STATE OF INDIANA STRATEGIC PLAN

STRATEGIC PREVENTION FRAMEWORK STATE INCENTIVE GRANT

INTRODUCTION

The Strategic Prevention Framework State Incentive Grant (SPF SIG) is a five year cooperative agreement from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention (SAMHSA/CSAP) awarded to the Office of the Governor to reduce substance use and abuse across the lifespan of Indiana citizens. The vision of the SPF SIG is to Imagine Indiana Together- with a network of grassroots organizations collaborating to develop 'healthy, safe, and drug-free environments that nurture and assist all Indiana citizens to thrive.' With the administration of the initiative being awarded to the Division of Mental Health and Addiction (DMHA), a five year cooperative agreement involving assessment, capacity building, strategic planning, implementation and evaluation has begun. In creating a solid foundation for the SPF SIG, an Advisory Council, appointed by the Governor, was organized as well as a State Epidemiological Outcomes Workgroup (SEOW). The Governor's Advisory Council (GAC) was established to advise and assist in implementing the strategic planning process as required by CSAP. The focus of the SEOW is to collect and analyze data which indicates the focus for priorities to write an RFS, provide core support to the GAC for prevention decision making and provide systematic and analytical data to support recommendations of priorities for the project. This Strategic Work plan is organized in such a manor as to address, in sequence the requirements of building a cohesive plan which delineates the comprehensive assessment process, a review of the systems (capacity and infrastructure), the priorities, the planning and allocation process, cultural competency, sustainability, implementation and the evaluation of the SPF SIG project.

ASSESSMENT

1. Assessing the Problem – Indiana State Epidemiological Profile

Alcohol

Alcohol is the most frequently used drug in both Indiana and the United States. According to estimates from the 2004 National Survey on Drug Use and Health, NSDUH (Substance Abuse and Mental Health Services Administration, SAMHSA, 2006), 47.37% of Indiana residents 12 years and older currently consume alcohol (U.S.: 50.71%). Risky consumption patterns, such as binge and heavy drinking, as well as underage drinking, are of particular interest. The most recent 2004 NSDUH estimates report, 21.70% of Hoosiers 12 years and older engaged in binge drinking in the past month, i.e., they had five or more drinks on the same occasion (U.S.: 22.69%); and 40.60% reported heavy use, or consumption of five or more drinks on the same occasion on at least 5 different days in the past 30 days (U.S.: 41.30%). Especially, young adults between the ages of 18 and 25 seemed to be at risk, with 43.47% stating to have engaged in binge drinking within the last 30 days (U.S.: 41.39%; see Figure 1). The Behavioral Risk Factor Surveillance System, BRFSS (Centers for Disease Control and Prevention, CDC, 2005), shows that in 2005, 30.30% of all adults (18 years and older) reported binge drinking in the past month (U.S.: 23.50%).

According to the Youth Risk Behavior Surveillance System, YRBSS (CDC, 2006a), 41.4% of Indiana high school students had consumed at least one alcoholic beverage in the past 30 days.
Alcohol, Tobacco, and Other Drug Use by Indiana Children and Adolescents Survey, ATOD (Indiana Prevention Resource Center, IPRC, 2006) and Monitoring the Future Survey, MTF (National Institute on Drug Abuse, 2006a) report that in 2005, alcohol consumption in Indiana for 8th, 10th, and 12th grade students combined was as follows: lifetime use 49.0% (U.S.: 41.0%), annual use 39.0% (U.S.: 33.9%), monthly use 21.1% (U.S.: 17.1%), daily use 1.8% (U.S.: 0.5%), and binge drinking 11.6% (U.S.: 10.5%; see Figure 2).

Heavy alcohol use can lead to alcohol abuse and dependence and is associated with unsafe behaviors, such as smoking cigarettes, illicit drug use, and risky sex. According to the Treatment Episode Data System, TEDS (Substance Abuse and Mental Health Data Archive, SAMHDA, n.d.), 7.6% of Indiana residents were diagnosed with alcohol abuse and/or dependence in 2004 (U.S.: 7.5%). Another serious, long-term consequence of chronic alcohol use is liver disease. The Alcohol-Related Disease Impact (ARDI) database (CDC, 2004) estimated that in 2001, 8.0% of all deaths in Indiana were alcohol-related (U.S.: 8.0%). Furthermore, alcohol seems to be a contributing factor in fatal motor vehicle accidents, certain types of crime (e.g., aggravated assaults, sexual assaults, robberies, driving under the influence, liquor law violations, and public intoxication), and even homicides and suicides.

Tobacco

The deleterious effects of tobacco on population health have been widely studied and the results published. Cigarette smoking remains the leading cause of preventable death in the United States, accounting for approximately 1 of every 5 deaths (CDC, 2006b). Based on the 2003 – 2004 NSDUH, it is estimated that 32.32% of the Indiana population 12 years and older used a tobacco product in the past month (U.S.: 29.49%). The highest rate of current use was found among 18 to 25-year olds, with 48.20% (U.S.: 44.68%). Cigarettes were the most widely used tobacco product, contributing to a prevalence rate of 27.40% for Hoosiers 12 years and older (U.S.: 25.16%). Again, 18- to 25-year olds displayed the highest rate, with 42.48% (U.S.: 39.88%; see Figure 3). According to the 2005 BRFSS, the prevalence rate for adult smoking in Indiana was 27.3% (U.S.: 20.6%). The highest smoking rates were found in males (29.7%), s (36.8%; see Figure 4), 18- to 24-year olds (39.0%), individuals with less than high school education (49.3%), and persons whose annual income was below $15,000 (37.3%). Currently, Indiana ranks 2nd in adult smoking prevalence, exceeded only by Kentucky (28.7%).

The YRBSS reported that in 2005, 29.2% of Indiana high school students consumed a tobacco product (U.S.: 28.4%) and 21.9% smoked cigarettes (U.S.: 23.0%) in the past month. The highest smoking prevalence rates were found in males (23.2%), students who identified themselves as White (23.4%), and 12th grade students (22.9%). The Indiana Youth Tobacco Survey, IYTS (Indiana Tobacco Prevention and Cessation, ITPC, n.d.), and ATOD both show a steady increase in smoking rates from 6th to 12th grade. White and Hispanic middle and high school students displayed much higher smoking rates than Black students. Fortunately, both survey systems were able to report a decline in student smoking over the years.

Many health consequences are associated with tobacco consumption, particularly cancers (e.g., lung, oral cavity, larynx, pharynx, esophagus, etc.), coronary heart disease, respiratory illnesses, and others. Environmental tobacco smoke (ETS), or second-hand smoke, has been shown to cause major health problems as well. Furthermore, research shows that teens who smoke are three times more likely than nonsmokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine.

Smoking is also associated with a host of other risky behaviors, such as fighting and engaging in unprotected sex. The economic costs of tobacco use in the U.S. have been substantial; more than $167 billion in direct (medical) and indirect (e.g., lost productivity) expenses (CDC, 2006b).

Marijuana

Marijuana is the most commonly used illicit drug both in Indiana and the U.S. According to 2004 NSDUH estimates, 5.6% of Indiana residents age 12 years and older reported current use (U.S.: 6.1%), and 10.4% conveyed past year use of the drug. The age group mostly affected was 18- to 25-year olds (14.7%; see Figure 5). Current use increased from 4.4% in 1999 to 5.6% in 2004, but rates were still below the national average.

The 2005 YRBSS results for Indiana show that current marijuana use increased by grade, from 16.3% in 9th grade (U.S.: 17.4%) to 21.0% in 12th grade (U.S.: 22.8%). In regard to lifetime use, 38.2% of Indiana high school students admitted to having used marijuana one or more times during their life (U.S.: 38.4%), with 12th graders reporting the highest rate, 45.5% (U.S.: 47.6%; see Figure 6). ATOD and MTF surveys concluded similarly that past month and lifetime use of the substance increased with grade.

According to the 2004 TEDS, 52.6% of Indiana patients entering substance abuse treatment reported marijuana use at the time of admission (U.S.: 36.2%), and 24.6% stated that marijuana was their primary drug of choice (U.S.: 15.7%). Particularly, adolescents and young adults were affected: of patients under the age of 18 years, 86.7% reported using marijuana and 71.6% identified the substance as their primary drug; among the 18- to 24-year olds, 69.6% admitted to using marijuana and 39.1% named it their primary substance of abuse.

Health consequences of marijuana use include respiratory illnesses, weakened immune systems, and increased risk of heart attack and cancer. Individuals who take the drug are more likely to engage in risky sexual behaviors, use of tobacco and “harder” drugs, exhibit lower academic performance, and are less likely to graduate from high school. Long-term marijuana use can lead to dependence (NIDA, 2005). Legal/criminal consequences include drug possession and sale/manufacture arrests.

Cocaine

Cocaine is an addictive and powerful stimulant. It can be taken orally, intranasally, rubbed onto mucous tissues, injected intravenously, and its freebase form (e.g., crack) can be smoked (NIDA, 2004). The 2003 – 2004 NSDUH results reveal that an estimated 2.37% of Hoosiers 12 years and older used cocaine in the past year (U.S.: 2.42%), the highest rate of use was found among 18- to 25-year olds, 6.68% (U.S.: 6.62%; see Figure 7).

TEDS data for 2004 show that that 11.6% of Hoosiers in treatment reported cocaine as their primary substance problem (U.S.: 13.7%). Among Indiana patients citing cocaine as their primary drug problem, females (16.4%), s (21.7%), and 35- to 44-year olds (18.3%) displayed the greatest rate of use.

According to the 2005 YRBSS, 6.8% of Indiana high school students reported lifetime cocaine use (U.S.: 7.6%) and 3.0% confirmed they currently used the substance (U.S.: 3.4%). More male than female students reported lifetime and current use. The two racial/ethnic groups that displayed the highest rates of use in Indiana, lifetime and current, were White high school students and students who identified themselves as belonging to other racial categories. However, it is important to note that on the national level Hispanic students reported by far the greatest use of cocaine, but Indiana data for this ethnic group were not available. YRBSS data for Indiana from 2003 and 2005 show

a slight decline in lifetime use, from 7.9% to 6.8%, while current use remained fairly stable, 3.1% and 3.0%. The YRBSS as well as ATOD show an increase in rates by grade, with 12th grade students displaying the highest rate of use (see Figure 8).

The medical consequences of cocaine abuse are primarily cardiovascular problems, respiratory difficulties, neurological effects, and gastrointestinal complications. Babies born to mothers who abuse cocaine during pregnancy are often prematurely delivered and have low birth weights (NIDA, 2004). Additionally, users who inject cocaine intravenously are at a higher risk for acquiring and/or transmitting sexually transmitted diseases, if needles or other injection equipment is shared (Office of National Drug Control Policy, 2006). Legal consequences include drug arrests. During federal fiscal year 2003, cocaine was the primary drug involved in Federal arrests (11,794 Federal drug arrests for cocaine).

Heroin

Heroin is an illegal, highly addictive drug. It is both the most abused and the most rapidly acting of the opiate-type drugs. According to the U.S. Drug Enforcement Administration, DEA (2006), heroin does not present a major threat to Indiana, as it is not readily available in central and southern Indiana. The 2003 NSDUH estimated that 1.1% of Indiana residents 12 years and older had tried heroin at least once (U.S.: 1.6%). According to 2004 TEDS data, 3.0% of Hoosier patients reported heroin use at the time of treatment admission (U.S.: 17.1%). Within these treatment admissions, the highest use was found among males (60.4%), Whites (61.8%; see Figure 9), 25- to 34-year olds (26.9%) as well as 45- to 54-year olds (26.0%).

The ATOD surveys collected from 2000 to 2005 show that lifetime, annual, and monthly heroin use from 8th, 10th, and 12th grade students combined remained fairly constant in Indiana. For 2005, 1.90% of these students reported lifetime use (U.S.: 1.50%), 1.27% conveyed annual use (U.S.: 0.83%), and 0.80% admitted to monthly use (U.S.: 0.50%; see Figure 10).

Heroin abuse is associated with serious health conditions, including heroin dependence, fatal overdose, spontaneous abortion, collapsed veins, and, particularly in users who inject the drug, infectious diseases, including HIV/AIDS and Hepatitis C. Other health problems that have been reported in heroin abusers are infections of the heart lining and valves, abscesses, cellulites, liver disease, and pulmonary complications (NIDA, 2006b).

Methamphetamine

Methamphetamine (meth) is a powerful, highly addictive stimulant that affects the central nervous system. The drug is easily made in clandestine laboratories with over-the-counter ingredients.
Based on 2004 NSDUH results, it is estimated that of the national population 4.9% used meth at least once in their life, 0.6% used it in the past year, and 0.2% claimed current use of the substance. [No state-specific data was publicly available.]

The 2004 TEDS data show that at time of treatment admissions, 9.2% of Hoosier patients reported meth use at admission (U.S.: 10.2%). Highest rates were found among females (12.0%; see Figure 11), individuals who identified themselves as White (11.5%), and 25- to 34-year olds (12.9%). TEDS data from 2000 to 2004 demonstrate an increase in meth use in treatment admissions, from 4.0% (U.S.: 6.5%) to 9.2% (U.S.: 10.2%).

According to the YRBSS, 7.0% of Indiana high school students in 2005 reported to have tried methamphetamine at least once (U.S.: 6.2%). The rates of lifetime meth use were highest for males, 7.9% (U.S.: 6.3%), White students, 7.7% (U.S.: 6.5%), and increased with age, from 5.7% in 9th graders (U.S.: 5.7%) to 9.0% in 12th grade students (U.S.:

6.4%). Comparison of 2003 and 2005 data demonstrates a decline in lifetime meth use among high school students, from 8.2% (U.S.: 7.6%) to 7.0% (U.S.: 6.2%). However, it is important to note that while all other racial/ethnic groups decreased their rate of use from 2003 to 2005, Black students in Indiana increased their use from 2.7% to 3.7% (see Table 1).

Short-term health effects of methamphetamine use include increased wakefulness, physical activity, and decreased appetite as well as cardiac problems, hyperthermia, depression, and confusion. When used long-term, meth can cause impaired memory, mood alterations, diminished motor coordination, and psychiatric problems, insomnia, violent behavior, hallucinations, weight loss, stroke, and dependence. Other health consequences of prolonged meth use include cardiovascular collapse; brain, liver, and kidney damage; severe tooth decay (or "meth mouth"); hepatitis; extreme weight loss; mental illness; unsafe sex/risky sexual behavior; increased risk of STD/HIV transmission; unwanted pregnancy; and death (U.S. Office of National Drug Control Policy, ONDCP, 2003; NIDA, 2002 and 2005). Furthermore, meth labs and parental addiction pose serious risks to children due to the highly toxic fumes generated during production and because users frequently sleep for days, children often are neglected (National Drug Intelligence Center, NDIC, 2002). Over the last four years, Indiana has ranked in the top 10 states in the number of clandestine meth labs seized. In 2004, Indiana was ranked 10th and rose to 3rd in 2005, with 1,300 clandestine labs seized (U.S. DEA, 2006).

Prescription Drugs

The abuse of prescription drugs is a serious and growing public health problem in the United States. According to the U. S. Drug Enforcement Administration (2006), pain-reliving opioids and benzodiazepines are the most commonly abused prescription drugs in Indiana. The abuse of Ritalin by young people in high school and college settings is also an area of increasing concern.

Prescription Pain Relievers: According to 2004 NSDUH estimates, 5.44% of Indiana residents 12 years and older reported non-medical use of pain relievers in the past year (U.S.: 4.79%). The greatest rates of use were found among 18- to 25-year olds, 14.40% (U.S.: 11.95%), followed by 12- to 17-year olds, 8.31% (U.S.: 7.53%), and finally individuals 26 years and older, 3.38% (U.S.: 3.16%; see Figure 12).

The 2004 TEDS data reveal that 7.5% of Hoosiers reported using any pain reliever or other morphine-like substance at the time of treatment admission (U.S.: 6.0%). Of those admitted to treatment, mostly males (52.9%), White individuals (93.8%), and young adults (specifically, 25- to 34-year olds, 34.0%) were identified. A comparison of the data over the last 5 years shows a steady incline from 5.4% in 2000 to 7.5% in 2004.

Only a very small percentage of individuals under the age of 18 (less than 3.0%) reported current use of prescription pain medication or other morphine-type drugs upon entering substance abuse treatment in Indiana.

Benzodiazepines: The TEDS is currently the only source of information regarding benzodiazepine consumption available at both local and national levels. The 2004 TEDS data show that 3.7% of Indiana patients reported benzodiazepine use at treatment admission (U.S.: 2.2%); younger adults between 18 and 44 years being mostly affected. The rate of benzodiazepine use in patients remained fairly stable between 2000 (3.9%) and 2004 (3.7%).

Both in Indiana and in the rest of the U.S., approximately 5% or less of young people under the age of 18 reported benzodiazepine use at the time of treatment admission.

Ritalin: Information on general or adult consumption of Ritalin for non-medical purposes is currently not available on either the national or the local-level. According to the ATOD

and MTF surveys for 2005, 3.8% of 12th grade students in Indiana reported to have used Ritalin within the past year (U.S.: 0.2%; see Figure 13). This represents a small decrease in the annual use rate from 2001 (4.7%).

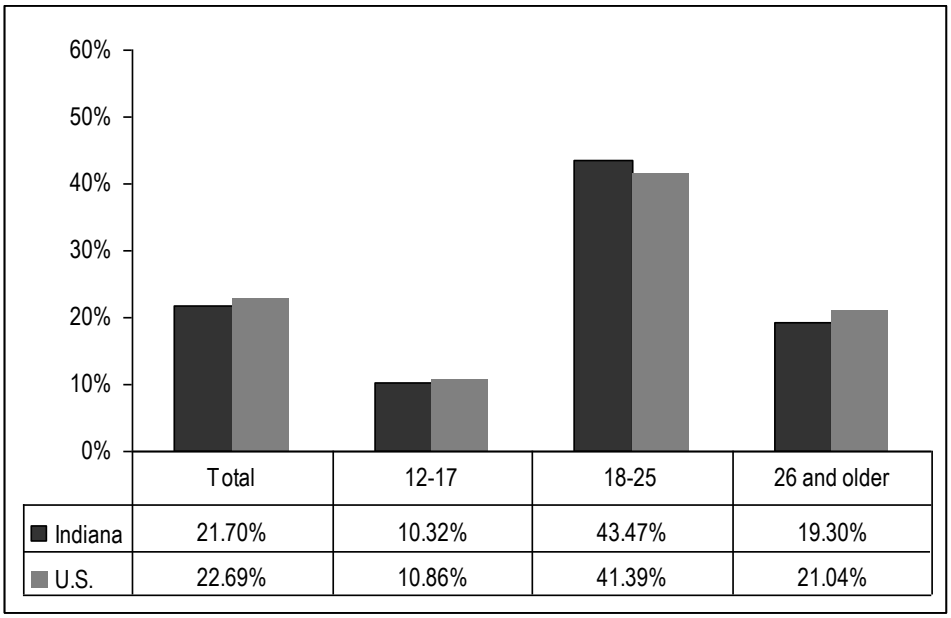
The consequence for prescription drug abuse is substance dependence.

Polysubstance Abuse

Polysubstance abuse refers to using two or more substances in combination. A review of Indiana and United States TEDS data for the years 2000 through 2004 shows that over 50% of individuals seeking substance abuse treatment report using at least two drugs at the time they enter treatment. Across the years, polysubstance abusers were more likely to be male, White, and between 18 and 44 years of age. According to the 2004 TEDS data, the drugs mostly named as primary, secondary, or tertiary substance problem by patients at the time of treatment admission were alcohol, marijuana/hashish, and cocaine/crack. The rates for all tertiary substance use in Indiana exceeded national rates (see Table 2). Hoosier patients also reported more substances used at admission into treatment than U.S. patients.

