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- **Communities That Care, Substance Abuse and Mental Health Services Administration:** “Module 2: Collecting Resource Information, Trainer’s Guide,” and “Module 3: Assessing Resource and Identifying Gaps, Trainer’s Guide.”

- **Tri-Ethnic Center for Prevention Research:** “Community Readiness: A Handbook for Successful Change.”

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INTRODUCTION TO PREVENTION PLANNING

What is Prevention?

“Prevention is the active process of creating conditions and fostering personal attributes that promote the well-being of people.”
– William Lofquist, 1989

We believe that prevention is about fostering healthy, strong communities.

Why Plan?

We believe that good planning will lead to effective prevention programs, policies and practices. Those effective strategies will result in healthy, strong communities where everyone’s well being is enhanced.

Our philosophy is that for prevention to work best, we must be guided by the following three principles:

- Local people solve local problems best;
- People support what they help create; and
- Science matters.

What this means is that communities like yours have the knowledge and the power to solve local substance abuse problems. It means that communities that actively participate in solving their own problems are more invested in the work and in the results. It means that using real evidence from the community as the basis for prevention planning is crucial for this important work to be successful.

Why Toolkits?

Each one in Nebraska’s series of prevention planning Toolkits is intended to be used as a technical guide. We hope these guides will provide communities with useful road maps to:

- Gain a deeper understanding of the essential components of substance abuse prevention planning;
- Learn how to develop, implement, evaluate and refine prevention strategies;
- Achieve positive outcomes; and
- Develop the necessary skills and capacities to sustain those outcomes.
The Strategic Prevention Framework

The Strategic Prevention Framework (SPF) is the planning model Nebraska communities will use to address priority substance use and related behaviors. (The steps are shown in Figure 1 and described below.) Developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), the SPF’s elements assist coalitions to develop the infrastructure needed to successfully implement community-based approaches organized around the public health model, that lead to effective and sustainable reductions in alcohol, tobacco, and other drug (ATOD) use and abuse. The SPF is considered “data-driven" because it requires every step in prevention planning to be supported by the collection and analysis of objective data.

The Public Health Model

In the past, substance abuse prevention traditionally focused on approaches designed to affect the individual, peers or families. Today, many coalitions implement comprehensive, multi-strategy approaches that work to reduce substance use in the overall community, thereby impacting the public’s health.

NOTE:
Definitions for all terms found in bold in these Toolkits can be found in the accompanying glossary.

Figure 1
**Step 1: Assessment.** Assessment is the systematic collection and analysis of data about a community. Coalitions must be able to periodically assess themselves as well as be able to collect data in the community that is relevant to their prevention projects. During the assessment process, coalitions will examine data around local needs, community resources and readiness. That means collecting data to define problems, identify resources, and examine community readiness to address needs. Coalitions should know where to go and who to ask for access to local data, and they should have the skills to collect, analyze and report on that data in a manner that takes into consideration the diversity of the community. In addition, coalitions will analyze their own current capacities for completing every step of the SPF. This information will prove invaluable later on when coalitions begin planning to enhance their own skills and abilities to engage in effective prevention planning.

**Step 2: Capacity.** The capacity of your coalition includes its membership and leadership, as well as a broad array of skills, abilities and organizational structures and functions:

- **Membership:** Everything that happens through a coalition occurs because people and organizations lend their time, energy, resources, enthusiasm, and expertise to a collective effort. The membership of the coalition serves 1) as a bridge for moving resources, information, and influence between the coalition and the community, and 2) as a team, that shares skills, abilities, resources, and time to accomplish together something that no one entity can achieve by working alone.

- **Leadership:** Leadership is an important key to the effectiveness of a coalition because leaders can both create a bridge to the community and simultaneously help in fashioning a cohesive team. Leadership roles are often spread among various members of the coalition. This allows members to contribute their skills and abilities to the common good and feel ownership in the work of the coalition. In addition, new members and partners must be recruited to continue strengthening the coalition by infusing it with new ideas, energy, and excitement.

- **Skills & Abilities:** In order to be successful, your coalition members must have the skills and abilities to engage effectively in every step of the SPF.
process in a manner that is culturally competent and helps to propel the coalition towards sustainable change.

- **Organizational Structure and Functioning:** Effective coalitions have developed policies and procedures to ensure a smooth operation of the coalition business. This process includes addressing practical issues such as by-laws, minutes, and job descriptions, as well as addressing decision-making, interpersonal relationships, and trust issues. Furthermore, coalitions must be able to demonstrate fiscal responsibility. That involves appropriate accounting procedures and financial reporting, as well as the ability to plan for and leverage the necessary resources to maintain the positive outcomes resulting from the coalition’s work.

- **Step 3: Planning.** Coalitions must plan effectively. This step involves developing a comprehensive strategic plan that includes the coalition’s vision and substance abuse prevention priorities. The plan will also include an analysis of contributing factors and root causes—including risk and protective factors—and the appropriate evidence-based policies, programs, and practices that have been selected to influence those factors. The prevention strategies implemented by coalitions must be **evidence-based**—that is, found to be effective through rigorous evaluation. Finally, it is important for coalitions to plan for evaluation before starting to implement prevention initiatives.

- **Step 4: Implementation.** Actually carrying out the strategic plan for substance abuse prevention is the coalition’s next step. That involves developing time-lines and action plans to implement selected prevention programs, policies and practices. And, it involves ensuring that those individuals selected to implement prevention strategies are well-trained.

- **Step 5: Evaluation.** Evaluation is the systematic collection and analysis of data in order to measure the impact of the SPF and implemented programs, policies, and practices. Good evaluation is the key to demonstrating your coalition’s success in achieving positive prevention outcomes. Evaluation should be a process that continues on a regular basis throughout the life of your project—that way you will always be informed about whether or not you are on the road to achieving your goals. It is best to examine both the process of implementing evidence-based prevention strategies, and the outcomes of those strategies. If you are not getting the results you hoped for, doing both kinds of evaluation will help you discover any flaws that might exist in the implementation of the project, or in its design.

- **Cross-Cutting Components: Cultural Competence and Sustainability.** Cultural competence and sustainability are at the center of the SPF model because these concepts must be addressed at every step of the process:
o **Cultural Competence**: Cultural competence is a set of congruent behaviors, attitudes and policies that come together within a system, agency or among professionals, and enables that system, agency or those professionals to work effectively in cross-cultural situations. In Nebraska, we believe that cultural competence goes hand in hand with inclusion. **Inclusion** is the right of all of Nebraska’s diverse populations to participate fully and equally in decision-making, policy development, and implementation of programs, policies and practices. Striving for cultural competence means that your coalition is working to have positive interactions in culturally diverse environments. Every community is composed of subgroups with unique and complex cultural needs—inclusion means that these diverse groups must be included in every facet of prevention planning. Coalitions made up of a cross section of community members bring diverse perspectives and expertise to the collaborative effort in order to address issues of concern. The coalition represents the connection these separate entities have around a common issue.

o **Sustainability**: Sustainability is the process of ensuring an adaptive and effective prevention system that achieves and maintains the human, social and material resources needed to achieve your coalition’s long-term goals. Sustainability requires creating an adaptable and effective community prevention system that is able to achieve and maintain positive outcomes over the long haul. That involves mobilizing the community and prevention system in order to build a strong coalition with the organizational capacity to leverage financial and non-financial resources to support the coalition’s work.

**The Strategic Prevention Framework State Incentive Grant**

In October of 2006, Nebraska was awarded the Strategic Prevention Framework State Incentive Grant (SPF SIG) from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention in the U. S. Department of Health and Human Services. The purpose of the SPF SIG project, nationally, is to reduce substance abuse at the state and local levels by implementing evidence-based policies, programs, and practices. The national goals developed by the Center for Substance Abuse Prevention are:

- Prevent the onset and reduce the progression of substance abuse, including underage drinking;
- Reduce substance abuse related problems in communities; and
- Build prevention capacities and infrastructure at the state/tribal and community levels.

The SPF is the planning model Nebraska communities will use to address the state’s SPF SIG substance abuse prevention priorities.
While the Strategic Prevention Framework State Incentive Grant is an important source of funds for Nebraska communities engaged in prevention planning, it is certainly not the only way that communities support this important work. We hope that this Toolkit will be used for any community working on substance abuse prevention, no matter where your support comes from. Indeed, it is the Strategic Prevention Framework planning model—not the State Incentive Grant dollars—that is the key to this Toolkit.

**Nebraska’s Strategic Prevention Framework Logic Model**

The SPF model is “outcomes oriented” because every step of the SPF is designed to lead ultimately to the positive changes we want to see in our communities in terms of improving overall health and well being by reducing use and the negative consequences of use. The SPF provides a logical sequence of steps that help communities to devise comprehensive substance abuse prevention plans to achieve desired outcomes. This logical sequence of steps is called a logic model.

A logic model is a visual outline for a project that maps out the logical links between desired outcomes and chosen strategies. In Nebraska’s SPF logic model (see Figure 2, below), prevention strategies influence root causes, which will in turn affect the contributing factors that are directly linked to alcohol use and abuse. And, of course, alcohol use and abuse results in a variety of health consequences that have a negative impact on our community populations.

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**Prevention Priorities**

At a meeting on October 31, 2007, Nebraska Partners in Prevention—the advisory council for the state’s Strategic Prevention Framework State Incentive Grant—decided that Nebraska’s SPF SIG will focus on the following three substance abuse prevention priorities:

- Prevent alcohol use among persons 17 and younger
- Reduce binge drinking among 18-25 year olds
- Reduce alcohol impaired driving across all age groups

Each SPF SIG funded community coalition must select one or more priorities on which to focus, and must justify that choice based on the assessment process.
Figure 2: Logic Model for Nebraska SPF SIG Prevention Priorities

- **Substance-Related Consequences**
  - Alcohol-related death and injury
  - Alcohol dependence and treatment
  - Unintended sexual activity
  - Crime and punishment
  - Poor academic and work performance

- **Substance Use and Related Behaviors***
  - Alcohol use among persons 17 and younger
  - Binge drinking among 18-25 year olds
  - Alcohol impaired driving across all age groups

- **Contributing Factors**
  - Easy retail access to alcohol
  - Easy social access to alcohol
  - Low enforcement of alcohol laws
  - Social norms accepting and/or encouraging of underage alcohol use, binge drinking, and impaired driving
  - Low perceived risk of alcohol use and impaired driving
  - Promotion of alcohol use (advertising, movies, music, etc.)
  - Low or discount pricing of alcohol

- **Root Causes***
  - High density; ID issues (use of fake IDs, failure to check IDs)
  - Friends and relatives provide alcohol to minors; alcohol availability at community events/celebrations
  - Shortage of law enforcement personnel, low priority among city leaders, few consequences for first-time offenders
  - Cultural acceptance (part of most community activities); parents/adults view alcohol use as a "rite of passage"
  - Low perceived risk of legal consequences/health consequences
  - Alcohol sponsorship at community events, signs/ads on billboards and storefronts
  - Drink specials (happy hour, ladies night); discounted price for buying in bulk, low alcohol tax

* Red shading indicates the three SPF SIG prevention priorities.

** These are the seven factors shown to contribute to alcohol use and related behaviors.

*** These are just a few examples of root causes but many more exist, some that may be more community specific. In addition, you should expect to identify more than one root cause per contributing factor.

Note: This model was adapted from the New Mexico SPF SIG logic model.
ASSESSMENT—AN OVERVIEW

This Toolkit focuses on Step 1: Assessment of the Strategic Prevention Framework. An assessment is a comprehensive description of your target community (however your coalition defines community). The assessment process is a systematic gathering and analysis of data about the community your coalition serves for the purpose of identifying and addressing local alcohol use and related problems.

Think about assessment as a way to get the "lay of the land" so that your coalition can target real problems specific to your community, capitalize on existing efforts, and fully understand existing coalition and community resources and capacities that will help you to successfully implement desired programs, policies and practices. The assessment process can, and should, be repeated regularly to ensure that your coalition is keeping up with changes in your community.

NOTE:

It is important to engage as many individuals from your coalition as possible in the assessment process. This will help to ensure maximum buy-in to the results of your assessment. In addition, greater inclusion will help to set the stage for a more culturally competent assessment process. Finally, the more inclusive you are during assessment, the better prepared you will be to be inclusive during the remaining steps of planning.

You might wonder why it is important to assess the substance abuse prevention needs and resources in your community, especially if you feel you already know what they are. Until you gather data—based on either factual information or observation—showing what is happening, where the problems occur, to whom, and why, the anecdotal evidence you have may be only one piece of a much larger picture. By going through the assessment process, you may find that the issues facing your community are somewhat different than you first thought. You may need to realign your planning effort in a completely new direction than you originally imagined. You may also identify new opportunities that you didn't know existed.

REMEMBER:

The SPF model is considered “evidence-based” because it requires every step in prevention planning to be supported by the collection and analysis of objective data.

Undertaking an assessment can provide many opportunities for the coalition and the community. A comprehensive assessment should:
• Create community consensus about alcohol, tobacco and other drug (ATOD) problems in the community;
• Identify underlying factors that contribute to those problems;
• Identify and analyze environmental, social, and individual factors that contribute to the problems;
• Increase the likelihood that your coalition will select and implement programs, policies and practices that actually will reduce ATOD problems in the community; and
• Establish baseline information to track the coalition’s progress.

Steps of Assessment

Nebraska has identified five steps in the assessment process:

I. Define Community  
II. Coalition Capacity Assessment  
III. Community Readiness Assessment  
IV. Needs Assessment  
V. Prevention Strategy Assessment

This Toolkit will provide you with information and tools to help you complete each component of your assessment. While only the Needs Assessment section will be formally submitted to the state as part of the SPF SIG assessment process, all five components of assessment are critical to your coalition’s development of a successful strategic plan for prevention.

NOTE: Your SPF SIG coalition coordinator will be provided with an electronic version of this Toolkit.

Normally an assessment is conducted at the beginning of a coalition’s development. But they can, and should, occur as an ongoing process—like a regular check up. Communities and coalitions are not static; they change and develop over time. Understanding how community strengths, needs, resources and make-up change and evolve is critical to coalition effectiveness. This can occur through regular (annual or biannual) assessments so that your coalition can be responsive to the community in a proactive and effective manner.
As you embark on the assessment process, it is critical to keep cultural competence in mind, and to remember to attend to cultural competence during every step of assessment. Communities include a diverse array of human beings with many unique and distinctive traits. In order to foster a genuine climate of equity, inclusion and mutual respect among a community’s diverse individuals and sub-groups, you must consider the extent to which your words and actions during the assessment process help you to work effectively in cross-cultural situations. (Depending on your community, “cross-cultural situations” may include those involving individuals of different ethnicity, race, age, physical and cognitive abilities, family status, sexual orientation, socioeconomic status, religious and spiritual values, and/or geographic location.)

Assessment Data Collection and Analysis

Throughout your assessment you are going to collect local data in order to learn more about the conditions that exist within your community, the capacity of your coalition and community to plan for and implement effective prevention strategies, as well as the nature and scope of local alcohol use and related problems. These data should correspond as closely as possible to the coalition’s geographic boundaries. Otherwise, it will be of limited value for assessment purposes. You will need to use both quantitative and qualitative data.

The State of Nebraska will be providing your coalition with a Community Data Document (CDD) that will include a considerable amount of state, regional and county-level data to assist you in the data collection process. However, you will have to supplement the information provided in the CDD. This Toolkit includes information and data collection instruments to assist you in collecting additional information to round out your assessment.

Quantitative and Qualitative Data

- **Quantitative Data**: Expressed in numerical terms, counted, or compared on a scale. These data help to answer the question “how many?” and can give your coalition perspective about the breadth of an issue, e.g., how many people are affected. When statistics are collected and analyzed about the percentage of people who smoke, binge drink or are arrested for drunk driving, those statistics are called quantitative data.

- **Qualitative Data**: Non-numerical data rich in detail and description. These data are usually presented in narrative form, such as information obtained from focus groups, key informant interviews and/or observational data collection. Qualitative methods are often used when no quantitative data are available. In addition, they can help make sense of quantitative/numerical data by exploring the question “what does it mean?” These data provide depth and texture about a situation.
Data Collection Methods

Assessments with the richest information use multiple sources for data collection. Those may include surveys, key informant interviews, focus groups, observational data collection, town hall meetings and mapping (a variety of data collection methods are summarized in Appendix A on p. 114). Be sure your data collection is culturally responsive and appropriate, e.g., consider whether questions might be seen as too personal or inappropriate. Consider appropriate translation and make sure that the interviewers or group facilitators reflect the composition of the interviewees or group(s).
I. DEFINE COMMUNITY

The first step in the assessment process is to define the community that your coalition represents. This description will include details about the area covered by your coalition, information about community demographics, including socio-economic indicators, as well as more general information about the overall community that will provide background and context (i.e., history, economics, politics, and prevention system).

NOTE:
If your coalition has been funded through the Nebraska SPF SIG, you should already have completed a definition of community when you developed your SPF SIG Request for Applications. However, you may find that you can enhance your definition of community by completing this section. Your community definition will be included as part of your overall strategic plan.

Coverage Area

For the purpose of the Nebraska SPF SIG, community will represent a place—a neighborhood, city, county, or tribal land. You should describe the geographical location and define the geographic boundaries of your community. Include information such as the lay of the land, whether it is urban or rural, any major highways that intersect or create boundaries, major rivers and lakes, borders with other states, distance to access resources, etc. If your coalition covers more than one county, your coalition must identify those counties and explain the differences between them in terms of infrastructure.

Demographics

Communities vary widely in terms of size of the population, ethnic/cultural characteristics, education, economic status, primary languages, and other factors that are essential as you work to set up coalition initiatives. Demographic data describe a place and the people living in it.

