



Vermont's
Strategic Prevention
Framework
Strategic Plan REVISED
May 16, 2007

*Vermont Department of Health

Table of Contents

Introduction	5
A. Assessment	
1. Epidemiological Profile	5-51
a. Data sources & indicators used	6
b. Rationale & procedures used in identifying & collecting data	6
c. Summary of patterns & trends in epidemiological data	8
2. Assessing the Systems (Capacity & Infrastructure)	21
a. State Level infrastructure already in place: personnel, resources & systems	21
b. Significant gaps in the current state-level infrastructure	28
c. Capacity to implement the strategic prevention framework at the state level	31
d. Capacity for data-driven decision making at the state level	34
e. The community prevention infrastructure in place	36
f. The effectiveness of the community prevention in place	42
g. Significant gaps in the current community prevention systems	43
h. Capacity of communities to implement the strategic prevention framework	44
i. Capacity of communities to collect, analyze and report on data	46
3. Criteria and Rationale for SPF SIG Priorities	46
a. Criteria used to identify statewide priorities	46
b. Determining state-level critical needs	47
c. Additional criteria used	47
d. The rationale for use of each criterion	48
e. Process used in applying the criteria	49
4. Description of the Priorities	50
a. Statewide priorities for the SPF-SIG	50
b. Procedures used in determining the final priorities	50
c. Group responsible for determining final set of priorities	51
B. Capacity Building	52-54
1. Areas Needing Strengthening	52
2. State and Community Level Activities	52
3. Role of the State Epidemiological Workgroup	54

C. Planning	55-65
1. State Planning Model	55
2. Community-based Activities	56
3. Allocation Approach	57
a. How community-based activities will address critical needs	58
b. How community-based activities will address capacity enhancement	58
c. Allocation of SPF funds to communities	59
d. How allocation mechanism will enable state to address statewide priorities	61
e. Ensuring appropriate use of funds by communities	61
f. Ensuring cultural competence and inclusiveness	62
g. Ensuring sustainability	62
4. Implications of Allocation Approach	62
a. Implications for successfully addressing statewide priorities	62
b. Implications for state’s ability to effectively support community grantees	64
c. Use of additional non-SIG resources	64
D. Implementation	65-67
1. Planned Implementation Activities	65
a. Assessment	65
b. Training	66
c. Communications	66
d. Community grants	66
e. Data collection	67
2. Assurance of non-duplicative efforts of drug-free community grantees	67
E. Evaluation	67-73
1. Overview of evaluation design & activities	67
2. State level surveillance, tracking & evaluation activities	68
3. Community level surveillance, tracking & evaluation activities	69
4. Anticipated measurable outcomes	71
5. Collection & submission of National Outcome Measures Data	71
F. Cross-cutting Components and Challenges	73-86
1. Cultural competency	73
2. Underage drinking efforts in Vermont	76
3. Address the sustainability of your SPF SIG Efforts	78
4. Marketing/communications	79
5. Challenges	83
a. Challenges in Applying a “Need-based” Allocation	83
b. The challenges expected during implementation	84

G. Appendices

1. Appendix I: Constructs & Indicators chart
2. Appendix II: Epidemiological profile
3. Appendix III: Prevention Consultants’ role
4. Appendix IV: Vermont prevention model
5. Appendix V: Summary of Vermont’s status on the IOM
6. Appendix VI: Summary of Task Force recommendations
7. Appendix VII: Model campaigns & programs
8. Appendix VIII: New Directions survey highlights
9. Appendix IX: A review of qualitative data
10. Appendix X: Vermont Acronyms

H. Charts

1. Chart 1.1: Per capita cigarette sales _____ 11
2. Chart 1.2: Cigarette use in past 30 days/SES _____ 12
3. Chart 1.3: 30 day marijuana use across grades _____ 15
4. Chart 1.4: Age distribution _____ 16
5. Chart 1.5: Marijuana use of past 30 days/SES _____ 16
6. Chart 1.6: 30 day alcohol use across grades _____ 18
7. Chart 1.7: Binge drinking across grades _____ 18
8. Chart 1.8: Relationship between alcohol consumption & grades _____ 19
9. Chart 1.9: Driving after drinking/binge drinking _____ 20
10. Chart 1.10: Past 30 days consumption/binge drinking/SES _____ 20

I. Tables

1. Table 1.1: Population Growth by County _____ 8
2. Table 1.2: Distribution of 15-24 year olds by County _____ 9
3. Table 1.3: Distribution of mother’s education level _____ 9
4. Table 1.4: Age-adjusted mortality rate _____ 11
5. Table 1.5: Prevalence of past 30 days illicit drug use _____ 13
6. Table 1.6: Prevalence of past year marijuana use _____ 13
7. Table 1.7: Prevalence of past month marijuana use _____ 14
8. Table 1.8: Perception of once a month marijuana use _____ 14
9. Table 1.9: First use of marijuana _____ 14
10. Table 1.10: Past 30 day alcohol use _____ 17
11. Table 1.11: Past month binge drinking _____ 17

Introduction

In 2004 the Center for Substance Abuse Prevention (CSAP) conducted an assessment of Vermont's substance abuse prevention system. CSAP's report on Vermont's system states: "Vermont's ability to plan and manage the prevention system in such a way that outcomes are achieved, documented, and reported is at a critical juncture. Many of the elements for a viable strategic planning process are in place, including strong needs assessment systems, effective local planning procedures, and a body of knowledge and expertise about planning and providing best practices. What is lacking is a formalized strategic planning process and a consistent, standardized, and effective management information system to collect and analyze data that measure and track program outcomes, both at the local and state level." (CSAP, 2003) To strengthen Vermont's prevention efforts, Gov. James Douglas proposes the following Strategic Prevention Framework (SPF) plan, addressing CSAP's concerns.

The need for an enhanced infrastructure to increase Vermont's capacity is critical. Preliminary results from a survey of key stakeholders in Vermont support CSAP's assessment. The survey (funded through the State Prevention Advancement and Support Project) is of 50 key stakeholders, including prevention program managers, regional coordinators of state services, community coalition coordinators, state staff and local prevention grantees. Results from this assessment indicate that the majority (90%) of those interviewed identified a community and state-level need for facilitation of a strategic planning process, as well as the need for skill-building training programs on topics such as planning, evaluation, youth leadership and involvement and evidence-based programs. When asked to identify what prevention strategy should be a top priority for funding in the next five years, stakeholders identified two critical components of the Strategic Prevention Framework (SPF): conducting a needs assessment to determine Vermont's top substance abuse prevention priorities, and the need for inter-connected environmental strategies, such as media and communications strategies.

While originally disappointed with not being funded in the first cohort, Vermont has come to appreciate the complexity of the Strategic Prevention Framework process and has gained insight to the project through dialogue with our former project officer, Grant Hills and other SPF state coordinators. In preparation for the writing of this plan and throughout the last year of intensive work by the State Epidemiological Workgroup (SEW), we have relied heavily on the expertise of CSAP, PIRE and cohort I states for lessons learned. The SPF meetings designed by CSAP and PIRE held in December 2005 and October 2006 provided materials and information that has been instrumental in guiding our work in Vermont over the past year.

A. Assessment

1. Epidemiological Profile

This section summarizes patterns and trends in statewide indicators of substance use and related consequences, as captured in the state's epidemiological profile, and the process used in creating the profile. In addition, we present the procedure used by the State Epidemiological Workgroup

(SEW) to assess particular indicators of the profile as well as the process engaged in to evaluate and select overall priorities as approved by the Vermont SPF-SIG Advisory Council.

a. Data sources and indicators used

Appropriate data indicators on substance use and substance related consequences you have used to assess need in your State and portray and detail the nature and extent of the problem, assess needs and other relevant information.

The State Epidemiological Workgroup (SEW) reviewed the 41 indicators (14 consequences / 27 consumption) contained in the State Epidemiological Data Set (SEDS) provided by the Center for Substance Abuse Prevention (CSAP). A complete list of the constructs and indicators examined is provided in Appendix I. In addition to the SEDS data, the SEW examined data from: the Vermont Department of Health including treatment admissions data, county and school district level data from the Youth Risk Behavior Survey (YRBS), county level Behavioral Risk Factors Surveillance System (BRFSS), and hospital admissions and Emergency Room data; from the Department of Corrections on youth offenders; current and trend substance use and abuse data from national surveys including the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) and the National Survey on Drug Use and Health (NSDUH); Uniform Crime Reports (UCR); National Vital Statistics System (NVSS); Drug Abuse Warning Network (DAWN); Smoking-Attributable Mortality, Morbidity, and Economic Costs data base (SAMMEC); National Highway Traffic Safety Administration (NHTSA).

b. Rationale and procedures used in identifying and collecting epidemiological data

Discussion of all policies, procedures, and processes that were considered or were utilized to identify and collect these indicators.

Initial SEW meetings were held in January, February, and March of 2005 among VDH staff and outside consultants to discuss the SPF-SIG SEW guidelines, develop a work plan, and conduct a preliminary assessment of which appropriate data sources were available and should be considered. In addition, CSAP criteria for which public and private sectors should be represented on the work group were considered and a preliminary list of potential members was compiled. Discussions also occurred about general methodological issues and particular substance abuse problems in Vermont based on the expertise of individual group members. The full SEW was formed in mid 2005 with members who were identified based on a variety of criteria including familiarity with data gathering and analysis techniques, access to critical data sets, expertise in the substance abuse prevention field, community partnership members, and academic researchers. The group is chaired by Kelly Hale LaMonda from the Vermont Department of Health.

The first full SEW meeting was held on September 29, 2005 where the charge of the workgroup was discussed and a plan developed for obtaining and analyzing relevant data sets of substance use/abuse indicators. Technical assistance at this inaugural meeting was provided by staff

members from the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Pacific Institute for Research and Evaluation (PIRE).

Subsequent meetings were held monthly. The purpose of these meetings was to examine as many relevant data sources as possible in order to provide an empirically-based guide for the recommendations to the Advisory Council (AC) in selecting the aims, goals, and priorities for prevention programs in the State of Vermont to be funded by the SPF-SIG initiative. Additional considerations were subsequently considered by the AC in finalizing the statewide priorities (see section 3.c, page 47-48).

The SEW first considered the SEDS data provided to SPF-SIG states by CSAP. Of the 41 indicators described in this data set, one was determined to be redundant with other data (“current heavy alcohol use”) and one (“current inhalant use”) was not available in SEDS because the Vermont version of the YRBS does not ask this question. These two items were dropped from further consideration. In addition, the SEW decided that hospital admissions and ER data from the Department of Health was unreliable because of the reliance on ICD-9, ICD-10 coding criteria. Initial analysis of these data proved too malleable; that is, it appeared that the calculated rates were very sensitive to local and temporal variability in coding practices. While the coding is standardized, the application of the codes is not. Codes are assigned primarily by independent coders, not the treating physicians and are thus at least one-level removed from patient contact. In a busy ER, it is often the case that physicians are primarily interested in treating the admitting problem and may be insensitive to ancillary issues such as drugs and alcohol unless they are florid cases or cases that may be related to outside influences (e.g., law enforcement). Based on current prevalence rates of alcohol and drug use in Vermont, it was the assessment of the SEW that illicit drugs were over-represented in this data base and did not reflect an accurate proportion of actual hospital/ER admissions and treatment patterns. Therefore, this indicator was not pursued or analyzed any further. However, as we suggest below, we intend to pursue this data in the future with greater specificity.

The SEW used all other available data to assess and compare indicators at the state and national levels, and also (where possible) at the county and community levels. Comparisons were made across indicators, and also for the same indicator across geographical areas (e.g., the state to the nation as a whole). Because Vermont is so small and sub-state data are limited, most of the data were aggregated across the State so that reliable estimates could be obtained. The SEW quickly determined that of the data accessible, only the YRBS data set was extensive enough to be examined reliably at a sub-state level. Although the lack of community-level data precluded a complete assessment of how the levels of substance abuse and related consequences varies geographically within the state, the YRBS data were able to provide at least a partial view. Analyses of the YRBS data revealed considerably homogeneity in rates of substance use behaviors across Vermont’s counties. Somewhat more variation was observed at the level of School Supervisory Unions (SUs), but that appeared to be due in large part to deviations caused by small numbers of students in certain smaller SUs. Thus, prioritization of statewide substance abuse problems could precede some confidence that no widely fluctuating substance pockets of substance use/abuse indicators would skew interpretation of the underlying data.

c. Summary of patterns and trends in epidemiological data

Demographics of Vermont

According to the 2000 census (as well as current projections), Vermont ranks 49th among the 50 states in population. Table 1.1 presents the estimated population growth from the period April 1, 2000 to July 1, 2005 of the 14 counties that comprise Vermont. The most populated county (Chittenden) has 24% of the total population while the least populated (Essex) has 1%. Table 1.2 presents the distribution of the youth and young adult population across Vermont. The State has a relatively homogeneous racial make-up with 96.8% of the population listing their race as white. The largest minorities are Hispanic (1%) and Asian/Pacific Islanders (1%); 54% of Asian/Pacific Islanders and 41% of Hispanics reside in Chittenden County. While the minority population of Vermont is slowly increasing, analyzing epidemiological data by race remains problematic and imprecise because of the low numbers in the population.

	2005	2004	2003	2002	2001	2000
Vermont	623,050	621,233	619,092	616,274	612,824	609,937
Addison	36,965	36,822	36,636	36,469	36,203	36,038
Bennington	36,999	37,022	37,085	37,107	36,968	36,992
Caledonia	30,440	30,391	30,075	29,974	29,744	29,767
Chittenden	149,613	149,379	148,813	148,457	147,764	146,973
Essex	6,602	6,640	6,574	6,551	6,501	6,463
Franklin	47,914	47,498	47,080	46,619	46,117	45,597
Grand Isle	7,703	7,633	7,502	7,313	7,140	6,940
Lamoille	24,495	24,356	24,240	23,981	23,646	23,342
Orange	29,287	29,190	29,059	28,842	28,700	28,310
Orleans	27,640	27,364	27,123	26,686	26,544	26,346
Rutland	63,743	63,550	63,554	63,304	63,289	63,419
Washington	59,478	59,118	58,941	58,912	58,527	58,073
Windham	44,143	44,206	44,385	44,178	44,068	44,176
Windsor	58,028	58,064	58,025	57,881	57,613	57,501

Table 1.1 Population Growths by County in Vermont (Source: Population Division, US Census Bureau)

County	2005	2000	Increase	Under 21	%	20-24	%	15-24	%
	Projected	Actual	%						
Addison	36,965	36038	2.6	11448	31.8	2835	7.9	6216	17.3
Bennington	36,999	36992	0.0	10144	27.4	1893	5.1	4491	12.1
Caledonia	30,440	29767	2.3	8874	29.9	1678	5.6	4064	13.6
Chittenden	149,613	146973	1.8	43973	30.0	13191	9.0	25052	17.1
Essex	6,602	6463	2.2	1855	28.7	269	4.2	724	11.2
Franklin	47,914	45597	5.1	14247	31.4	2129	4.7	5351	11.8
Grand Isle	7,703	6940	11.0	1894	27.4	266	3.9	706	10.3
Lamoille	24,495	23342	4.9	6720	28.9	1609	6.9	3305	14.2
Orange	29,287	28310	3.5	8487	30.0	1388	4.9	3603	12.7
Orleans	27,640	26346	4.9	7464	28.4	1289	4.9	3174	12.1
Rutland	63,743	63419	0.5	17351	27.4	3502	5.5	8042	12.7
Washington	59,478	58073	2.4	16137	27.8	3512	6.0	7736	13.4
Windham	44,143	44176	-0.1	11975	27.1	2050	4.6	5154	11.6
Windsor	58,028	57501	0.9	14950	26.0	2241	3.9	6004	10.5

Table 1.2: Distribution of 15-24 Year Olds by County in Vermont

The median age of the population in Vermont is 40.7 years (US median = 36.4 years). Males make up 49.9% of the population and females 50.1% (same as US). The median household income in Vermont is \$45,686 (2005 inflation adjusted dollars), slightly less than the US average of \$46,242; the average household size is 2.47 persons compared to 2.60 for the US as a whole.

The SEW and Bridge Group also examined data relevant to cultural competency in Vermont. As mentioned in the “Demographics” section of the EPI part of the plan, the population of Vermont is not particularly diverse with respect to race, ethnicity, or sexual orientation. In the YRBS, for example, 0.9% of those surveyed identified themselves as gay or lesbian (males = 0.6%, females = 1.1%); 3.6% reported they were bisexual (males = 1.9%, females = 5.3%; 2.7% reported they were unsure of their sexual orientation (males = 2.6%, females = 2.8%). The rest of the sample described themselves as heterosexual (males = 94.2%, females = 91.4%).

As a surrogate for socio-economic status, we looked at the highest level of education for the mother on the YRBS. Table 1.3 presents these data

Level of Education	Valid Percent
Completed grade school or less	1.1
Some high school	5.8
Completed high school	25.4
Some college	14.7
Completed college	31.9
Graduate or professional school	13.6
Not sure	7.4
Total	100.0

Table 1.3: Distribution of Mother’s Highest Level of Education (Source YRBS 2005, Vermont Department of Health)

For efficiency and clarity, we made this variable a 4-category indicator: less than high school, high school, college, and post-graduate. Individuals who indicated they were “not sure” of their Mother’s educational attainment were dropped from subsequent analyses.

Alcohol, Tobacco, and Other Drugs in Vermont: Consumption and Consequences

The data presented in this section represent a summary of significant highlights from all data analyzed and interpreted by the SEW. We note this summary paints only a partial picture of the work of the SEW, but reflects the empirical data sifting process used by the SEW to arrive at the SPF-SIG priorities. Appendix I contains a more extensive summary of these data in a tabular format. In particular, this table characterizes each consumption and consequence indicator examined by the SEW with respect to how Vermont compares to the U.S. (if available), the trend for the indicator over the past five years (if available), the actual indicator values (i.e., rates or percentages), and the number of persons or events on which the values are based. Many of the observations noted in this section of the strategic plan are based on the patterns and values depicted in the summary table; others are from data sources more recently mined. We further note that the summary table was developed through an examination of a much more voluminous set of data tables and displays. These data are collectively organized in Appendix II: Vermont’s State Epidemiological Profile. We note that the profile was developed for use by the SEW, but the current version is not designed for public dissemination. One task for the SEW in the upcoming year is to determine the potential utility of preparing a more user-friendly version of the epidemiological profile that could be widely disseminated and/or readily available on the VDH web site.

All data described in this section were gleaned from the sources discussed above. We have used expanded and current data where possible. For example, since the Department of Health administers the biennial YRBS of 8th to 12th graders in Vermont schools and participates the annual BRFSS of individuals 18 years and older, we have access to more current and complete data than contained in the SEDS.

The smallest geographic unit to which the available data can be reliably disaggregated is the Supervisory Union (SU), and that level of disaggregation is only possible for the YRBS data. SU’s in Vermont are typically composed of a collection of schools in contiguous geographic areas. For example, Chittenden South Supervisory Union consists of the K-8 schools in the towns of Charlotte, Hinesburg, Shelburne, St. George, and Williston, plus the high school (9-12) which is fed by these towns. We note that while there were some between SU differences in outcomes, when aggregated across county most YRBS results were quite similar suggesting that variability of consumption and consequence indicators across the State (i.e., between county) is minimal. The results from surveys with fewer respondents (e.g., BRFSS) are imprecise at the sub-state level. Therefore, the data analyses and interpretation we present below are at the state level (but see the complete State Epidemiological Profile for limited sub state analyses). The small population and geographic size of Vermont constrains the level at which many of the indicators examined by the SEW can be reliably parsed.

Tobacco

Although consequences of long-term smoking remain a significant health problem across the United States, tobacco sales and consumption in Vermont and all states has been declining for several years across all age levels.

Chart 1.1 presents the per capita annual packs of cigarettes (wholesale tax rates) sold in Vermont from 1990-2002. Sales of cigarettes have decreased by 32.6% over this time period.

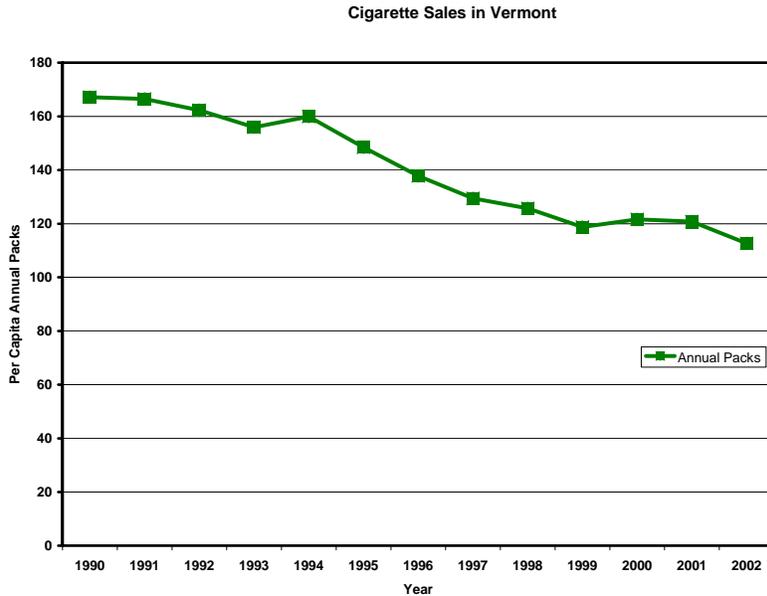


Chart 1.1: Per Capita Cigarette Sales in Vermont based on Wholesale Taxation (Source: University of San Diego Social Science and Humanities [SEDS]).

Based on YRBS data, youth smoking has decreased dramatically over the past 10 years across all grades for both boys and girls. Past 30 day cigarette smoking has declined from a high of 45% in 1995 to the current rate of 23% among 12th graders, which is significantly below the 2005 national average of 27.6%. Also in 1995, 29% of 8th graders reported recent cigarette consumption which has declined to 8% by 2005. Furthermore, adult rates of smoking in Vermont have remained relatively stable over the past 10 years which mirrors the national data. In fact, with prevalence 19.5%, Vermont is below the national average of 22.5% for current smokers (Content source: [National Center for Chronic Disease Prevention and Health Promotion](#)).

Age-adjusted mortality rates for smoking-related diseases have decreased significantly over the past few years and Vermont is below the national average on all of them as shown in Table 1.4.

Smoking Related Mortality

	Respiratory Disease¹	Lung Cancer²	Heart Disease²	Cerebrovascular Diseases³
VT	72.7	48.6	199.3	44.9
US	79.4	54.9	232.3	53.5

Table 1.4: Age-Adjusted Mortality Rates/100,000 (Sources: ¹Smoking-Attributable Mortality, Morbidity, and Economic Costs 1997-2001; ²CDC Wonder, 2002; ³National Vital Statistics Reports, 2003)

Finally, smoking appears to be related to SES. Chart 1.2 shows declining rates of smoking as a function of increasing SES (measured as Mother’s highest level of education).

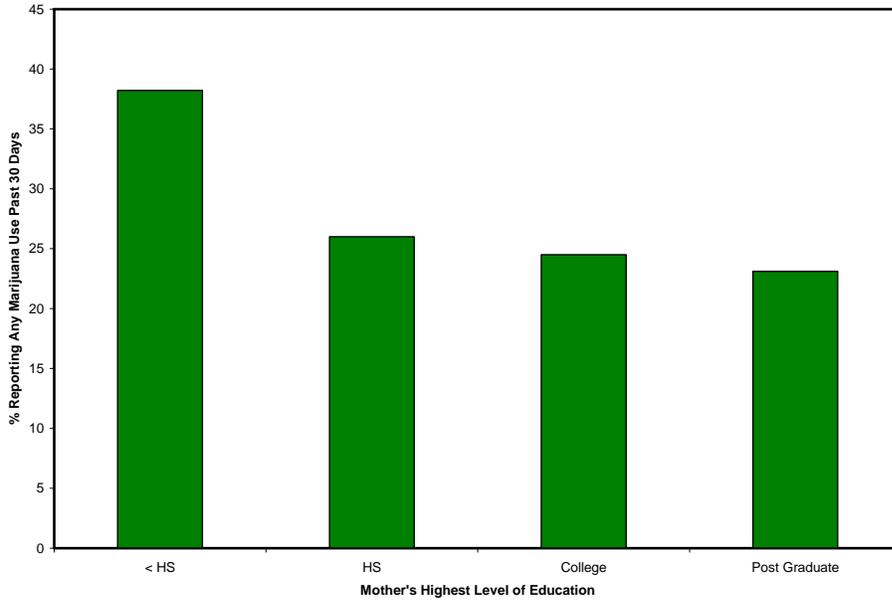


Chart 1.2: Reported cigarette Use Past 30Days as a function of SES (Mother’s Highest Level of Education) (Source: YRBS, 2005, Vermont Department of Health)

In sum, youth smoking has decreased significantly and adult smoking rates have not increased, suggesting that state and national prevention efforts aimed at reducing smoking particularly among adolescents have been effective. Smoking-related consequences in Vermont are decreasing and are currently below the national average. The SEW determined that because consumption and consequence rates were not increasing, and Vermont’s rates are below the national averages, tobacco would not be recommended to the AC as priority for the SPF-SIG.