FIGURES

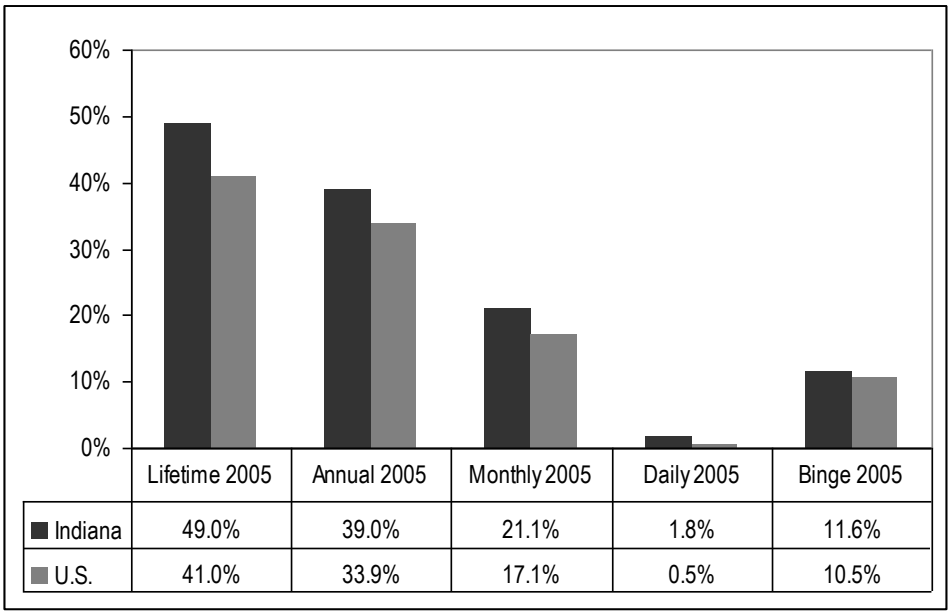
Figure 1: Percentage of Indiana and U.S. Population, 12 Years and Older, Reporting Binge Drinking in the Past Month, Based on 2003 and 2004 Averages (NSDUH, 2003 - 2004)



	Total	12-17	18-25	26 and older
Indiana	21.70%	10.32%	43.47%	19.30%
U.S.	22.69%	10.86%	41.39%	21.04%

Source: Substance Abuse and Mental Health Services Administration, 2006

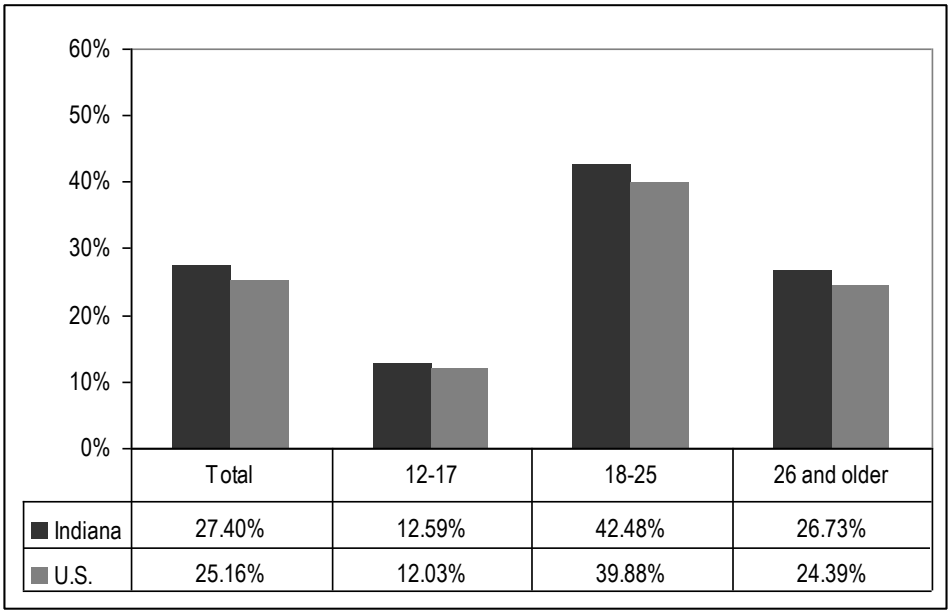
Figure 2: Percent of Indiana and U.S. Middle and High School Students (8th, 10th, and 12th Grades Combined) Reporting Alcohol Use, for 2005 (ATOD and MTF, 2005)



	Lifetime 2005	Annual 2005	Monthly 2005	Daily 2005	Binge 2005
Indiana	49.0%	39.0%	21.1%	1.8%	11.6%
U.S.	41.0%	33.9%	17.1%	0.5%	10.5%

Source: Indiana Tobacco Prevention and Cessation, n.d.; National Institute on Drug Abuse, 2006a

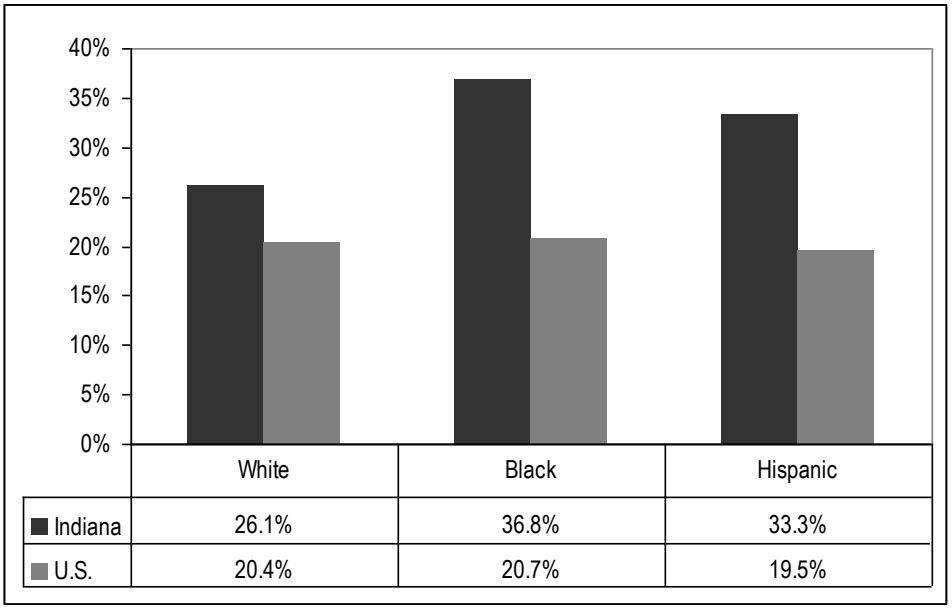
Figure 3: Percentage of Indiana and U.S. Population (12 Years and Older) Reporting Cigarette Use in the Past Month, Based on 2003 and 2004 Averages (NSDUH, 2003-2004)



	Total	12-17	18-25	26 and older
Indiana	27.40%	12.59%	42.48%	26.73%
U.S.	25.16%	12.03%	39.88%	24.39%

Source: Substance Abuse and Mental Health Services Administration, 2006

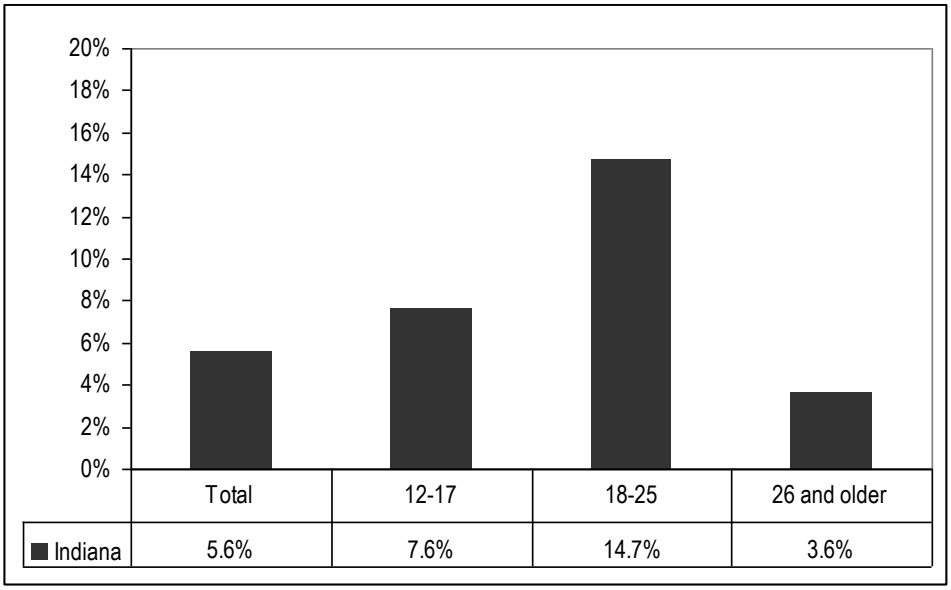
Figure 4: Adult (18 Years and Older) Smoking Prevalence for Indiana and the U.S., by Race/Ethnicity, for 2005 (BRFSS, 2005)



	White	Black	Hispanic
Indiana	26.1%	36.8%	33.3%
U.S.	20.4%	20.7%	19.5%

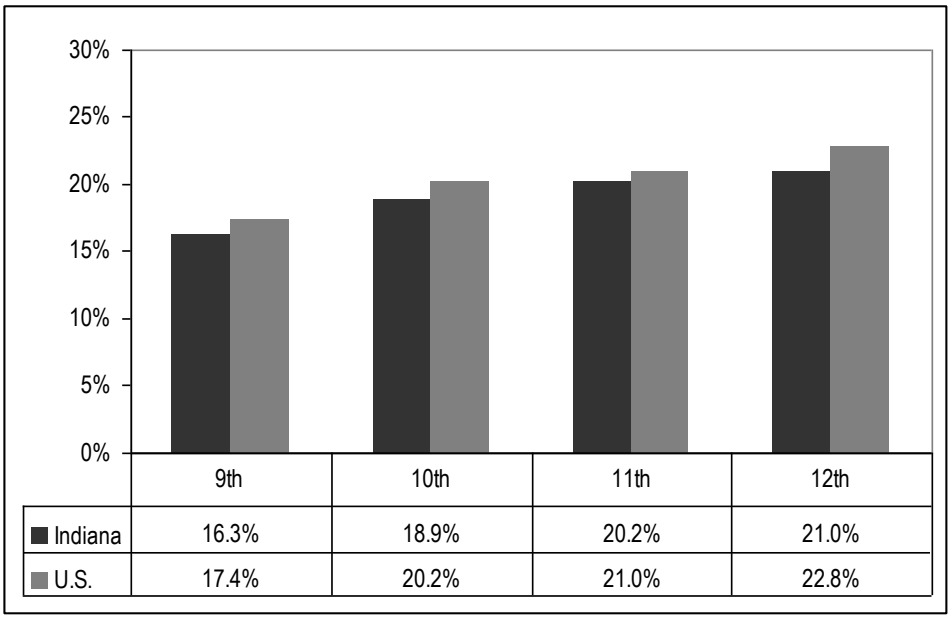
Source: Centers for Disease Control and Prevention, 2005

Figure 5: Percentage of Indiana Residents Reporting Current (Past Month) Marijuana Use, by Age Group, Based on 2003 - 2004 Averages (NSDUH, 2003 - 2004)



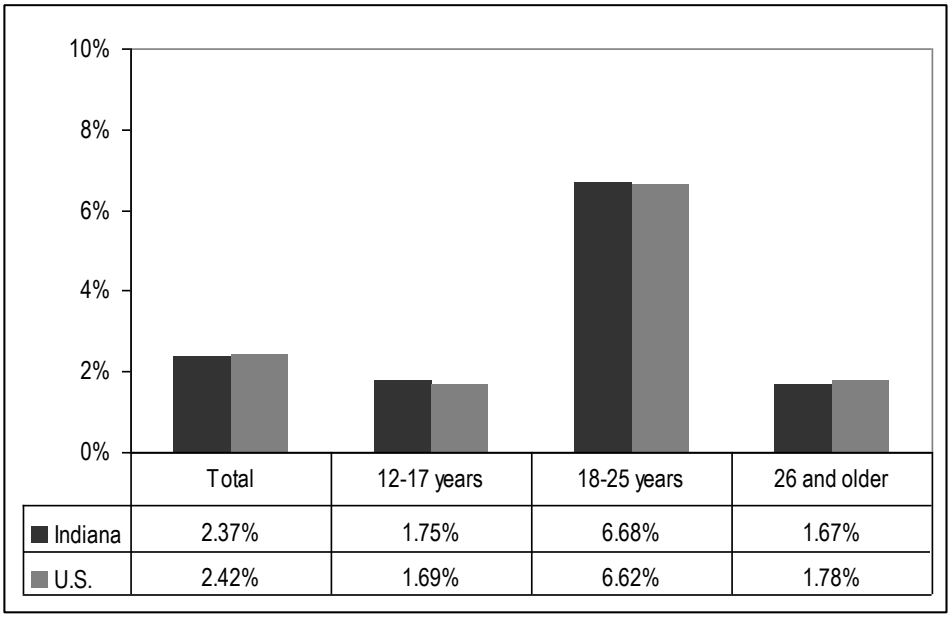
Source: Substance Abuse and Mental Health Services Administration, 2006

Figure 6: Percentage of Indiana and U.S. High School Students (9th – 12th grade) Reporting Current Marijuana Use, by Grade, for 2005 (YRBSS, 2005)



Source: Centers for Disease Control and Prevention, 2006a

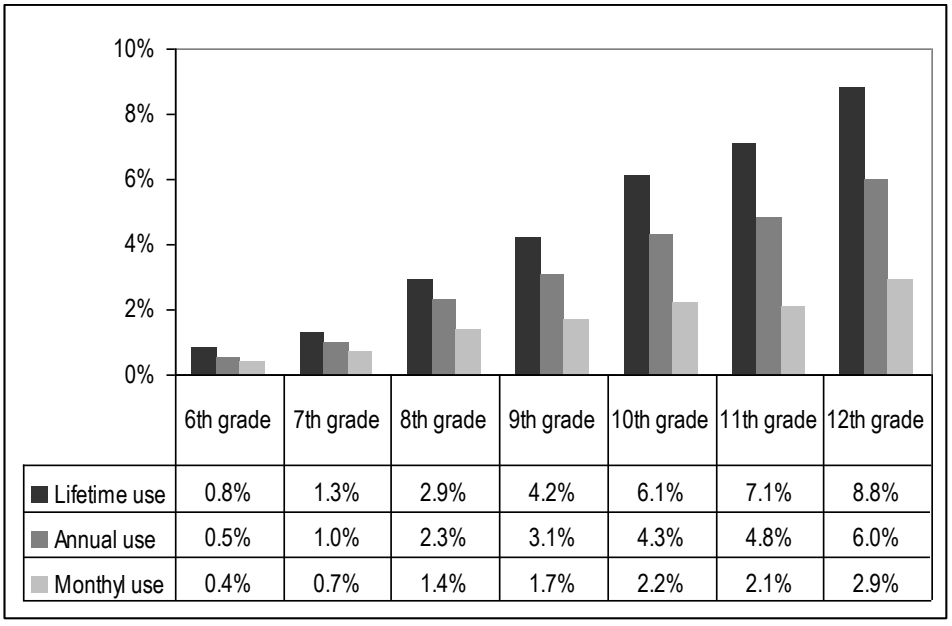
Figure 7: Percentage of Indiana and U.S. Population (12 years and older) Reporting Cocaine Use in the Past Year, by Age Group, Average from 2003 and 2004 (NSDUH, 2003 – 2004)



	Total	12-17 years	18-25 years	26 and older
Indiana	2.37%	1.75%	6.68%	1.67%
U.S.	2.42%	1.69%	6.62%	1.78%

Source: Substance Abuse and Mental Health Services Administration, 2006

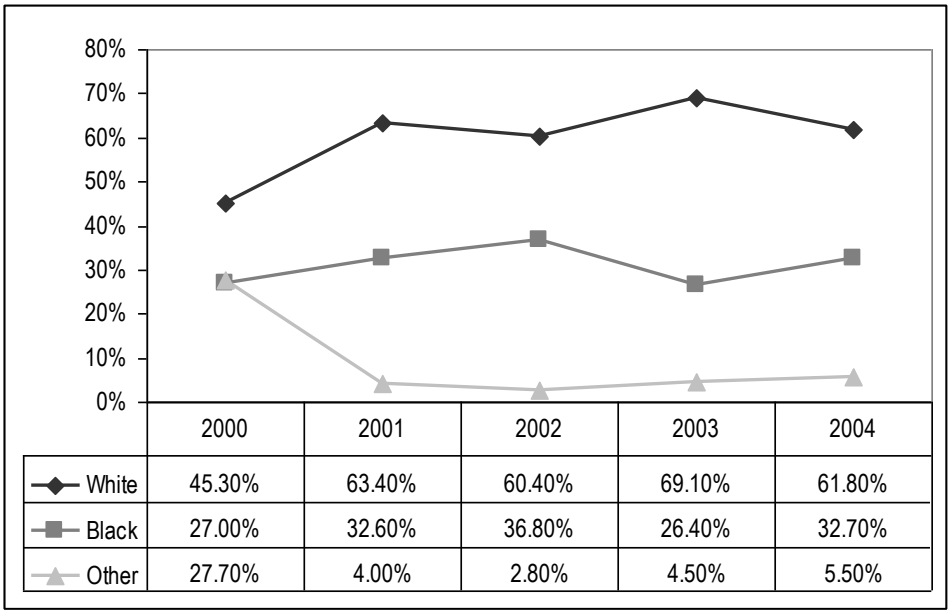
Figure 8: Percentage of Indiana 6th – 12th Grade Students Reporting Lifetime, Annual, and Monthly Cocaine Use, by Grade, for 2005 (ATOD, 2005)



	6th grade	7th grade	8th grade	9th grade	10th grade	11th grade	12th grade
Lifetime use	0.8%	1.3%	2.9%	4.2%	6.1%	7.1%	8.8%
Annual use	0.5%	1.0%	2.3%	3.1%	4.3%	4.8%	6.0%
Monthyl use	0.4%	0.7%	1.4%	1.7%	2.2%	2.1%	2.9%

Source: Indiana Prevention Resource Center, 2006

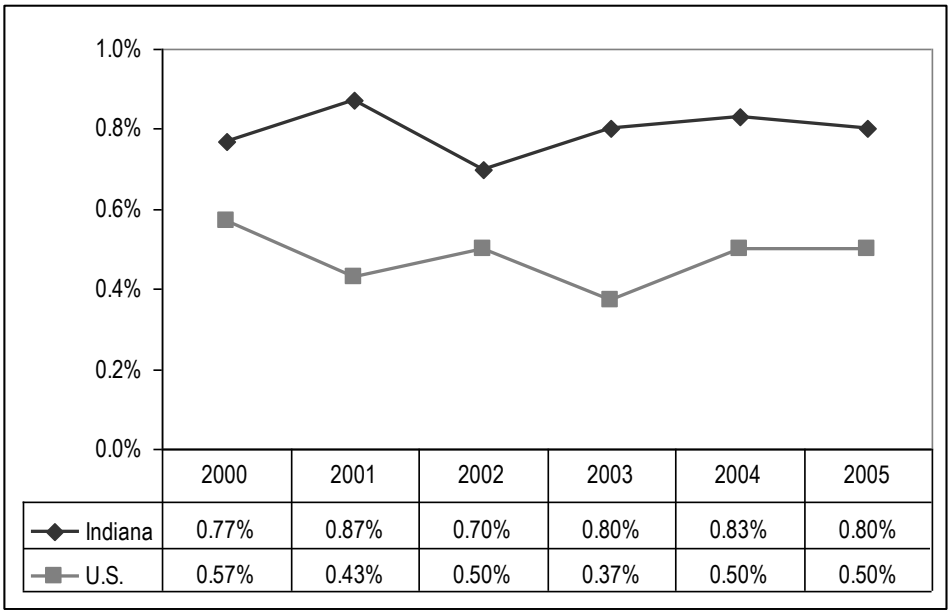
Figure 9: Percentage of Indiana Adults Reporting Heroin Use at Time of Treatment Admission, by Race, from 2000 to 2004 (TEDS, 2000 – 2004)



	2000	2001	2002	2003	2004
White	45.30%	63.40%	60.40%	69.10%	61.80%
Black	27.00%	32.60%	36.80%	26.40%	32.70%
Other	27.70%	4.00%	2.80%	4.50%	5.50%

Source: Substance Abuse and Mental Health Data Archive, n.d.

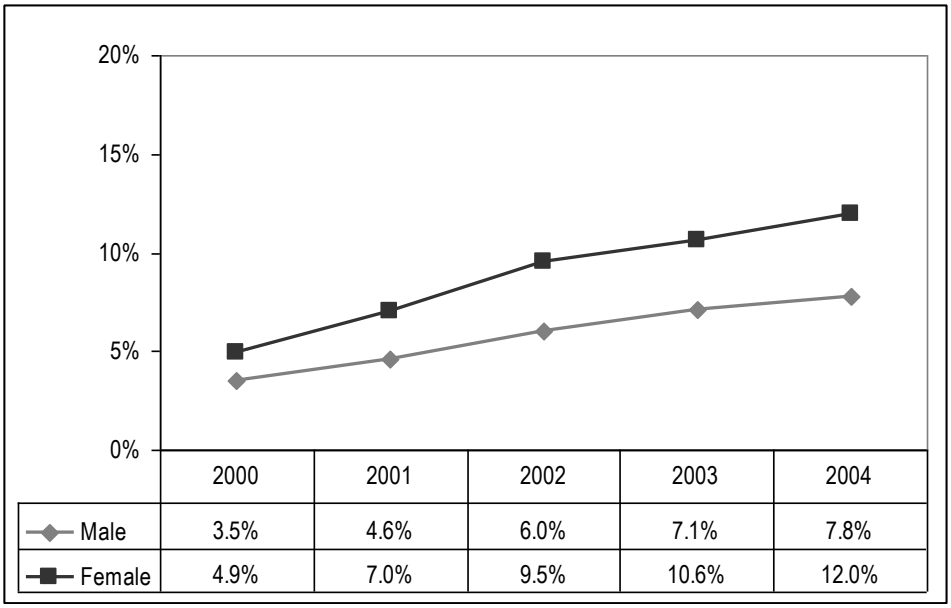
Figure 10: Percentage of Indiana and U.S. Students (8th, 10th, and 12th Graders Combined) Reporting Monthly Heroin Use, from 2000 to 2005 (ATOD and MTF, 2000 – 2005)



	2000	2001	2002	2003	2004	2005
Indiana	0.77%	0.87%	0.70%	0.80%	0.83%	0.80%
U.S.	0.57%	0.43%	0.50%	0.37%	0.50%	0.50%

Source: Indiana Prevention Resource Center, 2006

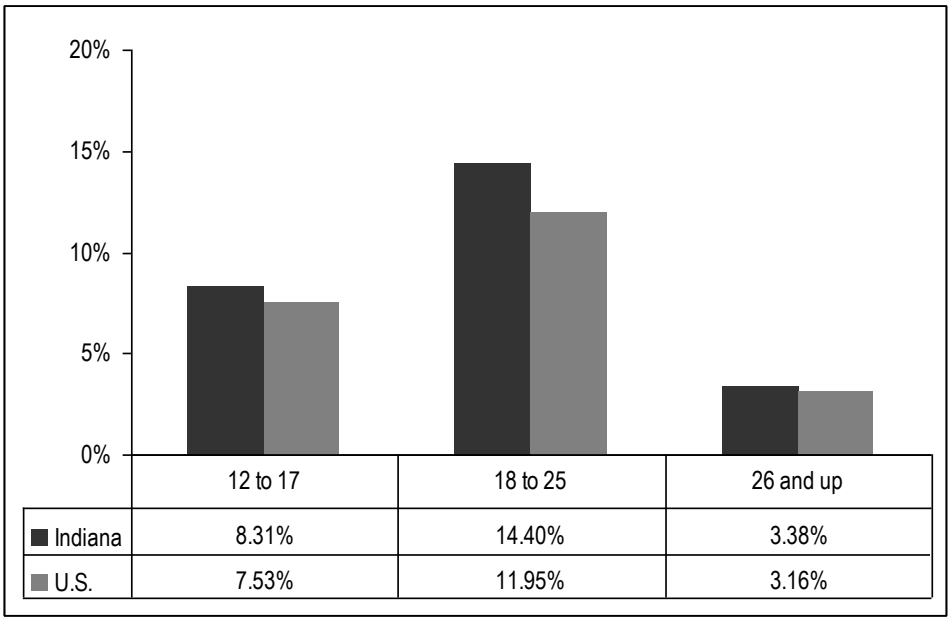
Figure 11: Percentage of Indiana Treatment Admissions Reporting Methamphetamine Use at Admission, by Gender, from 2000 to 2004 (TEDS, 2000 – 2004)



	2000	2001	2002	2003	2004
Male	3.5%	4.6%	6.0%	7.1%	7.8%
Female	4.9%	7.0%	9.5%	10.6%	12.0%

Source: Substance Abuse and Mental Health Data Archive, n.d.

