SPF SIG Grant FY 2009-2010

Date Application	Person Submitting Application		No. Pages	County	
Submitted to State	Holona Do Eina		67	Dork	
			07	Faik	
Fiscal Agent Information				1	
Name of Agency Serving a	as Fiscal Agent: West Park	Hospital District			
Contact Person: Helena D	De Fina	Title: Prevention S	Specialist		
Address: 707 Sheridan Av	enue, Cody, WY 82414				
Phone: (307) 578-2703		Fax: (307) 578-27	Fax: (307) 578-2713		
Email: hdefina@wphcod	y.org				
Program Manager Inform	nation				
Name: Helena De Fina		Title: Prevention	Specialist		
Address: West Park Hospi	tal, 707 Sheridan Avenue,	Cody, WY 82414			
Work Phone: (307) 578-2	703	Cell Phone:			
Email: hdefina@wphcody.org					
Coalition Information					
Formal Name of Community Coalition: Powell Coalition Against Substance Abuse (PCASA)					
Date/Time/Location of Regular Meetings: 2 nd Thursdays, 3 pm, Northwest College					

EXECUTIVE SUMMARY: (Please provide a brief narrative of your Coalition, its successes in achieving program goals of reducing underage drinking and binge drinking, and its planned prevention efforts. You may include information about your county that you feel is particularly relevant, or about specific barriers you have encountered and how you plan to overcome them. Your summary should be suitable for publication to third parties, including our federal partner, CSAP. Your summary should be at least one page and may be two pages or more, provided it contains sufficient substantive content that an outsider reading it would get a good sense of prevention efforts within your county).

Park County is located in the northwest corner of Wyoming adjacent to Yellowstone National Park and has a population of 27,073 (2007 U.S. Census estimate). Park County has two incorporated towns (Cody and Powell) each with a municipal law enforcement department and three school districts (Powell, Cody and Meeteetse). Cody's economy is largely based on summer-season tourism associated with the national park. Powell's economy is more associated with the agricultural sector. Northwest College, a residential two-year community college with approximately 1,800 students, is located in Powell.

There are four different coalitions or groups actively addressing substance abuse issues in Park County: the Park County Health Coalition, the Powell Coalition Against Substance Abuse, the Core Team, and Northwest College's Choosing Healthy Options in College Environments. Additionally, there are numerous other agencies and individuals addressing the problem.

The Park County Health Coalition (PCHC) has been in existence since 1999. Its mission is to enhance the health and wellness of all community members by fostering collaboration between agencies through networking and education. Members of the PCHC include representatives from many social service providers, the schools, hospitals, area businesses, and interested community members. PCHC has approximately 100 individuals on its email list and meets on a monthly basis, alternating meetings between the towns of Powell and Cody to increase local participation.

The Powell Coalition Against Substance Abuse (PCASA) was formed in 2002 to specifically address

substance abuse concerns in Powell. PCASA went through the Communities that Care model to analyze local data, review risk and protective factors, and develop a comprehensive substance abuse prevention plan. PCASA selected five key goals:

- 1. Reduce community acceptance of alcohol abuse
- 2. Reduce underage alcohol use
- 3. Reduce availability of illegal substances
- 4. Provide drug-free alternatives / activities for the community
- 5. Reduce driving under the influence

PCASA meets monthly in Powell.

The Core Team is comprised of several agency heads and key organization representatives. It meets monthly and has addressed a wide range of issues including preventing child abuse, general public health concerns such as seeking regulation of tattoo businesses, mental health issues such as handling patients in crisis, as well as substance abuse related concerns. Presently, the Department of Family Services, Public Health, the Park County Health Officer, law enforcement, the County Attorney's Office, Crisis Intervention, the school district, Yellowstone Behavioral Health Center, West Park Hospital, and Bright Futures Mentoring regularly attend meetings. The Core Team is facilitated by Ed Heimer, the regional manager of the Department of Family Services.

Choosing Healthy Options In College Environments (CHOICES) is sponsored by Northwest College (NWC), located in Powell. Currently, CHOICES is addressing underage alcohol use prevention but is moving towards tackling the issue of misuse of alcohol by those of legal age. CHOICES meets monthly and has representation from the school resource officer, residential housing, residential directors, counseling staff, faculty, and community representatives. CHOICES has helped to facilitate the adoption of an uniform code of conduct for athletes as well as introduce BASICS as an evidenced-based intervention for students who are found in violation of the college's alcohol policies.

Park County uses a risk and protective factor model to design prevention activities aimed at individuals and a norms / availability / regulations framework to design prevention activities addressed at environments. For the Prevention Framework in Park County, the following causal factors were identified: criminal justice, social availability, and community norms.

For criminal justice, we are seeking ways to reduce recidivism among impaired drivers. The specific strategies involve promoting use of ignition interlocks and offering a brief intervention for adults as a potential court sanction. We have successfully developed and implemented the brief intervention and are now focusing on promoting it among community members, workplaces, and the courts. An interlock law was passed in Wyoming and is now in effect. We will work with local judges and prosecutors to promote and support implementation.

To address social availability, we are seeking ways to reduce availability of alcohol to youth. The data clearly indicate that the greatest source of alcohol for underage youth in Park County is adults over the age of 21 who are not family members. Efforts at improving source investigations by law enforcement have been challenging due to limited options in sentencing which can be used as incentives to get youth to reveal their sources. Most youth simply choose to pay the fine and will not reveal their source. In addition to source investigations, we are seeking improved policies and ordinances around public events where alcohol may be present. We are seeking the local city councils to establish guidelines for public policy around alcohol as a way to establish standards for alcohol ordinances, special use requests, and waivers.

To address community norms, we are implementing intensive campaigns focused on three key audiences

- high school youth, Northwest College students, and adults in the community. Data available at the local level reveal tremendous gaps between actual behaviors and beliefs and perceived behaviors and beliefs. There is extensive research showing that if these gaps in perceived behaviors and beliefs can be corrected, risky behaviors will decrease and protective behaviors will increase. By closing these gaps, the community's perception of alcohol use (both by adults and youth) is transformed and numerous behaviors change including enforcement, supplying, parental protective behaviors, and individual usage.

The following table summarizes alcohol use by Park County youth in recent years.

	2001	2004	2006	2008
30-day Alcohol Use				
Grade 8	22.7%	17.1%	18.1%	23%
Grade 10	41.0%	40.7%	33.6%	36%
Grade 12	48.9%	51.7%	40.7%	42%
Grades 10 & 12	45.0%	46.2%	37.2%	39%
Dangerous Drinking ¹				
Grade 8	11.8%	9.7%	8.8%	14%
Grade 10	31.3%	26.6%	22.3%	22%
Grade 12	32.7%	39.6%	26.3%	29%
Grades 10 & 12	32.0%	33.1%	24.3%	26%

Table 1. Alcohol Use Among Park County Youth

Notes: 1. Dangerous Drinking is binge drinking defined as drinking 5 or more drinks in a 2-hour period at least once in the past 2 weeks. Source: Prevention Needs Assessment

A more comprehensive summary is attached at the end of this proposal.

Worksheet 1. Targeted Causal Areas and Identified Strategies

Potential Causal Areas	Is Your Community Currently Targeting this Causal Area? (Yes or No)	What Evidence-Based and/or Environmental Strategies Have You Implemented This Year to Address this Causal Area? (Please be Specific)
Retail Availability	No	
Criminal Justice	Yes	 Sanctions and monitoring for convicted drunk drivers Enacted by legislature to begin July 1 supporting enactment and local awareness Brief intervention with motivational interviewing Intervention was developed; staff trained Brochures created and distributed
Social Availability	Yes	 Social norms campaign in the high school, college and community Implemented at NWC Initial design done for high school (to begin in Aug) Alcohol source investigation – support law enforcement efforts Challenged by inability to get youth to reveal source (no leverage)
Promotion	No	
Community Norms	Yes	 Social norms campaign in the high school, college and community Implemented at NWC Initial design done for high school (to begin in Aug)
Individual Factors	No	

Worksheet 2: Causal Area & Evidence-Based Strategy Assessment

Question 1.

Have your targeted causal areas changed? If yes, what data supports this change?

No.

Question 2.

Have your chosen evidence-based strategies changed from the original? If yes, what are the changes and why did you make them?

Add to Social Availability:

Restricting Access to Alcohol

Restriction on Drinking Locations and Possession

Tip Line

We have recognized an increased need to educate and support appropriate decisions by city councils regarding special use permits, waivers, and alcohol ordinance review. We feel the time is appropriate to address these issues more directly.

Efforts at source investigations regarding alcohol supplied to underage youth are hampered by the lack of leverage with these youth to get them to talk (these strategies have been more effective in states which allow for the suspension of a drivers license upon a MIP conviction). Therefore, a Tip Line may be a more effective alternative to identifying source providers and reducing social availability of alcohol to underage youth.

Furthermore, we would like to take this opportunity to add an additional evidenced-based program to the county, Reconnecting Youth, to address those youth who are at extreme-risk for dropping out of school (often because of alcohol use). Reconnecting Youth (RY) is a CSAP model program which can be implemented at the high school. Powell currently implements RY, and Cody is now ready. We want to take advantage of the opportunity with the school and the available resources to bring this successful program to Cody (and potentially Meeteetse). Information about RY is included at the end of this proposal.

Member Name	Organization	Address	Email	Phone	Attended Meeting? (Y/N)
Ruth Edge, RN	Community Member	1760 Dutcher Springs Trail, Powell	edges@directairnet.com	754- 5084	n
Ronda Church, RN	Park County Public Health	109 W 17 th St Powell	rchurch@parkcounty.us	754- 8870	у
Ingrid Eickstedt	Powell Valley Community Education	231 W 6 th Powell	pvce@northwestcollege.edu	754- 6469	у
Chief Tim Feathers	Powell Police Department	250 N Clark St Powell	tfeathers@cityofpowell.com	754- 2212	у
Cynthia Garhart, Counselor	Success Center/Northwest College	231 W 6 th Powell	cynthia.garhart@northwestcollege.edu	754- 6135	у
Connie Zierke	Tobacco Prevention/West Park Hospital	707 Sheridan Cody	czierke@wphcody.org	578- 2426	у
Cathy Florian	Migrant Health	146 S Absaroka Powell	cflorian@tctwest.net	754- 5252	n
Lee Blackmore, Resource Officer	Law Enforcement/ NWC	231 W 6 th Powell	lee.blackmore@northwestcollege.edu	754- 6067	n
Jay Otto	SPF-SIG /West Park Hospital	707 Sheridan Cody	jotto@wphcody.org	578- 2657	У
Helena De Fina	SPF-SIG /West Park Hospital	707 Sheridan Cody	Hdefina@wphcody.org	578- 2703	у
Roena Halbur, Counselor	Northwest College	231 W 6 th Powell	roena.halbur@northwestcollege.edu	754- 4286	у
Jennifer Skinner, Residence Director	Northwest College	231 W 6 th Powell	Jennifer.Skinner@northwestcollege.edu	754- 6162	n
John Ginther, Residence Director	Northwest College	231 W 6 th Powell	john.ginther@northwestcollege.edu	754- 6655	n
Annemarie Merager	Safe Schools/Safe Kids/ WPH	707 Sheridan Cody	amerager@wphcody.org	578- 2703	У
Burt Mace	K-Bar Saloon	219 E 1st St Powell	bert_mace@msn.com	754- 4286	n

Worksheet 3. Current CAC Membership Roster & Planning Meeting Attendance

Debbie	Heart Mtn	931	y4ranch@msn.com	754-	n
Hamilton	Volunteer	Sylvan		2828	
	Clinic/Community	ĊT			
	Member				

Make Additional Pages of This Roster As Needed

Date of Initial CAC Planning Meeting July 16, 2009		Place of Meeting Trapper Room, Northwest College		Length of Meeting 87 minutes, 34 seconds	No. CAC Members Attending: 9
STRATEGIES IDE		D FOR PRIMARY PLAN			
Name of Strategy	why Di	d You Select This Strategy?	what Are You Going	g to Accomplish?	Potential Barriers
1. Sanctions and monitoring for convicted drunk drivers.	Reduc (recog assessi	e repeat DUI offenders nized in initial needs ment)	Promote and supp interlocks to reduc among repeat DU	oort use of ce recidivism I offenders.	Court support; funding for equipment; adapting to change
2. Brief intervention with motivational interviewing.	Reduce repeat alcohol offenders; reduce adult binge drinkers.		Make brief interventions a part of alcohol sanctions; make SBIRT a part of alcohol related ER procedures; promote SBIRT among local physicians.		Overcoming stigma associated with SA screening and treatment.
3. PCN campaign in the high school, college and community	Evider reduce impair	nced-based strategy to e UAD, adult binge, and ed driving.	Reduce perception youth, college, and County resulting in protective behavior risky behaviors.	n of use among l adults in Park n increased ors and reduced	Contradicting media
4. Restricting Access to Alcohol; Restriction on Drinking Locations and Possession	Increa difficu making special alcoho	sed awareness of lties city councils have in g decisions regarding l use permits, waivers, and l policy in general.	Promote adoption policies; promote guidelines for alco policies by elected on public input.	of improved use of hol public officials based	
SPECIAL PROJE	CTS SE	LECTED			
Name of Project	Why Did	I You Select This Project?	What Are You Going	g to Accomplish?	Potential Barriers
1. Reconnecting Youth (RY)	Improv youth v extrem add an based	e services provided for who are using and at e-risk for dropping out; additional evidenced- program to the county.	Reduce substanc drop outs among indicated users.	e abuse and selected and	
2.					
3.					

4.		
Did you request any type of technical assistance from WyPTAC or the Division for this meeting? If no, why not? If yes, what type did you request? No. Not needed.	Did you request WyPTAC or the Division provide direct assistance in facilitating this meeting? If no, why not? No. Not needed.	Did you receive the TA requested? N/A

Use Additional Sheets if Necessary

Worksheet 5. Lo	cal Community	Prevention Efforts
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Local Prevention	Major Strategies	Critical	Local Contact	Potential
Initiatives other		Dates and		Y/N
than the PF		Events		
Federal	On-site Prevention (RY)		Jay Otto	Y
Prevention Block	Teacher training to improve			
Grant	bonding to school			
Most of Us PCN	At NWC, high schools, and		Helena De Fina	Y
Campaign	community			
The Line social				
marketing				
campaign				
Wyoming's First	Community Awareness		Helena De Fina	Y
Lady's Initiative				
Community	Comprehensive Planning		Annmarie Merager	Y
Initiative to	project involving schools and			
integrate	agencies			
prevention				
Youth Initiatives		Fall,	Deb White	Υ
(post-FACE	Youth for Justice, CAN	legislative		
activities)		session		
Anti-Drug				
Programs				
School Prevention	All-Stars		Shelley Hill	Y
Programs	Here's Looking at You		Patty Brus	Y
	Toward No Drug Use		Jill Smith	Y
Law Enforcement	Compliance Checks		Tim Feathers	Y
Prevention	Local TIPS training		Perry Rockvam	Y
Programs	WY Communities in Action			
	Take Back Program			
	Training with drug company			
Suicide	Local Suicide Coalition		Alice Russler	Y
Prevention	NWC Suicide Prevention		Cynthia Garhart	Y
Programs				
3377				X 7
Wyoming	Social norms on tobacco use		Connie Zierke	Y
	(smoking and spit)			
Prevention and				
Deblie II 11				V
Public Health	Addressing prescription drug			Ŷ
Programs and	storage and disposal with	1		

Initiatives	seniors Addressing ATOD use among pregnant women (Best Beginnings / Welcome Home) NFP – longer term support for at-risk new mothers (also addressed ATOD use)		
Juvenile Justice	Park County Youth Services	Joe Michelson	Y
DFS-Foster Care	Independent Living Program (life skills training, counseling, access to resources)	Abby Resch	Y
Alive at 25 / Driver Education	Driver skills training; prevention of impaired driving	Ingrid Eickstedt	Y
Powell Area Health Fair	Community awareness and education	Ingrid Eickstedt	Y

NOTE: If you checked "Y" for potential collaboration with one of the agencies or programs identified in the above chart, please use Worksheet 6 on the next page to explain how that collaboration might work. Then, when appropriate, incorporate that in your strategic planning for next year and in your development of a workplan.

Worksheet 6 – Potential Local Partnerships and Collaborations

AGENCY NAME/CONTACT:

West Park Hospital, Block Grant

IDEAS FOR COLLABORATION:

- Integration with various school efforts
- Connect with Onsite Prevention / Reconnecting Youth

AGENCY NAME/CONTACT:

West Park Hospital, PCN Campaign, Helena De Fina

IDEAS FOR COLLABORATION:

- Integrate PCN messages with support for policy, intervention
- Focus on high school, college, and adult populations

AGENCY NAME/CONTACT:

Wyoming First Lady's Initiative Local Contact / Helena De Fina

IDEAS FOR COLLABORATION:

Support awareness of underage drinking problems and consequences.

AGENCY NAME/CONTACT:

West Park Hospital, Community Initiative, Annmarie Merager

IDEAS FOR COLLABORATION:

- Integrate comprehensive planning project with current prevention efforts
- Expand knowledge of key players regarding substance abuse, mental health, child well-being.

AGENCY NAME/CONTACT:

Youth for Justice, CAN, Deb White

IDEAS FOR COLLABORATION:

- Support student policy efforts at both the local and state level.

AGENCY NAME/CONTACT:

High School Health Teachers, All-Stars, Here's Looking at You, Toward No Drug Use Patty Brus, Jill Smith, Shelley Hill

IDEAS FOR COLLABORATION:

- Provide access to resources to stay current
- Provide speakers for health classes

AGENCY NAME/CONTACT:

Cody Police Department (Perry Rockvam) / Powell Police Department (Tim Feathers)

IDEAS FOR COLLABORATION:

- Support on-going compliance checks (alcohol and tobacco)
- Support access to local TIPS training / train-the-trainer
- Promote use of Take Back program for prescription drugs
- Promote training from drug companies on reducing PDA

AGENCY NAME/CONTACT:

Suicide Prevention / Yellowstone Behavioral Health Center / Alice Russler

Northwest College / Cynthia Garhart

IDEAS FOR COLLABORATION:

Support data collection, information sharing, and access to resources and training

- Help various agencies connect substance abuse and risk for suicide

AGENCY NAME/CONTACT:

Wyoming Tobacco Prevention and Control Program / Connie Zierke

IDEAS FOR COLLABORATION:

- Integrate tobacco norms clarification messages into PCN campaign at high school, college, and within the community.

AGENCY NAME/CONTACT:

Public Health / Addressing storage and disposal of prescription drugs among seniors

IDEAS FOR COLLABORATION:

Ensure information about misuse of prescription drugs is included in prevention activities

AGENCY NAME/CONTACT:

Juvenile Justice / Park County Youth Services / Joe Michelson

IDEAS FOR COLLABORATION:

- Support access to brief interventions, programs at schools
- Support access to training and resources regarding mental health, suicide prevention, and life skills training

AGENCY NAME/CONTACT:

West Park Hospital Independent Living Program / Abby Resch

IDEAS FOR COLLABORATION:

- Support at-risk youth with access to counseling (onsite counseling) and programs (RY)
- Connect resources regarding mental health, substance abuse with various programs serving IL youth

AGENCY NAME/CONTACT:

Alive at 25 / Ingrid Eickstedt

IDEAS FOR COLLABORATION:

- Promote program among area youth

AGENCY NAME/CONTACT:

Powell Area Health Fair / Ingrid Eickstedt

IDEAS FOR COLLABORATION:

- Opportunities for community education
- Tack Back Program for prescription drugs

Use Additional Sheets if Needed

Worksheet 7. Steps to Accomplish PF Strategies

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Strategy: Sanctions and monitoring for convicted drunk drivers.					
Action Steps	Day/Month/Year of Completion	Responsible Party			
1. Meet with area judges to discuss new sanctions / interlocks.	10/31/2009	De Fina, Otto			
2. Develop media plan with coalition for awareness about new sanctions.	12/31/2009	De Fina, Coalition			
3. Begin media campaign using press releases, articles, email.	1/30/2010	De Fina, Coalition			
4. Integrate messages about sanctions with PCN campaign on impaired driving.	3/1/2010	Otto, Coalition			
5. Continue campaign throughout remainder of project.	9/30/2010	De Fina, Coalition			
Note: Strategy is highly dependent on response of judges which is hard to predict. If a judge is not supportive to the use of interlocks, than there will have to be education and advocacy work by the coalition to get the judge on board.					

