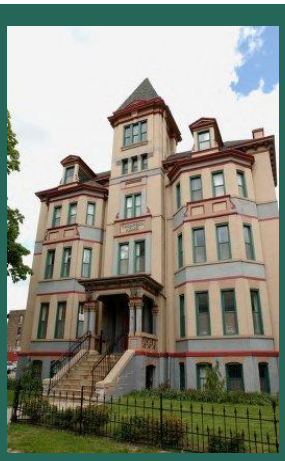


WAYNE STATE UNIVERSITY
SCHOOL OF SOCIAL WORK

The Center for Social Work Practice and Policy Research

Environmental Scan
For the
State Prevention Enhancement Grant

Submitted to: Michigan Department of Community Health Bureau of Substance Abuse and Addiction Services: Prevention Section

April 2012

Bureau of Substance Abuse and Addiction Services: Prevention Section

Environmental Scan for the State Prevention Enhancement Grant

Introduction

The State of Michigan Department of Community Health Bureau of Substance Abuse and Addiction Services (MDCH-BSAAS) is implementing a federally supported prevention enhancement grant with a goal of building upon and increasing the reach of its Strategic Prevention Framework. MDCH-BSAAS supports the use of the framework by Coordinating Agencies (CAs) responsible for the administration and oversight of prevention at the local level. However, in order to meet the expansion goals of the framework as specified by SAMHSA, an environmental scan and assessment are necessary to capture the capacity of its prevention partners. Five high-need regions (coordinating agencies) were selected as pilot target communities to participate in an assessment of their current prevention infrastructure. Ultimately the results from the assessment are expected to inform the State's five year prevention plan.

The purpose of the scan is to understand stakeholder's perspectives about a variety of resource and capacity issues in the environment that impact on provision prevention services. The scan will document if prevention partners are ready to integrate mental health, substance abuse and primary care for the development of a prevention prepared community. It will identify barriers to service integration that must be overcome for successful integrated prevention. It will determine the training needs of the workforce that will be necessary for implementing a Recovery Oriented System of Care. The scan will also assess the capacity for evaluation and data collection systems. With up-to-date information on the targeted CA's the State can develop strategic action steps to guide the expansion plans for building an infrastructure utilizing the strategic prevention framework.

Methods

A web-based survey was developed by Wayne State University School of Social Work with direction from staff at the Bureau of Substance Abuse and Alcohol Service Prevention Section, and with review and input from the members of the Strategic Prevention Enhancement Workgroup. To ensure confidentiality, identifying information was securely maintained by the researchers and participants understood that the results would be only be reported in aggregate. All procedures and measures used to administer the survey were approved by Wayne State University's Institutional Review Board (IRB) and also by the Michigan Department of Community Health IRB.

A hotlink to the Zoomerang survey was generated and sent out with an introductory letter via email from the Bureau of Substance Abuse and Alcohol Services. The email was sent to directors of the five coordinating agencies for distribution to their network of providers and

coalitions. Reminder emails were sent after two weeks, the survey was open for three weeks. A total of 67 providers completed the survey.

Organizational Characteristics

Respondents were asked to provide basic organizational characteristics that would help BSAAS understand the sample and the range of resources that exist in these agencies.

- Only 17% of respondents are Coordinating Agencies; 83% are not
- 35% of the respondents come from the Bay Arenac/Riverhaven; 20% of the respondents come from Kalamazoo; 19% of the respondents come from the Mid-South; 9% of the respondents come from Pathways to Healthy Living; and 17% of the respondents come from the Western Upper Peninsula.

3. What county is your organization located in? (N=54)

- Bay Arenac Behavioral Health (BABH)/Riverhaven Coordinating Agency (serving: Arenac, Bay, Huron, Montcalm, Shiawassee & Tuscola) n=19
- Kalamazoo Community Mental Health & Substance Abuse Services (serving: Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph & Van Buren Counties) n=11
- Mid-South Substance Abuse Commission (serving: Clinton, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Jackson, Lenawee & Newaygo Counties) n=10
- Pathways to Healthy Living (serving: Alger, Chippewa, Delta, Luce, Mackinac, Marquette, Menominee & Schoolcraft Counties) n=5
- Western Upper Peninsula Substance Abuse Services Coordinating Agency (serving: Baraga, Dickinson, Gogebic, Houghton, Iron, Keweenaw & Ontonagon Counties) n=9

4. In which counties do you most frequently work? (Please list up to THREE) (N=70)

- Bay Arenac Behavioral Health (BABH)/Riverhaven Coordinating Agency (serving: Arenac, Bay, Huron, Montcalm, Shiawassee & Tuscola) n=28
- Kalamazoo Community Mental Health & Substance Abuse Services (serving: Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph & Van Buren Counties) n=12
- Mid-South Substance Abuse Commission (serving: Clinton, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Jackson, Lenawee & Newaygo Counties) n=13
- Pathways to Health Living (serving: Alger, Chippewa, Delta, Luce, Mackinac, Marquette, Menominee & Schoolcraft Counties) n=4
- Western Upper Peninsula Substance Abuse Services Coordinating Agency (serving: Baraga, Dickinson, Gogebic, Houghton, Iron, Keweenaw & Ontonagon Counties) n=13

Respondents frequently noted that they were employed within the same county as their agency. This varied slightly for Barry, Branch, Cass, Ionia, and Van Buren counties (2% reported difference between location and work area).

Agency budgets for 2011 ranged from $5,000 to $14 million (see appendix for complete list). The average 2011 budget for the participating agencies was $2,786,014.

6. What percentage of your budget is devoted to substance abuse prevention? (N=45)	
0-20%	38%
21%-40%	15%
41%-60%	7%
81%-100%	40%

Twenty-two agencies (42.3%) noted that over 40% of their budget was allocated to substance abuse prevention, while 27 agencies allocated less than 40% of their budget to these services. This data may indicate that prevention of substance abuse issues is not the primary function for all respondents, while the others may not have the support to adequately cover substance abuse prevention in addition to their other roles and responsibilities. However, because there is a great variation in the type of agencies responding to the survey, it is difficult to draw many conclusions.

Budget Allocation to Prevention by County

	Percentage of budget allocated to substance abuse prevention	
County	**Over 40%**	**Under 40%**
Bay Arenac Behavioral Health	31.8%	37.0%
Kalamazoo Community Mental Health & Substance Abuse Services	18.2%	14.8%
Mid-South Substance Abuse Commission	22.7%	11.1%
Pathways to Healthy Living	18.2%	11.1%
Western Upper Peninsula Substance Abuse Coordinating Agency	9.1%	25.9%

Please describe the sources of your substance abuse prevention funding. (N=113)	
Federal Grant	24%
Foundation Grants	5.5%
Local/County grant or contract	23%
Nonprofit grants/awards	10%
Private donations	4%
State grant/contract	28%
Other: Justice/delinquency prevention (n=2) Regional Coordinating Agency (n=2) Self-pay/service fees	5.5%

Please describe the sources of your substance abuse prevention funding. (N=113)	
EAP Contracts	

Many of the agencies (69 %) receive funding for their substance abuse prevention programs from federal, state, or local county grants or contracts. Few (10%) of the agencies receive funding from foundation grants or private donations. The fact that most dollars are state or federal grants and contracts means that agencies have little discretionary funding.