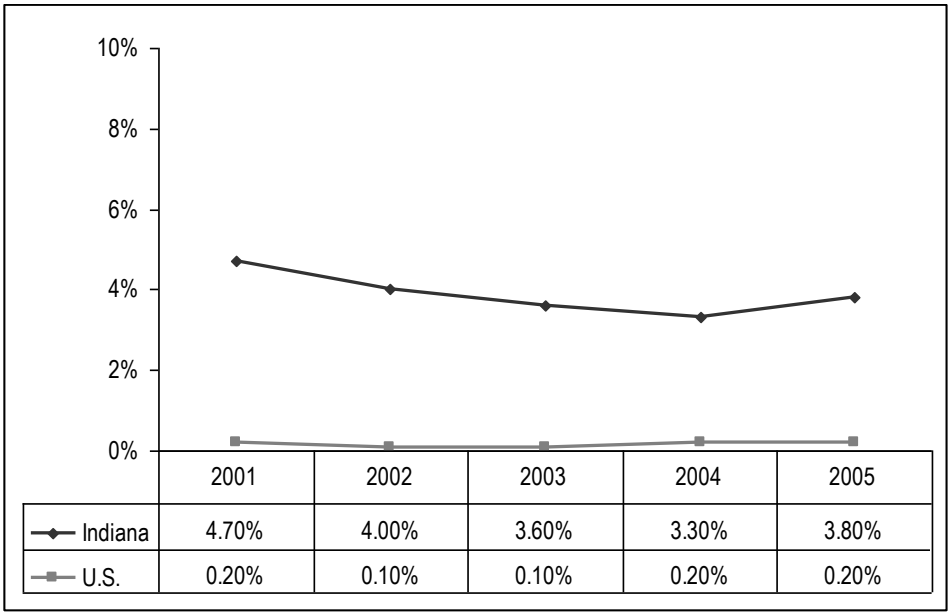
Figure 12: Prevalence of Lifetime Pain Reliever Use in Indiana and the U.S., by Age Group, for 2004 (NSDUH, 2004)



	12 to 17	18 to 25	26 and up
Indiana	8.31%	14.40%	3.38%
U.S.	7.53%	11.95%	3.16%

Source: Substance Abuse and Mental Health Services Administration, 2006

Figure 13: Percentage of Indiana and U.S. 12th Grade Students Reporting Annual Ritalin Use, from 2001 to 2005 (ATOD and MTF, 2001 – 2005)



	2001	2002	2003	2004	2005
Indiana	4.70%	4.00%	3.60%	3.30%	3.80%
U.S.	0.20%	0.10%	0.10%	0.20%	0.20%

Source: Source: Indiana Tobacco Prevention and Cessation, n.d.; National Institute on Drug Abuse, 2006a

TABLES

Table 1: Percentage of Indiana and U.S. High School Students (9th – 12th Grade) Reporting Lifetime Methamphetamine Use, by Race, for 2003 and 2005 (Youth Risk Behavior Surveillance System, 2003 and 2005)

	Year	Indiana	U.S.
Black students	2003	2.7%	3.1%
	2005	3.7%	1.7%
White students	2003	8.6%	8.1%
	2005	7.7%	6.5%
Other students	2003	12.8%	10.4%
	2005	4.6%	6.4%

Source: Centers for Disease Control and Prevention, 2006a

Table 2: Percentage of Indiana and U.S. Patients in Substance Abuse Treatment Reporting Primary, Secondary, and Tertiary Drug Problems (Treatment Episode Data System, 2004)

Substance	Primary problem		Secondary problem		Tertiary problem	
	Indiana	**U.S.**	**Indiana**	**U.S.**	**Indiana**	**U.S.**
Alcohol	48.9%	41.0%	30.0%	19.3%	17.3%	7.6%
Cocaine/crack	11.6%	14.0%	11.1%	15.9%	13.3%	5.7%
Marijuana/hashish	24.6%	16.2%	35.6%	17.7%	17.4%	7.6%
Heroin	2.2%	14.5%	0.7%	2.3%	1.2%	1.0%
Non-prescription methadone	0.2%	0.2%	0.2%	0.2%	0.3%	0.1%
Other opiates and synthetics	3.8%	3.3%	3.4%	2.2%	5.0%	1.3%
PCP	0.2%	0.2%	0.2%	0.2%	0.3%	0.2%
Hallucinogens	0.8%	0.1%	1.2%	0.3%	1.7%	0.5%
Methamphetamine	5.0%	7.0%	4.1%	2.7%	5.4%	1.5%
Other amphetamines	0.2%	1.2%	0.5%	0.6%	0.9%	0.5%
Other stimulants	0.1%	0.1%	0.3%	0.2%	0.6%	0.2%
Benzodiazepines	0.8%	0.4%	2.5%	1.2%	4.3%	1.0%
Other tranquilizers	0.0%	0.0%	0.2%	0.1%	0.4%	0.1%
Barbiturates	0.2%	0.1%	0.2%	0.1%	0.3%	0.1%
Other sedatives or hypnotics	0.3%	0.2%	0.6%	0.4%	1.1%	0.3%
Inhalants	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%
Over-the-counter medication	0.0%	0.0%	0.2%	0.1%	0.2%	0.1%
Other	0.4%	0.5%	3.0%	1.5%	6.2%	1.0%

Source: Substance Abuse and Mental Health Data Archive, n.d.

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Assessing the Systems (Capacity and Infrastructure)

The findings and supporting material from the first Indiana State Incentive Grant (SIG 1) final report, *Imagine Indiana Together: The Framework to Advance the Indiana Substance Abuse Prevention System* (2005), provides
useful background information on state- and community-level programs and activities. The nature of Indiana's prevention infrastructure is varied and comprises a number of resources, including the following:

- Programs and initiatives supporting prevention activities and targeting risk factors,
- Community support/coalition building,
- Media campaigns,
- Research and data collection,
- Technical assistance, and
- Alcohol, tobacco, and other drug (ATOD) supply and reduction/enforcement.

A select list and brief description of specific state- and community-level programs is provided below. (See Capacity Building Section 2).

The Division of Mental Health and Addiction (DMHA) oversees the state's prevention infrastructure in Indiana. DMHA works closely with the Indiana Criminal Justice Institute (ICJI) to link the resources, advocacy, collaboration, and coordination among state, regions, localities and citizens of Indiana to mobilize and create a safer and healthier state. In turn ICJI has organized the Local Community Councils that are charged with identifying alcohol, tobacco and other drug abuse problems, and to plan, promote and coordinate community efforts and resources to reduce the abuse. DMHA coordinates its efforts through a contract with the Indiana Prevention Resource Center (IPRC) at IU Bloomington, to serve as a RADAR Center, a statewide clearinghouse for alcohol, tobacco and other drug prevention resources for those working in drug prevention in Indiana. The IPRC also coordinates the annual survey of Children and Adolescents for Alcohol, Tobacco and Other Drug Use. ICJI and the IPRC are instrumental in assisting the efforts of DMHA to bring a collaboration of efforts for substance abuse to the state of Indiana.

Indiana is fortunate in having Local Community Councils (LCC's) in all 92 counties. The LCC's lead the efforts in each county of the state to develop local strategic plans in the areas of Prevention, Treatment and Criminal Justice and to the build capacity to address these issues. Many of the LCC's have established relationships with a corresponding Drug Free Community. To assist the LCC's the Governor's Commission for a Drug Free Indiana (Commission) has a system of Community Consultants that provide technical assistance, resources and serve as a liaison between the counties and the state. The SPF process is currently being promoted in each county through the LCC's. These efforts along with other activities are assisting in the solidification and coordination of the many organizations and agencies, under the authority of the Division of Mental Health and Addiction, to create a more cohesive and solid infrastructure for addressing the substance abuse issues of Indiana.

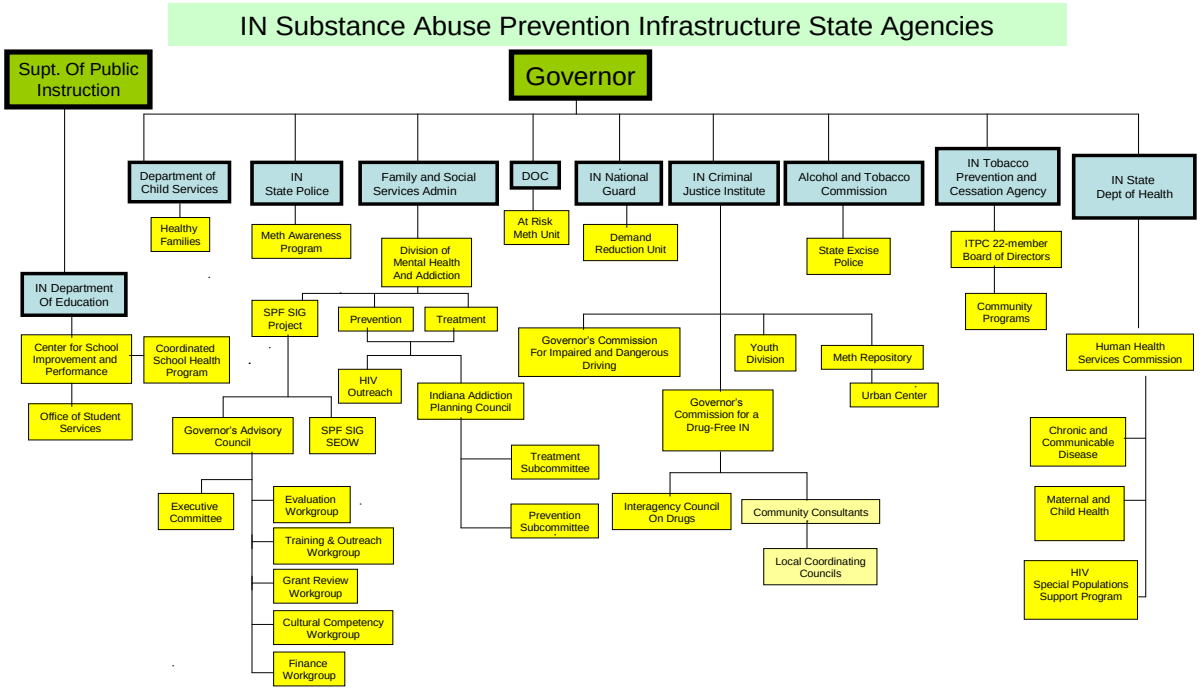
The Indiana Prevention Resource Center (IPRC) is another vital avenue to assist with the SPF processes**.** The IPRC at Indiana University is a statewide clearinghouse for alcohol, tobacco and other drug prevention resources for those working in drug prevention in Indiana. They have worked with the state in training many of the communities on the processes of assessment and development with the first State Initiative Grant. The IPRC understands the intricacies of the SPF process and how to guide the communities in identifying, understanding and analyzing data to identify their problem areas. The IPRC is partnering with the DMHA Staff, LCC's, Community Consultants, Office of Faith Based Community Initiatives, and the SEOW in providing Regional Technical Assistance to potential applicants and is one of the main leaders

the communities will have available to them in walking through the planning phase of the SPF processes.

Another strong foundation in Indiana is the Office of Faith Based Initiatives. They are a state leader in assisting communities in organizational assessment and development while establishing the SPF process as a cornerstone component of strategic planning.

DMHA is directing the efforts of the SPF SIG, providing the beginnings of a solid foundation from which the SPF process can begin to become a foundational keystone in building data-driven decision making for our state, with these pre-existing infrastructures, as well as others.

Some of the gaps that Indiana is challenged with are the silos that have formed in addressing prevention of substance abuse in the state. These are a product of federal and state funding streams. Currently there are a handful of organizations/agencies that work only within their own domain to address these issues. Efforts are at times duplicated and competitive relationships have surfaced, which poses the antithesis of having a unified effort to combat the state's substance abuse issues. The Commission for Drug Free Indiana established by the Governor brings together the efforts of treatment, prevention and criminal justice within the state to coordinate these efforts. The SPF SIG staff has collaborated with The Commission and created this flowchart identifying resource entities to assist in offering a visual of all the players attempting to reduce substance abuse within the state of Indiana.



The Commission has welcomed the input and embraces the SPF process as a reliable tool with which the various entities can create their own individual strategic plans. The Commission has recognized and accepted the flowchart as a tool to continue the work in bringing together and building the infrastructure within the state. The six priorities, identified by the SEOW, have been accepted as state priorities and are recognized by The Commission and the State as such, and are not only the priorities of the SPF SIG project.

The capacity of the state to collect, analyze, and report data to support the data-driven decision making process will be greatly enhanced by the LCC's and work of the IPRC, and now the SEOW. Each potential recipient will need to identify themselves as a high need/high capacity community through reviewing the SEOW reports, priority indicators, and tables and graphs. The communities will also have available the LCC's and IPRC to assist in interpreting the available data or to further explore additional comparable data. The LCC's are specifically established to be a community resource to assist with prevention infrastructure. The gaps that exist with the LCC's are with those whose communities which are quite small and are in need of support from bordering counties which the Community Consultants who work with the LCC's are helping us to identify and connect with. Each community has a Consultant assigned to them and the availability of the IPRC staff to walk them through the process of identifying and building capacity where they are lacking. The SEOW will also be available to assist communities in the state in coordinating and analyzing the collection of state-wide data.

Some of the counties who haven't an established relationship with the Community Consultant's may try and come to the table without that partnership. They will be redirected to return and partner with the consultants. It will be the expectation that each community awarded grant monies will already have or need to establish a working relationship with the Consultant's and the LCC's and respond to the request of exploring and reporting their data, and use the SPF process. The SPF SIG Evaluation Team is establishing an electronic reporting system to be utilized by each community to increase data collection within the state of Indiana. The communities will be instructed and informed on what specific data needs to be reported and how to report it. The SPF SIG Evaluation Team will report all data collected back to the state and the Workgroups of the SPF SIG.

Financial Resources

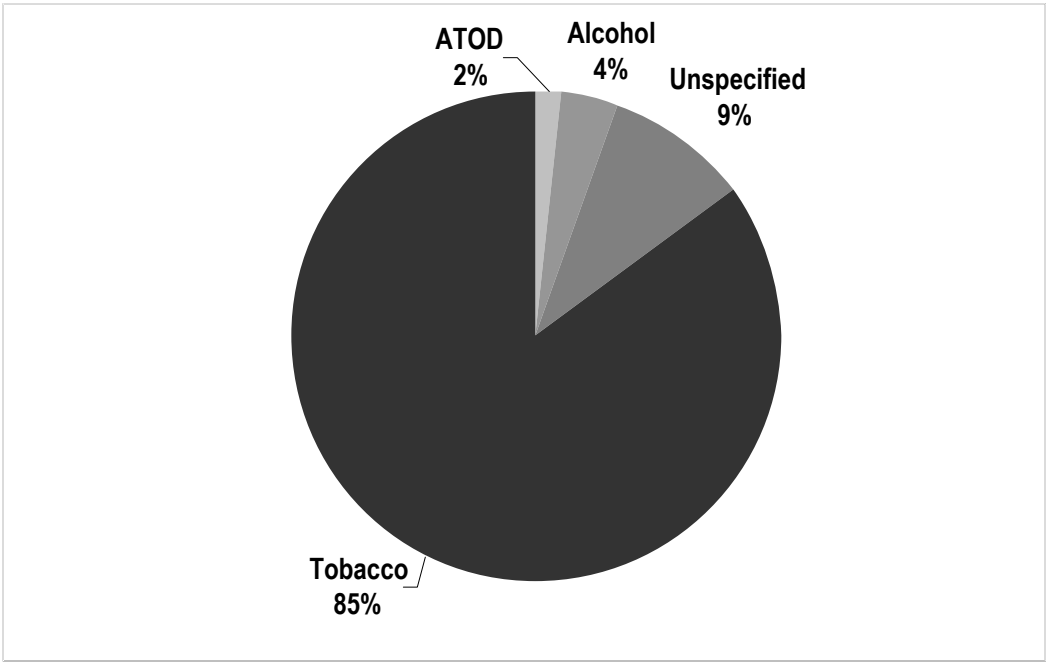
Information regarding current, State Fiscal Year (SFY) 2006, allocation of financial resources to prevention programming and activities is more easily accessible. The SIG 1 report referenced above included three tables covering differences in state and federal funding between SFY 2000 and 2003, as well as interagency fund transfers for the same periods. For this effort, these tables were updated to include resource allocation for SFY 2006. Three additional columns were added to these tables and highlight, when available, substances targeted, target population(s), and specific programs funded. The information included in these tables was provided by a number of state agency representatives with knowledge of state and federal funding streams and substance abuse prevention programming. (See Tables 3 through 5 below and associated endnotes for further detail.)

State Funding

Table 3 depicts state prevention dollars and clearly illustrates that tobacco settlement dollars represent the vast majority of state-level funding ($10.8 million, SFY '06). The Indiana Tobacco Prevention and Cessation program (ITPC) is the recipient of these funds. Figure 14 further demonstrates that, in terms of substances targeted with state dollars, 85% of funding is aimed at tobacco. Other recipients of relatively substantial state funding, specifically state user fees, include ICJI's Governor's Council on Impaired and Dangerous Driving (GCIDD) and Safe Haven programs. Based on currently available data, overall state funding for prevention has dropped by 64.3

percent from $35.6 million in SFY '03 to $12.7 million, due to lower tobacco settlement funds in SFY '06 than '03[1] and state user fees.

Figure 14: Percentage of State Funding Resources Allocated to Target Substances, SFY 2006

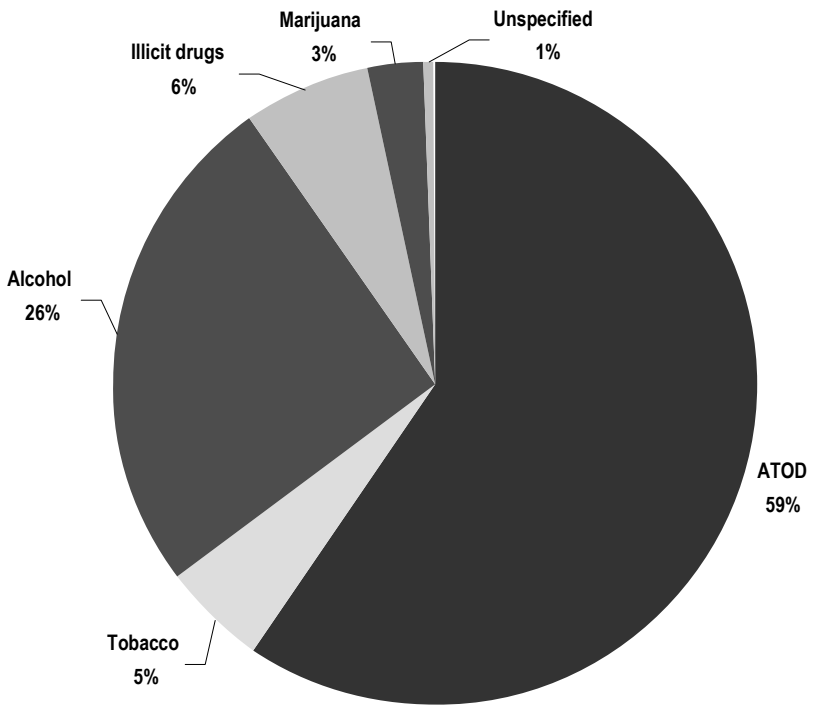


Federal Funding

The majority of available resources for prevention in Indiana come from federal government grants and/or from block grants. Among all state prevention agencies, the DMHA is the recipient of the largest federal prevention funding dollars, including the prevention portion of the SAMHSA Substance Abuse Prevention and Treatment (SAPT) block grant and SIG funds. Regulations of the block grant require a minimum of 20 percent of available funds be set aside for substance abuse prevention. Overall, federal funding for Indiana prevention activities has declined by 13.7 percent from $30.7 million in SFY '03 to $26.5 million SFY '06. Many of the figures provided for agencies listed in Table 4 reveal less federal funding in SFY '06 than in previous years. While most state-level funding is associated with tobacco use prevention, federal resources support a number of programs that target a broader range of substances, i.e. ATOD. (See Figure 15)

[1] According the SIG 1 final report, *Imagine Indiana Together: The Framework to Advance the Indiana Substance Abuse Prevention System*, "In the 2003 legislative session, the Indiana General Assembly reduced the amount of the settlement available for tobacco control to $10.8 million and diverted the remaining amount to the state General Fund." (2005, 37)

Figure 15: Percentage of Federal Funding Resources Allocated to Target Substances, SFY 2006



Interagency Transfers

The volume of interagency transfers also has declined from roughly $6.1 million in 2003 to $4.3 million in 2006. This is likely a reflection of lower state and federal funding levels. A substantial portion of current interagency financial collaborations target ATOD (43 percent), with roughly one-third aimed at alcohol and one-fifth dedicated to tobacco prevention. (See Table 5 and Figure 16)

Figure 16: Percentage of Interagency Fund Transfers Allocated to Target Substances, SFY 2006

