Appendix C: Sample Needs Statement

Sample Needs Statement from the Minnesota Strategic Prevention Framework State Incentive Grant (SPF-SIG) Proposal

Project Narrative and Supporting Documentation

Section A: Statement of Need

Despite strong prevention initiatives, the burden of substance use and misuse remains high in Minnesota. Overall, alcohol, tobacco, and other drug (ATOD) consumption rates and associated negative consequences have declined or remained stable since the late 1990s, but the enduring magnitude and severity of these problems warrants attention from Minnesota citizens, businesses, and government officials.

Characteristics of Communities in Minnesota and Populations Who Will Receive Services

Minnesota, like our neighbors in the upper Midwest, has a strong culture of acceptance of alcohol use. Minnesota ranked 41st in the nation, with 50th being the highest, for percentage of the population reporting binge drinking: 17.6% (BRFSS data in United Health Foundation, 2007). In the 2007 Legislative session, a state representative introduced a bill to lower the state's drinking age to 18 (MN House File 3495, 2008). Although the bill was not passed into law, that the minimum legal drinking age is debatable speaks to the culture and situation in Minnesota.

Commonly and historically considered a relatively homogeneous state by people unfamiliar with Minnesota, we are rapidly becoming a more diverse state. Many of the demographic and cultural trends experienced in our state directly and indirectly affect our prevention system. With 27% of the state population in rural areas (Economic Research Service, 2008), we must identify efficient ways to serve, not overlook, outstate communities. When schools adapt to serve the changing needs of students and families, such as the 90 languages spoken in Hennepin County, which is the 18th highest number in any county in the United States (U.S. English Foundation, 2005), we must be creative in finding ways schools can adapt prevention services. Minnesota is committed to understanding the many aspects that influence individual and community cultures and adapting our prevention system to meet those needs.

The complexity of fully describing and understanding Minnesota's communities of color is beyond the scope of this proposal discussion, but has been a primary focus of the SEOW. Minnesota is home to many populations of color, 11 Federally recognized American Indian nations, one of the largest urban Indian populations in the U.S, and a large immigrant population. Minnesota's nonwhite and Latino populations are projected to grow substantially faster than the white population (McMurry, 2005; MDC 2004).

Our SEOW has consulted with underserved populations through the Community ATOD Information Needs Planning Project with a goal to gather and distribute information needed to describe the scope of ATOD problems in underserved communities. The process of generating information in communities is as important as the information itself. We have partnered with communities on all aspects of the project—from defining key questions to dissemination

of findings. The SEOW recruited associates from the African American, American Indian, Hispanic, Asian, and recent immigrant communities to ensure the profile is culturally sensitive. This project illustrates the priority Minnesota places on understanding the needs of a culturally diverse state and working with members of the community in planning prevention efforts.

Another facet of cultural competence is understanding Minnesota's military veteran population. Since 9/11, the Minnesota National Guard has mobilized more than 11,000 Soldiers and Airmen in support of the Global War on Terror and state support operations. In the years since the War on Terror began, citizen Soldiers have served in 33 different countries, as well as multiple disaster relief and homeland security missions. (MN National Guard, 2008). Army National Guard soldiers in Iraq and Afghanistan have often had 12- to 18-month deployments; Air National Guard airmen deploy to combat zones usually for no more than three months but tend to deploy more frequently (Jensen, 2008). Deployments, whether long or frequent, place tremendous stress on our veterans. As with SAMHSA, Minnesota state leaders including Governor Pawlenty, recognize veterans as a priority population.

Need to Implement the Strategic Prevention Framework

While Minnesota has a strong prevention system, we will benefit from the opportunity to fully implement all aspects of the SPF through a concerted effort to address the priority need identified. After extensive review of data, the Minnesota State Epidemiological Outcomes Workgroup (SEOW) has determined that Minnesota faces significant ATOD-related challenges compared to the nation, alcohol places the greatest burden on Minnesota of all substances, 18- to 24-year olds are a priority population, and college-enrolled young adults in that age group are the most in need of alcohol prevention initiatives.

Minnesota has higher alcohol use than the nation in many indicators.