Is your organization a… (N=47)		
	Yes	No
Licensed Substance abuse treatment provider	51%	49%
Licensed Substance abuse prevention provider	81%	19%
Licensed Mental Health services agency	35%	65%
Licensed Early Intervention services provider	14%	86%
Licensed Early Childhood services provider	12%	88%
Community Coalition	62%	38%

Over half of the agencies are licensed substance abuse treatment providers (51%). A smaller number of these agencies (35%) are licensed to provide mental health services. Most other providers are licensed for substance prevention services (81%), while a smaller portion (12-14%) of providers are licensed in early intervention and early childhood services. A large number of community coalitions also participated. Additionally, agencies noted that they were licensed as a Community Mental Health Authority or as a Regional Administrative Agency. While 81% of agencies noted that they were able to provide substance prevention 53% reported that less than 40% of the budget was allocated to these services. Evaluation of current funding structures might be beneficial to determine if changes in fund allocation might strengthen prevention in these agencies. Agencies that are currently licensed to provide substance prevention services but allocate little funding in this area may benefit most from trainings and assistance that could (1) inform agency decision makers on alternative funding sources and (2) strengthen the ability for front line staff to provide more prevention services within the existing funding framework.

When examining the overall relationships of all agencies to substance abuse prevention resources, most agencies (44.2%) reported that they coordinated in formal relationships, which included some joint planning and open communication. Agencies that allocated less than 40% of their budgets (n=25) to substance abuse services, coordinated with prevention agencies more frequently than agencies that allocated more than 40% of their budget to substance abuse prevention (n= 18). As the table below shows, the relationships engaged in are fairly equal in terms of collaboration. This data analysis shows that a third of agencies, regardless of prevention focus, need work on developing cooperative and collaborative relationships across agencies; an important concept for future integration.

Relationships with Prevention Providers by Budget Allocation

	Percentage of budget allocated to substance abuse prevention	
Level of Cooperation and Coordination	**Under 40%**	**Over 40%**
Not Much to Average Levels of Cooperation and Coordination	36.0%	33.3%
Good to Great Levels of Cooperation and Coordination	64.0%	66.7%

Readiness for a Prevention Prepared Community

22. We'd like your perceptions about the integration of mental health, substance abuse prevention and primary care toward the development of a Prevention Prepared Community. (N=47)						
	Mean	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
My organization's current vision, mission, and strategic plan is aligned with the goals of Prevention Prepared Communities	4.00	2%	4%	15%	49%	30%
My organization's goals and objectives will be supported by Prevention Prepared Communities	4.09	0%	4%	12%	49%	35%
My organization has an administrative/clinical champion for Prevention Prepared Communities	3.60	2%	19%	21%	28%	30%
My organization has Board support for the development of Prevention Prepared Communities	3.65	2%	13%	28.5%	30%	26.5%
My organization has resources available for the initial planning activities to develop Prevention Prepared Communities	3.60	2%	20%	20%	36%	22%
My organization has staff available to work on the Prevention Prepared Communities initiatives	3.80	2%	11%	19%	43%	25%
Changes to integrate systems will make my job easier	3.50	0%	15%	41%	26.5%	17.5%
My organization is involved with other initiatives that are competing against the development of Prevention Prepared Communities	2.44	16%	40%	31%	11%	2%

It doesn't make much sense for us to initiate changes related to systems integration	2.11	24.5%	47%	24.5%	2%	2%
My organization's culture supports process innovations such as Prevention Prepared Communities	4.00	0%	2%	23.5%	51%	23.5%
I do not anticipate any problems adjusting to the work I will have when systems integration changes are adopted	3.40	0%	15%	37%	41%	7%
There are some tasks that will be required when we change that I don't think I can do well	2.40	14%	36%	45%	5%	0%
I think that my organization will benefit from systems integrations	3.74	0%	4%	33%	48%	15%
The time that will be spent on making such changes for system integration should be spent on something else	2.48	13%	37%	41%	7%	2%

Most respondents (80%) agree that their organization's current vision, mission, and strategic plans are aligned with the goals of Prevention Prepared Communities. The majority (79%) of the providers believe that their organization's goals and objectives will be conducive to Prevention Prepared Communities. Two thirds believe their organization will benefit from systems integration.

Just over half (54%) of the respondents feel that their organization has a board supportive of the development of Prevention Prepared Communities. Similarly just only about half feel they have an organizational champion for PPCs. Respondents also convey having the resources available for the initial planning activities to develop Prevention Prepared Communities.

In general, respondents felt that their agencies had the staff available for the Prevention Prepared Communities initiative, and did not feel that there would be tasks that they would not be able to do well under the initiative. Respondents agreed that their agencies culture supported Prevention Prepared Communities and disagreed that time implementing this initiative should be spent elsewhere. While still somewhat positive, there may be some uncertainty around availability of resources, and the sense that integration will make life easier. Overall, it appears from these responses that agencies are willing to implement the Prevention Prepared Community initiative, but there are points of ambivalence in the responses. For this reason technical assistance around planning and problem solving during the transition may be most useful.

When examining readiness and budget allocation, participants were more agreeable to feeling ready to implement Prevention Prepared Communities initiative if over 40% of the agency budget was allocated to substance abuse services. This analysis may show that prevention agencies feel well suited to the challenges of Prevention Prepared Communities.

Budget Allocation	Total Agreeability with Readiness				
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Under 40% of Agency Budget Allocated for Prevention	0%	0%	68.0%	32.0%	0%
Over 40% of Budget Allocated for Prevention	0%	0%	38.9%	61.1%	0%

Recovery Oriented Systems of Care (ROSC)

23. Please select the response that best matches your opinion for each statement. (N=47)						
	Mean	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
My organization understands how the ROSC model will affect prevention services	3.43	2%	22%	24%	35%	17%
My organization has changed programs and/or processes to reflect ROSC principles	3.40	2%	11%	40%	38%	9%
Significant changes will need to be made for my organization to participate in a ROSC	2.80	4%	35%	39%	20%	2%
My organization has participated in regional ROSC transformation workshops	3.85	4.5%	6.5%	21%	36%	32%
My organization has provided training on the ROSC model	2.79	6.5%	38%	30%	21%	4.5%
My organization has developed interagency agreements with other organizations that support recovery and promote wellness	3.17	4%	27%	28%	28%	13%
My organization is working toward practice alignment in a ROSC model	3.72	2%	2%	34%	45%	17%
Prevention programs fit well with the ROSC model	3.79	2%	6%	23.5%	47%	21.5%