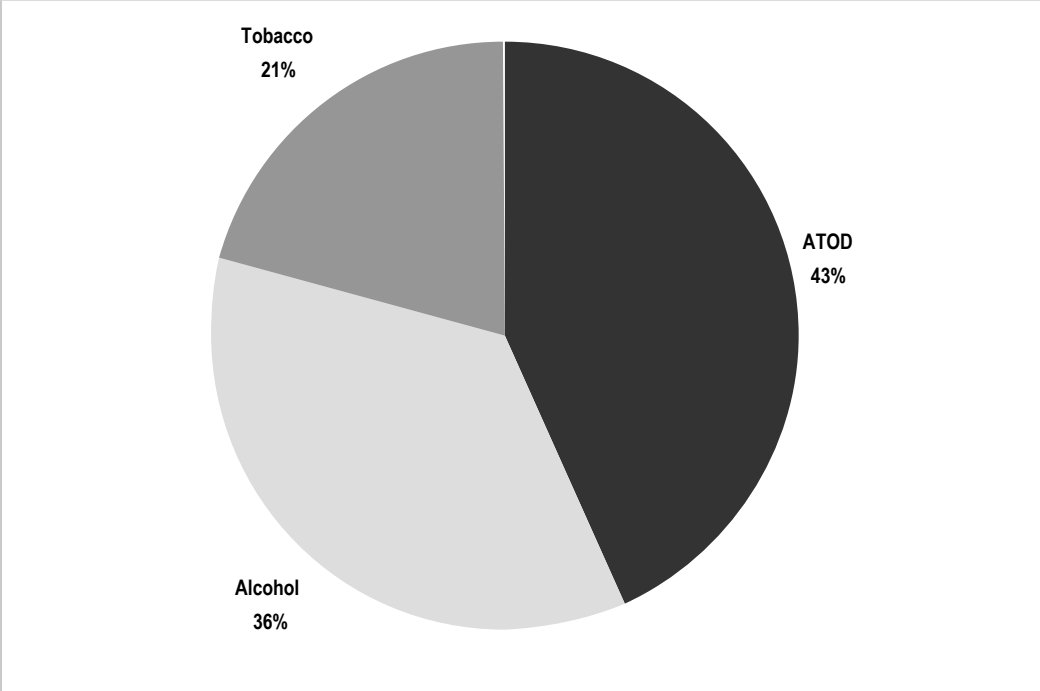


Table 3: Differences in State Funding: 2000, 2003, 2006

From	To State Agency	$ Amount '00	$ Amount '03	$ Amount '06	Substance(s) targeted	Target Population	Specific Programs Funded
General Revenue	IDOE	70,000	71,230	72,454[1]	ATOD	Youth in grades K through 12	Programs and strategies that reduce violence and the illegal use of drugs, alcohol, and tobacco
Controlled Substances Excise Tax (Drug-Free Communities Fund)	GCDFI	509,000		132,587[2]	ATOD	Total	GCDFI administration
State User Fees (Alcohol Counter Measures)	GCIDD	500,000		500,000[3]	Alcohol	Unspecified	Unspecified
State User Fees (Safe Haven State Fund)	ICJI	3,000,000	3,000,000	1,200,000[4]	Unspecified	Unspecified	Unspecified
Tobacco Settlement (pre-ITPC)	Attorney General	1,500,000	0	0[5]	Tobacco		
Tobacco Settlement Funds	ITPC	0	32,500,000	10,800,000	Tobacco	Tobacco retailers, among others	TRIP, SYNAR, among others
TOTAL		**5,579,000**	**35,571,230**	**12,705,041**			

See Appendix A for a list key abbreviations

Table 4: Differences in Federal Funding: 2000, 2003, 2006

From Federal Source	To State Agency	$ Amount '00	$ Amount '03	$ Amount '06	Substance(s) targeted	Target Population	Specific Programs Funded
SAMHSA: SAPT Treatment	DMHA	25,406,000[vi]	25,652,000	25,499,633[vii]	ATOD	Total[viii]	Treatment services
SAMHSA: SAPT Prevention	DMHA	7,104,000	7,258,000	7,588,518[ix]	ATOD	10-14 year olds[x]	Afternoons ROCK Prenatal and postnatal programs
SAMHSA: SIG Grant	DMHA	2,500,000	2,500,000		ATOD	Substance-specific[xi]	
SAMHSA: SPF SIG Grant	DMHA			2,300,000	ATOD	Substance-specific	
DOE: SDFS – Gov's Port.	Gov's Office/ ICJI	1,500,000	1,500,000	1,175,950[xii]	ATOD[xiii]	Youth in grades K through 12	Programs and strategies that reduce violence and the illegal use of drugs, alcohol, and tobacco
DOE: SDFS	IDOE	6,170,000	5,994,000	4,703,801[xiv]	ATOD[xv]	Youth in grades K through 12	Programs and strategies that reduce violence and the illegal use of drugs, alcohol and tobacco
CDC, Office of Smoking and Health	ISDH	1,500,000	1,500,000	1,340,167[xvi]	Tobacco	Unspecified	Unspecified
Title V Maternal & Child Health BG	ISDH – PSUPP	91,363	100,158	147,301[xvii]	Unspecified	Prenatal	PSUPP
Federal DOT – 402 & 410 funds	GCIDD	5,100,000	8,100,000	6,478,431[xviii]	Alcohol	Total, with focus on 18 to 34 year old white males	Alcohol and DUI enforcement aimed at reducing crashes and fatalities from driving under the influence of drugs and alcohol
OJJDP – EUDL	ICJI – Youth Division	360,000	360,000	350,000[xix]	Alcohol	Youth, under the age of 21	Unspecified
DoD Congressional "Plus-up"	ING	1,000,000	500,000	0[xx]	Illicit drugs	Lake County Middle Schools	Drug Demand Reduction
DoD	ING	2,200,000	2,200,000	1,700,000[xxi]	Illicit drugs	Indiana Middle Schools – Mainly Indianapolis	Drug Demand Reduction
U.S. DEA	ISP	625,000	675,000	704,227[xxii]	Marijuana	Total/Unspecified	Marijuana Eradication
FDA	ISEP		0	0[xxiii]	Tobacco	Under 18	TRIP
TOTAL (Prevention funds)[xxiv]		**28,150,363**	**30,687,158**	**26,488,395**			

See Appendix A for a list key abbreviations

Table 5: Differences in Interagency Funding Transfers: 2000, 2003, 2006

From State Agency	To State Agency	$ Amount '00	$ Amount '03	$ Amount '06	Substance(s) targeted	Target Population	Specific Programs Funded
DMHA (SAPT Block Grant)	FSSA, Bureau of Child Development for Healthy Families	300,000	300,000	300,000[25]	ATOD	Postnatal	Healthy Families
DMHA (SAPT Block Grant)	ISDH – PSUPP	306,000	338,610	$363,600[26]	ATOD	Prenatal	PSUPP
DMHA (SAPT Block Grant)	ISEP – SYNAR	48,000	0	0[27]	Tobacco	Under 18	SYNAR
DMHA (SAPT Block Grant)	GCDFI (Outreach)	155,000	230,000	No longer in place[28]			
Gov's Office (SDFS Gov's Portion)/ICJI	GCDFI (Community Consultants)	1,500,000	1,500,000	1,175,950[29]	ATOD	Youth All ages	Unknown
Attorney General	ISDH	250,000	0	0[30]			
Attorney General	ISEP	250,000	0	0[31]			
ICJI – YD	GCDFI (Part of EUDL grant)	160,000	160,000[32]	200,000[33]	Alcohol	Youth in middle and high school	Sub-grantees include ISEP, GCDFI, Point of Youth
GCIDD	ISEP	118,000	118,000	225,000[34]	Alcohol	Total/Unspecified	Overtime hours
GCIDD	ISP	792,504	792,491	1,100,000[35]	Alcohol	Total/Unspecified	Overtime enforcement
ITPC	ISDH (PSUPP)	0	456,610	139,500[36]	Tobacco	Prenatal	PSUPP
ITPC	ISEP (TRIP)	0	2,100,000[37]	$500,000[38]	Tobacco	Under 18	TRIP
ITPC	ISEP (SYNAR)	0	78,000 [39]	0[40]	Tobacco	Under 18	SYNAR
FSSA (new contract)	ISEP (TRIP)			$250,000[41]	Tobacco	Under 18	TRIP

See Appendix A for a list key abbreviations

Criteria and Rationale for Indiana's SPF SIG Priorities

The Indiana State Epidemiology and Outcomes Workgroup (SEOW) was established in April 2006 to review epidemiological data on the patterns and consequences of substance use and abuse in Indiana. The SEOW makes recommendations to the Governor's Strategic Prevention Framework (SPF) Advisory Council regarding priorities for prevention funding for 2007. The priorities were developed based on a systematic analysis of available data, the results of which are detailed in this report.

In developing these priorities, the SEOW reviewed data on the consumption and consequences of alcohol, tobacco, marijuana, cocaine, heroin, methamphetamine, prescription drug use, and poly-substance use. In evaluating the data and making comparisons across substances, the SEOW members considered three primary factors:

1. The overall current rate and estimated number of people affected by each substance,
2. The extent and nature of commonly-identified short- and long-term consequences associated with the abuse of each substance, and
3. Recent trends in patterns of consumption and consequences associated with each substance.

Because of differences in the nature of each substance and limitations in the available data, substance-to-substance comparisons were not possible. In general, the SEOW attempted to identify areas where Indiana exhibits significantly higher rates than the nation in consumption and/or negative consequences associated with each substance.
The SEOW relied on a number of publicly available and generally well-respected data sources. These include:

- the Alcohol, Tobacco and Other Drugs Use by Indiana Children and Adolescents Survey,
- the Behavior Risk Factor Surveillance System,
- the Fatality Analysis Reporting System,
- the Monitoring the Future Survey,
- the National Survey on Drug Use and Health,
- the National Clandestine Laboratory Seizure System,
- the National Vital Statistics System,
- the National Youth Tobacco Survey,
- the Indiana Youth Tobacco Survey,
- the Treatment Episode Data System,
- the Uniform Criminal Record, and
- the Youth Risk Behavior Surveillance System.

Description of State Priorities

The SEOW Chair and a team of data analysts conducted all the analyses under the supervision of the SEOW. Because of the timeline associated with the CSAP grant that funded this work, the analyses in this first year focused on publicly available data sets. As a result, there are significant limitations with the data. Most important, the ability of the data analysts to explore complex patterns was

limited because of the de-identification required to make data available to the public.

Based on the careful analysis and review of these data, the SEOW identified a list of *prevention targets of significant epidemiological concern*. This initial list was examined carefully, discussed at length, and revised by the SEOW. To provide additional guidance to the Governor's Advisory Council, the SEOW evaluated this list of prevention targets in terms of the relative importance of each item. This was done using a balloting process in which voting members of the SEOW evaluated each target using a rating scale to evaluate its overall significance. Members were instructed to evaluate each potential target in terms of its overall magnitude, trend over time, severity, and changeability.

At the SEOW meeting on July 21, 2006, members reviewed their collective ratings, discussed the rankings, and voted to approve the final list of recommendations. The final list includes six priorities. These six priorities are divided into two groups: those that clearly reflect state-wide concerns, and those that reflect more localized concerns that are concentrated within certain sub-populations, communities, or regions of the state. The six priorities stand independent of the SPF SIG, and are unchanging for this year, although funding of the project will be limited to three of the six priorities as detailed below.

STATE-WIDE CONCERNS

The first three priorities describe state-wide prevention challenges. The SEOW observed that the negative consequences associated with these patterns are significant in virtually every Hoosier community.

Prevent and reduce underage drinking and binge drinking among 18- to 25-year-olds.

Alcohol is the most frequently used substance in Indiana, and it is often a "gateway" to more severe and life-long substance abuse problems (NIAAA, 2006). In terms of the number of Hoosiers affected, alcohol abuse is clearly the most significant substance abuse problem in Indiana. Despite state law which dictates that any alcohol use by young people under the age of 21 is illegal, underage drinking is a significant problem in Indiana (26.74% of Hoosiers between the ages of 12 and 20 used alcohol in the past month in 2004). In addition, the high rate of binge drinking among 18- to 25-year-old Hoosiers is also significant (43.5% reported binge drinking in the past 30 days in 2004). While the challenges of underage drinking and youth binge drinking are significant in their own right, these patterns are of particular concern because they also contribute to Indiana's high arrest rates for driving under the influence (DUI, 6.17 per 1,000 population in 2003), public intoxication (3.29 per 1,000 population in 2003) and liquor law violations (2.66 per 1,000 in 2003).

Prevent the first use of tobacco among 12- to 17-year-olds and reduce tobacco use among 18- to 24-year-olds, Blacks, and individuals with lower incomes and/or less than a high school education.

Smoking also represents a significant problem in Indiana. Recent estimates suggest that the rates of smoking and/or using other tobacco products in Indiana are significantly higher than rates in the nation. In 2004, 27.4% of Hoosiers reported using cigarettes (compared with 25.2% in the nation) and 32.3% reported using any tobacco products (compared with 29.5% in the nation). Of

greatest concern is the use of tobacco products among 18- to 25-year-olds, Blacks, and individuals with low household incomes and/or less than a high school education. Among 18- to 25-year olds, smoking prevalence in Indiana for 2004 was 42.5%, which is statistically significantly higher than the national prevalence of 39.9%. In 2005, the overall smoking rate for Blacks in Indiana was 36.8%, significantly higher both than the national rates for Blacks (20.7%) and for Whites in Indiana and the nation. It is important to note, however, that the increase in smoking among Blacks appears to occur in adulthood after high school, as the smoking rates for high school students in Indiana are significantly lower than for other racial/ethnic groups. In 2005, Hoosiers with less than a high school education had the highest smoking rate (49.3%), and 37.5% of the Indiana population with household incomes less than $15,000 reported smoking. Tobacco use has been shown to cause a variety of chronic health conditions and to be the second leading cause of death in the world. In Indiana, 10,000 people die annually due to tobacco use, and Indiana's high rate of tobacco use also contributes to Indiana's significantly high rate of chronic obstructive pulmonary disease (COPD, 42.5 per 100,000 population versus 35.9 per 100,000 population in the nation in 2002).

Prevent the first use of marijuana among 12-17-year-olds and reduce the use of marijuana among 18- to 25-year-olds.

Marijuana represents the most commonly used illicit drug in Indiana, with approximately 10.4% of Hoosiers reporting consuming this drug in 2004 during the prior year. In general, the patterns of consumption and consequences mirror those of the nation. Rates for both Indiana and the nation suggest that the use of marijuana increases dramatically at each grade level beginning in middle school through high school, with the peak period of use occurring between 12th grade and the transition years of 18 to 25. In terms of negative social consequences, Indiana demonstrates significantly higher rates of substance abuse treatment admissions as well as higher arrest rates for possession and manufacture of marijuana than the nation.

LOCAL, REGIONAL, AND COMMUNITY CONCERNS

In addition to the above broader, state-wide concerns, the SEOW noted that there were concerns about three significant substance abuse prevention patterns which appear to be concentrated in particular social groups and/or social geographic areas within the State.

Prevent the first use and reduce the use of cocaine among 18-25 year olds.

Cocaine represents another commonly used illicit drug in Indiana—in 2004, approximately 2.37% of the adult population in the state reported consuming this drug during the prior year. In general, the patterns of consumption and consequences in Indiana mirror the nation's. The rate of cocaine use in Indiana increases dramatically at each grade level beginning in middle school through high school, with the peak period of use occurring between 12th grade and the transition years of 18 to 25. With regard to consequences of cocaine abuse, rates in Indiana for substance abuse treatment admissions and arrests for possession and/or production/sales offenses have typically been lower than the national rates. While overall trends in consumption have been fairly stable in recent years, there is concern about the recent increases in negative consequences associated with cocaine abuse, specifically increases in treatment admissions and arrests for possession and/or production/sales of cocaine.

Prevent and reduce the abuse of prescription drugs among individuals 12 to 25 years.

While much more difficult to monitor than illicit drug abuse, the abuse of prescription drugs appears to be a significant problem in the nation, and especially in Indiana. Using treatment admission data, Indiana's estimated rate of abuse exceeds that for the nation for prescription pain relievers (7.5% v. 6.0% respectively) and benzodiazepines (3.7% versus 2.2%). School surveys also indicate that abuse of Ritalin® is also a more common problem in Indiana than in the nation (3.8% v. 0.2%). The abuse of prescription drugs appears to be most severe among adolescents age 12 to 17 years of age (8.3% versus 7.5% in the United States) and especially young adults between the ages of 18 and 25 (14.4% versus 11.95% in the United States). In addition to being concentrated among younger age groups, prescription drug abuse is significantly more common among women and Whites.

Prevent and reduce the use of methamphetamine among Black youth and among White women and men 18 to 44 years of age.

Compared with alcohol, tobacco, marijuana, and cocaine, methamphetamine is not as significant a problem in Indiana. Special law enforcement efforts and new state laws regulating the sale and distribution of ephedrine or pseudo ephedrine have been successful in slowing the production and availability of methamphetamine (e.g., the number of lab seizures dropped from 1,549 in 2004 to 1,300 in 2005; Figure 6.13). There also has been a slight decline both nationally and in Indiana in the numbers of young people reporting having ever used methamphetamine (from 8.2% in 2003 to 7.0% in 2005; Figure 6.1). School surveys suggest that use among Hoosier students is generally on the decline, but there is evidence that methamphetamine use is rising among Black youth (from 2.7% in 2003 to 3.7% in 2005). There is, however, some indication that the negative consequences of methamphetamine abuse may be increasing. Specifically, treatment admissions for methamphetamine abuse, while slightly lower than national averages, have increased steadily in Indiana from 4.0% in 2000 to 9.2% in 2004, with those between the ages of 18 and 44 having the most significant increases. This may suggest that, despite significant gains in efforts to curb the methamphetamine problem, those who continue to use into young adulthood are experiencing more significant problems associated with abuse and dependence.

Description of SPF SIG Priorities

As noted above, the SEOW identified six priorities for the State of Indiana. The six priorities were identified based on the SEOW's analysis of available epidemiological data and emphasized identifying the most significant prevention needs at the state level. Because of the limited amount of SPF SIG funding, the Council determined that additional criteria should be applied to select a subset of the six priorities for which SPF SIG funding will be made available. With the advice and counsel of CSAP, three additional criteria were selected: 1) existing capacity and resources; 2) preventability and changeability; and 3) community readiness and political will. Because of its commitment to using SPF SIG funding to expand the capacity of the State to more effectively address high-need areas, the Council gave greater weight to its assessment of the State's existing capacity (e.g., existing funding, available infrastructure, the level of integration of prevention providers working on a particular substance, potential for leveraging

non-SPF SIG funding, potential for sustainability). Based on an assessment of the available data on capacity and funding (reported above), the intervention science literature, and the political situation across the state, the Council, Executive Committee, and SEOW developed a matrix to guide the selection of the priorities to be the focus of SPF SIG funding.

Priority	*Existing Capacity/ Resources*	*Preventability and Changeability*	*Community Readiness/ Political Will*
Alcohol	Weak	High	High
Tobacco	Strong	High	High
Marijuana	Weak	Low	Low
Cocaine	Weak	Modest/Low	High
Methamphetamine	Weak to Moderate	Modest	High
Prescription Drugs	Weak	Low	Low

Because the primary concern was in improving the State's capacity, the Council determined that tobacco should not be a focus of SPF SIG funding because currently approximately 85% of the prevention dollars in Indiana are dedicated to reducing tobacco use. Within the five remaining priorities, the Council judged that marijuana and prescription drug use should not be the focus of SPF SIG funding because of their relatively low preventability and changeability and present low levels of political will and community readiness to address these substances. Consequently, the Council decided that SPF SIG funding should be dedicated to addressing the three remaining priorities regarding alcohol, cocaine, and methamphetamine. Because alcohol affects a significantly larger number of Hoosiers, the Council will target 60% of the available SPF SIG programmatic funding for communities identified as having high needs for alcohol prevention. The remaining funds will be used for communities with high prevention needs with regard to cocaine (20%) and methamphetamine (20%). While the Council will use these targets for making the final allocation decisions, the final proportions will also reflect the quality of the applications received and thus may vary somewhat from these targets.

ALLOCATION OF FUNDS TO HIGH NEED COMMUNITIES

Upon recommendations by the SEOW, the Council will allocate funds to high need/high contributor communities based on a discrete set of allocation indicators. As noted above, 60% of the funds will be allocated to alcohol due to its more pervasive impact on the State, with 20% being set aside for communities facing significant problems with cocaine and methamphetamine (40% total). The allocation formulas used to identify high-need communities are described below:

ALCOHOL

To identify the highest need communities in Indiana, the Council examined the ranking of communities in terms of six indicators: 1) number of alcohol-related fatal auto accidents; 2) rate of alcohol-related fatal auto accidents; 3) number of alcohol-related crashes; 4) rate of alcohol-related crashes; 5) number of arrests for public intoxication; and 6) rate of public intoxication arrests. These indicators were selected by the Council, based on the advice and consent of the SEOW, because they represent the best proxy measures of our alcohol priority which highlights the underage drinking and binge drinking by 18-25 year olds at the county level. Further by using both the rate of occurrence (highest need) and the total number of events (highest contributor), we endeavor to empirically operationalize the Council's commitment to a highest need/highest contributor model for identifying communities. The indicators used and reported here reflect

data from 2004 and come from the Uniform Crime Reports (UCR) and 2005 data provided by the Indiana State Police (e.g., alcohol related motor vehicle accidents and fatalities). For each of the six indicators, counties were given 4 points if they were in the top 10th percentile, 3 points if they were in the top 15th percentile, 2 points if they were in the top 25th percentile and 1 point if they were in the top 50th percentile. The total points were then summed to total an overall alcohol priority score. The counties identified as "high need" using this methodology are reported in Table 1.

Table 1. Communities Identified As "High Need" For Alcohol-Related SPF SIG Funding

COUNTY	ALCOHOL PRIORITY SCORE	COUNTY	ALCOHOL PRIORITY SCORE
Lake	21	Porter	14
Tippecanoe	20	Elkhart	13
Marion	19	Shelby	13
Allen	18	Wayne	12
La Porte	17	Delaware	11
St. Joseph	17	Jasper	10
Vanderburgh	17	Kosciusko	10
Floyd	16	Marshall	10
Vigo	15	Monroe	10
Madison	14	Newton	10

COCAINE AND METHAMPHETAMINE

For both cocaine and methamphetamine, a similar methodology was used to identify the "high need" communities. Because both of the original priorities highlighted rising rates of use, the Council used the rate and total number of arrests for possession as the proxy indicators. As noted above, UCR data represent the primary county-level data source available to the Council and SEOW. While there are cocaine-specific data, there are no such data available for methamphetamine (drug-specific reporting for methamphetamine began July 1, 2006 in accordance with new state law). Consequently, for methamphetamine, we used the rate and number of arrests for possession of synthetic drugs as a proxy. As with alcohol, we used 2004 UCR data as it was the only data available at the county-level at the time the State Strategic Plan was developed. For the list of "high need" communities for cocaine and methamphetamine, we selected the counties in the top 10^{th} percentile of either high need (i.e., highest rate) or highest contributor (i.e., largest number) of arrests for possession. The counties identified based on this methodology are listed in Table 2.

Table 2. Communities Identified As "High Need" For Cocaine and Methamphetamine-Related SPF SIG Funding

COCAINE	METHAMPHETAMINE
Marion (HN/HC)	Gibson (HN)
Wayne (HN/HC)	Bartholomew (HN/HC)
St. Joseph (HN/HC)	Vigo (HN/HC)
Howard (HN/HC)	Daviess (HN)
Allen (HN/HC)	Warrick (HN/HC)
Grant (HC)	Greene (HN)
Elkhart (HN/HC)	Vanderburgh (HN/HC)
Lake (HC)	Tippecanoe (HC)
Tippecanoe (HC)	Elkhart (HC)
	Hamilton (HC)

CAPACITY BUILDING

1. Areas needing strengthening

Due to the nature of the state's governmental structure, Indiana's prevention infrastructure and capacity is varied, fragmented, and lacks overall coordination. Planning efforts and resource allocation often occur within a number of different state agencies tasked with addressing substance abuse prevention. Based on a preliminary evaluation of the states' 92 LCC's, approximately two-thirds are considered "low" capacity and the remaining one-third are identified as "high" capacity with regard to implementing substance abuse prevention programming in targeted communities. The following are identified state and community level agencies and organizations that as a state we are committed to coordinating efforts of to build the infrastructure of prevention.