NOTE:
As mentioned earlier, the state will be providing a Community Data Document including some state, regional, and county-level demographic and socioeconomic data to assist you in the process of “defining community.”
Start with basic demographic information about your community. Collecting demographic data over at least two census periods (e.g., 1990 and 2000) provides a way to see emerging population trends. Between official census periods, you also may be able to get annual estimates of some local demographic information that may be calculated by state or local planning departments (e.g., population growth by age, gender, race/ethnicity, etc.).

Your Community Data Document will include the data listed below. If additional details are needed, they are available through the U.S. census:

- Total population;
- Gender;
- Racial/ethnic breakdowns;
- Age groups;
- Average household income, size, and poverty data (so that you can understand the economic status of the community and what resources may be available);
- Average educational level (to assess appropriate reading levels and message content for materials you develop); and
- Primary language to identify groups of non-English speaking residents and help determine the need to use alternate communication methods or media, such as newspapers or radio/television broadcasts in prevalent languages.

It is helpful to collect and compare the same data from communities of similar size from the same city, county, and/or state. Comparison data are useful to determine how serious a problem may be in your locale, but will not help you plan your coalition's response—only local data can do that.

**Community History**

Every community has a history of major events and forces that affect and help shape it. However, it is not uncommon for people in diverse ethnic or cultural groups to interpret the same event differently.

Being unaware of or insensitive to the community’s history can lead to a variety of problems. For example:

- Not accounting for key events that help explain current conditions can result in misinterpreting what those events really mean to community members.
- Misunderstanding the context of a situation can result in a loss of credibility for the coalition.
- Failing to build on the community’s past successes can result in duplication of efforts.
- Inappropriately claiming credit for progress attributable to other factors or historical trends can result in mistrust from the community.
Describe your community’s history of major events and forces that affect and help shape it.

**Economics**

Every community has economic factors that influence it’s growth and development. Describe major employers, tourist attractions, and trends, etc. about the community served by your coalition.

**Politics**

Every community has political factors that make the community unique. Describe how local decisions are made—this may be different from county to county and city to city. Describe the priorities of those in charge (i.e., mayors, city councils, village councils, etc.).

**Prevention System**

Describe the prevention system in your community (i.e., the coalitions, agencies and organizations that make up the infrastructure that supports prevention efforts, such as education, public health, behavioral health, health care, health services, treatment, law enforcement, courts). Describe how well these members of the prevention system function and work together. It is critical to identify the way that your community’s prevention system is organized, and who is involved, because it is upon this foundation that your coalition will be building as you move forward with developing and carrying out your comprehensive substance abuse prevention plan.
II. COALITION CAPACITY ASSESSMENT

The second step in the assessment process is to conduct a coalition capacity assessment. The coalition capacity assessment documents the internal capacities of your coalition by examining who participates, the skills and abilities of coalition members and leaders, as well as the ability of the group to function effectively as a team—that is, the coalition’s organizational capacity. All coalitions need to have the capacity to effectively engage partners, stakeholders, and the community, maintain high levels of commitment among their membership, and organize their work effectively. The capacity of your coalition affects how (and how effectively) it will go about every other aspect of its work. The effectiveness of your work depends upon developing an organizational structure that is strong enough and broad enough to bring about population-level change in your community.

Through your coalition capacity assessment you will examine whether your coalition has all the right people on board to help it function most effectively. You will examine the skills, abilities and resources both of members and leaders as well as the coalition’s organizational structures and functioning. Examining skills and abilities includes assessing your coalition’s capacity to engage in the comprehensive prevention planning required by the SPF process. That means analyzing the capacity of your coalition to engage in assessment, capacity building, planning, implementation, and evaluation, as well as assessing the coalition’s ability to successfully address issues around cultural competency and sustainability. Since all of these components are essential to the coalition’s ultimate goal of achieving long-term positive outcomes and community change, it’s critical to know the facts about your coalition’s capacities so that you can work to strengthen weaknesses as well as build on existing strengths.

There are two components to the coalition capacity assessment, (1) the coalition capacity survey and (2) the coalition membership registry. The following information provides details on how to complete each component.

Conducting the Coalition Capacity Survey

In order to assess the capacity of your coalition along the various dimensions mentioned above, the active members of your coalition will need to complete an online coalition capacity survey. All active members of your coalition are required to complete the survey. An active member is someone who has been involved in coalition activities (meetings, coalition activities, communication with the coalition coordinator and coalition members) on a regular basis during the past three to six months.

If your coalition is a SPF SIG grantee, your coalition coordinator will need to identify all coalition members who meet these criteria and ask them to complete the survey within the first month of receiving the SPF SIG grant award. Once all active members have completed the survey, the coalition coordinator will be able to download a summary of the results along with a supplemental guide to help you better understand and use your
results. You will use your analysis of coalition capacity later on in the SPF process, to develop a plan to enhance capacity.

Following the announcement of SPF SIG grant recipients, all coalition coordinators will be sent the internet link for the survey along with a set of instructions for how to login and complete it. This survey will be completed three times over the course of the SPF SIG grant—once at the inception of the grant award, after the second year of grant funding, and at the end of the grant funding period.

Creating and Updating the Coalition Membership Registry

To help your coalition maintain an updated list of active members as well as help the State SPF SIG Program maintain a list of active members across all coalitions, a SPF SIG membership registry has been established. This registry includes detailed information on each coalition member, including their contact information, the sector they represent, the position (if any) they hold within the coalition, how long they have been a member, and whether or not they are currently active members (i.e., have been involved in coalition activities during the previous six months).

This registry will need to be filled out by the coalition coordinator during the first month after your coalition receives the SPF SIG grant award. Following the announcement of SPF SIG grant recipients, all coalition coordinators will be sent the internet link for the registry along with a set of instructions for how to login and fill it out. The registry will need to be updated every six months (at the same time the bi-annual progress report is due). Once completed, the registry can be accessed by your coalition coordinator at any time to update information or download a list of all members.

Report Out

Once you have completed your coalition capacity assessment, it is time to review and summarize your findings and report out on the results to the coalition as a whole.
III. COMMUNITY READINESS ASSESSMENT

The next step is to assess your community’s level of readiness. By conducting a community readiness assessment, your coalition will discover the degree to which the overall community is prepared to plan for—and take action on—substance abuse prevention issues. Because community readiness is a process, the factors associated with community readiness can be assessed and enhanced. If you increase a community’s level of readiness to plan for and implement prevention strategies, you will improve the likelihood that the community’s prevention work will succeed.

The community readiness approach addresses developmental stages that a community has to work through in order to move itself forward to successfully achieve and maintain desired prevention outcomes. In 1995, researchers at the Tri-Ethnic Center for Prevention Research in Colorado found that as communities reached higher levels of readiness to plan for and take action on issues of importance, they were increasingly better able to achieve their desired prevention outcomes. Furthermore, they discovered that communities could implement strategies to move themselves to greater levels of readiness, and thereby increase their chance of achieving success.

Matching substance abuse prevention interventions to a community’s level of readiness is absolutely essential for success. Interventions must be challenging enough to help move a community forward in its level of readiness. However, efforts that are too ambitious are likely to fail because community members will not be ready or able to respond. To maximize chances for success, the community readiness model offers tools to measure readiness and to develop stage-appropriate methods for enhancing readiness.

The community readiness approach requires your community to:

1. Assess community readiness in order to determine its current stage of readiness;
2. Develop a plan and implement readiness strategies to move the community to higher levels of readiness; and
3. Design a community substance abuse prevention plan that uses prevention strategies that match the community’s current stage of readiness.

NOTE:
For the purposes of this Toolkit, we will be focusing exclusively on the assessment piece described in Step #1, above. Later on in the SPF planning process you will have the opportunity to design and implement approaches to increase your community’s readiness (CAPACITY step of the SPF), and to select prevention programs, policies and practices that are a good fit for your community’s current level of readiness (PLANNING step of the SPF).
Stages of Community Readiness

Movement toward each subsequent stage of readiness is not a sudden leap; it is a thoughtful progression. The nine levels of community readiness consist of the following stages:

1. **No Awareness**: At this stage, the issue is not generally recognized by community members or leaders as a problem. The community may unknowingly encourage the behavior, although the behavior may be expected of one group and not another (e.g., by sex, race, social class or age). The behavior, when occurring in the expected social context, is viewed as acceptable or as part of the community norm. “It’s just the way things are.”

2. **Denial / Resistance**: At this stage, there is usually some recognition by at least a few members of the community that the behavior is or can be a problem, but there is little recognition that it might be a local problem. If there is some idea that it is a local problem, there is a belief that nothing needs to be done about it locally, or that nothing can be done about it. The community climate tends to match the attitudes of leaders, and may be passive or guarded. “It’s not our problem.” “We can’t do anything about it.”

3. **Vague Awareness**: At this stage, there is a general belief by at least some community members that there is a local problem and that something ought to be done about it, but there is no immediate motivation to actually do anything. There may be stories or anecdotes about a problem, but ideas about why the problem occurs and who has the problem tend to be stereotyped and/or vague. No identifiable leadership exists, or leadership lacks energy or motivation for dealing with the problem. The community climate does not serve to motivate leaders.

4. **Pre-Planning**: At this stage, there is clear recognition on the part of at least some in the community that a local problem exists and that something should be done about it. There is general information about local problems, but ideas about risk factors tend to be stereotyped. There are identifiable leaders, and there may be a committee, but no real planning. There is discussion, but efforts are not focused or detailed. The community climate is beginning to acknowledge the necessity for dealing with the problem.

5. **Preparation**: At this stage, planning is going on and focuses on practical details. There is general information about local problems, and about the pros and cons of prevention strategies (programs, policies or practices), but it may not be based on formally collected data. Some strategies may have been implemented on a trial basis. Leadership is active and energetic. Resources (people, money, time, space, etc.) are being actively sought or have been committed. The community climate offers support for the efforts.
6. **Initiation**: At this stage, enough information is available to justify that prevention strategies (policies, programs, practices) are implemented, but knowledge of the underlying causes of the problem is likely to be stereotyped. A strategy has been started and is underway, but is still viewed as a new effort. Staff is in training or just finished with training. There may be great enthusiasm because limitations and problems have not yet been experienced. An improved attitude in community climate is reflected by the modest involvement of community members in the efforts.

7. **Stabilization**: At this stage, one or two strategies are underway, supported by community leaders, and accepted as stable, routine and valuable activities. Staff are generally trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is no in-depth evaluation of effectiveness, nor is there a sense that any recognized limitations suggest a need for change. There may be some form of routine tracking of prevalence. There is an established prevention planning process that moves forward the implementation plan. The community climate generally supports what is occurring.

8. **Confirmation / Expansion**: At this stage, there are standard strategies (policies, programs, practices) in operation in the community. These strategies are viewed as valuable, and community leaders support expanding or improving the prevention planning process. Original efforts have been evaluated and modified, and new efforts are being planned or tried out in order to reach more people (e.g., those thought to be more at risk or different demographic groups). Community members appear comfortable with the strategies being employed. Resources for new strategies are being committed. Data are being obtained regularly on the extent of local problems, and efforts are being made to assess the underlying causes of the problem. Due to increased knowledge and the desire for improved progress, the community climate may challenge specific efforts, but is fundamentally supportive.

9. **High Level of Community Ownership**: At this stage, there is detailed and sophisticated knowledge of the incidence, prevalence, and other factors (e.g. contributing factors or root causes) associated with the problem. Some strategies may be aimed at the general population, while others are targeted at specific contributing factors or at-risk groups. Highly trained staff are in charge of implementing initiatives. Community leaders are supportive and community involvement is high. Effective evaluation is used to test and modify strategies. Community members are fundamentally supportive, but continue to hold efforts accountable to meet community needs and achieve desired outcomes.

**Dimensions of Readiness**

Dimensions of readiness are key factors that influence your community’s preparedness to take action on an issue. These five dimensions are very comprehensive in nature. They are an excellent method for diagnosing your community’s needs and (later on) for developing strategies that meet those needs.
A. **Community Efforts**: To what extent are there efforts (e.g., programs, policies and practices) that address the issue?

B. **Community Knowledge of the Efforts**: To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

C. **Leadership**: To what extent are appointed leaders and influential community members supportive of addressing the issue?

D. **Community Climate**: What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?

E. **Community Knowledge about the Issue**: To what extent do community members know about the causes of the problem, consequences of the problem, and how it impacts your community?

Your community’s status with respect to each of the dimensions forms the basis of the overall level of community readiness. In addition, when it comes time to develop strategies to move your community’s readiness to the next levels, you will want to pay close attention to the scores for each individual dimension. These dimensions should be interpreted within the context of the culture of your specific community. For example, in an authoritarian culture (e.g., on a military base), leadership may be the most important dimension. Another example is a culture with powerful cultural leaders—in this case, any effort to change the readiness level of the dimension called “community climate” will likely have to start by involving those cultural leaders.

**How to Conduct a Community Readiness Assessment**

To perform a complete assessment, you will be asking individuals in your community—called key informants—to complete a survey that includes 36 questions. Each interview should take 30-60 minutes (NOTE: If you are interviewing a tribal elder, it is not appropriate to interrupt that person, even if he or she is getting off track from the subject at hand. Consequently, you should schedule more time for these interviews in order to account for this fact). The questions in the interview are all open-ended and issue or topic-specific. Each of the state’s three substance abuse prevention priorities is included in each of the interview questions.

After the interviews are completed, follow the directions for scoring using the instructions and scoring tools on pages 86 to 90. These scores will determine your community’s level of readiness for each of the five dimensions, as well as produce an overall score. Once you have completed your community readiness assessment, it is time to review and summarize your findings and report out on the results to the coalition as it is time to review and summarize your findings and report out on the results to the coalition as a whole.
**Key Informant Interviews:**

Key informant interviews are an important method for collecting qualitative data. These one-on-one interviews are conducted by a skilled interviewer who asks open-ended, probing questions of individuals who have particular knowledge or experience with the problems being assessed.

Key informant interviews can help inform your quantitative data. For example, you find that there is an increasing trend in DUI (Drinking Under the Influence) arrests and want to know whether it is due to increased enforcement or because more people who are driving under the influence are getting into car crashes. Interviewing someone from the local police department who can explain what is influencing the trend can help your coalition better understand what is happening and why, and thus make a more informed and strategic decision about its approach.

**Identifying and Interviewing Key Informants:**

Identify a minimum of four to six individuals in your community who are connected in some way to one or more of the state’s three substance abuse prevention priorities. In some cases it may be “politically advantageous” to interview more people. However, only four to six interviews are generally needed to accurately score the community. Try to find people who represent different segments of your community. Depending on the issue, individuals may represent:

- Schools/Universities
- City/county/tribal government
- Law enforcement
- Tribal elders
- Health & medical professions
- Social services
- Mental health & treatment services
- Clergy or spiritual community
- Business community
- Media
- Community at large
- Youth

You should select one or more individuals from your coalition to be the interviewer(s). (You may also consider using your local evaluator as an interviewer.) Be aware that some individuals—because of their role or position in the community—may cause interviewees to inflate their responses in order to impress that person. It would be best not to select people with that kind of influence to be interviewers. Then, you will contact the key informants you want to interview to see if they are willing to participate.
may conduct the interviews by telephone or face-to-face, using the Community Readiness Assessment Interview on p. 79. Use Appendix E, the Key Informant Interview Tip Sheet on p. 128 to help you prepare for, as well as effectively conduct the interviews.

**Report Out**

Once you have completed your community readiness assessment, it is time to review and summarize your findings and report out on the results to the coalition as a whole.
IV. NEEDS ASSESSMENT

The next step in the assessment process consists of completing the needs assessment. Your needs assessment will help you determine the nature and scope of alcohol misuse and related problems in your community so that you are in the best position to choose the issues on which your SPF strategic plan will focus. The needs assessment process is divided into three parts, Part 1: Selecting Prevention Priorities; Part 2: Assessing, Prioritizing, and Selecting Contributing Factors; and Part 3: Selecting Root Causes.

To complete the needs assessment, you will use epidemiological data (data that describe the distribution and determinants of death, disease, and injury in human populations) as well as the information you have already collected on your coalition’s capacity and your community’s readiness to address each of the three potential priorities. Throughout this process, you will be asked to interpret data on your community and region that was provided to your coalition by the state, obtain and interpret locally available data, and collect some qualitative data.

Community Data Document

To help you complete this assessment, the State SPF SIG Program has prepared a supplemental Community Data Document (CDD) that is specific to your community. This document contains most of the data necessary for completing this section. The data in this document has been analyzed and displayed in tables that allow you to (in most instances) compare your community to your behavioral health region and the state as a whole (see Appendix I on p. 143 for a map of Nebraska’s behavioral health regions). Throughout the needs assessment process you will be referred to specific tables within your CDD that will help you better understand and answer questions about data related to alcohol misuse and associated issues.

Data Sources in the CDD

Data from the following sources can be found in your CDD. In addition to the data itself, the CDD will provide you with more information on each source, including its strengths and weaknesses:

- **Alcohol Outlets (Source: Nebraska Liquor Control Commission):** Includes information on the number and types of alcohol outlets within the state, which is used to calculate alcohol outlet density rates.

- **Arrest Data (Source: Uniform Crime Reports, Nebraska Crime Commission):** Includes information on arrests made within Nebraska, including arrests for DUI and non-DUI liquor law violations.
• **Behavioral Risk Factor Surveillance System (BRFSS):** Telephone survey of Nebraska adults 18 and older that includes statewide and regional information on alcohol use, binge drinking, and impaired driving.

• **Motor Vehicle Crash Data (Source: Nebraska Department of Roads):** Includes information on fatal and non-fatal alcohol-related motor vehicle crashes that occur on Nebraska roadways.