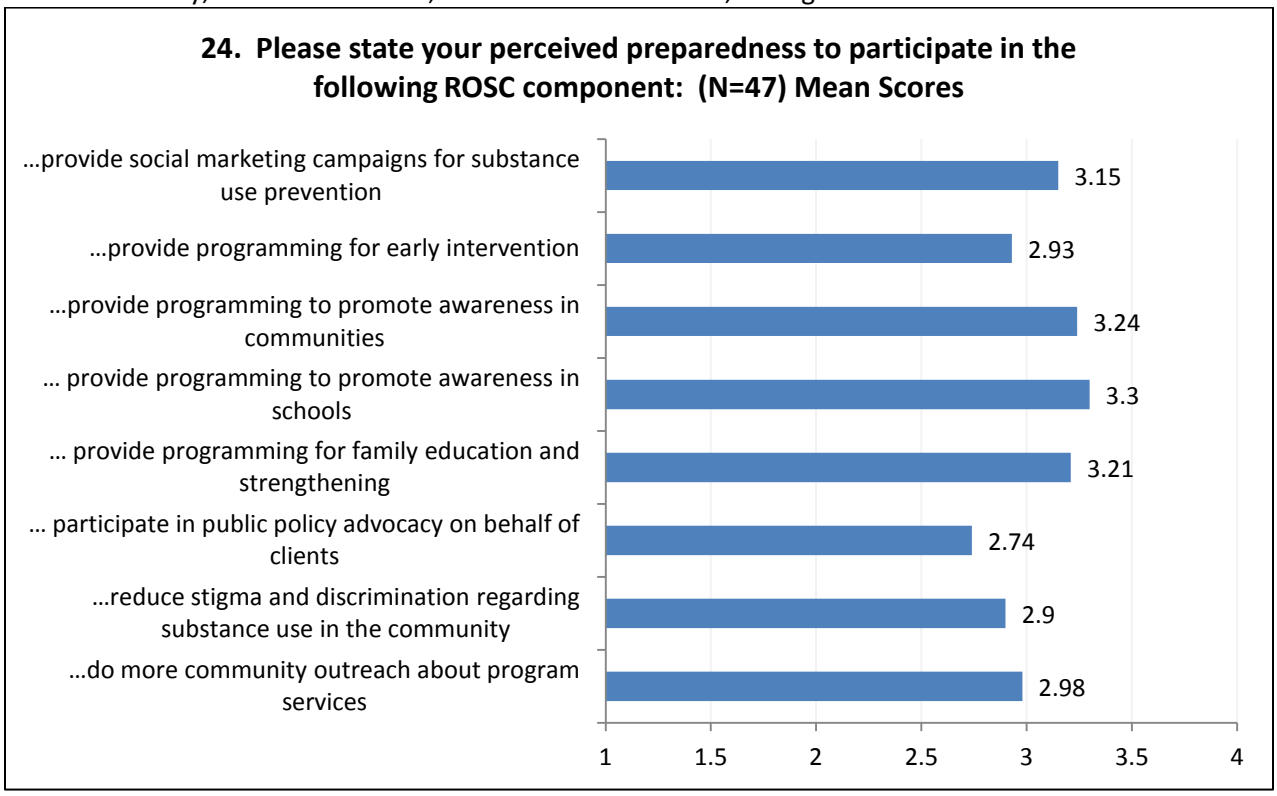
Respondents tended to agree that their prevention programs fit well with the ROSC model and stated that they were working towards the ROSC model. Many organizations reported that they had participated in a regional ROSC transformation workshop, however relatively few stated that they had provided training on the ROSC model to others. A specialized “train the trainers” approach may provide greater uptake of the ROSC model across communities and be useful, especially for small prevention agencies and coalitions who have rolling membership.

On average respondents did not feel that drastic changes would have to be made to their current organization in order to participation in ROSC, although some did. Several respondents noted that they had built interagency agreements with other organizations and felt that they understood how the ROSC model would affect the existing prevention. Despite this, for some agencies additional assistance focused on strengthening interagency communications, templates for agreements and documents and handouts about how the ROSC model will enhance prevention services will be beneficial.

When examining ROSC and agency budgets, participants were slightly more likely to be in agreement with readiness for ROSC if their agencies allocated 40% or more of their budgets to prevention. Again, prevention providers are familiar with the concept of ROSC and this is reflected in their more positive responses.

	Total Agreeability with Recovery Oriented Systems of Care				
Budget Allocation	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Under 40% of Agency Budget Allocated for SA	0%	3.7%	59.3%	25.9%	11.1%
Over 40% of Budget Allocated for SA	0%	0%	57.1%	42.9%	0%

1 - Not Ready, 2 - Low Readiness, 3 - Moderate Readiness, 4 - High Readiness



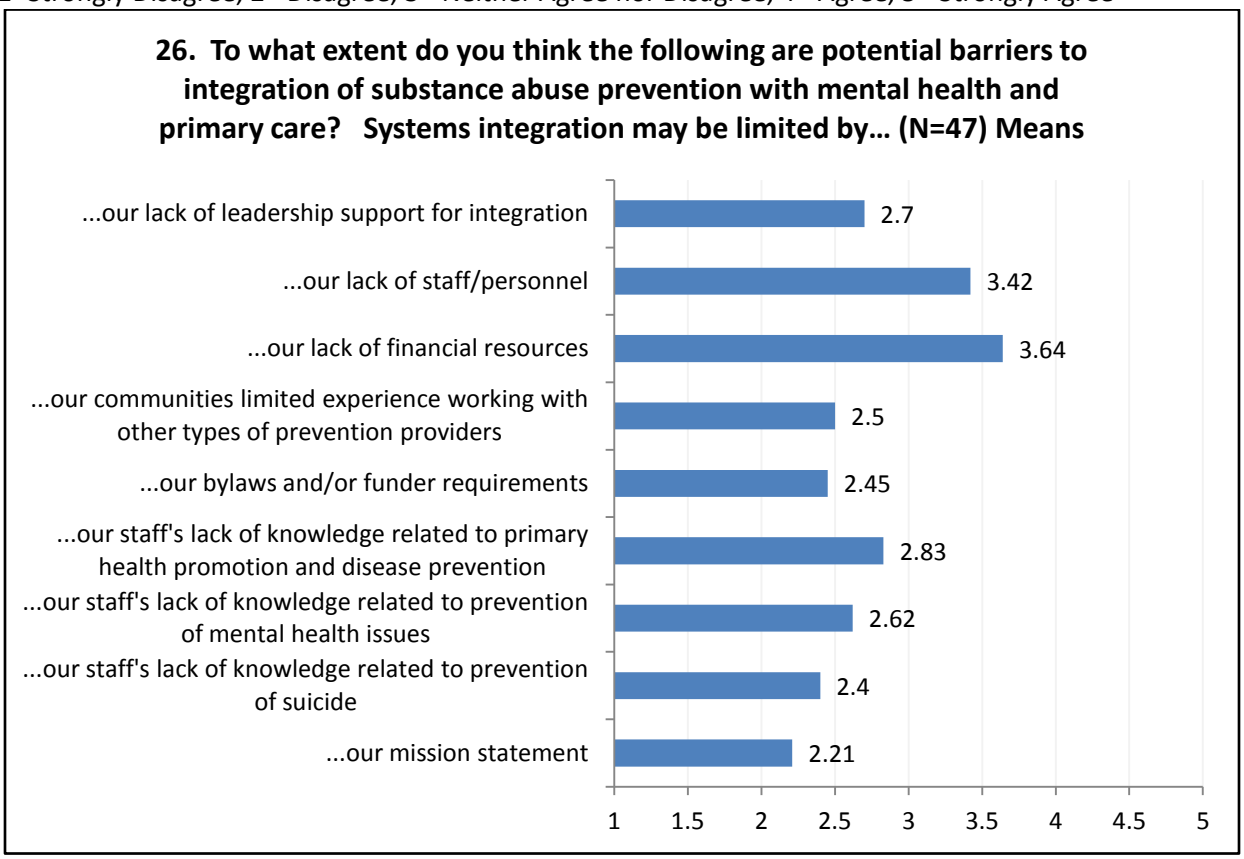
In general, respondents noted that they felt they were prepared to participate in several ROSC components. The strongest indicators of readiness were in providing family education and strengthening, promoting awareness in schools, and promoting awareness in communities. Areas that agencies could use additional strengthening was in participating in public policy advocacy, providing social marketing campaigns, and reducing stigma and discrimination regarding substance use in the community. These areas then become potential targets for training and technical assistance support.