Illicit Drugs Other than Marijuana

This category includes cocaine, heroin, hallucinogens, inhalants, methamphetamines, and any prescription medication used for nonmedical purposes. Use of illicit drugs other than marijuana has remained relatively stable in Vermont over the last several years – across age groups there has been neither a significant increase nor decrease from 1999-2004 based on data from the National Survey on Drug Use and Health. The highest prevalence in 2004 (9.47%) is among 18-25 year olds, but this rate has declined slightly though not significantly so from 2001 (10.51%). NSDUH estimates of past 30-day use among adolescents 12-17 show a slight but nonsignificant increase from 1999 (5.22%) to 2004 (6.08%). Data from the YRBS indicates adolescent prevalence rates of illicit drugs other than marijuana have declined from already low rates between 2003 and 2005. Table 1.5 presents the past 30-day use of all illicit drugs other than marijuana from the 2003-2004 NHSDUH surveys.

Past Month

Age Group	VT Prevalence (%)	US Prevalence (%)	VT Rank
<i>All</i>	3.74	3.73	20
<i>12-17</i>	6.08	5.70	4
<i>18-25</i>	9.47	8.17	13
<i>26+</i>	2.45	2.68	28

Table 1.5: Prevalence of Past 30-day Illicit Drug Use Other than Marijuana. (Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2003-2004)

With respect to illicit drug use consequences, injury and medical complications are perhaps the leading indicators. However, as mentioned above, the SEW determined that hospital admissions and ER data were unreliable indicators and were not evaluated further. Data from the Drug Abuse Warning Network (DAWN) indicated that 55 individuals in Vermont in 2003 died from misuse of illicit drugs other than marijuana. An additional 19 deaths were attributable to alcohol misuse. The highest fatality rates were in males (19.1/100,000) and in those in the 35-54 age group (20/100,000). The lowest rates occurred in females (5.1/100,000) and the under 21 age group (3.4/100,000). However, data from SEDS - National Vital Statistics System -shows only 30 (19 male, 11 female) drug-related deaths in Vermont over a 4-year period (1999-2003). Of the 30 cases identified as drug-related deaths by NVSS between 1999-2003, 12 (40%) were among individuals older than 55 years. We were unable to determine the reasons for the discrepancies between the DAWN and the NVSS sources. Apparently, these two data sets draw on different reporting mechanisms and it is unclear whether DAWN overestimated or NVSS underestimated drug-related mortality. DAWN relies on its own coding methods from ER cases, while NVSS uses ICD-9/10 codes. In any case, the raw numbers and the prevalence rates were quite low.

In sum, these data suggested to the SEW that illicit drugs other than marijuana should not be recommended as a focus of the SPF-SIG. When we applied our most influential criteria to assessing rates and consequences of use, these indicators were relatively low compared to alcohol and marijuana, and in some cases so low that it could be difficult to discern meaningful change.

Marijuana

Vermont is one of only eight states that were in the top fifth in prevalence rates of marijuana consumption across all three age groups (12-17, 18-25, and 26 & older). Table 1.6 presents past year marijuana use in Vermont and the US as well as Vermont's national rank

Past Year

Age Group	VT Prevalence (%)	US Prevalence (%)	VT Rank
<i>All</i>	14.90	10.60	2
<i>12-17</i>	19.80	14.74	2 (Tied)
<i>18-25</i>	43.33	28.17	1
<i>26+</i>	9.37	6.94	6

Table 1.6: Prevalence of Past Year Marijuana Use. (Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2003-2004)

Data from NSDUH on marijuana use in the past month paints a similar picture (see Table 1.7)

Past Month

Age Group	VT Prevalence (%)	US Prevalence (%)	VT Rank
<i>All</i>	8.99	6.11	3
<i>12-17</i>	11.11	7.73	4
<i>18-25</i>	26.35	16.58	1
<i>26+</i>	5.73	4.05	4

Table 1.7: Prevalence of Past Month Marijuana Use. (Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2003-2004)

Another indicator of use of marijuana is perception of harm. Table 1.8 shows the percentage of Vermonters and rankings across age groups compared to the US National average for perception of great risk of smoking marijuana once a month. This table indicates that individuals across all age groups in Vermont have a lower perception of great risk associated with regular marijuana use than all other states except one.

Perception of Great Risk

Age Group	VT (%)	US (%)	VT Rank
<i>All</i>	27.75	39.74	2
<i>12-17</i>	26.96	34.92	2
<i>18-25</i>	15.38	25.20	2
<i>26+</i>	29.98	42.96	2

Table 1.8: Perception of Great Risk of Smoking Marijuana Once a Month. (Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2003-2004)

Finally, NSDUH provides data on average annual rates of first use of marijuana. As can be seen in Table 1.9, Vermont ranks the highest overall and in two of the three specified age groups.

First Use of Marijuana

Age Group	VT (%)	US (%)	VT Rank
<i>All</i>	2.49	1.76	1
<i>12-17</i>	8.82	6.25	1
<i>18-25</i>	10.47	6.63	1
<i>26+</i>	0.15	0.13	9

Table 1.9: First Use of Marijuana: Average Annual Rates. (Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2003-2004)

Vermont has been participating in the biennial Youth Risk Behavior Survey of 8th to 12th graders since 1993. This is a school-based survey and therefore reflects a slightly different data perspective. The YRBS data show significant and sustained marijuana use across participating age groups and gender congruent with the NSDUH reports. Chart 1.3 presents the long term trends of past 30-day reported use of marijuana for 8th, 10th, and 12th graders assessed by the YRBS. Over the course of the 12-year reporting period, rates among all three age groups (and

both genders) have increased. That is, although the general trend has either been steady or slightly declining, overall rates in 2005 are still greater than those measured in 1993.

Further analysis of the 2005 YRBS data indicates that adolescent males are significantly more likely to report using marijuana than females. In addition, while there only slight gender difference in reports of riding in a vehicle with someone who has smoked marijuana, males significantly more likely to report driving a vehicle after using marijuana than females. Of great concern is that rates of driving after using marijuana (males = 16.7%, females = 9.5%) and riding in a car with a driver who has smoked marijuana (males = 27.3%, females 25.9%) are even higher than rates of the same behaviors with alcohol (see “Alcohol” below).

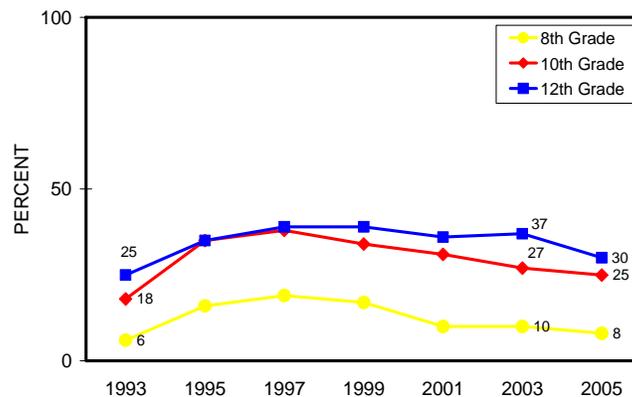


Chart 1.3 Vermont Prevalence of Past 30-Day Use of Marijuana Reported by 8th, 10th, and 12th Grade Students Across Time (Source: Youth Risk Behavior survey, Vermont Department of Health)

Other consequences include the fact that marijuana represents a significant portion of the treatment population in the State of Vermont. We understand that treatment data are subject to a number of external factors (access, capacity, etc.) that are independent of a prevention needs assessment, but we also believe these data can still be used for illustrative purposes. Since 1999 the proportion of individuals treated for a marijuana abuse or dependence increased from 17.3% to 19.8%. Of those treated, 72.8% were under the age of 25. Data from the National Treatment Episode Data Set (TEDS) indicate that admissions for treatment of marijuana-related disorders in Vermont more than tripled from 1992 to 2002. Chart 1.4 presents the age distributions from 1999-2004 of those individuals treated for marijuana abuse/dependence in Vermont facilities. As can be seen, over 70% of the marijuana treatment population in Vermont is under the age of 24. Marijuana represents the second largest burden in the treatment system exceeded only by alcohol.

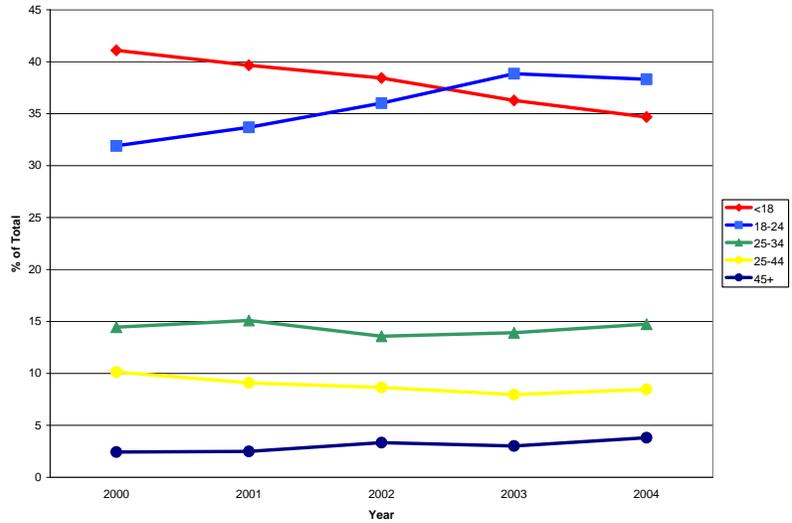


Chart 1.4 Age Distribution Across Years of Individuals Treated in Vermont for Marijuana Abuse or Dependence (Source: Vermont Department of Health)

Chart 1.5 shows that SES is also related to marijuana prevalence rates among high school students. Students who came from economically disadvantaged families are more likely to report using marijuana.

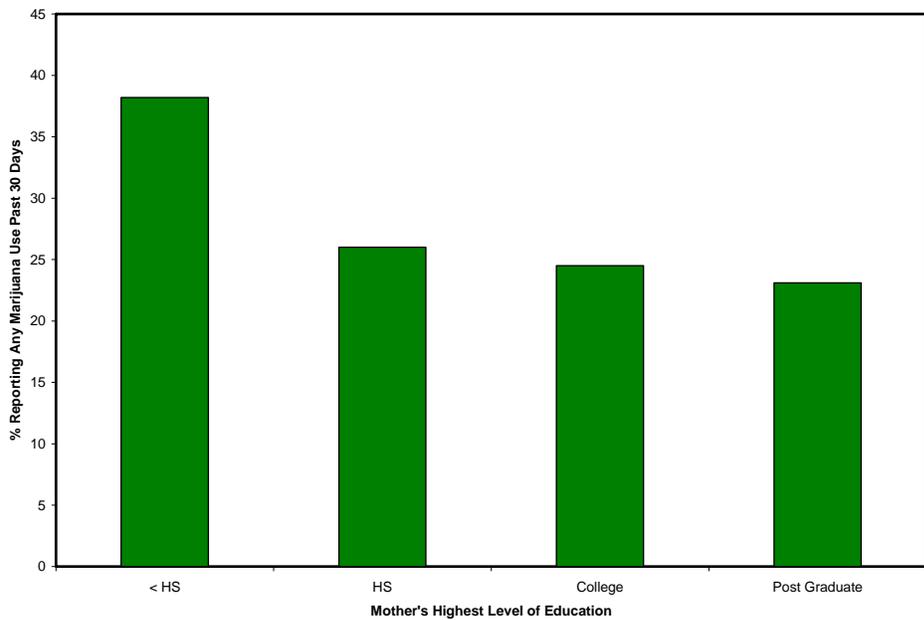


Chart 1.5: Report of Marijuana Use Past 30-Days as a function of SES (Mother's Highest Level of Education) (Source: YRBS, 2005, Vermont Department of Health)

In sum, all available data suggest that marijuana is in general a significant and growing problem in the state of Vermont. Marijuana consumption and the associated risky use pattern of driving after using marijuana, among individuals under the age of 25 is of particular concern.

Alcohol

Underage drinking and early adult heavy drinking are significant National problems and are reflected in the Vermont specific data. The good news is data indicate that both consumption indicators are decreasing over time; the bad news is these indicators and associated consequences remain at unacceptably high rates.

Past Month Alcohol Use

Age Group	VT (%)	US (%)	VT Rank
<i>All</i>	58.43	50.50	11
<i>12-17</i>	22.00	17.67	6
<i>18-25</i>	73.45	60.91	1
<i>26+</i>	60.69	53.22	9

Table 1.10: Prevalence of Past 30-day Alcohol Use in Comparison to US Average across Age Groups (Source: NSDUH 2002-2003)

Past Month Binge

Age Group	VT (%)	US (%)	VT Rank
<i>All</i>	25.51	22.75	11
<i>12-17</i>	14.70	10.65	4
<i>18-25</i>	49.19	41.25	7
<i>26+</i>	22.87	21.20	15

Table 1.11: Prevalence of Past Month Binge Drinking in Comparison to US Average across Age Groups (Source: NSDUH 2002-2003)

Tables 1.10 and 1.11 indicate Vermont’s prevalence rates for two important consumption indicators in comparison with other states. Vermont ranks in the top 9 across all age groups except one on both these indicators. Of particular concern is the highest in the nation drinking among 18-25 year olds and the high rates of binge drinking among those 25 years of age and younger.

The YRBS data demonstrate that current use (past 30 days) and heavy episodic use (5 or more drinks in a row) have declined significantly across all grade levels. Charts 1.6 and 1.7 present these data for 8th, 10th, and 12th graders from Vermont (data not shown for gender). While gradually decreasing over time, the number of students who regularly engage in the consumption of alcohol and/or who drink relatively large quantities in single sittings remains alarmingly high.

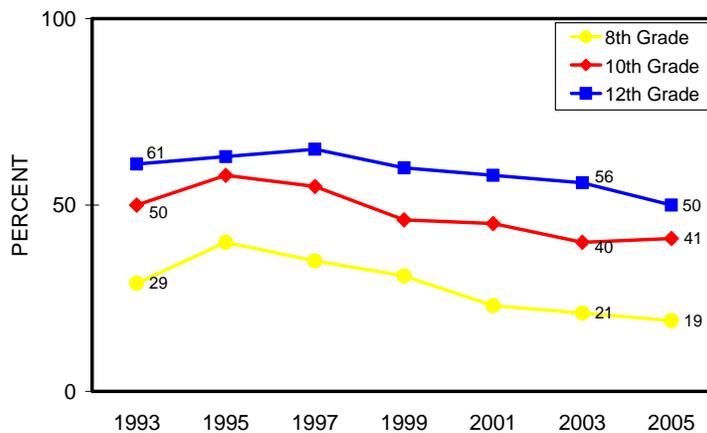


Chart 1.6: Vermont Prevalence of Past 30-Day Use of Alcohol Reported by 8th, 10th, and 12th Grade Students Across Time (Source: Youth Risk Behavior survey, Vermont Department of Health)

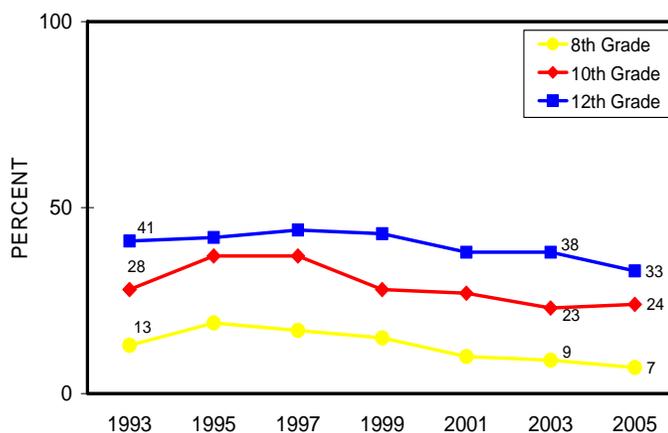


Chart 1.7: Vermont Prevalence of Binge Drinking (defined as 5 or more drinks in a row) Reported by 8th, 10th, and 12th Grade Students Across time (Source: Youth Risk Behavior survey, Vermont Department of Health)

Although these data are encouraging, and mirror national trends, alcohol use among adolescents remains a significant problem in Vermont. An additional concern is driving after drinking. Among 12th graders, in 2005 21.8% of males and 11.8% of females report they drove a vehicle after drinking alcohol; 26.5% of males and 22.9% of females reported riding with someone who had been drinking. In Vermont, individuals under the age of 25 accounted for approximately a third of single vehicle nighttime crashes from 1995-2003. Of those, approximately 60% were under the age of 21. Although we have no hard data, it can be assumed that alcohol was involved in a large proportion of these incidents.

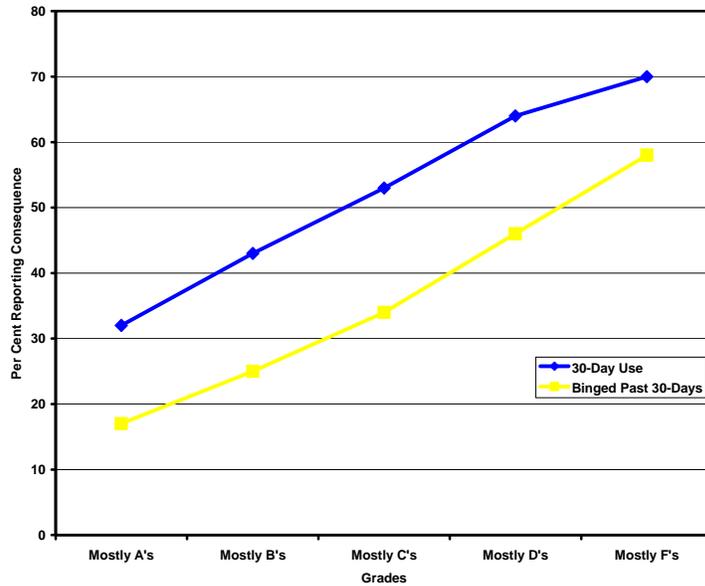


Chart 1.8: Relationship between Alcohol Consumption and Reported Grades (Source: YRBS, 2005, Vermont Department of Health)

Chart 1.8 suggests a relationship between drinking indicators and self-reported grades on the YRBS of Vermont students in grades 9-12. Although the directional effect of this relationship cannot be determined by these data, there are two points that can be made. First, even good students (i.e., those obtaining A's and B's) are drinking at significant levels and second, there is an inverse linear relationship between consumption indicators and grades as reported by the students.

The BRFSS data indicate that between 2001-2005 the combined prevalence rate for “driving after perhaps drinking too much” in the past 30 days for 18-24 year olds was 10.0% (CI 7.8 - 12.7) compared to 3.6% (CI 3.2-3.9) of individuals 25 and older. Over the same time period the BRFSS also showed 37.6% (CI 34.4 – 41.0) of those under 25 report heavy episodic drinking (more than 5 drinks on one occasion) at least once in the past 30 days compared to 13.3% (CI 12.9 – 13.9) of those over age 25. Overall, this puts Vermont in the top third among all States in heavy episodic drinking. Chart 1.9 presents these data disaggregated by year (we do not have data on binge drinking in 2001). Furthermore, almost three times as many males (24.0%) engaged in heavy episodic drinking as females (8.2%). At 6.6% (CI 5.8 – 7.4) Vermont ranks 4th in the Nation on the rate of adult heavy or chronic drinking defined as averaging more than two drinks per day for males and more than one drink per day for females.

Vermont has the highest mortality rate of alcohol-related cirrhosis among the five New England states for the combined years 1999-2003. The crude rate increased from 3.5/100,000 in 1999 to 6.1/100,000 in 2003. Vermont has the lowest rate of nonalcoholic cirrhosis mortality among the five New England states.

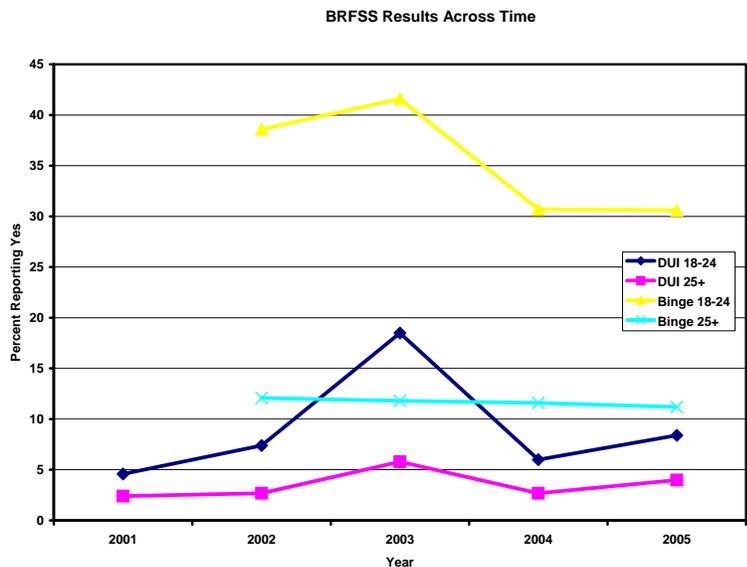


Chart 1.9: Age Groups across Years Self-Reports of Driving after Drinking and Binge Drinking (Source: BRFSS, Vermont Department of Health)

Chart 1.10 shows the relationship between alcohol consumption and binge drinking among 9th to 12th graders as a function of SES. These data suggest that lower SES is associated with increased consumption.

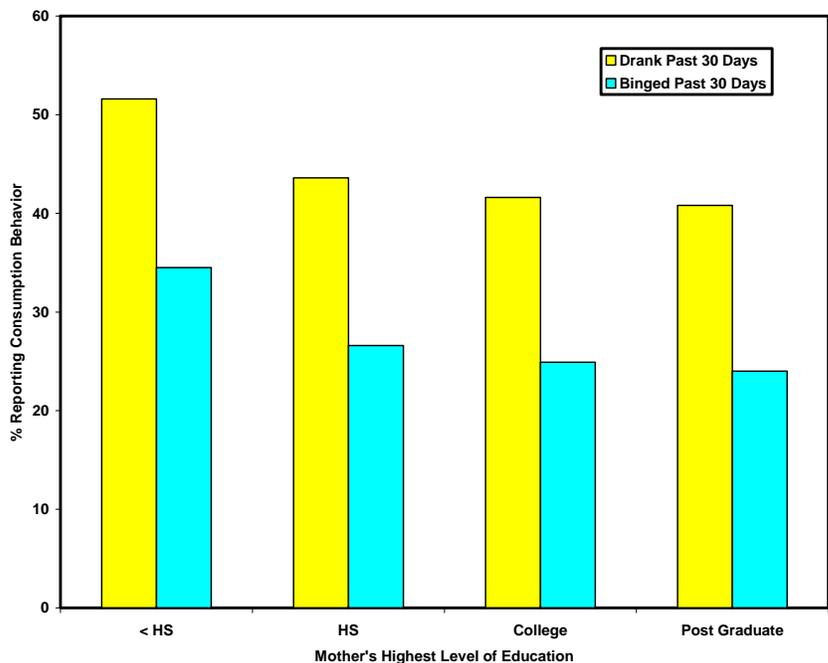


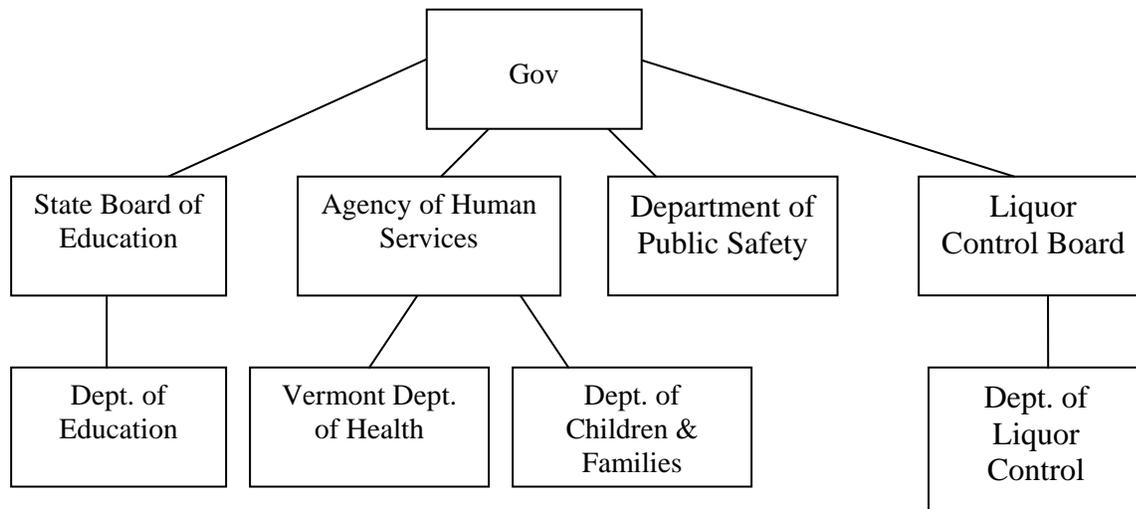
Chart 1.10: Past 30-Day Consumption and Past 30-Day Binge Drinking as a Function of SES (Mother's highest Level of Education) (Source: YRBS, 2005, Vermont Department of Health)

These data suggest that alcohol consumption patterns and consequences meet and often exceed our model of most influential criteria for selecting SPF-SIG priorities. Of particular importance is the impact of alcohol on school-age children and young adults in Vermont. Efforts focused on reducing underage drinking, binge drinking among young adults, and the associated consequences of such consumption present a singular opportunity for community-level coalitions to enhance existing evidenced-based prevention programs and/or implement new ones.