Strategy: Brief intervention with motivational interviewing.					
Action Steps	Day/Month/Year of Completion	Responsible Party			
1. Identify appropriate physician to act as spokesperson / champion.	10/31/2009	Otto (with Coalition approval)			
2. Interview judges about using BASE as a sanction.	10/31/2009	Otto, De Fina			
The steps taken to get BASE as a sanction d	epend on outcomes from ir	nterviewing the judges.			
3. Interview ER managers / physicians and assess readiness.	10/31/2009	De Fina			
4. Learn about SBIRT training options from the state.	10/31/2009	De Fina			
5. Create a presentation on SBIRT for champion to share with doctors through hospital meetings.	12/31/2009	Otto, (physician), Coalition			
6. Schedule SBIRT trainings for spring.	1/15/2010	De Fina			
7. Schedule Advanced MI training for BASE counselors.	1/31/2010	De Fina			
8. Conduct presentations with doctors.	2/28/2010	(physician)			
9. Develop support materials / referral materials for use during SBIRT.	3/31/2010	De Fina, Coalition			
10. Conduct SBIRT training.	5/1/2010	(unknown)			
11. Conduct Advanced MI training for BASE counselors.	6/1/2010	(MI trainer)			
12. Monitor utilization of SBIRT by ER departments and physicians.	On-going	De Fina			
13. Monitor utilization of BASE by judges.	On-going	Finley			

Strategy: PCN campaign in the high school, college, and community.				
Action Steps	Day/Month/Year of Completion	Responsible Party		
High Schools				
1. Continue developing poster media for high schools.	11/30/2009, 1/30/2010, 3/30/2010, 5/20/2010	Resch		
2. Conduct pilot testing and group interviews with high school students	On-going throughout school year	Resch		
3. Place ads in school newspaper	On-going throughout school year	Resch		
4. Conduct sessions in health classes in Cody, Powell, and Meeteetse	12/31/2009, 5/20/2010	Resch		
5. Partner with schools to get out parent materials.	12/31/2009, 5/20/2010	Otto, Resch		
Northwest College	· · · · · · · · · · · · · · · · · · ·			
1. Continue developing poster media for NWC.	11/30/2009, 1/30/2010, 3/30/2010, 5/20/2010	De Fina		
2. Conduct pilot testing and group interviews with NWC students	On-going throughout school year	De Fina		
3. Place ads in NWC school newspaper	On-going throughout school year	De Fina		
4. Conduct guidelines sessions with teams	On-going throughout school year	De Fina		
Community				
1. Place radio ads in community.	12/31/2009	Otto		
2. Conduct email messages to key leaders	on-going, monthly	Merager		
3. Conduct community presentations with existing groups.	One every other month	Otto, Merager		
4. Conduct guidelines sessions with key employers.	4 throughout year	Otto, De Fina		
The coalition is a key stakeholder in the PC placement, and helps hear and steer the loca	N campaign and reviews me l conversation.	dia, helps with		

Strategy: Restricting Access to Alcohol, Restriction on Drinking Locations and Possession					
Action Steps	Day/Month/Year of Completion	Responsible Party			
1. Foster adoption of alcohol public policy guidelines by Powell City Council (PCC)	10/31/2009	Coalition, Otto, De Fina			
2. Dialog with Cody City Council (CCC) and various stakeholders about conducting a public meeting on alcohol public policy guidelines.	12/31/2009	Coalition, Otto			
3. Continue supporting PCC during alcohol ordinance review.	On-going	Coalition, Otto			
4. Identify stakeholders, date, location, facilitator for Cody guidelines session.	2/28/2010	Coalition, De Fina			
5. Conduct guidelines session.	5/30/2010	Facilitator, Otto, De Fina			
6. Present results to CCC.	7/30/2010	Otto, De Fina			
7. Foster adoption of guidelines by CCC	9/30/2010	Coalition, Otto, De Fina			
8. Integrate Tip Line media in existing media normative media, information to parents, and press releases to reducing UAD parties and adults who supply.	(depends on Tip Line schedule)	Coalition, Otto, De Fina			

Strategy: Special Project: Reconnecting Youth (RY)					
Action Steps	Day/Month/Year of Completion	Responsible Party			
1. Identify date for training with trainers and school districts.	11/15/2009	De Fina			
2. Handle all logistics for training.	12/31/2009	De Fina			
3. Promote training.	12/31/2009	De Fina			
3. Conduct training.	5/31/2010	Trainers			

Worksheet 8. Meeting Report – Workplan and Calendar Meeting

Date of CAC Workplan	Place of Meeting		Length of	No. CAC	
Meeting			Meeting	Members	
	Trapper Room, NW	C		Attending	
7/16/2009			87 minutes,	, C	
			34 seconds	9	
Names of CAC Members Atten	dina:			I	
	ionig.				
Ronda Church RN Ingrid Fick	stedt Chief Tim Feath	hers Cynthia Garh	art Counselor	Connie Zierke	
Jay Otto Helena De Fina Roe	na Halbur, Counselor	Annmarie Merade	r		
		, / Infinitiane Merage	·1 •		
What Challenges and/or Proble	me Did Coalition Mor	nhore Exporionco i	n Completing th	wa Warkalan?	
What Challenges and/or Frobit					
Difficulty of planning when yor	aua unknowna aviat	"wo woo't know ov	actly what the r	ovt otopo oro until	
Difficulty of planning when vari		we work know ex	actly what the r		
we interview the council memb	ers or the judges and	see now they reac	t. Otherwise, n	o problems.	
	D				
How Did the Coalition Member	s Decide to Address I	hose Challenges?			
Plan as best as possible and b	e flexible to adapt as i	needed.			
Did Any of the Strategies Decid	led at the First Meetin	g Change During t	he Workplan Pr	ocess? (If Yes,	
How Did They Change and Wh	ıy?)				
No.					
Please provide any final com	ments regarding the	strategic plannin	a process with		
	inonio rogaranig ino				
As we did not make significant	changes to our origin	al plan the process	s was verv strai	abt-forward	
no we did not make significant	changes to our origin	ai pian, the procest	s was very strai	gint for ward.	
Diduces as a first first	hulast said (Distance		Distance	
Did you request any type of tec	cnnical assistance	טומ you request V	vyPIAC or the	Did you receive	
trom WyPTAC or the Division for this meeting? If Division provide direct the TA					
no, why not? If yes, what type	did you request?	assistance in facil	litating this	requested?	
		meeting? If no, wl	hy not?		
No. Not needed.					
		No. Not needed.			

COST DESCRIPTION	STRATEGY 1 (Primary Plan)	STRATEGY 2 (RY Training)	STRATEGY 3 (n/a)	TOTAL BUDGET
PERSONNEL SERVICES				
Salaries & Wages	47,158			47,158
Employer Paid Benefits	9,432			9,432
SUPPORTING SERVICES				
Communications:				
Internet				
Telephone				
Vehicle Expenses				
TRAVEL/TRAINING/MEETINGS				
Travel In-State	2,410			2,410
Travel Out-of-State	2,500			2,500
Training Costs	5,500	9,500		15,000
Miscellaneous Meeting Exp.	1,000			1,000
SUPPLIES				
Consumable Supplies	1,800			1,800
Commercial Printing	1,000			1,000
Publications Purchased				
ADVERTISING/MEDIA COSTS	3,500			3,500
EQUIPMENT RENTAL				
CONTRACTUAL SERVICES (please describe)				
1. Facilitator for Guidelines Session	750			750
2.				
3.				
OTHER COSTS (specify)				
A. Indirect Costs	2,500			2,500
B. Computer	900			900
С.				
Sub- Total	75,050	9,500		87,950
Program TA & Evaluation				
1. WyPTAC @ 8%				7,036
2. WYSAC @ 5%				4,397
Total				99,383

Worksheet 9.	Prevention Framework Budget for	r October 2009 thru	September 2010

USE ADDITIONAL BUDGET WORKSHEETS AS NEEDED PLEASE ATTACH BUDGET NARRATIVE TO ALL WORKSHEETS

Budget Justification

A. PERSONNEL SERVICES

Role	Name	Ann. Salary	Ann. Fringe Benefits	Level of Effort	Annual Cost
Prevention Framework Coordinator	Helena De Fina	\$36,920	\$7,384	100%	\$ 44,304
Assistant to PF (Prevention and Wellness Office manager)	Jay Otto	\$51,188	\$10,237	20%	\$12,285

Justification: West Park Hospital District is the fiscal agent and implementing agent for the PF project in Park County. Helena De Fina has been with the project since the beginning. She is 100% on the project. Jay Otto assists with various aspects of the project. He works 20% on PF activities. The salaries include an estimated 3% COLA increase to take place in January of 2010. Benefits include payroll taxes, workers compensation, retirement plan, and health benefits and are calculated as 20% of gross salary. De Fina's and Otto's résumés are provided at the end of this application.

REQUEST FOR PERSONNEL SERVICES: \$56,590

B. SUPPORTING SERVICES

Туре	Rate	Cost

Justification:

REQUEST FOR SUPPORTING SERVICES: \$0.00

C. TRAVEL/TRAINING/MEETINGS

Purpose of Travel	Location	Item	Rate	Cost
Necessary travel for PF	In-state	Rental car, daily	Prevailing State	\$1,750
Coordinator to attend		per-diem, hotel		
required meetings for				
Primary Plan				
Travel for PF	In-state	Mileage estimated	Prevailing Federal	\$660
Coordinator to attend		at 100 miles /		
local and regional mtgs		month		
PF Coordinator travel	Out-of-	Daily per-diem,	actual out-of-	\$2,500
to approved national	State	hotel, registration,	pocket costs for	
prevention conference		lodging ; standard	lodging and	
		airfare	airfare	
Training for MI (basic	WPH	Includes travel	Estimate from	\$5,500
and advanced) for		for instructor,	Center for	
counselors		materials, and	Change (see	
implementing BASE		training	attached proposal	
			at end of this	
			document)	
Training for	WPH	Includes travel	Reconnecting	\$9,500
Reconnecting Youth		for instructor,	Youth	
		materials, and		
		training		
Miscellaneous meeting	WPH or	Lunch, materials,	Actual	\$1,000
costs for SBIRT	local facility	etc.		
training for local				
medical professionals				
and for Cody guidelines				
on alcohol public				
policy.				
			TOTAL	\$20,910

Justification: Travel is requested for PF Coordinator to attend one WY required training and one national prevention conference. Additional funds are for local mileage within the county and region. The training for Motivational Interviewing (MI basic and advanced) is to support the implementation of the brief intervention, BASE, for adults. BASE was developed during year 2 of the PF. We now need to follow up with advanced training (for those who were trained in year 2 and have been practicing as well as provide a basic MI for those who are new (due to turnover in the counseling field). We have had great success with the identified trainer. In addition, we want to offer training on Reconnecting Youth (a CSAP model program) for those working with youth at extreme risk for dropping out of school (this is our special project). The miscellaneous meeting costs are to support efforts to train local physicians / nurses in SBIRT and to host another community meeting on creating guidelines for alcohol public policy.

REQUEST FOR TRAVEL/TRAININGS/MEETINGS: \$20,910

D. SUPPLIES

Item	Rate	Cost
Consumable Supplies for	\$150/month	\$ 1,800.00
Primary Plan		
Commercial Printing	\$2.50 per 11 x 17 full color on	\$1,000.00
	poster paper	
	TOTAL	\$2,800.00

Justification: Consumable office supplies include all office supplies such as paper, toner, copier, simple brochures and handouts, postage, etc. Commercial printing is for posters for media campaigns within the school and community.

REQUEST FOR SUPPLIES: \$2,800.00

E. ADVERTISING AND MEDIA COSTS

Item	Rate	Cost
Primary Plan	Actual Cost for Paid Media	\$ 3,500.00
	TOTAL	\$3,500.00

Justification: Media will be purchased using local radio stations (reaches all of the county, provide a 1:1 match). Media campaigns will address normative misperceptions (PCN Campaign) as well as promote the Tip Line (when made available by state for local implementation). 200 30-second ads will be purchased (average price of \$17.25) which will result in 400 ads played on 3 stations. These will be utilized for ten 1 week intervals with 8 ads played per day for 5 consecutive days. A quiet period of 1 or 2 weeks will be used between the intervals.

REQUEST FOR ADVERTISING AND MEDIA COSTS: \$3,500.00

F. EQUIPMENT RENTAL

No costs for Equipment are budgeted.

REQUEST FOR EQUIPMENT: \$0.00

G. CONTRACTUAL COSTS

Consultant Costs

Name	Service	Rate	Period	Cost
Rhonda Shipp	Facilitation, meeting	Flat rate	Guidelines Public	\$ 750
	design		Meeting	
			TOTAL	\$750

Justification: Rhonda Shipp is a professional facilitator with extensive experience designing and leading public meeting around contentious issues. We propose to use her services to help design and implement the meeting(s) in Cody to develop guidelines on alcohol public policy.

REQUEST FOR CONTRACTUAL COSTS: \$750.00

H. OTHER COSTS

Item	Rate	Cost
Indirect Costs		\$2,500
Computer		\$ 900
	TOTAL	\$3,400

Justification: Indirect costs include book-keeping, accounting, audit, all facilities, maintenance, staff training, oversight. In addition, we are requesting \$900 to replace an outdated computer used by the PF Coordinator. This computer is over seven years old and is unable to run current software.

REQUEST FOR OTHER COSTS: \$3,400

<u>1. Introduction to Park County Chemical Health Comprehensive Needs Assessment</u> This document is a comprehensive needs assessment of chemical health in Park County, Wyoming. The specific substances impacting chemical health discussed in this document are alcohol, tobacco, and other drugs. Other drugs include illicit drugs (e.g., cocaine, methamphetamine, etc.) as well as the misuse of prescription drugs.

Park County is located in the northwest corner of Wyoming adjacent to Yellowstone National Park and has a population of 27,073 (2007 U.S. Census estimate). Ninety-six percent (96.3%) of the residents are white with 3.7% of the total population reporting Hispanic or Latino origin. The percentage of persons below poverty is 12.7%. Park County has two incorporated towns (Cody and Powell) each with a municipal law enforcement department and three school districts (Powell, Cody and Meeteetse). Cody's economy is largely based on summer-season tourism associated with the national park. Powell's economy is more associated with the agricultural sector. Northwest College, a residential two-year community college with approximately 1,800 students, is located in Powell.

Alcohol is the most widely used substance in the nation, Wyoming, and Park County. Alcohol related accidents are the leading cause of death among 15-24 year-olds accounting for more deaths than all other drugs combined. Underage drinking has been recognized as a public health priority by the National Institutes of Health and the Surgeon General's Office. Alcohol is involved in the overwhelming majority of law enforcement activities. The consequences of the misuse of alcohol by adults include impaired driving, domestic violence, addiction, cancer, liver cirrhosis, and others. Approximately 55% of Wyoming adults report drinking in the past 30 days; 45% report not using alcohol (Source: BRFSS 2007).

Tobacco is the leading cause of cancer in the United States; cancer is the second leading cause of death. The vast majority of tobacco is consumed in the form of cigarettes. Smokeless tobacco (also know as chewing tobacco or spit tobacco) is more prevalent in Wyoming than the nation. The health problems associated with tobacco extend beyond the user to those who come in contact with second-hand smoke. Exposure to second-hand smoke increases incidence of cancer, asthma, and severe cardiac events such as heart attacks. Approximately 18% of Park County adults (age 18 and older) report being current smokers, and 7% report using spit tobacco. 82% of Park County adults do not smoke, and 93% do not use spit tobacco. (Source: BRFSS 2001-2005 County Estimates)

The most widely used illicit drug in Park County is marijuana. The vast majority of marijuana is smoked, thus causing many health problems similar to cigarettes. In addition, marijuana impairs motor coordination and negatively impacts learning. Among high school students, 14% in Park County report using marijuana in the past 30 days (Source: PNA 2008). Among Northwest College students, 13% report using marijuana in the past 30 days (Source: 2005 NWC Core Survey). Data on adult use of marijuana in Park County are not available.

In previous years, methamphetamine was recognized as significant problem among law enforcement. In recent years, availability of methamphetamine has significantly dropped and law enforcement is reporting fewer interactions with the drug. With the decline in methamphetamine use, there has been a notable increase in the misuse of prescription drugs. The most widely abused prescriptions drugs are pain medications and sedatives. These drugs have been stolen from people's homes and obtained through falsely seeking prescriptions from physicians as well

Park County Comprehensive Chemical Health Needs Assessment

as forging prescriptions. Park County has had four fatal overdoses of prescription drugs in the several months. Limited data are available regarding the prevalence of the problem.

2. Brief History of Community Activity Addressing Chemical Health

There are four different coalitions or groups actively addressing substance abuse issues in Park County: the Park County Health Coalition, the Powell Coalition Against Substance Abuse, the Core Team, and Northwest College's Choosing Healthy Options in College Environments. Additionally, there are numerous other agencies and individuals addressing the problem (see Section 6. Community Agencies, Resources, and Activities, below).

The Park County Health Coalition (PCHC) has been in existence since 1999. Its mission is to enhance the health and wellness of all community members by fostering collaboration between agencies through networking and education. Members of the PCHC include representatives from many social service providers, the schools, hospitals, area businesses, and interested community members. PCHC has approximately 100 individuals on its email list and meets on a monthly basis, alternating meetings between the towns of Powell and Cody to increase local participation. The West Park Hospital Prevention and Wellness Office facilitates the PCHC (contact: Helena De Fina, 578-2703, hdefina@wphcody.org).

The Powell Coalition Against Substance Abuse (PCASA) was formed in 2002 to specifically address substance abuse concerns in Powell. PCASA went through the Communities that Care model to analyze local data, review risk and protective factors, and develop a comprehensive substance abuse prevention plan. PCASA selected five key goals:

- 1. Reduce community acceptance of alcohol abuse
- 2. Reduce underage alcohol use
- 3. Reduce availability of illegal substances
- 4. Provide drug-free alternatives / activities for the community
- 5. Reduce driving under the influence

PCASA meets monthly in Powell; the West Park Hospital Prevention and Wellness Office facilitates the meetings (contact: Helena De Fina, 578-2703, hdefina@wphcody.org).

The Core Team is comprised of several agency heads and key organization representatives. It meets monthly and has addressed a wide range of issues including preventing child abuse, general public health concerns such as seeking regulation of tattoo businesses, mental health issues such as handling patients in crisis, as well as substance abuse related concerns. Presently, the Department of Family Services, Public Health, the Park County Health Officer, law enforcement, the County Attorney's Office, Crisis Intervention, the school district, Yellowstone Behavioral Health Center, West Park Hospital, and Bright Futures Mentoring regularly attend meetings. The Core Team is facilitated by Ed Heimer, the regional manager of the Department of Family Services.

Choosing Healthy Options In College Environments (CHOICES) is sponsored by Northwest College (NWC), located in Powell. Currently, CHOICES is addressing underage alcohol use prevention but is moving towards tackling the issue of misuse of alcohol by those of legal age. CHOICES meets monthly and has representation from the school resource officer, residential housing, residential directors, counseling staff, faculty, and community representatives. CHOICES has helped to facilitate the adoption of an uniform code of conduct for athletes as well

as introduce BASICS as an evidenced-based intervention for students who are found in violation of the college's alcohol policies. CHOICES is facilitated by the West Park Hospital Prevention and Wellness Office (contact: Helena De Fina, 578-2703, hdefina@wphcody.org).