25. Can you provide one example of how your agency partners with other resources/agencies to support a recovery oriented system of care? (N=51) *Multiple responses	
Collaborate with local treatment agencies	14% (n=8)
Collaborate with drug court/court system	12% (n=6)
Work with County/CA ROSC Workgroup	8%(n=4)
Collaborate with community and local agencies	8% (n=4)
A referral process/system	8% (n=4)
Work with prevention providers	6% (n=3)
Working with recovery community/AA meetings	6% (n=3)
Intervention/prevention programs	4% (n=2)
We are developing MOU's with recovery support organizations	4% (n=2)

Currently, agencies most frequently reported that they collaborate with local treatment agencies and drug court systems. Less frequently agencies reported that they work within the community or partner with AA meetings. It may be beneficial to spend some ROSC training time to have agencies discuss the current collaborations they are utilizing and how they built those relationships to guide other agencies to gain successful partnerships with external resources and agencies. A complete list is provided in the appendix.

Barriers to Service Integration

1- Strongly Disagree, 2 - Disagree, 3 - Neither Agree nor Disagree, 4 - Agree, 5 - Strongly Agree



Not surprising, the largest barriers identified by providers were the lack of staff and/or financial resources with many barriers falling into the mid range of frequency. Additional barriers to integrated mental health and substance abuse services that were mentioned by respondents included the following statements:

> "Our barriers have to do with collaboration. There is a lack of an appropriate agency(s) available that are willing/able to implement or champion specific strategies that are needed to provide the spectrum of services that the community needs."

> "Many CMH agencies don't provide prevention services as seen in the SA community. The Mental Health and primary Care systems lack of knowledge around SA prevention and treatment and their limited capacity around the prevention of mental health and public health."

> "System integration will take time, strong leadership and trust among partners, the capacity of current staff will have to be closely monitored in order to ensure that a project of this magnitude is getting the attention needed and isn't an add-on to a currently stretched staff member."

When discussing barriers or issues to the promotion of Prevention Prepared Communities or the creation of ROSCs respondents once again noted that there may be funding issues,

collaboration barriers, or difficulty with implementing a system change that will take time from current tasks and responsibilities. Other barriers mentioned included:

"Need to retrain in ROSC due to staff turn-over"

"Lack of practical guidance for treatment providers have made it difficult to transition to ROSC"

"The only words I have heard related to prevention being part of ROSC is that prevention can implement programs to assist with recovery or early intervention. I have not heard any examples of how treatment and recovery personnel may assist in environmental approaches to increase community capacity. Until the language changes, there remains the danger to prevention of being assumed into supporting case finding and relapse prevention. Prevention resources will be focused on individual cases and we will lose a significant focus on making real community level changes."

When examining identification of barriers to the implementation of integration of service agencies that allocated less than 40% of their budgets to substance abuse services were identified as having greater barriers than agencies that allocated over 40% of their budget to substance abuse services.

	Total Agreeability with Ability to Manage Barriers				
Budget Allocation	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Under 40% of Agency Budget Allocated for SA	0%	16.7%	58.3%	25%	0%
Over 40% of Budget Allocated for SA	0%	5.3%	57.9%	26.3%	10.5%

Training Needs

1- Strongly Disagree, 2 - Disagree, 3 - Neither Agree nor Disagree, 4 - Agree, 5 - Strongly Agree

29. To what extent do you agree that you need training in the following areas? Training related to the integration of substance abuse prevention with mental health and primary care… (N=46)						
	Mean	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
Understanding policies and practices of other systems	4.0	0%	4%	11%	64%	20%
Developing Memorandum of Understanding and service agreements with partners	3.6	4%	13.5%	16%	53%	13.5%
Indentifying variables and sharing de-identified data	3.9	2%	11%	9%	54%	24%
Collaborative planning for service provision	3.9	2%	13%	7%	50%	28%

Cross training substance abuse prevention staff in mental health prevention and promotion	4.3	2.5%	2.5%	4%	49%	42%
Increasing relationships across systems to improve prevention	4.2	0%	9%	4%	44%	42%

In identifying training needs for integrating substance abuse, mental health, and primary care the greatest need was in cross training substance abuse prevention and mental health prevention. The second greatest need for training was identified as learning ways to increase relationships across systems to improve prevention services. Lastly, trainings were requested in better understanding the policies and practices that guide other systems. These top three training needs all related to systems issues and cross system learning. This topic may require full day training with ongoing follow-up. The development of such a program will also involve planning effort from prevention, mental health and primary care experts.

Over half (53%) of the respondents express a desire to receive training in developing memorandums of understanding (MOUs) and service agreements with partners. Other needs that were identified included: identifying variables and sharing de-identified data, collaborative planning for service provision, and increasing relationships across systems to improve prevention. Some items could be met through workshops developed by the training cadre.

1- Strongly Disagree, 2 - Disagree, 3 - Neither Agree nor Disagree, 4 - Agree, 5 - Strongly Agree

All responses to the training needs list were in the positive range. The highest need is around training in implementing screening brief intervention and referral to treatment (SBIRT). All other items are rated fairly similarly. This scale may need more refinement and clarity of examples in order to adequately formulate training for prevention staff. In addition, there may be a need to provide additional information about the importance of each of these strategies for prevention success and linking these strategies to ROSC and PPC. When asked about specific trainings that would enhance the integration of substance abuse prevention with mental health and primary care responses focused on understanding “models utilized in mental health and primary care settings", and additional mental health training for substance abuse providers including “evidence based suicide prevention programs and practices".

When examining identification of training needs for the implementation of integrated services, agencies that allocated less than 40% of their budgets to substance abuse services were identified as having similar training needs of agencies that allocated over 40% of their budget to substance abuse services. Overall it appears all participants agreed that training was needed for the provision of integrated services.

	Total Agreeability with Training Needs				
Budget Allocation	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Under 40% of Agency Budget Allocated for SA	0%	0%	44.4%	48.1%	7.4%
Over 40% of Budget Allocated for SA	0%	0%	28.6%	66.7%	4.8%

When examining reported training needs and readiness to provide integrated services, individuals who reported more training needs reported feeling slightly less ready to implement prevention services. This relationship is not unexpected and planners of training sessions may want to incorporated practice tips in all trainings to facilitate use of training materials.

	Training Needs	
Ready to Implement Prevention Services	Agency Does Not Have a Strong Need for Training	Agency Has a Strong Need for Training
Do Not Feel Ready	50.0%	58.6%
Feel Ready	50.0%	41.1%

Strategic Prevention Framework

33. Please select response that best describes the condition(s) at your agency. Assess Needs: collection of data to understand community need. (N=42)	
My organization has not, or rarely, collects community need data.	10%
My organization has collected some data but does not routinely use the data.	24%
My organization regularly collects and uses community data.	66%

When assessing needs and collecting the data to understand community needs 66% of organizations regularly collects and uses community data. Almost one-quarter (24%) of the organizations collect some data but does not routinely use the data.

34. Please select response that best describes the condition(s) at your agency. Develop Capacity: mobilizing human, organizational, and financial resources to meet project goals. (N=41)	
My organization rarely engages in capacity building activities.	2%
My organization conducts limited capacity building activities.	34.5%
My organization takes regular action to build capacity.	63.5%

Almost two-thirds (63.5%) of agencies reported that they take regular action to build their capacity while one-third (34.5%) of organizations conduct limited capacity building activities.

35. Please select response that best describes the condition(s) at your agency. Planning: developing goals, objectives, and strategies for use of evidence-based programs. (N=42)	
My organization has not or rarely engages in formal planning.	2%
My organization engages in formal planning for some programs.	33.5%
My organization implements all programs according to plans.	64.5%

When organizations were asked about their planning and developing goals, objectives, and strategies for use with evidence-based programs, 64.5% of agencies report implementing all programs according to plans and 33.5% of organizations engage in formal planning for some programs.