Minnesota has had higher rates of past 30-day alcohol use among adults than the U.S in the past six years. Rates were trending down until 2007, at which point they jumped back up to 60.0% from 58.4% (Table 1). The percent of Minnesota adults reporting binge/high-risk drinking in the past 30 days was higher than the nation from 2002 to 2006. The binge-drinking rate in Minnesota has been trending downward and dipped below the national average in 2007 (Table 2). State prevention efforts should be focused on continuing this trend.

Table 1. Adults reporting any use of alcohol in the past 30 days

	2002	2003	2004	2005	2006	2007
Minnesota	67.2%	67.5%	66.3%	64.7%	58.4%	60.0%
U.S.	58.1%	59.4%	57.1%	56.2%	55.4%	54.8%

Behavioral Risk Factor Surveillance System (BRFSS)

Table 2. Adults reporting binge drinking in the past 30 days (five or more drinks in a row on one occasion for men; four or more drinks for women)						
	2002	2003	2004	2005	2006	2007
Minnesota	21.1%	19.7%	19.8%	18.7%	17.4%	14.3%
U.S.	16.1%	16.5%	14.9%	14.4%	15.4%	15.8%

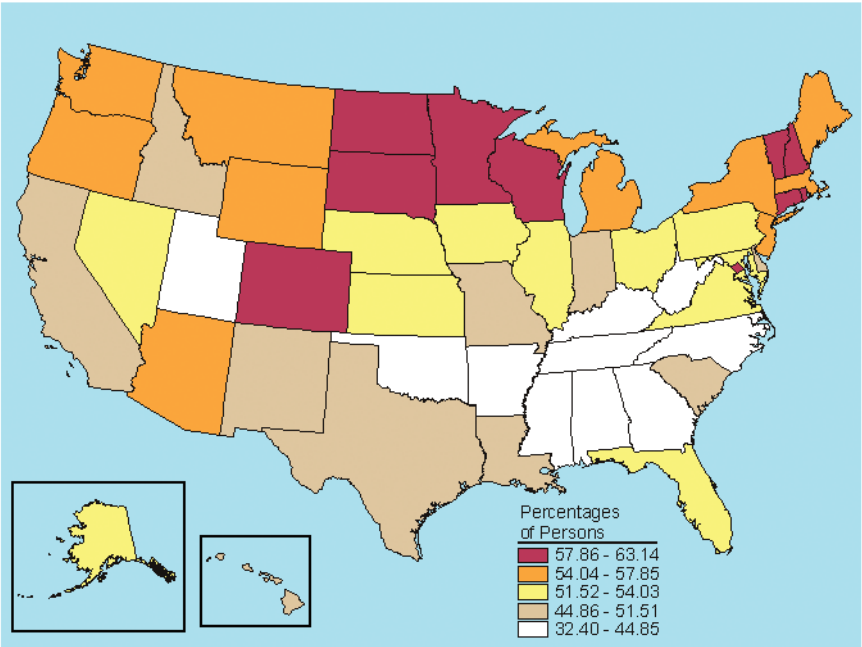
Behavioral Risk Factor Surveillance System (BRFSS)

The arrest rate per 1,000 population for driving under the influence (DUI) has been higher than the national average (Table 3).

Table 3. Arrest rates for DUI per 1,000 population						
	2002	2003	2004	2005	2006	2007
Minnesota	6.07	5.47	5.77	6.01	6.76	6.43
U.S.	4.97	3.46	4.88	4.63	4.79	4.68

Uniform Crime Reports (UCR)

Figure 1. Alcohol Use in Past Month among Persons Aged 12 or Older, by State: Percentages, Annual Averages Based on 2004 and 2005 NSDUHs



Minnesotans, both adults and youth, report that alcohol is the most commonly used drug.
Furthermore, alcohol use among Minnesotans has decreased less than tobacco use has—the percent change from 2002 to 2007 was -10.7% for alcohol and -24.0% for tobacco (BRFSS).