3. Current Consumption Data

The following section provides local data regarding alcohol, tobacco, and other drug use in Park County by youth, Northwest College students, and adults. When reviewing other drug use, marijuana is the most widely used illicit drug. Usage levels of methamphetamine are also reported due to the intense impact that the drug had several years ago. Currently, there is growing concern regarding the misuse of prescription drugs; however, there is little survey data available regarding this trend.

3.1	Alcohol	

Table 1. Alcohol	Use Among Pa	rk County Yout	h	
	2001	2004	2006	2008
	2001	2004	2000	2000
30-day Alcohol Use				
Grade 8	22.7%	17.1%	18.1%	23%
Grade 10	41.0%	40.7%	33.6%	36%
Grade 12	48.9%	51.7%	40.7%	42%
Grades 10 & 12	45.0%	46.2%	37.2%	39%
Dangerous Drinking ¹				
Grade 8	11.8%	9.7%	8.8%	14%
Grade 10	31.3%	26.6%	22.3%	22%
Grade 12	32.7%	39.6%	26.3%	29%
Grades 10 & 12	32.0%	33.1%	24.3%	26%
Notes: 1. Dangerous Drinking is a 2-hour period at least once in the Source: Prevention Needs Assess	binge drinking define past 2 weeks.	ined as drinking 5 o	or more drinks in	

1 4 1

Table 2. Alcohol Use Among Northwest College Students

	2005 Core Survey	2009 NCHA Survey	
30-day Alcohol Use			
Age 23 or younger	55%		
Dangerous Drinking ¹			
Age 23 or younger	37%		
Notes: 1. Dangerous Drinking is a 2-hour period at least once in the	binge drinking def ne past two weeks.	ined as drinking 5 o	or more drinks in

Table 3. Alcohol Use Among Park County Adults

	2001 - 2005		
Dangerous Drinking ¹			
Adults age 18 and older	14.4%		
Notes: 1. Dangerous Drinking is a 2-hour period at least once in th Source: Behavioral Risk Factor S	binge drinking def ne past 30 days. Surveillance Survey	ined as drinking 5 o	or more drinks in

3.2 Tobacco

	2001	2004	2006	2008
30-day Cigarette Use				
Grade 8	9.2%	8.9%	6.6%	4%
Grade 10	23.6%	20.8%	13.5%	18%
Grade 12	33.3%	20.7%	15.9%	16%
Grades 10 & 12	28.5%	20.8%	14.7%	17%
Half Pack of Cig/day				
Grade 8	0.4%	3.0%	0.4%	0%
Grade 10	6.6%	8.3%	2.8%	3%
Grade 12	6.0%	7.8%	3.1%	5%
Grades 10 & 12	6.3%	8.1%	3.0%	4%
30-day Spit Tobacco Use				
Grade 8	4.4%	3.4%	3.6%	4%
Grade 10	11.2%	13.9%	6.8%	5%
Grade 12	19.3%	17.1%	11.3%	9%
Grades 10 & 12	15.3%	15.5%	9.1%	7%
Source: Prevention Needs Assessm	ent			

	2005 Core Survey	2009 NCHA Survey	
30-day Tobacco Use			
Age 23 or younger	38%		

Table 5. Tobacco Use Among Northwest College Students

Table 6. Tobacco Use Among Park County Adults

	2001 - 2005		
Current Smokers			
Adults age 18 and older	17.8%		
Spit Tobacco Use			
Adults age 18 and older	6.3%		
Source: Behavioral Risk Factor S	Surveillance Survey	1	

3.3 Other Drugs

 Table 7. Other Drug Use Among Park County Youth

	2001	2004	2006	2008
30-day Marijuana Use				
Grades 10 & 12	16.7%	10.1%	11.1%	14%
30-day Methamphetamine Use				
Grades 10 & 12	n/a	n/a	0.7%	0.5%
30-day Misuse of Prescription				
Drugs				
Grades 10 & 12	n/a	n/a	n/a	9%
Source: Prevention Needs Assessment				

		e onege staaten	•5
	2005 Core Survey	2009 NCHA Survey	
30-day Marijuana Use			
Age 23 or younger	13%		
30-day Methamphetamine¹ Use			
Age 23 or younger	2%		
Notes: 1. Survey question asked about amp	phetamines and me	thamphetamines.	

Table 8. Other Drug Use Among Northwest College Students

4. Causal Areas / Risk Factors

4.1 Community Norms

Various needs assessments and coalition planning efforts have identified community norms as a causal factor for substance abuse in Park County. Norms are defined as the behaviors, attitudes, and beliefs of a majority of the population, or, in other words, what individuals believe "most" people do and think. Extensive work in Park County has shown that perceived norms (that is, what individuals think the norms are) are often incorrect. This is especially true among youth. For example, many youth significantly over-estimate the prevalence of smoking among adults and among their peers. The research clearly shows that abuse increases as individuals over-estimate the prevalence of substance abuse in their peer group or community.

For the first time, the 2008 Prevention Needs Assessment (PNA) measured perceptions of peer use of alcohol, tobacco, and other drugs. The following figures indicate the misperceptions among youth.

10th Grade		0%	25%	50%	75%	100%
Alcohol	Actual (36%) Perceived Norm (94%)					
Marijuana	Actual (12%) Perceived Norm (85%)					
Methamphetamines	Actual (0%) Perceived Norm (64%)	-				
Illegal Drugs	Actual (15%) Perceived Norm (79%)]			
Binge Drinking	Actual (22%) Perceived Norm (90%)					
Cigarettes	Actual (18%) Perceived Norm (85%)					-
Chewing Tobacco	Actual (5%) Perceived Norm (83%)					

12th Grade		0%	25%	50%	75%	100%
Alcohol	Actual (42%) Perceived Norm (94%)					
Marijuana	Actual (16%) Perceived Norm (83%)]			_
Methamphetamines	Actual (1%) Perceived Norm (52%)					
Illegal Drugs	Actual (17%) Perceived Norm (77%)					
Binge Drinking	Actual (29%) Perceived Norm (87%)					
Cigarettes	Actual (16%) Perceived Norm (80%)					
Chewing Tobacco	Actual (9%) Perceived Norm (77%)					

Note: Actual indicates percent of students who reported use of the drug. Perceived Norm indicates percentage of students who thought **most students** used the drug.

During the summer of 2008, a survey of adults throughout Wyoming was conducted to measure their behaviors and beliefs about alcohol use. Adults over estimated the prevalence of underage drinking (81% of Park County adults believed most high school students in their community drink 3 or more times per month).

Most adults believed that binge drinking by adults is wrong (55% of Park County adults strongly or somewhat agreed that "it is wrong for men to drink five or more drinks or women to drink four or more drinks on one occasion"). However, many did not think that other community members would agree with them (66% of Park County adults did not perceive most Wyoming adults would agree that "it is wrong for men to drink five or more drinks or women to drink four or more drinks on one occasion").

Most adults had not driven while under the influence of alcohol in the past year (88% of Park County adults reported that they had not driven under the influence in the past 12 months). However, many adults perceived that others had (46% of Park County adults perceived most Wyoming adults had driven under the influence of alcohol in the past 12 months).

Most adults believed that driving while impaired is wrong (95% of Park County adults strongly agreed that "it is wrong to drive after drinking enough alcohol to be impaired"). However, many did not think that others felt the same way (56% of Park County adults did not perceive most Wyoming adults would strongly agree that "it is wrong to drive after drinking enough alcohol to be impaired").

Most adults strongly supported intervening to prevent someone from driving after having too much to drink (91% of Park County adults strongly agreed that "people should intervene to prevent someone from driving after drinking enough alcohol to be impaired"). However, many did not think others would agree (58% of Park County adults did not perceive most Wyoming adults would strongly agree that "people should intervene to prevent someone from driving after drinking enough alcohol to be impaired").

Prevention efforts in Park County have worked to correct misperceptions held by many different groups about community norms regarding substance abuse. These efforts have included working with youth, parents, schools, Northwest College, adults in the community, and the judicial system (including law enforcement). Based on the recent data, there is clearly much work needed to be done in this area.

4.2 Availability

As a substance is more available, its use increases. As a substance is less available, its use decreases. The single largest source of alcohol to underage youth is adults over the age of 21 other than parents (see Figure 1). Therefore, social availability of alcohol is a significant causal factor for underage drinking.





Presently, Wyoming, Cody, and Powell do not have a smoke-free ordinance. The research shows that as the availability of smoking environments decreases, tobacco use decreases as well. Presently, 95% of Park County restaurants are smoke-free. However, this community norm of wanting smoke-free restaurants has not been codified in a law or city ordinance.

4.3 Low Commitment to School

The 2008 Prevention Needs Assessment indicated that 46% of high school students are at-risk for substance abuse based on a low commitment to school. For high school students, school is a significant part of their daily life. Students who drop out of school are at much greater risk for a wide array of risky behaviors including substance abuse. Therefore, it is critical to develop and promote activities which improve bonding to school.

4.4 Low Family Attachment for Specific Populations

Populations of youth that have been placed out of the home are at significantly higher risk for a wide variety of challenges including teenage pregnancy, dropping out of high school, dropping out of college, and substance abuse. These youth need a wide variety of services including life skills training, healthy relationships with positive adult role models, and financial support.

4.5 Lack of Early Intervention (Level .5) Resources (family, youth, and adults) Presently, Park County provides very limited evidenced-based early interventions for families, youth, and adults with early warning signs of problems. This is an area where various agencies are seeking to provide better services. The research shows that appropriate early intervention with selected (e.g., identified as at-risk for a problem) or indicated (e.g., identified as having a problem) populations can significantly reduce the incidence of more severe problems later. Early intervention efforts are being developed to serve three key populations: families identified by schools as needing extra support; youth (high school and college) identified as using alcohol, tobacco, or other drugs; and adults who may self-refer or be referred by family members or workplaces with early problems with alcohol.

5. Areas for Future Investigation

The following are three areas identified for future exploration given available resources:

- 1. alcohol, tobacco, and other drug use among pregnant women
- 2. prescription drug abuse
- 3. drug abuse among senior citizens

<u>6. Community Agencies, Resources, and Activities</u> (alphabetical comprehensive listing)

F

Agency / Organization	Prevention Activities / Programs
Big Brothers/ Big Sisters (Powell)	Adult mentoring for youth.
Boy's and Girl's Clubs of Park County Cody, Powell	After-school and summer programming; Smart Moves Program
Bright Futures Mentoring Program Cody	Adult mentoring for youth.
City of Cody After-School Activities Program (ASAP)	After-school and summer programming; life and leadership skills
Cody Police Department	Periodic alcohol compliance checks with alcohol retailers.
Crisis Intervention Services Cody, Powell	Life Skills Training Program
Dano Youth Camp	Summer leadership development program for youth.
Future Farmers of America (FFA) Cody, Powell	Providing in-school and out-of-school activities for youth.
Head Start Cody, Powell	
Meeteetse Recreation District	After-school and summer programming for youth including life skills.
Northwest College Student Success Center	On-site chemical dependency counselor; BASICS intervention; prevention activities with various teams; presentations
Northwest Wyoming Family Planning (NWFP) Cody, Powell	Unintended pregnancy prevention, STD prevention, basic reproductive health services.
NOWCAP	
Park County Drug Court	A program providing an alternative to jail for certain, qualifying adult offenders. Program includes counseling, life skills, job skills, and regular monitoring.
Park County Public Health	Best Beginnings Program provides counseling and education for new mothers. Nurse Family Partnership for first time mothers.
Park County School District #1 Powell	All-Stars, elementary after-school and summer programming, middle and high school health classes; Onsite Prevention Counselor; WHAT'S UP
Park County School District #6 Cody	Here's Looking at You (middle and high school health classes); Onsite Prevention Counselor; WHAT'S UP
Park County Sheriff's Office DARE Program- 5th Grade classes	DARE Education program.
Park County Youth Services Cody, Powell	Alcohol MIP Diversion Program

Agency / Organization	Prevention Activities / Programs
Powell Police Department	Periodic alcohol compliance checks with alcohol retailers; TIPS Beverage Service Training; efforts to address adults who supply alcohol to youth.
Powell Valley Community Education	Community education on a wide array of topics; intense driver education programs for youth.
Powell Valley Health Care Hospital Powell	Provides TEG/TAP tobacco cessation services (youth) as well as Treating Nicotine Together services (adults)
UW Cooperative Extension Agency: 4-H	After-school and summer programming; youth leadership development; character development
West Park Hospital's Cedar Mountain Center Cody, Powell	Comprehensive substance abuse treatment including outpatient, intensive outpatient, and inpatient treatment. Also provides licensed chemical dependency counselors to high schools and Northwest College. Provides Level 0.5 intervention for youth (WHATS UP).
West Park Hospital's Prevention and Wellness Office	Provides strategic design, planning, and implementation for comprehensive substance abuse prevention throughout the county; nicotine cessation services (WY Quit Tobacco Program); independent living skills program for youth who have had out-of- home placement.
WIA Cody Employment Center	
Women's Wellness / Migrant Health Program Powell	
Yellowstone Behavioral Health Center Cody, Powell	Comprehensive mental health services to include co- occurring treatment for mental health and substance abuse, transitional housing, family-based therapy; Gate Keepers Suicide Prevention
Young Marines Program	After-school and summer programming for youth including leadership and life-skills training.



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Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later

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Abstract

Objectives: Alcohol screening and brief interventions in medical settings can significantly reduce alcohol use. Corresponding data for illicit drug use is sparse. A Federally funded screening, brief interventions, referral to treatment (SBIRT) service program, the largest of its kind to date, was initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in a wide variety of medical settings. We compared illicit drug use at intake and 6 months after drug screening and interventions were administered.

Design: SBIRT services were implemented in a range of medical settings across six states. A diverse patient population (Alaska Natives, American Indians, African-Americans, Caucasians, Hispanics), was screened and offered score-based progressive levels of intervention (brief intervention, brief treatment, referral to specialty treatment). In this secondary analysis of the SBIRT service program, drug use data was compared at intake and at a 6-month follow-up, in a sample of a randomly selected population (10%) that screened positive at baseline.

Results: Of 459,599 patients screened, 22.7% screened positive for a spectrum of use (risky/problematic, abuse/addiction). The majority were recommended for a brief intervention (15.9%), with a smaller percentage recommended for brief treatment (3.2%) or referral to specialty treatment (3.7%). Among those reporting *baseline illicit drug use*, rates of drug use at 6-month follow-up (4 of 6 sites), were 67.7% lower (p < 0.001) and heavy alcohol use was 38.6% lower (p < 0.001), with comparable findings across sites, gender, race/ethnic, age subgroups. Among persons recommended for brief treatment or referral to specialty treatment, self-reported improvements in general health (p < 0.001), mental health (p < 0.001), employment (p < 0.001), housing status (p < 0.001), and criminal behavior (p < 0.001) were found.

Conclusions: SBIRT was feasible to implement and the self-reported patient status at 6 months indicated significant improvements over baseline, for illicit drug use and heavy alcohol use, with functional domains improved, across a range of health care settings and a range of patients. Published by Elsevier Ireland Ltd.

Keywords: Services; Treatment; Prescription drug abuse; Preventive medicine; Marijuana; Cocaine; Heroin; Methamphetamine; CPT[®] codes; Primary health care; Trauma centers

1. Introduction

Substance abuse is a major public health burden worldwide, contributing significantly to morbidity and mortality (World Health Organization (WHO), 2002, 2008). In the United States,

the 2006 National Survey on Drug Use and Health (NSDUH) estimated that 22.6 million people harbor a diagnosable (DSM-IV) alcohol or illicit drug use disorder (15.6 million: alcohol disorder alone; 3.8 million: illicit drug use disorder; 3.2 million: combined alcohol and drug disorder, Substance Abuse and Mental Health Services Administration, 2007a). Yet, it is estimated that the vast majority of this population, 95.5% do not recognize they harbor a problem and do not seek treatment. If one factors in risky, problematic use, the public health burden

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may even exceed that of populations with more severe substance abuse conditions (Institute of Medicine, 1990). Alcohol and illicit drug abusers are also at higher risk for the burgeoning problem of misuse or abuse of prescription medications (Carise et al., 2007; Huang et al., 2006; McCabe et al., 2006; McCabe and Teter, 2007).

To alleviate this public health burden, the World Health Organization and others developed sensitive screening questionnaires capable of identifying a continuum of substance use and brief interventions (e.g. Babor et al., 2001; Gavin et al., 1989; Knight et al., 2002; WHO, 2008). A positive screen with low to moderate risk prompts a protocol-driven brief intervention, which has been repeatedly shown to reduce alcohol intake, and associated injury recidivism, driving under the influence, and other adverse consequences (Babor and Higgins-Biddle, 2001; Babor et al., 2007; Burke et al., 2003; Cuijpers et al., 2004; Fleming et al., 1997, 2002; Gentilello et al., 1999, 2005; Schermer et al., 2006; Whitlock et al., 2004). Based on the preponderance of evidence, the World Health Organization, the United States Preventative Services Task Force, (United States Preventive Services Task Force, 2004) and the Committee on Trauma of the American College of Surgeons have endorsed routine alcohol screening and brief interventions in primary health care settings and Level I Trauma Centers (American College of Surgeons, Committee on Trauma, 2007; Substance Abuse and Mental Health Services Administration, 2007c).

The documented effectiveness of SBI for reducing heavy alcohol use is extensive, but corresponding research for illicit or prescription drug abuse is sparse, even though evidence is mounting that medical conditions are overrepresented in illicit drug abusers (e.g. Mertens et al., 2003, 2005; Swanson et al., 2007). Investigator-initiated research (e.g. Bernstein et al., 2005; Copeland et al., 2001) and a World Health Organization (WHO) sponsored study of screening and brief interventions for illicit drugs (marijuana, cocaine, amphetamine-type stimulants, opioids) are gradually filling this void. In the WHO-sponsored randomized control, multi-national study, SBI yielded significant short-term reductions (\sim 3 months) in illicit drug use in combined data from 731 participants (World Health Organization, 2008).

In 2003, the largest SBIRT service program of its kind was implemented by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Administration (SAMHSA). Designated screening, brief intervention, and referral to treatment (SBIRT) service, the program has screened over 690,000 to date. SBIRT programs for states and tribal organizations were implemented in various healthcare sites (inpatient, emergency departments, ambulatory, primary and specialty healthcare settings, and community health clinics). Patients were screened concurrently for illicit drug abuse and alcohol consumption, and those screening positive were determined to be in need of a brief intervention, brief treatment, or referral to specialty care, based on score severity. A random sample of populations screening positive and recommended for brief intervention, brief treatment or referral to treatment were interviewed 6 months after receiving SBIRT services, in accordance with reporting requirements of the Government Performance

and Results Act (GPRA) Client Outcome Measures for Discretionary Programs.

We now describe secondary data analysis of these outcome measures, based on screening results of 459,599 people. The uniqueness of this report resides in the large population sample, the heterogeneity of the population, the varied healthcare settings, the diversity of personnel and SBI procedures, and the service orientation of the program.

Given the copious data in support of SBI procedures for reducing heavy alcohol use and the paucity of published reports on SBI effectiveness for illicit drug abuse, we focused on feasibility and outcome measures of illicit drug screening and interventions. Alcohol screening results were included for several reasons. The new (2008) SBI procedural and reimbursable codes for these services adopted by the AMA CPT®, by Medicare (CMS), and Medicaid (CMS) bundle screening and brief interventions for alcohol and other drugs into a single service. Since there is strong scientific evidence, based on randomized control trials, that SBI is effective for reducing heavy alcohol use, we included alcohol results in the study to serve as a standard for validation and for comparison with randomized control trials. Based on the large, diverse populations provided these services in range of healthcare settings, the information is critical for healthcare professionals motivated to provide SBI services for all intoxicants in various settings. Finally, both data sets provide estimates of the relative incidence of alcohol and drug abuse, in healthcare settings.