• **National Survey on Drug Use and Health (NSDUH):** Face-to-face survey of persons 12 and older in Nebraska that includes information on alcohol use and binge drinking as well as perceptions of risk from binge drinking.

• **Nebraska Broadcasters Association (NBA) Survey:** Telephone survey of Nebraska adults 21-54 years old that includes statewide and regional information on attitudes toward alcohol use among youth and adults in their community.

• **Nebraska Risk and Protective Factor Student Survey (NRPFSS):** Paper and pencil survey of Nebraska students in 6th, 8th, 10th, and 12th grade that includes information on alcohol use, binge drinking, impaired driving, perceptions, and factors that have been shown to contribute to the misuse of alcohol (such as access). Note: Representative local data are available for many Nebraska communities.

• **Substance Abuse Treatment Data (Source: Magellan Database, Nebraska Division of Behavioral Health):** Includes information on alcohol and drug treatment admissions within Nebraska.

• **Trauma Data (Source: Nebraska Trauma Registry, Nebraska Division of Public Health):** Includes information on blood alcohol concentration at the time of admission into trauma centers.

• **Youth Risk Behavior Survey (YRBS):** Paper and pencil survey of 9th-12th grade public school students in Nebraska that includes information on alcohol use, binge drinking, and impaired driving. Note: Local data are not available.

**Additional Data Requirements**

To supplement the data available within your CDD, you will need to obtain and use local data as well as collect some new qualitative data to enrich the decision-making process. For instance, your community may have a local college or university survey asking students about alcohol use, or it may have data available on businesses, schools, healthcare, or law enforcement that is more detailed than what is available through state and regional surveillance systems. There will likely be some instances when no local data are available for a particular issue (such as the promotion of alcohol in your community) or when local data do not fully explain the issue (such as the enforcement of alcohol laws). As a result, you will need to collect some qualitative data to better understand these issues in your community. More detail is provided on the
types of qualitative data you will need—and methods for collecting it—later on in the needs assessment section.

**Completing the Needs Assessment**

Throughout the needs assessment you will be asked to interpret data within your CDD, utilize local data when available, and collect some new qualitative data. This information will be used to answer a series of questions designed to help you better understand issues related to alcohol misuse in your community. All questions and scoring tables located within the needs assessment must be answered or completed. You are required to enter your answers *directly into the electronic version of this document* or into the Supplemental Needs Assessment Reporting Tool. Type your answers directly into the gray boxes provided below each question—these boxes appear only in the electronic versions, and they will expand as you type.

**NOTE:**

Electronic versions of this Toolkit as well as the Supplemental Needs Assessment Reporting Tool will be made available to SPF SIG coalition coordinators.

Answer the questions in a way that is most helpful to your coalition decision making process—there is no restriction on how to answer the questions. Upon completion, submit the completed needs assessment section to the State SPF SIG Program. Completing this template is a critical step in the assessment process, and essential to the successful development of your community’s SPF SIG strategic plan.

As noted, throughout the needs assessment, you will be interpreting data from numerous sources and using it to answer a variety of questions. These questions ask you to explain what you have discovered about the consequences of alcohol misuse, alcohol use and related behaviors, as well as the contributing factors and root causes to alcohol misuse within your community. Prior to beginning, you may find it helpful to read through the data interpretation tips found within your CDD. These tips may help you better answer the questions and more accurately score your potential priorities and contributing factors.

**PART 1: Selecting Prevention Priorities**

The first step of the needs assessment is to select which of the three prevention priorities your coalition will address through its SPF strategic plan. Your coalition may select one or more of the following prevention priorities:

1. Prevent alcohol use among persons 17 and younger.
2. Reduce binge drinking among 18-25 year olds.
3. Reduce alcohol impaired driving across all age groups.
In order to select your prevention priorities, you must complete three steps to help you better understand the consequences of alcohol misuse within your community as well as patterns of alcohol use and related behaviors:

- **Step 1:** Profile consequences associated with the misuse of alcohol;
- **Step 2:** Profile alcohol use and related behaviors (including alcohol use, binge drinking, and impaired driving); and
- **Step 3:** Score and choose your community’s prevention priority or priorities.

To complete these steps, you will need to obtain and interpret epidemiological data to answer a series of questions about indicators (or measures) related to each priority. Then, you will have to work collaboratively as a coalition to score and then choose the prevention priorities that will drive your SPF strategic plan.

After completing the profile of alcohol use and associated consequences, you will need to meet as a coalition to score and select your prevention priorities. The intent of this process is to lead you to the priorities that need to be addressed in your community and that your coalition has a high probability of being able to change as a result of your prevention efforts.

**Data Collection Methods, Requirements and Sources**

As noted, most of the data used to complete this section are available within your CDD, including (in many instances) community data along with regional and state level data for comparison. In addition, while not a requirement, we encourage you to obtain and use local surveys or other local data as sources of information to supplement the decision-making process by providing more information on alcohol use, impaired driving, and alcohol-related consequences.

**Step 1 of Selecting Prevention Priorities: Profile Consequences of Alcohol Misuse**

The first step in selecting your prevention priorities is to examine data about the consequences of alcohol misuse in order to help you identify which of these negative outcomes exist in your community. Alcohol-related consequences are defined as the social, economic, and health problems associated with the use of alcohol, such as crime, car crashes, dependence, and hospitalizations. Not all communities experience exactly the same problems and not all age groups will be equally affected. This step will help you to know exactly what is happening in your community.

To complete this step, you will be asked to look at the following types of data:

- Alcohol-related arrests;
- Alcohol-related motor vehicle crashes;
- Substance abuse treatment admissions;
• Trauma center admissions involving alcohol; and
• Other locally attainable data related to the consequences of alcohol misuse.

For each of the five types of data listed above, you will be asked to look in your CDD and among local data sources for pertinent information. You will be asked to describe any local data that you collect, and you will be required to answer questions about your findings. Information about the local data you collect as well as your answers to specific questions should be entered below each question—and into the gray boxes provided, if you are using an electronic version of this Toolkit.

Alcohol-Related Arrests

One of the major consequences of drinking alcohol is alcohol-related crime. For community specific data on driving under the influence (DUI) arrests and arrests for non-DUI liquor law violations (such as minor in possession and providing/selling alcohol to a minor) refer to Section 1 in your CDD. These tables provide information on the number of arrests, the proportion of arrests that resulted from alcohol related crimes, and the arrest rates for your community compared to your behavioral health region and the state as a whole.

If you have access to other local data on alcohol-related crime in your community (such as community crime statistics on specific violations, e.g., minor in possession) please describe them below (use one paragraph or less per data source), and consider that information prior to answering Question 1.

Describe Other Local Data on Alcohol-Related Crime: (type information into the gray box, below, if applicable)

Question 1.
Based on Section 1 of your CDD and other local data, how do DUI and non-DUI liquor law violation arrests in your community compare to the rest of the state? If differences exist, discuss possible reasons why. Which age groups are most likely to be arrested in your community?

Answer to Question 1: (type into the gray box, below)

Alcohol-Related Motor Vehicle Crashes

Another major consequence of drinking is motor vehicle crashes that result from alcohol impaired driving. For community specific data on fatal and non-fatal alcohol-involved crashes refer to Section 2 in your CDD. These tables provide information on the number of crashes, the proportion of crashes that involved alcohol, and alcohol-related crash rates in your community compared to your behavioral health region and the state.
Question 2.
Based on Section 2 of your CDD, how do alcohol-involved motor vehicle crashes in your community compare to the rest of the state? If differences exist, discuss possible reasons why. Which age groups are most likely to be killed or injured in alcohol-involved crashes in your community?

Answer to Question 2: (type into the gray box, below)

Substance Abuse Treatment Admissions

One of the risks associated with drinking alcohol is becoming alcohol dependent or engaging in a regular pattern of alcohol abuse. Individuals who become alcohol dependent or regularly abuse alcohol may attend a substance abuse treatment program, either voluntarily, by court order, or by pressure from family and friends. For community specific data on all substance abuse treatment admissions and those that involved alcohol abuse, refer to Section 3 in your CDD. These tables provide information on the number of admissions and the proportion of admissions that involved alcohol abuse in your community compared to your behavioral health region and the state as a whole.

If you have access to further data on substance abuse treatment in your community (such as treatment centers that do not report into the state system) please describe that information, below (use one paragraph or less per data source), and consider that information before answering Question 3.

Describe Other Local Data on Substance Abuse Treatment Admissions: (type information into the gray box, below, if applicable)

Question 3.
Based on Section 3 of your CDD and other local data, how do treatment admissions involving alcohol in your community compare to the rest of the state? If differences exist, discuss possible reasons why. Which age groups are most likely to receive treatment for alcohol abuse/dependence in your community?

Answer to Question 3: (type into the gray box, below)

Trauma Center Admissions Involving Alcohol

Another major consequence of drinking is the risk of health problems and injuries resulting from alcohol consumption. These health problems and injuries sometimes
require emergency medical care through a trauma center. Most, but not all trauma centers in Nebraska have patient data available for analysis through the Nebraska Trauma Registry. Further detail on the Trauma Registry and its limitations can be found in your CDD.

Patients receiving care at these participating trauma centers are tested (at the discretion of each center) for alcohol at the time of admission. As a result, information is available on the blood alcohol concentration (BAC) of patients at the time of admission for those patients who receive inpatient care. For community specific data on alcohol-involved trauma center admissions refer to Section 4 in your CDD. These tables provide information on the number of alcohol-involved admissions and the proportion of admissions that involved alcohol among residents of your community.

**Question 4.**
Based on Section 4 of your CDD, how do alcohol-involved trauma center admissions affect residents in your community and how does this compare to patient data from all participating centers? If differences exist, discuss possible reasons why. Which age groups in your community are most likely to have alcohol in their system at admission?

**Answer to Question 4:** (type into the gray box, below)

**Other Local Data on the Consequences of Alcohol Misuse**

In addition to those described above, feel free to use other local data that will help you better understand the consequences associated with alcohol misuse in your community. For example, you may have additional data on alcohol involved fatalities or injuries, alcohol-related suspensions or expulsions from local schools, or alcohol-related consequences that may have occurred among college or university students in your community. If you have other local data, briefly describe the results below (use one paragraph or less per data source).

**Describe Other Local Data on the Consequences of Alcohol Misuse:** (type information into the gray box, below, if applicable)

**Step 2 of Selecting Prevention Priorities:**
**Profile Alcohol Use and Related Behaviors**

The next step in selecting your prevention priorities is to look at current alcohol use, binge drinking, and alcohol impaired driving in your community. To complete this step, you will examine each of the above indicators using numerous data sources, including:

- Nebraska Risk and Protective Factor Student Survey (NRPFSS);
- Youth Risk Behavior Survey (YRBS);
• Behavioral Risk Factor Surveillance System (BRFSS);
• Other locally attainable data related to alcohol use and impaired driving.

The next three sections tell you where to look in your CDD and among local data sources for information related to current alcohol use, binge drinking, and alcohol impaired driving in your community, and require you to answer questions about that information.

Current Alcohol Use

Current alcohol use refers to the self-reported consumption of alcohol during the previous 30 days. Since each survey asks slightly different questions, the way each survey defines 30-day use is provided below:

• **NRPFSS**: Percentage of students in 6th, 8th, 10th, and 12th grade who report having beer, wine, or hard liquor to drink during the 30 days preceding the survey.

• **YRBS**: Percentage of students in grades 9-12 who report having at least one drink of alcohol on one or more of the 30 days preceding the survey.

• **BRFSS**: Percentage of adults 18 and older who report having at least one alcoholic beverage during the 30 days preceding the survey.

For community specific data on current alcohol use, refer to Section 5 in your CDD. These tables provide information on the percentage of residents in your community and/or region who are current alcohol users.

If you have access to additional data on current alcohol use in your community (such as a college alcohol survey, another student based survey, or a survey of employees at local worksites) please describe them below (use one paragraph or less per data source) and consider those data before answering Question 5.

**Describe Other Local Data on Current Alcohol Use**: (type information in the gray box below, if applicable)

**Question 5.**
Based on Section 5 of your CDD and other local data, how does current alcohol use in your community compare to the rest of the state? Which age groups are most likely to consume alcohol?

**Answer to Question 5**: (type into the gray box, below)
Binge Drinking

For this assessment, **binge drinking** is defined as the consumption of five or more drinks of alcohol on one occasion. Each of the three data sources used for this assessment (NRPFSS, YRBS, and BRFSS) asks about binge drinking in the past month, or the 30 days preceding the survey. By definition, according to the National Institute for Alcohol Abuse and Alcoholism (NIAAA), binge drinking is a pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 gram percent or above. For the typical adult, this pattern corresponds to consuming five or more drinks for males or four or more drinks for females in about two hours.

Since each survey asks slightly different questions, the way each survey defines binge drinking is provided below:

- **NRPFSS**: Percentage of students in 6th, 8th, 10th, and 12th grade who report having five or more alcoholic drinks in a row during the 30 days preceding the survey.

- **YRBS**: Percentage of students in grades 9-12 who report having five or more drinks of alcohol in a row on one or more of the 30 days preceding the survey.

- **BRFSS**: Percentage of adults 18 and older who report having five or more drinks on at least one occasion during the 30 days preceding the survey. Note: Modifications were made to the 2006 and 2007 BRFSS data to allow for analysis using the five drink definition for both genders.

For community specific data on binge drinking, refer to Section 6 in your CDD. These tables provide information on the percentage of residents in your community and/or region who are binge drinkers.

If you have access to additional data on binge drinking in your community (such as a college alcohol survey, another student based survey, or a survey of employees at local worksites) please describe those data below (use one paragraph or less per data source), and consider those data before answering Question 6.

**Describe Other Local Data on Binge Drinking:** (type information into the gray box, below, if applicable)

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**Question 6.**

Based on Section 6 of your CDD and other local data, how does binge drinking in your community compare to the rest of the state? Which age groups are most likely to binge drink?
Answer to Question 6: (type into the gray box, below)

Alcohol Impaired Driving

Alcohol impaired driving indicators vary quite dramatically from one data source to another. As a result, you should avoid making direct comparisons between data sources and should take into account the indicator definition when observing alcohol impaired driving across different age groups. Since each data source asks different questions on alcohol impaired driving, the indicator definitions are provided below:

- **NRPFSS**: Percentage of students in 6th, 8th, 10th, and 12th grade who report driving a car, truck, or motorcycle after drinking alcohol during the one year preceding the survey.
- **YRBS**: Percentage of students who drove a car or other vehicle one or more times when they had been drinking alcohol during the 30 days preceding the survey.
- **BRFSS**: Percentage of adults 18 and older who report driving after having had perhaps too much to drink during the 30 days preceding the survey.

For community specific data on alcohol impaired driving refer to Section 7 in your CDD. These tables provide information on the percentage of residents in your community and/or region who drive under the influence of alcohol.

If you have access to additional local data on alcohol impaired driving in your community (such as a college alcohol survey, another student based survey, or a survey of employees at local worksites) please describe those data below (use one paragraph or less per data source), and consider before answering Question 7.

Describe Other Local Data on Alcohol Impaired Driving: (type information into gray box, below, if applicable)

**Question 7.**
Based on Section 7 of your CDD and other local data, how does alcohol impaired driving in your community compare to the rest of the state? Which age groups are most likely to drive under the influence of alcohol?

Answer to Question 7: (type into the gray box, below)
Step 3 of Selecting Prevention Priorities:
Score and Choose Prevention Priorities

The final step in selecting prevention priorities is to score each of the three potential priorities across three criteria (described below), and ultimately to choose the one or more priorities that your community will address through its SPF SIG strategic plan. The three criteria that will be applied to each potential priority are:

1. **Prevalence**: Incorporates the number of persons involved, comparison with the State of Nebraska, and historical trends (trends are optional).

2. **Economic/Social Impact**: Reflects how the consequences of alcohol misuse impact your community, including productivity within school and the workforce, the health of the population, crime and punishment, and treatment of alcohol dependence and abuse.

3. **Community Capacity**: Encompasses your analysis of coalition capacity and community readiness.

Each of these three criteria will have an equal weight in the overall score for each potential priority (with each criterion accounting for one-third of the overall score). It is conceivable that a sub-group of coalition members could score the prevalence criterion. However, it is extremely important that all coalition members meet to discuss and score the criteria related to economic/social impact and capacity for each of the three potential priorities. Once the scoring is complete, the entire coalition should also have input into the final selection of the priority or priorities that will be addressed through the SPF SIG strategic plan. Remember the principle that “people support what they help create.” By involving all coalition members in the scoring and selection process, you will help to ensure that everyone has bought into the ultimate goals of your community’s strategic plan for prevention.

### Prevalence

The first criterion, prevalence, consists of three components, with “trends” being optional:

- **Number of persons involved**: Answers the question, “What percentage of the population is engaging in this behavior?”

- **Comparison with the State of Nebraska**: Answers the question, “How does our community/region compare with the state as a whole?”

- **Historical trends (optional)**: Answers the question, “Is the problem getting better, worse, or remaining stable?” (Note: This component is optional because trend data are not provided to you as part of your CDD. However, your coalition may have access to trend data from local sources and should consider these results when scoring each potential priority.)
To begin Step 3, look back at your answers to Questions 5-7 as well as other local data that you utilized as part of Step 2.

**Questions 8-10.**
Using the above components (number of persons involved, comparison with the State of Nebraska, and historical trends), score the “prevalence” of each potential priority within your community on a scale from zero to 10, where zero represents a low prevalence and 10 represents a high prevalence. (Place an “x” in the gray box next to a number from 0 to 10.)