Table 4. Reported past 30-day use in Minnesota						
Adults	2002	2003	2004	2005	2006	2007
Alcohol	67.2%	67.5%	66.3%	64.7%	58.4%	60.0%
Cigarettes	21.7%	21.1%	20.7%	20.0%	18.3%	16.5%
		2002/2003	2003/2004	2004/2005	2005/2006	
Marijuana		6.4%	6.1%	7.0%	7.2%	

Adult alcohol and cigarette consumption data from BRFSS; adult marijuana consumption data from NSDUH

Table 5. Reported past 30-day use in Minnesota				
Students	1998	2001	2004	2007
Alcohol	30.6%	26.8%	25.4%	23.1%
Cigarettes	18.8%	19.9%	14.9%	11.9%
Marijuana	11.8%	11.3%	10.2%	9.2%

Youth consumption data from the Minnesota Student Survey

Alcohol-related consequences place a significant burden on Minnesota.
The human and economic costs associated with alcohol use in 2001 amounted to an estimated $4.5 billion. This amounts to over $900 per person in Minnesota. (MN Dept. of Public Safety, 2008). Among Minnesotans placed in treatment programs in 2007, 53% identified alcohol as their primary substance of abuse. This was up from 47.4% in 2006. An additional 16.9% identified alcohol as their secondary substance of abuse in 2007 (Drug and Alcohol Abuse Normative Evaluation System—DAANES).

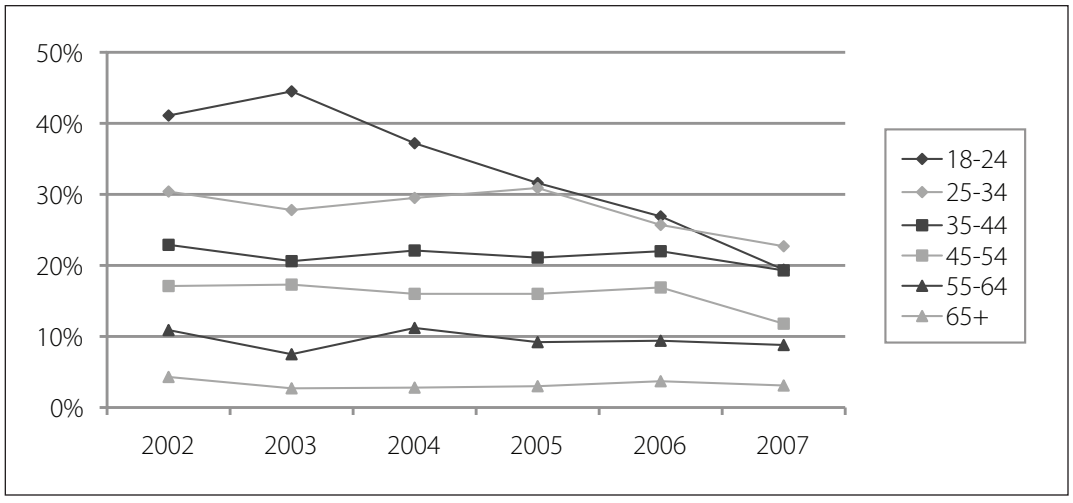
Alcohol use is higher among males, American Indians, and Whites but is a concern for all races/ethnicities.

Table 6. Adults having 5 or more drinks in a row (4 for females) on one occasion in the past 30 days				
	Males		Females	
	Metro	Non-metro	Metro	Non-metro
White	24%	26%	15%	13%
African-American, African or Black	13%	0%	7%	12%
American Indian/Alaska Native	52%	49%	19%	19%
Asian American/Pacific Islander	17%	15%	11%	2%
Hispanic/Latino	25%	28%	5%	6%

Minnesota Survey on Adults Substance Use, 2004/2005

Alcohol-related consumption and consequences are concentrated among 18- to 24-year-olds.
Eighteen to 24-year-old adults had the highest rates of binge/high-risk drinking in Minnesota from 2002 to 2006 (Figure 2). This age group has had the highest number of 'impaired driving incidents' in Minnesota (Table 7). The number of emergency room, trauma visits related to alcohol spiked among 18- to 24-year-olds from 2004 to 2005—increasing 81% (Figure 3).