2. State- and community-level activities

State-level activities

- **14 Designated Service Areas (DSAs)**

  The DSA's serve as local prevention service coalitions which focus on comprehensive support with contract requirements, data management, program management, program design and implementation/evaluation. The Division of Mental Health and Addiction (DMHA) is the funding source.

  Afternoons R.O.C.K. in Indiana

  The Division of Mental Health and Addiction (DMHA) and it's community-based partners provide programs statewide such as Afternoons R.O.C.K. in Indiana. Afternoons R.O.C.K. in Indiana is an after school drug prevention program for youth aged 10 - 14 years. The acronym "R.O.C.K." represents the mission of the program to provide **R**ecreation, **O**bject lessons, **C**ulture and values and **K**nowledge via active and entertaining Focused and Supportive Prevention Activities designed to teach youth about social and media influences, conflict resolution and refusal/resistance skills, gang and violence prevention and the structuring of leisure time to be free of alcohol, tobacco and other drug use. (Descriptive text excerpted directly from program website: http://www.rock.indiana.edu/.)

- **Local Coordination Councils (LCC's)**

  LCCs are organized to identify alcohol, tobacco and other drug abuse problems, and to plan, promote and coordinate community efforts and resources to reduce the abuse.

- **Drug Free Communities**

  The Drug-Free Communities program provides grants to community coalitions that mobilize their communities to prevent or reduce substance abuse among youth.

- **Prenatal Substance Use Prevention Program (PSUPP), Indiana State Department of Health (ISDH)**

This program is designed to help prevent birth defects and other negative birth outcomes by assuring that babies born in Indiana are born to women who decrease or eliminate alcohol, tobacco, and other drug use during pregnancy.

- **Healthy Families, FSSA/Division of Family and Children**
  Voluntary home visitation program designed to promote healthy families and healthy children through a variety of services including child development, access to health care and parent education. The program serves families identified as at-risk, with children 0-5 years. Program goals include prevention of negative birth outcomes (low birth weight, substance abuse, child abuse and neglect); increased parenting skills, healthy pregnancy practices; and the use of social systems.

- **Indiana Coalition to Reduce Underage Drinking (ICRUD)**
  A non-profit, advocacy coalition addressing the way alcohol is marketed to, sold to, and bought by underage persons through policy change.

- **Indiana Tobacco Retailer Inspection Program (TRIP)**
  TRIP is designed to systematically monitor the effectiveness of tobacco retail compliance. The purpose is to enforce Indiana laws restricting the sale of tobacco products to minors. The IN State Excise Police contract with off-duty officers to lead three member inspection teams in conducting unannounced inspections of retail outlets that sell tobacco. There has been a 28% reduction of tobacco sales to minors since 2000.

- **Indiana Criminal Justice Institute (ICJI)**
  The Substance Abuse Services Division of ICJI encourages the linking of resources, advocacy, collaboration, and coordination among state, regions, localities, and citizens of Indiana to mobilize to create a safer, healthier place to live

- **Governor's Commission for a Drug-Free Indiana (GCDFI)**
  The Governor's Commission for a Drug-Free Indiana (GCDFI) was established by legislative statute to coordinate drug policy throughout the state. It supports planning, training, and technical assistance provided to the state's Local Coordinating Councils (LCCs), a statewide system of county-based prevention, treatment, and enforcement coordinating bodies funded through local court fees.

- **Indiana Collegiate Action Network**
  A statewide coalition of campuses committed to lead Indiana in reducing alcohol misuse, tobacco use, and violence through environmental change.

- **Smoke Free Indiana**
  The mission of Smoke free Indiana is to improve the quality of life in Indiana by promoting tobacco-free, healthy lifestyles through community action and advocacy to prevent tobacco use, provide assistance to tobacco users who want to quit and protecting nonsmokers from secondhand smoke.

- **Indiana Tobacco Prevention and Cessation (ITPC)**
  The Indiana Tobacco Use Prevention and Cessation Trust Fund and Executive Board exists to prevent and reduce the use of all tobacco

products in Indiana and to protect citizens from exposure to tobacco smoke. Following the Centers for Disease Control (CDC) Best Practices for Tobacco Control, Indiana established a tobacco control program that is coordinated, comprehensive and accountable. In addition, guidance is provided through recommendations outlined in the Guide to Community Preventive Services for Tobacco Control Programs. This Guide provides evidence the effectiveness of community-based tobacco interventions within three areas of tobacco use prevention and control**:** 1) Preventing tobacco product use initiation, 2) Increasing cessation 3) Reducing exposure to secondhand smoke. The Hoosier Model for tobacco control incorporates all elements recommended by the CDC and has five major categories for funding. The Hoosier Model consists of Evaluation and Surveillance; Community Based Programs; Statewide Media Campaign; Enforcement; and Administration and Management.

- **Indiana Department of Education (IDOE) Safe and Drug-Free Schools Program (SDFS)**

  SDFS is the federal government's primary vehicle for reducing substance use and violence through education and school-based prevention activities. This program is designed to prevent violence in and around schools, and strengthen programs that prevent the illegal use of alcohol, tobacco, and other drugs, involve parents, and are coordinated with related Federal, State, and community efforts and resources. SDFS provides funding for the National Prevention Coordinator initiative and this Training and Technical Assistance Center.

- **Mothers Against Drunk Driving (MADD)**

  MADD's mission is to stop drunk driving, support the victims of this violent crime and prevent underage drinking. MADD is a 501 (c) (3) charity with approximately 400 affiliate offices and 2 million members and supporters nationwide. Founded in 1980, MADD has helped save more than 300,000 lives.

- **Indiana Prevention Resource Center (IPRC)**

  The IPRC at Indiana University is a statewide clearinghouse for alcohol, tobacco and other drug prevention resources for those working in drug prevention in Indiana. The IPRC coordinates the annual survey of Alcohol, Tobacco and Other Drug Use by Indiana Children and Adolescents.

- **Indiana National Guard Demand Reduction program**

  The Indiana National Guard Demand Reduction program works with Boys and Girls Clubs, public housing authorities, Weed and Seed programs, and schools to provide mentoring and other drug-free alternative activities.

- **Indiana Point of Youth**

  Promotes youth leadership and drug-free activities for youth from across Indiana. Supports annual Youth Summit where youth set an annual ATOD advocacy agenda.

- **Governor's Safe Haven program**

Grant pays schools to keep their doors open after regular hours and offers various activities such as tutoring, substance abuse prevention and structured recreation.

- **Drug Reduction Program**
  Consists of providing guard personnel as speakers, for events, to help at camps, aimed at informing students of the consequences of drug abuse and teaching how to avoid abusing drugs.

- **L.E.A.D Initiative**
  The goal of the LEAD ((Leading and Educating Across Domains) program is to strengthen youth leadership across Indiana by providing opportunities for youth including training, resources, and networking.

- **SYNAR Amendment Compliance**
  Compliance checks to document required 20% compliance with no sales to youth under Synar amendment.

Community-level activities

- **Students Again Destructive Decisions (SADD)**

To provide students with the best prevention and intervention tools possible to deal with the issues of underage drinking, other drug use, impaired driving and other destructive decisions.

- **4-H**

An organization committed to teaching leadership, citizenship and life skills to young people across America.

- **Boys Scouts of America (BSA)**

BSA provides an educational program for boys and young adults to build character, to train in the responsibilities of participating citizenship, and to develop personal fitness.

- **Girl Scouts of America (GSA)**

GSA is dedicated to building girls of courage, confidence, and character, who make the world a better place

- **Boys and Girls Clubs**

This organization inspires and empowers all young people, especially those from disadvantaged circumstances, to realize their full potential as productive, responsible, and caring individuals.

- **Young Men's Christian Association (YMCA)**

The YMCA is focused on putting Christian principles into practice through programs that build healthy spirits, minds and bodies for all.

- **PRIDE Youth Programs**

A national peer-to-peer organization devoted to drug abuse and violence prevention through education and is celebrating its' 30th anniversary.

Where the numbers of agencies and organizations focused on the prevention of substance issues may appear impressive, this also creates some of the oppositional issues within the state. The areas that are in most need of strengthening are focused primarily on the 'silo'ing of services amongst agencies and not on building a more unified effort in addressing the substance use and abuse within the state. Another major concern is with the lack of reporting critical data from the counties to assist in the identification of a comprehensive picture illustrating the most prevalent areas of Indiana's listed priorities. There are communities in the state that are not connecting with the LCC's nor using the Community Consultants instruction on the SPF process, preferring to work independently. It has been agreed upon by the Governor's Advisory Council for the SPF SIG, The Commission for a Drug Free Indiana, The Office of the Governor and other prevalent government agencies that for those communities not willing to join together and support the infrastructure already established, they will not be considered as future recipients for state or this federal grant opportunity. A strong message is being echoed in Indiana that the SPF process, now the keystone to unify efforts in creating a solid foundation for the fight against substance abuse, is not optional. Reporting county data is not optional either, if the communities and counties want to be supported by grant funds they will be required to comply with assessment analysis and the analysis of their

capacity to show where they can focus efforts based on data-driven decision making, which will in turn drive the strategic plan for their communities.

The state has identified and met with specific agencies to assist the workings of these communities. The IPRC, OFBCI, and LCC's have been trained specifically on how to assist these communities in collecting, identifying, analyzing and reporting on data to drive their efforts. The SPF staff has scheduled mandatory conferences in which the communities will be instructed on what expectations are required and where to go for someone to walk through with them each step of the process. The Community Consultants, leading the LCC's have committed to working with the SPF SIG staff with each community and have committed to increasing their staff if necessary. The IPRC has made similar commitments. In addition to these agencies's support, the Evaluation team and Evaluation Workgroup are committed to monitoring the activities along with the SPF SIG staff and will have quarterly face to face meetings to establish benchmarks which will allow each community to return and report their efforts. The Training and Outreach Workgroup has also taken a very active role in identifying ways to support the communities throughout the state. With training and instruction being offered to all 92 counties, and additional contact being offered to the communities awarded the SPF SIG funding, it is the focus of the Training and Outreach Workgroup to follow the trainings and conferences being careful to offer critical suggestions and direction to increase the understanding and ability to work the SPF process.

3. Role of the SEOW workgroup

The Indiana State Epidemiology and Outcomes Workgroup (SEOW) was established in April 2006 to review epidemiological data on the patterns and consequences of substance use and abuse in Indiana. The SEOW makes recommendations to the Governor's Advisory Council (GAC) for the SPF SIG regarding priorities for prevention funding for 2007. The priorities were developed based on a systematic analysis of available data, the results of which are reported above.

In developing these priorities, the SEOW reviewed data on the consumption and consequences of alcohol, tobacco, marijuana, cocaine, heroin, methamphetamine, prescription drug use, and poly-substance use. In evaluating the data and making comparisons across substances, the SEOW members considered three primary factors: 1) the overall current rate and estimated number of people affected by each substance, 2) the extent and nature of commonly-identified short and long term consequences associated with the abuse of each substance, and 3) recent trends in patterns of consumption and/or consequences associated with each substance. Because of differences in the nature of each substance and because of limitations in the available data, substance-to-substance comparisons were not possible. In general, the SEOW attempted to identify areas where Indiana exhibited significantly higher rates than the nation in terms of consumption of and/or negative consequences associated with each substance.

The SEOW relied on a number of publicly available and generally well-respected data sources. These included the Alcohol, Tobacco and Other Drugs Use by Indiana Children and Adolescents survey, the Behavior Risk Factor Surveillance System, the Fatality Analysis Reporting System, the Monitoring the Future survey, the National Survey on Drug Use and Health, the National Clandestine Laboratory Seizure System, the National Vital Statistics System, the National Youth Tobacco Survey, the Indiana Youth Tobacco Survey, the Treatment

Episode Data System, the Uniform Criminal Record, and the Youth Risk Behavior Surveillance System. The SEOW Chair and a team of data analysts conducted all the analyses under the supervision of the SEOW. Because of the timeline associated with the CSAP grant that funded this work, the first year analyses focused on publicly available data sets. As a result, there are significant limitations with the data. Most important, the ability of the data analysts to explore complex patterns was limited due to the de-identification required to make data available to the public.

Based on the careful analysis and review of these data, the SEOW identified a list of *prevention targets of significant epidemiological concern*. This initial list was examined carefully, discussed at length, and revised by the SEOW. To provide additional guidance to the GAC, the SEOW evaluated this list of prevention targets in terms of their relative importance. This was done using a balloting process in which voting members of the SEOW evaluated each target using a rating scale to evaluate its overall significance. Members were instructed to evaluate each potential target in terms of its' overall magnitude, trend over time, severity, and changeability. At the July 21st 2006 SEOW meeting, members reviewed their collective ratings, discussed the rankings, and voted to approve the final list of recommendations. The final list includes six state priorities and is described above and in the 2006 State Epidemiology Profile, of which three will be funded by SPF SIG dollars.

In addition to identifying data-based prevention priorities, the SEOW will continue to examine epidemiological data as it becomes available over the next five years and make reports regularly to the GAC. The SEOW is already working to secure access to more restricted access datasets that will permit a deeper exploration of these priorities both at the State and county levels. Working closely with the SPF SIG Evaluation Team, the SEOW also will examine the extent that the SPF SIG funded programs have an impact on their targeted communities and how these program-level outcomes impact the priority patterns identified at the State level. The SEOW will update the State Epidemiology Profile annually and report interim findings as needed to the GAC. In its advisory capacity, the SEOW will support the GAC in maintaining the data-driven decision-making process required under the SPF SIG program. In the coming years, IDMHA officials also plan to turn to the SEOW to carry out the needs assessment required for the CSAPT Block Grant Program. Because of its interdisciplinary, multi-agency, and scientific expertise, it is believed that relying on the SEOW to serve this additional function will be more efficient and facilitate a more coordinated and data-based approach in funding substance abuse prevention and treatment programming across the state. The SEOW work findings will be used as a planning tool for the SAPT Block Grant.

The state has recognized the work of the SEOW as an independent from the SPF SIG. This has been to the great advantage of Indiana in that the findings of this workgroup provide vital and available data for the state. An example of this is exemplified by the six identified priorities, regardless of whether the SPF SIG was granted to the state of Indiana, it has been explicitly stated that the workings of the SEOW are to stand alone to serve the state. The SPF SIG project has identified only 3 of the 6 State Priorities to fund, but regardless of this the state recognizes all 6 as the State Priorities and they can be used in building community strategic plans to apply for other funding sources. The state has accepted that the SEOW will continue long beyond the life of the SPF SIG to serve the state in collecting and identifying areas of concern and in building the capacity within the state to increase the data collection process.

PLANNING

State planning model

Based on the analyses and recommendations put forward by the SEOW, a model was developed to help aid the state in making data-based decisions regarding the six priorities, of which three have been targeted for funding.

State Planning Model	Highest need, however, special consideration will be given to counties who are highest contributors.
Funding Process	State RFS is required for grants exceeding $75,000. Grants will be awarded to communities that demonstrate they are the highest need/highest contributors of alcohol, cocaine or methamphetamine, based on analyses conducted by the SEOW and submit the strongest applications.
Grantees	Communities are to apply for grants to address one of the three identified funded priorities. Grants will be awarded as follows: • **10-15 grants (funding up to $132,146.00 annually based on 15 recipients)** • **The first year awards will be given to communities for the Planning Phase; assessment, capacity building and strategic planning. As each community is able to provide the state with a comprehensive strategic plan, and gains approval, the community can proceed to the Program Implementation Phase.**
Priority	**Prevent and reduce underage drinking and binge drinking among 18- to 25-year-olds.**
Resource Allocation Indicator(s)	To identify the highest need communities in Indiana, the Council examined the ranking of communities in terms of six indicators: 1) number of alcohol-related fatal auto accidents; 2) rate of alcohol-related fatal auto accidents; 3) number of alcohol-related crashes; 4) rate of alcohol-related crashes; 5) number of arrests for public intoxication; and 6) rate of public intoxication arrests. These indicators were selected by the Council, based on the advice and consent of the SEOW, because they represent the best proxy measures of our alcohol priority which highlights the underage drinking and binge drinking by 18-25 year olds at the county level. Further by using both the rate of occurrence (highest need) and the total number of events (highest contributor), we endeavor to empirically operationalize the Council's commitment to a highest need/highest contributor model for identifying communities. The indicators used and reported here reflect data from 2004 and come from the Uniform Crime Reports (UCR) and 2005 data provided by the Indiana State Police (e.g., alcohol related motor vehicle accidents and fatalities). For each of the six indicators, counties were given 4 points if they were in the top 10th percentile, 3

	points if they were in the top 15th percentile, 2 points if they were in the top 25th percentile and 1 point if they were in the top 50th percentile. The total points were then summed to total an overall alcohol priority score. The counties identified as "high need" using this methodology are reported in Table 1 on page 32.
Outcome Expectations	• Reduction in self-reported use of alcohol by Hoosiers under 21. • Reduction in self-reported binge-drinking by Hoosiers ages 18 to 25. • Reduction in arrest rates for driving under the influence, liquor law violations, and public intoxication. • Reduction in alcohol-related fatal motor vehicle accidents • Reduction in the number of alcohol abuse/dependence admissions for 18- to 25-year-olds.
Priority	**Prevent the first use and reduce the use of cocaine among 18-25 year olds.**
Resource Allocation Indicators	For cocaine a similar methodology was used to identify the "high need" communities. Because the original priority highlighted rising rates of use, the Council used the rate and total number of arrests for possession as the proxy indicators. As noted above, UCR data represent the primary county-level data source available to the Council and SEOW. As with alcohol, we used 2004 UCR data as it was the only data available at the county-level at the time the State Strategic Plan was developed. For the list of "high need" communities for cocaine, we selected the counties in the top 10th percentile of either high need (i.e., highest rate) or highest contributor (i.e., largest number) of arrests for possession. The counties identified based on this methodology are listed in Table 2 as illustrated on page 32.
Outcome Expectations	• A decline in the rate of self-reported cocaine use by Hoosiers between 18 and 25 years of age. • A decline in the rate of treatment admissions for cocaine abuse and/or dependence. • A drop in the number of cocaine-related arrests. • A drop in cocaine-related hospital admissions. • A drop in the number of infants diagnosed at birth with cocaine dependence
Priority	**Prevent and reduce the use of methamphetamine among Black youth and among White women and men 18 to 44 years of age.**
Resource Allocation Indicator(s)	For methamphetamine, a similar methodology was used to identify the "high need" communities. Because the original priority highlighted rising rates of use, the Council used the rate and total number of arrests for possession as the proxy indicators. As noted above, UCR data represent the primary county-level data source available to the Council

	and SEOW. Because there are no methamphetamine-specific data (drug-specific reporting for methamphetamine began July 1, 2006 in accordance with new state law), we used the rate and number of arrests for possession of synthetic drugs as a proxy. As with alcohol, we used 2004 UCR data as it was the only data available at the county-level at the time the State Strategic Plan was developed. For the list of "high need" communities for methamphetamine, we selected the counties in the top 10th percentile of either high need (i.e., highest rate) or highest contributor (i.e., largest number) of arrests for possession. The counties identified based on this methodology are listed in Table 2 as illustrated on page 32.
Outcome Expectations	• Decline in self-reported methamphetamine use among Black youth in Indiana. • Reduction in self-reported methamphetamine use among White men and women 18 to 44 years of age. • Decrease in the number of substance abuse treatment admissions for methamphetamine dependence for White women and men in Indiana between ages 18 and 44. • Reduction in the number of clandestine methamphetamine lab seizures. • Decline in reported number of children affected by methamphetamine.

2. Community Based Activities

There are many avenues being established to assist the communities in understanding the requirements and offering assistance in the processes necessary to apply as a sub-recipient of the SPF SIG. Regional Technical Assistance Workshops will be offered in 3 counties strategically and geographically identified throughout the state. At these mandatory workshops, indicator documents depicting the top 10th, 15th, 25th, and 50th percentiles for county substance use and abuse of each of the three sets of resource allocation indicators. Graphs and tables to show areas and populations most affected by these substances will be distributed and explained to assist the communities in identifying whether they are a high need/high contributor community. The workshops will also review the RFS process, offer instruction on the steps of the SPF, the application process, and on how to complete the Organizational Assessment Tool. Results from the Community Assessment Survey will be shared and explained at these Regional Workshops as well, to assist communities in understanding their level of readiness to begin the SPF process. Information will also be provided on what organizations each community can look for assistance from in working through the required processes. Following the Regional Technical Assistance Workshops question/answer opportunities will be open to all potential applicants. Responses will be printed and placed on the SPF SIG and other state websites. The Training and Outreach Workgroup has been established, and dedicated remarkable efforts with the preparation necessary, to disseminate information to the state announcing the grant, establishing training and educational opportunities, and connecting and

identifying options for technical assistance. Conferences, such as DMHA's Many Voices One Vision (MVOV) and other training conferences will be offered where the communities will come together to share and learn from experts and one another. Meetings have been held with identified agencies and organizations in the state that the awardees can contract with to learn and apply the specifics of the planning and implementation phases of the project. The SPF SIG funds will be awarded to communities who can demonstrate they are a high need/high contributor community based on the data analysis the SEOW has provided, or supplementary/local data comparable with the UCR data evidencing a high need community, and an ability to show they are able and willing to learn and implement the processes of the SPF to reduce the use and abuse of substances in the state of Indiana.

The communities will be expected to go through the 5 steps of the SPF SIG process; assessment, capacity analysis, strategic planning development, implementation, and evaluation. The communities will be monitored based on adherence to Cultural Competence and Sustainability components as well. It is not the intent of this project to solely fund community programming, but rather to assist communities in learning and implementing the Strategic Prevention Framework.

3. Allocation Approach

To allocate SPF SIG program funds, the Governor's Advisory Council (GAC) will solicit applications for the Planning Phase from communities through a standard, state-wide competitive request-for-services (RFS), as required and outlined by Indiana State Law. All applicants will be required to address the specific SPF SIG program requirements. The applications submitted will be evaluated systematically by an Expert Review Team and then by the Grant Review Workgroup appointed by the GAC. Members of the Grant Review Workgroup will use a standardized system for scoring the applications, which will be established, based on the criteria outlined below, and will in turn report their rankings and the application recommendations for funding to the entire GAC. The GAC will discuss the Grant Review Workgroup's recommendations and make the final decision regarding who shall receive the funding.