**Question 8:** Alcohol use among persons 17 and younger

<table>
<thead>
<tr>
<th>Low prevalence</th>
<th>High prevalence</th>
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<tr>
<td>0      1       2       3       4       5       6       7       8       9       10</td>
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**Question 9:** Binge drinking among 18-25 year olds

<table>
<thead>
<tr>
<th>Low prevalence</th>
<th>High prevalence</th>
</tr>
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<tbody>
<tr>
<td>0      1       2       3       4       5       6       7       8       9       10</td>
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</table>

**Question 10:** Alcohol impaired driving across all age groups

<table>
<thead>
<tr>
<th>Low prevalence</th>
<th>High prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>0      1       2       3       4       5       6       7       8       9       10</td>
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</tbody>
</table>

**Question 11.**
Now that you have scored the “prevalence” of each potential priority, briefly describe how you reached the scores you did. What components (number of people, comparisons, and trends) were more and less of a factor in the scoring? Do you see the potential priorities being similar at this point, or do you see one or two standing out from the rest?

**Answer to Question 11:** (type into the gray box, below)

**Economic/Social Impact**

The second criterion is economic/social impact. To begin analyzing this criterion, look back at your answers to Questions 1-4 as well as other local data that you utilized as part of Step 1. As a coalition, discuss these findings as well as other data including anecdotal evidence (information passed along by word-of-mouth but not documented scientifically) related to the economic/social impact of each potential priority in your community.
Questions 12-14.

As a coalition, score the “economic/social impact” of each potential priority within your community on a scale from zero to 10, where zero represents a low economic/social impact and 10 represents a high economic/social impact. (Place an “x” in the gray box next to a number from 0 to 10.)

**Question 12:** Alcohol use among persons 17 and younger

<table>
<thead>
<tr>
<th>Low economic/social impact</th>
<th>High economic/social impact</th>
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</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
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</tbody>
</table>

**Question 13:** Binge drinking among 18-25 year olds

<table>
<thead>
<tr>
<th>Low economic/social impact</th>
<th>High economic/social impact</th>
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<tbody>
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<td>0 1 2 3 4 5 6 7 8 9 10</td>
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</tbody>
</table>

**Question 14:** Alcohol impaired driving across all age groups

<table>
<thead>
<tr>
<th>Low economic/social impact</th>
<th>High economic/social impact</th>
</tr>
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<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
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</table>

**Question 15.**

Now that you have scored the “economic/social impact” of each potential priority, briefly describe how you reached the scores you did. What statistics or factors were more and less important when scoring? Were most coalition members in agreement with these scores?

**Answer to Question 15:** (type into the gray box, below)

**Community Capacity**

The third criterion is community capacity. To begin analyzing this criterion, look back at your coalition capacity and community readiness assessment results. In instances where differences may exist between the two assessments, such as high coalition capacity and low community readiness to address a particular priority, you will have to decide as a coalition how to choose a value that takes into account the information from both assessments.
Questions 16-18.
As a coalition, score the “capacity” of each potential priority within your community on a scale from zero to 10, where zero represents a low capacity and 10 represents a high capacity. (Place an “x” in the gray box next to a number from 0 to 10.)

Question 16: Alcohol use among persons 17 and younger

<table>
<thead>
<tr>
<th>Low capacity</th>
<th>High capacity</th>
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</thead>
<tbody>
<tr>
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<td>1</td>
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<tr>
<td>1</td>
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</tbody>
</table>

Question 17: Binge drinking among 18-25 year olds

<table>
<thead>
<tr>
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<th>High capacity</th>
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</tbody>
</table>

Question 18: Alcohol impaired driving across all age groups

<table>
<thead>
<tr>
<th>Low capacity</th>
<th>High capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
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<tr>
<td>1</td>
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<td>10</td>
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</tbody>
</table>

Question 19.
Now that you have scored the community “capacity” of each potential priority, briefly describe how you reached the scores you did. What factors were more and less important when scoring? Did you weigh the coalition capacity and community readiness assessments equally, or did you give more weight to one of the assessments? Were most coalition members in agreement with these scores?

Answer to Question 19: (type into the gray box, below)

Final Priority Selection

Finally, you’re at the point of selecting the prevention priority or priorities that your coalition will address through your SPF SIG strategic plan. In order to accomplish this task, you will use the table below, titled Rank Prevention Priorities. First, you must place the three scores for each criterion into the appropriate boxes in the table. Once the prevalence, economic/social impact, and capacity scores are entered for each possible prevention priority, add them together to calculate an overall score for each priority (out of a possible 30). Then rank the three priorities from 1 to 3, with 1 having the highest score (meaning it’s the most important priority) and 3 having the lowest score. In the case of a tie, decide which priority is of more importance for your community. After completing the ranking, justify your selection in your answer to Question 20. Please note that as a coalition you are free to choose one, two, or all three of the possible prevention priorities; however, you must justify why you have chosen your priorities.
INSTRUCTIONS: Place the scores for Questions 8-10, 12-14 and 16-18 into the appropriate gray boxes within the table below; add the scores for Questions 8, 12 and 16 to generate an Overall Score for the first priority; add the scores for Questions 9, 13 and 17 to generate and Overall Score for the second priority; add the scores for Questions 10, 14 and 18 to generate an Overall Score for the third priority. Then, rank each priority on a scale from 1 to 3, with 1 as the highest score (greatest importance), and place those ranks in the appropriate gray boxes.

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Economic/Social Impact</th>
<th>Capacity</th>
<th>Overall Score</th>
<th>Rank</th>
<th>Possible Prevention Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8</td>
<td>Q12</td>
<td>Q16</td>
<td></td>
<td></td>
<td>Prevent alcohol use among persons 17 and younger</td>
</tr>
<tr>
<td>Q9</td>
<td>Q13</td>
<td>Q17</td>
<td></td>
<td></td>
<td>Reduce binge drinking among 18-25 year olds</td>
</tr>
<tr>
<td>Q10</td>
<td>Q14</td>
<td>Q18</td>
<td></td>
<td></td>
<td>Reduce alcohol impaired driving across all age groups</td>
</tr>
</tbody>
</table>

Question 20.
What prevention priority or priorities is your community going to address through the SPF SIG and why?

Answer to Question 20: (type into the gray box, below)

Part 2: Assessing, Prioritizing, and Selecting Contributing Factors

Now that you have chosen your prevention priorities, you are ready to embark on the next step of the needs assessment—determining which factors in your community are contributing most to the priority or priorities you have just chosen.

Within this section, you will be completing an assessment across seven factors that contribute to the misuse of alcohol, referred to as contributing factors. Through this assessment, you will determine which of these factors contributes most to the priorities you have chosen to focus on within your community. This process is particularly important to the overall planning process since the factors you identify in this section will eventually be addressed in your community through evidence-based strategies.
The seven contributing factors are:

1. Easy retail access to alcohol;
2. Easy social access to alcohol;
3. Low enforcement of alcohol laws (underage drinking and impaired driving);
4. Social norms accepting/encouraging of underage alcohol use, binge drinking, and impaired driving;
5. Low perceived risk of alcohol use and impaired driving;
6. Promotion of alcohol use (advertising, movies, music, etc.); and
7. Low or discount pricing of alcohol.

Underlying each of the contributing factors is a set of root causes. The root causes are the actual conditions that a prevention strategy will directly try to affect through evidence-based approaches. Examples of root causes are listed under each of the seven contributing factors discussed throughout the remainder of this section, and are consolidated in one place in Appendix C on p. 119. While these examples include some of the more common root causes, there may be community specific root causes, not identified in this document, that warrant attention.

In addition to assessing each of the contributing factors in your community, you may choose—though it’s not required—to analyze community risk and protective factors and/or developmental assets that relate to substance abuse. For youth, these data are available from the Nebraska Risk and Protective Factor Student Survey or other school specific assessments, such as the 40 Developmental Assets. Knowing this information can help identify individual and community factors (beyond the seven described above) that are contributing to the misuse of alcohol in your community. Again, while the risk and protective factor assessment is optional and is not a required component of your community plan, we encourage you to include it as it is likely to provide important information that will strengthen your planning process.

Completing the Contributing Factor Assessment

This section will take you through a step-by-step process to better understand each of the seven contributing factors (and eventually their underlying root causes) for the prevention priorities you have chosen to address. Similar to the selection of your prevention priorities, much of the data necessary for completing this section has already been analyzed and is available for you to use through your CDD. Throughout this section you will be referred to specific data tables within your CDD that will help you better understand and answer questions specific to contributing factors. In addition, you are required to collect some new data that is described below in further detail.
After assessing each contributing factor, you will need to determine the degree to which it impacts your prevention priorities by choosing a number ranging from zero to 10. Before you select an impact score for each contributing factor, it is important to discuss the assessment results with your coalition members and collectively choose an impact score that best represents the feelings of all members. In addition, your coalition will need to score each contributing factor on how changeable you believe it is in your community.

### Impact & Changeability

- **Impact:** The degree to which you believe making changes to the contributing factor will result, in turn, in measurable changes to your prevention priorities.

- **Changeability:** The degree to which you believe your coalition’s work can measurably influence the contributing factor. You should consider issues such as your community’s readiness to address the contributing factor (e.g., political will, attitudes among residents, etc.) as well as the resources currently available to address it in your community.

Once your coalition has scored the **impact** and **changeability** of each contributing factor, you will need to record these scores in a table, calculate an overall score for each factor, and rank them. The overall scores for each contributing factor should lead you to prioritize and select those factors that most need to be addressed in your community and that have the highest likelihood of changing under the influence of your coalition’s prevention plan. Once you have determined the contributing factors that you will address in your community, your coalition will need to select the root causes that you believe are the most important issues underlying those contributing factors.

### Contributing Factor Data Collection Methods and Requirements

#### Collection of Existing Data

As noted, most of the data used to complete the contributing factor assessment are available within your CDD, including (in many instances) community data along with regional and state level data for comparison. In addition, while not a requirement, we encourage you to obtain and use local surveys or other local data as sources of information to enrich the decision-making process by providing more information on contributing factors and root causes for alcohol misuse in your community.

#### Collection of New Data

In order to accurately assess the seven contributing factors in your community, in addition to examining data from your CDD, you will be required to collect a variety of **qualitative data.** As described in the Overview of this Toolkit, qualitative data are non-numerical data rich in detail and description. These data are usually presented in
narrative form, and are collected through methods such as town hall meetings, observational data collection, information obtained from key informant interviews, and focus groups. Qualitative methods are often used when no quantitative data are available. In addition, they can help make sense of quantitative (numerical) data by exploring the question “what does it mean?” These data provide depth and texture about a situation.

Required qualitative data collection methods for coalitions funded through Nebraska’s SPF SIG are described below.

- **Town Hall Meetings:** A minimum of one town hall meeting is required for a single county applicant or tribe, and two for a multi-county applicant. The goal is to gather a wide variety of community views regarding contributing factors that may be influencing the prevention priorities you have chosen to address in your community. A sample protocol for this meeting can be found in Appendix D on p. 122.

  **NOTE:**
  
  If you recently completed or are schedule to host a SAMHSA funded town hall meeting in your community, it can be substituted in place of this town hall meeting. However, even if you completed a SAMHSA funded town hall meeting, you are encouraged to conduct additional town hall meeting(s) to collect information that will help you with your SPF SIG assessment and planning process.)

- **Observational and Library Research:** Newspapers, billboards, bars/restaurants, and stores/retail outlets must be observed or analyzed to help understand the promotion and pricing of alcohol in your community. The goal is to help you better understand contributing factors within your community using locally attainable and readily available sources of information. These methods of data collection are described in further detail later in this section.

- **Law Enforcement Interviews:** A minimum of two key informant interviews with law enforcement personnel is required. The goal is to conduct interviews that would be most appropriate and informative for your community. This may consist of a representative from the local police department and county sheriff’s office within a single county, or it may consist of an officer from each of the two or three counties that your coalition represents. You may also want to consider interviews with persons working in your local judicial system, emergency rooms, schools, and treatment facilities. A sample protocol for the law enforcement interviews can be found in Appendix F on p.130.
• **Focus Groups:** These are encouraged but *not required.* You may find it helpful to conduct one or more focus groups of persons in your target population. For example, you may want to conduct a focus group of high school students if you chose underage drinking as a priority, college students or other young adults if you chose binge drinking as a priority, or persons of any appropriate age if you chose alcohol impaired driving as a priority. A sample protocol for collecting focus group data from youth and young adults can be found in Appendix G on p. 135.

NOTE:

If you chose alcohol impaired driving as a priority and want to conduct a focus group with an age group other than youth, you should work with your local evaluator and State SPF SIG Program staff to develop focus group questions that will fit your needs.

**Access**

The first contributing factor you will examine is **access.** In general, access refers to the degree to which alcohol is available to individuals in the community, and how easy it is to obtain. There are two types of access that have been shown to contribute to the misuse of alcohol—retail access and social access. **Retail access** refers to how available alcohol is through retail outlets in your community, and how easy it is to obtain by purchasing. In contrast, **social access** includes the relative ease of obtaining alcohol from friends, associates, and family members, as well as the availability of alcohol-related gatherings such as parties and other social events where alcohol is accessible as part of the event.

Some of the possible root causes of retail and social access are included in Table 1 and Table 2 below:

<table>
<thead>
<tr>
<th>Table 1: Examples of Root Causes for Easy Retail Access</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category</strong></td>
</tr>
<tr>
<td>ID issues</td>
</tr>
<tr>
<td>Compliance with laws/regulations</td>
</tr>
<tr>
<td>Density</td>
</tr>
<tr>
<td>Employees</td>
</tr>
<tr>
<td>Product placement</td>
</tr>
</tbody>
</table>
Table 2: Examples of Root Causes for Easy Social Access

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of alcohol to minors</td>
<td>Parents, older siblings, and other relatives provide alcohol to or purchase alcohol for underage persons; legal age friends and acquaintances provide alcohol to or purchase alcohol for underage persons; strangers purchase alcohol for underage persons when asked</td>
</tr>
<tr>
<td>Adults unaware of penalties for providing alcohol to minors</td>
<td>Adults do not know that they can be arrested and jailed for providing alcohol to a minor</td>
</tr>
<tr>
<td>Community celebrations</td>
<td>Alcohol is obtained by underage person at community celebrations where there is little supervision; binge drinking is often acceptable</td>
</tr>
<tr>
<td>Availability of unsupervised drinking locations</td>
<td>Numerous party settings that are unsupervised (vacant lots/buildings, parks, fields); friends with their own apartments</td>
</tr>
<tr>
<td>Lack of parental monitoring of alcohol supply in the home</td>
<td>Take or steal alcohol from parents' home</td>
</tr>
<tr>
<td>Workplace promotion</td>
<td>Workplaces promote drinking as part of the culture (company parties, company sponsored events)</td>
</tr>
<tr>
<td>Parents providing a location for underage drinking</td>
<td>Parents think it is safer for youth to drink in their homes (so they are not driving around), so they provide them a location to consume.</td>
</tr>
</tbody>
</table>

While it is important to understand each type of access independently, and how each contributes to alcohol misuse in your community, we chose to merge retail and social access together into one 'access' section to better streamline the contributing factor assessment process. However, at the end of this section you will be asked to score retail and social access independently.

To better understand access in your community, you will be asked to look at the following types of data:

- Alcohol outlet density (including per capita liquor licenses);
- Sales of alcohol to minors (captured through local compliance checks);
- Self-reported data on how alcohol is obtained and where it is consumed among youth;
- Youth perceptions about alcohol availability in their community;
- Self-reported adult attitudes and behaviors related to the provision of alcohol to minors; and
- Qualitative data collected through key informant interviews, town hall meetings, and/or focus groups.
Alcohol Outlet Density (Per Capita Liquor Licenses)

One of the most fundamental ways to understand retail access is the number of opportunities people have to buy alcohol. For community specific data, refer to Section 8 in your CDD. This table provides information on the number of liquor licenses issued in your community compared to your behavioral health region and the state as a whole. Data are based on the rate of retail liquor outlets per 100,000 population aged 21 and older. This table includes all liquor license types except special designated (event) licenses. The included license types are: beer on sale only; beer off sale only; beer, wine, liquor on and off sale; beer, wine, liquor off sale only; beer, wine, liquor on sale only; brew pub; farm winery; and micro distillery.

Question 21.
Based on Section 8 of your CDD, how does the alcohol outlet density rate in your community compare to the rest of the state? If differences exist, discuss possible reasons why.

Answer to Question 21: (type into the gray box, below)

Sale of Alcohol to Minors (Failed Compliance Checks)

The selling of alcohol to minors can contribute to the misuse of alcohol in your community. One measure of this is the failure of compliance checks by retail outlets. To better understand this, work with your local law enforcement, the State Patrol, and other prevention stakeholders to obtain whatever data are available for alcohol compliance checks conducted in your community. If possible, try and obtain the total number of checks along with the number of failed checks so that you can calculate a compliance check failure rate (or the percentage of all checks that failed).

If you were able to obtain local data on compliance checks for the sales of alcohol to minors please describe that data below (use one paragraph or less per data source), and consider that data before answering Question 22.

Describe Local Data on Sale of Alcohol to Minors (Failed Compliance Checks): (type information into the gray box below, if applicable)

Question 22.
If local data were obtained, describe the sale of alcohol to minors in your community. Does the compliance check failure rate suggest to you that this is a big problem in your community? Are certain types of establishments more likely to sell alcohol to minors?
Answer to Question 22: (type into the gray box, below)

How Alcohol is Obtained and Where it is Consumed among Youth

The Nebraska Risk and Protective Factor Student Survey (NRPFSS) and Youth Risk Behavior Survey (YRBS) ask youth where they obtain and consume their alcohol in some very specific questions. These data provide a starting point for understanding the most common access points for youth consumption, and allow for comparisons to be made between retail and social access. These data can be found in Sections 9 and 10, respectively, of your CDD. It should be noted that YRBS data are only available down to the behavioral health region level (for communities that do not conduct an oversample of the YRBS) and include less detailed survey questions than are available on the NRPFSS. However, for communities that did not participate or had poor participation in the NRPFSS, the YRBS may assist in better understanding this issue.