36. Please select response that best describes the condition(s) at your agency. Implementation: carrying out prevention plans. (N=42)	
My organization implements some programs according to plans.	33%
My organization implements all programs according to plans.	67%

As far as, the implementation process goes when carrying out prevention plans 67% of agencies state that they implement their programs according to plans. One third (33%) report implementing some of their programs as planned.

37. Please select response that best describes the condition(s) at your agency. <u>Evaluation:</u> measuring what they have done well and what areas need improvement. (N=42)	
My organization does not or rarely conducts program evaluation.	2%
My organization conducts process evaluation on our programs.	43%
My organization conducts process and outcome evaluation on all programs.	55%

When evaluating and measuring what they have done well and what areas need improvement, a majority (98%) of organizations is conducting process evaluation activities on their programs, with over half (55%) also conducting outcome evaluations of their programs.

38. Please select response that best describes the condition(s) at your agency. <u>Sustainability:</u> process through which a prevention system becomes a norm and is integrated into ongoing operations. (N=42)	
My organization has little to no formal plans for program sustainability.	7%
My organization has a limited sustainability plan for core programs.	71.5%
My organization has a well-defined sustainability plan for all programs.	21.5%

Sustainability surrounding the process through which a prevention system becomes a norm and is integrated into ongoing operations is vital and almost three-fourths (71.5%) of the organizations report having a limited sustainability plan for core programs.

39. Please select response that best describes the condition(s) at your agency. <u>Cultural competence:</u> communicating with audiences from diverse geographic, ethnic, racial, cultural, economic, social and linguistic backgrounds. (N=39)	
My organization rarely or never examines our programs to assess cultural competency.	8%
My organization reviews programming and adjusts to meet cultural competency.	59%
My organization's programs are regularly reviewed by cultural experts to assess competency.	33%

Over half (59%) of organizations review programming and adjusts to meet cultural competency, while 33% of organizations report that cultural experts regularly review their programs to assess competency.

In general, most respondents seem to rank themselves in the moderate range on strategic prevention framework conditions. Sustainability is one area that appears to be limited and where agencies could benefit from additional technical assistance to diversify funding, build partnerships for programs and ongoing plans. In addition, 34% of respondents note they are not collecting or using community data and 45% are only up to the stage where they are using process evaluation. Both of these areas are also good targets for workshops and assistance.

When examining existing factors within agencies that would provide a framework for integrated prevention services, agencies that allocated less than 40% of their budgets to

substance abuse services were identified as having a slightly less supportive framework than agencies that allocated over 40% of their budget to substance abuse services.

	Total Agreeability with Prevention Supportive Framework		
Budget Allocation	Non- Supportive Framework	Neither Supportive nor Non-Supportive Framework	Supportive Framework
Under 40% of Agency Budget Allocated for SA	0%	56.0%	44.4%
Over 40% of Budget Allocated for SA	0%	18.8%	81.2%

Agencies indicated that they needed the most training in the Strategic Prevention Framework to include sustainability, evaluation, and planning. Developing capacity, cultural competence and mobilizing resources were also noted to a lesser extent.

Data Collection

41. Please select the item that best reflects your organizations' status with respect to each type of data collection: (N=42)						
	Mean	Do not collect	Collect regu-larly	Collect regularly and analyze data to understand needs	Regularly collect and analyze, and use to inform planning and program selection	Regularly collect, analyze, use for planning and share data with stakeholders
Participant data (demographics, #'s serviced)	4.14	2%	9%	16%	18%	55%
Program process data (# hrs provided, attendance, satisfaction)	4.20	0%	9%	11%	31%	49%
Outcome data (change in behavior, knowledge)	3.70	7%	11%	24.5%	24.5%	33%
Local community data on underage drinking	4.02	2%	7%	18%	33%	40%
Local community data on adult problem drinking	3.16	20.5%	9%	27%	20.5%	23%
Local community data on prescription drug misuse and abuse	3.50	14%	11%	23%	20%	32%
Local community data on suicide and attempted suicide	3.00	22%	18%	20%	20%	20%
State level data	3.62	7%	16%	22%	20%	35%
National data (Monitoring the future, NSDUH)	3.50	9%	13%	29%	18%	31%

- 60% of agencies collect participant data (demographics, #'s serviced) which is regularly collected, analyzed, used for planning, and shared with stakeholders.
- 54% of organizations regularly collect, analyze, use for planning and share data with stakeholders about their program process data (# hours provided, attendance satisfaction).

- 44% of agencies regularly collect, analyze, use for planning and share data with stakeholders with regards to local community data on underage drinking.
- 34-39% of the agencies regularly collect, analyze, use for planning and share data with stakeholders on a State level and nationally (monitoring the future, NSDUH).

42. What other types of data do you collect? (n=24)

- MIPHY – work closely with schools to assure data is collected, if we did not assist this would probably not get done (n=14)
- Community, youth, informal, and satisfaction surveys among groups when needed for specific strategies, Parent surveys, coalition surveys, all of these surveys are approved by the Drug Free Community National Evaluators (n=5)
- Juvenile Crime/Delinquency Data (n=3)
- Demographic, income level, and others (N=3)

43. How do you use the data you collect? (n=26)

- For Strategic Planning at the regional and local level, develop annual plans, and programs based on future identified needs (n=11)
- To evaluate gaps in programming and measure program effectiveness (track outcomes) (n=8)
- For reporting, educating, and disseminating information to the community in literature (n=4)
- Develop Programs/Prevention Programs/Logic Model design (n=3)

44. What needs does your organization have with respect to data collection?

- Continuation of funding to train staff, utilize tools for collecting and analyzing data, and resources to spend time on the process (n=4)
- Full community needs assessment
- We are just learning how to formulate logic models, implement them, and evaluate the outcomes
- Need survey writing expertise, and access to chart and graphics technician

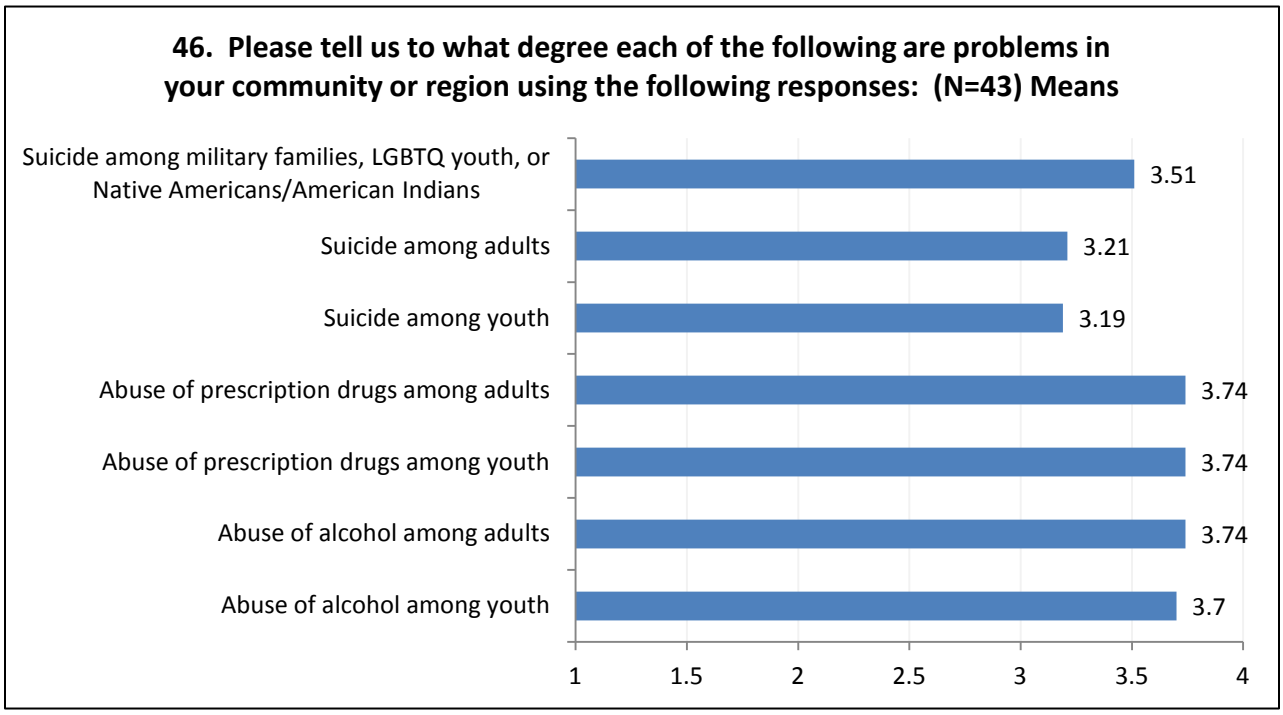
Most participants are interested in continuing funding to train staff on data collection and the use of data collection tools, housing data electronically, as well as using the data to formulate strategic building and assessing needs. For training purposes it seems that programs need assistance with using data to develop programs, without this the goal of data driven decision making falls short. The lack of expressed needs with respect to data collection may speak more to the need than the rest of the items – perhaps describe a case where even formulating a request for help is too difficult since they may be unsure of what the options are for data use. Beyond traditional trainings, I think that peer learning sessions where case studies of successful uses of data could be shared and studied alongside standard information presentations.