The allocation strategy approved by the GAC for the State of Indiana reflects a dual commitment to allocate funds to the highest need/highest contributor communities for the three priorities outlined above and to identify communities which will embrace the learning and implementation of the SPF process. The SEOW has developed indicator documents for each of the priorities and has ranked all 92 counties accordingly. Each county can refer to the indicator documents and the maps, tables and graphs in the Epidemiological Profile Report to quickly identify whether they are a county which is in the top percentage of use and abuse of the Priority substance in Indiana.

Communities will need to identify, based on the SEOW's documents or surveys, or may present supplementary/local comparable data to support their application request, as to whether they are a high need/high contributor community. The explanation of how Indiana is defining the highest need/highest contributor communities is outlined earlier in this plan in tables 1 and 2 on page 32. Communities will also be assessed using data from the Organizational Assessment Tool and the Community Readiness Survey made available during the Pre-Conference Informational Session provided by the state. When the applications have been reviewed and awards announced, up to 15 communities will be funded. Within the first 12 to 18 months each community will be required

to work through the first three steps of the SPF process. Each community will receive an award in the amount of up to $132,146.00 annually based on 15 awards being given. Each award will be for 3 years with a one year optional renewal based on availability of funds and progress. During the first year they will go through an analysis of data to understand their priority of focus. Communities will then be expected to complete a comprehensive analysis of their organization and community capacity in order to illuminate areas where they need to focus building their infrastructure to support their identified needs. The communities will then develop a strategic plan to submit for approval in order to proceed to the next phase of the award process; Program Implementation. Evaluation of each step will be documented and reported throughout the life of the grant to gauge the quality and effectiveness of the community's efforts. Submitting a thorough strategic plan will allow the state to monitor the fidelity of the process and ensure the communities are using the funding to address each of the goals of the SPF SIG.

The monies awarded to each sub-recipient community will need to fund a full-time program director, a clerical staff member and cover the in-depth assessments necessary to comply with the requirements of the Planning Phase of the grant. Each community will need to hold out funds for assistance with the assessment process and evaluation processes required by the project. As stated before, the communities will be given a menu of agencies such as the IPRC, OFBCI and the Community Consultants leading the LCC's, as well as other identified sources within the state that have been pre-approved and are qualified to assist the communities through a thorough assessment process. The funds initially dedicated to the efforts of assessment during the first phase will become available to be transferred to program implementation during the second phase. Each of the consultants and agencies identified as appropriate and competent mentors through the assessment process will have an in-depth knowledge of the three funding priorities and how to assist the communities in addressing the specific indicators to analyze data in accordance with their findings.

The SPF SIG staff will work closely with the representatives of the agencies, chosen by the communities, in ensuring that relevant and appropriate policies, practices and programs are adhered to. A staff member will also meet quarterly with the community's program director to establish and monitor benchmarks that bring the community along with the goals established and in moving through the SPF process. In addition to the SPF SIG staff member, a member of the SPF SIG Evaluation Team will partner with the staff so that each communities efforts can be monitored to mirror the steps the state has completed in the state epidemiological process.

The applicants will also be required to provide a statement of commitment that their community will address issues of cultural competency. These components must be present and monitored throughout each phase of the process. A representative from the Cultural Competency Workgroup will instruct communities in various ways to become more aware and sensitive to the Cultural issues within their own community. To assist in this process the Division of Mental Health and Addiction will maintain a Cultural Competency Workgroup to ensure that the Strategic Framework addresses issues relative to racial, ethnic, and cultural groups in Indiana. This committee will be multi-cultural, multi-racial and multi-ethnic, and comprised of representatives from around the state. The Division will ask organizations such as the Indiana Latino Institute and Indiana Minority Health Coalition to recommend workgroup members. This workgroup will assist the sub-grant recipients, Evaluation Contractor, and communities in the development of educational materials and in the adaptation of evidence-based

prevention models, while ensuring program fidelity. With the support and assistance of this workgroup the sub-grant recipients will be required to conduct readiness, resource and needs assessments which will look at the populations for which they are targeting program development or infastructure building. The assistance will be inclusive but not limited to input into the identification of local intervening variables and the selection and modification of stakeholder representatives. Local evaluation will necessesitate the sub-grant recipient to assess the operationalization of cultural competency issues during the SPF SIG implementation. Literature will be provided and trainings will be offered and mandatory for each of the funded communities.

Another statement of commitment the communities must provide is that they will work with the SPF SIG staff and other organizations providing technical assistance to develop a sustainability plan. The sustainability of the programs implemented with the SPF SIG are crucial to the success of the project. Multiple stakeholders throughout the state have been utilized to assist in the assessments and development of this project, through the GAC and the other workgroup memberships. With the various organizations and agencies represented and support of the SPF SIG Project a natural growth and awareness of specific areas for building the infastructure are identified. The findings of the research have been made available throughout the state and results have been targeted as the state priorities. Expectations of continued assessments of epidemiological data and prevention resources are anticipated to be complemented by plans to explore alternatives for working collaboritively with respect to prevention planning in the state of Indiana, and building a stronger need and acceptance for evidence-based practices.

The community level sustainability will be expected to implement data-driven prevention practices, begun with the strategic planning the state has implemented, introduced by a systematic and comprehensive approach to prevention. As the sub-grant recipients use the framework of assement, capacity building, planning, implementation and evaluation, a more comprehensive and definable product will be available to other community stakeholders to assist them with buying into and supporting programs initiated by the SPF SIG. Incorporating the community stakeholders enables increased conformity of ideas which will lead to a stronger foundation for sustainabilty.

Each community must identify community sources and their level of readiness within the community to build infrastructure. One of the obvious and most applicable points of sustainability will be the connection communities develop with their Community Consultants. The relationship established with the SEOW will be vital as well. As the SEOW is independent of the SPF SIG, and will provide a service for the state beyond the life of the SPF SIG, it will be a vital resource for the communities to use to continue the identification of problems that arise based on empirical data. The strengthening of the data reporting will enable the communities to provide data-driven evidence in the future for other grants and opportunities that may be advantageous to their community.

The specific criteria for scoring the applications is found in the Scoring Criteria Document attached to the end of this report-Attachment #1.

The Priority Indicator Documents will also be attached to the end of this document-Attachment #2.

Phases of Grants and Anticipated Amounts

A total of approximately 1.98 million dollars will be awarded during each year of the SPF-SIG initiative pending continuation funding from CSAP to support the program. The SPF SIG Grant will be split into two phases; the first being an assessment, capacity building, and strategic planning phase, and the second a program implementation phase.

Each year the communities (15 maximum) will be awarded funding up to $132,146.00, based on 15 communities being awarded funding. Funds will be allocated on a competitive basis, and awards will be made to applicants who can demonstrate they are a highest need/highest contributor community of one of the three identified funded priorities and the commitment to use the funds to meet the grant's purposes, inclusive of leaning and gaining experience of the SPF process and building capacity. Communities are to use the Indicator documents and maps provided by the SEOW to create a data-driven proposal, or may present comparable indicators from supplementary/local current data to support their application request. Each community will also offer a statement of intent to complete all steps of the SPF process; assessment, capacity building, strategic planning, implementation and evaluation, as well as addressing Cultural Competence and Sustainability components.

During the first year of the grant all communities will focus on the first phase, which includes the first three steps of the SPF process. It is anticipated that communities, all being at different capacity levels, will need varying time frames to complete the comprehensive assessment of the first phase. The first phase will need to be completed within 12 months of receiving the award. The first phase will be inclusive of a thorough assessment, building capacity and writing their community's strategic plan. The communities will also focus on establishing implementation steps. The evaluation process will be integrated through all steps of the SPF process, as will adhere to Cultural Competency and Sustainability components. Sub-recipient communities who demonstrate an ability to thoroughly complete the SPF process and have their strategic plan approved by the state will be eligible to move onto the implementation phase.

The program implementation phase will be the second tier of the grant process, with each consecutive years funding awarded on demonstrated satisfactory progress from the previous year and availability of funds.

In all cases, each community will be provided with a prescriptive budget to complete for the first year. Additional matching funds may be required in subsequent years with a minimum of 10% anticipated in the second year, and to up to 50% in the final year of the grant to promote the sustainability of the project.

4. Implications of Allocation Approach

Priorities	Planning Model	Problem Reduction	State Support/ Non-SPF
Alcohol	Highest Need/Highest Contributor	Reduce problem in targeted communities & possibly state	SPF SIG Staff, CAPT& PIRE/ LCC'S, IPRC, OFBCI, and other state and community organizations and agencies
Cocaine	Highest Need/Highest Contributor	Reduce problem in targeted communities & possibly state	SPF SIG Staff, CAPT& PIRE/ LCC'S, IPRC, OFBCI, and other state and community organizations and agencies
Methamphetamine	Highest Need/Highest Contributor	Reduce problem in targeted communities & possibly state	SPF SIG Staff, CAPT& PIRE/ LCC'S, IPRC, OFBCI, and other state and community organizations and agencies

The SPF SIG staff and state does not expect to see dramatic changes in the state levels of consumption and consequences. However, we do anticipate some reduction in the funded communities' rates.

The SEOW, IPRC, and Community Consultants will be strong resources for the communities to use in data collection, training and technical assistance, and to increase their knowledge of evidence-based strategies. Each of these agencies and organizations are independent of the SPF SIG and can provide continued support and data beyond the life of this project. One of the non SPF SIG resources, as mentioned earlier, is the SEOW's data collecting systems and resources for collecting future data. Communities can tap into the analysis of the SEOW to seek for further funding opportunities, and build relationships with other organizations within their communities that may offer personnel support, or share space in newsletters that inform a larger network of citizens, such as the OFBCI is doing now for this project. With the six state priorities being labeled outside the scope of just the SPF SIG project, many organizations will be able to use their data-driven evidence to gain leverage for entrance into new funding opportunities.

IMPLEMENTATION

Logic models are the key to effective strategic planning, implementation and achieving targeted outcomes. Logic models depend heavily on community needs and the needs of its constituents. Prevention resources are targeted most effectively when models establish the logical connections between needs identified among Indiana's target population, the interventions selected, and the outcomes sought. Communities will receive training and technical assistance to help them develop community-specific logic models consistent with their proposed intervention strategy.

In the Program Implementation Phase of the Indiana SPF SIG Project community based agencies and coalitions throughout the state will be required to develop proposals that address one of the priorities identified by the State Epidemiological Outcomes Workgroup, approved by the GAC and consistent with the statewide strategic plan. The State process has begun with the submission of a formal Letter of Intent to the Indiana Department of Administration (IDOA). Upon receiving consent to proceed and approval for the Strategic Plan, an RFS will be executed by Project Staff and reviewed by the GAC and the Executive Committee prior to being submitted to the IDOA and Center for Substance Abuse Prevention (CSAP) for approval. The RFS will also be presented to CSAP for approval.

Once approved, a competitive RFS funding process will be used to identify potential sub-recipients. No one community can submit more than one application. If two or more applications are received from the same community they will be informed and counseled to combine and coordinate efforts. Indiana will not fund duplicative substate anti-drug coalition infrastructures, but will utilize those already functioning and funded by programs such as the Drug Free Community Program. A Pre-Conference Informational Session will be held to announce the application process and disseminate information regarding the steps necessary for applications. This meeting will also detail important elements of the grant requirements in addressing Cultural Competency and Sustainability. This meeting will be attended by key stakeholders, Workgroup members, selected members of the GAC and identified personnel of the Indiana Prevention Resource Center (IPRC) and Office of Faith Based Community Initiatives (OFBCI).

Shortly after this meeting a number of Regional Technical Assistance Workshops will be conducted for all potential grant applicants. After the Regional Technical Assistance Workshops are completed the Letter of Intent will be due, followed by the RFS. Prior to the RFS proposal due date, a two week time period will open for applicants to contact the state and request responses to specific concerns, issues and general questions.

The Chair of the Governor's Advisory Council has selected a group of personnel to serve as the Grant Review Workgroup, comprised of Indiana State employees, as required by law in the State of Indiana. The applications will be screened by an Expert Review Advisory Committee before going to the Grant Review Workgroup. The procedure for evaluating the proposal against the evaluation criteria will be inclusive of but not limited to the following:

1. Each proposal will be evaluated on the basis of the categories listed below in the Attachments. A point score will be established for each response in each category.
2. Based on the results of the initial evaluation, the proposals determined to be most advantageous to the state, taking into

account all of the evaluation factors, may be selected by the State for further evaluative action.

3. If technical proposals are close to equal, greater weight could be given to cost

All proposals will be reviewed by both the Expert Review Advisory Committee and the Grant Review Workgroup. References may be contacted. It is possible that finalists will be interviewed by persons participating in the selection process. The Governor's Advisory Workgroup will, in the exercise of it's sole discretion, determine which proposals offer the best means of servicing the interests of the State. The exercise of this discretion will be final.

The second quarter of 2007 is the anticipated timeframe for announcing to whom the grants are being awarded. New sub-grant recipient training conferences will begin at that point and the implementation process will proceed.

EVALUATION

The evaluation of the SPF-SIG will be multifaceted and include state-level and community-level data collection. On a state-level, Indiana will participate in the two nationally-mandated state-level interviews: the State Infrastructure Interview and the SPF Implementation Interview. Both sets of interviews will require the participation of selected representatives knowledgeable of the state's prevention efforts. The two state-level interviews will be administered at least twice during the life of the grant. Additionally, the state evaluators will develop a state-specific evaluation designed to assess how well Indiana has completed the five SPF-SIG steps of assessment, capacity building, planning, implementation, and evaluation.

At the community level, all grantees will participate in the nationally-mandated Community Level Interview (CLI). The CLI is a web-based survey administered by Westat shortly after a community receives funding and then at the end of the grant period. All funded communities will also participate in the mandated collection of the National Outcome Measures (NOMS) data. Once communities have been selected through the RFS process, members of the evaluation team will meet with both state and grantee representatives to determine a core dataset to be collected by all sites which will include the NOMS and other state-required data.

- Along with national and state-mandated data collection, grantees will be required to complete community-specific evaluations. As with the state-level evaluations, communities will be asked to develop both an outcome and a process evaluation.

Within each grantee community, changes are expected in the following areas: First, the evaluation team anticipates positive, community-level changes in consumption behaviors and consequences associated with the targeted prevention priorities. Second, the evaluation team expects to see an increase in both the use of data-driven decision making regarding prevention activities and in the use of evidence-based prevention practices for those communities who implement the second phase of the project. In addition the evaluation team hopes to see change in the capacity of communities to collect information and base their efforts on the data-driven need for services.

Each community funded will be required by the IDMHA to collect all NOMS data necessary for the national, cross-cutting evaluation. The data will be gathered through a web-based data collection system which will be integrated into communities' current MIS systems. The data will be submitted by the evaluation team to the national evaluators electronically in the specified format.

Appendix A: Key Abbreviations and Definitions

Abbreviation	Name
ATC	Alcohol and Tobacco Commission
ATOD	Alcohol, Tobacco and Other Drugs
CDC	Centers for Disease Control and Prevention
CAPT	Center for the Application of Prevention Technology
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DCS	Department of Child Services
DFR	Division of Family Resources
DMHA	Division of Mental Health and Addiction
DOC	Department of Corrections
DOD	Department of Defense
DOT	Department of Transportation
DSA	Defined Service Area (Afternoon's R.O.C.K.)
DSS	Decision Support System
EUDL	Enforcing Underage Drinking Laws
FSSA	Family and Social Services Administration
IPRC	Indiana Prevention Resource Center
ING	Indiana National Guard
IDOE	Indiana Department of Education
ICJI	Indiana Criminal Justice Institute
IAC	Interagency Council on Drugs
GCIDD	Governor's Council on Impaired and Dangerous Driving
GCDFI	Governor's Commission for a Drug-Free Indiana
GCIDD	Governor's Council on Impaired and Dangerous Driving
IAC	Interagency Council on Drugs
ICJI	Indiana Criminal Justice Institute
IDOE	Indiana Department of Education
ING	Indiana National Guard
IPRC	Indiana Prevention Resource Center
ISDH	Indiana State Department of Health
ISEP	Indiana State Excise Police
ISP	Indiana State Police
ITPC	Indiana Tobacco Prevention and Cessation
LCC	Local Coordinating Council
NHTSA	National Highway Traffic Safety Administration

NIDA	National Institute on Drug Abuse
NPN	National Prevention Network
OJJDP	Office of Juvenile Justice and Delinquency Prevention
ONDCP	Office of National Drug Control Policy
OSH	Office of Smoking and Health
SAMHSA	Substance Abuse Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment Block Grant
SDFSC	Safe and Drug-Free Schools and Communities (Title IV)
SIG	Center for Substance Abuse Prevention State Incentive Grant
SPF SIG	Strategic Prevention Framework State Incentive Grant
SYNAR	CSAP tobacco inspection program named for Congressman Mike Synar

Endnotes (Tables 3 through 5)

[1] State general fund appropriation that IDOE receives for Drug Free Schools. IDOE-related figures provided by Yvette Hauser (August 17,2006) and Jeff Barber (September 13, 2006) via email communication.
[1] This amount is based on SFY '05-'06 as per Sonya Cleveland, Substance Abuse Services Division Director, ICJI, by phone and email communication (September 13, 2006).
[1] GCIDD-related amounts and program details provided by Carl Heck, Fiscal Management, Traffic Safety Division, ICJI, via phone (August 22, 2006 and September 14, 2006).
[1] Figure provided by Joshua Ross, Interim Youth Division Director, ICJI, by phone (August 30, 2006).
[1] ITPC-related amounts provided by Miranda Spitznagle, via email and phone communication, August 22, 2006.
[1] This figure represents the balance of the SAPT block grant after the Prevention portion is removed. This balance does not reflect other set-asides, including AIDS, pregnancy, and other.
[1] DMHA amounts and program details provided by Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative,
IPRC and DMHA, by email (August 16, 2006) and phone (September 7, 2006).
[1] $ 3 million (10 % of total SAPT Treatment and Prevention funding) is directed at services for women and children.
[1] Dollar amount provided by David Bozell, DMHA by email (October 5, 2006).
[1] The 10 to 14 age group target is not a grant requirement, as per Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative, IPRC and DMHA, by email (August 16, 2006) and phone (September 7, 2006).
[1] See SPF SIG 2006 Prevention Priorities.
[1] GCDFI figures provided by Sonya Cleveland, Substance Abuse Services Division Director, ICJI, via phone and email communication on September 13, 2006.
[1] According to Jeff Barber of Safe & Drug-Free Schools and Communities, these funds can also be used for school safety expenditures related to violence prevention. IDOE prevent program details also provided by Jeff Barber, via email (September 14, 2006).
[1] IDOE-related figures provided by Yvette Hauser by email (August 17,2006).
[1] According to Jeff Barber of Safe & Drug-Free Schools and Communities, these funds can also be used for school safety expenditures related to violence prevention. IDOE prevent program details also provided by Jeff Barber, via email (September 14, 2006).
[1] ISDH amounts provided by Linda Brown, Finance Division, ISDH, by email (August 22, 2006).
[1] Linda Brown, Finance Division, ISDH, via email (August 22, 2006).
[1] U.S. DOT 402 funds for SFY '06 total $4,478,43, and 410 funds are approximately $2 million. These figures provided by Carl Heck, Fiscal Management, Traffic Safety Division, ICJI, via phone (August 22, 2006 and September 14, 2006).
[1] Figure provided by Joshua Ross, Interim Youth Division Director, ICJI, by phone (August 30, 2006).
[1] ING-related amounts and program details provided by Lt. Jospeph Luckett via email (September 6, 2006).
[1] ING-related amounts and program details provided by Lt. Jospeph Luckett via email (September 6, 2006).
[1] ISP and DEA figures provided by Niki Crawford (ISP) in consultation with Dennis Wischern, Drug Enforcement Agency , by email (September 5, 2006).
[1] ISEP amounts and program details provided by Major Robin Poindexter, ISEP, via email (August 30, 2006).
[1] 2000, 2003 and 2006 totals do not include SAPT Treatment funds.
[1] Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative
IPRC and DMHA, by email (August 16, 2006) and phone (September 7, 2006).
[1] Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative
IPRC and DMHA, by email (August 16, 2006) and phone (September 7, 2006).

[1] According to Mary Lay, this is no longer Block Grant funding. DMHA will transfer state dollars to the Alcohol and Tobacco Commission. The dollar amount will be $250,000 when the payment structure is confirmed.
[1] Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative
IPRC and DMHA by email (August 16, 2006) and phone (September 7, 2006).
[1] Sonya Cleveland, Substance Abuse Services Division Director, ICJI (September 13, 2006).
[1] Linda Brown, Finance Division, ISDH (August 22, 2006).
[1] Major Robin Poindexter, ISEP (August 30, 2006).
[1] This is a $360,000 grant. GCDFI receives $160,000. In FY 00 the $200,000 was used by ICJI – YD to support the Saturn Initiative.
[1] Joshua Ross, Interim Youth Division Director, ICJI, by phone (August 30, 2006).
[1] ISEP amounts and program details provided by Major Robin Poindexter, ISEP, August 30, 2006 and Carl Heck, Fiscal Management, Traffic Safety Division, ICJI, via phone (August 22, 2006 and September 14, 2006).
[1] Carl Heck, Fiscal Management, Traffic Safety Division, ICJI, via phone (August 22, 2006 and September 14, 2006).
[1] Linda Brown, Finance Division, ISDH, via email (August 22, 2006). ITPC-related figures provided by Miranda Spitznagle, Director of Program Evaluation, ITPC, via email and phone communication (August 22, 2006).
[1] This program was originally by an FDA grant; during 2000 it was supported through funding by FSSA, DMHA; now it is funded by the ITPC.
[1] Miranda Spitznagle, Director of Program Evaluation, ITPC, via email and phone communication (August 22, 2006); and Major Robin Poindexter, ISEP via email (August 30, 2006).
[1] This does not represent an increase in funds; $78,000 total is for an 18 month period rather than 12 months for the $48,000 in FY 00.
[1] Miranda Spitznagle, Director of Program Evaluation, ITPC, via email and phone (August 22, 2006); and Major Robin Poindexter, ISEP, by email communication (August 30, 2006).
[1] Major Robin Poindexter, ISEP, by email (August 30, 2006).