It should also be noted that the NRPFSS and YRBS contain information on youth in middle and high school only, and do not include information on young adults who are out of high school but under the legal drinking age. This group of young adults (generally between 18 and 20 years of age) may be more likely than middle and high school students to have purchased alcohol from a retail establishment.

If you have access to additional local data on how alcohol is obtained or where it is consumed (such as a college alcohol survey or another student based survey), please describe it, below (use one paragraph or less per data source), and consider that data before answering Question 23.

Describe Other Local Data on how Alcohol is Obtained and Where it is Consumed Among Youth: (type information in gray box, below, if applicable)

Question 23.
Based on Sections 9 and 10 of your CDD, where are youth in your community getting and consuming their alcohol? How does retail access compare with social access? How do your percentages compare to the rest of the state? If differences exist, discuss possible reasons why. What have other local data sources (if available) told you about the issue?

Answer to Question 23: (type into gray box, below)

Youth Perceptions about Alcohol Availability in the Community

On the NRPFSS, youth are asked how easy it would be for them to get beer, wine, or hard liquor if they wanted it. These data can be found in Section 11 of your CDD.
Question 24.
Based on Section 11 of your CDD, does alcohol appear to be easily accessible to youth in your community? How do your percentages compare to the rest of the state? If differences exist, discuss possible reasons why.

Answer to Question 24: (type into gray box, below)

Adult Attitudes/Behaviors Related to the Provision of Alcohol to Minors

In 2007 Nebraska adults were surveyed and asked about their attitudes and behaviors related to the provision of alcohol to minors. These data were collected via telephone from adults 21-54 years of age as part of the Nebraska Broadcasters Association Survey and can be found in Section 12 of your CDD. Although not available at the community level, they are available for residents statewide and by behavioral health region.

If you have access to additional local data on the provision of alcohol to minors (such as community crime statistics on arrests for providing alcohol to a minor), please describe those data below (use one paragraph or less per data source), and consider those data before answering Question 25.

Describe Other Local Data on Adult Attitudes/Behaviors Related to the Provision of Alcohol to Minors: (type information into the gray box, below, if applicable)

Question 25.
Based on Section 12 of your CDD, how do adult attitudes toward allowing minors to drink alcohol in your region compare to the rest of the state? If differences exist, discuss possible reasons why. What have other local data sources (if available) told you about the issue of providing alcohol to minors?

Answer to Question 25: (type into the gray box, below)

Qualitative Data Collection around Access

For this section you will need to review any relevant data collected through your town hall meeting(s). In addition, you may have collected some data through key informant interviews or focus groups that would help you better understand access to alcohol in your community.
**Question 26.**

Based on information gathered through your key informant interviews and town hall meeting(s), what did you discover about access to alcohol in your community? What attitudes or issues continued to surface? Did retail or social access seem to be more of a concern?

**Answer to Question 26:** (type into the gray box, below)

**Other Local Data Around Access**

Feel free to use other local data that will help you better understand how, and to what extent, retail and social access may influence alcohol misuse in your community. For example, you may have additional data on the density of retail outlets, or anecdotal data on specific outlets that are known for selling to minors or intoxicated persons. In addition, you may have data from your college campus or local police department on parties where alcohol is freely available. If you have other local data, briefly describe them below (use one paragraph or less per data source).

**Describe Other Local Data Around Access:** (type information into the gray box below, if applicable)

**Access: Impact and Changeability**

The next four questions relate to the degree to which you think access impacts selected priorities, and the degree to which you think access can be changed through your coalition’s work. When answering these questions, consider all of the data and information you have gathered and/or interpreted about retail and social access.

**Question 27.**

Based on the above considerations, to what degree does your coalition believe retail access is impacting the priorities you have chosen to address in your community? (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>No impact</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>Major impact</th>
<th>10</th>
</tr>
</thead>
</table>

**Justify Decision / Score for Question 27:** (type into the gray box below)
Question 28.
As a coalition, how changeable do you believe retail access to alcohol is in your community, as it relates to your priorities? When making this decision, consider factors such as your community’s readiness to address this issue (political will, attitudes among residents, etc) and the resources currently available to address it in your community. (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>Not changeable</th>
<th>Very changeable</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Justify Decision / Score for Question 28: (type into the gray box below)

Question 29.
Based on the above considerations, to what degree does your coalition believe social access is impacting the priorities you have chosen to address in your community? (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>No impact</th>
<th>Major impact</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Justify Decision / Score for Question 29: (type into the gray box below)

Question 30.
As a coalition, how changeable do you believe social access to alcohol is in your community, as it relates to your priorities? When making this decision, consider factors such as your community’s readiness to address this issue (political will, attitudes among residents, etc) and the resources currently available to address it in your community. (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>Not changeable</th>
<th>Very changeable</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Justify Decision / Score for Question 30: (type into the gray box below)
Enforcement of Alcohol Laws

The next contributing factor has to do with the enforcement of alcohol laws within your community. While this contributing factor focuses primarily on the practices of law enforcement agencies and the judicial system, it can also include the practices of parents, schools, worksites, and others in response to alcohol laws.

To better understand the enforcement of alcohol laws in your community you will need to look at arrest and conviction rates for alcohol related offenses. In addition, you will need to collect qualitative data through interviews with law enforcement personnel.

Some of the possible root causes to low enforcement of alcohol laws are included in Table 3 below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>Shortage of law enforcement personnel; lack of training on alcohol issues;</td>
</tr>
<tr>
<td></td>
<td>low priority among community leaders; few or no retail compliance checks</td>
</tr>
<tr>
<td>Law enforcement practice</td>
<td>Inconsistent application of underage drinking laws, laws regarding selling</td>
</tr>
<tr>
<td></td>
<td>to intoxicated persons, DUI, and social host laws; low number of arrests/</td>
</tr>
<tr>
<td></td>
<td>citations for alcohol use by minors; low agency priority</td>
</tr>
<tr>
<td>Judicial practice</td>
<td>No prosecution by county/district attorney of filed cases;</td>
</tr>
<tr>
<td></td>
<td>inconsistent application of legal consequences; few first-offender</td>
</tr>
<tr>
<td></td>
<td>consequences</td>
</tr>
<tr>
<td>Parental enforcement</td>
<td>Parents have few rules, if any, around drinking; parents don’t enforce</td>
</tr>
<tr>
<td></td>
<td>underage drinking laws</td>
</tr>
</tbody>
</table>

Arrest and Conviction Rates

While completing your priority assessment, you were asked to examine the number of arrests within your community for DUI and non-DUI alcohol-related offenses and examine how these compared to your region and the state. Go back and review these data, found in Section 1 of your CDD, and use this information to help complete Question 31, below.

To understand how the court system in your community addresses the misuse of alcohol, you are encouraged, but not required, to obtain information on how local courts are handling DUI and other liquor law violations (such as minor in possession, procuring alcohol for a minor/selling to a minor, open container). For example, you may be able to access data on how many alcohol-related crimes have been filed and what the outcomes of these filings were (e.g., conviction, dismissal, not guilty). Please note that the state SPF SIG Program is working to make these data available at the state, regional, and SPF SIG community level and will share the findings when available.
**Question 31.**
How do your community’s arrest rates for alcohol-related offenses compare to the rest of the state? If available and accessed, how is your community court system handling alcohol-related crimes?

**Answer to Question 31:** (type into the gray box, below)

**Qualitative Data Collection around Enforcement**

In order to obtain qualitative data around enforcement, you will need to conduct key informant interviews on the enforcement of alcohol laws in your community. In addition, you may choose (or you may already have chosen) to address this topic as part of a town hall meeting or through a focus group with law enforcement or judicial system personnel or other individuals familiar with law enforcement and judicial system practices.

**Key Law Enforcement Interviews**

To better understand law enforcement capacity and attitudes around alcohol laws you will need to conduct a minimum of two key informant interviews with law enforcement personnel in your community. The goal is to conduct interviews that would be most appropriate and informative for your community. This may consist of a representative from the local police department and county sheriff’s office within a single county, or it may consist of an officer from each of the two or three counties that your coalition represents. You may also want to consider interviews with persons working in your local judicial system or others who regularly interact with the criminal justice system. A sample protocol for the law enforcement interviews can be found in Appendix F on p.130.

**Question 32.**
Based on your interviews, what efforts are your law enforcement agencies pursuing or not pursuing when it comes to the misuse of alcohol? Do they have the resources to properly enforce the laws? What are their attitudes toward the enforcement of alcohol laws? What do community members feel about law enforcement?

**Answer to Question 32:** (type into the gray box, below)

**Other Local Data around Enforcement**

Feel free to consider and analyze other local data that will help you better understand how, and to what extent the enforcement of alcohol laws in your community may contribute to the misuse of alcohol and its consequences. For example, you may have
information on unique policies or enforcement practices related to underage drinking laws or other alcohol laws in your community. If you have other local data that have not been utilized and described above, briefly describe the findings below (use one paragraph or less per data source).

**Describe Other Local Data Around Enforcement:** (type information in gray box, below, if applicable).

**Enforcement: Impact and Changeability**

The next two questions relate to the degree to which you think enforcement impacts selected priorities, and the degree to which you think enforcement can be changed through your coalition’s work. When answering these questions, consider all of the data and information you have gathered and/or interpreted about enforcement.

**Question 33.**

Based on the above considerations, to what degree does your coalition believe enforcement of alcohol laws is impacting the priorities you have chosen to address in your community? (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>No impact</th>
<th></th>
<th>Major impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Justify Decision / Score for Question 33:** (type into the gray box below)

**Question 34.**

As a coalition, how changeable do you believe enforcement of alcohol laws is in your community, as it relates to your priorities? When making this decision, consider factors such as your community’s readiness to address this issue (political will, attitudes among residents, etc) and the resources currently available to address it in your community. (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>Not changeable</th>
<th>Very changeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Justify Decision / Score for Question 34:** (type into the gray box below)
Social/Community Norms Related to Underage Alcohol Use, Binge Drinking, and Impaired Driving

Social/community norms refer to the acceptability or unacceptability of certain behaviors in a community. Of the seven contributing factors addressed in this needs assessment, community norms is the one that most often overlaps with other factors. For instance, community norms influence retail and social access to alcohol (including adults providing alcohol to minors), law enforcement practices, and perceptions of risk from alcohol use and impaired driving. Given that social norms are addressed indirectly under other contributing factors, this section will focus mostly on individual attitudes related to alcohol use and impaired driving.

Some of the possible root causes of social/community norms that are accepting and/or encouraging of alcohol misuse are included in Table 4 below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>Parents permit underage drinking at home; parents/community residents do not care if teenagers drink; drinking is better than drug use (i.e., lesser of two evils); workplaces promote drinking and binge drinking as part of the culture; alcohol is expected to be available at community events; drinking and driving is not discouraged</td>
</tr>
<tr>
<td>“Rite of passage”</td>
<td>Using alcohol and binge drinking are what kids do</td>
</tr>
<tr>
<td>Public alcohol use</td>
<td>Adults of all ages drink in public, highly visible in the community</td>
</tr>
<tr>
<td>Youths’ attitudes and perceptions</td>
<td>Drinking helps you bond with others and make new friends; binge drinking is normal, most kids are doing it; drunkenness/excessive alcohol consumption is OK; alcohol equals fun</td>
</tr>
</tbody>
</table>

Self-Reported Perceptions and Attitudes toward Alcohol Use among Youth and Adults in Your Community and Region

The NRPFSS includes data from 6th, 8th, 10th, and 12th grade students on a variety of issues related to social/community norms around alcohol. Data on the perceived acceptability of alcohol use as well as the perceived alcohol use itself can be found in Section 13 of your CDD.

In 2005 and 2007, Nebraska adults were surveyed and asked about their perceptions and attitudes related to alcohol use among youth and adults in their community. These data were collected via telephone from adults 21-54 years of age as part of the Nebraska Broadcasters Association Survey. Although not available at the community level, these data are available for residents statewide as well as by behavioral health
region. Data on the following topics can be found in Section 14 of your CDD:

- Acceptability and perceptions of alcohol use.
- Attitudes toward the provision of alcohol for minors.
- Perceptions of parental influence on alcohol use among youth.
- Parental attitudes and behaviors related to alcohol use among their children.

**Question 35.**
Based on Sections 13 and 14 of your CDD, what perceptions and attitudes about alcohol use exist in your region? How does your region compare to the state as a whole? If differences exist, discuss possible reasons why.

**Answer to Question 35:** (type into the gray box, below)

**Qualitative Data Collection Around Social/Community Norms Toward Alcohol Use**

Now you will need to review the qualitative data around social and community norms that you have collected through your town hall meeting(s) and key informant interviews. In addition, you may have collected data from a focus group of youth, young adults or others that will help you better understand this issue.

**Question 36.**
Based on your town hall health meeting(s), interviews, and focus groups what did you learn about social/community norms around alcohol use (including binge drinking) and impaired driving? What norms came up most often? How important do community members feel it is to address these social/community norms?

**Answer to Question 36:** (type into the gray box, below)

**Other Local Data Around Social/Community Norms Toward Alcohol Use**

Feel free to consider and analyze other local data that will help you better understand how, and to what extent community norms may influence alcohol-related problems in your community. For example, you may have data on social/community norms from a survey of college students or through focus groups or surveys of youth, parents, school personnel, or community members. If you have other local data describe the results below (use one paragraph or less per data source).

**Describe Other Local Data Around Social/Community Norms Toward Alcohol Use:** (type information in the gray box below, if applicable)
Social Norms: Impact and Changeability

The next two questions relate to the degree to which you think social norms impact selected priorities, and the degree to which you think social norms can be changed through your coalition’s work. When answering these questions, consider all of the data and information you have gathered and/or interpreted about social norms.

Question 37.
Based on the above considerations, to what degree does your coalition believe social/community norms are impacting the priorities you have chosen to address in your community? (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>No impact</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

Justify Decision / Score for Question 37: (type into the gray box below)

Question 38.
As a coalition, how changeable do you believe social/community norms are in your community, as they relate to your priorities? When making this decision, consider factors such as your community’s readiness to address this issue (political will, attitudes among residents, etc) and the resources currently available to address it in your community. (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>Not changeable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

Justify Decision / Score for Question 38: (type into the gray box below)

Perceived Risk of Alcohol Use and Impaired Driving

The next contributing factor has to do with how people in your community perceive the risks associated with alcohol use and impaired driving. To measure this, data on the perceived risks of alcohol use are available for persons 12 and older from the National Survey on Drug Use and Health (NSDUH), as well as for youth in grades 6, 8, 10, and 12 through the Nebraska Risk and Protective Factor Student Survey (NRPFSS). In addition to these data, you should have already collected data through town hall meetings and key informant interviews that will help you better understand the perceived risk of alcohol use and impaired driving.
Some of the possible root causes to low perceived risk of alcohol use and impaired driving are included in Table 5 below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low perceived risk of legal consequences</td>
<td>Belief that there is a low risk of getting caught drinking (if underage) or drinking and driving; belief that penalties for underage drinking are not serious; belief that police won’t actually arrest them or give them a citation; adults do not know laws related to providing alcohol to minors</td>
</tr>
<tr>
<td>Low perceived risk of health problems</td>
<td>Belief that alcohol is less dangerous than other drugs; belief that alcohol is safe as long as you are not driving; belief that alcohol is good for you; belief that hard liquor is dangerous but beer is not</td>
</tr>
</tbody>
</table>

**Self-Reported Perceptions of Risk from Alcohol Use among Youth and Adults in your Community and Region**

The NRPFSS included data from 6th, 8th, 10th, and 12th grade students on how much they think people risk harming themselves (physically or in other ways) if they take one or two drinks of an alcoholic beverage (beer, wine, liquor) nearly everyday.

The NSDUH includes data from persons 12 and older on whether or not they perceive great risk from having five or more drinks of an alcoholic beverage once or twice a week. Although the NSDUH data are not available at the community level, they are available for residents statewide as well as by behavioral health region.

These data provide a starting point for understanding the perceived risk associated with alcohol use among members of your community, and can be found in Sections 15 and 16 of your CDD.

**Question 39.**

Based on Sections 15 and 16 of your CDD, how do youth and adults in your community and region perceive the risk associated with alcohol use? How do your percentages compare to the rest of the state? If differences exist, discuss possible reasons why.

**Answer to Question 39:** (type into the gray box, below)

**Qualitative Data Collection around Perceived Risks**

Now you are encouraged to review qualitative data around perceived risks of alcohol use and impaired driving that may have been collected through town hall meeting(s), key informant interviews, or focus groups with youth and young adults administered in your community.
**Question 40.**
Through qualitative data collection, what did you discover about perceived risks of alcohol use and impaired driving in your community?

**Answer to Question 40:** (type into the gray box, below)

**Other Local Data around Perceived Risks**
Feel free to consider and analyze other local data that will help you better understand the perceived risks of alcohol and drug use in your community. If you have other local data that have not been utilized and described above (such as information from college alcohol survey or another source), briefly describe the findings below (use one paragraph or less per data source).

**Describe Other Local Data Around Perceived Risks:** (type information into the gray box, below, if applicable)

**Perceived Risk: Impact and Changeability**

The next two questions relate to the degree to which you think perceived risk impacts selected priorities, and the degree to which you think perceived risk can be changed through your coalition’s work. When answering these questions, consider all of the data and information you have gathered and/or interpreted about perceived risk.