In this secondary analysis, we addressed the following: (1) Was screening for any illicit drug use feasible in the context of simultaneous screening for heavy alcohol use, in general healthcare settings? (2) Was drug use altered 6 months later in persons screening positive for illicit drug? (3) Were there significant variations in 6-month outcomes as a function of age, gender, and race/ethnicity? (4) For patients that screened positive and designated in need of brief treatment or referred to specialty care, did health and social outcomes change?

2. Methods

2.1. Sites and clinical procedures

All sites used "universal screening", that is, screening everyone who came through the door of the site (ED or clinic), unless the patient was too ill, very old, or already had been screened. Although there was not a standard protocol across all sites for approaching patients, each site typically had a "script" to follow. The number of screen positive clients was comparable to what is reported in the literature.

Table 1 summarizes the clinical procedures used by SBIRT programs (sites located in each of the six states are coded Sites 1–6, respectively). Screening was conducted by a wide range of health care personnel with varied backgrounds, all of whom were hired specifically for these projects. The majority of patients presented in healthcare settings for other purposes, and were approached to answer questions related to substance abuse. From site to site, screening questionnaires varied. Thresholds for interventions varied from site to site. Overall, a positive screen for heavy alcohol use was defined as reporting over the past 30 days more than five drinks in one sitting or within a brief period of approximately 1–2 h. Illicit drug use within the past 30 days constituted a positive screen, regardless of the amount used. Generally, patients with low risk use patterns for alcohol and no drug use, received screening only; those with moderate risk alcohol use pat-

Table 1	
Feasibility of screening across all sites	

Site	Healthcare settings	Screening tools	Number screened	Screen positive% (<i>n</i>)	BI tools	BI% (n)	BT tools	BT% (<i>n</i>)	RT% (n)
1	Trauma centers; emergency rooms; primary health care centers; hospitals (inpatient/outpatient)	DAST; AUDIT	191,037	18.7 (35,816)	Custom protocols based on FRAMES	14.6 (27,967)	Six sessions based on FRAMES and cognitive behavior therapy	2.4 (4,519)	1.7 (3,330)
2	Trauma centers' emergency room; hospitals (inpatient/outpatient)	DAST; AUDIT	69,112	39.9 (27,551)	Feedback on DAST and AUDIT; motivational interviewing to explore patient views of use and develop change strategies	24.9 (17,198)	Provider choice (without a structured curriculum)	5.9 (4,078)	9.1 (6,275)
3	Emergency rooms; inpatient and outpatient services; primary care health centers; hospitals (inpatient/outpatient); other	Quantity and frequency of alcohol consumption; CAGE (modified for drugs); DAST; AUDIT	68,185	20.9 (14,239)	Custom protocols based on FRAMES	12.9 (8,773)	Motivational interviewing intervention	3.5 (2,368)	4.5 (3,098)
4	Emergency rooms; primary care health centers; hospitals (inpatient/outpatient)	CAGE; drug abuse items; quantity and frequency of alcohol consumption	60,111	22.8 (13,702)	Custom protocols based on FRAMES	16.1 (9,704)	Motivational enhancement therapy	2.1 (1,292)	4.5 (2,706)
5	Rural primary health care clinics; public health offices; school health clinics; one rural hospital	AUDIT (adapted for drugs); CRAFFT (for adolescents)	51,078	16.6 (8,490)	Clinical motivational intervention and telephone follow up (telehealth) counseling	12.5 (6,404)	Cognitive behavioral therapy, assertive community reinforcement approach (for adolescents)	3.4 (1,725)	0.7 (361)
6	Primary health care centers	AUDIT plus drug abuse item	20,076	23.4 (4,707)	Custom protocols based on FRAMES	14.5 (2,908)	Six to eight sessions focused on patient education and motivation	2.6 (516)	6.4 (1,283)
Total	-	-	459,599	22.7 (104,505)	-	15.9 (72,954)	-	3.2 (14,498)	3.7 (17,053)
Total among screen positives	-	-			-	69.8 (72,954)	-	13.9 (14,498)	16.3 (17,053)

Settings, screening tools, number of patients screened, intervention tools and proportion receiving brief intervention (BI), brief treatment (BT) or referral to specialty treatment (RT) at each site. AUDIT: Alcohol Use Disorders Identification Test; DAST: Drug Abuse Screening Test; CAGE: Cut Down, Annoyed, Guilt, Eye-opener Questionnaire; FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy, and Self-Efficacy.

terns and/or illicit drug use received brief interventions, those with heavy alcohol use patterns and/or heavy illicit drug use received brief treatment, and patients that fulfilled criteria for addictive patterns of behavior (compulsive drug-seeking behavior, loss of control over use, adverse consequences) were referred to specialty care. Brief interventions generally followed a scripted program, which varied by site. Currently, SBIRT sites use the ASSIST screening tool (WHO, 2008) which provides clear guidance on the relationship between scores and levels of severity of substance use.

Personnel were trained at each site in SAMHSA-sponsored training sessions, prior to initiation of the SBIRT program. We report the number of persons who were screened and the proportions recommended for brief intervention (BI), brief treatment (BT) and referral to specialty treatment (RT).

Site 1 integrated substance abuse screening services into emergency rooms in hospitals and medical centers, Federally-qualified health centers (FQHCs), and community health clinics in a single large urban county. Peer health educators conducted screening using the Drug Abuse Screening Test (DAST) and the Alcohol Use Disorders Identification Test (AUDIT) Babor et al., 2001; Gavin et al., 1989). Brief interventions were also conducted by peer health educators using the Feedback, Responsibility, Advice, Menu of options, Empathy, and Self-Efficacy (FRAMES) model with motivational interviewing to raise awareness of the risks of substance use, to assess motivation for change, and to helping persons commit to utilizing self-management skills for changing their substance abuse behaviors. Brief treatment involved one session of enhanced brief intervention and motivational interviewing, one assessment session, and four additional sessions based on the cognitive behavioral treatment (CBT) model (Carroll, 1998). Referrals to specialty care were based on collaborative relationships with 19 specialized treatment agencies. Service features included bilingual staff; English/Spanish interpretation for medical staff as well as patients; on-site referral services, including referrals/transportation of intoxicated patients to sobering services; and continued management support through phone calls, e-mails, letters, or inperson contacts during medical visits. Of the 191,037 patients screened, 27,967 (14.6%) were recommended for a brief intervention, 4519 (2.4)% were recommended for a brief treatment, and 3330 (1.7)% were recommended for a referral to specialty treatment.

Site 2 provided SBIRT services for adults in emergency room departments and trauma centers and is affiliated with nine urban hospitals. The site also had established relationships with 12 specialized treatment agencies. Screenings were performed by substance abuse professionals using the AUDIT and a brief version of the DAST (Babor et al., 2001; Gavin et al., 1989). Brief interventions were conducted immediately following the screening for those patients who scored in moderate or high-risk range. Addicted patients were referred to a certified treatment provider for care. Linkages between screening sites and community provider agencies allowed for seamless transition of patients from screening, to brief intervention, to brief treatment, and/or to traditional addiction services. Of the 69,112 patients screened at Site 2, 17,198 (24.9%) were recommended for a brief intervention, 4078 (5.9%) were recommended for a brief treatment and 6275 (9.1%) were determined to need referral to secondary treatment.

Site 3 provided services in community clinics, school clinics, and hospitals within a single large urban county health district. Services were provided at over 15 sites, and at these sites, healthcare professionals performed screenings using the National Institute on Alcohol Abuse and Alcoholism (NIAAA) quantity and frequency question, a single substance use question (SSUQ) related to drug abuse, and the CAGE-AID (Cut down, Annoyed, Guilty, Eye-opener-Adapted to Include Drugs), (Ewing, 1984; Brown and Rounds, 1995). Staff specialists completed a brief assessment using the AUDIT and the DAST, and conducted brief interventions using the FRAMES model (Babor et al., 2001; Gavin et al., 1989). Patients addicted to alcohol or drugs were referred to the local treatment council for further assessment, referral, and placement. Of the 68,185 patients screened in Site 3, 8773 (12.9%) were recommended for a brief intervention, 2368 (3.5%) were recommended for a brief treatment, and 3098 (4.5%) were recommended for a referral to specialty treatment.

Site 4 services were provided in three hospitals, six health centers, and one outpatient clinic, operated by a large urban bureau of health services in conjunction with a group of local substance abuse treatment programs. General health care staff conducted screening, using an instrument that incorporated three quantity-frequency and four CAGE questions for alcohol and a two-item screen for drugs (Ewing, 1984). Brief interventions, which were conducted

using the FRAMES model, consist of two sessions for hospital patients, two to six sessions for community health center patients, and one session for emergency department patients. Licensed behavioral health counselors, primary care providers, and community health workers/case managers conducted the brief interventions in community health centers, and SBIRT counselors conducted brief interventions in hospital and emergency department settings. Brief treatments were conducted using motivational enhancement therapy strategies at participating treatment centers and community clinics. Of the 60,111 patients screened in Site 4, 9704 (16.1%) were recommended for a brief intervention, 1292 (2.1%) were recommended for a brief treatment, and 2706 (4.5%) were recommended for a referral to secondary treatment.

Site 5 provided services across a broad rural area through over 30 primary health clinics, public health offices, and school-based clinics and had established relationships with six specialized treatment agencies. Health care providers conducted screenings using a Personal Health Profile, the Substance Abuse Subtle Screening Inventory, the AUDIT-AID, and the Mental Health Screening Form III (Babor et al., 2001; Lazowski et al., 1998). Screening of adolescents was conducted using the Health Lifeways Questionnaire, the Car, Relax, Alone, Forget, Family, Friends or Trouble (CRAFFT) instrument, and the Depression Identification and Treatment Protocol (Knight et al., 2002). Licensed behavioral health counselors and primary care providers made referrals for brief interventions and to Community Health Workers/Case Managers. Telehealth technology was used to conduct patient clinical interviews and counseling at over 20 telehealth sites. Licensed behavioral health counselors conducted brief treatment, using protocols and modalities based primarily on brief cognitive behavioral therapy. Adolescent brief treatment was conducted using the Adolescent Community Reinforcement Approach (ACRA) and the Alcohol Treatment Targeting Adolescents in Need (ATTAIN) model (Gil et al., 2004; Godley et al., 2007). Referrals to community mental health centers or other substance abuse treatment providers were made only for those who failed to respond to brief intervention/treatment or those whose life situations were unstable. Of the 51,078 patients screened at Site 5, 6404 (12.5%) were recommended for brief intervention, 1725 (3.4%) were recommended for brief treatment, and 361 (0.7%) were recommended for a referral to secondary treatment.

Site 6 served a modest sized metropolitan area along with a large, widely distributed rural population through a primary care center that routinely conducted screenings on all applicants for services. Announcements for the project were frequently presented in the community through press releases, newspaper ads, and radio broadcasts. Specialists conducted screening using the AUDIT plus one drug use question (Babor et al., 2001). Brief interventions consisted of up to five, 15-min sessions using motivational interviewing and the FRAMES, which were incorporated into basic substance abuse education and goal setting, to lower or eliminate high-risk behaviors. Brief treatment consisted of six to eight weekly sessions (30-60 min each) focused on educating the patient about substance abuse, building motivation to quit, analyzing the patient's drinking/drugging pattern and identifying situations that precipitate relapse. Patients were assessed and referred to traditional treatment and continuing care provided by several local treatment agencies. Importantly, if a person was waitlisted, the SBIRT program offered pre-treatment group counseling and case management for up to 6 months. Of the 20,076 patients screened in Site 6, 2908 (14.5%) were recommended for a brief intervention, 516 (2.6%) were recommended for a brief treatment, and 1283 (6.4%) were recommended for referral to specialty treatment.

2.2. Data collection

Data elements are from the administratively required data for the CSAT SBIRT grant program through August 1, 2007, based on the CSAT Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs (Substance Abuse and Mental Health Services Administration, 2007b). No patient identifiers are included in submitted data. Grantees are not required to seek IRB approval since data collected is for administrative, not research, purposes. That being said, 5 of the 6 sites did seek and received IRB approval.

At intake, age, gender, and race/ethnicity were recorded on all patients screened at each site. Race/ethnicity were determined using the GPRA tool. Participants are asked to respond to questions at intake (baseline) and can respond "yes", "no" or "refused" to the following self-identifiers: Hispanic or Latino (and further refined into country of origin), Black or African American, Asian, Native Hawaiian or other Pacific Islander, Alaska Native, White, American Indian.

For those with negative screens, demographic data alone were collected. Based on the degree of problems identified, positive screens were referred to one of three different levels of intervention: brief intervention (BI), brief treatment (BT), or referral to specialized treatment (RT). Patients who screened negative were not offered any intervention, but it has been noted that the process of screening alone has been shown to be effective (Saitz et al., 2007).

Baseline information on all patients requiring any level of intervention included demographic data and information about past 30 day use of alcohol and illicit drugs, and for some locations, prescription drug abuse, as documented in the "other drug" category. For this report, rates were calculated for any past 30-day use of an illicit substance and any past 30-day use of alcohol to intoxication ("heavy alcohol use"). For patients determined to need either a BT or RT (i.e. the more intense levels of intervention), additional baseline measures of past 30 day income, education, employment, family and living conditions, mental illness, general physical health, sexual behavior, housing, social connectedness, and criminal behavior were also documented.

Outcomes were evaluated at 6-month post intake. Across the six sites, only those who screened positive and recommended for interventions were in the follow-up pool, and of this population, the majority (more than 63%) received an intervention (BI, BT, or RT). To be conservative, all analysis was conducted using an "intent to treat" approach so that patients requiring an intervention were assessed regardless of whether or not they actually received the intervention. Patients were selected for follow-up by the following method: each grantee was given a randomly selected 10-digit range by SAMHSA (e.g. 20-29). If the last two digits of the SSN fell into the randomly selected range, the patient became part of the follow-up sample. Outcomes assessed at this follow-up depended on the level of intervention. For patients recommended for a BI, substance abuse measures were repeated at follow-up. For those who were determined to need a BT or RT, follow-up also included repeat assessment of the additional baseline measures of general health status, mental health, social functioning, sexual risk taking, and criminal behavior. Six-month follow-up was conducted either by phone or in person within a range of 30 days prior to or 60 days after the anniversary date. Follow-up rates varied considerably.

Grantees were required to sample 10% of those that were classified as BI, BT or RT. Each grantee was given a range of digits and those social security numbers that fell within those digits were used for follow-up samples. The follow-up rate is derived by the number of patients within the fixed sample size due that were contacted. In four of six sites the rate exceeded 70% and outcome measures are compared for all sites and for sites with high follow-up levels.

Site 1 had a follow-up rate of 25.3%; Site 2: 74.2%; Site 3: 38.8%; Site 4: 95.9%; Site 5: 72.3%; and Site 6: 81.6%, of the follow-up rate required by GPRA. The lower rate of follow-up at Site 1 (which used the standard randomly selected sample) was due to program interruption, and consequent reduced follow-up rate. Nevertheless, results from Site 1 were comparable to the other sites. At Site 3, the reduced rate was due to the initial protocol, which attempted to conduct follow-up of patients via an office visit at 6 months. The low response to a request for an office visit led Site 3 to follow-up via phone interviews. The initial follow-up method could have resulted in bias in self-reports. Among persons queried at baseline and follow-up, average missing data rates were as follows: Site 1: 0.9% missing; Site 2: 1.2% missing; Site 3: 1.1% missing; Site 4: 0.1% missing; Site 5: 0.1% missing; and Site 6: 10.3% missing. Across all the baseline and follow-up interviews, 2.4% of responses were missing. No imputation was done. Only cases with valid responses were included in each analysis.

2.3. Data analysis

Output and data analyses for this report were generated using SAS software, Version 9.3.1 (SAS Institute, Cary, NC, 2000). Cross tabs function was used to determine rates according to site and demographic subgroup. Comparisons of baseline to follow-up rates of all outcome variables were tested for statistical significance (two-tailed p < 0.05) using the paired *t*-test. Comparisons were not tested when there were fewer than 10 subjects reporting use of a particular substance at baseline. Analyses were conducted on each site separately because of considerable variation of sites in patient characteristics, clinical interventions, and follow-up rates. Summary statistics are provided for the combined sites. We recognize that conducting multiple *t*-tests can generate false positives, but the robust statistical significance in the majority of data sets (see Tables 3–8) is consistent with the overall direction of the results across sites.

Table 2

Mean age, gender and racial/ethnic composition of patients screened at each site

State	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Total	
Overall N	191,037	69,112	68,185	60,111	51,078	20,076	459,599	
Race/ethnicity								
%African American	9.2	9.7	28.4	68.7	0.5	0.4	18.5	
%Asian	5.9	1.6	1.9	3.7	0.2	0.1	3.3	
%Native Hawaiian/Pacific Islander	1.0	0.8	0.01	0.2	0.1	0.04	0.5	
%Alaska Native	0.03	0.3	0	0.01	0.03	87.8	4.3	
%Caucasian	57.8	78.5	18.1	11.5	84.0	2.8	49.6	
%American Indian	1.4	7.0	0.5	0.2	13.9	5.9	3.7	
%Other	24.1	1.2	16.6	0.9	0.4	0.4	12.1	
%Multi-racial	0.3	0.9	3.7	0.01	0.03	2.1	0.9	
%Hispanic	36.5	9.8	49.8	20.8	63.8	0.7	33.9	
Mean age (S.D.)	48.7	37.4	44.1	47.4	39.2	37.7	44.6	
%Female	57.5	48.5	54.2	50.5	57.6	60.2	54.9	
Screen positive (<i>n</i>)	35,816	27,551	14,239	13,702	8,490	4,707	104,505	
Substance endorsed among those screeni	ng positive ^a							
Heavy alcohol% (n)	55.3	55.0	55.6	43.6	49.0	42.1	52.6	
Marijuana% (n)	20.8	31.3	21.3	27.8	28.7	15.5	24.9	
Cocaine% (n)	3.4	14.2	24.6	30.3	6.9	4.9	13.0	
Methamphetamines $\%$ (<i>n</i>)	7.2	9.9	1.8	0.10	2.2	0.6	5.5	
Heroin% (<i>n</i>)	1.6	6.0	1.4	18.8	2.3	0.3	5.0	
Other drugs% (n)	4.6	9.7	10.0	3.4	6.6	2.0	6.6	

^a May add to greater than 100% if patients endorsed multiple substances and may add to less than 100% if patients screen positive for problematic alcohol consumption in the absence of heavy alcohol use or changed their responses between the screening protocol and when they were queried about substance consumption.