2. Assessing the Systems (Capacity & Infrastructure)

a. State level infrastructure already in place: personnel, resources & systems

Vermont is unique in its size and commitment to prevention across state agencies and the current level of coordination and collaboration among these state agencies. The state level infrastructure currently in place in the State of Vermont can be illustrated by the organizational chart below:



In addition, there are three statewide boards/councils, the Tobacco Evaluation and Review Board, the Children and Family council for Prevention Programs and the Strategic Prevention Framework Advisory Council that provides oversight of specific prevention funding streams.

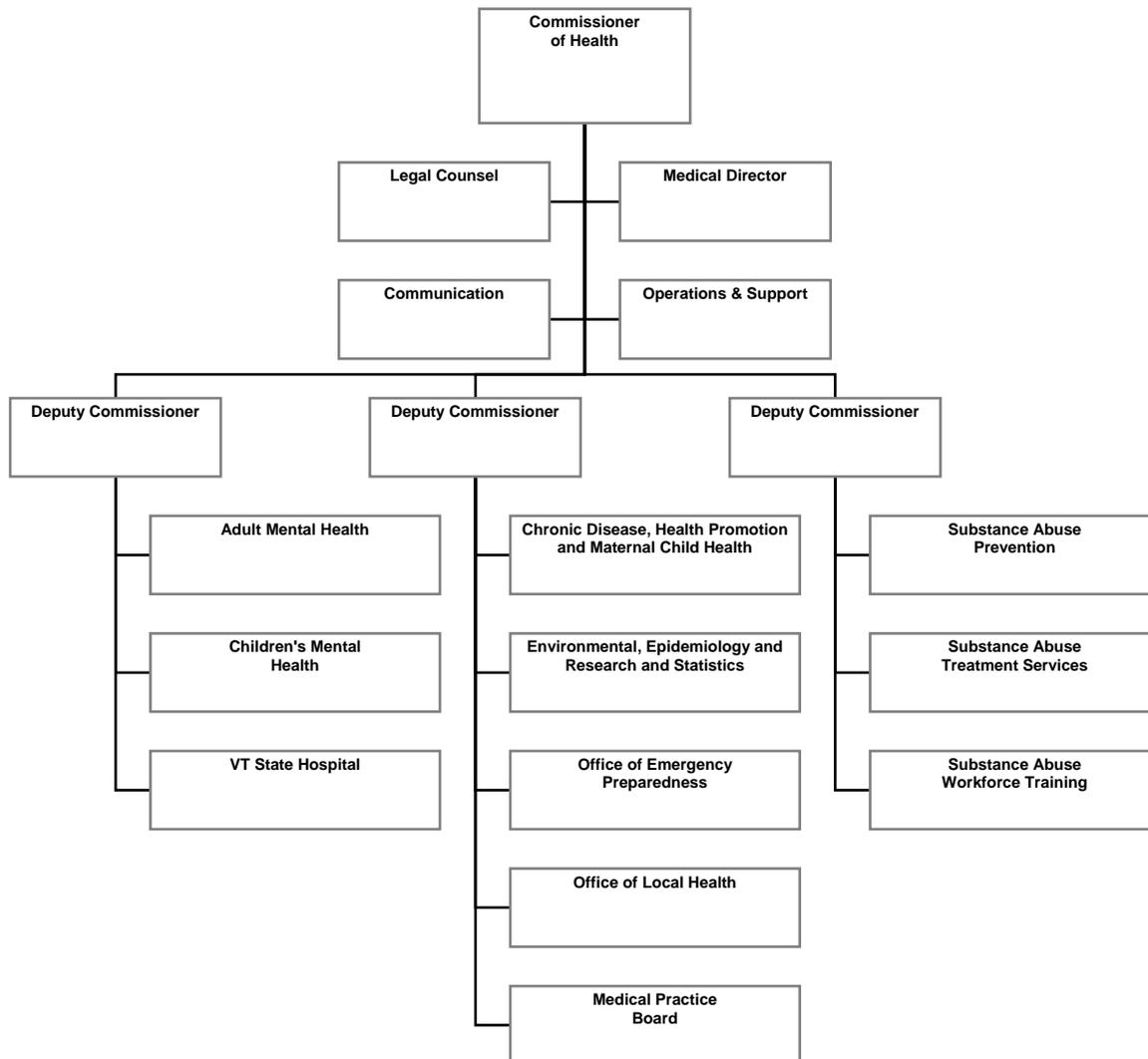
Agency of Human Services

Vermont is unique in its size and commitment to prevention across state agencies and the current level of coordination and collaboration among these state agencies. Created in 1969 to serve as the umbrella agency for all human service activities within State government, the **Agency of Human Services (AHS)** is responsible for strategically leading the agency and its departments and establishing and implementing agency-wide policies and practices that cross departmental boundaries. The Strategic Prevention Framework Advisory Council is pleased to have the active

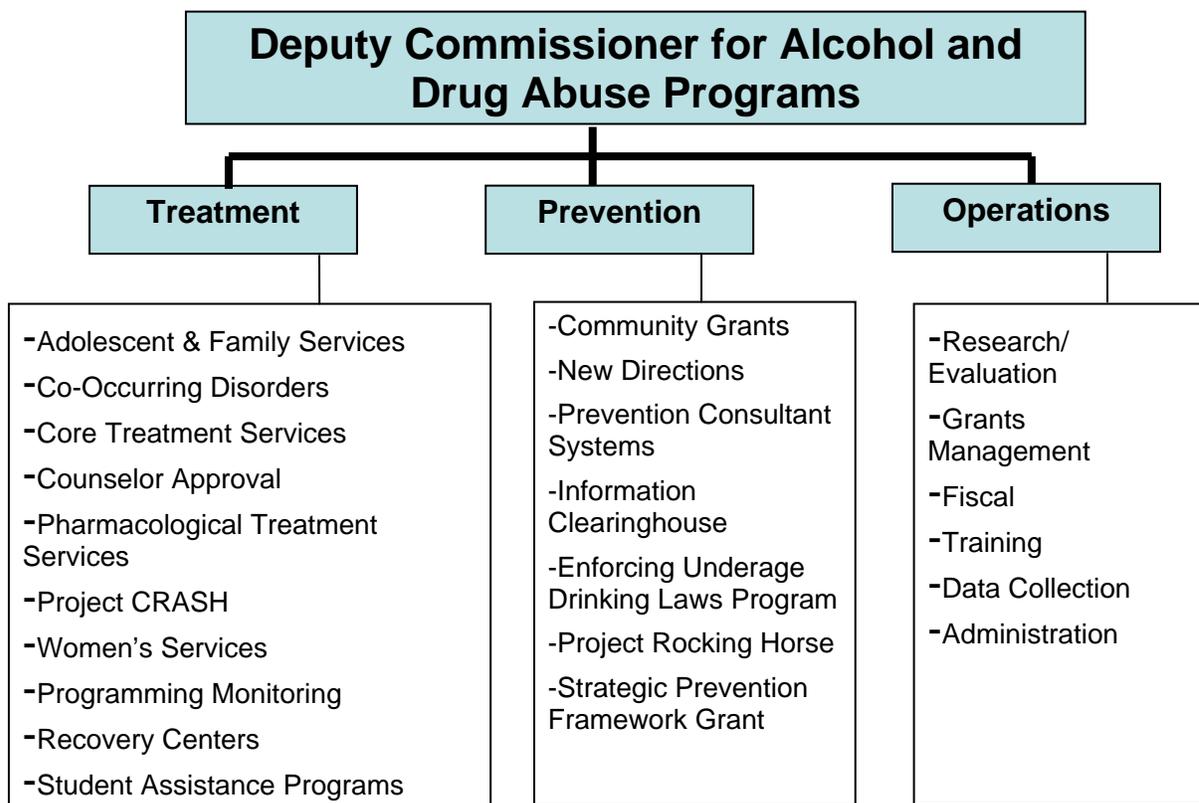
involvement of Secretary Cindy LaWare, who leads the agency in its charge of strategic leadership across departments. Vermont is divided into 12 Agency of Human Service Districts, with a Field Director assigned to oversee the Agency’s services in each of these districts. There is little county government in Vermont; so much of the regional resource allocation and prevention planning is conducted through the 12 AHS Districts. AHS departments that play a key role in the prevention of substance abuse are the Vermont Department of Health and the Department of Children and Families.

Vermont Department of Health

The vision of the Vermont Department of Health is to have the nation’s premier system of public health, enabling Vermonters to lead healthy lives in healthy communities. Our mission is to lead our state and communities in the development of systematic approaches to health promotion safety and disease prevention; to continuously assess, vigorously pursue and document measurable improvements to the health and safety of Vermont’s population; and to succeed through excellence in individual achievement, organizational competence and teamwork within and outside of the Department of Health.



Within VDH, is the **Division of Alcohol and Drug Abuse Programs (ADAP)** which is the Single State Authority (SSA) for Alcohol and Drug Services. It has the statutory responsibility to “. . . operate and evaluate a consistent, effective program of substance abuse programs.” ADAP Unit programs are summarized below. Please note that the Division is currently implementing the SPF SIG and SAMHSA’s Adolescent Treatment Grant. In addition, the Division of Mental Health has a SAMHSA Co-Occurring Disorders State Incentive Grant (CoSIG) on which ADAP is a partner. This trio of infrastructure grants provides an incredible opportunity for system change across the continuum. Barbara Cimaglio, Deputy Commissioner for Substance Abuse Programs leads these infrastructure development efforts, assuring that they are moving in concert with one another.



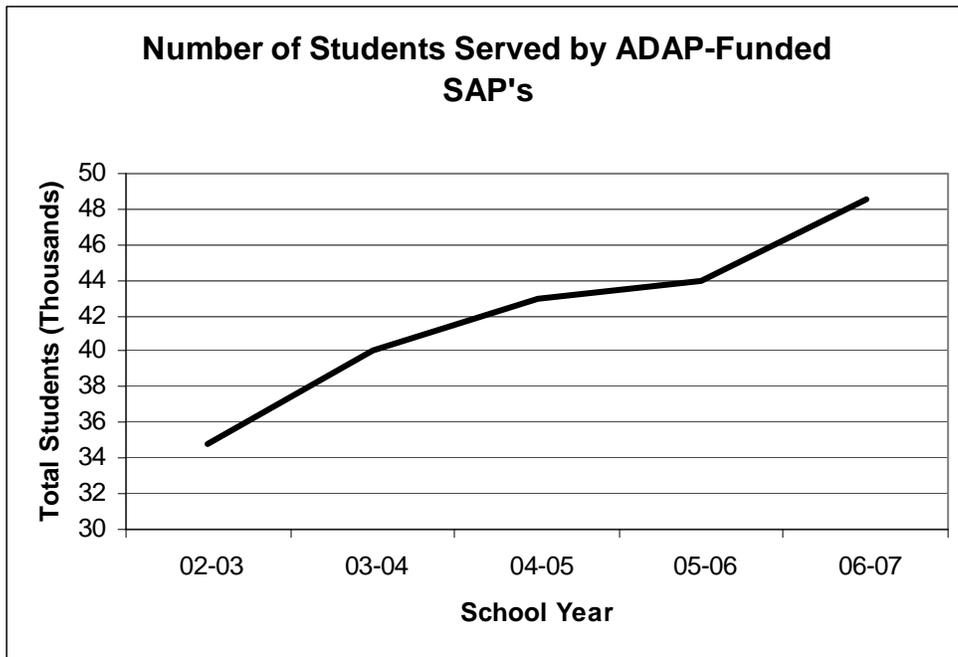
Currently the ADAP prevention system supports and maintains key programs, services and resources. ADAP oversees each of the prevention programs associated with SPF SIG objectives listed below.

- Regional Substance Abuse Prevention Consultants (PC) increase local capacity through presentations and trainings, program planning and consultation, community organizing, technical assistance and information and referral. Services are provided regionally through 10 prevention consultant positions. ADAP’s Prevention Unit manages the

regional Substance Abuse Prevention Consultant program, which is funded through the SAPT Block Grant. The **Office of Local Health** District Health Directors supervise the PC's and assure that substance abuse prevention services are integrated with other public health services at the regional level. This matrix management agreement has been operational for one year. The SPF planning process is being applied to the PC system to assure regional capacity to carry out technical assistance on the SPF SIG.

- The New Directions Grants fund community-based coalitions, several of which were originally funded by the Vermont State Incentive Grant awarded in 1997. Funds support community education, implementation of at least one evidence-based program and enhanced coalition development. Training and networking opportunities are provided to all community coalitions that have a primary objective of alcohol, tobacco and other drug prevention.
- The projects and activities supported by the Community Grants Program work to reduce the likelihood of alcohol, tobacco and other drug use and abuse. Statewide grants are targeted to programs that address high priority issues, increase services targeted to specific populations and support statewide training projects. For example, community grants support a statewide network of “Project Rockinghorse” educational support groups for pregnant and parenting women living in poverty.
- Enforcing Underage Drinking Laws Program provides OJJDP grants to increase public awareness about underage drinking issues and enhance enforcement of underage drinking laws. The EUDL coordinator serves as the point person for underage drinking and coordinates related efforts across the Departments of Health, Education, Children and Families, Liquor Control and Public Safety. This includes Chairmanship of the Underage Drinking Taskforce which conducted a review of Vermont’s status on the Institute of Medicine Recommendations on Reducing Underage Drinking
- The Department of Health currently funds Student Assistance Programs (SAP) in more than 100 schools. A Student Assistance Program is a prevention and early intervention program where substance abuse counselors are accessible to students, primarily in middle and high schools. The in-school SAP counselor and teams identify students with substance use problems, intervene, and when necessary, refer them to community agencies for more specialized or intensive services. Counselors work with the students, school staff, the community, and referring organizations to help students address issues that can lead to or are the results of substance use. In the 2005-2006 school year nearly

5000 students met individually with SAP counselors in more than 100 Vermont schools.



- The purpose of the Vermont Alcohol and Drug Information Clearinghouse (VADIC) is to provide alcohol, drug, and tobacco educational materials (print and media) to Vermont residents and institutions. Print materials include brochures, fact sheets and other print materials that are drug specific or population specific. Media materials include video in VHS and DVD format as well as power point presentations.

The **Division of Chronic Disease and Maternal Child Health** within the Department of Health oversees the Tobacco Control Plan with leadership from the Tobacco Review and Evaluation Board (see boards, page 27). VDH's Tobacco Control Program supports community-based coalitions, youth services, tobacco cessation services, provider education, media and public education. The Tobacco Control Program and the Division of Alcohol and Drug Abuse Prevention (ADAP) collaborate to provide training, technical assistance and grants to community coalitions. Most recently this collaboration was strengthened through a co-funding of a media specialist. This specialist is supported through a mix of SAPT Block Grant and tobacco Master Settlement Agreement funds. This media specialist is a member of the SPF SIG team and is leading the development of the communications component of the SPF SIG plan.

Department of Children and Families

The **Department of Children and Families (DCF)** provides protective, developmental, therapeutic, probation, economic, and other support services for children and families. The Department also staffs the Children and Family Council for Prevention Programs. Under the guidance of the Children and Family Council for Prevention Programs (CFCPP), the Department supports a myriad of prevention programs targeting youth and families. DCF oversees the Safe and Drug Free Schools/Communities Governor's Set-Aside, OJJDP delinquency prevention

funds, and the Vermont Children's Trust Fund. As part of the SDFSC program, DCF supports a regional network of Youth Initiated Granting programs.

Vermont Department of Education

The **Department of Education** is an essential partner on the SPF SIG and has had active representation on the Epidemiological Workgroup, The SPF SIG Advisory Council and the VT Taskforce on Underage Drinking. The Department's Safe and Healthy Schools Team oversees the following systems directly related to Vermont's Alcohol and Drug Prevention Strategic Plan:

- The Safe and Drug-Free Schools and Communities (SDFSC) program
- Comprehensive Health Education Standards and Education Centers, providing training, materials and technical assistance on the implementation of curricula and comprehensive health policies
- Tobacco Use Prevention Program science-based curricula, policies, and parent/community education in an effort to reduce youth tobacco by 50 percent by 2010.
- ATOD and Traffic Safety Program supervises the administration and evaluation of driver and traffic safety programs in Vermont's public schools. The goal of the program is to keep young people safe by reducing alcohol, tobacco and other drug use while promoting safe driving as well. This includes the Vermont Teen Leadership Safety Program (VTLSP), a school-based statewide network affiliated with national SADD. VTLSP members are students in grades 9 through 12 who participate in year-round leadership opportunities at school, community, state and national levels.
- Alcohol, tobacco and other drug prevention training for teachers, health, and guidance personnel on as part of Vermont's alcohol and drug prevention education act (Act 51).

Department of Liquor Control

The **Department of Liquor Control (DLC)** provides community education, retailer education and policy enforcement. DLC leads compliance testing for both tobacco and alcohol retailers in the state. DLC's Commissioner and staff have played a key role in the development Vermont's recommendations for reducing underage drinking.

Department of Public Safety

The **Department of Public Safety (DPS)** works closely with the Department of Health on substance abuse initiatives. The Governor's Traffic Highway Safety Council and the Vermont State Police staff have been directly involved in developing Vermont's SPF SIG. There will be a strong link between Vermont's Strategic Highway Safety Plan and the SPF SIG.

Statewide Boards and Councils/Oversight of Prevention Funds

The Vermont **Tobacco Evaluation and Review Board** resides within the Office of the AHS Secretary but is an independent board. The Board establishes a budget (for legislative approval), program criteria and policy recommendations and oversees evaluation of the tobacco control program. The Board then disperses funds to the Departments of Health, Education and Liquor Control.

The **Children & Family Council for Prevention Programs** develops the state’s Primary Prevention Plan and oversees the administration of the Vermont Children’s Trust Fund for primary prevention programs, OJJDP Delinquency prevention funds, and the Safe and Drug Free Schools/Communities - Governor’s set aside fund. Council is staffed by the Department of Children and Families.

The departments, boards and councils outlined above are all actively represented on the **Strategic Prevention Framework State Incentive Grant (SPF SIG) Advisory Council**. This Council oversees the development of Vermont’s Strategic Alcohol and Drug Prevention Plan and the SPF SIG grant. Barbara Cimaglio, Deputy Commissioner of Alcohol and Drug Programs is the SPF SIG Project Director and Council Chairperson.

Vermont Prevention Grants Infrastructure

Agency of Human Services		
Program Name	Funding Source	Staff
Vermont Strategic Prevention Framework State Incentive Grant	SAMHSA/CSAP	Project Director: Barbara Cimaglio Project Manager: Marcia LaPlante Project Coordinator: Lori Uerz
Substance Abuse Prevention Treatment Block Grant	SAMHSA/CSAP	Program Manager for treatment: Peter Lee Program Manager for Prevention: Marcia LaPlante
Enforcing Underage Drinking Laws (EUDL)	OJJDP	Program Manger: Marcia LaPlante
Student Assistance Programs	Master Tobacco Settlement Agreement, Governor Deter Initiative	Program Manager: Peter Lee
Adolescent Treatment Infrastructure	SAMHSA/CSAP	Program Manager: Michael McAdo
Vermont CO-SIG	SAMHSA/CSAP	Program Manager:

		Paul Dragon
Tobacco Control Plan/ Community Media	Master Tobacco Settlement Agreement, CDC	Program Manager: Sheri Lynn
Children's Trust Fund	Children's Trust Foundation	Program Manager: Susan Kamp, Executive Director, CFCPP
Drug Free Schools and Community Grants/ Governor's Set Aside	Agency of Human Services	Program Coordinator, Cassie Isabelle
Department of Education		
Program Name	Funding Source	Staff
Drug Free Schools and Community Grants/ School- Based	U.S. Department of Education	Program Manager: Carol Rose
Tobacco Control Plan/School- based Activities	Master Tobacco Settlement Agreement	Program Manager: Carol Rose

b. Significant gaps in the current state-level infrastructure

In 2004, the Vermont Department of Health conducted a Key Stakeholders Survey, supported by CSAP's State Prevention Assessment System, on Vermont's alcohol and drug prevention infrastructure. Respondents at the statewide, regional and local levels identified the following challenges:

- Lack of a statewide strategic vision
- Prevention Consultant system understaffed and lacks role clarity
- Need for communications/public information program
- Need for a stronger evaluation system
- Linkage between prevention and treatment systems needed
- Insufficient and short-term funding

Strategic Plan

Lack of strategic priorities has impacted all other infrastructure issues cited above. The SPF SIG process is extremely well timed for Vermont and provides an excellent opportunity to develop priorities and a vision for infrastructure development. It is intended that the SPF plan and process will drive ADAP's prevention system, as well as our investment of SIG funds.

Workforce Development

Vermont currently has no systemic approach to training prevention workforce. The Division of Alcohol and Drug Abuse Programs (ADAP) has a workforce development manager position which has been vacant for some time. A contract supports a workshop series and prevention grantees are also informed about regional and national resources, such as the Northeast CAPT, New England Prevention School and CADCA's Leadership Forum. Vermont does not have a prevention certification system. Two PC's are certified through another state. When stakeholders were polled about state services needed to ensure that prevention workers are equipped to deliver effective prevention services, the top three responses were:

- Skill-building programs such as planning, evaluation, meeting facilitation, youth leadership and involvement, etc.
- Training on evidence-based model programs
- Mentorship or coaching for front line prevention workers

ADAP's ten regional substance abuse prevention consultants (PC's) provide information, training and technical assistance at the local level. Stakeholders rated this system as among the most valuable prevention resources provided, and also recommended their roles and job duties be defined more clearly. New PC's are oriented by the two prevention coordinators who administer programs within ADAP's Prevention Unit. Training is provided through referral to existing resources. Regional PC's come to the position with a variety of professional backgrounds, a strong knowledge of local organizations, and a lack of consistent knowledge skills and abilities. A training needs assessment has been conducted with the PC's based on the ICRC standards. No assessment has been conducted with the two Prevention Coordinators who supervise the system. In addition, a SPF capacity assessment was conducted with the prevention unit staff and stakeholders.

Substance abuse prevention services are primarily funded through grants to community coalitions. The skill level of coalition staff and volunteers varies greatly around the state. Some coalition staff participated in the original State Incentive Grant training which was provided in a learning community format over nearly four years. ADAP and Tobacco Control Program staff organize two networking meetings per year to provide a forum for peer support and education. Grantees are referred to other existing regional and national resources for training

There are some alcohol and drug leadership training opportunities available to middle and high school age youth through statewide organizations, schools and coalitions, and the regional PC's. There is almost no participation by 18 to 24 year-olds in existing workforce development opportunities.

Few leadership or advocacy training experiences exist for coalition coordinators or other prevention workers. This contributes to a rather low level of advocacy for prevention resources within the state.

Communications

ADAP has demonstrated strength in the areas of community mobilization and community development. Several local coalitions and other organizations have developed small campaigns. This has led to a proliferation of inconsistent messaging around the state. In a series of needs assessments, community partners have identified the lack of any consistent statewide communications system as an infrastructure gap. VDH's Tobacco Control Program has strong capacity in communications. A memorandum of understanding was established between ADAP and the Tobacco Control Program. A media specialist, co-funded by SAPT Block Grant and Tobacco Master Settlement funds, conducted an analysis of this gap. Gaps in personnel, resources, systems and policies were identified and are discussed below.

While there is a network of staff that has a broad range of education and experience around media and public education, there is still a ways to go to build the capacity of these personnel resources. The experiences of the field staff (PCs and District Directors) have been most focused on prevention and general health promotion. The knowledge gained is not consistent across the state. In addition, while social marketing is a respected area, the fundamentals of this discipline are not familiar to most people.

Vermont's stakeholders indicated that statewide media efforts are needed to support the local activities so that the target audience hears a consistent message from multiple sources. This idea is the major tenant of effective marketing communications. Vermont is a small rural media market which is not often penetrated as heavily by national media campaigns compared to larger states.

The need to understand the cultures and lives of Vermonters in order to utilize and develop effective media and public education campaigns and materials bears further emphasis as it relates to systems and policies. While we tend to think about media and public education as mass media – like television, radio and print – more and more media is defined by non-traditional methods. Things like web-based tools and games, guerilla marketing actions and activities, product placement, events, media literacy, etc. Many of these things will be coordinated at the state level and implemented at the local level. In doing so state agencies and communities must be prepared to interact with the target audience in a way that is culturally appropriate, and the systems and policies of the services that we are leading people to must also reflect this level of cultural understanding.