**Question 41.**
Based on the above considerations, to what degree does your coalition believe that concerns around low perceived risk of alcohol use and impaired driving impact the priorities you have chosen to address in your community? (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>No impact</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Major impact</th>
</tr>
</thead>
</table>

**Justify Decision / Score for Question 41:** (type into the gray box below)
**Question 42.**
As a coalition, how changeable do you believe low perceived risk of alcohol use and impaired driving is in your community, as it relates to your priorities? When making this decision, consider factors such as your community’s readiness to address this issue (political will, attitudes among residents, etc) and the resources available to address it in your community. (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>Not changeable</th>
<th>Very changeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

**Justify Decision / Score for Question 42:** (type into the gray box below)

**Promotion of Alcohol Use**

**Promotion** refers to attempts by alcohol retailers and the industry to increase demand through the marketing of their products. In order to assess promotion, you will need to do some original data collection in order to acquire a sense of the depth of marketing surrounding alcohol in your community. This data collection is specific to alcohol **sponsorship** at community events as well as the local promotion of alcohol through newspapers and billboards.

Some of the possible root causes to the promotion of alcohol use are included in Table 6 below:

**Table 6: Examples of Root Causes to the Promotion of Alcohol Use**

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local promotion</td>
<td>Retail establishments have excessive numbers of alcohol ads and alcohol signage; large number of alcohol ads on college campuses; community events often have alcohol sponsorship; drinking is promoted at community events; highly visible placement of alcohol in convenience stores; large number of billboards promoting alcohol products; local advertising encourages excessive consumption (drink specials)</td>
</tr>
<tr>
<td>National promotion</td>
<td>Pro-alcohol messages from alcohol industry, including alcohol use as sexy and fun-filled; television and movie content promotes binge drinking; Internet websites (e.g., MySpace and YouTube) create expectations for youth and young adults around binge drinking</td>
</tr>
</tbody>
</table>
Sponsorships

In this section you will need to list all the major community events that took place in your community between July 2007 and June 2008, and determine how many of them had alcohol-related sponsorship. Community events include such things as festivals, fairs, parades, shows, Main Street days, rodeos, and fireworks displays. These are substantial events that draw a large sector of the community and/or tourists. Use the table, below, titled Community Events and Festivals and Their Alcohol-Related Sponsors.

First, you will need to list all major community events in the column headed Community Event/Festival. Due to the number of community events that are hosted in large communities, those communities with populations between 25,000 and 49,999 (as defined in the Define Community section of this Toolkit) may choose to limit their examination to the six months of the year during which the majority of events take place (these months do not have to be consecutive). Those communities with populations above 50,000 may choose to limit their examination to the three months of the year during which the majority of events take place (again, these months do not have to be consecutive).

Next, find out how many of these events had alcohol-related sponsors. In the column headed Alcohol-Related Sponsorship, write the sponsor’s name(s) if there is an alcohol-related sponsorship, and “no” if there is not. For example, Bud Light and Miller Lite are corporate sponsors of the Nebraska State Fair. Then calculate the percentage of events in your community that had alcohol-related sponsorships (that is, the total number of events with alcohol-related sponsorship divided by the total number of all events, multiplied by 100).

<table>
<thead>
<tr>
<th>Community Event/Festival</th>
<th>Dates</th>
<th>Alcohol-Related Sponsorship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What percentage of events/festivals had alcohol-related sponsorship?:
(Total number of events with alcohol-related sponsorship divided by the total number of all events/festivals, multiplied by 100.)
Answer to Question 43: (type into gray box, below)

Advertising

To gain a better sense of the magnitude of alcohol advertising and promotion in your community you are going to follow a specific protocol to gather data on alcohol marketing from local newspapers and on billboards across your community. First you will be examining billboards, second you will be looking at newspaper advertisements and promotion, and third you will analyze other local data.

Billboards Advertising Alcohol

The first measure of alcohol advertising in your community will be to count the billboards on the busiest roads in your community. To begin, select what you believe are the ten busiest roads in your community. For each road you select, think of the busiest three to five mile stretch on that road. If your community covers multi-counties, think about the ten busiest roads across your entire community, not necessarily within each county or town. The total distance traveled for data collection during this activity should be between 30 and 50 miles.

Once you have selected the roads, drive each stretch of them that you identified to be the busiest in your community. While driving, count ALL of the billboards on each road and, of those, identify the sub-total that advertise alcohol, alcohol sales, or alcohol establishments. If a billboard is visible from more than one road, highway or interstate, then it should only be counted once.

To calculate the percentage of billboards that advertise alcohol in your community, simply divide the number of alcohol-related billboards by the total number of billboards, and multiply by one-hundred. While this is a snapshot of billboard advertisements in your community, the information can provide good insight into advertising practices.

<table>
<thead>
<tr>
<th>Billboard Alcohol Advertising</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of billboards advertising alcohol:</td>
</tr>
<tr>
<td>Number of billboards NOT advertising alcohol:</td>
</tr>
<tr>
<td>Total number of ALL billboards:</td>
</tr>
<tr>
<td>PERCENTAGE of billboards advertising alcohol (%):</td>
</tr>
</tbody>
</table>

%
Newspaper Advertisements/Promotion of Alcohol

In this step there will be two concurrent parts. The first part will involve counting the number of alcohol advertisements in your local newspaper. The second part will involve counting the number of alcohol advertisements that specifically market promotional events that encourage the increased use of alcohol. The basic methodology you follow is the same for both parts.

To measure the number of alcohol advertisements you will need to look at copies of the major local newspaper in your community during two one-week periods. Think of the single largest newspaper that is operated and distributed within your community. You will need to examine all issues of this paper from June 2nd to June 8th 2008 and from June 30th to July 6th 2008. (The reason for these specific date selections is explained in more detail, below.) If these newspapers are not immediately available, they should be archived and available either from the local library or local newspaper supplier.

NOTE:

You will need to examine ALL issues of the newspaper during the identified time periods. For instance, if your major newspaper only appears once per week you would only count that single day. If the newspaper is biweekly, then you will examine the two issues in the week. If the newspaper is daily, then you will examine all seven issues in the week. If your newspaper only appears once per month, count the ads that appear in that single monthly issue regardless of which week it appears.

The reason for this data collection is to better understand exposure to alcohol marketing in your community during one week that contains a holiday (4th of July) and one week that does not contain a holiday. Newspapers that appear only once a week provide less exposure than ones that appear every day.

When examining the newspapers, count all advertisements for alcohol brands, alcohol distributors, liquor stores, bars, and saloons. You will also need to count restaurant advertisements appearing in the paper that mention alcohol or bar service. You should look at both the regular print advertisements and the classifieds in your search.

As you count the alcohol advertisements, also note the number of advertisements that market promotional events encouraging the increased use of alcohol. To be more exact, count the number of advertisements for events like “ladies’ night,” “happy hour,” unlimited drinking for a fixed price or over fixed time period, free or reduced priced drinks with a coupon, or “2-for-1 night,” that encourage people to over-consume alcohol in retail establishments.

After counting the number of advertisements and special promotions in all your local newspapers, complete the table below.
Local Newspaper Alcohol Advertisements & Promotional Events, June/July 2008

**Alcohol Advertisements**: Advertisements for alcohol brands, alcohol distributors, liquor stores, bars, and saloons; restaurant advertisements appearing in the paper that mention alcohol or bar service.

**Promotional Events**: Events encouraging the increased use of alcohol in retail establishments, including “ladies’ night,” “happy hour,” unlimited drinking for a fixed price or over fixed time period, free or reduced priced drinks with a coupon, or “2-for-1 night.”

<table>
<thead>
<tr>
<th>Name of Paper</th>
<th>Frequency of Paper (e.g., daily, weekly, monthly)</th>
<th>Time Period</th>
<th>Total Number of Alcohol Advertisements in Local Newspaper</th>
<th>Total Number of Promotional Event Advertisements in Local Newspaper</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>June 2–8, 2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>June 30–July 6, 2008</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Question 44.**
What did you learn about alcohol advertising on community billboards and through your largest local newspaper?

**Answer to Question 44**: (type into the gray box, below)

**Other Local Data around Alcohol Advertising/Promotion**

Feel free to consider and analyze other local data that will help you better understand how and to what extent the promotion of alcohol in your community may influence alcohol-related problems in your community. For example, you may have information on alcohol advertising in or on liquor stores, convenience stores, etc., or flyers passed out around town, or other ways that alcohol might be promoted on college campuses or at schools. If you have other local data, describe the results below (use one paragraph or less per data source).

**Describe Other Local Data Around Alcohol Advertising/Promotion**: (type information into the gray box below, if applicable)
Promotion: Impact and Changeability

The next two questions relate to the degree to which you think promotion impacts selected priorities, and the degree to which you think promotion can be changed through your coalition’s work. When answering these questions, consider all of the data and information you have gathered and/or interpreted about promotion.

**Question 45.**
Based on the above considerations, to what degree does your coalition believe promotion impacts the priorities you have chosen to address in your community? (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>No impact</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Major impact</th>
</tr>
</thead>
</table>

**Justify Decision / Score for Question 45:** (type into the gray box below)

**Question 46.**
As a coalition, how changeable do you believe the promotion of alcohol is in your community, as it relates to your priorities? When making this decision, consider factors such as your community’s readiness to address this issue (political will, attitudes among residents, etc) and the resources currently available to address it in your community. (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>Not changeable</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very changeable</th>
</tr>
</thead>
</table>

**Justify Decision / Score for Question 46:** (type into the gray box below)

**Pricing of Alcohol**

**Pricing** refers to the cost of alcohol and the extent to which changes in pricing (e.g., discounting or price increases) affect consumption.

Some of the possible root causes to low or discount pricing of alcohol are included in Table 7 below:
Table 7: Examples of Root Causes to Low Pricing of Alcohol

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink pricing</td>
<td>Bars near campus compete for student purchasers with drink specials; pricing specials that target young adults (e.g., 50-cent drafts); happy hours; high density can lead to competition and low pricing</td>
</tr>
<tr>
<td>Container pricing</td>
<td>Discount pricing is available for large quantities (24-packs of beer or large bottles of hard liquor); convenience stores price beer cheaply to attract customers; holiday discounts of alcohol; high density can lead to competition and low pricing</td>
</tr>
</tbody>
</table>

Pricing for On-Premise Consumption

You will need to identify what you believe are two of the more popular alcohol establishments (e.g., bars, restaurants) for young adults in your community (21-25 years of age). Once selected, you will gather data from each of these establishments through observation and/or interviewing. Please review and complete the Pricing Assessment Tool in Appendix H on p. 139 to determine the degree to which pricing is or is not a problem in your community.

Pricing for Off-Premise Consumption

You will need to identify what you believe are two of the more popular establishments (e.g., gas stations, liquor stores, grocery stores) where young adults (21-25 years of age) in your community purchase alcohol for off-premise consumption. Once selected, you will gather data from each of these establishments through observation. Please review and complete the Pricing Assessment Tool in Appendix H on p. 139 to determine the degree to which pricing is or is not a problem in your community.

Other Local Data on Pricing

Feel free to consider and analyze other local data that will help you better understand how and to what extent pricing of alcohol in your community may influence alcohol-related problems in your community. For example, you may have information on alcohol pricing that was obtained through flyers passed out around town, through some of your key informant interviews and town hall meetings, or through some other way that alcohol might be priced to attract youth and young adults. If you have other local data, describe the results below (use one paragraph or less per data source).

Describe Other Local Data on Pricing: (type information into the gray box, below, if applicable)
Pricing: Impact and Changeability

The next two questions relate to the degree to which you think pricing impacts selected priorities, and the degree to which you think pricing can be changed through your coalition’s work. When answering these questions, consider all of the data and information you have gathered and/or interpreted about pricing.

Question 47.
Based on the above considerations, to what degree does your coalition believe price impacts the priorities you have chosen to address in your community? (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>No impact</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Major impact</th>
</tr>
</thead>
</table>

Justify Decision / Score for Question 47: (type into the gray box below)

Question 48.
As a coalition, how changeable do you believe low or discount pricing of alcohol is in your community, as it relates to your priorities? When making this decision, consider factors such as your community’s readiness to address this issue (political will, attitudes among residents, etc) and the resources currently available to address it in your community. (Place an “x” in the gray box next to a number from 0 to 10.)

<table>
<thead>
<tr>
<th>Not changeable</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very changeable</th>
</tr>
</thead>
</table>

Justify Decision / Score for Question 48: (type into the gray box below)

Risk and Protective Factors / Developmental Assets

The seven contributing factors you have just completed assessing have been shown to contribute to the misuse of alcohol, and are the primary factors your coalition will address through the Nebraska SPF SIG logic model. However, there may be other factors that you believe are contributing to your chosen priorities within your community. As a result, this section allows you to assess community level data that does not fit well under the seven contributing factors.

Examples of additional factors and/or assets that you believe either protect individuals from misusing alcohol or, conversely, contribute to the misuse of alcohol include such things as opportunities for pro-social involvement within the community, strong family
support, regular family communication, school engagement, honesty, self-confidence, community disorganization, or gang involvement. As noted earlier, this section is optional. However, if you do choose to complete this section, and then choose to address any of the areas that you discover to be significant, you must clearly justify why it is important in your community and why it should be addressed.

If you chose to complete this assessment, briefly describe the data sources that you used, the variables that you analyzed and/or interpreted, and consider those findings prior to answering Question 49.

**Describe Local Risk and Protective Factors / Developmental Asset Data:** (type information into the gray box below, if applicable)

---

**Question 49.**
Based on the data you had available in your community, what did you discover about other factors (e.g., risk/protective factors or developmental assets) related to the misuse of alcohol in your community, outside of the seven previously identified contributing factors? Which factors/assets appear to be particularly important? What is the evidence demonstrating that these factors/assets contribute to or protect against the misuse of alcohol?

**Answer to Question 49:** (type into the gray box, below)

---

**Prioritizing and Selecting Contributing Factors**

The next step involves selecting the contributing factors that you will address through your SPF strategic plan. To do this, use the table, below, titled Rank Contributing Factors. First, place the scores from the earlier questions about impact and changeability into the appropriate boxes. Then, add those scores together to calculate an overall score for each contributing factor. Rank the overall scores, with 1 as the highest score and 7 the lowest (in other words, the contributing factor ranked as “1” will be the most important, and so on). In the case of a tie, decide which area is of higher priority for your community in relation to the misuse of alcohol. After completing the ranking, you will have to justify your prioritization in your answer to Question 50.
**Rank Contributing Factors**

**Instructions:** Place the scores for Questions 27 & 28, 29 & 30, 33 & 34, 37 & 38, 41 & 42, 45 & 46, and 47 & 48 into the appropriate gray boxes within the table below; add the scores for Questions 27 & 28 to generate an Overall Score for the first contributing factor; add the scores for Questions 29 & 30 to generate an Overall Score for the second contributing factor (and so on, until you have generated Overall Scores for all seven contributing factors). Then, rank each contributing factor on a scale from 1 to 7, with 1 as the highest score (that is, the most important contributing factor), and place those ranks in the appropriate gray boxes.

<table>
<thead>
<tr>
<th>Impact Score</th>
<th>Changeability Score</th>
<th>Overall Score</th>
<th>Rank</th>
<th>Contributing Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q27</td>
<td>Q28</td>
<td></td>
<td></td>
<td>Easy Retail Access</td>
</tr>
<tr>
<td>Q29</td>
<td>Q30</td>
<td></td>
<td></td>
<td>Easy Social Access</td>
</tr>
<tr>
<td>Q33</td>
<td>Q34</td>
<td></td>
<td></td>
<td>Low Enforcement of Alcohol Laws</td>
</tr>
<tr>
<td>Q37</td>
<td>Q38</td>
<td></td>
<td></td>
<td>Favorable Social/Community Norms</td>
</tr>
<tr>
<td>Q41</td>
<td>Q42</td>
<td></td>
<td></td>
<td>Low Perceived Risk</td>
</tr>
<tr>
<td>Q45</td>
<td>Q46</td>
<td></td>
<td></td>
<td>Promotion of Alcohol Use</td>
</tr>
<tr>
<td>Q47</td>
<td>Q48</td>
<td></td>
<td></td>
<td>Low or Discount Pricing of Alcohol</td>
</tr>
</tbody>
</table>

Now that you have ranked each contributing factor, you need to decide which one or more you will address. There are no requirements on the number of factors you can and cannot address, but this decision will ultimately be part of your community’s SPF strategic plan and will lead to the selection of very specific evidence-based strategies for each of the factors you select.

For now, think about and discuss as a coalition the final scores you generated for each of the contributing factors. In addition, discuss any other factors or assets outside of these seven (if you completed that section) that you found to be contributing to or protecting against the misuse of alcohol in your community. Also, mull over the possible connections among all of these factors. Would it be possible to target social availability without also targeting community norms? Will changes in retail availability necessarily require changes in the enforcement of policy? Remember, it is very unlikely that your community can or needs to address every possible contributing factor influencing your selected prevention priorities. Once your coalition has considered these issues, it is time to make a final decision about what contributing factors you will address. Once your coalition has completed this process, answer Question 50.
Question 50.
What one or more contributing factors is your community going to target with the SPF SIG and why?

Answer to Question 50: (type into the gray box, below)

Part 3: Selecting Root Causes

The last step of the needs assessment process is to choose one or more root causes for each of the contributing factors you will be addressing through your SPF strategic plan. As a reminder, the root causes are the conditions that underlie and are driving the problem and that an evidence-based prevention strategy will directly try to affect. Before moving on, you may want to look back at the possible root causes listed under each contributing factor in this section, or view the complete list of root causes within Appendix C on p. 119. While these examples include some of the more common root causes, there may be other, community specific root causes, not identified in this document that your coalition may choose to address.