Perceptions of Problems

45. Which best reflects your community's attitude toward substance abuse? (N=40)	
Zero tolerance	7.5%
Accepting of some substance use	37.5%
Accepting of substance use on a regular basis	50%
In denial that there is a substance use problem	5%

A majority (87.5%) of agencies perceive their communities as accepting of some substance use; with half reporting that their communities accept substance use on a regular basis. This data supports the need for environmental strategies and enhanced prevention to change community norms.

1 Not a problem; 2 Minor problem; 3 Moderate problem; 4 Major problem



Reporting organizations feel that abuse of alcohol among youth (78%) and adults (72%) is a major problem in their community or region. Prescription drug use was also noted as a major problem among youth (72%) and adults (75%). Also, 44-48% of organizations report that suicide among youth and adults is a moderate problem. In contrast, 45% of reporting organizations either do not know or are unsure about the rates of suicide among military families, LGBTQ youth, or Native Americans/American Indians.

Conclusion

The environmental scan provides an interesting overview of the five pilot areas that are part of the Strategic Prevention Enhancement Grant in Michigan. Most respondents were not representatives of CAs, but were likely prevention providers' staff and coalition members. Overall it seems that replies were positive, but many were tempered by moderate replies that may signal the need for additional clarity around goals, objectives, and especially the expectations for providers of the prevention services. At this early planning phase there is unlikely much information to be shared.

Environmental Scan Survey Key Points:

- This data shows that a third of agencies, regardless of prevention focus, need work on developing cooperative and collaborative relationships across agencies; an important concept for future integration.
- Most respondents had positive perceptions about their organizational readiness to participate in Prevention Prepared Communities. However they expressed some ambivalence as to whether PPCs will make their job easier or whether they can handle the tasks required. In addition, only about half believe that their board will support the efforts and only half see an organizational champion for the work. This may be a sign that more practical information about PPCs is needed.
- Respondents were positive about readiness for participating in Recovery Oriented Systems of Care. They noted that prevention fits well with the ROSC and that their organization was working toward practice alignment with ROSC; however only 47% say that their organization has changed programs or processed to reflect ROSC, signaling more work is needed.
- The most frequently mentioned barriers to system integration are a lack of staff, and a lack of financial resources. In comments, respondents also noted the lack of cross-system knowledge and sharing among prevention, mental health and primary care institutions.
- Regardless of budget devoted to prevention all respondents agreed that training was needed for the provision of integrated services. Those who reported more training needs also feel slightly less ready to implement integrated services.
- The survey posed three questions on training needs which were more fully covered in the workforce development survey. Respondents rated their own top three training needs as: cross training for prevention staff in mental health prevention and promotion, how to increase relationships across systems, and the policies and practices of other systems.

- In response to training needs for staff, the highest rated item was training in Screening, Brief Intervention and Referral to Treatment (SBIRT). This evidence-based practice is an excellent public health approach to achieve additional system integration.
- Regarding the Strategic Prevention Framework respondents note the need for further training in three components: planning, evaluation and sustainability. Staff turnover and the State commitment to using the model means ongoing training is required.
- With respect to data collection, respondents seem to be comfortable using a range of data sources, but there appears to be a need for more local data on suicide and adult problem drinking.
- Respondents view abuse of prescription drugs and abuse of alcohol, both among adults and youth, as moderate to major problems. They rate suicide among various groups slightly lower, perhaps based on a lack of information.
- Data analyses showed that respondents who identify as being in an organization that devotes more than 40% of their budget to prevention are more somewhat different. These individuals have more positive assessments about readiness for Prevention Prepared Communities and ROSC, and see fewer barriers to integration. This is a positive sign for work in this area and speaks to the excellent communication already provided on these topics by the Prevention Section and the CA directors.

Key Recommendations

1. Develop presentations that describe the role of prevention in both ROSC and the link to Prevention Prepared Communities. Stakeholder agencies, staff and community members would benefit from a common language and framework for discussing the key ideas and seeing clear examples of how they are a part of the process.

2. Develop templates of policies, procedures and actions that would facilitate movement to ROSC, PPC, and systems integration. This could include sample MOUs, brief case examples of how partnerships were developed, a website for sharing information about what agencies and coalitions are doing to support ROSC, PPC and systems integration and how to manage reimbursements across systems and payers.

3. Respondents may need additional preparation to participate in more expansive parts of the ROSC including public policy advocacy, providing social marketing campaigns, and reducing stigma and discrimination regarding substance use in the community.

4. Ongoing training in the Strategic Prevention Framework that the State provides should include enhanced attention to planning, evaluation and sustainability.

5. Despite the respondents stated comfort with data, better strategies and tools for data collection under pin planning and evaluation in the SPF, so additional modules on data collection and utilization should be developed. Verification of the collection and use of

data should be incorporated in routine site visits and yearly reporting by Prevention Section staff.

6. The perception of problem section provides information that underscores the concerns around alcohol use and prescription drug use in the state. The view of tolerance suggests that much work still needs to be done in changing community norms around use in both of these areas and to continue to provide education through coalitions to community members beyond those with children in schools.

7. Given the potential scope of the changes, a web-space for current happenings and updates with the SPE grant and the movement toward integration may serve to keep people informed. This could be integrated into current offerings on the state substance abuse website.

This is by no means a definitive scan; the questions chosen reflect a fairly narrow range of interests based on the current planning needs. Some items may have been more understandable to prevention only agencies, while others may have made more sense to treatment agencies. In addition, the sample size at present is small. The instrument was intended for a pilot group at first, but we expect to increase the implementation of some, or all, of the scan in the future. Also, despite repeated invitations, within each CA a fairly small number of participants completed the scan. Individual CAs may wish to expand use of the scan or repeat use of some or all sections for their own planning and needs.