Figure 2. Minnesota adults reporting binge drinking in the past 30 days (5 or more drinks in a row on one occasion for men; 4 or more drinks for women), by age

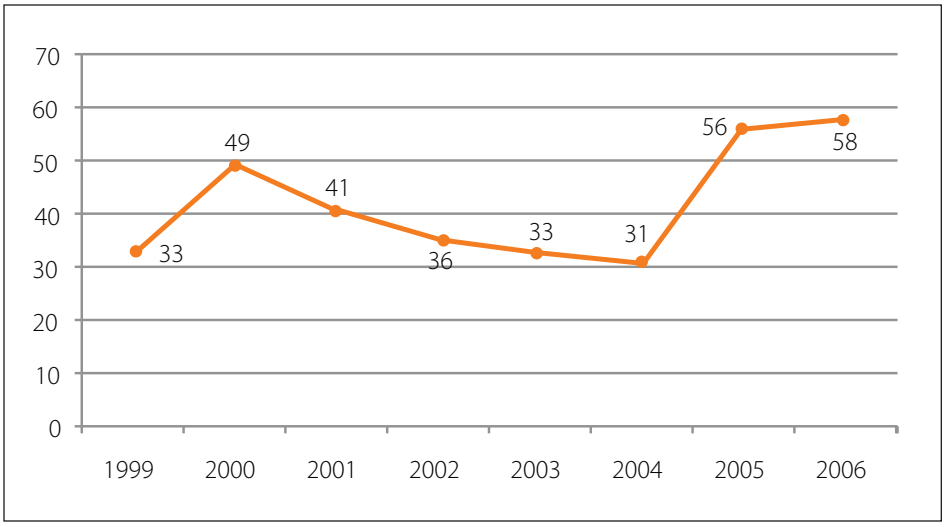


Behavioral Risk Factor Surveillance System (BRFSS)

Table 7. Impaired driving incidents ("DWIs"[1]) by age, 1991 – 2007												
	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
2000	5	2,139	7,725	5,819	4,805	5,071	3,922	2,479	1,396	692	368	34,803
2001	2	1,956	7,839	5,437	4,545	4,408	3,887	2,445	1,450	649	333	33,305
2002	6	1,937	8,080	5,255	4,345	4,030	3,849	2,500	1,451	754	355	32,948
2003	3	2,010	8,195	5,394	3,993	3,621	3,646	2,465	1,380	753	381	32,193
2004	3	1,986	8,689	5,895	4,260	3,660	3,817	2,708	1,641	789	425	34,199
2005	5	2,202	9,594	6,790	4,360	3,778	3,850	2,929	1,664	920	410	36,870

Minnesota Motor Vehicle Crash Facts, 2007

Figure 3. Deaths due to alcohol use/abuse among 18-24 year olds, in Minnesota:



Minnesota Department of Health, January 2008 (based on hospital e-codes)

Among 18- to 24-year olds, college students are a priority population.

Rates of alcohol consumption among college-enrolled young adults have been consistently high, both nationally and in Minnesota. Data show a persistently high rate of drinking among young people, including college students, since World War II—a trend that continues to the present. College students generally have higher prevalence rates of alcohol use than their peers who graduate from high school but do not attend college. Although their non-college same-age peers are somewhat more likely to drink every day, college students are more likely to drink at

weekend parties and social gatherings. Data suggest that there are aspects of the college environment that support heavy episodic drinking in ways that are not experienced by non-college peers. Binge drinking rates among college students tend to be highest in the Northeast and North Central regions and lowest in the South and West (Task Force [NIAAA], 2002).

Nationally, rates of binge-drinking among college students held steady from 1993 to 2001: 43.9% in 1993, 43.2% in 1997, 44.5% in 1999, and 44.4% in 2001 (Wechsler, 2002). The percent of college-enrolled, occasional heavy drinkers increased from 24.3% in 1993 to 45.5% in 2006, nationally (Kapner, 2008). Past-month alcohol use was higher among Minnesota college and university students in 2007 than the national average: 70.5% vs. 67.2% (ACHA-NCHA, 2007). Average number of drinks per week: 5.9 drinks in Twin Cities metro-area colleges and universities vs. 5.8 drinks in the US (2005 National CORE vs. 2005 Twin Cities CORE).