Below, list each of the contributing factors that you have chosen to address in your community, and as a coalition identify up to three root causes that you believe contribute most to these factors, and/or that your coalition and community have the best capacity, readiness and resources to successfully impact. Then explain your rationale for selecting each root cause. Use Appendix C, the comprehensive list of root causes, to help you with this process.

NOTE:
Appendix C: Root Causes, is not necessarily all-inclusive. As mentioned earlier, other root causes may exist that are specific to your community. If you identify additional root causes, you may list these, as well—just note that they are “community specific.”

On the next page, you will find root causes tables for three contributing factors. Use only those tables you need. If your coalition has selected more than four contributing factors, please copy and paste additional root causes tables into this document. If you chose factors other than the seven identified contributing factors, you may enter “other factors” as the contributing factor and enter associated root causes underneath.
### Selected Root Causes

<table>
<thead>
<tr>
<th>Contributing Factor:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Root Cause 1:</td>
<td>Rationale:</td>
</tr>
<tr>
<td>Root Cause 2:</td>
<td>Rationale:</td>
</tr>
<tr>
<td>Root Cause 3:</td>
<td>Rationale:</td>
</tr>
</tbody>
</table>

### Selected Root Causes

<table>
<thead>
<tr>
<th>Contributing Factor:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Root Cause 1:</td>
<td>Rationale:</td>
</tr>
<tr>
<td>Root Cause 2:</td>
<td>Rationale:</td>
</tr>
<tr>
<td>Root Cause 3:</td>
<td>Rationale:</td>
</tr>
</tbody>
</table>

### Selected Root Causes

<table>
<thead>
<tr>
<th>Contributing Factor:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Root Cause 1:</td>
<td>Rationale:</td>
</tr>
<tr>
<td>Root Cause 2:</td>
<td>Rationale:</td>
</tr>
<tr>
<td>Root Cause 3:</td>
<td>Rationale:</td>
</tr>
</tbody>
</table>

### Report Out

Once you have completed your needs assessment, it is time to review and summarize your findings and report out on the results to the coalition as a whole. In addition, you will need to submit an electronic version of your completed needs assessment to the State SPF SIG Program.
V. PREVENTION STRATEGY ASSESSMENT

The **prevention strategy assessment** will help your coalition gain a clear idea of the prevention strategies that are currently being implemented in your community that target one or more of your selected priorities, and one or more selected contributing factors. The purpose of conducting the prevention strategy assessment is to ensure that existing strategies are not unnecessarily duplicated, and that successful efforts are built upon.

This section on Prevention Strategy Assessment will provide you with information and tools to help you to:

- Develop a **Prevention Strategy Assessment Work Plan**;
- Develop an **inventory** of the substance abuse prevention programs, policies and practices in your community that address selected priorities and contributing factors;
- Conduct an assessment of locally implemented prevention programs;
- Identify **gaps** in existing programs, policies and practices; and
- Create a **Prevention Strategy Summary**.

Prevention Strategy Assessment Work Plan

The very first thing you should do is take some time to figure out how you plan to go about conducting your prevention strategy assessment. Identify the action steps that must be completed, by when and by whom. You may decide to form a subcommittee to focus on prevention strategy assessment, or you may find some other way to allocate the workload. Don’t forget to create an overall time line for when you will complete the entire prevention strategy assessment process. Use the tool called Prevention Strategy Assessment Work Plan on p. 91 to develop your action plan.

Inventory Existing Prevention Strategies

The first step in assessing existing prevention strategies is to identify the prevention **programs, policies** and **practices** in your community that address the priority or priorities for alcohol prevention that your coalition has selected, as well as one or more of the contributing factors that your coalition has decided to focus on.
**Programs, Policies and Practices**

- **Program**: A structured intervention designed to change individual attributes or environmental conditions within a defined geographic area or for a defined population. An example of a program is skill-building for adolescents so that individuals are more ready and prepared to turn down offers of drugs; programs also include what are called environmental strategies aimed at changing the behavior of populations by changing the environment in which people live, work and play (e.g., by doing things such as increasing law enforcement or influencing social norms).

- **Policy**: Standards for behavior that are formalized to some degree (i.e., written), and embodied in rules, regulations, and operations procedures. Government regulations are an example of policies, but they can also include nongovernmental regulations put into place at institutions like schools, colleges, liquor stores, bars, restaurants, and workplaces.

- **Practice**: A procedure or course of action that supports existing policy and helps to change or sustain behavior. Examples of practices include activities such as ID checks for tobacco sales, parents calling other parents to substantiate monitoring of alcohol-free events, parents staying up to monitor youth as they return home in order to gauge using or non-using behaviors, etc.

In order to create a comprehensive inventory, you should examine local resource guides, directories and publications, as well as use the knowledge base within your coalition. In fact, it might be a good idea to start by reviewing the information provided by key informants during the community readiness assessment interviews. In addition, a list of existing Nebraska drinking laws is provided in Appendix B, on p. 116.

See the tools titled (1) Inventory of Alcohol Use Prevention Programs and (2) Inventory of Alcohol Policies and Practices, on pages 92 and 93 for useful forms to complete your inventory of the existing prevention strategies in your community that target the prevention priorities and contributing factors selected by your coalition.

**Program Assessment**

Once you have completed the inventory of programs, policies and practices that address selected state priorities and selected contributing factors, it’s time to do an in-depth assessment of the alcohol use prevention programs currently being implemented in your community. There are two steps to this process, Step 1: Visit the online National Registry of Evidence-Based Programs and Practices (NREPP) in order to see if local programs are listed there; and, Step 2: If a locally implemented program is not listed there, then use the Program Survey tool on p. 94 to develop an in-depth assessment of the strategy in question.
Step 1 of Program Assessment: Visit the National Registry of Evidence-Based Programs and Practices at www.nrep.samhsa.gov. NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. It is a service of the Substance Abuse and Mental Health Services Administration (SAMHSA) which developed this resource to help people, agencies, and organizations implement programs and practices in their communities.

If a program is listed on NREPP, the database will provide you with most of the information you will need to know, including:

- A program description and the intervention approaches utilized;
- State priorities addressed (listed on NREPP under “areas of interest” or “outcomes”);
- Contributing factors addressed (listed on NREPP under “areas of interest” or “outcomes”);
- Ages, genders and racial sub-populations for which the program is designed;
- Target population classification (universal, selected, indicated—a description of these categories is provided later in this section);
- Settings for which the program is designed;
- Population- or culture-specific adaptations;
- Outcomes achieved.

You can use the Summary of Programs and Summary of Policies & Practices worksheets (pages 99 and 100, respectively; note that there is one tool for programs and another tool for policies and practices) to start noting down important information from your strategy assessment.

After using NREPP to collect the above information, you will still need to make a phone call to the local program coordinator in order to identify the program’s main funding sources, and whether or not funding for the program is expected to continue indefinitely. This information is important because it will help you later on to identify potential funding gaps (see the section on Gap Analysis, further down in this section).

Step 2 of Program Survey: If the local program is not listed on NREPP, you must use the Program Survey tool mentioned above, to collect data about the intervention. Through the survey, you will collect all the same information described above.

Before you begin the Program Survey process, you should choose which method or methods you will use to conduct the survey (i.e., informational interviews by phone or in person, mailing, etc.). In addition, you will have to make some modifications to the survey tool so that it only asks questions related specifically to the contributing factors that your coalition has selected. To do this, go into an electronic version of the survey tool and delete the questions about the priorities and contributing factors your coalition
is NOT targeting, prior to printing the survey for your use. (Note: Each SPF SIG coalition coordinator will have an electronic version of this Toolkit.)

### Target Population Classification

Generally, the target population of an intervention will fit into one of three overarching categories:

1. **Universal**: A universal target population is the entire population, e.g., all students in a school, all residents in a community, or all parents in a neighborhood.

2. **Selected**: A selected population is a specific group within the general population that is deemed to be at risk for substance abuse by virtue of its membership in a particular population segment, e.g., dropouts, underachieving students, or children of alcoholic parents. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse, and targeted subgroups may be defined by age, gender, family history, place of residence (e.g., low-income neighborhood), victimization by physical or sexual abuse, or membership in a group at risk (e.g., youth experiencing transition, such as fifth or sixth graders moving to middle school or eighth or ninth graders moving to high school).

3. **Indicated**: An indicated population includes only those individuals who are at high-risk for alcohol and other drug problems, e.g., those who are already experimenting with substances or who exhibit other risk behaviors related to substance abuse such as a history of driving while intoxicated, truancy, aggressiveness/violence, or teenage pregnancy.

### Gap Analysis

Now it's time to identify any gaps among the local programs, policies and practices that address your selected prevention priorities and contributing factors. There are seven types of gaps that can exist: (1) effectiveness gaps; (2) funding gaps; (3) domain gaps; (4) developmental gaps; (5) demographic gaps; (6) geographic gaps; and (7) implementation gaps:

- **Effectiveness Gaps**: Result when a community has few if any tested, effective strategies to address substance abuse prevention priorities, and/or when there are few if any strategies aimed at one or more of the seven identified contributing factors.

- **Funding Gaps**: Occur when funds are unavailable to implement or maintain tested, effective programs, policies and practices to address priorities.
- **Domain Gaps**: Occur when tested, effective strategies are not available to address priorities in multiple domains (community, family, school, peer, and individual).

- **Developmental Gaps**: Occur when tested, effective strategies don’t address the appropriate age group for identified priorities.

- **Demographic Gaps**: Occur when tested, effective strategies do not cover all the races, cultures, genders, languages and economic classes that are represented in your community.

- **Geographic Gaps**: Occur when the location or coverage area of tested, effective strategies limits or prohibits access and/or participation by relevant target populations.

- **Implementation Gaps**: Occur when tested, effective strategies are not implemented with fidelity—that is, when they are not implemented as designed.

To complete the Gap Analysis, go to the Gaps Analysis Worksheet on pages 97 and 98. Note that there is one tool focusing on programs and another focusing on policies and practices.

Once your Gap Analysis is completed, you will have to consider which identified gaps are most critical for your community. For example, a coalition working on tribal lands may decide that demographic gaps carry more weight than domain gaps. In this case, one of the conclusions of this coalition’s Prevention Strategy Assessment may be to focus on closing those demographic gaps first. Alternatively, this coalition might decide that an identified fidelity gap was unimportant because a local adaptation had been evaluated and found to be effective with the local target population. Another example of how to weigh the relative importance of gaps is to imagine a coalition working in a community that has been implementing a very effective strategy aimed at selected priority areas and contributing factors, but for which funding has dried up—in this case, the coalition may decide that the funding gap is the most critical gap needing to be addressed.

**Prevention Strategy Assessment Conclusions & Report-Out**

When the results of your Program Survey are combined with the information from your inventory of policies and practices, and gap analysis, the information will help you determine:

- Which existing community programs, policies and practices address your coalition’s selected prevention priorities;
• Which existing community programs, policies, and practices address one or more of the contributing factors targeted by your coalition;

• Which of these community prevention strategies has been tested and found to be effective;

• What gaps exist among available programs, policies and practices; and

• The issues and barriers that exist related to delivery of and access to existing prevention services.

The last steps of your Prevention Strategy Assessment are to summarize and report-out on your above findings. If you haven’t already done so, complete the Summary of Programs and Summary of Policies & Practices worksheets for each program, policy or practice listed on the initial Resource Inventory. (See the tools on pages 99 and 100, respectively.)

Remember, the entire Prevention Strategy Assessment is intended to focus in on strategies that address the priority or priorities and contributing factors selected by your coalition. You will use these results later on in the planning process to assist you in selecting appropriate strategies to implement. The process is intended to ensure that existing strategies are not unnecessarily duplicated and that successful efforts are built upon. Now it is time to report out on the results of your Prevention Strategies Assessment to the coalition as a whole.
TOOLS
INTRODUCTION:

The purpose of this interview is to get your thoughts on how ready this community is to plan for—and take action on—preventing alcohol abuse. I will be asking you a series of questions about:

- Alcohol abuse prevention efforts and community knowledge of those efforts;
- The role of community leadership in alcohol abuse prevention;
- The community’s response to alcohol abuse prevention efforts; and
- Local knowledge about problem drinking.

Remember, there are no right or wrong answers. If you are uncertain about how to respond, it is okay to say so. Please don’t guess—just use your best understanding of how to answer.

During the interview, I will be asking you similar questions about three types of problem drinking—underage drinking, binge drinking, and drinking and driving. Please answer each question as completely as possible. I will be writing down your answers as you speak. From time to time, I may ask you to elaborate to make sure that I understand your meaning. Please be aware that your answers will be kept completely confidential. This interview should take between 30 and 60 minutes.

(NOTE: If you want to use a tape recorder, ask the interviewee’s permission, first.)

A. COMMUNITY EFFORTS (programs, activities, policies, etc.)

AND

B. COMMUNITY KNOWLEDGE OF EFFORTS

1. Using a scale from 1-10, how much of a concern is **underage drinking** in your community (with 1 being “not at all” and 10 being “a very great concern”)? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

Using a scale from 1-10, how much of a concern is **binge drinking** in your community (with 1 being “not at all” and 10 being “a very great concern”)? Please explain.

Using a scale from 1-10, how much of a concern is **drinking and driving** in your community (with 1 being “not at all” and 10 being “a very great concern”)? Please explain.
2. Please describe the efforts that are available in your community to address **underage drinking**. (A)

Please describe the efforts that are available in your community to address **binge drinking**. (A)

Please describe the efforts that are available in your community to address **drinking and driving**. (A)

3. How long have these efforts toward **underage drinking** been going on in your community? (A)

How long have these efforts toward **binge drinking** been going on in your community? (A)

How long have these efforts toward **drinking and driving** been going on in your community? (A)

4. What does the community know about these efforts or activities? (B)
   - **Underage Drinking**:
   - **Binge Drinking**:
   - **Drinking and Driving**:

5. What are the strengths of these efforts? (B)
   - **Underage Drinking**:
   - **Binge Drinking**:
   - **Drinking and Driving**:
6. What are the weaknesses of these efforts? (B)

- Underage Drinking:
- Binge Drinking:
- Drinking and Driving:

C. LEADERSHIP

7. Using a scale from 1 to 10, how much of a concern is **underage drinking** to the leadership in your community (with 1 being “not at all” and 10 being “of great concern”)? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

Using a scale from 1 to 10, how much of a concern is **binge drinking** to the leadership in your community (with 1 being “not at all” and 10 being “of great concern”)? Please explain

Using a scale from 1 to 10, how much of a concern is **drinking and driving** to the leadership in your community (with 1 being “not at all” and 10 being “of great concern”)? Please explain

8. How are these leaders involved in efforts regarding **underage drinking**? Please explain. (For example: Are they involved in a committee, task force, etc.? How often do they meet?)

How are these leaders involved in efforts regarding **binge drinking**? Please explain

How are these leaders involved in efforts regarding **drinking and driving**? Please explain

9. Would the leadership support additional efforts? Please explain.
D. COMMUNITY CLIMATE

10. How does the community support the efforts to address **underage drinking**?

   How does the community support the efforts to address **binge drinking**?

   How does the community support the efforts to address **drinking and driving**?

11. What are the primary obstacles to efforts addressing **underage drinking** in your community?

   What are the primary obstacles to efforts addressing **binge drinking** in your community?

   What are the primary obstacles to efforts addressing **drinking and driving** in your community?

E. KNOWLEDGE ABOUT THE ISSUE

12. How knowledgeable are community members about **underage drinking**? Please explain. (Prompt: For example, dynamics, signs, symptoms, local statistics, effects on family and friends, etc.)

   How knowledgeable are community members about **binge drinking**? Please explain

   How knowledgeable are community members about **drinking and driving**? Please explain

13. What type of information is available in your community regarding **underage drinking**?

   What type of information is available in your community regarding **binge drinking**?

   What type of information is available in your community regarding **drinking and driving**?
14. What local data are available on **underage drinking** in your community?

What local data are available on **binge drinking** in your community?

What local data are available on **drinking and driving** in your community?

15. How do people obtain this information in your community?
Scoring is an easy step-by-step process that gives you readiness scores for each of the five dimensions. The following pages provide the process for scoring. There is a scoring worksheet, below, and anchored rating scales for each of the assessed dimensions. Ideally, two people should participate in the scoring process in order to ensure valid results for this type of qualitative data. The end scores identified through this process will help you determine which priority or priorities your community is most ready to tackle.

**Step-by-Step Instructions for Scoring:**

- Working independently, both scorers should read through each interview in its entirety before scoring any of the dimensions in order to get a general feeling and impression from the interview. Remember, the answers to questions relevant to one dimension may also provide insight that is helpful in scoring another dimension.

  The survey includes questions pertaining to each of the state’s three priorities, so each interview must be scored three times—one for each priority.

  **REMEMBER!**

  When scoring, it is critical that answers to questions about each priority (called the **priority response set**) should be scored independently from the others in order to obtain a readiness score for each of the three priorities.

- Again, working independently, the scorers should read through the anchored rating scale for the dimension being scored. Go through the interview responses for each dimension separately and highlight or underline the responses that reflect one or more of the statements within the anchored rating scale for that dimension.

  Then, begin to score each dimension. Do this by selecting the anchored rating scale for the dimension. Begin with the first statement in the scale, and determine—based on the interview—if the community exceeds that statement. If the community has achieved or exceeded what is described in that statement, move to the second statement; if the community has achieved that statement, move to the third, and so on. The scorer should proceed with this process until reaching a statement that the community has not achieved.