Attachment A

Scoring Criteria

The *Substance Abuse Mental Health Services Administration* (SAMHSA) and *The Center for Substance Abuse Prevention* (CSAP), the funding grantors of the SPF SIG, have dictated that all grants must be awarded based upon data-driven evidence to assist in building capacity and infrastructure to address the needs of substance abuse within the State.
The SEOW has provided analysis documents for the communities to use to evaluate whether they are potential recipients of the award based on the highest needs:

- **Priority Indicators**-listing the top 10th, 25th and 50th percentile use rate of the priority substances in each of Indiana's 92 counties
- **Epidemiological Profiles Maps, Graphs & Tables-**depicting where and what populations the data identifies as the highest use areas and populations for the 6 Priority Substances
- **Literature –**offering explanation of the data to identify highest needs areas

Based on these sources of information, communities will be able to identify and build a data-driven validation to apply as a recipient of the SPF SIG Grant. In the event that a community has additional comparable data, *other than the above mentioned*, to support their case as a high needs community, the Expert Grant Review Committee and Grant Review Workgroup will review and listen to the community's validation for their presenting data.

Potential applicants will include specific community coalitions; and should include, but are not limited to the Local Coordinating Councils, Drug Free Communities, Indiana Tobacco Prevention and Cessation, and Defined Service Area (Afternoon's R.O.C.K.). It is anticipated that the coalitions will work the Community Consultant's which have been established as a main foundation of Indiana's infrastructure.
One of the main focuses of this grant is to assist communities in learning and gaining experience in using the Strategic Prevention Framework process to address the substance problems of their community.
The scoring of the applications will be based on each applicant's ability to show evidence of their community as one of the highest needs community within the State and will be scored as follows:

Section A: Community Assessment (20 pts.)
In this section each community must document their mission statement and indicate whether the mission statement is reviewed on an ongoing basis, to begin the project narrative. Information on the community's demographics; inclusive of whether the community is economically disadvantaged, and whether or not they are a minority community should also be addressed. Communities should provide a general assessment of the substance abuse problems down to the specific concerns of the community, evidenced by the data provided by the SEOW's analysis documents. (10 pts.)

1. Based on the SEOW reports listed above, is your community able to show that they are high need community? What specific data, findings, or information supports your decision to apply as a recipient of the award monies? Describe the specific sources of the data and how your community interprets and justifies your findings. (5 pts.)

2. What methods did you use to analyze data and other information? (i.e. State Epidemiological Profile, school surveys, focus groups, mining existing data sources from law enforcement, hospitals, etc.) (2pts)

3. How do you plan to continually check the validity and accuracy of your original community assessment? (3 pts.)

Section B: Indicator point scores for each Priority: (40 pts.)

COUNTY	ALCOHOL PRIORITY SCORE	COUNTY	ALCOHOL PRIORITY SCORE
Lake	21	Porter	14
Tippecanoe	20	Elkhart	13
Marion	19	Shelby	13
Allen	18	Wayne	12
La Porte	17	Delaware	11
St. Joseph	17	Jasper	10
Vanderburgh	17	Kosciusko	10
Floyd	16	Marshall	10
Vigo	15	Monroe	10
Madison	14	Newton	10

The communities will be awarded points in this section based on Tables 1 and 2:

Table 1. Communities Identified As "High Need" For Alcohol.

Table 2. Communities Identified As "High Need" For Cocaine and Methamphetamine-Related SPF SIG Funding

Communities can only be awarded scoring points in this section for one priority.
Refer to the indicator documents in Attachment 2 of the States Strategic Plan for percentage identification.

COCAINE	METHAMPHETAMINE
Marion (HN/HC)	Gibson (HN)
Wayne (HN/HC)	Bartholomew (HN/HC)
St. Joseph (HN/HC)	Vigo (HN/HC)
Howard (HN/HC)	Daviess (HN)
Allen (HN/HC)	Warrick (HN/HC)
Grant (HC)	Greene (HN)
Elkhart (HN/HC)	Vanderburgh (HN/HC)
Lake (HC)	Tippecanoe (HC)
Tippecanoe (HC)	Elkhart (HC)
	Hamilton (HC)

All applicant communities listed in Tables 1 and 2 will be awarded **40 points** as they have been pre-identified by the SEOW as being high need/high contributor communities.

Other communities may choose to apply; however, applicant communities are required to present a thorough data-based argument, using the detailed data tables prepared by the SEOW (see Attachment 2) and/or other local sources. The analysis must demonstrate that the applicant's community falls in the top half of the distribution of counties in Indiana on at least one of the allocation indicators within the applicant's targeted priority, used by the SEOW to establish high need within the selected targeted SPF SIG priority. For alcohol, this included six indicators: 1) number of alcohol-related fatal auto accidents; 2) rate of alcohol-related fatal auto accidents; 3) number of alcohol-related crashes; 4) rate of alcohol-related crashes; 5) number of arrests for public intoxication; and 6) rate of public intoxication arrests. For cocaine and methamphetamine this included two indicators: 1) rate of arrests possession of marijuana or "other synthetic drugs" and 2) number of arrests for possession of marijuana or "other synthetic drugs." (See above for a

more detailed discussion of the SEOW's methodology.) Applicant communities able to demonstrate they fall within the top have of the distribution on one of the indicators within each set, we will be awarded points as follows:

- one indicator in the top 10% = **30 points**
- one indicator in the top 15% = **25 points**
- one indicator in the top 25% = **20 points**
- one indicator in the top 50% = **15 points**

Section C: Capacity Building (20 pts.)

In this section of the Project's Narrative, applicants should make a statement of intent to address capacity building efforts within the community and the coalition's ability to lead and manage change within the community. (7 pts.)

1. What current financial and other resources (people, leadership, training, knowledge, etc.) do you have in place that is appropriate to address the identified drug use problems in your community? (3 pts.)
2. How do you plan to maintain and strengthen the community over the life of the project? (3 pts.)
3. How does your community anticipate training, encouraging, and mobilizing your current and future leaders, workers, and volunteers? (4 pts.)
4. Please provide the past 3 months meeting minutes, listing the frequency of meetings, and a list of the members and what organizations they represent from the community of your coalition. (3 pts.)

Section D: Financial Capacity (20 pts.)

Applicants must complete and submit the prescriptive budget outlined by the State for the first year of the award. They must also indicate who the fiscal agent will be managing the funds of the grant. Please report to the experience in financial accounting and reporting of your fiscal agent. What are the current safeguards within your community to ensure proper management of the funds? See attachment C.

Criteria	Points
Adherence to Mandatory Requirements	Pass/Fail
A. Community Assessment	20 Points
B. Indicator Points for Each Priority	40 Points
C. Capacity Building	20 Points
D. Financial Capacity	20 Points
5. (5) Minority and Women Business, (5) Subcontractor Commitment, (5) Drug Free Communities	Bonus Points
Total	**100**

ATTACHMENT 2

Proxy Indicator of Binge Drinking for Indiana Counties

County	Rate of Alcohol-Related Motor Vehicle Crashes (2005)*	
Lake	10.05	
St. Joseph	7.40	
Dearborn	1.53	
Ohio	1.45	
Shelby	1.36	
Steuben	1.01	
Vermillion	1.00	
Brown	0.92	
Parke	0.89	Top 10th percentile (0.8803)
Tippecanoe	0.85	
Crawford	0.85	
LaPorte	0.84	
Vigo	0.84	
Franklin	0.82	Top 15th percentile (0.8238)
Vanderburgh	0.79	
Marshall	0.77	
Floyd	0.76	
Starke	0.76	
Jackson	0.75	
Clark	0.72	
Harrison	0.71	
Jasper	0.71	
Allen	0.69	
Marion	0.68	Top 25th percentile (0.6846)
Clinton	0.67	
Porter	0.66	
Fountain	0.66	
Newton	0.66	
Jefferson	0.63	
Rush	0.62	
Elkhart	0.61	
Ripley	0.61	
Knox	0.60	
Madison	0.59	
Miami	0.59	
Montgomery	0.59	
Delaware	0.58	
Orange	0.58	
Fulton	0.58	
Daviess	0.57	

White	0.57	
Gibson	0.57	
Kosciusko	0.57	
Jennings	0.56	
Fayette	0.56	
Wayne	0.55	
Dubois	0.54	
Greene	0.54	Top 50th percentile (0.5438)
Wabash	0.53	
Martin	0.53	
Noble	0.53	
Carroll	0.51	
Warren	0.51	
Monroe	0.51	
Grant	0.51	
Warrick	0.51	
Bartholomew	0.50	
Cass	0.50	
Jay	0.49	
Posey	0.48	
Washington	0.48	
Owen	0.48	
Pike	0.47	
Whitley	0.46	
Randolph	0.45	
Howard	0.45	
Johnson	0.44	
Hancock	0.44	
Lawrence	0.43	
Henry	0.42	
Hendricks	0.42	
DeKalb	0.40	
Benton	0.39	
Morgan	0.38	
Hamilton	0.37	
Boone	0.36	
Union	0.35	
Adams	0.34	
Perry	0.32	
Clay	0.31	
Switzerland	0.31	
Tipton	0.31	
Decatur	0.30	
Spencer	0.30	
Pulaski	0.25	
Huntington	0.25	
Wells	0.23	
Blackford	0.18	
Putnam	0.16	
Scott	0.05	

LaGrange	0.04
Sullivan	0.00

*Data on motor vehicle crashes was provided by the Indiana Criminal Justice Institute.

Proxy Indicator for Binge Drinking - Highest Contributor Model

County	Number of Alcohol-Related Motor Vehicle Crashes (2005)*	
Marion	1167	
Lake	741	
Allen	473	
St. Joseph	304	
Vanderburgh	274	
Tippecanoe	262	
Elkhart	240	
Porter	209	
LaPorte	186	Top 10th percentile (184)
Hamilton	180	
Vigo	172	
Madison	155	
Clark	146	
Delaware	136	Top 15th percentile (137)
Monroe	124	
Johnson	112	
Floyd	110	
Hendricks	107	
Kosciusko	86	
Dearborn	77	
Wayne	76	
Howard	76	
Bartholomew	74	Top 25th percentile (74)
Marshall	72	
Grant	72	
Steuben	68	
Shelby	65	
Jackson	63	
Warrick	57	
Hancock	55	
Morgan	53	
Harrison	52	
Noble	50	
Clinton	46	
Knox	46	
Jasper	45	
Montgomery	45	
Dubois	44	
Miami	42	
Jefferson	41	
Cass	40	

Lawrence	40	
Henry	40	
DeKalb	39	
Franklin	38	
Gibson	38	Top 50th percentile (38)
Boone	37	
Greene	36	
Wabash	36	
LaGrange	36	
Starke	35	
Daviess	35	
Ripley	34	
Vermillion	33	
Jennings	32	
Parke	31	
Whitley	30	
Scott	29	
Brown	28	
White	28	
Fayette	28	
Washington	27	
Posey	26	
Spencer	26	
Decatur	25	
Fulton	24	
Randolph	24	
Fountain	23	
Orange	23	
Adams	23	
Rush	22	
Owen	22	
Carroll	21	
Jay	21	
Crawford	19	
Newton	19	
Huntington	19	
Ohio	17	
Clay	17	
Wells	13	
Pike	12	
Perry	12	
Putnam	12	
Martin	11	
Tipton	10	
Warren	9	
Benton	7	
Pulaski	7	
Switzerland	6	
Union	5	
Blackford	5	
Sullivan	0	

*Data on motor vehicle crashes was provided by the Indiana Criminal Justice Institute.

Proxy Indicator of Binge Drinking for Indiana Counties - Highest Contributor Model

County	Number of Alcohol-Related Fatal Crashes (2005)*	
Marion	28	
Lake	21	
St. Joseph	15	
Allen	12	
LaPorte	10	
Madison	9	
Elkhart	8	
Tippecanoe	6	
Porter	6	Top 10th percentile (6)
Johnson	5	
Newton	4	
Posey	4	
Jasper	4	
Knox	4	
Floyd	4	
Vigo	4	
Delaware	4	
Hendricks	4	
Vanderburgh	4	
Hamilton	4	Top 15th percentile (4)
Shelby	3	
Greene	3	
Montgomery	3	
Marshall	3	
Henry	3	
Boone	3	
Kosciusko	3	Top 25th percentile (3)
Crawford	2	
Pulaski	2	
Parke	2	
Orange	2	
Jay	2	
Starke	2	
Ripley	2	
Steuben	2	
Miami	2	
Harrison	2	
Huntington	2	
Decatur	2	
Noble	2	
Howard	2	
Clark	2	

Scott	2	
LaGrange	2	
Warren	1	
Switzerland	1	
Brown	1	
Fulton	1	
Franklin	1	
Fayette	1	
Dearborn	1	
Randolph	1	
Wells	1	
Jennings	1	
Whitley	1	
Wabash	1	
Clinton	1	
Spencer	1	
Warrick	1	
Hancock	1	
Wayne	1	
Morgan	1	
Grant	1	
Bartholomew	1	
Monroe	1	Top 50th percentile (1)
Jackson	0	
Dubois	0	
Jefferson	0	
Cass	0	
Lawrence	0	
DeKalb	0	
Gibson	0	
Daviess	0	
Vermillion	0	
White	0	
Washington	0	
Fountain	0	
Adams	0	
Rush	0	
Owen	0	
Carroll	0	
Ohio	0	
Clay	0	
Pike	0	
Perry	0	
Putnam	0	
Martin	0	
Tipton	0	
Benton	0	
Union	0	
Blackford	0	
Sullivan	0	

*Data provided by the Indiana Criminal Justice Institute

Proxy Indicator of Binge Drinking for Indiana Counties

County	Rate of Alcohol-Related Fatal Crashes (2005)*	
St. Joseph	0.37	
Lake	0.28	
Newton	0.14	
Crawford	0.09	
Posey	0.07	
Pulaski	0.07	
Jasper	0.06	
Parke	0.06	
Shelby	0.06	
Warren	0.06	Top 10th percentile (0.0574)
Jay	0.05	
Knox	0.05	
LaPorte	0.05	
Orange	0.05	
Switzerland	0.05	Top 15th percentile (0.0465)
Greene	0.04	
Montgomery	0.04	
Ripley	0.04	
Starke	0.04	
Boone	0.03	
Brown	0.03	
Floyd	0.03	
Harrison	0.03	
Henry	0.03	
Huntington	0.03	
Madison	0.03	
Marshall	0.03	
Miami	0.03	
Steuben	0.03	Top 25th percentile (0.0312)
Allen	0.02	
Dearborn	0.02	
Decatur	0.02	
Delaware	0.02	
Elkhart	0.02	
Fayette	0.02	
Franklin	0.02	
Fulton	0.02	
Hendricks	0.02	
Jennings	0.02	
Johnson	0.02	
Kosciusko	0.02	
Marion	0.02	
Noble	0.02	
Porter	0.02	

Randolph	0.02	
Tippecanoe	0.02	
Vigo	0.02	
Wells	0.02	
Whitley	0.02	Top 50th percentile (0.0167)
Bartholomew	0.01	
Clark	0.01	
Clinton	0.01	
Grant	0.01	
Hamilton	0.01	
Hancock	0.01	
Howard	0.01	
Morgan	0.01	
Spencer	0.01	
Vanderburgh	0.01	
Wabash	0.01	
Warrick	0.01	
Wayne	0.01	
Adams	0.00	
Benton	0.00	
Blackford	0.00	
Carroll	0.00	
Cass	0.00	
Clay	0.00	
Daviess	0.00	
DeKalb	0.00	
Dubois	0.00	
Fountain	0.00	
Gibson	0.00	
Jackson	0.00	
Jefferson	0.00	
LaGrange	0.00	
Lawrence	0.00	
Martin	0.00	
Monroe	0.00	
Ohio	0.00	
Owen	0.00	
Perry	0.00	
Pike	0.00	
Putnam	0.00	
Rush	0.00	
Scott	0.00	
Sullivan	0.00	
Tipton	0.00	
Union	0.00	
Vermillion	0.00	
Washington	0.00	
White	0.00	

*Rates calculated from data provided by the Indiana Criminal Justice Institute

Proxy Indicator of Cocaine use for Indiana Counties - Highest Contributor Model

County	UCR Coverage Index	Number of Cocaine Possession Arrests (2004 UCR Data)*	
Marion	100.00	1690	
St. Joseph	100.00	369	
Allen	98.67	341	
Lake	69.69	251	
Elkhart	100.00	141	
Wayne	90.35	122	
Tippecanoe	99.57	111	
Howard	100.00	107	Top 10th percentile (108)
Vanderburgh	100.00	97	
Delaware	100.00	59	
Grant	100.00	54	
Hamilton	94.84	53	Top 15th percentile (53)
LaPorte	96.27	52	
Porter	92.70	42	
Bartholomew	100.00	40	
Madison	55.47	34	
Hendricks	60.49	31	
Clark	65.66	29	
Johnson	93.30	29	Top 25th percentile (28)
Vigo	57.79	26	
Morgan	32.33	23	
Putnam	72.78	21	
Hancock	26.45	18	
Floyd	100.00	17	
Monroe	100.00	17	
Kosciusko	16.92	17	
Steuben	100.00	16	
Knox	58.34	15	
Marshall	25.63	12	
Noble	26.30	12	
Dearborn	63.65	11	
DeKalb	30.39	10	
Gibson	66.35	10	
Dubois	47.31	10	
Shelby	59.13	9	
Jackson	44.43	9	
Fountain	33.11	9	
Clinton	48.54	8	Top 50th percentile (8)
Jefferson	37.98	7	
Jasper	19.84	7	
Montgomery	40.10	7	
Fayette	59.38	7	

Whitley	29.89	7	
Daviess	62.42	6	
Washington	11.45	6	
Newton	100.00	6	
Posey	27.23	6	
Wabash	50.80	6	
Ripley	21.97	6	
Franklin	50.00	6	
Jennings	61.36	6	
Henry	100.00	6	
Decatur	41.87	5	
Cass	43.81	5	
Scott	25.10	5	
Carroll	14.63	5	
Blackford	100.00	5	
White	100.00	4	
Jay	28.79	4	
Rush	32.15	4	
Lawrence	84.85	4	
Greene	75.15	4	
Warrick	100.00	4	
Adams	40.43	4	
Vermillion	29.88	3	
Tipton	23.89	3	
Randolph	95.87	3	
Wells	100.00	3	
Huntington	85.00	1	
Perry	100.00	1	
Clay	100.00	1	
Starke	92.11	0	
LaGrange	100.00	0	
Harrison	100.00	0	
Brown	100.00	0	
Martin	84.81	0	
Benton	0.00	n/a	No UCR Data
Boone	0.00	n/a	
Crawford	0.00	n/a	
Fulton	0.00	n/a	
Miami	0.00	n/a	
Ohio	0.00	n/a	
Orange	0.00	n/a	
Owen	0.00	n/a	
Parke	0.00	n/a	
Pike	0.00	n/a	
Pulaski	0.00	n/a	
Spencer	0.00	n/a	
Sullivan	0.00	n/a	
Switzerland	0.00	n/a	
Union	0.00	n/a	
Warren	0.00	n/a	

*Counties with a UCR Coverage Index of zero (0) are not reported. The Coverage Index represents the proporition of county data that IS NOT IMPUTED for a given year. The indicator ranges from 100, indicating that all ORIs in the county reported for 12 months in the year, to 0, indicating that all data in the county are based on estimates, not reported data.

Proxy Indicator of Cocaine Use for Indiana Counties

County	UCR Coverage Index	Cocaine Possession Arrest Rate (2004 UCR Data)*	
Marion	100.00	2.78	
Wayne	90.35	2.40	
St. Joseph	100.00	1.97	
Howard	100.00	1.74	
Allen	98.67	1.42	
Grant	100.00	1.05	
Elkhart	100.00	1.05	Top 10th percentile (1.0099)
Tippecanoe	99.57	0.99	
Putnam	72.78	0.77	
Vanderburgh	100.00	0.77	
Bartholomew	100.00	0.76	Top 15th percentile (0.7353)
Lake	69.69	0.72	
Fountain	33.11	0.71	
Delaware	100.00	0.69	
Steuben	100.00	0.65	
LaPorte	96.27	0.64	
Newton	100.00	0.56	
Knox	58.34	0.54	
Blackford	100.00	0.49	Top 25th percentile (0.4791)
Morgan	32.33	0.46	
Gibson	66.35	0.41	
Hancock	26.45	0.39	
Clark	65.66	0.39	
Fayette	59.38	0.38	
Porter	92.70	0.36	
Noble	26.30	0.36	
Marshall	25.63	0.36	
Franklin	50.00	0.36	
Madison	55.47	0.35	
Vigo	57.79	0.35	
Dubois	47.31	0.34	
DeKalb	30.39	0.34	
Hendricks	60.49	0.34	
Carroll	14.63	0.33	
Clinton	48.54	0.33	
Floyd	100.00	0.33	
Hamilton	94.84	0.32	
Johnson	93.30	0.32	Top 50th percentile (0.3153)

Kosciusko	16.92	0.31	
Rush	32.15	0.31	
Dearborn	63.65	0.31	
Jasper	19.84	0.31	
Posey	27.23	0.31	
Ripley	21.97	0.31	
Whitley	29.89	0.30	
Jennings	61.36	0.30	
Washington	11.45	0.30	
Jefferson	37.98	0.29	
Jackson	44.43	0.29	
Scott	25.10	0.29	
Daviess	62.42	0.29	
Shelby	59.13	0.28	
Decatur	41.87	0.28	
Jay	28.79	0.26	
Montgomery	40.10	0.25	
Tipton	23.89	0.25	
Vermillion	29.88	0.24	
Wabash	50.80	0.24	
White	100.00	0.22	
Monroe	100.00	0.19	
Adams	40.43	0.18	
Cass	43.81	0.17	
Henry	100.00	0.17	
Greene	75.15	0.16	
Randolph	95.87	0.15	
Wells	100.00	0.15	
Lawrence	84.85	0.12	
Warrick	100.00	0.10	
Perry	100.00	0.07	
Clay	100.00	0.05	
Huntington	85.00	0.04	
Brown	100.00	0.00	
Harrison	100.00	0.00	
LaGrange	100.00	0.00	
Martin	84.81	0.00	
Starke	92.11	0.00	
Benton	0.00	n/a	UCR Data Not Available
Boone	0.00	n/a	
Crawford	0.00	n/a	
Fulton	0.00	n/a	
Miami	0.00	n/a	
Ohio	0.00	n/a	
Orange	0.00	n/a	
Owen	0.00	n/a	
Parke	0.00	n/a	
Pike	0.00	n/a	
Pulaski	0.00	n/a	
Spencer	0.00	n/a	

Sullivan	0.00	n/a	
Switzerland	0.00	n/a	
Union	0.00	n/a	
Warren	0.00	n/a	

*Counties with a coverage index of zero (0) were NOT included in the calculation of percentile cut scores. The Coverage Index represents the proportion of county data that IS NOT IMPUTED for a given year. The indicator ranges from 100, indicating that all ORIs in the county reported for 12 months in the year, to 0, indicating that all data in the county are based on estimates, not reported data.