Evaluation/Data Collection

As will be described below in section 2.d, the state possesses numerous useful data systems that can be used to assess, monitor, and evaluate substance Vermont's substance abuse and related consequences at the state level. Very few of these systems, however, can provide precise and stable estimates at the community level. In addition, the capacity for generating and analyzing program-specific data is limited. Vermont's system for collecting program level data includes:

- (a) An electronic management information system that collects regional substance abuse prevention consultant process data on technical assistance services.
- (b) Grantee narrative reports from which data is extracted by hand.

Each prevention grants program has its own separate paper-based reporting system. There is no consistency in reporting format across various prevention grants programs in ADAP or across VDH.

In 2002 the VDH published its State Incentive Grant (SIG) evaluation, outlining population level outcomes achieved through that program. When the SIG ended, the New Directions coalition grants program was continued on a much smaller scale. Grantees' evaluation plans were locally designed with technical assistance from state staff. Although grantees report on their outcomes, each locality identified which outcomes will be measured. Therefore no program level outcome measures have been aggregated across the state since the SIG concluded. Prevention process indicators and local program level evaluations are reported.

Linkages

Few statewide prevention agencies exist in Vermont. Thus, some of the capacity building with coalitions funded through Vermont's first SIG focused on their capacity to deliver evidence based prevention services. There was less focus on building meaningful linkages across prevention, treatment and recovery efforts at the state or local level. Additionally the substance abuse treatment system in Vermont has grown increasingly complex. These factors have contributed to a lack of understanding and coordination across the continuum.

Funding

The state, alone, does not have the capacity to adequately fund and support coalition-based prevention systems in every community. Existing community coalitions and organizations find themselves competing amongst themselves for limited dollars with coordinators reporting they spend a large percentage of their time seeking out additional funding sources to maintain their funding levels and sustain their operations.

c. Capacity to implement the strategic prevention framework at the state level

Sub-sections a and b above discuss the state-level infrastructure in general, including gaps and deficits. This section describes the capacity that is in place or under development specifically as needed to implement the SPF (including all 5 steps of the SPF process). A number of important capacity building steps have already been implemented, including the formation of the SPF SIG Advisory Council, the formation of the State Epidemiological Workgroup (SEW), the naming of a state SPF SIG coordinator, media specialist and support staff, the selection of an evaluation subcontractor, the selection of a training and technical assistance provider, and the operationalization of a SPF Leadership and Planning Team charged with ensuring overall planning and execution of the SPF.

Assessment

Building upon an already established system of statewide surveys and surveillance systems, there has been strong support for and participation in the SEOW across departments. The SEOW has further enhanced the understanding and application of epidemiological data on consumption and consequences to the prevention planning process. Capacity for assessment of prevention

capacities and readiness is not as high. However, the recruitment of a strong SPF state staff has strengthened and expedited the work, currently ongoing, of identifying appropriate readiness and capacity assessment tools for grantees.

Capacity Building

SPF Advisory Council process of reviewing the Epi study, identifying plan priorities and developing a resource allocation plan has contributed to an increase in understanding of the SPF and support for substance abuse prevention across departments. There continues to be a need for information, training and technical assistance to the Advisory Council in order to strengthen leadership and advocacy on the state level for prevention issues.

There are gaps in training and workforce development discussed in the previous section. This includes a need for training on human development, cultural competency and social marketing. This gap will be addressed through the implementation of trainings via a learning community format. Target audiences will include advisors, state and regional staff and grantees.

Needs assessment of VDH's regional prevention consultant system revealed the need for enhanced training and evaluation of the PC system. This program is essential to capacity building with SPF SIG sub-recipients, and represents Vermont's largest Block Grant prevention set-aside investment. The greatest skill development needs were:

- (1) Understanding and using data in systemic community needs assessments;
- (2) Facilitation of planning processes, prioritizing needs, and guiding program selection.

These needs will be addressed through training and technical assistance provided by the Northeast CAPT and the SPF staff. The technical assistance role of the prevention consultants on each of the SPF five steps has been defined through both a review of the ICRC Standards for Substance Abuse Prevention Specialists and stakeholder input. This material will serve as the basis for a PC system logic model and provides a blueprint for PC participation in enhancing the state's capacity to implement the SPF SIG. These details are provided in Appendix III.

Planning and Implementation

The SPF Advisory Council, reflecting a broad array of state and community partners, has provided guidance on overall priorities and resource allocation strategies. With that direction, the SPF Leadership Team has strong capacity to develop the plan and guide implementation. In addition, the CHAMPPS Advisory Council and Operations Group (see below) are fully committed to working with the SPF Team to plan and implement programs, practices and policies.

The Leadership Team charged with development of the plan includes:

- SPF Director and Deputy Commissioner of Alcohol and Drug Abuse Programs (SSA Director)
- SPF Manager and National Prevention Network (NPN) representative
- SPF Coordinator
- Epidemiological Workgroup Chairperson

- New Directions (Coalitions) Coordinator
- Prevention Coordinator in charge of prevention workforce issues (also supervises 5 regional PC's)
- Prevention Coordinator in charge of underage drinking initiatives (also supervises 5 PC's)
- ADAP Chief of Operations
- Evaluator
- Media Specialist (ADAP/Tobacco Control)
- Facilitator of Strategic Planning
- Research and Policy Analyst

This team reflects an array of expertise needed to develop Vermont's strategic plan. They meet weekly to review decisions data and Advisory guidance, discuss next steps and further information needed. It is anticipated that 2 more members will be added to the team to address gaps in expertise – cultural competency consultant and lead trainer.

Coordinated Healthy Activity, Motivation and Prevention Programs (CHAMPPS)

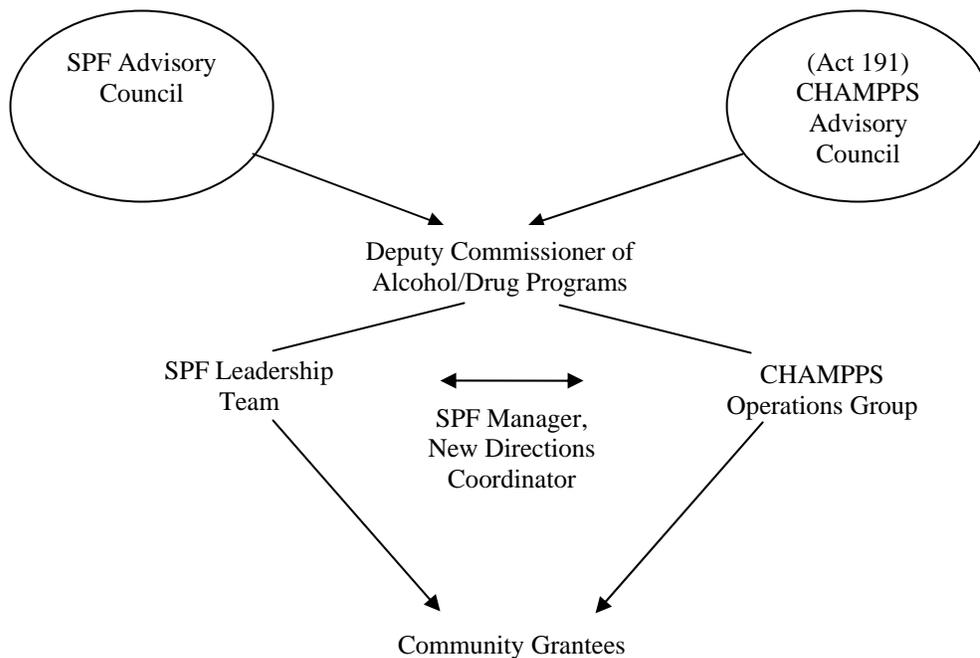
In the spring of 2006 the Vermont Legislature enacted Common Sense Initiatives in Health Care legislation. Coordinated Healthy Activity, Motivation & Prevention Programs (CHAMPPS) was part of that legislation. The legislation recognized the importance of managing prevention infrastructure in a way that facilitates the implementation of effective, sustained and comprehensive prevention at the community level. CHAMPPS charged the Vermont Department of Health (VDH) with implementing comprehensive and substantial community health and wellness grants supported through braided prevention funding streams. This legislation, in spirit, supports the principles of the SPF SIG. The act further required that SPF SIG funds in the amount of \$500,000 partially support the program which has an appropriated budget of approximately one million dollars in the first year. The use of SPF funds for the CHAMPPS initiative has been discussed with both our former project officer Grant Hills and in a phone conference with Mike Lowther of SAMHSA on January 10, 2007. The legislation further requires that:

- a grant committee be established by September 1, 2006
- a resource inventory of community prevention programs and grants be completed by December 15, 2006
- the grant review committee recommends grant awards by July 1, 2007

This change process and grants program is led by the SPF Director (who is also the SSA Director and Deputy Commissioner of Alcohol and Drug Abuse Programs). The CHAMPPS Operations group charged with implementing the granting system includes the Vermont Blueprint for Health Coordinator, the SPF Manager (who is also the NPN) and the New Directions Coalition Coordinator, the Tobacco Control Chief, the Fitness and Nutrition Chief, and a Community Public Health manager.

To date, the CHAMPPS work group and grants committee have adopted SAMHSA's five-step Prevention Framework as the planning process for CHAMPPS. The group has adopted a

modified social-ecological model for framing programs, policies and practices across health behaviors. See Appendix IV for more detail on the model.



Evaluation and Monitoring

With the continuing operation of the SEW, and the contractual arrangement with PIRE for evaluation guidance and services, we believe the state has the requisite capacity for implementing this step of the SPF. This will include the services of a SPF evaluator on site in Vermont. The experience with the original SIG demonstrated the state’s capacity to both evaluate the overall New Directions project and provide the necessary technical assistance to community grantees to conduct their own evaluation activities as well. Many of these grantees went on to use their evaluation findings to help secure additional funding from a variety of sources.

To a considerable extent the state’s ability to implement this step also depends on the data resources and infrastructure that are either already in place or will be developed over the course of the project. The following subsection (subsection d) addresses this issue.

d. Capacity for data-driven decision making at the state level

Capacity to collect, analyze and report data to support data-driven decision-making in each step of the SPF (surveillance, program monitoring data, etc...) at the state level

Vermont’s capacity to collect, analyze and report data to support data-driven decision-making in each step of the SPF at the state level currently includes bi-yearly surveying of Vermont 9th-12th graders using the Youth Risk Behavior Survey (YRBS). The Vermont Department of Health and

the Department of Education have sponsored the survey since 1985 which measures the prevalence of behavior that contributes to the leading causes of death, disease and injury. With over 31,000 students participating in the 2005 survey, and participation by over 90% of the School Supervisory Unions, the data allows us to monitor trends at both the state and community levels and compare Vermont to national data. This analysis is used by the Vermont Department of Health and its partners to plan, evaluate and improve community and school programs that prevent health problems and promote healthy behavior. The YRBS collects data on tobacco, alcohol, marijuana and other drug use.

A second statewide survey targeted towards adults is the Adult Behavioral Risk Factor Survey (BRFS) which has been conducted yearly in Vermont since 1990. Information is collected through a telephone survey with a standardized sample selection procedure and a uniform set of questions, as does the YRBS. The BRFS reports on tobacco use, alcohol use and drinking and driving behavior.

The state also maintains a number of surveillance systems that provide data relevant to substance abuse consequences, including traffic crash data, hospital data, crime data and vital statistics. In addition to these two statewide surveys and surveillance systems, the Vermont Department of Health monitors and collects narrative, qualitative data on its statewide funded New Directions program which funds community-based coalitions.

Our current data collection system regarding the work of the regional Prevention Consultants is a Management Information System or MIS that tracks process measures such as hours worked by “service” type (consultation, facilitation, presentations, planning and delivery of training, technical assistance, etc...), hours worked by project “type” (information dissemination, education, community-based process, environmental,, problem identification and referral and substance free recreation) and populations served. .

The establishment of the SEW through the SPF has allowed Vermont to expand its ability to review and analyze data sources directly and indirectly linked to substance abuse issues. The state, however, has limited experience in systematically using these sources to drive planning decisions. The SPF SIG grant is helping to address this need. State capacity to track process and program level data for the purpose of program monitoring with regional prevention consultants and grantees is also limited as discussed in section 2.b, page 30. Next steps in system improvement include:

Step 1: ADAP staff will develop one consistent data reporting form to be implemented across prevention grant programs. To start, consistent format will collect those indicators required for National Outcome Measures. ADAP staff will work closely with the SPF evaluator to assure this format will be consistent with the SPF SIG evaluation.

Step 2: Prevention Management Information System for regional substance abuse prevention consultants will be modified to collect all process measures required by National Outcome Measures, including data on technical assistance services provided to operationalize the SPF SIG at the regional and local level.

Step 3: Training and technical assistance will be provided to staff and grantees on data collection modifications

Step 4: The SPFAS will assess and provide consultation to ADAP on long term goals and resources needed for development of a quality assurance system. Milestones for data infrastructure development will be greatly informed through the process of working with SPF SIG evaluator and grantees.

e. The community prevention infrastructure in place

Local governance is among Vermont's most highly treasured traditions. With a population of 623,050, Vermont has 256 townships and 60 public school supervisory unions. Vermont is comprised of 14 counties, but has little county government. Most local planning and decision-making is conducted at the town and supervisory union levels. Such a structure has presented challenges to be discussed in section g. The current Vermont prevention infrastructure is comprised of state district offices, coalitions, school-based student assistance programs and statewide organizations that contract with the state to implement evidence based and other prevention programs.

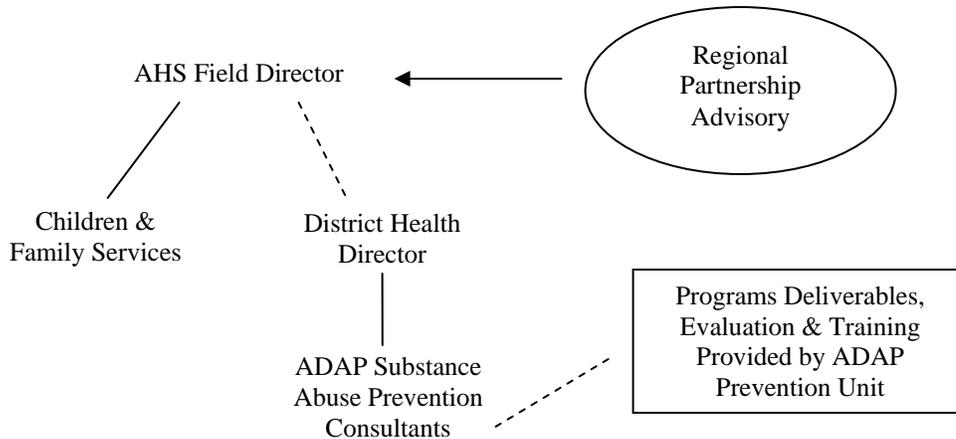
Agency of Human Services Districts

To support regional planning and resource allocation, the Agency of Human Services (AHS) has developed 12 districts around which agency services are delivered. Each district has a Field Director (FD) charged with improving coordination of all human services and addressing service gaps in the district. Each district has a Health District Director (DD) who is supervised by the Department of Health but works closely with the FD (note dotted line on reporting structure). The 10 regional substance abuse prevention consultants are supervised by Health District Directors, with ADAP managing the PC system programmatic supervision.

Funded through the Agency of Human Services (AHS) are 12 **Regional Health Partnerships** that were created to improve the well-being of children, families and individuals and to make their communities healthier places to live. Staffed by part-time regional coordinators and formalized as a statewide association, membership includes individuals and families served by human services and education programs; other community citizens; non-profit and state providers of health, education and human services; economic development representatives, and business leaders. The role of the Partnerships is to develop and implement local strategies for improving the social well-being of Vermonters, to engage diverse community members as partners, and to mobilize community resources to enhance local support services and systems to improve outcomes. A few partnerships have sub-committees dedicated to substance abuse.

Agency of Human Services
12 District Offices

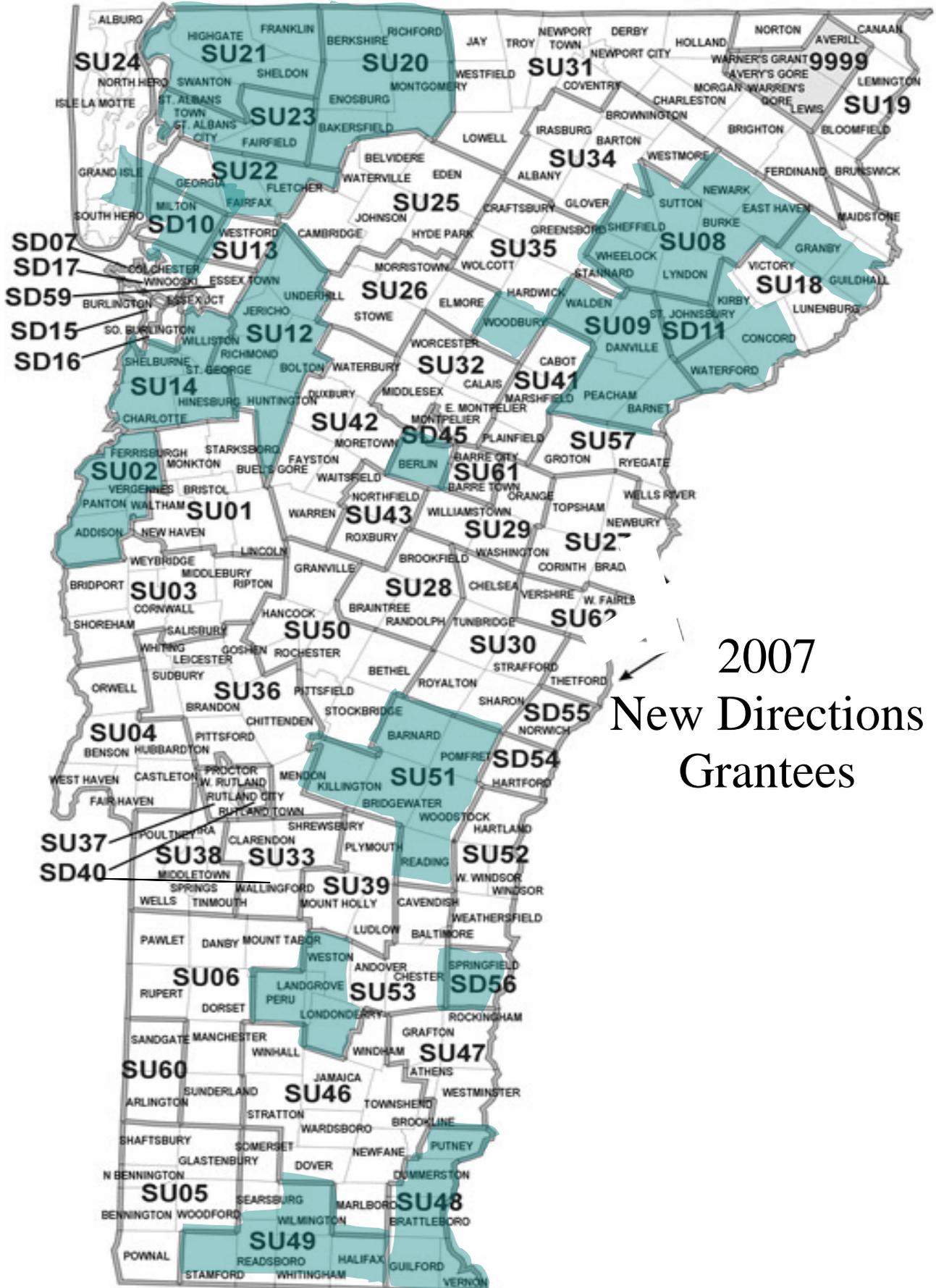
Local Structure



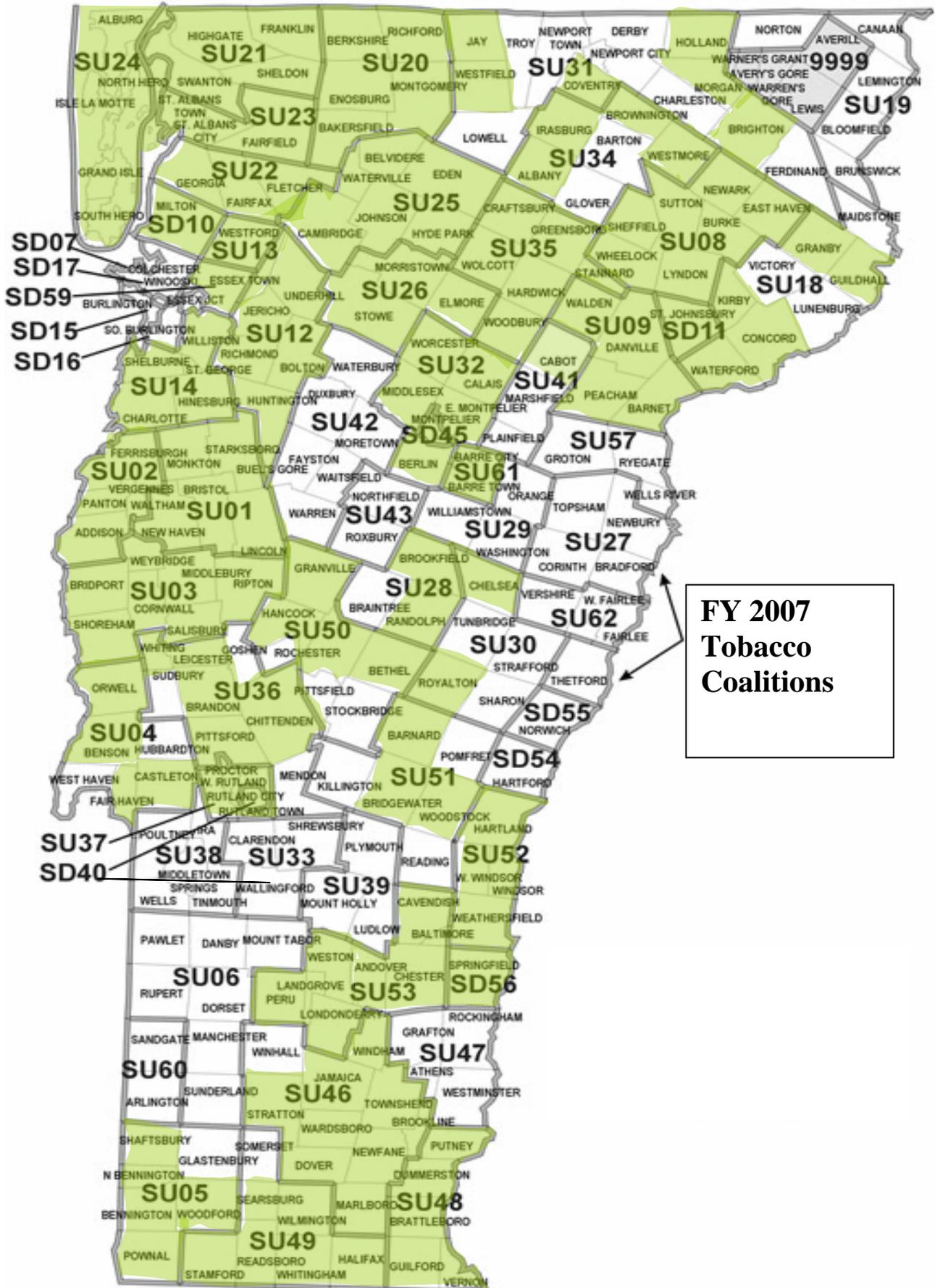
Community Coalitions

In 1998, Vermont’s original SIG, entitled New Directions, funded 23 community-based substance abuse coalitions across the state to increase community capacity and implement evidence-based programs. The success of this initiative has enabled the department to continue funding community-based substance abuse coalitions on a smaller scale. Many of the current New Directions coalitions are staffed by highly seasoned coalition coordinators who have benefited from years of training and technical assistance provided through the SIG and CADCA. While SIG funding ended in 2001, 17 of the original 23 coalitions were successful in garnering state or federal funds and have continued to implement evidence-based programs, as well as community development on a smaller scale. ADAP currently funds fifteen community coalitions through our continued New Directions initiative.

Informed by the successes achieved through the first SIG, the Vermont Tobacco Review and Evaluation Board established a community coalition grants program as one component of the Tobacco Control Plan. Currently 19 tobacco coalitions are funded. Some communities receive both New Directions and Tobacco grants, although many tobacco coalitions are free standing and focus solely on tobacco control programs.



2007
New Directions
Grantees



**FY 2007
Tobacco
Coalitions**

Currently 14 communities across Vermont receive the federal **Drug Free Communities Support Program (DFC)** grants with the objectives of reducing substance abuse among youth and adults. They address factors in a community that increase the risk of substance abuse; promote factors that minimize the risk of substance abuse; and strengthen collaboration. The capacity building and mobilization that occurs in communities funded by this program carries over into neighboring towns and cities by virtue of shared media, public events and resources. The total DFCS fund in Vermont is equal to Vermont's entire SAPT Block Grant prevention set-aside. Thus a significant portion of Vermont's infrastructure is based on the DFCS program.