College students, as a population, are most likely to binge drink. "Binge drinking is widespread on college campuses, with almost half of students reporting binge drinking. They are also particularly prone to Alcohol Impaired driving. Thus, we needed to understand why a population that knows better than to engage in impaired driving still does." (Marczinski, 2008).

Consequences related to alcohol use are also prevalent among college students nationally. In 2001, more than 500,000 students were unintentionally injured and more than 600,000 were hit/assaulted by another drinking student (Hingson, 2005). The average number of negative alcohol-related consequences experienced over the past 12 months, reported by college-enrolled Minnesotans from a list of 19 consequences ranging from mild to severe, was 5.6 for those reporting 5 or fewer drinks per week vs. 21.6 for those reporting 6 or more drinks per week. The number was 4.4 for non-high-risk drinkers vs. 18.5 for high-risk drinkers (ACHA-NCHA, 2007). Table 8 displays specific alcohol-related negative consequences reported by college students.

Table 8. Percent of students reporting high-risk drinking and selected consequences

	All Students	Non-high-risk Drinking Students	High-risk Drinking Students
Driven while intoxicated	20.5	9.3	39.7
Argument	22.0	11.4	40.0
Poor test/project	21.8	12.1	38.4
Missed class	25.4	13.5	45.7
Been taken advantage of sexually (includes males and females)	4.2	2.3	7.5

2007 College Student Health Survey Report

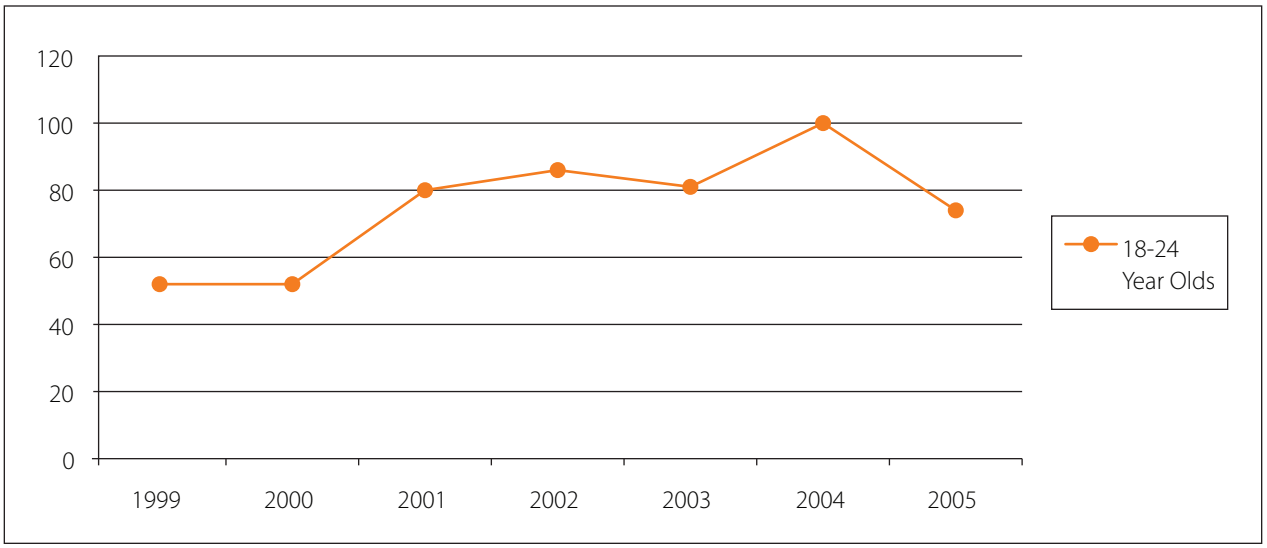
While college students are a high-need population, the needs of Minnesota's National Guard veterans are a growing concern and require further assessment for prevention planning.

In the U.S., National Guard troops are more likely than active-duty soldiers to develop drinking problems. Fifty-four percent of personnel with combat exposure report binge drinking; 15% percent report alcohol-related problems. Combat-deployed troops were almost twice as likely to report new-onset heavy weekly drinking, binge drinking, and alcohol-related problems than non-deployed personnel. Possible reasons for increased risk among National Guard members include increased stress among individuals and their families transitioning between civilian and military settings and reduced access to services in civilian communities (JAMA). Minnesota has mobilized more than 11,000 Soldiers and Airmen since September 11, 2001 (MN National Guard, 2008).