County	Number of Alcohol-Related Fatal Accidents	Rate of Alcohol-Related Fatal Accidents	Number of Alcohol-Related Crashes	Rate of Alcohol-Related Crashes	Number of Public Intoxication Arrests	Rate of Public Intoxication Arrests	Total Score
Lake	4	4	4	4	4	1	21
Tippecanoe	4	1	4	3	4	4	20
Marion	4	1	4	2	4	4	19
Allen	4	1	4	2	4	3	18
LaPorte	4	3	4	3	2	1	17
St. Joseph	4	4	4	4	1	0	17
Vanderburgh	3	0	4	2	4	4	17
Floyd	3	2	2	2	3	4	16
Vigo	3	1	3	3	3	2	15
Madison	4	2	3	1	3	1	14
Porter	4	1	4	1	3	1	14
Elkhart	4	1	4	1	3	0	13
Shelby	2	4	1	4	1	1	13
Wayne	1	0	2	1	4	4	12
Delaware	3	1	3	1	2	1	11
Jasper	3	4	1	2	0	0	10
Kosciusko	2	1	2	1	2	2	10
Marshall	2	2	1	2	1	2	10
Monroe	1	0	2	0	4	3	10
Newton	3	4	0	1	0	2	10
Clark	1	0	3	2	2	1	9
Parke	1	4	0	4	0	0	9
Crawford	1	4	0	3	0	0	8
Dearborn	1	1	2	4	0	0	8
Hamilton	3	0	3	0	2	0	8
Jefferson	0	0	1	1	2	4	8
Knox	3	3	1	1	0	0	8
Starke	1	2	0	2	1	2	8
Steuben	1	2	1	4	0	0	8
Brown	1	2	0	4	0	0	7
Grant	1	0	1	0	2	3	7
Jackson	0	0	1	2	1	3	7
Posey	3	4	0	0	0	0	7

Cass	0	0	1	0	1	4	6
Franklin	1	1	1	3	0	0	6
Greene	2	2	0	1	1	0	6
Harrison	1	2	1	2	0	0	6
Hendricks	3	1	2	0	0	0	6
Johnson	3	1	2	0	0	0	6
Montgomery	2	2	1	1	0	0	6
Bartholomew	1	0	2	0	1	1	5
Decatur	1	1	0	0	1	2	5
Henry	2	2	1	0	0	0	5
Howard	1	0	2	0	1	1	5
Jay	1	3	0	0	0	1	5
Miami	1	2	1	1	0	0	5
Noble	1	1	1	0	1	1	5
Orange	1	3	0	1	0	0	5
Pulaski	1	4	0	0	0	0	5
Vermillion	0	0	0	4	0	1	5
Warren	1	4	0	0	0	0	5
Boone	2	2	0	0	0	0	4
Jennings	1	1	0	1	0	1	4
Lawrence	0	0	1	0	1	2	4
Ohio	0	0	0	4	0	0	4
Randolph	1	1	0	0	1	1	4
Ripley	1	2	0	1	0	0	4
Scott	1	0	0	0	1	2	4
Switzerland	1	3	0	0	0	0	4
Clinton	1	0	1	1	0	0	3
Daviess	0	0	0	1	1	1	3
Dubois	0	0	1	1	1	0	3
Fayette	1	1	0	1	0	0	3
Fulton	1	1	0	1	0	0	3
Hancock	1	0	1	0	1	0	3
Huntington	1	2	0	0	0	0	3
Rush	0	0	0	1	0	2	3
DeKalb	0	0	1	0	1	0	2
Fountain	0	0	0	1	0	1	2
Gibson	0	0	1	1	0	0	2
Morgan	1	0	1	0	0	0	2
Putnam	0	0	0	0	1	1	2
Warrick	1	0	1	0	0	0	2
Washington	0	0	0	0	1	1	2
Wells	1	1	0	0	0	0	2
White	0	0	0	1	0	1	2
Whitley	1	1	0	0	0	0	2
LaGrange	1	0	0	0	0	0	1
Spencer	1	0	0	0	0	0	1
Wabash	1	0	0	0	0	0	1
Adams	0	0	0	0	0	0	0

Benton	0	0	0	0	0	0	0
Blackford	0	0	0	0	0	0	0
Carroll	0	0	0	0	0	0	0
Clay	0	0	0	0	0	0	0
Martin	0	0	0	0	0	0	0
Owen	0	0	0	0	0	0	0
Perry	0	0	0	0	0	0	0
Pike	0	0	0	0	0	0	0
Sullivan	0	0	0	0	0	0	0
Tipton	0	0	0	0	0	0	0
Union	0	0	0	0	0	0	0

Proxy Indicator of Binge Drinking for Indiana Counties

County	UCR Coverage Index	Public Intoxication Arrests (2004 UCR Data)*				
Marion	100.00	5118.00				
Allen	98.67	1320.00				
Lake	69.69	1199.00				
Tippecanoe	99.57	845.00				
Vanderburgh	100.00	841.00				
Monroe	100.00	563.00				
Wayne	90.35	464.00	Top 10th percentile (438.10)			
Floyd	100.00	427.00				
Elkhart	100.00	363.00				
Vigo	57.79	358.00				
Porter	92.70	326.00				
Madison	55.47	326.00	Top 15th percentile (326.00)			
LaPorte	96.27	301.00				
Delaware	100.00	277.00				
Clark	65.66	273.00	Top 20th percentile (270.60)			
Grant	100.00	267.00				
Jefferson	37.98	249.00				
Hamilton	94.84	234.00				
Kosciusko	16.92	223.00	Top 25th percentile (221.25)			
Cass	43.81	216.00				
Howard	100.00	215.00				
Bartholomew	100.00	210.00				
Jackson	44.43	180.00				
Lawrence	84.85	171.00				
St. Joseph	100.00	170.00				
Marshall	25.63	137.00				
Hancock	26.45	118.00				
Shelby	59.13	100.00				
Noble	26.30	96.00				
Decatur	41.87	86.00				
Scott	25.10	84.00				

DeKalb	30.39	80.00				
Putnam	72.78	80.00				
Washington	11.45	78.00				
Dubois	47.31	76.00				
Starke	92.11	72.00				
Daviess	62.42	71.00				
Randolph	95.87	69.00				
Greene	75.15	68.00	Top 50th percentile (68.50)			
Jay	28.79	60.00				
Jennings	61.36	60.00				
Wabash	50.80	59.00				
Dearborn	63.65	54.00				
Morgan	32.33	54.00				
White	100.00	53.00				
Warrick	100.00	53.00				
Rush	32.15	53.00				
Montgomery	40.10	51.00				
Posey	27.23	51.00				
Steuben	100.00	50.00				
Clay	100.00	49.00				
Newton	100.00	46.00				
Henry	100.00	46.00				
Gibson	66.35	41.00				
Whitley	29.89	40.00				
Jasper	19.84	40.00				
Adams	40.43	39.00				
Perry	100.00	39.00				
Vermillion	29.88	37.00				
Fountain	33.11	36.00				
Johnson	93.30	34.00				
Hendricks	60.49	29.00				
Wells	100.00	29.00				
Ripley	21.97	25.00				
Carroll	14.63	25.00				
Franklin	50.00	24.00				
Tipton	23.89	23.00				
Harrison	100.00	19.00				
Clinton	48.54	19.00				
Huntington	85.00	17.00				
LaGrange	100.00	15.00				
Knox	58.34	12.00				
Fayette	59.38	11.00				
Blackford	100.00	9.00				
Martin	84.81	9.00				
Brown	100.00	2.00				
Benton	0.00	n/a	UCR Data Not Available			
Boone	0.00	n/a				
Crawford	0.00	n/a				
Fulton	0.00	n/a				
Miami	0.00	n/a				

Ohio	0.00	n/a				
Orange	0.00	n/a				
Owen	0.00	n/a				
Parke	0.00	n/a				
Pike	0.00	n/a				
Pulaski	0.00	n/a				
Spencer	0.00	n/a				
Sullivan	0.00	n/a				
Switzerland	0.00	n/a				
Union	0.00	n/a				
Warren	0.00	n/a				

*Counties with a coverage index of zero (0) were NOT included in the calculation of percentile cut scores. The Coverage Index represents the proportion of county data that IS NOT a given year. The indicator ranges from 100, indicating that all ORIs in the county reported for 12 months in the year, to 0, indicating that all data in the county are based on estimat reported data.

Proxy Indicator of Methamphetamine Use for Indiana Counties

County	UCR Coverage Index	Rate of Synthetic Drug Possession Arrests (2004 UCR Data)*				
Gibson	66.35	1.71				
Bartholomew	100.00	1.51				
Vigo	57.79	1.49				
Daviess	62.42	1.48				
Warrick	100.00	1.39				
Greene	75.15	1.18				
Vanderburgh	100.00	1.13	Top 10th percentile (1.1029)			
LaGrange	100.00	1.09				
Jackson	44.43	1.01				
Grant	100.00	0.95				
Clay	100.00	0.92	Top 15th percentile (0.9092)			
Tippecanoe	99.57	0.90				
Randolph	95.87	0.87				
Starke	92.11	0.85				
Dubois	47.31	0.78				
Marshall	25.63	0.76				
Floyd	100.00	0.67				
Posey	27.23	0.67				
Elkhart	100.00	0.63	Top 25th percentile (0.6316)			
Jefferson	37.98	0.63				
Rush	32.15	0.63				
Wayne	90.35	0.63				
Decatur	41.87	0.61				
Noble	26.30	0.60				
Putnam	72.78	0.59				
Madison	55.47	0.54				
Scott	25.10	0.52				

Ripley	21.97	0.51				
Kosciusko	16.92	0.50				
Tipton	23.89	0.50				
Perry	100.00	0.48				
Jay	28.79	0.46				
Adams	40.43	0.44				
DeKalb	30.39	0.41				
Hamilton	94.84	0.40				
Montgomery	40.10	0.36				
Wabash	50.80	0.36				
Hancock	26.45	0.35	Top 50th percentile (0.3440)			
Delaware	100.00	0.34				
Carroll	14.63	0.33				
Clark	65.66	0.33				
Clinton	48.54	0.33				
Vermillion	29.88	0.32				
Cass	43.81	0.31				
Washington	11.45	0.30				
Hendricks	60.49	0.28				
Shelby	59.13	0.28				
Martin	84.81	0.26				
Lawrence	84.85	0.26				
Dearborn	63.65	0.23				
White	100.00	0.22				
Jasper	19.84	0.22				
Monroe	100.00	0.22				
Fayette	59.38	0.22				
Morgan	32.33	0.18				
Brown	100.00	0.17				
Whitley	29.89	0.17				
Porter	92.70	0.16				
Steuben	100.00	0.16				
Fountain	33.11	0.16				
Knox	58.34	0.14				
Franklin	50.00	0.12				
Harrison	100.00	0.11				
St. Joseph	100.00	0.11				
Lake	69.69	0.11				
Wells	100.00	0.10				
Blackford	100.00	0.10				
LaPorte	96.27	0.05				
Johnson	93.30	0.04				
Marion	100.00	0.02				
Allen	98.67	0.00				
Henry	100.00	0.00				
Howard	100.00	0.00				
Huntington	85.00	0.00				
Jennings	61.36	0.00				
Newton	100.00	0.00				
Benton	0.00	n/a	UCR Data Not Available			

Boone	0.00	n/a				
Crawford	0.00	n/a				
Fulton	0.00	n/a				
Miami	0.00	n/a				
Ohio	0.00	n/a				
Orange	0.00	n/a				
Owen	0.00	n/a				
Parke	0.00	n/a				
Pike	0.00	n/a				
Pulaski	0.00	n/a				
Spencer	0.00	n/a				
Sullivan	0.00	n/a				
Switzerland	0.00	n/a				
Union	0.00	n/a				
Warren	0.00	n/a				

*Counties with a coverage index of zero (0) were NOT included in the calculation of percentile cut scores. The Coverage Index represents the proportion of county data that IS NOT IMPUTED for a given year. The indicator ranges from 100, indicating that all ORIs in the county reported for 12 months in the year, to 0, indicating that all data in the county are based on estimates, not reported data.

Methamphetamine Proxy Indicator for Indiana Counties - Highest Contributor Model

County	UCR Coverage Index	Synthetic Drug Possession Arrests (2004 UCR Data)*	
Vanderburgh	100.00	143	
Vigo	57.79	112	
Tippecanoe	99.57	101	
Elkhart	100.00	85	
Bartholomew	100.00	80	
Hamilton	94.84	66	
Warrick	100.00	57	Top 10th percentile (54)
Madison	55.47	52	
Grant	100.00	49	
Gibson	66.35	42	
Lake	69.69	37	Top 15th percentile (36)
Floyd	100.00	35	
Wayne	90.35	32	
Jackson	44.43	31	
Daviess	62.42	31	
Delaware	100.00	29	
Greene	75.15	29	
Kosciusko	16.92	27	
Hendricks	60.49	26	
LaGrange	100.00	26	Top 25th percentile (26)
Clark	65.66	25	
Marshall	25.63	25	

Dubois	47.31	23	
St. Joseph	100.00	20	
Monroe	100.00	20	
Noble	26.30	20	
Porter	92.70	19	
Clay	100.00	18	
Randolph	95.87	17	
Putnam	72.78	16	
Hancock	26.45	16	
Jefferson	37.98	15	
Starke	92.11	14	
Posey	27.23	13	
DeKalb	30.39	12	
Marion	100.00	11	
Decatur	41.87	11	
Montgomery	40.10	10	
Ripley	21.97	10	
Adams	40.43	10	Top 50th percentile (10)
Morgan	32.33	9	
Shelby	59.13	9	
Wabash	50.80	9	
Cass	43.81	9	
Scott	25.10	9	
Lawrence	84.85	9	
Dearborn	63.65	8	
Clinton	48.54	8	
Rush	32.15	8	
Jay	28.79	7	
Perry	100.00	7	
Washington	11.45	6	
Tipton	23.89	6	
Jasper	19.84	5	
Carroll	14.63	5	
LaPorte	96.27	4	
Johnson	93.30	4	
Steuben	100.00	4	
Knox	58.34	4	
Fayette	59.38	4	
Whitley	29.89	4	
White	100.00	4	
Vermillion	29.88	4	
Harrison	100.00	3	
Fountain	33.11	2	
Franklin	50.00	2	
Wells	100.00	2	
Brown	100.00	2	
Martin	84.81	2	
Blackford	100.00	1	
Allen	98.67	0	
Howard	100.00	0	

Newton	100.00	0	
Jennings	61.36	0	
Henry	100.00	0	
Huntington	85.00	0	
Benton	0.00	n/a	UCR Data Not Available
Boone	0.00	n/a	
Crawford	0.00	n/a	
Fulton	0.00	n/a	
Miami	0.00	n/a	
Ohio	0.00	n/a	
Orange	0.00	n/a	
Owen	0.00	n/a	
Parke	0.00	n/a	
Pike	0.00	n/a	
Pulaski	0.00	n/a	
Spencer	0.00	n/a	
Sullivan	0.00	n/a	
Switzerland	0.00	n/a	
Union	0.00	n/a	
Warren	0.00	n/a	

*Counties with a UCR Coverage Index of zero (0) are not reported. The Coverage Index represents the proporition of county data that IS NOT IMPUTED for a given year. The indicator ranges from 100, indicating that all ORIs in the county reported for 12 months in the year, to 0, indicating that all data in the county are based on estimates, not reported data.

ATTACHMENT 3

LOCAL PREVENTION SERVICES COALITION
BUDGET SUMMARY

Planning Phase	DMHA Request	In-Kind Budget	Total Allocation
			$

	DMHA Request	In-Kind Budget	Total Allocation
ADMINISTRATIVE			
Personnel*			
Fringe Benefits: FICA Workers Compensation			
	$	$	$
	$	$	$
Contract			
Requirement:			
LEOW (Local Epidemiology & Outcomes Workgroup)			
❖ State/Cross-site Evaluation**			
❖ Local Project Evaluation**			
	$	$	$
	$	$	$
Office Supplies and Expenses (Computer, Copier, Paper, insurance, phone, DSL, etc.)			
	$	$	$
Coalition Support & Training			
Training			
Community Coalition Building, MVOV, Professional Certification, etc.			
	$	$	$
In State Travel			
	$	$	$
Out of State Travel			
	$	$	$

TOTAL PRIMARY CONTRACTOR BUDGET			
	$	**$**	**$**

***These funds are not intended to replace existing funds for personnel, only funds that would bring staff up to 1 FTE.**

Contract: Generally amount paid to non-employees for services or products. A consultant is a non-employee who provides advice and expertise in a specific program area.

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[1] State general fund appropriation that IDOE receives for Drug Free Schools. IDOE-related figures provided by Yvette Hauser (August 17,2006) and Jeff Barber (September 13, 2006) via email communication.
[2] This amount is based on SFY '05-'06 as per Sonya Cleveland, Substance Abuse Services Division Director, ICJI, by phone and email communication (September 13, 2006).
[3] GCIDD-related amounts and program details provided by Carl Heck, Fiscal Management, Traffic Safety Division, ICJI, via phone (August 22, 2006 and September 14, 2006).
[4] Figure provided by Joshua Ross, Interim Youth Division Director, ICJI, by phone (August 30, 2006).
[5] ITPC-related amounts provided by Miranda Spitznagle, via email and phone communication, August 22, 2006.
[vi] This figure represents the balance of the SAPT block grant after the Prevention portion is removed. This balance does not reflect other set-asides, including AIDS, pregnancy, and other.
[vii] DMHA amounts and program details provided by Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative,
IPRC and DMHA, by email (August 16, 2006) and phone (September 7, 2006).
[viii] $ 3 million (10 % of total SAPT Treatment and Prevention funding) is directed at services for women and children.
[ix] Dollar amount provided by David Bozell, DMHA by email (October 5, 2006).
[x] The 10 to 14 age group target is not a grant requirement, as per Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative, IPRC and DMHA, by email (August 16, 2006) and phone (September 7, 2006).
[xi] See SPF SIG 2006 Prevention Priorities.
[xii] GCDFI figures provided by Sonya Cleveland, Substance Abuse Services Division Director, ICJI, via phone and email communication on September 13, 2006.
[xiii] According to Jeff Barber of Safe & Drug-Free Schools and Communities, these funds can also be used for school safety expenditures related to violence prevention. IDOE prevent program details also provided by Jeff Barber, via email (September 14, 2006).
[xiv] IDOE-related figures provided by Yvette Hauser by email (August 17,2006).
[xv] According to Jeff Barber of Safe & Drug-Free Schools and Communities, these funds can also be used for school safety expenditures related to violence prevention. IDOE prevent program details also provided by Jeff Barber, via email (September 14, 2006).
[xvi] ISDH amounts provided by Linda Brown, Finance Division, ISDH, by email (August 22, 2006).
[xvii] Linda Brown, Finance Division, ISDH, via email (August 22, 2006).
[xviii] U.S. DOT 402 funds for SFY '06 total $4,478,43, and 410 funds are approximately $2 million. These figures provided by Carl Heck, Fiscal Management, Traffic Safety Division, ICJI, via phone (August 22, 2006 and September 14, 2006).
[xix] Figure provided by Joshua Ross, Interim Youth Division Director, ICJI, by phone (August 30, 2006).
[xx] ING-related amounts and program details provided by Lt. Jospeph Luckett via email (September 6, 2006).
[xxi] ING-related amounts and program details provided by Lt. Jospeph Luckett via email (September 6, 2006).
[xxii] ISP and DEA figures provided by Niki Crawford (ISP) in consultation with Dennis Wischern, Drug Enforcement Agency , by email (September 5, 2006).
[xxiii] ISEP amounts and program details provided by Major Robin Poindexter, ISEP, via email (August 30, 2006).
[xxiv] 2000, 2003 and 2006 totals do not include SAPT Treatment funds.
[25] Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative
IPRC and DMHA, by email (August 16, 2006) and phone (September 7, 2006).
[26] Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative
IPRC and DMHA, by email (August 16, 2006) and phone (September 7, 2006).
[27] According to Mary Lay, this is no longer Block Grant funding. DMHA will transfer state dollars to the Alcohol and Tobacco Commission. The dollar amount will be $250,000 when the payment structure is confirmed.
[28] Mary Lay, Research Associate, Coordinator-Indiana Problem Gambling Prevention Initiative
IPRC and DMHA by email (August 16, 2006) and phone (September 7, 2006).
[29] Sonya Cleveland, Substance Abuse Services Division Director, ICJI (September 13, 2006).
[30] Linda Brown, Finance Division, ISDH (August 22, 2006).
[31] Major Robin Poindexter, ISEP (August 30, 2006).
[32] This is a $360,000 grant. GCDFI receives $160,000. In FY 00 the $200,000 was used by ICJI – YD to support the Saturn Initiative.
[33] Joshua Ross, Interim Youth Division Director, ICJI, by phone (August 30, 2006).
[34] ISEP amounts and program details provided by Major Robin Poindexter, ISEP, August 30, 2006 and Carl Heck, Fiscal Management, Traffic Safety Division, ICJI, via phone (August 22, 2006 and September 14, 2006).
[35] Carl Heck, Fiscal Management, Traffic Safety Division, ICJI, via phone (August 22, 2006 and September 14, 2006).
[36] Linda Brown, Finance Division, ISDH, via email (August 22, 2006). ITPC-related figures provided by Miranda Spitznagle, Director of Program Evaluation, ITPC, via email and phone communication (August 22, 2006).
[37] This program was originally by an FDA grant; during 2000 it was supported through funding by FSSA, DMHA; now it is funded by the ITPC.

[38] Miranda Spitznagle, Director of Program Evaluation, ITPC, via email and phone communication (August 22, 2006); and Major Robin Poindexter, ISEP via email (August 30, 2006).
[39] This does not represent an increase in funds; $78,000 total is for an 18 month period rather than 12 months for the $48,000 in FY 00.
[40] Miranda Spitznagle, Director of Program Evaluation, ITPC, via email and phone (August 22, 2006); and Major Robin Poindexter, ISEP, by email communication (August 30, 2006).
[41] Major Robin Poindexter, ISEP, by email (August 30, 2006).