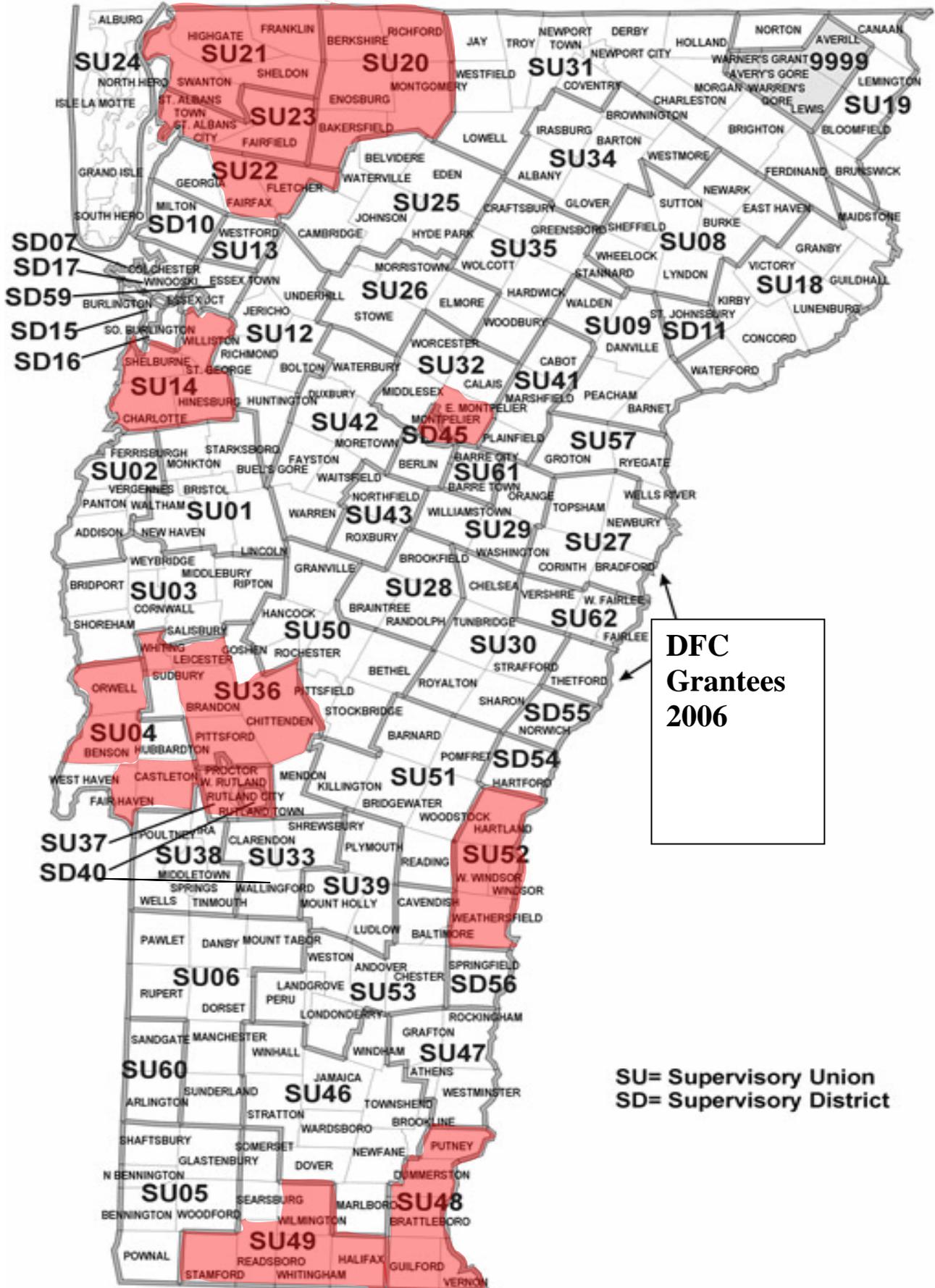
Vermont boasts a total of 34 substance abuse coalitions throughout the state. Block grant funds are devoted to coalition training, networking and technical assistance in the areas of prevention planning, community assessment, evaluation and strategies for ensuring sustainability. Trainings and networking events are frequently co-planned and funded by ADAP and the Tobacco Control Program. All coalitions have access to this service irregardless of their funding source. As we move ahead with the CHAMPPS program described on page 33, we anticipate efficiencies can be gained by working together on core capacity development activities. The DFCS funded coalitions are familiar with the SPF process. Their knowledge is an asset on which we will build.

On a statewide basis, the **Vermont Drug and Alcohol Coalition** was established as vehicle for organized advocacy for communications and discussions between treatment, intervention, prevention and recovery entities and the state legislators. The coalition is a grass-roots organization whose members work to provide access to services for the full substance abuse continuum for all Vermonters.

Community-Based Organizations - Family Strengthening and Youth Development

Community based organizations, such as Prevent Child Abuse-Vermont provide family strengthening programs such as the Nurturing Program, to communities around the state. In addition, ADAP's prevention and treatment units co-fund Project Rocking horse, an educational support group for young women, implemented through designated treatment providers.

There are several statewide networks of youth development and after school programs in the state. These include the VT Teen Leadership Safety Program (SADD); VT kids Against Tobacco; Green Mt Prevention Projects; Vermont Out of School Time Network. With the growth of coalitions around the state, much of the funding for community-based youth programs has been diverted to the coalitions, with information on the services these organizations provide. This has tended to increase the number of youth reached but erode capacity to carry out consistent substance abuse prevention services with youth around the state. As we move forward with SPF, this issue will be examined with our community grantees.



ADAP provides a mini-grant to the Vermont College Alcohol Network. This network provides information and networking opportunities to alcohol and drug prevention professionals on college campuses around the state. Community infrastructure for reaching 18 to 24 year-olds out of college is low.

Each level of community infrastructure outlined in this section is represented on the SPF SIG Advisory Council.

f. The effectiveness of the community prevention infrastructure in place

Community Coalitions

The evaluation of Vermont's first SIG revealed that population level outcomes were achieved through the strategies employed. New Directions communities collectively achieved greater reductions in student substance use prevalence among 12 to 17 year-olds relative to the remainder of the state for all nine substance abuse measures examined. The greatest relative reductions were observed for marijuana and cigarette use. In general, greater intensity and coverage of research-based primary prevention activities was associated with greater reductions in student substance use. Coalitions that had been functioning longer, and were able to implement a comprehensive array of strategies were most likely to achieve those outcomes. Published findings from the evaluation suggest that collaborative community-based efforts implemented within a supportive framework such as New Directions can have a real impact on the prevalence of substance use behaviors among youth.

From 2001-2003 New Directions communities saw a 15% drop in tobacco use and an 8% drop in recent alcohol use (2003 YRBS). The New Directions coalitions currently funded continue to implement evidence based substance abuse prevention programs and strategies with fidelity and as of 2003, continue to show decreases in substance abuse as measured by the Youth Risk Behavior Survey.

The positive findings from the New Directions evaluation spoke to the potential efficacy of a strong and well-funded community coalition-based prevention system throughout the state. New Directions also demonstrated the state's capacity to support community coalitions through training and networking opportunities. As discussed in the following two subsections, an important gap in the current infrastructure is the absence of a well-functioning coalition-based prevention system in a number of Vermont's communities.

Statewide Community Grants At the program level, family strengthening programs have achieved measurable changes in risk and protective factors. For example, the Rocking Horse Circle of Support Program is an educational support group for low-income pregnant and parenting women between the ages of 18-35. Evaluation of the Rocking Horse Program indicates that participants reported an increase in their perception of risk for smoking and drinking during pregnancy.

Evaluation of Vermont's Nurturing Parent Program reveals an increase in parental comfort level in discussing alcohol tobacco and other drug use issues with their children and an increase in their ability to establish family rules and expectations regarding use.

Regional Prevention Consultants and Services. As described on pages 28 and 29, the results of a survey of key stakeholders reported that the Prevention Consultants were identified as one of the current strengths of the ADAP prevention system. Prevention Consultants were described as highly skilled, credible, substance abuse prevention experts, cooperative, eager to assist, responsive and team players. Our current data collection system regarding the work of the PC's is a Management Information System or MIS that tracks process measures such as hours worked by "service" type (consultation, facilitation, presentations, planning and delivery of training, technical assistance, etc...), hours worked by project "type" (information dissemination, education, community-based process, environmental,, problem identification and referral and substance free recreation) and populations served. A systematic review of process measures and stakeholder feedback indicates a level of effectiveness and satisfaction with the Prevention Consultants services to the community. However, we recognize more data on the services of the infrastructure is needed in order to monitor effectiveness and improve quality.

g. Significant gaps in the current community prevention systems

Coalition Coordinators

As part of the SPF capacity assessment, coalition coordinators statewide were asked to identify what they consider the most critical needs or gaps in the current community prevention system. In ranked order they were:

1) Adequate & long term funding

After the conclusion of Vermont's first State Incentive Grant, the Department of Health moved to a strategy of competitive, small, one year grants to support coalition plans. This funding strategy fails to nurture mature, comprehensive prevention approaches. Consistently the coalitions identified a lack of organized advocacy for prevention funding as a gap.

2) Human capacity

Challenges in recruiting staff and volunteers were identified. Training and technical needs were identified as follows:

- Skill-building programs such as planning, evaluation meeting facilitation, coalition development, youth leadership and involvement,
- Training on evidence-based prevention programs/practices
- Mentorship or coaching for front line prevention workers

In November 2006, ADAP's regional substance abuse prevention consultants were asked to answer the following question: *From your experience as a regional Prevention Consultant, what*

areas of capacity development are needed in your region that are needed to affect change in the areas of alcohol and marijuana prevention (our two priority substances) in the following areas:

- Organization structure
- Knowledge, skills and abilities
- Financial
- Cultural competency
- Sustainability

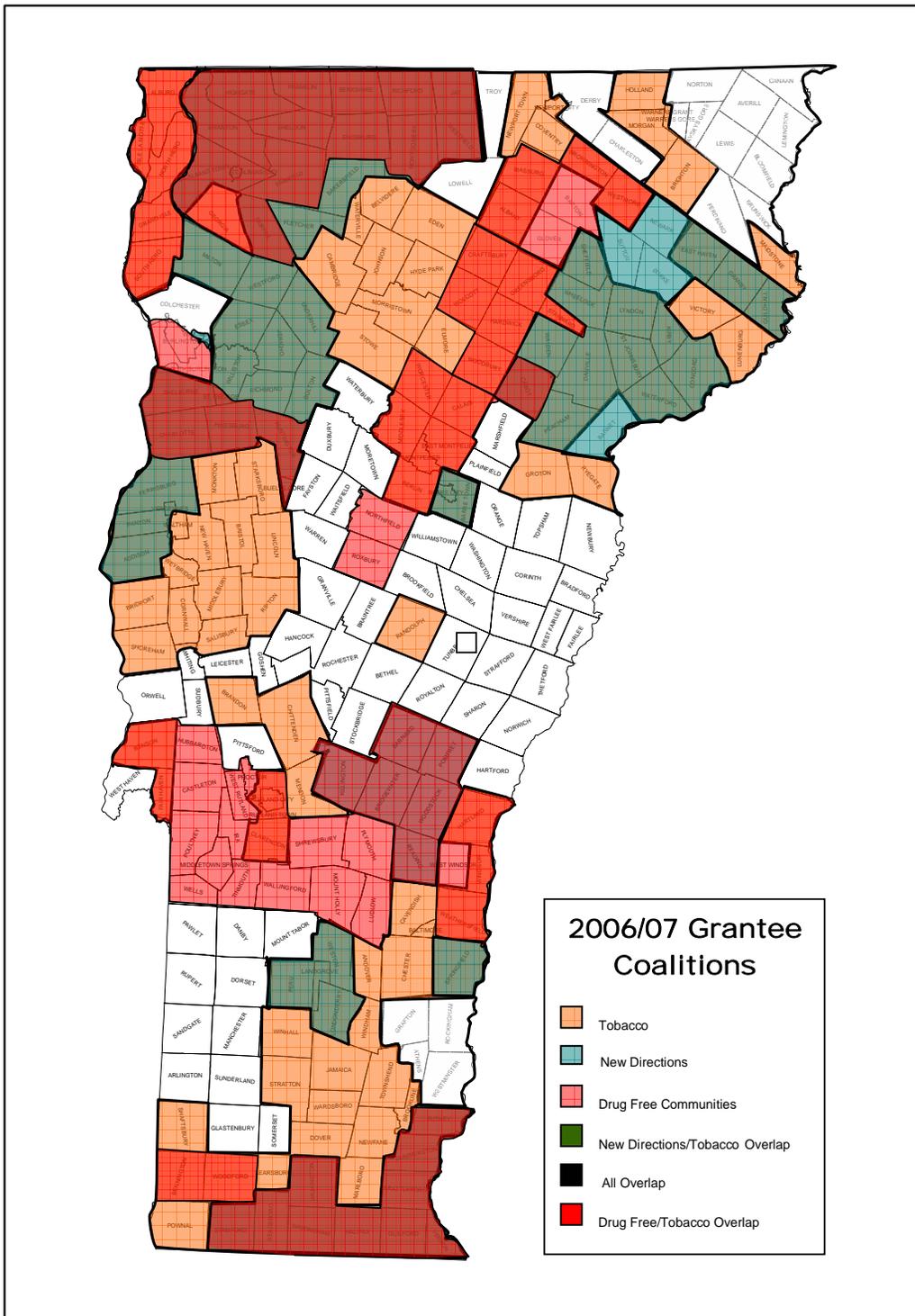
Nine out of 10 Prevention Consultants responded that on a regional level, all areas of capacity development are needed.

h. Capacity of communities to implement the strategic prevention framework

Vermont is fortunate to have a strong community-based infrastructure in place. However, significant inconsistencies exist. In the words of one SPF advisor, “Vermont communities take great umbrage with being defined”. This has resulted in varying sizes and configurations of community coalitions. Some cover regions or counties, some cover towns or supervisory unions. The patterns of funded and unfunded communities can also change from year to year. The map below depicts Vermont’s current status with the areas that are currently not covered by a funded coalition shown in white.

All towns have access to some training and technical assistance through the 2 AHS Districts, the 12 Regional Health Partnerships and the 10 regional PC’s. Since implementation of the original SIG many community based coalitions have received training on how to assess their communities needs, resources and readiness using data to identify gaps and using data to inform community planning and program development. Coalitions have received training on the purpose and development of logic models, risk and protection theory, coalition development, youth involvement, evaluation, how to gather and analyze data and sustainability. Vermont’s 15 DFCS funded coalitions are familiar with the five-step SPF process.

For those areas of the state that are considered low capacity due to no access to either a New Directions or Drug Free Communities coalition, VDH proposes to build capacity through capacity building community grants that will use a mentor model to pair an inexperienced community with an experienced one to lead and guide them through the strategic prevention framework process.



i. Capacity of communities to collect, analyze and report on data

Many Vermont communities are well versed on the organization of surveillance data provided to them by the Agency of Human Services through its “Community Profile” reports. They participate in the surveys and surveillance systems used to generate these data. Most VDH grantees have the capacity to report process indicators. The capacity to collect, analyze and report community-specific risk factors and program level outcome indicators varies around the state. These skills will be a key focus on training provided to community grantees through the SPF SIG.

3. Criteria and Rationale for SPF SIG Priorities

a. Criteria used to identify statewide priorities

The criteria the State is using to define “critical need” based on substance related consequence and consumption data presented in the State’s epidemiological profile.

The most influential criteria used by the SEW to identify statewide patterns were:

- a. Vermont’s ranking relative to other states on prevalence and consequence indicators.
- b. Relative prevalence of different problems within Vermont.
- c. Trends of consumption and consequences.

The SEW determined these three criteria in concert should unambiguously guide the process for prioritizing the relative importance of statewide patterns of substance use and abuse. We note again that information presented here is abstracted from the larger State Epidemiological Profile and is designed to highlight the complex process the SEW engaged in to select the SPF-SIG priorities. That is, the collaborative effort of the SEW, SPF-SIG Planning Group, and the Advisory Council to identify empirically-based statewide priorities was an in-depth process that encompassed as many data sources as could be gathered that were evaluated from multiple perspectives. It is our view that this procedure consistently pointed to the overall priorities and the specific indicators that could be influenced by additional prevention efforts from community-based groups.

The early discussion of Statewide priorities among the SEW members was based on the initial examination of the epidemiological data presented to them and the application of the criteria identified above, it was clear that addressing underage drinking, binge drinking, and marijuana use were three general areas of concern and critical need in Vermont. Local and National indicator data sets provided substantial support for this interpretation. The SEW continued to explore data sets as they became available for inspection. The SEW recognized that the priorities eventually recommended to the Advisory Council could be especially pertinent because they could potentially bridge several interconnecting critical areas and therefore address a number of dimensions both directly and indirectly. For example, while the overall rate of alcohol-related motor vehicle deaths in Vermont is similar to national averages (~35-45 % across years), the actual raw annual numbers are low compared to larger states. Attempting to show

significant quantifiable short-term reductions may be difficult. However, addressing issues that relate to underage drinking and binge drinking may have a positive long-term peripheral effect on this important public health problem. Furthermore, by targeting reduction of marijuana use in a vulnerable population (under 25 years of age), this could have the positive benefit of addressing driving while under the influence of marijuana—a relatively new area of concern for law enforcement. Finally, reduction of underage alcohol use, reduction of binge drinking, and reduction of marijuana consumption will likely all have enduring positive public health consequences well-beyond the life of the SPF-SIG spanning a number of specific indicators. Therefore, the SEW’s consideration of particular priorities were undertaken with primarily a short-term goal (demonstrable movement of particular indicators) but included a long-term perspective (improve the overall physical and mental health of Vermonters with respect to ATOD issues).

b. Determining state-level critical needs

The State-level areas of critical need: specific consumption patterns, consequences, populations, geographic areas, etc... Please describe how the criteria you described in element 1 above were applied to substance use and substance related consequences data to determine these areas of critical need.

As stated above, the size of the population and its distribution in the State of Vermont precluded examination of most data sets at sub-state levels. Thus, criteria were established and applied to the tasks of identifying state wide critical needs by the SEW. The epidemiological data were analyzed and the results discussed over the course of several SEW meetings. In addition, a smaller SPF planning and strategy group composed of selected staff within the Department of Health offered additional analysis and interpretation of the data for SEW consideration. Even in a small state like Vermont, there is a considerable amount of relevant data, so organization of the available resources becomes paramount. In this manner the SEW was able to efficiently perform its charge and determine state-level critical needs. At this point in the process, the priorities identified and recommended to the AC were:

1. Alcohol misuse across the lifespan.
2. Driving under the influence of marijuana

c. Additional criteria used

Any additional criteria (e.g. program, resources, readiness, capacity) that the State is using to determine priority targets

Following the initial submission of recommendations regarding statewide priorities by the SEW, the SEW, the SPF-SIG planning and strategy group, and a wider group of Department of Health staff in concert with the AC considered several additional criteria in finalizing the state’s priorities. These considerations included preventability/changeability, the level of prevention resources already being focused on certain problems, and the capacity of communities within the state to implement the steps of the SPF process.

In considering preventability/changeability, the SEW's decision to not recommend illicit drug use other than marijuana as a statewide priority was further supported. Specifically, this is a broad category of drugs each of which individually is at a low threshold of prevalence (at least half that of marijuana). Therefore, reductions in their use could be difficult to achieve and/or detect. In addition, targeted prevention efforts aimed at one drug may not be as effective for other drugs. For example, cocaine has dissimilar use patterns and physiological and psychological effects than prescription sedatives used illicitly. Prevention programs for each of these drugs would likely be very different and, given the very low prevalence of many illicit drugs, logistically complicated to implement at the community level. Finally, the data did not point to any particular area of the state where illicit drugs were either a significant problem in terms of consumption and consequences or that approached the consumption and consequences of marijuana and alcohol. This is an important consideration for maximizing both the breadth and depth of prevention programs for substance use and abuse problems across the state.

In considering other resources, the AC noted that substantial funds were already being applied to tobacco prevention activities through the Master Settlement Agreement and other sources. This provided further support to the SEW's recommendation to not focus on tobacco use as a statewide priority.

Regarding capacity as a consideration, the state was already well aware that substantial additional capacity building was needed for the state to successfully implement the SPF, and that the level of capacity varied considerably across communities within the state.

GIS maps were generated depicting the levels of existing sub-state resources and capacity in order to identify gaps in statewide coverage. These maps were overlaid onto maps of prevalence data and raw counts of indicators to identify areas in which capacity building would be the first increment in an overall prevention plan. These were exploratory steps meant to provide a general representation of the readiness of sub-state areas to develop and implement evidenced-based prevention programs that are relevant to the articulated priorities. Building prevention capacity is one of the key goals in the Vermont approach to the SPF-SIG. In order to achieve effective long-term prevention strategies across the State, an expanded infrastructure is imperative. Sustainable prevention capacity is a worthy and significant outcome in and of itself, but becomes even more potent when simultaneously linked to the implementation of evidenced-based prevention programs.

d. The rationale for use of each criterion

The SEW examined prevalence and burden (raw numbers associated with particular indicators within Vermont) in the context of both state and national substance use and abuse trends. Further, the SEW considered the resources already developed to address particular problems and the consequences of extant prevention programs. For example, while smoking is a major cause of a number of health harms in Vermont (and every other state), existing programs have demonstrated significant reductions in tobacco use across all age groups. While further reductions may be enhanced by additional resources it is likely not a linear function. Limited prevention funding must focus on the most urgent needs among an array of real and perceived harms. The SEW considered that children, adolescents, and young adults are exposed to a daily barrage of media messages that portray alcohol use in the most positive possible light in a not so

subtle appeal to these age groups as consumers or future consumers. Alcohol and televised sporting events appear to be inextricably woven together. One would be hard pressed to find any televised sporting event that does not have an alcohol producer as a major sponsor. The SEW determined that strengthening prevention efforts in this area is a necessary endeavor to counter the effects of such advertisements. The aim of these efforts should be to delay the onset of consumption among adolescents and to reduce the overall rate of drinking in young adults by utilizing the established efficacy of evidence-based prevention programs. Escalating and promoting community-based efforts with age-appropriate programs on the harmful consequences adolescent/young adult drinking (including medical, psychological, and social in conjunction with a statewide media campaign should result in measurable positive outcomes.

Prevalence rates of marijuana consumption in Vermont are among the highest in the nation. Given the rates reported among 8th -12th graders, the drug appears to be readily available and obtainable. There is a substantial amount of research showing the detrimental impact of marijuana on developing brain physiology of adolescents. However, as stated above, the perceived harm of marijuana among adolescents in Vermont is among the lowest in the country. Thus increasing the breadth and depth of prevention efforts in this area was deemed essential by the SEW.

Because of the rural nature of the Vermont, there are some areas in the state that have little established prevention capacity or resources. The SEW recognized that building this capacity across the state would significantly enhance the opportunity for success of any evidenced-based prevention programs implemented. Ensuring that these programs actually are community-based is an important facet in producing positive results. In addition, building or augmenting prevention infrastructure was seen as a vital factor for long-term success beyond the time frame of the SPF-SIG.

e. Process used in applying the criteria

A description of the procedures and/or processes that were utilized in the application of these criteria.

After reviewing all the data and available resources, the SEW developed recommendations for the State SPF-SIG priorities. This was an iterative process; however, given that these data were consistent across various sources and that the nature of the measurable outcomes became increasingly apparent, the SEW was able to form a consensus on the priorities to be recommended to the Advisory Council. The small size and homogeneity of the population of Vermont was seen as an asset in determining state wide priorities. The rural nature of the state was viewed as problematic in being able to adequately deliver programs that address the priorities and implement appropriate evaluation techniques (both process and outcome). However, the selected priorities identified substance use/abuse problems that were common to all areas of the state and that were linked to specific indicators which enhanced their importance relative to an alternative focus. Finally, as previously suggested, both concrete short-term outcomes and potential long-term effects were associated with each priority which further amplified their weight in comparison to other considerations.

With the guidance of the SEW, data were analyzed and reports prepared by appropriate VDH staff. These reports included detailed analytical results of the ATOD issues within the State of Vermont (including trend data) as well as how these problems compared to national estimates across states. In order to enhance the understanding of the data sifting and decision-making process, a Bridge Group was formed consisting of selected members of the SEW and the Advisory Council. The purpose of this group was threefold. First to make transparent the process of selecting data-based prevention priorities recommended to the AC. Second, to engage additional critical perspectives on the data gathering and analysis techniques used by the SEW. Third, to thoroughly evaluate the “changeability/preventability” valences of the indicators associated with the selected priorities.