Nationally, the percentage of military personnel aged 18 to 25, who reported past-month heavy alcohol use was higher than the percentage of civilians in the same age group in 2004/2005: 24.8% vs. 17.4% (DOD, 2006). "Despite initial decreases in heavy alcohol use from 1982 to 1992, rates increased slightly in later years, returning to a level similar to that reported in 1980" (Bray, 2007). Among males aged 18 to 25, veterans were more likely than non-veterans to report past month alcohol use in 2000 (Office of Applied Studies "NHDSA," 2001). An estimated 0.8% of veterans received specialty treatment for a substance use disorder (alcohol or illicit drugs) in the past year compared with 0.5 percent of comparable non-veterans from 2000-2003 (Office of Applied Studies. NHSDA "Substance," 2005). An estimated 13.2 percent of veterans reported driving while under the influence of alcohol or illicit drugs in the past year compared with 12.2% of comparable non-veterans from 2000-2003 (Office of Applied Studies "…Substance," 2005). Although primary alcohol admissions among veterans had declined since 1993, more than two-thirds of veteran admissions in 1999 were for alcohol (Office of Applied Studies "DASIS," 2001).

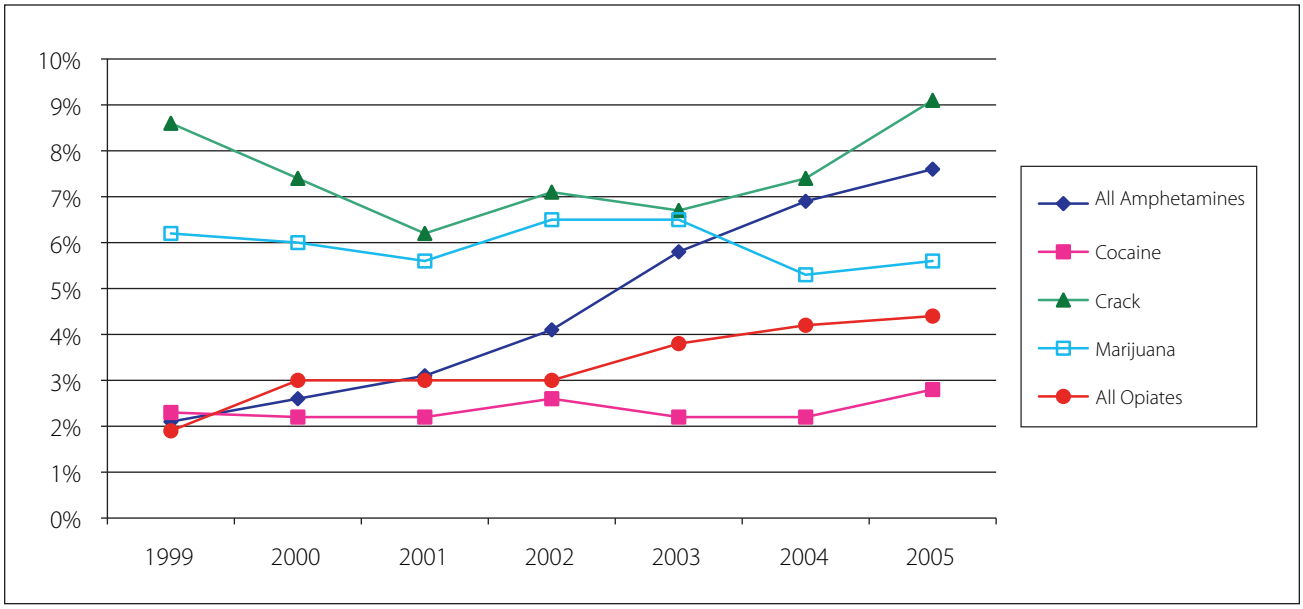
The number of 18-24 year-old veterans admitted to Minnesota treatment facilities nearly doubled from 1999 to 2004.