Appendix

Complete Data tables and not in text

5. What was your estimated agency budget for FY 2011? (N=47)			
Unknown/not sure	11% (n=5)	250,000	2% (n=1)
12,000,000	4% (n=2)	220,000	2% (n=1)
300,000	4% (n=2)	200,500	2% (n=1)
61,420	4% (n=2)	180,000	2% (n=1)
14,000,000	2% (n=1)	177,000	2% (n=1)
11,600,000	2% (n=1)	155,000	2% (n=1)
11,000,000	2% (n=1)	132,000	2% (n=1)
8,600,000	2% (n=1)	125,000	2% (n=1)
8,500,000	2% (n=1)	90,000	2% (n=1)
4,330,690	2% (n=1)	85,000	2% (n=1)
3,000,000	2% (n=1)	75,000	2% (n=1)
2,700,000	2% (n=1)	58,000	2% (n=1)
2,100,000	2% (n=1)	48,000	2% (n=1)
1,800,000	2% (n=1)	20,000	2% (n=1)
1,400,000	2% (n=1)	17,000	2% (n=1)
750,000	2% (n=1)	11,000	2% (n=1)
713,507	2% (n=1)	5,000	2% (n=1)
427,000	2% (n=1)		

24. Please state your perceived preparedness to participate in the following ROSC component: (N=47)				
	Not Ready	Low Readiness	Moderate Readiness	High Readiness
…do more community outreach about program services	11%	6%	57%	26%
…reduce stigma and discrimination regarding substance use in the community	15%	9%	48%	28%
… participate in public policy advocacy on behalf of clients	15%	15%	50%	20%
… provide programming for family education and strengthening	9%	6%	40%	45%
… provide programming to promote awareness in schools	7%	9%	33%	51%
…provide programming to promote awareness in communities	7%	2%	51%	40%
…provide programming for early intervention	7%	22%	43%	28%
…provide social marketing campaigns for substance use prevention	11%	7%	39%	43%

25. Can you provide one example of how your agency partners with other resources/agencies to support a recovery oriented system of care? (N=51) *Multiple responses	
Collaborate with local treatment agencies	14% (n=8)
Collaborate with drug court/court system	12% (n=6)
Collaborate with community and local agencies	8% (n=4)
Work with prevention providers	6% (n=3)
Working with recovery community/AA meetings	6% (n=3)
Intervention/prevention programs	4% (n=2)
We are developing MOU's with recovery support organizations	4% (n=2)
A referral process/system	4% (n=2)
Social marketing	4% (n=2)
Providing opportunities for providers to educate one another about the services available at each other's agency so that clients can receive integrated services	2% (n=1)
The coalition sponsored a Comedy Show for the recovery community during Recovery Month	2% (n=1)
The difficult part for our coalition is that we do not have any funding, we work off of volunteer agency time and also resources, and small community foundation grants	2% (n=1)
River Haven is our co-coordinating agency. Cherry Street Prevention Services is our fiduciary agent	2% (n=1)
Local schools are requesting Alateen resources	2% (n=1)
Group referrals from this prevention provider	2% (n=1)
Mental Health anti-stigma campaign	2% (n=1)
Provide staff support to convene the Eaton County Substance Abuse Advisory Group ROSC Committee	2% (n=1)
Assist with planning and promotion of ROSC, and have participated facilitating workshops on ROSC and the Role of Prevention	2% (n=1)
Our Prevention Dept and Substance Abuse Dept work closely together	2% (n=1)
Contractual relationship established for community based case management pilot	2% (n=1)
Peer supports coordination	2% (n=1)
Working with local providers to develop EI programs	2% (n=1)
Developed working and referral process with mental health, schools	2% (n=1)
Parenting programs	2% (n=1)
We participate in the county ROSC workgroup	2% (n=1)
Connect treatment agencies/providers with connections to other service providers such as housing assistance service agencies, parenting classes, etc.	2% (n=1)
Works with Department of Human Services	2% (n=1)
Work with the Substance Abuse Advisory Council and the River Haven Coordinating Agency on a planning process for developing a ROSC initiative	2% (n=1)

26. To what extent do you think the following are potential barriers to integration of substance abuse prevention with mental health and primary care? Systems integration may be limited by… (N=47)					
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
...our mission statement	13%	57%	26%	4%	0%
...our staff's lack of knowledge related to prevention of suicide	15%	42%	30%	13%	0%
...our staff's lack of knowledge related to prevention of mental health issues	15%	34%	28%	21%	2%
...our staff's lack of knowledge related to primary health promotion and disease prevention	15%	31%	26%	26%	2%
...our bylaws and/or funder requirements	17%	38%	32%	9%	4%
...our communities limited experience working with other types of prevention providers	13%	40%	28%	19%	0%
...our lack of financial resources	6%	9%	26%	33%	26%
...our lack of staff/personnel	4%	16%	27%	40%	13%
...our lack of leadership support for integration	15%	21%	45%	19%	0%

27. Are there any other items that may be a barrier to or issues with integration of substance abuse prevention with mental health and primary care? (N=18) *Multiple responses	
Our barriers have to do with collaboration. There is a lack of an appropriate agency(s) available that is willing/able to implement or champion specific strategies that are needed to provide the spectrum of services that the community needs. Information sharing and no collaboration.	11% (n=2)
Lack of funding to provide these services/budgets	11% (n=2)
Many CMH agencies don't provide prevention services as seen in the SA community. The Mental Health and primary Care systems lack of knowledge around SA prevention and treatment and their limited capacity around the prevention of mental health and public health	11% (n=2)
System integration will take time and will require strong leadership and trust among partners, the capacity of current staff will have to be closely monitored in order to ensure that a project of this magnitude is getting the attention needed and isn't an add-on to a currently stretched staff member	5.5% (n=1)
There are different requirements for reporting and paying for the varied type of care described. For example, Prevention services are typically funded by a staffing grant with reporting not tied to a specific consumer. Mental health and primary care however, are typically provided for a specific client and paid for on behalf of	5.5% (n=1)

27. Are there any other items that may be a barrier to or issues with integration of substance abuse prevention with mental health and primary care? (N=18) *Multiple responses	
that client which allows for reporting via an encounter to occur.	
Each role needs to be clearly defined	5.5% (n=1)
Limited availability of people to be involved	5.5% (n=1)
Area has a shortage of primary care providers	5.5% (n=1)
Needs to build professional network between mental health and prevention and treatment. Everyone is feeling threatened that another agency will usurp the jobs and result in unemployment for weakest link	5.5% (n=1)
Need MH and primary care to want to work together although, SUD prevention has been trying to reach out to these fields, I do not recall one time where they attempted to reach out to the SUD Prevention Field	5.5% (n=1)
Mental Health Prevention needs its own champions and own staffing	5.5% (n=1)
The community development and environmental approach to substance abuse prevention is unique and outside the understanding of clinical settings. The larger Mental Health and primary care focuses may not appreciate the benefits of these initiatives and look to directing resources to individual care/prevention approaches	5.5% (n=1)
The intentions of MDCH mental health are poorly defined, lacking specific expectations of the prevention field, SA prevention seems to be poorly understood by system integration advocates	5.5% (n=1)
Different philosophies, some persons reluctance toward change	6% (n=1)
None come to mind	6% (n=1)

28. Can you think of any other barrier(s) to, or issues with the promotion of Prevention Prepared Communities or the creation of ROSCs? (N=15) *Multiple responses	
Funding barriers	33% (n=5)
Collaboration barriers, agencies, courts	13% (n=2)
Implementing system change takes time	7% (n=1)
Would still be beneficial to have leadership from Regional CA's	7% (n=1)
Need to retrain in ROSC due to staff turn-over	7% (n=1)
Lack of practical guidance for treatment providers have made it difficult to transition to ROSC	7% (n=1)
Skill development	7% (n=1)
Lack of more educations regarding the program as a whole	7% (n=1)
We all need the funds for suicide prevention…not just another thing for SA Prevention to take on also, ROSC may be forgetting how things really work	7% (n=1)
Prevention is multiple approaches focusing on universal, indicated, and selected populations. The only words I have heard related to prevention being part of ROSC is that prevention can implement programs to assist with recovery or early intervention (selected and indicated populations). I have not heard any examples of how treatment and recovery personnel may assist in environmental approaches	7% (n=1)

to increase community capacity (universal population). Until the language changes to indicate this is a blending of services, there remains the danger to prevention of being assumed into supporting case finding and relapse prevention. As such, prevention resources will be focused on individual cases and we will lose a significant focus on making real community level changes.	

