotics use - Youth                             | Utah SHARP                            | Sub-recipient (LSAA) by grade (6, 8, 10, 12) | Biennial (odd years)     |
| 30 day non-medical sedative use-Youth   | Utah SHARP                            | Sub-recipient (LSAA) by grade (6, 8, 10, 12) | Biennial (odd years)     |
|   |                                       |  |                          |
| Perception of parental disapproval of alcohol use-Youth                           | Utah SHARP                            | Sub-recipient (LSAA) by grade (6, 8, 10, 12) | Biennial (odd years)     |
| Peer disapproval of alcohol use-Youth   | Utah SHARP                            | Sub-recipient (LSAA) by grade (6, 8, 10, 12) | Biennial (odd years)     |
| Perceived risk of harm of alcohol use-Youth                                       | Utah SHARP                            | Sub-recipient (LSAA) by grade (6, 8, 10, 12) | Biennial (odd years)     |
|   |                                       |  |                          |
| Alcohol related motor vehicle crashes (injury, fatal and/or property damage only) | Utah Department of Highway Safety     | Sub-recipient (LSAA)                         | Annual                   |
| Reported property crimes  | Unified Crime Reports                 | Sub-recipient (LSAA)                         | Annual                   |
| Reported violent crimes   | Unified Crime Reports                 | Sub-recipient (LSAA)                         | Annual                   |

|  |                           |  |                      |
|--|---------------------------|--|----------------------|
| Family communication around drug use:<br>a) My parents have set clear rules and expectations with me about NOT drinking ANY alcohol.<br>b) During the past year (12 months), how often have you talked with at least one of your parents about the rules and expectations of NO alcohol use?<br>c) During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug abuse? (Choose all that apply). | Utah SHARP                | Sub-recipient (LSAA) by grade (6, 8, 10, 12) | Biennial (odd years) |
| Emergency department (ED) encounters for alcohol poisoning   | Utah Department of Health | Sub-recipient (LSAA)                         | Annual               |
| Emergency department (ED) encounters for drug overdose/poisoning   | Utah Department of Health | Sub-recipient (LSAA)                         | Annual               |

D.2.

In addition to the required indicators listed above, the evaluation contractor will also work with each sub-recipient to identify more proximal outcome and process data elements that will be used to evaluate the specific implementation activities of each sub-recipient community. Through this process, each sub-recipient will have an individualized evaluation plan, rather than forcing all sub-recipients to a “one size fits all” approach. As a result, the evaluation data collected will be meaningful and useful for both state staff in examining the outcomes in each community, as well as for community level staff in monitoring and improving their interventions. Sub-recipients will be required to sign memorandums of understanding to collaborate with the state’s evaluation contractor, and collect data elements that are identified as part of each sub-recipient’s evaluation plan. Process measures will be identified or developed to monitor implementation fidelity for each intervention in order to obtain information that will shed light on why the observed outcomes (positive or negative) occurred. For example, implementation monitoring tools will be developed to allow the DSAMH to understand the

extent to which interventions were implemented to the intended target audience, in the planned dosage, and in the appropriate contexts. These data will be critical for providing contextual information for the outcomes associated with the interventions that are implemented. Measures will also be identified to examine short term outcomes that may precede the required outcome measures. This will allow a more detailed examination of the causal chain of events that are expected to occur as a result of intervention implementation. These additional outcome measures will complement the required indicators, and may afford the evaluation greater sensitivity in demonstrating the effect of each intervention.

The DSAMH will meet at least monthly with the evaluator to review the progress of the communities in meeting the goals, objective, and outcomes of the project. In order for these meetings to be productive, the process and outcome measures must be made available to all participants and presented in clear, understandable formats. This information must also be provided to the subrecipient communities and the agencies providing the prevention services. The responsibility of the evaluator will be to: 1) provide timely information to assist communities as they make necessary program changes, 2) collect relevant data through questionnaires, surveys, and social indicators, 3) conduct analyses that will allow an accurate description of the activities conducted by the SPF PFS project, 4) provide clear reports of the outcomes of prevention policies, practices, and programs, 5) present evaluation information so SPF PFS progress and outcomes are clear, 6) collect and analyze quantitative and qualitative data through process and outcome evaluations, 7) use a logic model approach to provide a systematic structure for organizing, collecting, and reporting community level prevention process and outcome data. The performance assessments will also review whether the project is having an impact on behavioral health disparities, and will review any barriers that were encountered and the methods that were used to overcome the barriers.

The DSAMH has good communications with the local communities. With the RPD in each region, the communication should improve and be more regular. Throughout the project, the RPD will monitor the communities as they go through the project planning process, develop their logic models, implement programs, and collect data. Through each of the project phases, the DSAMH and RPD will assess the progress of the communities and their ability to meet project goals. The DSAMH uses direct face-to-face meetings with groups of community prevention providers, one-on-one meetings, as well as teleconferences to provide TA and feedback to communities. Communities are also assessed annually through on-site reviews conducted by DSAMH staff where performance measures are reviewed and TA provided. The DSAMH has had considerable experience submitting data and reports through SAMHSA's online reporting platforms. As part of the SPF SIG project, state and community level data were submitted through the PMRT and the state continues to use the MDS to collect data from the communities.

D.3.

The performance assessment will be conducted quarterly in conjunction between DSAMH, the RPD, LSAAAs and the evaluator. While the project manager will complete the SAMHSA required quarterly reports, the data will be collected by all partners.

A template that the communities can complete will be developed and disseminated. In that template, the communities will have the opportunity to answer questions related to the project. These will include outcome questions addressing the following: the effect of the strategies on the key goals; the factors associated with outcomes; the individual factors associated with outcomes (including race, ethnicity, sexual identity); and durability of the effects. Additionally, process questions will assess the following: did the area follow their strategic plan; what changes were made (if any); did any behavioral health disparities require any changes; did the changes have any effect on the strategy and assessment; who provided what services to whom; and cost.

This template will also collect any and all challenges, barriers and accomplishments that the communities, RPD and DSAMH may have experienced that quarter.