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Table 3
Use of substances at baseline and follow-up among those reporting heavy alcohol and/or illicit drug use at baseline

Substance	Site	N ^a	Heavy alcohol (<i>n</i>) %		Marijuana (<i>n</i>) %		Cocaine (<i>n</i>) %		Methamphetamine (n) %		Heroin (n) %		Other drugs (n) %	
			Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U
	1	2996	(2511) 83.8	(1191) 39.8***	(756) 25.2	(377) 12.6***	(98) 3.3	(40) 1.3***	(175) 5.8	(57) 1.9***	(31) 1.0	(10) 0.3***	(169) 5.6	(56) 1.9***
	2	3258	(2363) 72.5	(1132) 34.7***	(1360) 41.7	(572) 17.6***	(648) 19.9	(174) 5.3***	(455) 14.0	(111) 3.4***	(266) 8.2	(78) 2.4***	(414) 12.7	(223) 6.8***
A h	3	3212	(2549) 79.4	(441) 13.7***	(829) 25.8	(86) 2.7***	(981) 30.5	(63) 2.0***	(83) 2.6	(3) 0.1***	(60) 1.9	(4) 0.1***	(351) 10.9	(23) 0.7***
Any neavy alconol or	4	811	(281) 34.6	(251) 30.9	(300) 37.0	(145) 17.9***	(367) 45.3	(109) 13.4***	-	-	(242) 29.8	(86) 10.6***	(35) 4.3	(9) 1.1***
hereiting reported at	5	887	(706) 79.6	(370) 41.7***	(412) 46.4	(215) 24.2***	(101) 11.4	(34) 3.8***	(24) 2.7	(4) 0.5***	(28) 3.2	(9) 1.0***	(91) 10.3	(28) 3.2***
baseline	6	1120	(1027) 91.7	(349) 31.2***	(389) 34.7	(86) 7.7***	(108) 9.6	(26) 2.3***	(15) 1.3	$(0) \ 0.0^{***}$	-	-	(49) 4.4	(8) 0.7***
	Total (Sites:	12284	(9437) 76.8	(3734) 30.4***	(4046) 32.9	(1481) 12.1***	(2303) 18.7	(446) 3.6***	(753) 6.1	(175) 1.4***	(634) 5.2	(189) 1.5***	(1109) 9.0	(347) 2.8***
	1–6)													
	Total (Sites: 2,	6076	(4337) 72.0	(2102) 34.6***	(2461) 40.5	(1018) 16.8***	(1224) 20.1	(343) 5.6***	(495) 8.1	(115) 1.9***	(543) 8.9	(175) 2.9***	(589) 9.7	(268) 4.4***
	4, 5, 6)													
	1	2511	100.0	(1095) 43.6***	(420) 16.7	(252) 10.0***	(61) 2.4	(27) 1.1***	(76) 3.0	(26) 1.0***	(12) 0.5	(5) 0.2	(85) 3.4	(38) 1.5***
	2	2363	100.0	(955) 40.4***	(812) 34.4	(352) 14.9***	(373) 15.8	(94) 4.0***	(211) 8.9	(58) 2.5***	(102) 4.3	(29) 1.2***	(257) 10.9	(134) 5.7***
	3	2549	100.0	(406) 15.9***	(503) 19.7	(59) 2.3***	(648) 25.4	(35) 1.4***	(53) 2.1	(3) 0.1***	(32) 1.3	(1) 0.0***	(201) 7.9	(12) 0.5***
Heavy alcohol reported at	4	281	100.0	(109) 38.8***	(75) 26.7	(30) 10.7***	(104) 37.0	(35) 12.5***	-	-	(39) 13.9	(17) 6.0***	(15) 5.3	(1) 0.4***
baseline	5	706	100.0	(333) 47.2***	(278) 39.4	(161) 22.8***	(73) 10.3	(24) 3.4***	(14) 2.0	(4) .6**	(12) 1.7	(7) 1.0	(55) 7.8	(19) 2.7***
	6	1027	100.0	(325) 32.6***	(316) 30.8	(78) 7.6***	(86) 8.4	(23) 2.2***	-	-	-	-	(35) 3.4	(6) 0.6***
	Total (Sites:	9437	100.0	(3233) 34.3***	(2404) 25.5	(932) 9.9***	(1345) 14.3	(238) 2.5***	(364) 3.9	(91) 1.0***	(201) 2.1	(60) 0.6***	(648) 6.9	(210) 2.2***
	1–6)													
	Total (Sites: 2,	4377	(4337) 100	(1732) 39.6***	(1481) 33.8	(621) 14.2***	(636) 14.5	(176) 4.0***	(235) 5.4	(62) 1.4***	(157) 3.6	(54) 1.2%***	(362) 8.3	(160) 3.7***
	4, 5, 6)													
	1	1022	(537) 52.5	(385) 37.7***	(756) 74.0	(313) 30.6***	(98) 9.6	(33) 3.2***	(175) 17.1	(46) 4.5***	(31) 3.0	(8) 0.8***	(169) 16.5	(41) 4.0***
	2	1978	(1083) 54.8	(623) 31.5***	(1360) 68.8	(502) 25.4***	(648) 32.8	(155) 7.8***	(455) 23.0	(105) 5.3***	(266) 13.4	(76) 3.8***	(414) 20.9	(186) 9.4***
	3	1618	(955) 59.0	(176) 10.9***	(829) 51.2	(81) 5.0***	(981) 60.6	(59) 3.6***	(83) 5.1	(3) 0.2***	(60) 3.7	(4) 0.2***	(351) 21.7	(19) 1.2***
Any illicit drug reported	4	696	(166) 23.9	(212) 30.5**	(300) 43.1	(144) 20.7***	(367) 52.7	(104) 14.9***	-	-	(242) 34.8	(83) 11.9***	(35) 5.0	(9) 1.3***
at baseline	5	495	(314) 63.4	(208) 42.0***	(412) 83.2	(178) 36.0***	(101) 20.4	(29) 5.9***	(24) 4.8	(4) 0.8***	(28) 5.7	(8) 1.6***	(91) 18.4	(27) 5.5***
	6	453	(360) 79.5	(139) 30.7***	(389) 85.9	(72) 15.9***	(108) 23.8	(22) 4.9***	(15) 3.3	$(0) \ 0.0^{***}$	-	-	(49) 10.8	(5) 1.1***
	Total (Sites:	6262	(3415) 54.5	(1743) 27.8***	(4046) 64.6	(1290) 20.6***	(2303) 36.8	(402) 6.4***	(753) 12.0	(158) 2.5***	(634) 10.1	(181) 2.9***	(1109) 17.7	(287) 4.6***
	1–6)													
	Total (Sites: 2,	3622	(1923) 53.1	(1182) 32.6***	(2461) 67.9	(896) 24.7***	(1224) 33.8	(310) 8.6***	(495) 13.7	(109) 3.0***	(543) 15.0	(169) 4.7***	(589) 16.3	(227) 6.3***
	4, 5, 6)													

Two sets of data analyses are shown based on total results from 6 sites and from 4 sites with high follow-up rates. (-) Results suppressed because fewer than 10 subjects reported use of that substance at baseline. *p < 0.05; **p < 0.01; ***p < 0.01.

^a Among subjects qualifying for any level of intervention, the number with data at baseline and follow-up who report the substance listed on the left (i.e. heavy alcohol or illicit drugs, heavy alcohol irrespective of drugs, any illicit drug irrespective of alcohol).

3. Results

3.1. Gender, age, race and ethnicity of patients screened

50% Hispanic patients. population. Site 3 had nearly 50% and Site 5 had greater than casian patients. Site 4 had a predominantly African American groups in Site 6. Sites 1, 2, and 5 had greater than 50% Cau-Alaska Native and American Indians were the two predominant male patients except Site 2 which had a slight excess of males considerably across the six sites. All sites had more female than Qf, nel hired specifically for this purpose (Table 1). The total number and heavy alcohol use was feasible across all sites, with personin Table 2, the demographic characteristics of patients varied patients screened across the six sites was 459,599. As seen Combined screening and brief interventions for illicit drug

a brief intervention, 14,498 (3.2%) were at a moderate level and (15.9%) were at a low clinical level and were recommended for screen, regardless of the amount used. More specifically, 72,954 Illicit drug use within the past 30 days constituted a positive а past 30 days more than five drinks in one sitting or within positive for heavy alcohol use (defined as reporting over the treatment. 14% for a brief treatment and 16% were referred to specialty itive screens, were recommended for referral to specialty treatment. Of poswere determined to need a brief treatment; while, 17,053 (3.7%) brief period of approximately 1-2h) and/or illicit drug use Of the 459,599 persons screened, 104,505 (22.7%) screened 70% were recommended for a brief intervention,

3.2. Baseline and follow-up alcohol and drug use

र्षु use was reported by 5.7%, cocaine by 3.0%, methamphetamine screened, heavy alcohol use was reported by 12.0%, marijuana use 1.3%, GPRA required grantees to report alcohol and illicit drug at intake and 6 months later. Among the full population heroin by 1.1%, and other drugs by 1.5%. Exam-



Use of substances at baseline and follows up among male and famale substances of these parenting any illigit days at baseline

(Table Fig. 1. Among persons reporting illicit drug use at baseline, percent people reporting specific drugs and heavy alcohol at baseline and 6 months after intervention (all p < 0.001). Data are based on the sites with higher follow-up rates 3, bottom row).

Table 4

	Site	N^{a}	Heavy alcohol (n) %		Marijuana (n))%	Cocaine (n) %	б	Methamphe	amine (n) %	Heroin (n) %		Other drugs (n) %	
			Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U
	1	673	(386) 57.4	(276) 41.0***	(512) 76.1	(225) 33.4***	(76) 11.3	(20) 3.0***	(120) 17.8	(27) 4.0***	(18) 2.7	(4) 0.6***	(97) 14.4	(21) 3.1***
	2	1292	(753) 58.3	(402) 31.1***	(908) 70.3	(312) 24.1***	(423) 32.7	(90) 7.0***	(294) 22.8	(65) 5.0***	(178) 13.8	(45) 3.5***	(252) 19.5	(94) 7.3***
	3	1077	(693) 64.3	(138) 12.8***	(565) 52.5	(62) 5.8***	(666) 61.8	(38) 3.5***	(56) 5.2	(3) 0.3***	(38) 3.5	(2) 0.2***	(214) 19.9	(11) 1.0***
	4	472	(115) 24.4	(158) 33.5***	(213) 45.1	(101) 21.4***	(238) 50.4	(70) 14.8***	-	-	(162) 34.3	(59) 12.5***	(19) 4.0	(7) 1.5**
Men	5	275	(172) 62.5	(114) 41.5***	(233) 84.7	(101) 36.7***	(54) 19.6	(14) 5.1***	(13) 4.7	(0) 0.0***	(18) 6.5	(5) 1.8***	(50) 18.2	(2) 7.3***
	6	214	(177) 82.7	(66) 30.8***	(189) 88.3	(38) 17.8***	(40) 18.7	(9) 4.2***	-	-	-	-	(23) 10.7	(3) 1.4***
	Total (Sites: 1-6)	4003	(2296) 57.4	(1154) 28.8***	(2620) 65.5	(839) 21.0***	(1497) 37.4	(241) 6.0***	(490) 12.2	(95) 2.4***	(418) 10.4	(116) 2.9***	(655) 16.4	(156) 3.9**
	Total (Sites: 2, 4, 5, 6)	2253	(1217) 54	(740) 32.8***	(1543) 68.5	(552) 24.5***	(775) 33.5	(183) 8.1***	(314) 13.9	(65) 2.9***	(362) 16.1	(110) 4.9***	(344) 15.3	(124) 5.5**
	1	348	(150) 43.1	(109) 31.3***	(244) 70.1	(88) 25.3***	(22) 6.3	(13) 3.7	(55) 15.8	(19) 5.5***	(12) 3.4	(4) 1.1*	(72) 20.7	(20) 5.7***
	2	685	(329) 48.0	(221) 32.3***	(451) 65.8	(190) 27.7***	(224) 32.7	(65) 9.5***	(161) 23.5	(40) 5.8***	(88) 12.8	(31) 4.5***	(161) 23.5	(92) 13.4**
	3	532	(255) 47.9	(36) 6.8***	(259) 48.7	(19) 3.6***	(308) 57.9	(21) 3.9***	(26) 4.9	(0) 0.0***	(21) 3.9	(2) 0.4***	(137) 25.8	(8) 1.5***
XX 7	4	224	(51) 22.8	(54) 24.1	(87) 38.8	(43) 19.2***	(129) 57.6	(34) 15.2***	-	-	(80) 35.7	(24) 10.7***	((16) 7.1	(2) 0.9***
women	5	219	(141) 64.4	(94) 42. 9***	(178) 81.3	(76) 34.7***	(47) 21.5	(15) 6.8***	(11) 5.0	(4) 1.8*	(10) 4.6	(3) 1.4*	(41) 18.7	(7) 3.2***
	6	237	(181) 76.4	(72) 30.4***	(198) 83.5	(34) 14.3***	(68) 28.7	(13) 5.5***	-	-	-	-	(26) 11.0	(2) 0.8***
	Total (Sites: 1-6)	2245	(1107) 49.3	(586) 26.1***	(1417) 63.1	(450) 20.0***	(798) 35.5	(161) 7.2***	(262) 11.7	(63) 2.8***	(214) 9.5	(65) 2.9***	(453) 20.2	(131) 5.8***
	Total (Sites: 2, 4, 5, 6)	1365	(702) 51.4	(441) 32.3***	(914) 67.0	(343) 25.1***	(468) 34.3	(127) 9.3***	(181) 13.3	(44) 3.2***	(181) 13.3	(59) 4.3***	(244) 17.9	(103) 7.5**

Among subjects qualifying for any level of intervention, the number with data from baseline and follow-up who reported use of one or more illicit drugs at baseline

Substance	Site	N ^a	Heavy alcohol (n) %		Marijuana (n) %		Cocaine (n)	Cocaine (n) %		Methamphetamine (n) %		Heroin (n) %		Other Drugs (n) %	
			Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	
	1	337	(209) 62.0	(164) 48.7***	(285) 84.6	(122) 36.2***	(31) 9.2	(12) 3.6***	(42) 12.5	(5) 1.5***	-	_	(41) 12.2	(18) 5.3**	
	2	526	(333) 63.3	(213) 40.5***	(453) 86.1	(177) 33.7***	(84) 16.0	(21) 4.0***	(100) 19.0	(34) 6.5***	(32) 6.1	(7) 1.3***	(129) 24.5	(59) 11.2***	
	3	256	(150) 58.6	(33) 12.9***	(190) 74.2	(17) 6.6***	(117) 45.7	(3) 1.2***	(31) 12.1	(1) 0.4***	_	_	(79) 30.9	(4) 1.6***	
Variation of the second	4	49	(13) 26.5	(27) 55.1**	(47) 95.9	(25) 51.0***	_	_	_	_	-	-	_	_	
Younger than 25	5	292	(186) 63.7	(128) 44.8***	(259) 88.7	(120) 41.1***	(42) 14.4	(12) 4.1***	(10) 3.4	(2) 0.7*	-	-	(56) 19.2	(19) 6.5***	
	6	135	(104) 77.0	(41) 30.4***	(124) 91.9	(27) 20.0***	(25) 18.5	(5) 3.7***	_	_	-	-	(23) 17.0	(1) 0.7***	
	Total (Sites: 1-6)	1595	(995) 62.4	(606) 38.0***	(1358) 85.1	(488) 30.6***	(304) 19.1	(53) 3.3***	(191) 12.0	(42) 2.6***	(57) 3.6	(9) 0.6***	(328) 20.6	(101) 6.3***	
	Total (Sites: 2, 4, 5, 6)	1002	(636) 63.5	(409) 40.8***	(883) 88.1	(349) 34.8***	(156) 15.6	(38) 3.8***	(118) 11.8	(36) 3.6***	(47) 4.7	(9) 0.9***	(208) 20.8	(79) 7.9***	
	1	249	(153) 61.4	(106) 42.6***	(186) 74.7	(82) 32.9***	(22) 8.8	(8) 3.2**	(52) 20.9	(13) 5.2***	-	-	(37) 14.9	(10) 4.0***	
	2	556	(296) 53.2	(167) 30.0***	(420) 75.5	(147) 26.4***	(158) 28.4	(24) 4.3***	(165) 29.7	(31) 5.6***	(78) 14.0	(23) 4.1***	(112) 20.1	(56) 10.1***	
	3	386	(219) 56.7	(47) 12.2***	(228) 59.1	(26) 6.7***	(213) 55.2	(15) 3.9***	(27) 7.0	(1) 0.3***	(15) 3.9	(2) 0.5***	(116) 30.1	(3) 0.8***	
Age 25–34	4	103	(21) 20.4	(40) 38.8**	(70) 68.0	(34) 33.0***	(37) 35.9	(14) 13.6***	-	-	(19) 18.4	(10) 9.7*	-	-	
	5	68	(50) 73.5	(32) 47.1***	(47) 69.1	(15) 22.1***	(28) 41.2	(8) 11.8***	_	-	-	_	(12) 17.6	(2) 2.9**	
	6	130	(101) 77.7	(41) 31.5***	(108) 83.1	(21) 16.2***	(36) 27.7	(6) 4.6***	-	-	-	-	(14) 10.8	(4) 3.1**	
	Total (Sites: 1-6)	1492	(840) 56.3	(433) 29.0***	(1059) 71.0	(325) 21.8***	(494) 33.1	(75) 5.0***	(255) 17.1	(46) 3.1***	(127) 8.5	(43) 2.9***	(295) 19.8	(76) 5.1***	
	Total (Sites: 2, 4, 5, 6)	857	(468) 54.6	(280) 32.7***	(645) 75.3	(217) 25.3***	(259) 30.2	(52) 6.1***	(176) 20.5	(32) 3.7***	(106) 12.4	(38) 4.4***	(142) 16.6	(63) 7.4***	
	1	189	(81) 42.9	(56) 29.6**	(122) 64.6	(50) 26.5***	(22) 11.6	(4) 2.1***	(35) 18.5	(13) 6.9***	(9) 4.8	(2) 1.1*	(40) 21.2	(7) 3.7***	
	2	502	(256) 51.0	(135) 26.9***	(295) 58.8	(103) 20.5***	(212) 42.2	(57) 11.4***	(152) 30.3	(31) 6.2***	(85) 16.9	(25) 5.0***	(99) 19.7	(48) 9.6***	
	3	475	(300) 63.2	(41) 8.6***	(208) 43.8	(19) 4.0***	(330) 69.5	(17) 3.6***	(19) 4.0	(1) 0.2***	(14) 2.9	(2) 0.4***	(65) 13.7	(6) 1.3***	
A an 25 11	4	218	(55) 25.2	(59) 27.1	(86) 39.4	(32) 14.7***	(136) 62.4	(34) 15.6***	-	-	(92) 42.2	(24) 11.0***	(12) 5.5	(3) 1.4**	
Age 33-44	5	69	(44) 63.8	(26) 37.7***	(59) 85.5	(22) 31.9***	(19) 27.5	(4) 5.8***	-	-	-	-	(10) 14.5	(3) 4.3*	
	6	101	(82) 81.2	(29) 28.7***	(84) 83.2	(10) 9.9***	(26) 25.7	(7) 6.9***	-	-	-	-	-	-	
	Total (Sites: 1-6)	1554	(818) 52.6	(346) 22.3***	(854) 55.0	(236) 15.2***	(745) 47.9	(123) 7.9***	(215) 13.8	(46) 3.0***	(205) 13.2	(55) 3.5***	(234) 15.1	(67) 4.3***	
	Total (Sites: 2, 4, 5, 6)	890	(437) 49.1	(249) 28.0***	(524) 58.9	(167) 18.8***	(393) 44.2	(102) 11.5***	(161) 18.1	(32) 3.6***	(182) 20.4	(51) 5.7***	(129) 14.5	(54) 6.1***	
Age 45–54	1	182	(76) 41.8	(48) 26.4***	(122) 67.0	(45) 24.7***	(18) 9.9	(7) 3.8**	(38) 20.9	(13) 7.1***	(11) 6.0	(2) 1.1**	(33) 18.1	(4) 2.2***	
	2	328	(170) 51.8	(88) 26.8***	(161) 49.1	(62) 18.9***	(160) 48.8	(47) 14.3***	(33) 10.1	(8) 2.4***	(60) 18.3	(19) 5.8***	(66) 20.1	(21) 6.4***	
	3	391	(226) 57.8	(45) 11.5***	(162) 41.4	(15) 3.8***	(257) 65.7	(24) 6.1***	_	-	(11) 2.8	$(0) \ 0.0^{***}$	(73) 18.7	(5) 13***	
	4	254	(65) 25.6	(71) 28.0	(70) 27.6	(40) 15.7***	(157) 61.8	(44) 17.3***	_	-	(104) 40.9	(41) 16.1***	(17) 6.7	(5) 2.0**	
	5	43	(25) 58.1	(19) 44.2	(30) 69.8	(14) 32.6***	(11) 25.6	(5) 11.6*	_	-	-	-	-	-	
	6	73	(61) 83.6	(22) 30.1***	(60) 82.2	(13) 17.8***	(19) 26.0	(3) 4.1***	_	-	-	-	-	-	
	Total (Sites: 1-6)	1271	(623) 49.0	(293) 23.1***	(605) 47.6	(189) 14.9***	(622) 48.9	(130) 10.2***	(76) 6.0	(21) 1.7***	(192) 15.1	(63) 5.0***	(202) 15.9	(38) 3.0***	
	Total (Sites: 2, 4, 5, 6)	698	(321) 46.0	(200) 28.7***	(321) 46.0	(129) 18.5***	(347) 49.7	(99) 14.2***	(34) 4.9	(8) 1.1***	(170) 24.4	(61) 8.7***	(96) 13.8	(29) 4.2***	

Use of substances at baseline and follow-up among age subgroups of those reporting any illicit drug at baseline

Table 5

Two sets of data analyses are shown based on total results from 6 sites and from 4 sites with high follow-up rates. (-) Results suppressed because fewer than 10 subjects reported use of that substance at baseline. *p < 0.05; **p < 0.01; ***p < 0.001.