29. To what extent do you agree that you need training in the following areas? Training related to the integration of substance abuse prevention with mental health and primary care: (N=46)

	Mean	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Understanding policies and practices of other systems	4.00	0% (n=0)	4% (n=2)	11% (n=5)	64% (n=29)	20% (n=9)
Developing Memorandum of Understanding (MOUs) and service agreements with partners	3.60	4% (n=2)	13.5% (n=6)	16% (n=7)	53% (n=24)	13.5% (n=6)
Identifying variables and sharing de-identified data	3.90	2% (n=1)	11% (n=5)	9% (n=4)	54% (n=25)	24% (n=11)
Collaborative planning for service provision	3.90	2% (n=1)	13% (n=6)	7% (n=3)	50% (n=23)	28% (n=13)
Cross training substance abuse prevention staff in mental health prevention and promotion	4.27	2.5% (n=1)	2.5% (n=1)	4% (n=2)	49% (n=22)	42% (n=19)
Increasing relationships across systems to improve prevention	4.20	0% (n=0)	9% (n=4)	4% (n=2)	44% (n=20)	42% (n=19)

30. To what extent do you agree that your staff need training in the following areas? *Training prevention staff to...* (N=46)

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
...implement universal prevention strategies	5% (n=2)	30% (n=13)	20% (n=9)	34% (n=15)	11% (n=5)
...implement selective prevention Strategies	4% (n=2)	24% (n=11)	17% (n=8)	46% (n=21)	9% (n=4)
...implement indicated prevention strategies	4% (n=2)	22.5% (n=10)	22.5% (n=10)	42% (n=19)	9% (n=4)
...implement evidence based practices	7% (n=3)	22% (n=10)	13% (n=6)	49% (n=22)	9% (n=4)
..implement Screening Brief Intervention	2%	11.5%	13.5%	49%	24%

30. To what extent do you agree that your staff need training in the following areas? *Training prevention staff to...* (N=46)					
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
and Referral to Treatment (SBIRT)	(n=1)	(n=5)	(n=6)	(n=22)	(n=11)
...gather feedback from providers/clients/consumers on implementation	2% (n=1)	28% (n=13)	20% (n=9)	35% (n=16)	15% (n=7)
...ensure cultural competency of our programming	9% (n=4)	17% (n=8)	28% (n=13)	35% (n=16)	11% (n=5)
...ensure participation from under-represented groups in our community	7% (n=3)	16% (n=7)	24% (n=11)	33% (n=15)	20% (n=9)

40. My organization needs training on this step of the SPF: (N=42)		
	Yes	No
Assess Needs: collection of data to understand community need	38%	62%
Develop Capacity: mobilizing human, organizational, and financial resources to meet project goals	52%	48%
Planning: developing goals, objectives, and strategies for use of evidence based programs	56%	44%
Implementation: carrying out prevention plans	36%	64%
Evaluation: measuring what they have done well and what areas need improvement.	67%	33%
Sustainability: process through which a prevention system becomes a norm and is integrated into ongoing operations	69%	31%
Cultural competence: communicating with audiences from diverse geographic, ethnic, racial, cultural, economic, social, and linguistic backgrounds.	50%	50%

42. What other types of data do you collect? (Describe) (n=24) **Some respondents gave more than one response)

School Drop-out data (academic, truancy, and suspensions) (n=2)
Mental Health data, Kids Count data, SUD treatment data, SYNAR data

MAPS data (n=2)
Local suicide data from medical examiner's office (n=2)
Risk and Protective factor data is collected, archival, and consequence data is collected (n=2)
Adult perception of problem data at community events (n=2)
Hospitalization/emergency room data (n=2)
Local Community Health Department Survey Data (n=2)
Treatment Utilization Data (n=2)
Family and Other Court Data (n=2)
Community Needs Assessments through United Way
Poverty Data
Michigan Traffic Safety data
Try to collect data that can be identified on a county level
Alcohol related crashes, TEDS, arrest data for ATOD, crimes data related to ATOD, pre/post test related to curriculum-based programs, perception of effectiveness of prevention intervention data
BRFS locally
Compliance Rates, Drunk/Drugged Driving, Mortality Rates
Substance use by client and parent recidivism rates and Physical violence rates
Data from first offender drunk driving programs (age, BAC level, gender, etc.)
Numbers of program participants, age, satisfaction

43. How do you use the data you collect? (n=26) **Some respondents gave more than one response.
To state need in grant applications and for writing grants with other community agencies (n=2)
Track and monitor local trends
Pre/Post surveys to use it as a focal point for working with each client and their family
We use the MIPHY with 7th, 9th, and 11th graders every other year with all 7 school districts in Montcalm County
To determine what our target audience should be in addressing prevention messages in regards to drinking and driving
Individual Programs designed for each school
Use if for surveillance, and engaging local community groups and schools in prevention planning efforts
Local agencies, school events, and Town Hall Meetings
Organization information

44. What needs does your organization have with respect to data collection?
None at this time (n=3)
A statewide data repository for data that can be found on a county level. It would be wonderful if data sources like MIPHY and Hospital SUD data could be mandated so it would be available to all
Training/knowledge to access more ATOD related data at the local and regional level
How to house the data electronically, MOU's, and efficiencies in collecting the data

Our organization lacks a lot of formalized/routine data collection mechanisms and processes that would increase capacity to utilize and integrate more data into strategy building and demonstration of needs

We have a lot of data but the data sets change, which makes trending and analyzing data difficult. It also has been difficult to collect data from different municipalities because they classify things (MIPs, etc.) differently and if a main contact moves you have to relationship build to get data all over again

46. Please tell us to what degree each of the following are problems in your community or region using the following responses: (N=43)					
	Not a problem	Minor problem	Moderate problem	Major problem	Don't know or Unsure
Abuse of alcohol among youth	0% (n=0)	2% (n=1)	20% (n=11)	78% (n=31)	0% (n=0)
Abuse of alcohol among adults	0% (n=0)	0% (n=0)	25% (n=12)	72% (n=30)	2% (n=1)
Abuse of prescription drugs among youth	0% (n=0)	2% (n=1)	22% (n=10)	72% (n=30)	2% (n=1)
Abuse of prescription drugs among adults	0% (n=0)	2% (n=1)	20% (n=10)	75% (n=31)	2% (n=1)
Suicide among youth	0% (n=0)	22% (n=11)	48% (n=20)	12% (n=5)	18% (n=7)
Suicide among adults	0% (n=0)	23% (n=12)	44% (n=17)	13% (n=5)	21% (n=8)
Suicide among military families, LGBTQ youth, or Native Americans/American Indians	8% (n=3)	20% (n=10)	18% (n=9)	10% (n=4)	45% (n=17)