The Bridge Group met twice (April & May, 2006) to discuss a wide range of topics relevant to the issues of preventability and changeability including:

- Prevention timing across the life course- differences between prevention and treatment
- The gap between resources and goals
- Which areas would offer the best opportunity to demonstrate change within the life of the plan
- Which areas need to be enhanced regardless of the timeframe constraints of the plan – building infrastructure throughout the state
- Are their current policies/procedures/systems in place that would more easily predispose and accommodate measuring change in identified indicators
- Focus on family environmental issues
- Consideration of current social norms
- Strategies and tools that have already been attempted and/or used effectively in other states
- Issues surrounding cultural competency and special populations

This was an important process because it was determined that no matter the relative ranking of the State on particular problem prevalence and/or burden, if indicators were selected that would not be amenable to demonstrating timely empirical variation or that were deemed not preventable within the timeframe of the SPF-SIG, the SEW would have to re-examine the data and modify the priorities accordingly. At the same time, the group was acutely aware that capacity building was necessary in some parts of the state and further develop existing infrastructure was important to other areas. In addition, these were the first discussions that focused on particular population and age subgroups that would benefit most from enhanced prevention efforts. Based on these considerations, the Bridge Group forwarded to the SEW augmented recommendations for the priorities. The full SEW reviewed the proposal and concluded that the specified priorities as amended by the Bridge Group represented an excellent combination of prevalence, burden, and overall changeability/preventability within the time constraints of the SPF-SIG. In addition, the considerations for increasing sustainable prevention capacity throughout the state were enthusiastically endorsed.

The draft priorities developed by the SEW were presented to the Advisory Council in June, 2006. The SEW Chair described the process that the group used over the previous months to select these priorities. In addition, the work of the SPF-SIG planning and strategy group was

discussed to further enlighten the Advisory Council members on the priority selection process. The procedures and methods that the SEW developed and employed to examine all available data sources were presented.

4. Description of the Priorities

a. Statewide priorities for the SPF-SIG

After a detailed examination of all the data and a thorough discussion of relevant State prevention interests (e.g., law enforcement, medical, social, economic) across several dimensions (e.g., prevalence, burden, impact) the Advisory Council adopted the following four priorities.

- 1 Reduce underage drinking
1. Reduce high-risk drinking among persons under 25
2. Reduce marijuana use among persons under age 25
3. Build prevention capacity and infrastructure at the state and community levels, including a sustainable evaluation system for prevention grantees.

b. Procedures used in determining the final priorities

The SEW's early draft recommendation for general priorities were:

- Alcohol misuse across the lifespan.
- Driving under the influence of marijuana

These priorities were significantly refined in a step-wise fashion by the SEW, Advisory Council, and SPF planning group to arrive at the final set listed above. For example, after a closer inspection of available data, it was determined that a broader approach to marijuana issues would be appropriate. It was noted that a direct consequence of reduction of marijuana consumption in the highest risk population (under age 25) would be a concomitant decrease in the prevalence of driving under the influence of marijuana. It was also determined that a narrower focus on particular age groups with regard to alcohol consumption would be more in alignment with the overall SPF-SIG mission to provide measurable outcomes as a function of evidenced-based prevention programs within the time frame of the grant. These empirical and practical considerations appropriately guided all discussions of the priority selection.

The Advisory Council was mindful that definitive actions on all four priorities have remarkable potential to achieve short-term change and effectuate dynamic long-term public health benefits across the state. In addition, Vermont has the intriguing possibility of acting as a natural experiment investigating the impact of evidenced-based prevention programs in a primarily rural state.

c. Group responsible for determining final set of priorities

Based on the 9 month review of the data by the SEOW, preliminary priorities were recommended and presented to the Advisory Council membership for review and input. Meeting

weekly, the internal Strategy Leadership Team reviewed the work of the SEOW and the input from the Advisory Council and developed final priority recommendations that were presented and approved by SPF Project Director Barbara Cimaglio. Deputy Commissioner Cimaglio presented the final priorities to the Advisory Council where they were adopted by the Advisory Council.

B. Capacity Building

1. Areas Needing Strengthening

Identify and describe areas in which the State needs to strengthen its capacity in order to effectively implement the SPF

Areas in Vermont's state and community prevention systems that need strengthening were identified as infrastructure gaps in sections A.2.b and A.2.g, respectively. Three areas that were especially significant concerns, and that will be addressed through the implementation of the SPF at both the state and community levels, pertain to:

- A. Workforce Development
- B. Communications
- C. Data Collection

2. State and Community level Activities

Describe SPF capacity building activities that will be conducted at the State-wide level and those that may occur at the local community level(s) (e.g. training for State personnel, surveillance and monitoring activities, etc...)

A. Workforce Development

State Level

Vermont currently has no systemic approach to training of its prevention workforce. The Northeast Center for the Application of Prevention Technology (NE CAPT) will be providing a series of trainings for SSA central staff, all regional Prevention Consultants and VDH District Directors. Needs assessments already completed will be provided to the NE CAPT as they prepare for the training.

A one day training will be held on March 1, 2007. The objectives for this training are:

- to increase the Prevention Consultants understanding of the SPF model including core principles and action steps at each step for the State and local communities;
- identify potential needs, concerns and resources at the local level for conducting the SPF planning model;
- gain clarity regarding the Prevention Consultants role as technical assistants and training providers as it relates to the SPF.

A two-day training will be held in May 2007. This training will be a Training of Trainers (TOT) on the Strategic Prevention Framework steps one through three and the delivery of Strategic Prevention Framework technical assistance on the local level.

The SSA is participating in the CSAP Prevention Fellowship Program (PFP). The goal of the PFP is to cultivate and enhance a prevention workforce and support the Strategic Prevention Framework. The program will support one individual for 35 hours a week for one year (with two option years). The Fellow will participate in SPF trainings and meetings and assist SSA central office staff.

Local Level

The SSA will identify a training contractor to oversee provision of SPF SIG training to grantees, utilizing both electronic and face to face methodologies. Community grantees will be required to budget for the procurement of training and technical assistance, to include but not limited to evaluation, media (common theme campaigns) and cultural competency. It is anticipated that this training will serve as the foundation for a learning community to continue through the life of the grant. The contractor will be expected to work closely with the NE CAPT. Regional PC's will assist with statewide trainings and provide local follow-up technical assistance to grantees.

Where possible high capacity grantees will be informally partnered with low capacity grantees and mentoring relationships encouraged. In the first year of SPF-SIG Community grants, it is anticipated that low capacity grantees will participate in training/skill development activities on SPF steps 1 and 2, and high capacity grantees will participate in training on steps 1- 3.

It is anticipated that all prevention funders supporting the Coordinated Health Activity, Motivation and Prevention Program (CHAMPPS) will work toward a collaborative workforce development strategy so that by the end of the SPF SIG there will be an on-going system for skill development on the five step SPF process. This is the rationale for involving VDH District Directors in the NE CAPT training of state staff in March.

B. Communications

At the state level, in Spring/Summer 2007 we will increase state capacity in social marketing principles and methods. The media specialist will provide training for state personnel and other key partners on focus group moderation and data collection. This train-the-trainers will include practice and follow-up supervision with the trainer. The media specialist will utilize and apply this assessment to the development of common theme campaigns.

At the community level, TOT participants will then train SPF SIG grantees in conducting focus groups and collection of data on key targets. The first set of data collection will focus on priority #1, underage drinking, but once this capacity is developed, it will be utilized to inform environmental strategies on all SPF priorities. Support for community partners to implement activities that are aligned with audience motivations and lifestyles will be provided through regular training and ongoing technical assistance for grantees. Local campaign implementation will be participation in common theme campaigns. Media literacy will be worked into the mix

of tactics, and the state will develop educational materials and training so that community partners may implement local activities.

C. Evaluation/Data Collection

Step 1: The SEW, in conjunction with the SPF evaluator, will continue to study gaps and limitations in the state's current data infrastructure, especially as they pertain to community-level data, and develop proposals for how to address the gaps and/or compensate for the limitations.

Step 2: ADAP staff will develop one consistent data reporting form to be implemented across prevention grant programs. To start, consistent format will collect those indicators required for National Outcome Measures. ADAP staff will work closely with the SPF evaluator to assure this format will be consistent with the SPF SIG evaluation.

Step 3: Prevention management information system for regional substance abuse prevention consultants will be modified to collect all process measures required by National Outcome Measures, including data on technical assistance services provided to operationalize the SPF SIG at the regional and local level.

Step 4: Training and technical assistance will be provided to staff and grantees on data collection procedures and related assessment, monitoring, and evaluation activities.

Step 5: The SPFAS will assess and provide consultation to ADAP on long term goals and resources needed for development of a quality assurance system. Milestones for data infrastructure development will be greatly informed through the process of working with SPF SIG evaluator and grantees. One key question to be considered by Year 3 of the SPF SIG is, "What system can serve our performance monitoring needs and is also sustainable?" and "Is it feasible and efficient to develop one performance monitoring system across all VDH prevention programs?"

3. Role of the State Epidemiological Workgroup

Describe the expected role of the SEOW in the remaining years of the grant and how the State plans to strengthen this workgroup. Please describe how the State will continue to collect and analyze data in order to identify emerging priority areas and monitor substance abuse consequences and consumption patterns over time.

In a relatively short amount of time, VT's SEW sifted through an enormous amount of alcohol and other drug consumption and consequence data to assess the critical need in Vermont. Although Vermont has access to a large amount of data, the SEW identified gaps in the state's data infrastructure and also noted the 2-3 year lag time in accessing some datasets. In the remaining years of the grant, the SEW will play a central role in enhancing the identification and processing of data pertaining to substance use and abuse in Vermont. Some priorities for the SEW to focus on are:

1. Revitalizing and reconstituting the SEW membership (Now that the SPF-SIG priorities have been identified and the Plan is drafted, attendance at bi-monthly meetings has waned.)
 - a. Identify strengths and weaknesses of current membership (e.g., access to particular data sets or targeted populations)
 - b. Identify individuals who would add a level of expertise currently lacking
 - c. Have Barbara Cimaglio, VDH Deputy Commissioner invite new and existing members to upcoming meeting
 - d. Redefine goals, missions, objectives

2. Preparing a more user-friendly version of the epidemiological profile for public distribution (Attached Epi Profile was developed for use by the SEW, but is not intended for public dissemination.). Part of this comprehensive project will be to make Vermont-relevant data available to SPF-SIG applicants and grantees.

3. Addressing gaps in the alcohol and other drug consumption and consequence data, most notably when looking at 18-24 year olds. This is especially a problem in a small state like Vermont. The SPF-SIG Advisory Council has already identified the need to obtain more extensive data on this age group
 - a. Identify all data gaps
 - b. Make recommendations to improve data collection systems

4. Creating a “rapid response” to monitor, acquire and analyze emerging substance use and abuse trends. For example, there have been several recent press releases regarding the increasing misuse of prescription drugs on a national level. Vermont has been aware of anecdotal reports these trends from reliable sources such as the State Police but we have not seen evidence of it in any extent consumption data sets. One approach would be to refine and expand current data collection methodology. Some data could be gathered relatively rapidly (e.g., ER data, police data, etc.), but several problems would have to be addressed first.
 - a. Identify potential data available real time
 - b. Identify mechanisms to make consumption data available more quickly

C. Planning

Describe the proposed approach to developing and deploying SPF grant resources and the programmatic mechanisms to address priorities.

1. State Planning Model

Provide a description of the planning model your state used to determine how to allocate funds (e.g. equity model; resourcing high needs areas/populations to address a specific problem; resourcing high need areas populations to address State-identified priority problems in or other planning models proposed by the grantee

Vermont has identified two overarching goals for its SPF SIG. A dual planning model will be employed to address both of these goals as robustly as possible.

GOAL A: Achieve reductions in identified priorities in selected communities/counties

Planning model: High need, high capacity areas will compete for funds to achieve reductions in Vermont's priority targets and will be referred to as **Implementation Grants**. Among the implementation grants, VDH intends to fund one grant targeting each of these special populations if feasible:

- Community that includes an institution of higher education
- Community that includes a Governor's Incarcerated Women's Initiative on 18 to 24 year-old parents and their children.

These sub-populations fall within our priority targets, have demonstrated high levels of consumption and are of high interest to the Governor, Vermont Legislature and the general public. The state substance abuse prevention system is sometimes perceived as working only with the "worried well." This allocation strategy is intended to increase public support for a sustainable substance abuse prevention system. If it can be demonstrated that applying the SPF process can improve outcomes with these populations in one community, then public perception of and support for the state substance abuse prevention system will improve.

GOAL B: Sustainable prevention infrastructure/capacity development at the community/regional level

Planning Model: Low capacity communities will compete for funds to improve prevention capacity and will be referred to as **Capacity Building Grants**. A partial equity model will be employed, meaning that where feasible, VDH will fund one capacity building grant within each AHS district. This will assure some SPF planning capacity across the state.

2. Community-based Activities

Describe the community-based activities (e.g. further needs assessment; capacity-building; implementation of programs, practices and policies, etc...) that the SPF allocations are expected to support

Implementation Grants (High Need/High Capacity Communities)

SPF SIG funds will support community grantees to implement all five steps for the SPF. An immediate grant payment will support work on steps 1 -3 of the SPF. Several high capacity communities in Vermont have conducted substantial needs assessments. They will be provided with data profiles on Vermont's priority outcomes and asked to build on work they have already completed. This may include a review of risk and protective factors, as well as community stages of readiness to address these factors.

The epidemiological workgroup has determined that the 18 to 24 year-old age group statewide has significant need. The SPF SIG Advisory Council has determined that the State as a whole is at a low capacity to reach 18 to 24 year-olds who are in the community and not enrolled in an institution of higher education. As part of their planning process, grantees will be asked to articulate how they will reach 18 to 24 year-olds in the community and engage in ongoing prevention efforts around their region.

Each grantee will be expected to participate in SPF SIG training through a learning community process on steps 1-3. Grantees will submit action plans to VDH for review. Upon approval of said plans, VDH will release second grant payment to support implementation of plans.

Capacity Building Grants (Low Capacity Communities)

Vermont will award up to 12 capacity building grants to communities or regions of low capacity. Funds will support needs, resource and readiness assessment, and a plan for building capacity and capacity building activities. Grantees will recruit a team to participate in SPF SIG training through a learning community process on steps 1 -2. Grantees will assess high and low need, resources and capacity in the region, and develop a plan for improving prevention capacity as it relates to leadership, infrastructure and workforce development. Grantees will be encouraged to participate in a community mentor process, where a seasoned coalition with substance abuse outcomes mentors a new community coalition. This approach has proven successful in increasing prevention capacity in Vermont.

The epidemiological workgroup has determined that the 18 to 24 year-old age group statewide has significant need. The SPF SIG Advisory Council has determined that the State as a whole is at a low capacity to reach 18 to 24 year-olds who are in the community and not enrolled in an institution of higher education. As part of their planning process, grantees will be asked to articulate how they will reach 18 to 24 year-olds in the community and engage in ongoing prevention efforts around their region. They will submit their capacity development plan to VDH. Upon approval of their plan grantees will receive a second payment to support capacity development activities.

All SPF SIG Grantees Statewide (Implementation and Capacity Building)

All SPF SIG grantees will be expected to support and participate in:

- Training on SPF SIG, including training on evidence-based practices for reaching Vermont's priority outcomes
- Evaluation activities aimed at assessing progress on Vermont's priorities, including participation in national cross-site evaluation
- A common theme communications campaign on underage drinking developed as part of the SPF SIG.

3. Allocation Approach

a. How community-based activities will address critical needs.

How the community-based activities listed in element 2 above address your State's definition of "high need" based on consequence and consumption data

A. Implementation Grants (High Need/High Capacity Communities)

Although there are differences among Vermont communities in YRBS consumption rates, the potential for comparison and identification of high need communities is still limited because of the variability across communities is generally not very substantial, and many of the more extreme values appear to be due to relatively low Ns and are therefore unstable. In addition, reliable community-level indicators of young adult substance use are unavailable. Therefore, a competitive RFP will be issued and applications scored. Communities will be selected primarily on the basis of their capacity to competently implement the five steps of the SPF. Applicants may be assigned additional points in grant review scoring based on consumption and population data (on Vermonters under age 25) which will be provided in the RFP.

Every grantee will be expected to address two of the three Vermont priority outcomes selected. Every grantee will be expected to address priority 1, underage drinking, in their implementation plan.

Implementation grants will be funded a stepped down rates in years 3-5.

B. Capacity Building Grants (Low Capacity Communities)

District Health Directors and Field Directors will review capacity building applications with support from regional Prevention Consultants and recommend grantees to VDH. These directors are already engaged in assessments of regional strengths and gaps in public health services. They will be provided with review criteria designed to help them assess the extent to which applications identify capacity resources and gaps, and which applications will move the state toward a strong state prevention system beyond the life of the grant. They will also be provided data on the number of people under the age of 25 who reside in the applicant area, as well as consumption and consequence rates provided by the Epidemiology Workgroup to further inform their decisions. To assure sustainability, minimum applicant community size will be a school supervisory union. However, multiple communities, representing more than one supervisory union may submit one application.

Each grantee will be expected to complete SPF steps 1-3. It is anticipated that capacity building grantees will have an opportunity to apply for implementation funds in years 3 to 5 of SPF implementation. (These funds will be available through two strategies: Implementation grantees will be funded at stepped down rates; and, if available, SPF carryover funds may also be applied to second tier implementation grants.)

b. How community-based activities will address capacity enhancement

How these activities address priorities that may emerge from applying additional criteria (e.g., resources, capacity, etc.) to areas of high need.

Capacity Building Grants

Capacity building grantees will assess capacity strengths and needs, and develop a plan for capacity building. That plan will be approved by VDH before the grantee receives a second payment to carry out said plan. Regional ADAP PC's will provide technical assistance after the grantee participates in statewide training, to assure that grantees are applying the SPF.

All Grantees (both Implementation and Capacity Building)

All grantees will be expected to participate in technical assistance and training opportunities aimed at increasing capacity and developing evidence-based approaches to the priority on which they are working. It is anticipated that every grantee will have a need for capacity development in the following areas: SPF planning; cultural competence; ability to reach and involve young adults; and capacity to carry out communications strategies. SPF training will include these cross cutting issues. All grantees will be expected to participate in common theme campaigns developed to address priorities, starting with underage drinking campaign. Each grantee will be expected to include these strategies in their local strategic plan

c. Allocation of SPF funds to communities

How you expect to allocate SPF dollars to support these activities and the mechanisms that you expect to use. Please indicate how many sub recipient grants/contracts the State expects to make and the process by which sub-recipient grantees will be chosen.

The anticipated allocation strategy is as follows:

- Up to 12 capacity building grants awarded, one per Agency of Human Services District, @ up to \$50,000
- Up to 10 implementation grants awarded per competitive process, @ up to \$125,000. Grantee funding in years 3 to 5 will be reduced at stepped down rates to be determined.
- Funds will budgeted by community grantees to support the following community services: communications campaign; training; evaluation; technical assistance on cultural competency.

Allocation mechanisms will be as follows:

1. Coordinated Healthy Activity, Motivation and Prevention Programs (CHAMPPS)

As detailed on page 33, The Appropriations Act of 2006 (Act 191) established the Coordinated Healthy Activity, Motivation and Prevention Programs (CHAMPPS) initiative to distribute competitive, substantial multi-year grants to communities beginning July 1, 2007. These grants are to be used to fund “comprehensive community health and wellness projects” that are designed to “promote healthy behavior and disease prevention across the community and across the lifespan of individual Vermonters”.

Inherent in the CHAMPPS model is the recognition that risk factors and protective factors are often shared across multiple health issues and conditions. CHAMPPS has adopted the Strategic Prevention Framework as its planning model for all funding sources, which include funds aimed at nutrition and health activity, health aging and the prevention of chronic health conditions.

Act 191 mandates that \$500,000 of SPF grants be issued as part of the CHAMPPS initiative. CHAMPPS applicants have the option of applying for either capacity development or implementation grants. All CHAMPPS/SPF SIG grantees will meet the same requirements as other SPF SIG sub-recipients. It is anticipated that other CHAMPPS funders may pick up capacity development in years 4 and 5 of the SPF, allowing ADAP to award more implementation grants in years 3-5 of the SPF SIG.

This model is similar to Maine’s Healthy Maine Partnerships braided funding approach. This presents a tremendous opportunity for Vermont’s SPF team to learn from and with Maine’s SPF SIG about braided funding approaches to addressing substance abuse prevention priorities.

2. SPF SIG grants issued through separate requests for proposals issued through the Division of Alcohol and Drug Abuse Programs(ADAP):

Implementation (high need/high capacity) grant applications will be solicited through a competitive process as described above

Capacity Building (low capacity) grant applications will be solicited through a competitive process. Eligible applicants will be a community coalition, a regional health partnership, a hospital or other entity which has demonstrated capacity to lead a SPF capacity development effort. Where feasible, one capacity building grant will be awarded per AHS district, to move the state toward a more equitable level of capacity. (There may be regions of the state that have already achieved implementation level and do not require a capacity building grant.)

The CHAMPPS grant review will occur first. SPF SIG staff will be available to grant reviewers to assure that applicants receiving SPF SIG funds are eligible, based on the criteria outlined above.

	CHAMPPS SPF SIG Grants Process	Alcohol & Drug Programs Division (ADAP) SPF SIG Grant Process	Total SPF SIG Grants
Implementation Grants			10
Capacity-Building Grants			12

d. How allocation mechanism will enable state to address statewide priorities

How these mechanisms enable your State to address the priorities that were defined.

The allocation mechanism will enable us to address statewide priorities in three ways:

1. All implementation grantees will be required to address at least 2 of the 3 priority outcomes. By limiting the number of priorities we will assure that grantees have a strong focus.
2. The number and size of implementation grants, as described on page 59, allows for a robust set of interventions to be developed and implemented over 5 years, given the population size of Vermont communities.
3. Development of a statewide communications strategy to be implemented at the local level will support cohesive work toward the priority outcomes.
4. The involvement of the District Directors and CHAMPPS funders in capacity building grant review will increase understanding of and long term commitment to developing long term capacity building strategies. We will move toward targeting of multiple funding streams on capacity building in core infrastructure areas.

e. Ensuring appropriate use of funds by communities

How the State will ensure that relevant and appropriate policies, practices and programs are funded at the sub recipient level.

Implementation grants (High need/High capacity) will be awarded based on need and capacity as assessed through competitive scoring on those factors. Grantees will be required to participate in training and technical assistance on steps 1-3 of the SPF SIG prior to development of implementation plan. VDH will issue funds for implementation only upon approval of implementation plan though which grantee must demonstrate a robust strategy for addressing priority areas.

Capacity Building grants (Low Capacity) will be awarded on an equity basis. Grantees will be required to meet early milestones, such as hiring staff and assembling team to participate in SPF training and learning community. VDH will issue funds for capacity development plan only after grantee has met those milestones.

In addition, SPF evaluator and staff will monitor progress through regular reports and other information to be provided by the grantees. Specifically, planning and implementation information will be obtained through the cross-site evaluation's community level instrument (CLI) and outcome data collection activities assumed by the grantees will be guided and monitored by the SPF evaluator.

All SPF SIG grantees will address the same requirements whether they are funded through CHAMPPS or the ADAP RFP.

f. Ensuring cultural competence and inclusiveness

How the State will ensure that all activities funded at the sub recipient level are culturally competent and culturally inclusive.

Vermont will secure a part time consultant to assist state staff in establishing a baseline and measurable objectives for increasing cultural competence – including the system’s ability to understand and work with youth, young adults and people living in poverty. In addition, cultural competency knowledge and skill development will be integrated into SPF training plan supported by the community grantees. (See Cultural Competency section on page 73 in Cross Cutting Section) .

g. Ensuring sustainability

How the State will ensure that activities funded at the sub recipient level are sustainable once grant funding has ended.

Over the life of the SPG SIG sustainability strategies will be included in training and learning community strategies. In their planning, grantees will be encouraged to consider those environmental strategies that target their outcomes and would be most sustainable beyond the life of the grant.

It is anticipated that over the life of the SPF SIG, more prevention funders will be “braided” into the Coordinated Healthy Activity, Motivation and Prevention Programs (CHAMPPS) planning and prevention funding process. All of these programs have common capacity and infrastructure challenges in our small state. We believe that this process, supported by Vermont’s Legislature, will lead to more shared support of basic prevention capacity development, such as training, so that an economy of scale will be achieved. This would sustain an essential prevention capacity, and allow the SSA to devote funds to those priorities that emerge from continued epidemiological study.

Thirdly, an expectation of our Goal B (Capacity Development) grantees is that they will advise the SSA in developing a sustainable infrastructure. In addition, as those grantees succeed in engaging young adults to become active substance abuse preventionists in their communities, a new pool of prevention workers will become motivated to enter the field, thus helping to address one of our sustainability challenges, which is lack of trained leaders.

4. Implications of Allocation Approach

a. Implications for successfully addressing statewide priorities

Include both State and community wide implications on reducing consumption and/or consequence and implications of State capacities to support community grantees.

The broad implications of the proposed funding allocation mechanism for addressing the statewide priorities were discussed in Section C.3.d on page 60. By successfully addressing our statewide priorities of reduction of underage drinking, binge drinking among 18-25 year olds and reduction of marijuana use among youth and young adults, we expect to observe reductions in indicators for these priorities in the funded communities. Although the SPF SIG may not lead immediately to statewide reductions, an ultimate goal of Vermont's SPF SIG is to build sufficient support and capacity to implement the SPF across the entire state, leading to the following statewide outcomes:

1. Reduce Underage Drinking, including specifically:
 - a) delay onset of use (percent used alcohol prior to age 13 as measured by the Youth Risk Behavior Survey (YRBS))
 - b) Reduce the percent who used during the past 30 days as measured by the YRBS and the Behavioral Risk Factor Surveillance System (BRFSS)
 - c) reduce the percent who report drinking and driving as measured by the YRBS and BRFSS.