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Jse of substances at baseline and follow-up among race/ethnic subgroups of those reporting any illicit drug at baseline	

Race/ethnic group	Site	N ^a	Heavy alcoho	ol (n) %	Marijuana (n) %	Cocaine (n)	%	Methamphe	tamine (n) %	Heroin (n)	%	Other drugs	(<i>n</i>) %
			Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U
	1	118	(50) 42.4	(35) 29.7*	(101) 85.6	(39) 33.1***	(12) 10.2	(4) 3.4*	(11) 9.3	(1) 8**	-	-	-	_
	2	263	(132) 50.2	(82) 31.2***	(157) 59.7	(61) 23.2***	(149) 56.7	(47) 17.9***	(15) 5.7	(3) 1.1**	(22) 8.4	(9) 3.4**	(28) 10.6	(15) 5.7*
	3	710	(417) 58.7	(57) 8.0***	(382) 53.8	(40) 5.6***	(468) 65.9	(25) 3.5***	(11) 1.5	(0) 0.0***	(14) 2.0	(1) 0.1***	(96) 13.5	(6) 0.8***
African American	4	598	(136) 22.7	(174) 29.1**	(249) 41.6	(114) 19.1***	(326) 54.5	(90) 15.1***	_	-	(212) 35.5	(73) 12.2***	(28) 4.7	(7) 1.2***
	Total (Sties: 1-4)	1698	(742) 43.7	(350) 20.6***	(895) 52.7	(256) 15.1***	(959) 56.5	(166) 9.8***	(37) 2.2	(4) 0.2***	(250) 14.7	(83) 4.9***	(161) 9.5	(33) 1.9***
	Total (Sites: 2, 4)	870	(275) 31.6	(258) 29.7	(412) 47.4	(177) 20.3***	(479) 55.1	(137) 15.7***	(15) 1.7	(3) 0.3**	(234) 26.9	(82) 9.4***	(56) 6.4	(22) 2.5***
	1	21	_	_	(15) 71.4	(6) 28.6***	_	_	_	_	_	_	_	_
	2	147	(91) 61.9	(47) 32.0***	(102) 69.4	(34) 23.1***	(61) 41.5	(13) 8.8***	(27) 18.4	(7) 4.8***	(14) 9.5	(3) 2.0***	(29) 19.7	(14) 9.5*
	3	27	(19) 70.4	(4) 14.8***	(18) 66.7	(3) 11.1***	(12) 44.4	(0) 0.0***	_	-	-	-	_	_
Alaska Native or American Indian	5	82	(59) 72.0	(47) 57.3*	(73) 89.0	(32) 39.0***	(17) 20.7	(2) 2.4***	_	-	-	-	-	-
	6	415	(329) 79.3	(131) 31.6***	(361) 87.0	(70) 16.9***	(97) 23.4	(20) 4.8***	(15) 3.6	(0) 0.0***	-	-	(45) 10.8	(5) 1.2***
	Total (Sties: 2, 3, 5, 6)	693	(506) 73.0	(236) 34.1***	(569) 82.1	(145) 20.9***	(191) 27.6	(35) 5.1***	(50) 7.2	(8) 1.2***	(23) 3.3	(5) 0.7***	(93) 13.4	(25) 3.6***
	Total (Sites: 2, 5, 6)	645	(479) 74.3	(225) 34.9***	(536) 83.1	(136) 21.1***	(176) 27.3	(35) 5.4***	(46) 7.1	(7) 1.1***	(20) 3.1	(5) 0.8***	(83) 12.9	(24) 3.7***
	1	541	(303) 56.0	(220) 40.7***	(423) 78.2	(179) 33.1***	(45) 8.3	(24) 4.4**	(74) 13.7	(30) 5.5***	(13) 2.4	(6) 1.1*	(105) 19.4	(28) 5.2***
	2	1393	(751) 53.9	(452) 32.4***	(985) 70.7	(374) 26.8***	(380) 27.3	(86) 6.2***	(373) 26.8	(91) 6.5***	(202) 14.5	(60) 4.3***	(321) 23.0	(147) 10.6***
	3	506	(282) 55.7	(56) 11.1***	(235) 46.4	(20) 4.0***	(265) 52.4	(15) 3.0***	(52) 10.3	(1) 0.2***	(21) 4.2	(2) 0.4***	(170) 33.6	(9) 1.8***
XX71 **	4	49	(15) 30.6	(23) 46.9	(30) 61.2	(18) 36.7**	(20) 40.8	(6) 12.2***	_	-	(12) 24.5	(2) 4.1***	-	-
white	5	394	(244) 61.9	(155) 39.3***	(323) 82.0	(139) 35.3***	(80) 20.3	(26) 6.6***	(20) 5.1	(4) 1.0***	(28) 7.1	(8) 2.0***	(79) 20.1	(21) 5.3***
	6	18	(14) 77.8	(2) 11.1***	(11) 61.1	(1) 5.6***	-	-	-	-	-	-	-	-
	Total (Sties: 1-6)	2901	(1609) 55.5	(908) 31.3***	(2007) 69.2	(731) 25.2***	(796) 27.4	(158) 5.4***	(519) 17.9	(126) 4.3***	(277) 9.5	(78) 2.7***	(683) 23.5	(205) 7.1***
	Total (Sites: 2, 4, 5, 6)	1854	(1024) 55.2	(632) 34.1***	(1349) 72.8	(532) 28.7***	(486) 26.2	(119) 6.4***	(393) 21.2	(95) 5.1***	(243) 13.1	(70) 3.8***	(408) 22.0	(168) 9.1***
	1	334	(181) 54.2	(118) 35.3***	(213) 63.8	(91) 27.2***	(37) 11.1	(5) 1.5***	(85) 25.4	(19) 5.7***	(16) 4.8	(2) 0.6***	(46) 13.8	(8) 2.4***
Winnerin	2	166	(108) 65.1	(50) 30.1***	(112) 67.5	(30) 18.1***	(37) 22.3	(7) 4.2***	(46) 27.7	(10) 6.0***	(25) 15.1	(2) 1.2***	(39) 23.5	(16) 9.6***
	3	407	(265) 65.1	(78) 19.2***	(218) 53.6	(23) 5.7***	(246) 60.4	(21) 5.2***	(23) 5.7	(1) 0.2***	(22) 5.4	(2) 0.5***	(87) 21.4	(3) 0.7***
	4	32	(10) 31.3	(12) 37.5	(16) 50.0	(10) 31.3	(13) 40.6	(5) 15.6**	-	-	-	-	-	-
Hispanic	5	290	(182) 62.8	(117) 40.3***	(232) 80.0	(94) 32.4***	(66) 22.8	(19) 6.6***	(15) 5.2	(2) 0.7***	(23) 7.9	(7) 2.4***	(62) 21.4	(10) 3.4***
	6	12	-	-	(11) 91.7	(3) 25.0***	_	-	_	-	-	-	-	-
	Total (Sties: 1-6)	1241	(755) 60.8	(376) 30.3***	(802) 64.6	(251) 20.2***	(405) 32.6	(58) 4.7***	(169) 13.6	(32) 2.6***	(95) 7.7	(16) 1.3***	(238) 19.2	(37) 3.6***
	Total (Sites: 2, 4, 5, 6)	500	(309) 62.8	(180) 36.0***	(371) 74.2	(137) 27.4***	(122) 24.4	(32) 6.4***	(61) 12.2	(12) 2.4***	(57) 11.4	(12) 2.4***	(105) 21.0	(26) 5.2***

Two sets of data analyses are shown, based on total results from 6 sites and from 4 sites with high follow-up rates. (-) Results suppressed because fewer than 10 subjects reported use of that substance at baseline. *p<0.05; **p<0.001; ***p<0.001.

^a Among subjects qualifying for any level of intervention, the number with data from baseline and follow-up who reported use of one or more illicit drugs at baseline.

Table 7			
Use of Substances at Baseline and Follow-Up An	mong Those Reporting	g Use of Specific Illicit	Drugs At Baseline

Substance	Site	N ^a	Heavy alcoho	d (n) %	Marijuana (n)	%	Cocaine (n) %		Methampheta	mine (n) %	Heroin (n) %		Other drugs (n)%
			Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U	Baseline	F/U
	1	756	(420) 55.6	(319) 42.2***	(756) 100.0	(298) 39.4***	(42) 5.6	(24) 3.2**	(66) 8.7	(26) 3.4***	(12) 1.6	(4) 0.5*	(59) 7.8	(34) 4.5**
	2	1360	(812) 59.7	(475) 34.9***	(1360) 100.0	(455) 33.5***	(317) 23.3	(75) 5.5***	(262) 19.3	(74) 5.4***	(115) 8.5	(38) 2.8***	(245) 18.0	(130) 9.6***
	3	829	(503) 60.7	(109) 13.1***	(829) 100.0	(73) 8.8***	(358) 43.2	(21) 2.5***	(46) 5.5	(2) 0.2***	(16) 1.9	(1) 0.1***	(165) 19.9	(10) 1.2***
Marijuana reported at	4	300	(75) 25.0	(120) 40.0***	(300) 100.0	(111) 37.0***	(83) 27.7	(25) 8.3***	-	-	(43) 14.3	(19) 6.3***	-	-
baseline	5	412	(278) 67.5	(179) 43.4***	(412) 100.0	(171) 41.5***	(57) 13.8	(18) 4.4***	(14) 3.4	(2) 0.5**	-	-	(56) 13.6	(24) 5.8***
	6	389	(316) 81.2	(129) 33.2***	(389) 100.0	(70) 18.0***	(58) 14.9	(16) 4.1***	(10) 2.6	(0) 0.0**	-	-	(33) 8.5	(3) 0.8***
	Total (Sites: 1-6)	4046	(2404) 59.4	(1331) 32.9***	(4046) 100.0	(1178) 29.1***	(915) 22.6	(179) 4.4***	(399) 9.9	(104) 2.6***	(201) 5.0	(67) 1.7***	(565) 14.0	(203) 5.0***
	Total (Sites: 2, 4, 5, 6)	2461	(1481) 60.2	(903) 36.7***	(2461) 100.0	(807) 32.8***	(515) 20.9	(134) 5.4***	(287) 11.7	(76) 3.1***	(173) 7.0	(62) 2.5***	(341) 13.9	(159) 6.5***
	1	98	(61) 62.2	(51) 52.0	(42) 42.9	(24) 24.5***	(98) 100.0	(15) 15.3***	(15) 15.3	(7) 7.1*	-	-	(13) 13.3	(6) 6.1
	2	648	(373) 57.6	(192) 39.6***	(317) 48.9	(111) 17.1***	(648) 100.0	(121) 18.7***	(164) 25.3	(37) 5.7***	(180) 27.8	(54) 8.3***	(183) 28.2	(69) 10.6***
	3	981	(648) 66.1	(106) 10.8***	(358) 36.5	(29) 3.0***	(981) 100.0	(56) 5.7***	(47) 4.8	(1) 0.1***	(27) 2.8	(2) 0.2***	(137) 14.0	(9) 0.9***
Cogging reported at baseling	4	367	(104) 28.3	(101) 27.5	(83) 22.6	(54) 14.7**	(367) 100.0	(96) 26.2***	-	-	(123) 33.5	(46) 12.5***	(18) 4.9	(3) 0.8***
Cocame reported at baseline	5	101	(73) 72.3	(51) 50.5***	(57) 56.4	(24) 23.8***	(101) 100.0	(21) 20.8***	-	-	(14) 13.9	(6) 5.9**	(27) 26.7	(8) 7.9***
	6	108	(86) 79.6	(23) 21.3***	(58) 53.7	(9) 8.3***	(108) 100.0	(13) 12.0***	-	-	-	-	(18) 16.7	(1) 0.9***
	Total (Sites: 1-6)	2303	(1345) 58.4	(524) 22.8***	(915) 39.7	(251) 10.9***	(2303) 100.0	(322) 14.0***	(241) 10.5	(47) 2.0***	(355) 15.4	(112) 4.9***	(396) 17.2	(96) 4.2***
	Total (Sites: 2, 4, 5, 6)	1224	(636) 52.0	(367) 30.0***	(515) 42.1	(198) 16.2***	(1224) 100.0	(251) 20.5***	(179) 14.6	(39) 3.2***	(321) 26.2	(107) 8.7***	(246) 20.1	(81) 6.6***
	1	175	(76) 43.4	(46) 26.3***	(66) 37.7	(34) 19.4***	(15) 8.6	(3) 1.7**	(175) 100.0	(33) 18.9***	-	-	(25) 14.3	(11) 6.3**
	2	455	(211) 46.4	(122) 26.8***	(262) 57.6	(86) 18.9***	(164) 36.0	(26) 5.7***	(455) 100.0	(73) 16.0***	(83) 18.2	(26) 5.7***	(124) 27.3	(39) 8.6***
Methamphetamine reported at	3	83	(53) 63.9	(9) 10.8***	(46) 55.4	(4) 4.8***	(47) 56.6	(1) 1.2***	(83) 100.0	(1) 1.2***	-	-	(36) 43.4	(2) 2.4***
hereiter	5	24	(14) 58.3	(8) 33.3*	(14) 58.3	(5) 20.8**	(9) 37.5	(4) 16.7*	(24) 100.0	(3) 12.5***	-	-	-	-
basenne	6	15	-	-	(10) 66.7	(2) 13.3**	-	-	(15) 100.0	(0) 0.0	-	-	-	-
	Total (Sites: 1-6)	753	(364) 48.3	(186) 24.7***	(399) 53.0	(131) 17.4***	(241) 32.0	(34) 4.5***	(753) 100.0	(110) 14.6***	(101) 13.4	(31) 4.1***	(196) 26.0	(54) 7.2***
	Total (Sites: 2, 4, 5, 6)	495	(235) 47.5	(131) 26.5***	(287) 58.0	(93) 18.8***	(179) 36.2	(30) 6.1***	(495) 100.0	(76) 15.4***	(87) 17.6	(27) 5.5***	(135) 27.3	(41) 8.3***
	1	31	(12) 38.7	(5) 16.1	(12) 38.7	(8) 25.8	-	_	-	-	(31) 100.0	(6) 19.4***	-	-
	2	266	(102) 38.3	(55) 20.7***	(115) 43.2	(38) 14.3***	(180) 67.7	(47) 17.7***	(83) 31.2	(29) 10.9***	(266) 100.0	(62) 23.3***	(106) 39.8	(33) 12.4***
	3	60	(32) 53.3	(5) 8.3***	(16) 26.7	(2) 3.3***	(27) 45.0	(3) 5.0***	-	-	(16) 100.0	(4) 6.7***	(17) 28.3	(2) 3.3***
Heroin reported at baseline	4	242	(39) 16.1	(56) 23.1*	(43) 17.8	(26) 10.7*	(123) 50.8	(41) 16.9***	-	-	(242) 100.0	(75) 31.0***	(27) 11.2	(8) 3.3***
	5	28	(12) 42.9	(9) 32.1	-	-	(14) 50.0	(7) 25.0*	-	-	(28) 100.0	(8) 28.6***	(16) 57.1	(6) 21.4***
	Total (Sites: 1-6)	634	(201) 31.7	(131) 20.7***	(201) 31.7	(81) 12.8***	(355) 56.0	(102) 16.1***	(101) 15.9	(33) 5.2***	(634) 100.0	(156) 24.6***	(175) 27.6	(53) 8.4***
	Total (Sites: 2, 4, 5, 6)	543	(157) 28.9	(121) 22.3**	(173) 31.9	(71) 13.1***	(321) 59.1	(95) 17.5***	(87) 16.0	(30) 5.5***	(543) 100.0	(146) 26.9***	(154) 28.4	(48) 8.8***
	1	169	(85) 50.3	(46) 27.2***	(59) 34.9	(29) 17.2***	(14) 7.7	(9) 5.3	(25) 14.8	(8) 4.7***	-	-	(169) 100.0	(12) 7.1***
	2	414	(257) 62.1	(119) 28.7***	(245) 59.2	(78) 18.8***	(183) 44.2	(41) 9.9***	(124) 30.0	(37) 8.9***	(106) 25.6	(38) 9.2***	(414) 100.0	(68) 16.4***
	3	351	(201) 57.3	(37) 10.5***	(165) 47.0	(17) 4.8***	(137) 39.0	(8) 2.3***	(36) 10.3	(2) 0.6***	(17) 4.8	(1) 0.3***	(351) 100.0	(8) 2.3***
Other drugs reported at	4	35	(15) 42.9	(14) 40.0	(7) 20.0	(6) 17.1	(18) 51.4	(6) 17.1***	-	-	(27) 77.1	(9) 25.7***	(35) 100.0	(5) 14.3***
baseline	5	91	(55) 60.4	(41) 45.1**	(56) 61.5	(30) 33.0***	(27) 29.7	(9) 9.9***	-	-	(16) 17.6	(6) 6.6**	(91) 100.0	(16) 17.6***
	6	49	(35) 71.4	(10) 20.4***	(33) 67.3	(8) 16.3***	(18) 36.7	(3) 6.1***	-	-	-	-	(49) 100.0	(3) 6.1***
	Total (Sites: 1-6)	1109	(648) 58.4	(267) 24.1***	(565) 50.9	(168) 15.1***	(396) 35.7	(76) 6.9***	(196) 17.7	(48) 4.3***	(175) 15.8	(57) 5.1***	(1109) 100.0	(112) 10.1***
	Total (Sites: 2, 4, 5, 6)	589	(362) 61.5	(184) 31.2***	(341) 57.9	(122) 20.7***	(246) 41.8	(59) 10.0***	(135) 22.9	(38) 6.5***	(154) 26.1	(55) 9.3***	(589) 100.0	(92) 15.6***

Two sets of data analyses are shown based on total results from 6 sites and from 4 sites with high follow-up rates. (-) Results suppressed because fewer than 10 subjects reported use of that substance at baseline. *p<0.01; ***p<0.001.

^a Among subjects qualifying for any level of intervention, the number with data from baseline and follow-up who reported use of the drug listed on the left at baseline.

ining patients who were screened positive, the most common substances reported varied considerably across the six sites (Table 2). Alcohol was the most commonly reported substance among patients screening positive at all sites. Marijuana was the second most common substance at all sites except Site 4, where cocaine was more commonly endorsed. Heroin was particularly common at Site 4 where it was endorsed by 4.1% overall (18.8% of the overall group screening positive). Methamphetamine was not common in any of the sites except Site 2 where it was reported by 3.9% of patients (9.9% of the overall group screening positive). Other drugs including prescription-type sedatives and opioids as well as hallucinogens and inhalants, were reported, on average, by 6.6% of patients screening positive.