Figure 4. Number of Veterans Admitted to Minnesota Treatment



Reflecting national trends, primary alcohol admissions among veterans have declined but still make up over two-thirds of treatment admissions in Minnesota. For all age groups combined, the percentage reporting illicit drugs as their primary substance of abuse has increased for all substance except marijuana.

Figure 5. Percent of Veterans Admitted to Minnesota Treatment Facilities Reporting Illicit Drugs as their Primary Substance of Abuse



Service Gaps, Barriers, and Other Problems

Through the SPF SIG, Minnesota will seek to address the following issues:

- There are a limited number of data sources that include college enrollment status. Additional data collection will need to be conducted to fully understand college-enrolled versus non-college-enrolled young adults.
- Some colleges and universities are reluctant to report alcohol use and consequence data because it may reflect poorly on the school. The SPF SIG will work to overcome the concern and help colleges build reputation based on proactively addressing substance abuse prevention.
- Many national and state data sources lack information about veterans and some surveillance instruments may lag behind the problems veterans are beginning to exhibit today.
- It is sometimes difficult to gain access to data sources relating to American Indians. Our SEOW must be culturally sensitive to a well-founded apprehension to how the data may be used. The Department of Human Services (DHS) Alcohol and Drug Abuse Division (ADAD) American Indian Section staff and our SEOW will continue to build trust with tribal colleges and other data holders to overcome reluctance linked to historical trauma.

- There is a lack of coordinated prevention initiatives aimed at the post-secondary population. Most of Minnesota's primary prevention resources focus on middle and high school youth, even though the majority of use and consequences are within the 18- to 24-year old population.
- We will support the adoption of environmental strategies to address the contextual and environmental variables that contribute to the current high-level of alcohol use among college students.
- Because of the historic focus on younger age populations, the prevention system lacks full capacity for addressing the prevention needs of college populations. For example, the SEOW needs to gather more data specific to this population and Regional Prevention Coordinators need to strengthen ties with campuses and surrounding communities across the state.

While Minnesota has identified several gaps and barriers in the prevention system, it is important to understand our track record in identifying and addressing problems. After a survey, focus groups, and key informant interviews conducted 2003-2004 and other system reviews, Minnesota has implemented several improvements (Minnesota Institute of Public Health, 2004).

Gap Identified	System Improvement
Rural resources: More resources needed outside the Twin Cities metro area, rural areas sought greater connection to the state prevention system.	• In 2004, created a system of seven Regional Prevention Coordinators (RPCs) located throughout the state to serve and provide resources to grantees, coalitions, and community members. • Regional Prevention Forums held twice each year around the state. • A MAPCC [a council of State agencies involved in prevention] representative attends each forum to build state relationship with rural communities.
Workforce development: lack of knowledge in prevention principles, opportunities for training	• Required RPCs to be Substance Abuse Prevention Specialist Training (SAPST) trainers and deliver the training at least once each year in their region.
Prevention funding: focused on programs/ providers not coordinated, short-term focus.	• Prevention funding is now focused on communities and coalitions to encourage broad involvement and collaboration and a focus on community-level change. • Funding cycle changed from 2 to 5 years to allow for community process and outcomes to be achieved.

Stakeholders and Resources

Minnesota has various partners and efforts that are building a comprehensive and coordinated system. The Minnesota ATOD Prevention Coordinating Council (MAPCC) meets monthly and provides an ongoing forum for discussion and coordination among the key state-level agency stakeholders. MAPCC was created by and sustained after the first State Incentive Grant that Minnesota received in 1999. It is convened by ADAD and includes representatives from the Departments of Health, Public Safety (including the Enforcing Underage Drinking Laws coordinator), and Education and the Minnesota Prevention Resource Center (MPRC). Through the SPF SIG, we will increase connections to the Office of Higher Education (a cabinet-level office), the Minnesota State Colleges and Universities System (MNSCU), and other networks within the arena of post-secondary education. ADAD and MPRC have already begun to coordinate efforts with MNSCU.

Minnesota has a strong prevention infrastructure including the Regional Prevention Coordinators, MPRC, annual Program Sharing conference, and semi-annual Regional ATOD forums (held in nine locations throughout the state). Minnesota also funds nine Planning and Implementation grantees, which are community coalitions that serve as leaders and mentors for other prevention initiatives.