2. Reduce high risk alcohol consumption among persons under age 25, including specifically:
 - a) reduce the percent who binged during the past 30 days as measured by the YRBS and BRFSS
 - b) reduce the percent who report drinking and driving as measured by the YRBS and BRFSS

3. Reduce marijuana use among persons under age 25, including specifically:
 - a) reduce the percent that drive under the influence of marijuana as measured by the YRBS and BRFSS
 - b) reduce the percent who used during the past 30 days as measured by the YRBS and BRFSS

As explained further in the justification for these priorities (section A.3.a-e, page 46-51), reductions in these stated priorities are expected to help reduce a variety of more specific high-risk consumption patterns (e.g., binge drinking by young adult males in bars) and negative consequences (e.g., injuries due to assaults). We have chosen not to identify all these specific consumption patterns and consequences in our priority statements for several reasons. First, there are a large number of them. Second, many of them have a relatively low frequency, and thus changes in prevalence or incidence resulting from the SPF-SIG may be hard to detect. Third, many consequences are caused by multiple factors, alcohol and drugs being only one of several contributing influences. Fourth, direct and valid measures for many specific consumption patterns and consequences are not readily available. For the reasons discussed in the preceding paragraph, driving under the influence of alcohol or marijuana is an exception, and therefore has been explicitly incorporated into the statement of priorities.

b. Implications for state's ability to effectively support community grantees

Include implications of State capacities to support community grantees (e.g. data collection, training and technical assistance; knowledge of evidence-based strategies, etc...)

The state's proposed funding allocation strategy was designed to help ensure that the state would be able to provide adequate guidance and programmatic support to the community grantees, which is viewed as a critically important element for ensuring successful community-level implementation of the SPF. Specifically, a manageable number of community grantees for which to provide training, TA and other supports will be funded, and the funded communities will be limited to select a maximum of only three priority problems on which to focus. These features will facilitate the state's efforts; in providing the necessary level and quality of training, as well as complementary services (e.g. media and communications support) to the grantee communities.

As experienced in Vermont's New Directions program, the importance of adequate training and support to community grantees cannot be overstated. The impact of the state's ability to support communities in the areas of data collection, training and technical assistance is an increase in the knowledge base and skill level to collect, analyze and use data as a driving tool in decision making regarding state and local priorities as they directly relate to outcomes. Through the success of our New Directions program, the state and many of our communities are well versed and knowledgeable of evidence-based strategies, issues of fidelity and evaluation.

The development of systematic training through the Learning Community model and provision of comprehensive technical assistance is germane to the SPF and will positively impact the state's prevention system. The state will augment its own resources with those available through the NE CAPT to ensure the necessary trainings and support are available to grantee communities. The resulting increase in knowledge and capabilities among prevention practitioners and public health systems will enhance state and community efforts to plan and implement substance abuse prevention initiatives and further build their capacity and share it with others. Training and technical assistance will be provided on topics specific to address the Vermont priorities including but not limited to youth and young adult development; coalition development; conflict resolution; paths to addiction; public advocacy; best practices on substance abuse prevention, with special focus on alcohol, marijuana and prescription drugs.

c. Use of additional non-SIG resources

Describe non SPF-SIG resources (e.g., data systems, other funding streams, personnel, etc.) the state is planning to direct, and/or currently directing, towards the statewide priorities.

Non-SPF SIG supported personnel who are conducting work on the SPF SIG are: Deputy Commissioner of Alcohol and Drug Programs, Operations Chief, Prevention Chief, Public Health Administrator, Public Health Specialist, two Prevention Coordinators, Media Specialist, and Public Health Analyst who also serves as Epidemiological Workgroup Chairperson, and 10 regional Prevention Consultants. The percentage of staff time devoted to SPF SIG implementation has exceeded that proposed in Vermont's SPF SIG application. Much of this

time is supported through the SAPT Block Grant. In addition, all Enforcing Underage Drinking Laws Program (EUDL) funds will be devoted to Vermont's Underage drinking priority.

D. Implementation

This section tells the approach the State will take in implementing State level capacity and infrastructure activities as well as community level SPF policies, programs and practices

1. Planned implementation activities

Many of the activities to be conducted at the state level have been described in several previous sections that pertain to assessment, capacity building and planning. A summary list of the specific upcoming state (and community) activities is provided in Section F. In this section we provide further information regarding the timing and logistics of specific state activities to be conducted in the course of Vermont's SPF SIG. Some of these activities focus on state-level tasks pertinent to overall coordination and management of the SPF SIG, while others focus more directly on activities conducted to support the community grantees. In summary, the major categories of activity to be implemented include:

- Assessment
- Training
- Communications
- Community Grants
- Data Collection

a. Assessment

As detailed in the Assessment section, Vermont has a wealth of substance abuse data and VDH will be providing community profile data to Vermont communities as they begin the process of their local needs and capacity assessments. While a number of communities have experience in gathering and analyzing existing data, due to the data driven focus of the SPF, VDH is committed to assisting communities with this critical first step in the form of the provision of data profiles and training on data-driven planning and evaluation issues. This will include assistance not only with interpreting available epidemiological data at the community level, but also collecting additional epidemiological data, information on prevention resources and capacity, and data on intervening variables that will be the focus on the community's prevention strategies. The SPF Data and Research Analyst and the evaluation contractor will be available to provide technical assistance on data analysis and interpretation.

The selection of a statewide capacity and readiness tool will also be a part of the state level implementation. A large number of potential community capacity instruments have been identified and are currently being further reviewed to determine which instruments, and/or which constructs and items, fit most closely with the capacity and infrastructure building goals of the Vermont SPF-SIG.

Following a recently completed review of existing community readiness tools, it has been recommended that Vermont utilize the Tri-Ethnic Center's tool. The review criteria included cost, time required to complete the survey, level of expertise required to implement, how results are available (descriptive statistics, tally scores, graphs, etc...), endorsement of the tool and locales/cultures where the tool has been implemented. The Tri-Ethnic Centers Community Readiness Tool has been successfully implemented in Vermont, contains a step-by-step guide that contains a level of detail that does not require an extensive level of expertise resources or time to implement. The Readiness Tool is easily adaptable to cultural issues within a community, is recommended by SAMHSA and increases community ownership by local involvement in the readiness assessment.

b. Training

VDH will be identifying a contractor to oversee the management and implementation of the SPF grantee training. One of the first deliverables will be the implementation of a training and technical assistance needs assessment with grantees. In addition, the contractor will work with SPF staff and the Northeast Center for the Application of Prevention Technology (NE CAPT), to develop a learning community process which is envisioned to include a combination of electronic and face-to-face statewide training events. With the NE CAPT, training will be provided on the five steps of the SPF process and core issues related to the SPF priorities. Over the course of the grant, the process will include ample opportunity for peer support and sharing of local data and key learnings.

The Regional Prevention Consultants will serve as one of the critical links between the community and the state level capacity building activities. The PC's will participate in a training of trainers on the five-step SPF model. Following the TOT, PC's will receive follow-up coaching and be monitored to assure quality. The NE CAPT will provide SPF training to assure that the national SPF model is integrated into Vermont's practice. The PC's will provide local follow-up through the provision of technical assistance with communities.

c. Communications

The VDH Media Specialist will organize a Training of Trainers (TOT) for state staff and regional Prevention Consultants on focus group testing. This group will train community grantees in focus group facilitation. This will be a means for gathering data from key target groups on specifics of the SPF priorities. This will improve state and local capacity to gather qualitative data and involve local communities in the SPF process. Common theme campaigns and other communications tactics based on the needs and interest of key target groups will be developed and implemented on both the state and community level. This bi-level approach addressed both state and community level activities specific to the implementation of the SPF to address our priorities.

d. Community Grants

Upon approval of this plan, SPF staff will develop and disseminate RFP's to address the priorities for both outcome and prevention infrastructure objectives. Once RFP's are released, an applicant training will be held as well as the recruitment and training of grant reviewers. A thorough grant review process will be conducted and grants awarded with deliverables clearly

defined. State level monitoring and evaluation activities will commence as well as training and technical assistance provided to build the capacity of communities to successfully implement the Strategic Prevention Framework process.

e. Data Collection

Vermont will strengthen our evaluation capacity through the steps detailed on page 54 by developing one consistent data reporting system across all prevention grant programs and the PC system consistent with NOMS, provide training and technical assistance on data collection processes, and seek consultation with SPFAS on long term goals and resources needed for development of a quality assurance system

In cases where the ideal measure for a specified outcome is not available, we will work closely with the communities, and/or the SEW as appropriate, to identify and obtain alternative (or “surrogate”) measures that can be used as valid indicators of the target outcome in question. Based on their own experience at reviewing existing Vermont data, and based on a recommendation from the SPF SIG Advisory Council, the SEW will be addressing gaps in the alcohol and other drug consumption and consequence data, most notably when looking at 18-24 year old.

2. Assurance that SPF SIG funding will not duplicate existing substance coalition Infrastructure

Currently Vermont has 14 funded Drug Free Communities Coalitions, with 5 of the 15 also New Directions funded Coalitions and 4 that are also funded with Tobacco Settlement Funds. These seasoned coalitions represent a significant contribution to our current community level infrastructure and are considered essential partners in achieving both our capacity development objective and our outcome objectives. The resource allocation process describes our approach to capacity development in low capacity communities that includes a mentor/mentee component where seasoned New Directions and/or DFC coalitions will be encouraged to serve as a mentor to a low capacity community or region. Applications for capacity building and implementation grants will require a clearly articulated work plan that will identify their DFC goals and objectives so **to assure that any funds provided to DFC communities will not be used for duplicative purposes.** Given Vermont’s strong tradition of peer support and mentorship between communities, we believe that engaging the DFC coalitions in the SPF SIG will greatly enhance capacity. Vermont is proud of the level of capacity and leadership demonstrated by our currently funded coalitions and fully expects to continue to support them.

E. Evaluation

1. Overview of Evaluation Design and Activities

A rigorous and carefully planned evaluative effort will be required to maximize the chances of unequivocally demonstrating impacts of the SPF-SIG. We will design and implement an outcome evaluation plan that we believe does have the capability to detect SPF-SIG impacts on target outcomes across the funded communities with an acceptable level of certainty. State-level

indicators of Vermont's priorities will also be tracked to determine if there is evidence of a statewide impact of the SPF-SIG. The outcome evaluation will be designed to be compatible with the goals of CSAP's national cross-site evaluation, and therefore contribute to the broader assessment of the SPF-SIG at the national level.

Equally important is the role of the planned process evaluation. At the state-level, the process evaluation will provide feedback to the SPF-SIG project director and the Advisory Council, as well as other key planners and stakeholders at both the state and community level, regarding the actual implementation of the program and how it might be improved or refocused. These activities are intended to help keep the project on its planned course, or otherwise steer it in an even more desirable and appropriate direction when necessary. The process evaluation also has the role of ensuring that there is adequate documentation regarding project implementation, including reasons for both successful and unsuccessful aspects of implementation. At the community level, process evaluation is necessary in order to understand and document what actually was done with the SPF-SIG funding and the planning and decision making processes that led to those activities. Such information is essential for helping to interpret the community-level SPF-SIG impacts that are observed, and for explaining variations in the levels of success in achieving those outcomes across communities.

2. State Level Surveillance, Tracking and Evaluation Activities

For this discussion, it is important to first clarify that "state level" refers to SPF-SIG impacts on measures of substance abuse consumption and/or consequences that reflect statewide prevalence or incident rates. Statewide outcomes measures will be examined to determine if the SPF-SIG is linked to decreased levels of the priority substance use outcomes established by the SEW and Advisory Council, both relative to other states and relative to prevalence levels in Vermont prior to the initiation of the SPF-SIG. These comparisons will be made purely at a descriptive level, as these data would be insufficient to support statistical analyses for conclusively attributing observed differences to the SPF-SIG. (Note: it will be the responsibility of the national cross-site evaluation effort to formally assess whether the SPF-SIG, collectively across all the funded states, achieves significant reductions in target outcomes). Nevertheless, evidence that statewide measures of underage drinking, binge drinking by youth and young adults, and marijuana use by youth and young adults declined during or immediately after SPF-SIG implementation, especially relative to other states, would be a welcome indicator of possible beneficial effects of the project and a sign that the state is moving in the desired direction. Based on the findings from the New Directions evaluation, it is certainly conceivable that a project as significant as the SPF-SIG, especially in a small state like Vermont, could in fact influence statewide indicators of specific outcome measures.

A variety of data sources provide useful statewide indicators for Vermont's SPF-SIG substance abuse priorities. These include the BFRSS, NSDUH, and YRBSS. The state prevalence estimates from these surveillance systems are all readily available from the sponsoring agencies, and also through SEDS. The chief limitation of these sources is the time lag in which the estimates become available. In addition to assembling and examining these survey-based estimates, we will also obtain statewide estimates for certain consequences of alcohol and marijuana use available through archival data sources, including specifically hospital discharge

data for assessing alcohol-related injuries, and traffic crash data for assessing motor vehicle accidents attributable to driver impairment. These data are maintained by the Vermont Center for Justice Research (VCJR), and the Vermont Association of Hospitals and Health Systems (VAHHS), respectively.

Process data for state-level implementation of the SPF-SIG will be obtained primarily through the state-level implementation and state-level infrastructures interviews being conducted as part of the national cross-site evaluation effort. These sources will be combined with information gained through direct observation of, and participation in, state-level planning and implementation meetings (e.g., the SPF-SIG Planning Group, the Advisory Council, and the SEW), along with reviews of archival records (e.g., the state quarterly and annual reports to CSAP, the state strategic plan, and the community grants RFP).

3. Community Level Surveillance, Tracking and Evaluation Activities

Vermont's approach for funding allocation is to select a discrete number of communities through a competitive bidding process (for the full implementation grants). Communities will be defined geographically on the basis of town or SU boundaries. Because there will be common outcomes targeted across many or all of the funded communities, this model allows for a quasi-experimental study design to assess the impacts of the SPF-SIG in those communities, as compared against a set of comparison communities that do not receive SPF-SIG funding and support. This approach is entirely consistent with the overarching purposes and objectives of the SPF/SIG, and is clearly reflected in the SPF national cross-site evaluation design. Significant SPF effects on community-level outcomes are expected to be more pronounced than state-level outcomes because of the concentration of SPF resources in the selected communities.

To implement this design, pre- and post-intervention measures of community-level outcomes will be needed for both the intervention communities and a set of comparison communities. The comparison set could be either ALL non-intervention communities in the state, similarly defined by geography, or a subset of the same. Of interest is whether post-intervention values (and/or time-related trajectories) in the intervention communities are lower than those in the comparison communities, adjusting for any pre-intervention differences. This was the approach adopted for assessing community-level outcomes for the Vermont SIG evaluation, based on YRBSS data from students in grades 8 through 12. Analyses that are conducted with individual-level record data (e.g., individual student responses on the student survey) will be conducted using appropriate techniques, such as mixed model regressions or generalized estimating equations (GEE), that accommodate the clustered nature of the response data within communities.

Assessing community-level outcomes, however, faces some major challenges. Unlike state-level data, the availability of relevant and useful community-level measures for anticipated targeted outcomes is less certain. This is especially true in Vermont, due to the fact that the grantee communities are defined at a geographic level that is smaller than county. Vermont is extremely fortunate to have a well-established YRBSS in which nearly all SUs of the state participate. Measures of alcohol and marijuana use by school-aged persons at the community level, therefore, will be available to the evaluation. Survey-based indicators for young adult substance use (beyond high school age), however, are generally not available at the community level, and

would be very expensive to obtain. We will, however, explore the possibility of implementing college student surveys in communities with a significant number of college students. Archival-based data may also be unavailable or more difficult to obtain at the community level. Furthermore, the validity of certain measures, such as drug-related arrests, treatment admissions, and school suspensions and expulsions, are significantly influenced by enforcement policies and generally not recommended for use as outcome measures in evaluation studies. Other measures (e.g., alcohol- and drug-related deaths) appear to be based on insufficient numbers of cases to be useful for community-level evaluation purposes.

In all cases where the ideal measure for a specified outcome is not available, we will work closely with the communities, and/or the SEW as appropriate, to identify and obtain alternative (or “surrogate”) measures that can be used as valid indicators of the target outcome in question. Two potential candidates, as previously mentioned, are assault-related injuries to males aged 19 to 24, and single vehicle night-time crashes involving drivers aged 19 to 24 (as proxy measures for young adult binge drinking). Initial examination of these data sources and measures has already been undertaken by the SEW, and will be further pursued in the coming year.

In addition to epidemiological outcome measures, two other classes of outcome measures will be tracked at the community level. The first pertains to prevention capacity. In both the full implementation grantee communities and the capacity building grantee communities, there is an expectation that prevention capacity and infrastructure will be enhanced as a result of the SPF-SIG. A large number of potential community capacity instruments have been identified and are currently being further reviewed to determine which instruments, and/or which constructs and items, fit most closely with the capacity and infrastructure building goals of the Vermont SPF-SIG. Most of these instruments are designed to be used with relatively small samples of key community informants, and thus are logistically feasible to use within the context of the SPF-SIG evaluation. These same instruments, administered at baseline, will also provide useful information for the assessment and planning phases of the community grantees.

A second additional class of measures of potential importance to the evaluation effort pertains to what are known as intervening variables (also referred to as causal factors, or risk/protective factors). A number of factors especially pertinent to community-based efforts attempting to achieve population level outcomes have been identified. These include enforcement, social access, retail access, social norms, promotion, and various individual, family, and school attributes. Measures for some of these factors will be available at the community level through the YRBSS. Other measures will need to be obtained through the assistance of the community grantees. A number of data collection approaches and measures for this purpose are currently under review, including measures that have been developed and recommended by the intervening variables work group of the SPF-SIG cross-site evaluation project. Which of these intervening variables, or others, will actually be tracked for purposes of evaluation is still to be determined based upon the findings from the community assessments.

Process data for community-level implementation of the SPF-SIG will be obtained primarily through the community-level implementation interviews (CLI) being conducted as part of the national cross-site evaluation effort. These sources will be augmented with information gained through grantee reports to the state, both informal and structured interviews with community

coordinators, occasional direct observation of, and participation in, community-level planning and implementation meetings, including training workshops, and reviews of reports, planning documents, and other materials developed by the community grantees.

4. Anticipated Measurable Outcomes

The established priorities for the Vermont SPF-SIG translate nicely into a set of specific measures for which changes are anticipated as a result of the project. These measures and their sources are identified in the table below.

Priority	Measures	Data Source
1. Reduce underage drinking	a. Any use of alcohol in past 30 days b. Any binge drinking in past 30 days c. Age of first use of alcohol d. Driving after drinking* e. Riding in car with drinking driver*	YRBSS, NSDUH YRBSS, NSDUH YRBSS YRBSS
2. Reduce high risk drinking by persons under age 25	a. Any binge drinking in past 30 days b. Alcohol-related injuries* c. Alcohol-related mv crashes*	BRFSS, NSDUH VAHHS VCJR
3. Reduce marijuana use by persons under age 25	a. Any use of marijuana in past 30 days b. age of first use of marijuana c. Driving after using marijuana* d. Riding in car driven by person who had used marijuana*	YRBSS, BRFSS, NSDUH YRBSS YRBSS YRBSS
4. Build prevention capacity and infrastructure	(To be determined)	

*Indicates measures that are indirect indicators, or consequences, related to the priority.

Note: Changes are expected at the community-level on all outcomes. The BRFSS and NSDUH, however, do not provide community-level estimates.

5. Collection and Submission of National Outcome Measures Data

Based on information available from the CSAP DCCC web site, constructs pertaining to SAMHSA’s National Outcome Measures (NOMs) for prevention are listed in the following table. Because SAMHSA will provide (or “pre-populate”) the state-level NOMs directly, the information in the table pertains to measures and data sources available at the community-level as defined for the Vermont SPF-SIG. All measures available at the community level will also be available at the state level. As shown in the table, only some of the NOMs are currently viewed as needed for the Vermont SPF-SIG evaluation. Obtaining these data will be the priority concern for the evaluation effort. Also identified in the table, however, are additional measures not necessarily required for the evaluation, but nevertheless are expected to be available at the community level.

As noted previously, one of the gaps in the community-level data is prevalence of use estimates for adults. The BRFSS does provide estimates for the county-level, aggregated over a five-year

period, and the NSDUH provides estimates for five regions in Vermont, aggregated over a three-year period. These geographical units, however, are larger than the communities as defined for the Vermont SPPF-SIG. As with many states, the prospect of implementing surveillance systems to reliably assess prevalence of use at the community level is poor due to the costs of conducting such surveys. As discussed above, we plan to use archival-based measures of consequences (i.e., alcohol-related injuries and motor vehicle crashes attributable to impairment) as surrogate measures for prevalence of use at the community level. The numbers of such events may turn out to be too low to provide definitive conclusions regarding the impacts of the Vermont SPF-SIG in Vermont, so interpretations will be made with due caution.

Of particular note regarding the table below are the two measures that may possibly be useful for the evaluation, but for which no data sources are currently identified (i.e., perceptions of workplace policies, and percentages of youth exposed to prevention messages). Whether these measures will be, in fact, pertinent to the evaluation effort will only be known after the grantee communities have decided upon their intervention strategies and the proximal targets (i.e., the intervening variables) of those strategies. If that is the case, the evaluation team will work with the community grantees to develop procedures for collecting data on these two measures.

Prevention NOMS	Needed for Evaluation	Available	Data Source
Abstinence from Drug Use/Alcohol Abuse			
30-day Substance Use (nonuse/reduction in use)	Yes	Yes	YRBSS*
Age of First Substance Use	Yes	Yes	YRBSS*
Perception of Disapproval/Attitude	Possibly	Yes	YRBSS*
Perceived Risk/Harm of Use	Possibly	Yes	YRBSS*
Increased/Retained Employment or Return to/Stay in School			
Perception of Workplace Policy	Possibly	No	
Substance Abuse-Related Suspensions and Expulsions	No	Yes	VT DOE
School Attendance and Enrollment	No	Yes	VT DOE
Decreased Criminal Justice Involvement			
Alcohol-Related Car Crashes and Injuries	Yes	Yes	VCJR
Alcohol and Drug-Related Crime	No	Possibly	UCR or VCJR
Increased Access to Services (Service Capacity)			
Number of Persons Served by Age, Gender, Race, and Ethnicity	Possibly	Yes	Cross-site CLI
Increased Retention in Service Programs – Substance Abuse			
Total Number of Evidence-Based Programs and Strategies Employed	No	Yes	Cross--site CLI
Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message	Possibly	No	
Increased Social Support/Social Connectedness			
Family Communication Around Drug Use	No	No	
Cost-Effectiveness of Services (Average Cost)			
Services Provided Within Cost Bands (Universal, Selective, and Indicated)	Possibly	Possibly	Cross-site CLI

Use of Evidence-Based Practices			
Total Number of Evidence-Based Programs and Strategies Employed	No	Possibly	Cross –site CLI

* School-aged respondents only

F. Cross-cutting Components and Challenges

In this section we have described how our Strategic Plan will ensure the inclusion of cultural competence in State and community level SPF steps, a focus on underage drinking in Vermont, Vermont’s communication plan and the sustainability of our SPF SIG efforts. Because marketing and communications will play essential overarching roles in the implementation of Vermont’s SPF SIG, we also provide a description of the rationale and plans for this important cross-cutting component. Also in this section are described the challenges we have encountered in applying a “need-based” allocation process, the challenges we expect during the implementation of the State’s plan and the timelines and milestones developed for implementing the activities in the State’s plan.

1. Cultural Competency

At the systems level, cultural competency has been defined as follows:

“A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals *to work effectively in cross-cultural situations...*” {affecting positively outcomes related to ATOD Use/above}.

Definition taken from: HRSA/DHHS Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile, prepared by the Lewin Group, Inc., April 2002.

In order to “work effectively in cross-cultural situations” CSAP offers the following two definitions of cultural competency that begin to describe the requisite knowledge, attitudes and skills:

“...A set of academic and a set of interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups. This requires a *willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports.*” Orlandi, et al (1992)

“...the attainment of knowledge, skills and attitudes, to enable administrators and practitioners within systems of care to provide for diverse populations. This includes an *understanding of that group’s or members’ language, beliefs, norms, and values, as well as socioeconomic and political factors that may have significant impact on their well-being* and incorporating those variables into assessment and treatment.” (CSAP 1993)

A systems level approach recognizes that cultural competency must be an integral component not only of service delivery at the program level but also a component of each step in the planning, targeting, implementation, and evaluation of substance abuse prevention efforts at the state and community levels as well.