Of the people randomly selected for follow-up and recommended for a BI, BT or RT, the majority were determined to need a BI, and fewer a BT or RT. Comparing baseline to followup rates of heavy alcohol use and illicit drug use (Tables 3–7), shows that in the majority of cases with adequate numbers of subjects, self-reported rates diminished from baseline to followup. At the bottom of each data set combined results are analyzed two ways. The first (Total Sites 1-6) includes data from all sites, regardless of follow-up rates. The second (Total Sites 2,4,5,6) averages data from sites which had follow-up rates exceeding 70% of the required number of follow-ups and excluded Sites 1 and 3 with low follow-up rates. Most of these reductions in substance use were statistically significant. Table 3 shows that irrespective of whether the sample includes those who reported using heavy alcohol, using an illicit drug, or using heavy alcohol or illicit drugs, reductions were seen across all substances examined, and similar data were obtained from combined sites with varying follow-up rates or from totals which excluded Sites 1 and 3. Summarized in Fig. 1 (Total Sites 2, 4, 5, 6) are the statistically significant reductions (p < 0.001) in heavy alcohol, marijuana, cocaine, methamphetamine, heroin and other drugs, with data sets from Sites 1 and 3 omitted because of the low follow-up rates. Additional analyses were conducted to determine whether changes reported overall for persons who reported illicit drug use at baseline were also seen among different age, gender and race/ethnic groups (Tables 4-6). Baseline to followup rates of heavy alcohol and illicit drug use were compared for men and women separately (Table 4), ages less than 25, 25-34, 35-44 and 45-54 (Table 5) and different race/ethnic groups (Table 6). Of note, in all cases where an adequate number of subjects allowed calculation of rates, decreases were seen from baseline to follow up across nearly every substance category. In both genders, in different age groups and in different race/ethnic groups, most of these reductions were statistically significant. The one exception was Site 4 where heavy alcohol consumption increased from baseline to follow-up among the group reporting illicit drugs at baseline. In contrast, no increases were seen at Site 4 among the overall group reporting either alcohol or drugs at baseline and decreases in heavy alcohol were seen when the group included just those reporting heavy alcohol at baseline. The overall increases in heavy alcohol at Site 4 for those reporting illicit drugs at baseline were seen in men, younger cohorts and African Americans, but not women, older cohorts, and the other race/ethnic groups. Table 7 shows the results among those

ibgroup	Site	γp	Mean overall h	ealth status ^c	Emotional p	roblems in past 30 days ^d (%)	Currently ei	nployed ^e (%)	Any arrest	s in past 30 days (%)	Currently h	omeless ^f
			Baseline mean	F/U mean	Baseline (n)	% F/U (<i>n</i>) %	Baseline (n)	% F/U (n) %	Baseline (1	i) % F/U (<i>n</i>) %	Baseline (n	% F/U (n) %
	-	1022	2.26	3.06***	(252) 24.7	(194) 19.0***	(449) 43.9	(509) 49.8**	(113) 11.1	(31) 3.0***	(106) 10.4	(35) 3.4***
γι.	2	1978	2.09	2.83***	(561) 28.4	$(446) 22.5^{***}$	(576) 29.1	$(684) 34.6^{***}$	(227) 11.5	$(102) 5.2^{***}$	(339) 17.1	$(209) 10.6^{***}$
ICIT	3	1618	2.27	2.81***	(461) 28.5	$(151) 9.3^{***}$	(511) 31.6	(577) 35.7**	(257) 15.9	$(71) 4.4^{***}$	(176) 10.9	$(67) 4.1^{***}$
	4	969	2.00	2.65***	(145) 20.8	(144) 20.7	(107) 15.4	(154) 22.1***	(59) 8.5	$(31) 4.5^{**}$	(70) 10.1	(34) 4.9 * * *
ported	5	495	2.72	3.10	(129) 26.1	$(85) 17.2^{***}$	(184) 37.2	(193) 39.0	(52) 10.5	$(24) 4.8^{***}$	(14) 2.8	(24) 4.8
	6	453	3.12	3.24	(54) 11.9	(81) 17.9**	(133) 29.4	(145) 32.0	(59) 13.0	$(15) 3.3^{***}$	(36) 7.9	(33) 7.3
-se	Total (Sites: 1–6)	6262	2.25	2.91***	(1602) 25.6 ($(1101) 17.6^{***}$	(1960) 31.3	(2262) 36.1***	(767) 12.2	$(274) 4.4^{***}$	(741) 11.8	$(402) 6.4^{***}$
e	Total (Sites: 2, 4, 5, 6)	3622	2.24	2.89***	(889) 24.5	$(756) 20.9^{***}$	(1000) 27.6	(1176) 32.5***	(397) 11.0	$(172) 4.7^{***}$	(459) 12.7	(300) 8.3***

Table 8

2 as as many g can 'n for patients in need of a brief treatment (\mathbf{b} I) of a referral to a specially treatment (\mathbf{k} I) program. only etc.) are reported as well as other outcomes. use

and is designed to address more than simply motivation to change behavior (the focus of brief interventions). *p < 0.05; **p < 0.01; ***p < 0.01.

Note that these outcomes are only available for persons with moderate to severe substance abuse at baseline (i.e. those receiving brief treatment or referred to specialty treatment).

Number responding to these questions at baseline and follow-up.

Excellent = 5; very good = 4; good = 3; fair = 2; poor = 1.

Any reported days of experiencing serious depression, serious anxiety, hallucinations, suicide attempts, trouble controlling violent behavior, trouble with memory or concentration or taking prescribed medications for osychological/emotional problems.

Full time or part time.

Not living in a domicile or residential facility.

reporting use of specific substances. Although the sample size was too small for certain of these analyses, in all cases for which there were sufficient samples, the numbers decreased from baseline to follow-up; in most cases, these reductions were statistically significant.

Notwithstanding the fact that sites differed on the basis of protocols, screening tools, cut-off scores, definitions and populations, heavy alcohol users and illicit dug abusers self-reported significant reductions at 6-month follow-up (Tables 3–7, Fig. 1).

3.3. Baseline and follow-up health, employment, criminal behavior and homelessness

GPRA also required grantees to report other outcomes using an approved uniform instrument. "Other outcomes" (employment, arrests, etc.) were reported only for patients recommended for a brief treatment (BT) or a referral to a specialty treatment (RT) program. Baseline and follow-up measures of past 30 day general physical health, symptoms of mental illnesses, employment, criminal behavior and homelessness were also collected among patients who required the more intense clinical interventions (brief therapy or referral to specialty treatment). Among persons that received a BT or RT, self-reported drug use declined significantly at follow-up. Self perception of overall health status improved significantly from baseline to follow-up at four sites (Table 8). Similarly, employment improved significantly at four of the six sites, self-reported arrests decreased significantly across all six sites and homelessness decreased significantly at four of the six sites. Emotional problems improved at four sites but at Site 6, self-report of emotional problems increased (p < 0.01) from baseline to follow-up. As a BT can be delivered in as many as 10 sessions and was designed to address more than simple motivation to change behavior (the focus of brief interventions), it is not unreasonable that BT could contribute to changes in these other outcomes.

4. Discussion

4.1. Summary

SBIRT is the largest service program to provide screening for combined illicit and alcohol use in a large and diverse population (>450,000 patients) and in a wide range of healthcare settings. Combined screening and brief interventions for illicit drug and heavy alcohol use was feasible across all sites, with personnel hired specifically for this purpose. Secondary analysis of a sample population reporting illicit drug abuse at baseline and at 6-month follow-up at four of the six sites with high follow-up rates, indicate that rates of drug use were lower by 67.7% (p < 0.001) and heavy alcohol use by 38.6% (p < 0.001). Persons requiring brief treatment or referral to specialty treatment self-reported improvements in general health, mental health and important social measures, across most sites. For the first time, in a large screened population (n > 450,000) and implemented in a broad spectrum of sites, demographics, and using various procedures, the self-reported patient status at 6 months indicated significant improvements over baseline in illicit drug and alcohol use.

4.2. Objectives and outcome measures

Our first objective was to assess the feasibility of providing screening for illicit drug use in the context of simultaneous screening for risky alcohol use in a service program across a range of healthcare settings. Screening for a wide range of illicit drugs, in addition to alcohol, was clearly feasible and clinically appropriate in diverse healthcare settings and for various populations. The prevalence of illicit drug abuse was clinically significant across a range of substances among the full population screened.

Our next objectives were, in populations screening positive for illicit drugs and/or alcohol and offered score-based progressive interventions (brief intervention, brief treatment, referral to specialty treatment) at intake, to compare self-reported use at intake and 6 months later. In this secondary analysis of service data, patients that screened positive (22.7% overall) selfreported significant reductions in illicit drug abuse and heavy use at 6-month follow-up. Results were consistent for most age, race/ethnic and gender subgroups across the different sites, across all the specific substances for which adequate numbers of subjects were available for consideration. These data are consistent with positive trends in published results conducted with smaller sample sizes that demonstrate an association between screening, brief interventions with reductions in marijuana, amphetamine-type stimulants, cocaine and heroin in the majority (Bernstein et al., 2005; Copeland et al., 2001; McCambridge and Strang, 2004; Stotts et al., 2001; World Health Organization Report, 2008), but not all studies (Marsden et al., 2006). The results for illicit drug use are consistent with findings from the WHO multi-national randomized, control trial, which found that overall, 82.8% of all participants who received the brief intervention at baseline reported attempting to cut down on substance use as a result of feedback they received. Of this population, 60.2% (n=224) reduced illicit drug use, as measured by the ASSIST scale (World Health Organization Report, 2008).

Alcohol data were included both for comparative purposes and to compare procedural effects on heavy alcohol with illicit drug use. The decline in alcohol use was consistent with previously reported reductions in heavy alcohol use (Fleming et al., 1997, 2002; Gentilello et al., 1999, 2005; Schermer et al., 2006; Soderstrom et al., 2007), supporting the validity of the current findings. Nonetheless, settings, interventions, selfreports, patient populations and other factors can affect response rates (Babor et al., 1987, 2000; Bien et al., 1993; Edwards and Rollnick, 1997; Wilk et al., 1997). For example, a population of medical inpatients, the majority with alcohol dependence, was unresponsive to brief interventions (Saitz et al., 2007).

The SBIRT programs also collected data on whether participants who received more intense interventions (brief treatment or referral to specialty treatment), reported changes in health and social outcomes. Patients in this group self-reported significant improvements across general and mental health measures, arrests, homelessness and employment, reflecting the potential for SBIRT to shift not just drug abuse, but also distal health and social outcomes.

4.3. Limitations

Notwithstanding these promising findings, it is appropriate to reflect on limitations in design, procedures and data collection. Foremost are concerns associated with reporting analysis of service/administrative data, and not research data. Yet this form of data is both a weakness (data gaps and differences in implementation procedures across sites) and a strength (data reflect a large and realistic view of practice). In this regard, authors of the WHO randomized control study speculated that the extensive protocol for informed consent in the USA research component of the study may have served as a brief intervention, potentially confounding outcome measures (World Health Organization, 2008). Another concern is the reliance on self-reports to screen populations and to determine drug use at 6-month follow-up. Previous studies indicated the reliability of self-reports under various conditions (Babor et al., 1987, 2000; Donohue et al., 2007; Lennox et al., 2006), but inclusion of simultaneous biological testing at baseline and follow-up may assist in diminishing under- or overreporting of drug (Vitale et al., 2006). On the other hand, results from a single biometric measure cannot provide information on quantity or frequency to be of adequate value in strengthening the accuracy of self-reporting. Self-reports of general health, mental health status (primarily depression), housing, employment, and arrests might have been independently verified (via rating scales, physical exam and official documents), but this was outside the scope of the GPRA reporting requirements. Equally important for future studies is whether apparent reductions in illicit drug use and heavy alcohol use persist beyond the 6-month period. Finally, the absence of comparison groups (e.g. randomized controls) could have resulted in a Type 1 error (i.e. that the improvements were unrelated to the procedures), arising from regression to the mean phenomenon (a tendency for those scoring differently from the population mean to regress towards the mean when re-assessed, Finney, 2007), self-selection by patients who volunteered their responses to screening questions, or screening effects alone, as demonstrated by the WHO report (2008).

Another limitation was the relatively low level of rates of follow-up at two sites. For this reason, all results were stratified by site and analysis was performed on all six sites and compared with outcomes from 4 sites with high follow-up rates. With the exception of Site 3, the fact that sites with high or low followup rates showed reductions in drug use of a similar magnitude, suggests that reductions in drug use were not compromised by rates of follow-up.

4.4. Conclusions and future research

The tentative conclusion that SBIRT services may be associated with a reduction in substance use is supported by a number of randomized controlled trials (e.g. Bernstein et al., 2005; Fleming et al., 1997, 2002; Gentilello et al., 1999, 2005; Soderstrom et al., 2007; WHO, 2008). Based on published reports, reductions in substance abuse can be attributable to the screening procedure alone or combined with the intervention or to other factors. The general consistency of the data across the majority of the sites and of most measures for these outcomes adds strength to the conclusions. As the majority of persons intended to receive an intervention received one, we are confident that the intervention was delivered adequately. Accordingly, the results demonstrate a promising strategy for addressing this public health burden.

Overall, the SBIRT program demonstrated that a rapid and simple set of procedures has potential for impacting the public health burden of substance abuse. There are substantive reasons for engagement in these procedures by medical professionals. The association between substance use and trauma/injuries is one of a mounting list of medical consequences of or associations of medical conditions and substance abuse (Bedard et al., 2007; Caputo et al., 2007; Centers for Disease Control, 2005; Dept of Transportation (US), National Highway Traffic Safety Administration (NHTSA), 2006; Hayatbakhsh et al., 2007; Howard et al., 2004; Macdonald et al., 2003; McFadden et al., 2005; Mertens et al., 2003, 2005; Moore et al., 2007; Nyenwe et al., 2007; O'Malley and Johnston, 2003; Rivara et al., 1997; Rootman et al., 2007; Shoptaw and Reback, 2007; Stein and Friedmann, 2006; Strathdee et al., 2001; Sullivan et al., 2005; Swanson et al., 2007; Sweeney et al., 2000; Volkow et al., 2007; Westover et al., 2007; Wilson and Saukkonen, 2004; Yeo et al., 2007). SBIRT provides a opportunistic teaching moment for primary care or emergency service providers to take proactive measures for their patients who may be engaged in risky use of substances, but are not currently seeking assistance and are not in need of specialty treatment. The documented cost-savings of approximately \$4 for each \$1 expended for alcohol SBI (Gentilello et al., 2005; Fleming et al., 2002) is another potential benefit for these procedures, but requires corresponding cost-savings analysis for illicit drug SBI, particularly for unrecoverable hospital costs (Swanson et al., 2007). For both alcohol and illicit drugs, the SBIRT program in Washington State (S. Estee, personal communication) was calculated to save Medicaid approximately \$2,000,000 for each 1000 Medicaid patients administered these services, with a significant portion attributable to reductions in re-hospitalizations.

In recognition of the value of screening, brief intervention procedures, new reimbursable procedural codes (CPT®, "H", "G" for third party insurers, Medicaid, Medicare, respectively) were introduced in 2007 and 2008. As a further incentive for implementing these procedures, patients who receive counseling services for alcohol problems reportedly perceive that they are receiving a higher level of primary care (Saitz et al., 2008). Even with promising evidence of effectiveness, cost-effectiveness, positive patient response, the widespread implementation of even alcohol SBI procedures remains an elusive goal (Kuehn, 2008). Although the SBIRT program provided sufficient funds to staff an SBIRT team, the combination of effectiveness measures, cost-savings, new procedural billing codes, and positive patients' perception of high quality of care, may catalyze widespread implementation of these practices in healthcare settings.

Another notable feature of SBIRT is its potential to identify patients at higher risk for prescription drug abuse. In the United States, non-medical use/abuse of prescriptions drugs ranks second (after marijuana) among illicit drug users (Substance Abuse and Mental Health Services Administration, 2007a). Patients with risky alcohol consumption or illicit drug use are at increased risk for prescription drug abuse, including opioid analgesics (Compton and Volkow, 2006; Huang et al., 2006; McCabe et al., 2006; McCabe and Teter, 2007; Simoni-Wastila and Strickler, 2004). Effective prescription drug abuse screening questions should be incorporated into standardized screening questionnaires to identify non-medical use of prescription drugs.

This report also serves as a guide to steer future research and practice. Randomized controlled trials that control for potential ecological confounds, and investigate populations at risk, those challenged by psychiatric diseases, stress, anxiety, depression (Oslin et al., 2006), unemployment, absence of family and social supports will further advance the scientific basis of these procedures. It remains to be shown whether SBIRT services can attenuate progression to drug addiction (Wagner and Anthony, 2002; Chen et al., 2005; O'Brien and Anthony, 2005) and whether SBIRT will improve medical conditions precipitated or exacerbated by illicit drug abuse (e.g. HIV-AIDS), alleviate prescription drug abuse, and lower the national burden of healthcare, legal, social, work-place costs.

Overall, these SBIRT service programs document reductions in illicit drug and alcohol abuse 6 months after a random sample of patients screened positive, with the majority receiving, at a minimum, a brief intervention. Given high rates of overlap across drugs and alcohol documented in this report, it makes great sense to encourage bundling of screening and intervention services for patients presenting in medical settings. An effective program should also provide for seamless referrals to treatment for the addicted, either to physicians' office-based practices or referral to specialty ambulatory or residential treatment, as necessary. SBIRT is a promising service for identifying illicit drug abuse and its associated adverse consequences in health care settings.

Role of funding source

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Contributors

Dr. Bertha Madras conceived, wrote and edited the manuscript and made substantial contributions to data analysis and data/statistical interpretation and administrative support for the program. Dr. Madras, Dr. Compton and Ms. Avula take responsibility for data integrity, and had full access to the data. Dr. Compton made substantial contributions to conception and design of the analysis, analysis and interpretation of the data, drafting of the manuscript, statistical analysis and technical support. Ms. Avula made substantial contributions to acquisition of data, data analysis, revision of the manuscript, and statistical analysis. Tom Stegbauer and Dr. Jack Stein contributed to the writing, reviews, and editing of drafts of the manuscript. Dr. Westley Clark, Director of the Center for Substance Abuse Treatment at SAMHSA, contributed to the manuscript by data acquisition, analysis, drafting and manuscript revision, and by providing administrative support and supervision.

Conflict of interest

All authors are current employees of the United States Government and have no conflicts of interest or financial interests. Dr. Madras is on leave of absence as Professor of Psychobiology in the Department of Psychiatry at Harvard Medical School. The SBIRT program is funded by SAMHSA grants to States and administered by the States, via local experts.

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Reconnecting Youth

Brief Description | Recognition | Program IOM | Intervention Type | Content Focus | Protective Factors Risk Factors | Interventions by Domain | Key Program Approaches | Outcomes | Evaluation Design Delivery Specifications | Intended Setting | Fidelity | Barriers and Problems | Personnel | Education Personnel Training | Cost | Intended Age Group | Intended Population | Gender Focus Replication Information | Contact Information

Program developers or their agents provided the Model Program information below.

BRIEF DESCRIPTION

Reconnecting Youth (RY) is an indicated school-based program for youth in grades 9 to 12 (14 to 18 years of age) at risk for school dropout and exhibit multiple behavior problems. It uses a partnership model involving peers, school personnel, and parents to deliver interventions that address decreased drug involvement, increased school performance, and decreased emotional distress.

PROGRAM BACKGROUND

The development and framework for RY were largely informed by early descriptive work of Leona Eggert, Ph.D., and her colleagues. Early work identified the vulnerabilities among youth at risk for high school dropout, "skippers," and the co-occurring problem behaviors of school deviance, drug involvement, and depression/suicidal behaviors. Reconnecting Youth was specifically designed to meet the participants' needs for inclusion and excitement while teaching them how to be "winners," stay in control, make wise decisions, and evaluate potential consequences of their choices. The program has been funded for testing by the National Institute on Drug Abuse (NIDA) and the National Institute of Mental Health (NIMH), National Institutes of Health, U.S. Department of Health and Human Services, and the U.S. Department of Education in suburban and urban areas of the Pacific Northwest. A twosemester version of the program, with a parent component, is currently being evaluated with funding from NIDA. RY has been adopted by Texas and Maine as an integral part of statewide prevention programming.