The recently developed competency standards acknowledge this multi-level approach. Specifically, CSAP identifies three levels of action (state, community, and program) and seven domains of cultural competence with corresponding indicators to measure performance related to cultural competency. Each of the three levels is vested with a different set of responsibilities as follows:

Responsibility at state level:

- Provide a shared framework—including definition, goals, objectives and measures—for approaching substance abuse prevention in a culturally competent manner
- Establish and monitor cultural competence policy statewide
- Support state and local partners—both internal and external—to develop the capacity, tools and skills necessary to be successful in conducting prevention efforts in a culturally competent manner

Focus at the Community Level:

- Implement policy and monitor prevention program service delivery
- Identify cultural communities and issues within the locality
- Draw on community-based values, traditions and customs, and work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports

Cultural Competency at the Program Level:

- Deliver culturally appropriate prevention services based on an understanding of a group's or members' language, beliefs, norms, and values, as well as socioeconomic and political factors that may have significant impact on their well-being
- Ensure that program staff evidence culturally competent knowledge, skills and attitudes in program delivery; provide tools and training to support staff

The seven domains identified in the HRSA/DHHS framework include:

Organizational Values: An organization's perspective and attitudes with respect to the worth and importance of cultural competence and its commitment to provide culturally competent care.

Governance: The goal-setting, policy-making, and other oversight vehicles an organization uses to help ensure the delivery of culturally competent care.

Planning and Monitoring/Evaluation: The mechanisms and processes used for: a) long- and short-term policy, programmatic, and operational cultural competence planning that is informed by external and internal consumers; and b) the systems and activities needed

to proactively track and assess an organization's level of cultural competence.

Communication: The exchange of information between the organization/providers and the clients/population, and internally among staff, in ways that promote cultural competence.

Staff Development: An organization's efforts to ensure staff and other service providers have the requisite attitudes, knowledge and skills for delivering culturally competent services.

Organizational Infrastructure: The organizational resources required to deliver or facilitate delivery of culturally competent services.

Services/Interventions: An organization's delivery or facilitation of clinical, public-health, and health related services in a culturally competent manner.

HRSA/DHHS Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile; prepared by the Lewin Group, Inc., April 2002.

Vermont's approach to ensuring cultural competence is infused into the SPF SIG and will involve four distinct processes:

1. Use the HRSA/DHHS model (as outlined above) as framework for refining VDH approaches and identifying the necessary levels of action and corresponding competency areas
2. Engage internal and external partners in the review of cultural competency framework. Develop or select existing cultural competency assessment tool and follow on activities
3. Integrate this cultural competency framework, and the SPF, with other VDH programs/activities (especially OMHHD and Tobacco) which are focused on health disparities and lower SES to ensure ADAP's efforts are consistent with statewide approaches when working with similar target populations within VT
4. Support technical assistance for ADAP staff and grantees to ensure culturally competency in substance abuse prevention efforts at the state, community and program levels.

VDH will utilize the HRSA/DHHS Indicators of Cultural Competence in Health Care Delivery Organizations as a starting point to inform development of the SPF approach to cultural competency and to ensure integration of the work of the SPF with other VDH initiatives. We will work closely with internal and external partners to ensure that this framework is appropriately tailored to Vermont, our substance abuse prevention efforts, and our target audiences.

Within VDH, the Office of Minority Health and Health Disparities (OMHHD) has developed a strategic plan and cross-cutting framework for addressing minority health and health disparities in VT. The OMHHD plan outlines strategies that focus on health disparities due to socioeconomic status, geographic area, gender, language, immigrant status, customs, other

cultural factors, sexual orientation, disability or special health need. Embedded within this plan are the beginnings of a statewide approach to cultural competency.

We will utilize the guidance provided by the OMHHD and Tobacco Control plans and the SPF SPG Advisory Council to guide this work. It is important that the SPF is consistent with the VDH-wide approach to cultural competency so our work is reinforced in program activities aimed at overlapping/shared target population (e.g. substance abusers who are smokers and/or are enrolled in WIC). For example, we will collaborate with Tobacco reduction efforts which include a strategic approach to eliminating health disparities. In addition we will seek build upon VT's successful history and existing capacity in using the "Bridges out of Poverty" approach in lower SES populations—a primary target audience for our proposed substance abuse prevention efforts as documented through the work of the State Epidemiological Workgroup (EWG) and the corresponding selection of the prevention priority areas.

OMHHD will remain an important internal partner in collecting and disseminating shared knowledge of the approaches, tools and skills needed for cultural competency in program planning and delivery. Additionally, OMHHD will be critical collaborators in the identification and/or development tools for training and evaluation of cultural competency.

VDH will also engage its extensive network of external partners working to eliminate substance abuse in VT to ensure that cultural competency is appropriately addressed throughout the SPF and in its implementation. Members of the Advisory Council—representing various state agencies, community service providers, and advocates—will be asked to work with VHD internal partners to oversee the development and implementation of assessments, tools and training for essential prevention partners at all three levels of the prevention system.

Last, VDH will support technical assistance and training for ADAP staff and grantees to ensure cultural competency in substance abuse prevention efforts at the state, community and program levels. When appropriate, other VDH employees and partners will be included in the technical assistance and training to further cultural competence and consistency in efforts aimed at similar and/or overlapping target populations.

2. Underage Drinking Efforts in Vermont

Among the specific priorities developed as part of the Strategic Prevention Framework process are the reduction of underage drinking and the reduction of high risk alcohol consumption among persons under age 25. The underage drinking priority is to be a required focus of all grantees. Efforts currently underway in Vermont to deal with the underage drinking problem include working with law enforcement, community coalitions and others throughout the state through OJJDP's Enforcing the Underage Drinking Laws (EUDL) block grant.

The goals of the EUDL program are:

- To encourage the coordination of Vermont's public policy enforcement efforts with the community based substance abuse prevention initiatives.
 - foster broad-based community support for reducing underage drinking.
 - foster collaboration between law enforcement, youth, and community prevention efforts.

- To create a consistent statewide and local law enforcement response to underage drinking that is connected to state's attorney's offices (prosecutors), court diversion boards, and substance abuse programs.
- To encourage communities to identify and implement public policy which increases community awareness and enforcement, and results in:
 - reducing youth access to alcohol
 - reducing alcohol sales to minors
 - reducing adult purchasing or supplying alcohol for minors
 - reducing rural, remote drinking and "keg" parties
 - reducing youth travel across state lines to purchase alcohol
 - reducing teen highway fatalities due to the consumption of alcohol
 - reducing adult approval and support of youth alcohol use.
 - increasing use of proven, integrated strategies to attack the problem of underage drinking.

The objectives of the program are:

- To support and mobilize thirteen START (Stop Teen Alcohol Risk Team) coalitions to examine regional efforts toward combating underage drinking and implement changes to increase their effectiveness. These coalitions, which are law enforcement at the core, are supported not only with funding, but with training and technical assistance from experts at the Vermont Police Academy.
- To intervene at underage drinking activities, and to decrease the numbers of alcohol related tragedies involving youth. This year we anticipate approximately 30 planned law enforcement proactive patrols during times when underage drinking is most likely to occur. We will also have organized teams in place in all areas of the state to avert or respond to reported parties. Our statewide, toll free party tip line will provide valuable information to these teams.
- To change the community's norms regarding underage drinking. We are organizing joint trainings for approximately 100 law enforcement officers and community coalition members to encourage and enable coordinated prevention efforts in our communities. We will also join with other underage drinking prevention initiatives in the state to promote clear and consistent messages through at least one targeted public information campaign this year.
- To support the Department of Liquor Control in their compliance checks with retailers. We expect to check on approximately 35% of the 2,415 first and second class licensees statewide. Our toll free license check line will enable retailers to more easily recognize fake ID's.

The work that we have done and continue to do through the EUDL program will provide a good base of collaboration and coordination between law enforcement and other community efforts to deal directly with the underage drinking problem and to work together toward changing community norms and other environmental factors that contribute to the problem.

This work will blend seamlessly with the Strategic Prevention Framework initiatives as we go forward.

In addition to our activities through the EUDL Block Grant, Vermont formed a state level underage drinking task force. The original purpose of the task force was to examine the recommendations for states and communities in the National Academy of Sciences / Institute of Medicine report *Reducing Underage Drinking: A Collective Responsibility*, to determine Vermont's status with respect to those recommendations, and to provide guidance for improvements to our laws, regulations, policies and methods for dealing with this problem. We were happy to learn through this work that we are in substantial compliance with the majority of the IOM recommendations. However, we were also able to develop 34 recommendations of our own that, if accomplished, will bring us more fully into compliance with the IOM report. Two summary documents are attached, Appendix V: *Summary of Vermont's Status on the IOM Recommendations*, and Appendix VI: *Summary of Task Force Recommendations*.

The Vermont Underage Drinking Task Force is now a sub-committee of the Strategic Prevention Framework Advisory Council. Using the information gathered from work on the IOM report and their combined expertise in the area of underage drinking, the task force members will provide valuable guidance to the larger group as we proceed toward the goal of reducing underage drinking and high risk drinking among persons under age 25.

3. Address the sustainability of your SPF SIG efforts

The ability to continually and consistently apply the SPF process to reduce ATOD related problems and their associated consumption patterns, at both the state and community is a goal for Vermont. One of the ways we plan to accomplish this goal is by increasing capacity through the provision of a learning community training process as detailed on page 66. Provision of SPF five-step training and coaching to our regional prevention consultants by the NE CAPT will also enhance our statewide capacity beyond the life of the grant. Vermont is confident in the power of training and technical assistance as an investment in building the needed capacity to maintain the SPF process and has experienced the success of this sustainability strategy through our first SIG grant.

All community grantees will be required to have a well developed sustainability plan and will be required to implement evidence-based programs, practices and policies as they did in the original SIG. Of the originally funded 23 New Directions Coalitions, 19 continue to operate in the community and credit their ability to sustain their efforts from the training and technical assistance they received specific to learning how to utilize their evaluation results to show both the community and the legislature that prevention works.

On the statewide level, the future role of the SEW (detailed on page 54) includes activities that will continue to inform VDH planning process through the examination and analysis of epidemiological data. This SEW deliverable is key to maintaining a data driven planning system and it is fully expected that as the SEW rebuilds its membership by reaching out to key partners,

the data driven process of the SPF will drive the state's substance abuse prevention planning process.

The large and diverse membership of the SPF Advisory Council was a deliberate strategy for sustainability as we work to build acceptance and ownership of the strategic prevention framework process within other state agencies and statewide organizations. In addition to the training provided at the community level, during our Advisory Council meetings we anticipate continuing to providing training on the SPF process through the examination of each of the five steps, sustainability and cultural competency. In addition, we are involving other state prevention leaders, such as the CHAMPPS Operations Group, AHS Field Directors and District Health Directors in grantee selection and needs assessment review. We intend that this strategy will increase understanding of our common infrastructure needs and pave the way for more efficient co-funding of core infrastructure needs, such as training.

4. Marketing/Communications

While most public health organizations agree that media and public education are critical, very few have the resources to support such initiatives. In Vermont this is a significant issue, because even with funding going to the local communities, statewide media efforts are needed to support the local activities, so that the target audience hears a consistent message from multiple sources. This idea is the major tenant of effective marketing communications. Although Vermont has access to national media campaigns focused on alcohol and drug prevention efforts, two key factors to consider are competition and media reach. Prevention efforts have huge competitors – alcohol advertising and the presence of drugs and alcohol in movies and television alone represents billions of dollars. The second issue is media reach. Vermont is a small rural media market, which is not often penetrated as heavily by national media campaigns compared to larger states.

The need to understand the cultures and lives of Vermonters in order to develop effective media and public education campaigns and materials is a key issue in Vermont. While we tend to think about media and public education as mass media – like television, radio and print – more and more media is defined by non-traditional methods. Things like web-based tools and games, guerilla marketing actions and activities, product placement, events, media literacy, etc. Many of these things will be coordinated at the state level and implemented at the local level. In doing so state agencies and communities must be prepared to interact with the target audience in a way that is culturally appropriate, and the systems and policies of the services that we are leading people to must also reflect this level of cultural understanding.

Current state level media and communication infrastructure

The Health Department has a number of staff working to develop communications materials, but the Tobacco Control Program (TCP) has had a media and social marketing specialist staff person since 2000 to support the needs of that program. While much of the research done to create media campaigns and materials for the Tobacco Control Program has focused on issues around smoking, a great deal of information has been collected on the lives and needs of their target audiences which is youth and young adults. Not surprisingly, many of the Vermont youth and young adults who are dealing with tobacco issues are also impacted by use of alcohol and other

drugs. Ultimately, these groups are the same ones that will be reached through the Prevention Framework. In addition to understanding the target audiences, the skills used in the application of social marketing and media techniques will be used in developing public education and media campaigns and materials for the Strategic Prevention Framework priorities.

Through a memorandum of understanding and co-funding of the position, the media and social marketing specialist represents another example of the Health Department's collaborative process across the division of alcohol and other drugs and the TCP. The media and social marketing specialist is currently working to increase the level of knowledge, coordination of efforts and training opportunities to both staffs.

In addition to the media and social marketing specialist within ADAP, as a state agency we have the resources and ability to learn about and access existing national resources. We have tapped into national research and national campaign materials, and continue to keep abreast of new materials and promising media approaches, and test those in our state to see how those nationally proven materials resonate with Vermonters. An extensive review of existing media campaign (and media literacy) resources was undertaken (see Appendix VII). Some of these messages and materials will be tested as part of Vermont's Strategic Prevention Framework media and public education development, and we hope that some existing materials will be used. And, at the very least these materials will provided a starting point to the work we intend to do over the next 5 years.

Significant gaps in the current state-level media and communications infrastructure

Vermont has identified our lack of statewide, coordinated media and communications strategic plan for substance abuse prevention. While there is an existing network of Prevention Consultants and District Directors and offices, there is an overall low level of education and experience around media and public education... The experiences of the field staff (PCs and District Directors) have been most focused on prevention and general health promotion and intervention, and the knowledge gained is not consistent across the state. In addition, while social marketing is a respected area, the fundamentals of this discipline are not familiar to many in our existing community infrastructure (community coalitions, regional partnerships, etc...).

Media and Communications Capacity at the state level

From a media and public education perspective, the state is in a very strong place to implement the Strategic Framework. The lessons learned from the Tobacco Control Program (TCP) and the techniques and experience of the Media & Social Marketing Specialist will be applied to all five elements of the Strategic Prevention Framework, as those elements are consistent with those of Social Marketing. Additionally, important lessons have been learned about using statewide media to support localized efforts called "Common Theme Campaigns."

Common Theme Campaigns (CTC) are developed to target very specific populations, and media messages and tactics are created based on consumer information and proven and effective strategies to reach them. Once the campaign messages and tactics are developed, including distribution of materials, local partners are trained. The training includes dissemination of background information, ideas and methods to reach out locally, overview of tools that can be used and tailored for community use, and local campaign evaluation methods. Campaign

materials are shared through several methods, including online via an extranet site setup for grantees and partners, where digital files are downloadable. Finally, specific campaign evaluation measures that were added into existing survey tools, are reviewed along with short-term measures and media evaluation tools (like media coverage, impressions, materials distribution, web hits and call volume) to evaluate overall campaign effectiveness.

Current community prevention infrastructure in place

The community coalitions were surveyed in order to understand their capacity in developing and implementing local media and public education. Highlights of the survey reported that the majority of coalitions surveyed have experience in developing their own print ads, have worked with their local newspapers, printed materials (posters, flyers, etc...) are the most commonly used items to promote local events, more than half of the coalitions pay for advertisement placements and distribute some type of giveaway item. 70% of those surveyed reported running some type of sustained print media effort and 65% are using media from national sources and have partnered with other organizations to share promotional costs. The full survey results can be found in Appendix VII.

Media and social marketing data

Qualitative data collection is integral to understanding the target audience, because it enhances the quantitative data to build a much fuller and in-depth picture of the consumer lifestyle and needs. As part of our needs assessment process, existing qualitative data relevant to the SPF has been compiled (see Appendix IX). While a few communities are collecting this type of information, there is a need for a consistent and standardized collection system for qualitative data that can be used to inform and drive decisions.

The effectiveness of the community prevention infrastructure in place to deliver media and communications

At this point there is not a lot of data available about local media effectiveness. Based on the review of local coalition media efforts, it is likely that much of the media (print and posters) has been targeted to parents to change child behavior, and there is little to no work being done with young adults.

Significant media gaps in the current community prevention systems

Our current local community coalitions are tasked with educating their communities about public health issues in order to encourage healthy behaviors around legal and illegal addictive substances, and they seek to create cultural norms that will result in a healthy community. In doing so, these community coalitions need to create local messages, media materials, events, etc. But, there is a wide range of experience and ability in this area, and while some have a great deal of experience, others have not shown that they can develop effective and consistent media outreach vehicles. In most cases this is due to a lack of understanding about how to develop audience-focused plans that tap into knowledge to audience needs and desires. Too often broad-based approaches are used, that are unsuccessful in reaching the audiences suffering from the largest health disparities, and there is a lack of knowledge (cultural competence) in how to interact with the intended audience.

Cultural competency is needed in order to develop effective media outreach and to work directly with our priority audiences, especially significant among the non-college young adult population. Community prevention networks have not focused on this target in a consistent fashion (except for those that might be parents), and capacity needs to be built not only around understanding the audience, but also with linking with partners already reaching this group and creating ways to collaborate with these groups directly.

The other media-related gap has been noted within the Tobacco Control Programs (TCP) grantee population many of which are also dealing with substance abuse issues in their communities, and that is the ability to develop sustained local media campaigns. Some are doing this through print media, but otherwise most campaigns are fairly short-term, so messages may come and go, but are not reinforced consistently in the community (or statewide).

Plans for implementing the marketing/communications component

What is needed to build statewide and local capacity for media and social marketing is training and technical assistance to increase:

- Cultural competency skills
- Understanding of social marketing principles and methods
- Additional Media & Social Marketing staff time to support implementation efforts
- Funding to support sustained statewide media efforts linked to local efforts

The current level of state capacity in **social marketing** principles and methods is a foundation that can be built and expanded upon and expanded through the following means:

- Focus group training for state personnel (train-the-trainers), who will then train community prevention partners. Support for community prevention partners to implement activities that are aligned with audience motivations and lifestyles, provided during regular trainings in RFP development and ongoing technical assistance for grantees.
- Another element of local campaign implementation will be the participation in sustained common themes campaigns. As above, training and technical assistance will be provided to community prevention partners and field personnel, like PCs and District Offices.

While specific campaign tactics and activities have not yet been determined, it is clear that **media literacy** will be an important component of the educational mix needed for youth and young adults. Recent research¹ has shown an association with media education and reduced smoking prevalence and reduced susceptibility to future smoking among youth. Past experience also shows a high level of interest in this topic among community partners, as well as youth and young adults. To this end media literacy will be worked into the mix of tactics, and the state will develop educational materials and training so that community partners may implement local activities.

Utilization of the public media (i.e., public relations) will likely be a component of the statewide media work that is done to promote Vermont's Strategic Prevention Framework, as well as to support specific statewide campaign activities. **Media advocacy** training is also needed for community prevention partners, in order to ensure that they are effectively promoting the

¹ Association of Cigarette Smoking and Media Literacy about Smoking among Adolescents. Primack; Gold; Land; Fine. Journal of Adolescent Health (volume 39 issue 4)

Prevention Framework to gain local support, as well as to build skills for local targeted prevention campaigns. This training will likely take place as a track in existing community partner trainings.

There are many examples of ongoing **partnership with youth and young adults**, many communities have worked with youth, but a clear message from the Advisory Council (AC) was that there needs to be further education on how to work with youth and young adults (cultural competency), and to create systems for ongoing and sustained partnerships with these groups. In addition, the AC felt that adults needed specific education on how to develop true partnerships that provide an equal voice for both parties.

One recommendation from the Advisory Council 18-25 year old workgroup was to plan for a youth/adult and young adult/adult summit to begin the work of determining how these individuals can come together to create a cohesive and structured way to develop local educational programs, activities and events.

Based on **social marketing** principles, campaign materials will be developed for statewide use, and will be supported and reinforced by local work. The Advisory Council echoed the need for consistent messages across the state. This approach is also a core tenant of marketing – to reinforce a consistent message through multiple sources.

Ensuring cultural competence and inclusiveness throughout our media and social marketing plan through training will assist all personnel and grantee organizations increase their level of knowledge of cultural issues and implementation of programs that reflect this learning. This training will be provided on an ongoing basis and will seek to grow knowledge over time by using experts, research and sharing of actual examples that communities are effectively using. In addition, grantees will be provided support to execute social marketing campaigns, which at their core are based in understanding the audience motivations, needs and lifestyles.

In summary, the implementation plans for the marketing/communications strategy for the SPF include the following three components:

- Common theme campaigns – statewide media and materials to support local activities, including media advocacy tools to promote the following statewide priorities:
 - Underage drinking – youth media/events, parent outreach
 - Binge drinking – young adult media/events
 - Marijuana use – media and parent outreach
- Development and distribution of core collateral (educational) materials
- Distribution of media literacy tools

5. Challenges

a. The challenges you have encountered in applying a “needs-based” allocation process

Careful development and implementation of the SPF model to date, even though at just the state-level, has proven to be a complicated and time-consuming process. We believe the effort has gone well, but obviously has taken considerable time and energy - more than had been initially anticipated. One of the primary challenges encountered so far has been the analysis and interpretation of the epidemiological data for the purpose of identifying the statewide priorities on which the SPF-SIG will focus. Accessing and organizing the data were fairly straight forward steps, although even that took considerable time. More vexing was the determination of which criteria, or dimensions, would be explicitly highlighted in the displays and comparisons of the indicators, and also the relative weights that different criteria were to be subjectively afforded in identifying the initial set of statewide priorities. We ultimately decided on using criteria that we believe could be most objectively defined and applied (e.g., such as state-to-nation comparisons of rates, and relative comparisons of trends). Other potentially important but less easily measured criteria (e.g., societal costs, degree of harm caused, etc.), therefore, received less consideration in the prioritization process.

Another challenge encountered was the application of epidemiological data to the funding allocation model developed. As explained earlier in the plan, the only epidemiological data that produced reliably stable estimates of community-level rates of substance use and related consequences was the YRBS. The ability for assessing levels of problems (or "need") at the community level, therefore, was limited to survey-based data on students. In addition, the YRBS data suggested that indicators of the statewide priorities did not vary tremendously across communities, and that every community experienced rates of these problems that could justifiably be considered problematic. These considerations, along with the recognition that the Goal A (Implementation Grants) was to demonstrably reduce rates of statewide priority problems in "selected" communities (not necessarily those with the highest problem levels), led to considerable discussion as to the role that assessed level of need should play in the allocating funds to communities.

A third significant challenge that was encountered and overcome was the need to obtain and consider input from a diverse mixture of stakeholders, as represented on the Advisory Council as well as other entities with an interest or role in Vermont's SPF-SIG. Vermont's traditional approach to public health initiatives, such as the SPF-SIG, has been participatory, and in recent years there has been even more of a push towards integrated and collaborative planning and implementation. This approach has involved a considerable amount of back and forth discussion among the stakeholders, but ultimately has resulted in a product which all involved can buy into and assume some level of ownership.

b. The challenges you expect during the implementation of the State's Plan

The major challenge we expect to encounter is the length of time a competitive RFP encompasses from the development of the RFP and applicant training, to the selection and training of reviewers and the final approval process through the Commissioner's office. Once this process is completed the required contractual process begins and typically takes longer than anticipated thus impacting the start point when communities can commence implementing the SPF SIG process.

Based on our experience with the SPF SIG thus far, we anticipate that recruitment of qualified prevention staff may be a challenge for grantees. Recruitment of some SPF SIG staff took significantly longer than planned. This is indicative of workforce challenges across the state and in the substance abuse field.

As detailed in the Evaluation section on page 67, a second anticipated challenge is dealing with anticipated gaps and delays in outcome indicator data that can be reliably broken out at the community level. The challenge we will encounter with evaluating the 18-25 year old population is that survey-based indicators for young adult substance use (beyond high school age), are generally not available at the community level.

Although we outlined our training plan for the SPF SIG at both the state and community level, we anticipate that both training and communications needs will strain our capacity to deliver the necessary training. One of the lessons learned from our original SIG, was the extraordinary dosage and levels of training needed by Coalition Coordinators to successfully respond to the demands of the grant. We look forward to addressing this challenge as its resolution will address long term sustainability issues such as workforce development, quality assurance and outcome measures.

6. Timelines and Milestones for implementing the activities of the State Plan

State Level Activities

1. Review current functions and goals – March 2007
2. Recruit SEOW members – April 2007
3. SEOW to meet quarterly beginning in April 2007
4. Prepare community data profiles for communities – April 2007
5. Inform partners and public of Epi findings, SPF plans and priorities – May 2007
6. Secure training contractor for Learning Community – by July 2007
7. Secure cultural competency technical assistant – July 2007
8. Develop and finalize RPF – April 2007

Community (Sub-recipient) Activities

1. Release RFP (contingent upon plan approval) – May 2007
2. Applicant Training – May 2007
3. Submit applications - July 2007
4. Grant Review – August/September 2007
5. Contracts awarded – September/October 2007
6. Training and technical assistance assessment – September/October 2007
7. Learning Community Training series – October, December 2007, February, April, June 2008
8. Conduct capacity and readiness assessments – October 2007

A more detailed timeline and identification of milestones for activities beyond 2007 will be developed and monitored as the grant progresses.