RECOGNITION

Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services: Model Program

National Institute on Drug Abuse, U.S. Department of Health and Human Services: Programs That Work

Drug Strategies, Inc.: Grade "A" and "A+"



INSTITUTE OF MEDICINE CLASSIFICATION (IOM)

INDICATED

Developed for an indicated audience. Targeted for youth at risk for school dropout and who may exhibit multiple behavior problems such as substance abuse, aggression, depression, or suicide risk behaviors. At risk for school dropout is defined as having fewer than the average number of credits earned for the grade level, high absenteeism, a significant drop in grades, or a history of dropping out of school.

INTERVENTION TYPE

SCHOOL-BASED

CONTENT FOCUS

ALCOHOL, ANTISOCIAL/AGGRESSIVE BEHAVIOR, ILLEGAL DRUGS, SOCIAL AND EMOTIONAL COMPETENCE, TOBACCO

The program targets general substance use and abuse.

PROTECTIVE FACTORS

INDIVIDUAL, FAMILY, PEER, SCHOOL

INDIVIDUAL

- Communicate using self-esteem enhancing talk
- Decisionmaking and the ability to apply it to drug use, school, and mood management
- Personal control, stress, and mood management skills
- Interpersonal communication and negotiation skills

FAMILY

- Practicing interpersonal communication skills at home
- Enlisting parent support for program goals

PEER

- · Daily reinforcement of the positive peer group culture norms
- Replacing deviant peer/group belonging with prosocial group behavior

SCHOOL

- Setting norms for and monitoring attendance, achievement, mood, and drug-use control
- School network support
- Facilitating prosocial activities

RISK FACTORS

INDIVIDUAL, FAMILY, PEER, SCHOOL

INDIVIDUAL

- Impulsiveness
- Poor decision making and coping skills
- Uncontrolled emotions
- Learned helplessness
- Low self-worth; deviant self-image
- Poor social/interpersonal skills

FAMILY

- Family distress and serious conflicts
- Poor family-school connections
- Unclear/unfair rules

PEER

- Deviant friends in peer group network
- Peers who skip school and use drugs
- · Peers lacking personal goals related to school achievement and attendance
- · Susceptibility to negative peer influences

SCHOOL

- Negative view of school experience
- Norms of skipping school
- Substance use at school
- Poor teacher-student relationships
- Low access to help
- Nonparticipation in school activities

INTERVENTIONS BY DOMAIN

INDIVIDUAL, FAMILY, PEER, SCHOOL, COMMUNITY

INDIVIDUAL

• Life/social skills training

FAMILY

• Task-oriented family education sessions to improve family interactions (e.g., parent involvement in program homework assignments, etc.)

PEER

- Alternative/recreational activities
- Peer-resistance education

SCHOOL

- Classroom drug education
- Classroom-based skills development
- Mentoring/tutoring

COMMUNITY

Multiagency activities and collaboration

KEY PROGRAM APPROACHES

ALTERNATIVE/RECREATIONAL ACTIVITIES, COMMUNITY INVOLVEMENT, COMMUNITY SERVICE, IN-SCHOOL CURRICULA, PARENT-CHILD INTERACTIONS, SKILL DEVELOPMENT

Program strategies used by the Model Program and how they are used:

ALTERNATIVE/RECREATIONAL ACTIVITIES

Social, recreational, and school activities are carried out to foster school bonding and reconnect high-risk youth to school and to health-promoting prosocial activities. These fun activities are alternatives to depression, loneliness, and substance use.

COMMUNITY INVOLVEMENT

This program is a partnership among the school, the family, and the community. It requires a community support team that can assist with funding, additional services, linkages with business community, and extra support for crises.

COMMUNITY SERVICE

Some of the suggested alternative prosocial activities involve community service.

CRISIS RESPONSE PLAN

Guidelines are presented to plan for and prevent suicide, respond to suicide or accidental death, and use postsuicide interventions.

IN-SCHOOL CURRICULA

Key components are support and caring through group work involving social support and facilitation of a positive peer-group culture and life skills training to foster self-esteem, enhancement, decisionmaking, personal control, and interpersonal communication skills.

The first 10 days of classes focus on getting started and bringing the youth into the purpose of the program through surveys and goal-setting activities.

PARENT-CHILD INTERACTION

Parent involvement is required for student participation and is essential for at-home support of the skills students learn in class. School contact is maintained through notes and calls from teachers who enlist parental support for activities and provide progress reports.

SKILL DEVELOPMENT

Life skills training is taught to foster self-esteem enhancement, decisionmaking, personal control, and interpersonal communication skills.

HOW IT WORKS

Four key RY components are integrated into the school environment. They include:

- **RY Class,** a core element, is offered for 50 minutes daily during regular school hours for 1 semester (80 sessions) in a class with a student-teacher ratio of 10 or 12 to 1. After a 10-day orientation to the program, approximately 1 month is spent on each of these topics—self-esteem, decisionmaking, personal control, and interpersonal communication.
- School bonding activities consisting of social, recreational, school, and weekend activities that are designed to reconnect students to school and health-promoting activities as alternatives to drug involvement, loneliness, and depression.
- **Parental involvement,** required for student participation, is essential for at-home support of the skills students learn in RY class. School contact is maintained through notes and calls from teachers who also enlist parental support for activities and provide progress reports.
- School Crisis Response planning provides teachers and school personnel with guidelines for recognizing warning signs of suicidal behaviors and suicide prevention approaches.

From planning through implementation of the RY curriculum, partnerships with school officials are vital. Typical partners include the RY teacher, RY coordinator, parents, designated district representative, the principal, vice principal, student support services, staff, and administrative support staff—especially attendance and registrar. Regular meetings to ensure readiness, commitment, and financial resources will help set a strong foundation for successful replication.

OUTCOMES

DECREASES IN SUBSTANCE USE, REDUCTIONS IN BEHAVIORS RELATED TO RISK FACTORS, IMPROVEMENTS IN BEHAVIORS RELATED TO PROTECTIVE FACTORS, OTHER TYPES OF OUTCOMES

DECREASES IN SUBSTANCE USE

Curbed progression of alcohol and other drug use

Decreased drug use and control problems

54% decrease in hard drug use

Decreased adverse drug use consequences

REDUCTIONS IN BEHAVIORS RELATED TO RISK FACTORS

Decreased suicidal behaviors (threats, thoughts, and attempts) Decreased anxiety 32% decline in perceived stress Decreased depression and hopelessness 48% decrease in anger control problems and aggression

IMPROVEMENTS IN BEHAVIORS RELATED TO PROTECTIVE FACTORS

18% improvement in grades in all classesCurbed increasing trend in daily class absences7.5% increase in credits earned per semesterDecreased high school dropout23% increase in self-efficacy

OTHER TYPES OF OUTCOMES

Benefits

Improved grades and school attendance

Reduced drug involvement

Decreased emotional distress

Increased self-esteem, personal control, prosocial peer bonding, and social support

EVALUATION DESIGN

A quasi-experimental design with repeated measures was used to test the efficacy of the RY indicated preventive intervention. Trend analyses served to compare the pattern of change for experimental and control groups across pre- and posttests (5 months) and followup tests (5 to 7 months).

DELIVERY SPECIFICATIONS

5-24 WEEKS

Amount of time required to deliver the program to obtain documented outcomes:

The RY class is held 50 minutes daily during regular school hours for 1 semester (80 sessions) in a class with a student-teacher ratio of 12 students to 1 teacher.

The first 10 sessions are used to orient and survey youth and set goals.

RY Class, a core element, is offered for 50 minutes daily during regular school hours for 1 semester (80 sessions).

INTENDED SETTING

URBAN, SUBURBAN

Developed for urban and suburban settings.

FIDELITY

Components that must be included in order to achieve the same outcomes cited by the developer:

- Partnership with school officials throughout the entire project, from planning through implementation, is essential.
- Implementers must be invited, not assigned, and must be highly motivated.
- Participants are identified and invited, not assigned.
- Participants are recruited from the entire school population to ensure diversity of age and culture.
- Classes are about 10 to 12 youth each. (It cannot be integrated into existing larger classes.)
- Implementers must be trained in using the curriculum.

PERSONNEL

FULL-TIME

One full-time program coordinator per every five to six classes is needed to provide teacher support and consultation through bimonthly meetings and weekly classroom observations. Ideally, the coordinator is a skilled Reconnecting Youth teacher.

A typical RY class has a student-teacher ratio of 10 or 12 to 1.

EDUCATION

UNDERGRADUATE, GRADUATE, SPECIAL SKILLS

Teachers with an undergraduate degree or higher.

Teachers are selected, using preestablished criteria, to ensure they are committed to working with high-risk youth and show special aptitude based on student, other teacher, and administrative recommendations, with supervisory and training expertise.

PERSONNEL TRAINING

Type: WORKBOOK, Location: ONSITE (user)/OFFSITE (developer or trainer location), Length: BASIC/REFRESHER (if required)

Initial implementation training lasts 5 days, with followup implementation consultation 1 day every 6 months during the first year of implementation, plus phone consultation.

One-year followup consultation to manage implementation challenges and to assess implementation fidelity in subsequent years.

Implementation Manual contains chapter on planning and preparation that includes key issues to consider in the initial planning phases through implementation of the partnership model; information about the program concept and research; an overview of the program; information for the group leader; and planning tools such as a Master Planning Tool and an Implementation Checklist.

COST (estimated in U.S. dollars)

\$5,001-10,000

Cost considerations for implementing this program as recommended by the developer:

In addition to the teacher and program coordinator, the teacher needs a classroom large enough to accommodate 10 to 12 students.

TRAINING

5 days in length, for 5 to 7 people, 1 trainer	.\$750/day plus expenses
5 days in length, 8 to 14 people, 2 trainers	.\$1,500/day plus expenses
Followup consultation days for 5 to 7 people	.\$750

MATERIALS

Reconnecting Youth: A Peer Group Approach to Building Life Skills—curriculum, with student	
handouts for photocopying	.\$179
Teacher manuals and reproducible forms book only	.\$69
Classroom materials sold separately in sets of five	
Parent training video	.\$49.95
Sets of support materials sold separately in packages of five and more (charms, stickers, magnets, memo pads, pencils, pins, signs, self-inking stamps, and T-shirts)	.\$15-\$22.50

INTENDED AGE GROUP

EARLY ADOLESCENT (12-14), TEENAGER (15-17), YOUNG ADULT (18-24)

Developed for high school youth in grades 9 to 12 (14 to 18 years of age).

INTENDED POPULATION

MULTIPLE ETHNIC GROUPS

Used with diverse populations.

GENDER FOCUS

BOTH GENDERS

Developed for both males and females.

REPLICATION INFORMATION

NO INFORMATION PROVIDED

CONTACT INFORMATION

ABOUT THE DEVELOPER

The developer is Leona Eggert, Ph.D., RN, FAAN, at the University of Washington School of Nursing. Liela Nicholas is co-developer and principal trainer. Materials are distributed by Solution Tree.

FOR INFORMATION, CONTACT

Beth McNamara, MSW Information and Training Coordinator Phone: (425) 861-1177 Fax: (206) 726-6049 - Email: ry.info@verizon.net

National Educational Service 304 West Kirkwood Avenue, Suite 2 Bloomington, IN 47404-5132 Phone: (800) 733-6786 Fax: (812) 336-7790 Web: www.solution-tree.com

HELENA De FINA 520 N. Division St., Powell, WY 82435 (307) 754-0894

EDUCATION

Master of Public Health (Health Education and Promotion), University of Arizona, 2001 Spanish, B.A., Northern Arizona University, 2001 Psychology, B.A., Northern Arizona University, 1993

WORK EXPERIENCE

West Park Hospital, Prevention and Wellness Office/ Cody, WY (June 2004 – present) Prevention Specialist

- Coordinate and support environmental prevention activities including research, media design, and working with schools and other groups.
- Develop and present educational prevention programs audiences in Park County.
- Coordinate and facilitate activities of the Powell Coalition against Substance Abuse Coalition and Northwest College CHOICES; serve on the following coalitions: 650 Forum, Park County Health.
- Keep informed of major health issues and new prevention strategy developments.

Northwest College - Cody Center (Fall 2007 – present)

Adjunct Faculty

• Teach Diet/Exercise and Wellness courses.

Park County Public Health/ Cody, WY (Aug. 2002 – June 2004) (part-time 20)

(Worked concurrently for ≈2yrs in this position and the Big Horn County, Community Program Specialist.) Health Educator

- Created and presented health presentations to a variety of community groups including schools.
- Promoted local public health programs by various outreach methods.
- Served on community coalitions and participated in its special events.
- Created brochures, flyers, and bulletin boards.
- Wrote newspaper articles and newsletter; and assisted with writing grants.

Big Horn County Public Health/ Greybull, WY (May 2001 – July 2003) (part-time 20 hrs) Community Program Specialist

- Assisted with and participated in advisory committee meetings, agendas and orientation of new members. Represent the agency on state/local committees or organizations.
- Participated in public relations and marketing activities; interpreted services and policies to community boards, agencies and individuals. Participated in collaborative activities to plan for community services.
- Translated services and office visits for Spanish-speaking only clients.
- Assisted with data collection and analysis, prepared required reports.

NAU / Sacred Mountain Youth Project/ Flagstaff, AZ (Sept. 1999 – Dec. 2000) Research Assistant, Northern Arizona University

- Conducted quantitative and qualitative interviews regarding HIV risk and protective factors of Native American teens.
- Implemented individualized HIV/STD risk assessments and risk reduction behavior strategies for teens; administered OraSure HIV tests to participants.

NACOG Head Start / Health Office / Flagstaff, AZ (Internship: Aug. 2000 – Dec. 2000) Intern

- Developed and administered staff and parent survey concerning barriers to dental/medical health prevention and compliance.
- Provided preventative dental/medical health education to center staff and parents.

NAU / Criminal Justice Department / Flagstaff, AZ (Feb. 1997 – Sept. 1999) Administrative Assistant / Secretary, Northern Arizona University

- Provided support functions for the Department Chair.
- Supervised and coordinated activities of office support staff.
- Managed departmental budget and grant.
- Assisted with the daily operations of graduate program.

NAU / Human Resources / Flagstaff, AZ (June 1994 – Feb. 1997)

Administrative Assistant / Secretary, Northern Arizona University

- Provided support functions for the Assoc. Director and Employee Relations Dept. staff.
- Assisted with the promotion and implementation of the Employee Relations and Development workshops.
- Assisted with the payroll distributions process for the entire university.

TRW Yellowstone National Park / Employee Assistance and Wellness Program (Summer, 1991)

Assistant Counselor

- Intake of employees seeking advice and guidance with personal issues.
- Referred employees to community agencies for further assistance.
- Coordinated and facilitated Alcohol Anonymous and other 12-step group meetings.

VOLUNTEER EXPERIENCE

Northwest College International Student Friendship Family (2008 – present) WY HIV/AIDS/Hepatitis Care and Planning Alliance (2007 – present) *Task Force and Voting Member – representing substance abuse population* Northwest Wyoming Family Planning Clinic, Powell WY (Nov. 2001 – 2008) *Board Member and Health Educator* WY High School Academic Marathon (2001) *Interviewer* Planned Parenthood, Flagstaff AZ (1994 – 2000) *Health Educator* Literacy Volunteers, Flagstaff AZ (1996 – 1997) *Tutor and Book Festival Volunteer* Arizona Academic Decathlon, Flagstaff AZ (1995) *Interviewer* Big Brother / Big Sister Organization, Fountain Hills AZ (1985 – 1988) *"Big Sister"* Joseph R. Otto, III (Jay) 28 Hitching Post Drive Cody, WY 82414

Summary

I have a diverse background in for-profit, non-profit, private, and public sectors where I have developed first hand experience in all functional areas of organizational development and operations. I have worked on public bodies with completely open proceedings as well as with private organizations. I have written, received, and managed grants from public, private, federal, state, and local sources. I have a strong working knowledge of Microsoft Office products including Word, Excel, Access, and FrontPage.

Education

MASSACHUSETTS INSTITUTE OF TECHNOLOGY Cambridge, MA Bachelors of Science in Electrical Engineering – January 1989 Masters of Science in Electrical Engineering – January 1989 General coursework included computer programming, computers systems, systems theory, field theory. Graduate work included circuit design, artificial intelligence, advanced circuit design, and biomedical measurements. Minor in Philosophy. Masters thesis conducted at Hewlett-Packard Imaging Systems Division on synthetic aperture imaging. GPA: 4.9/5.0

Experience

WEST PARK HOSPITAL

January, 2003 to Present

Manager, Prevention and Wellness Office. Supervise five employees and over \$500,000 funded projects to prevent various behaviors including the misuse of alcohol, tobacco use among adults and youth, and incidence of cancer. Office also provides independent living support for youth aging out of foster care. Responsible for employee evaluations, goal setting, and fiscal management. Principle writer for all grants.

NORTHWEST COLLEGE

Fall 2002, Spring 2003, Fall 2005, Spring 2006

Adjunct faculty member teaching remedial math (Beginning and Intermediate Algebra) and Electrical Circuit Theory with Laboratory. Taught utilizing existing curricula as well as developed own curriculum for Electrical Circuit Theory. Developed own lab exercises. Received a rating of 4.7/5.0 by students for teaching effectiveness in Fall semester.

HIGH ROCKS EDUCATIONAL CORPORATION

June 2000 – December 2002

Worked as an independent contractor/ consultant to the board of directors with an overall goal of improving office operations and moving the organization towards long-term sustainability. Worked closely with the Executive Director. Developed financial procedures, helped train and

Cody, WY

Hillsboro, WV

Powell, WY

Joseph R. Otto, III (Jay) Page 2

empower the board of directors, wrote and received grants, managed day-to-day operations, and assisted in program delivery. At the conclusion of one-year engagement, High Rocks ended the year on budget, had raised funds to increase the next year's budget by approximately 50%, and hired new staff to address operational weaknesses. I raised over \$100,000 in grant funds for this organization.

RENEWABLE ENERGIES INC.

Slaty Fork, WV

June 1994 – March 2000

Founder and president of private for-profit corporation manufacturing wood pellet fuel from sawdust. Responsible for all aspects of business including initial financing, plant design, product design, marketing, sales, personnel, and oversight. Operated with 11 employees on three shifts and exceeded annual sales of \$500,000. Developed systems for intense quality control, customer satisfaction, and innovative marketing approaches. Plant closed due to entrance of large Canadian based competition in immediate vicinity.

Training Programs and Conferences

Park County Leadership Institute (Fall 2003 - Spring 2004)

Challenging College Alcohol Abuse (Spring 2004)

Social Norms Institute (Summer, 2004, 2005, 2006, 2007, 2008)

CENTER FOR CHANGE

1790 30TH STREET, SVITE 245, BOVLDER, CO 80301

MOTIVATIONAL INTERVIEWING TRAINING COSTS

Service Provider: Anjali Nandi

PART I: Basic MI Training; two days; one trainer; 20 participants

Description	Quantity	Unit Price	Total
Trainer Fees : 2 days; 20 participants Trainer Fees : Travel and Preparation	2	\$875 \$875	\$1,750.00 \$875.00
Travel Costs (Estimated) Airfare Hotel Meals per diem Rental car / cab	1 3 3 3	\$ 500 \$ 100 \$ 50 \$ 50	\$500.00 \$300.00 \$150.00 \$150.00
TOTAL FOR PAR PART II: Advanced Training; One day	RTI		\$3,725.00
Description	Quantity	Unit Price	Total
Trainer Fees : 1 day Trainer Fees : Travel and Preparation	1 0.5	\$875 \$875	\$875.00 \$437.50
Travel Costs (Estimated) Hotel Meals per diem Rental car / cab	2 2 2	\$ 100 \$ 50 \$ 50	\$200.00 \$100.00 \$100.00
Training Supplies Handouts	20	\$3	\$60.00

TOTAL FOR PART II

\$1,772.50