  The community readiness level for each dimension is the final statement that the scorer is able to determine that the community has achieved. Please remember that in order to receive a score at a certain stage, all previous levels must have been met up to and including the statement that the scorer believes best reflects what is stated in the interview. In other words, a community cannot be at stage 7 and not have achieved what is reflected in the statements for stages 1 through 6.
• On the Community Readiness Assessment Scoring Sheet (see p. 86), each scorer puts his or her independent scores in the table labeled **INDIVIDUAL SCORES**, using the scores for each dimension of each of the interviews. The table provides spaces for up to six key respondent interviews.

• When the independent scoring is complete, the two scorers then meet to discuss the scores. Once consensus is reached, fill in the table labeled **COMBINED SCORES** on one of the scoring sheets. Add across each row to yield a total for each dimension.

<table>
<thead>
<tr>
<th>Interviews</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
<th>#5</th>
<th>#6</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimension A</td>
<td>3.5</td>
<td>5.0</td>
<td>4.25</td>
<td>4.75</td>
<td>5.5</td>
<td>3.75</td>
<td>26.75</td>
</tr>
</tbody>
</table>

To find the **CALCULATED SCORES** for each dimension, take the total for that dimension and divide it by the number of interviews. Below is an example in which two scorers have agreed on the following scores for Dimension A for each interview:

\[
\text{Dimension A: } 26.75 \div 6 = 4.46
\]

In this example, the total for Dimension A is 26.75. Take that figure and divide it by the number of interviews (6) to get 4.46. Repeat this process for all dimensions.

• To find the **OVERALL STAGE OF READINESS**, take the total of all calculated scores and divide by the number of dimensions (5). For example:

\[
\text{Dimension A: } 4.46 \\
\text{Dimension B: } 5.67 \\
\text{Dimension C: } 2.54 \\
\text{Dimension D: } 3.29 \\
\text{Dimension E: } 6.43 \\
\text{TOTAL: } 22.39 \\
\text{22.39 } \div 5 = 4.48
\]

• The result will be the overall stage of readiness of the community. The scores correspond with the numbered stages and are “rounded down” rather than up, so a score between a 1.0 and a 1.99 would be the first stage, a score of 2.0 to 2.99 would be the second and so forth. In the above example, the average 4.48 represents the fourth stage or Preplanning.

• Finally, under comments, write down any impressions about the community, any unique outcomes, and any qualifying statements that may relate to the score of your community. This information will be useful when you report back to the coalition.

<table>
<thead>
<tr>
<th>Remember:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Different people can have slightly different impressions, and it is important to seek an explanation for the decisions each scorer made. The goal is to reach consensus on the scores by discussing items or statements that might have been missed by one scorer and which may affect the final score that is assigned.</td>
</tr>
</tbody>
</table>

\[
\text{Different people can have slightly different impressions, and it is important to seek an explanation for the decisions each scorer made. The goal is to reach consensus on the scores by discussing items or statements that might have been missed by one scorer and which may affect the final score that is assigned.}
\]
Community Readiness Assessment
Scoring Sheet

INDIVIDUAL SCORES: Each scorer should record his/her independent results for each interview for each dimension, here. The table provides spaces for up to six interviews.

<table>
<thead>
<tr>
<th>Interviews</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
<th>#5</th>
<th>#6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimension A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension E</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMBINED SCORES: For each interview, the two scorers should discuss their individual scores and then agree on a single score. This is the COMBINED SCORE. Record a combined score for each interview in each dimension. Then, add across each row and find the total for each dimension. Use the total to find the calculated score below.

<table>
<thead>
<tr>
<th>Interviews</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
<th>#5</th>
<th>#6</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimension A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension E</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CALCULATED SCORES: Use the combined score TOTAL for each dimension from the table above, and enter it under the TOTAL for appropriate dimension in the table below; divide that figure by the number of interviews conducted. That is the CALCULATED SCORE. Add the calculated scores together and enter that figure under TOTAL Calculated Score.
### OVERALL STAGE OF READINESS:
Take the TOTAL calculated score and divide by 5 (the number of dimensions). Use the list of stages below to match the result with a stage of readiness. **Remember to round down instead of up.**

Total Calculated Score: _____ ÷ 5 = ______

<table>
<thead>
<tr>
<th>Score</th>
<th>Stage of Readiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No Awareness</td>
</tr>
<tr>
<td>2</td>
<td>Denial / Resistance</td>
</tr>
<tr>
<td>3</td>
<td>Vague Awareness</td>
</tr>
<tr>
<td>4</td>
<td>Preplanning</td>
</tr>
<tr>
<td>5</td>
<td>Preparation</td>
</tr>
<tr>
<td>6</td>
<td>Initiation</td>
</tr>
<tr>
<td>7</td>
<td>Stabilization</td>
</tr>
<tr>
<td>8</td>
<td>Confirmation / Expansion</td>
</tr>
<tr>
<td>9</td>
<td>High Level of Community Ownership</td>
</tr>
</tbody>
</table>

**COMMENTS, IMPRESSIONS, and QUALIFYING STATEMENTS about the community:**
Dimension A. Existing Community Efforts

1. No awareness of the need for efforts to address the issue.
2. No efforts addressing the issue.
3. A few individuals recognize the need to initiate some type of effort, but there is no immediate motivation to do anything.
4. Some community members have met and have begun a discussion of developing community efforts.
5. Efforts (programs/activities) are being planned.
6. Efforts (programs/activities) have been implemented.
7. Efforts (programs/activities) have been running for several years.
8. Several different programs, activities and policies are in place, covering different age groups and reaching a wide range of people. New efforts are being developed based on evaluation data.
9. Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.

Dimension B. Community Knowledge Of The Efforts

1. Community has no knowledge of the need for efforts addressing the issue.
2. Community has no knowledge about efforts addressing the issue.
3. A few members of the community have heard about efforts, but the extent of their knowledge is limited.
4. Some members of the community know about local efforts.
5. Members of the community have basic knowledge about local efforts (e.g., purpose).
6. An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.
7. There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.
8. There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.
9. Community has knowledge of program evaluation data on how well the different local efforts are working and their benefits and limitations.
Dimension C. Leadership (includes appointed leaders & influential community members)

1. Leadership has no recognition of the issue.
2. Leadership believes that this is not an issue in their community.
3. Leader(s) recognize(s) the need to do something regarding the issue.
4. Leader(s) is/are trying to get something started.
5. Leaders are part of a committee or group that addresses this issue.
6. Leaders are active and supportive of the implementation of efforts.
7. Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency.
8. Leaders are supportive of expanding/improving efforts through active participation in the expansion/improvement.
9. Leaders are continually reviewing evaluation results of the efforts and are modifying support accordingly.

Dimension D. Community Climate

1. The prevailing attitude is that it’s not considered, unnoticed or overlooked within the community. “It’s just not our concern.”
2. The prevailing attitude is “There’s nothing we can do,” or “Only ‘those’ people do that,” or “We don’t think it should change.”
3. Community climate is neutral, disinterested, or believes that the issue does not affect the community as a whole.
4. The attitude in the community is now beginning to reflect interest in the issue. “We have to do something, but we don’t know what to do.”
5. The attitude in the community is “we are concerned about this,” and community members are beginning to reflect modest support for efforts.
6. The attitude in the community is “This is our responsibility” and is now beginning to reflect modest involvement in efforts.
7. The majority of the community generally supports programs, activities, or policies. “We have taken responsibility.”
8. Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for efforts. Participation level is high. “We need to keep up on this issue and make sure what we are doing is effective.”
9. All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.
Dimension E. Community Knowledge about the Issue

1. Not viewed as an issue.
2. No knowledge about the issue.
3. A few in the community have some knowledge about the issue.
4. Some community members recognize the signs and symptoms of this issue, but information is lacking.
5. Community members know that the signs and symptoms of this issue occur locally, and general information is available.
6. A majority of community members know the signs and symptoms of the issue and that it occurs locally, and local data are available.
7. Community members have knowledge of, and access to, detailed information about local prevalence.
8. Community members have knowledge about prevalence, causes, risk factors, and consequences.
9. Community members have detailed information about the issue as well as information about the effectiveness of local programs.
<table>
<thead>
<tr>
<th><strong>Action Steps</strong></th>
<th><strong>By when?</strong></th>
<th><strong>By Whom?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete the Inventory of prevention programs, policies, practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Draft a letter to send with survey (if necessary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Implement Program Survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Complete a Program Summary Worksheet for each program surveyed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Use the Gaps Analysis Worksheet to identify gaps in existing programs, policies, practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Use the Summary Worksheet to summarize each program, policy or practice identified on the initial Inventory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Summarize Prevention Strategy Assessment results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Report out on the Prevention Strategy Assessment results</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Inventory of Alcohol Use Prevention Programs

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Provider Agency / Organization</th>
<th>3 State Priorities</th>
<th>7 Contributing Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Prevent alcohol use among persons 17 and younger</td>
<td>Reduce binge drinking among 18-25 year olds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Easy retail access to alcohol</td>
<td>Easy social access to alcohol</td>
</tr>
</tbody>
</table>
Inventory of Alcohol Use Prevention Policies and Practices

This checklist can help you to assess the number and types of alcohol policies and practices that are in place within your community.

<table>
<thead>
<tr>
<th>ALCOHOL—Public Policies &amp; Practices</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Excise taxes (local)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Limits on hours or days of sale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restrictions of density, location or types of outlets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mandatory server training and licensing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dram shop and social host liability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restrictions on advertising and promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mandatory warning signs and labels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restrictions on consumption in public places</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prevention of preemption of local control of alcohol regulation (home rule)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Minimum bar entry age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Keg registration/tagging ordinances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Compulsory compliance checks for minimum purchase age and administrative penalties for violations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Establishment of minimum age for sellers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ALCOHOL—Organizational Policies &amp; Practices</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Restrictions on alcohol advertisements (media)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restrictions on alcohol use at work and work events (businesses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restrictions on sponsorship of special events (communities, stadiums)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Police walkthroughs at alcohol outlets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Undercover outlet compliance checks (law enforcement agencies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Responsible beverage service policies (outlets)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mandatory checks of age identification (businesses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Server training (businesses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Incentives for checking age identification (businesses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prohibition of alcohol on school grounds or at school events (schools)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Enforcement of school policies (schools)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prohibition of beer kegs on campus (colleges)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Establishment of enforcement priorities against adults who illegally provide alcohol to youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sobriety checkpoints (law enforcement agencies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Media campaigns about enforcement efforts (media)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identification of source of alcohol consumed prior to driving-while-intoxicated arrests (law enforcement agencies)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from “Checklist of Policy Indicators for Alcohol, Tobacco and Other Drugs,” Center for Prevention Research and Development, Institute of Government & Public Affairs, University of Illinois at Champaign-Urbana.
Contact Information

Organization Name: _______________________________________________________________

Address: ______________________________________________________________________

Contact Information: _______________________________________________________________________
(phone, fax, e-mail, Web site)

Director: ___________________________________________________________________________
(name, title, phone, fax, e-mail)

Person Completing the Survey: ______________________________________________________
(name, title, phone, fax, e-mail)

Program Description

Program Name: _________________________________________________________________

• Please describe this program. List its goals, objectives and any expected outcome

Program Approach

• Please describe the intervention approach(es) this program uses to affect its target population (e.g., information distribution, social-skills training, etc.):

Target Population

• The target population of this resource is (check correct box or boxes):

<table>
<thead>
<tr>
<th>Universal (everyone in the community)</th>
<th>Selective (individuals at risk for problem behaviors)</th>
<th>Indicated (individuals engaging in problem behaviors)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Please describe the age(s), race(s), ethnicity(ies) and gender(s) of the target population:

<table>
<thead>
<tr>
<th>Age</th>
<th>Race</th>
<th>Ethnicity</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Please describe this program's location, or the geographic area this program serves:

SURVEY CONTINUED ON NEXT PAGE
### State Prevention Priorities

- Please indicate the extent to which the following alcohol prevention priorities are a focus of this program.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Not a focus</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Major focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevent alcohol use among persons 17 and younger.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major focus</td>
</tr>
<tr>
<td>2. Reduce binge drinking among 18-25 year olds.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major focus</td>
</tr>
<tr>
<td>3. Reduce alcohol impaired driving across all age groups.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major focus</td>
</tr>
</tbody>
</table>

### Contributing Factors

- Please indicate the extent to which the following contributing factors to alcohol use are a focus of this program.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Not a focus</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Major focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Easy retail access to alcohol</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major Focus</td>
</tr>
<tr>
<td>2. Easy social access to alcohol.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major focus</td>
</tr>
<tr>
<td>3. Low enforcement of alcohol laws (underage drinking and impaired driving)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major Focus</td>
</tr>
<tr>
<td>4. Low perceived risk of alcohol use and impaired driving.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major focus</td>
</tr>
<tr>
<td>5. Social norms accepting/encouraging of underage alcohol use, binge drinking, and impaired driving</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major focus</td>
</tr>
<tr>
<td>6. Promotion of alcohol use (advertising, movies, music, etc.).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major focus</td>
</tr>
<tr>
<td>7. Low or discount pricing of alcohol.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Major focus</td>
</tr>
</tbody>
</table>
Evaluation, Effectiveness and Adaptation

• Has this program been tested and found to be effective?  Yes  No
  If no, please explain:

• Has this program been evaluated locally?  Yes  No
  If yes, please describe the evaluation process:

  If yes, please describe the results of the most recent evaluation, or attach a copy of the evaluation results:

• Is this program currently operating with fidelity?  
  (i.e., was it implemented as designed, with all of its core elements?)  Yes  No
  If no, please explain:

• Has this program been adapted for cultural populations, locally?  Yes  No
  If yes, please describe the cultural adaptations that have been made:

Funding

• Please describe this program’s main funding sources:

  Is funding for this program expected to continue indefinitely?  Yes  No
  If no, please explain:

Thank you for taking the time to complete this survey!

Your input is an important contribution to the Community Assessment process. We invite you to contact us if you would like more information about our effort to prevent alcohol abuse in our community.

Please return the survey by:  Please return the survey to:
| Program Name | Effectiveness: Have high-quality evaluations found this program to be effective in promoting positive outcomes for one or more of the state's priorities and/or contributing factors? | Funding: Does sufficient funding exist to maintain this program? | Domains: In which domain (community, family, school, peer or individual) does this program operate? | Developmental: Which developmental period does this program target? | Demographic: Are any demographic groups that could benefit from this program excluded (through incomplete coverage or barriers to access)? | Geographic: Are any geographic areas that could benefit from this program excluded (through incomplete coverage or barriers to access)? | Fidelity: Is this program implemented with fidelity? |
# Gaps Analysis Worksheet (POLICIES & PRACTICES)

<table>
<thead>
<tr>
<th>Policy or Practice Name</th>
<th>Effectiveness: Have high-quality evaluations found this policy / practice to be effective in promoting positive outcomes for one or more of the state’s priorities and/or contributing factors?</th>
<th>Funding: Does sufficient funding exist to maintain this policy / practice?</th>
<th>Domains: In which domain (community, family, school, peer or individual) does this policy / practice operate?</th>
<th>Developmental: Which developmental period does this policy / practice target?</th>
<th>Demographic: Are any demographic groups that could benefit from this policy / practice excluded (through incomplete coverage or barriers to access)?</th>
<th>Geographic: Are any geographic areas that could benefit from this policy / practice excluded (through incomplete coverage or barriers to access)?</th>
<th>Fidelity: Is this policy / practice implemented with fidelity?</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Program Name</td>
<td>Universal (U) / Selected (S) / Indicated (I)</td>
<td>Age-range of target population</td>
<td>Race of target population</td>
<td>Ethnicity of target population</td>
<td>Gender of target population</td>
<td>Selected State Priorities Addressed</td>
<td>Selected Contributing Factors Addressed</td>
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# Summary of Policies & Practices Worksheet

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<tr>
<th>Policy / Practice Name</th>
<th>Universal (U) / Selected (S) / Indicated (I)</th>
<th>Age-range of target population</th>
<th>Race of target population</th>
<th>Ethnicity of target population</th>
<th>Gender of target population</th>
<th>Prevent alcohol use among persons 17 and younger</th>
<th>Reduce binge drinking among 18-25 year olds</th>
<th>Reduce alcohol impaired driving across all age groups</th>
<th>Easy retail access to alcohol</th>
<th>Easy social access to alcohol</th>
<th>Low enforcement of alcohol laws</th>
<th>Low perceived risk of alcohol use and impaired driving</th>
<th>Social norms accepting / encouraging of underage alcohol use, binge drinking, and impaired driving</th>
<th>Promotion of alcohol use</th>
<th>Tested and found to be effective</th>
<th>Local evaluation results available</th>
<th>Operating locally with fidelity</th>
<th>Local cultural adaptations (Y / N)</th>
<th>Critical Identified Gaps</th>
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**NOTE:**
An 8.5” x 14” electronic version of this table will be made available to SPF SIG coalition coordinators.
Access: There are two types of access that have been shown to contribute to the misuse of alcohol, retail access and social access. Retail access refers to how available alcohol is in the community and how easy it is to obtain by purchasing. In contrast, social access includes the obtaining of alcohol from friends, associates, and family members, but it also refers to the availability of alcohol gatherings such as parties and other social events where the alcohol is available as part of the event.

Alcohol Impaired Driving: This refers to operating a motor vehicle under the influence of alcohol, and is often synonymous with "drunk driving" and "drinking and driving". However, unlike DUI, alcohol impaired driving is not a term used within the legal system to describe legal consequences.

Anchored Rating Scale: An anchored rating scale is a numerical scale where each scale point is linked (or "anchored") to specific behaviors or circumstances that must be present to receive that rating. Relating to the community readiness anchored rating scales: For each dimension, the scale defines the critical circumstances that must be present at each level of readiness. Thus, a readiness level on the scale (represented by a number from 1-9) is directly linked to a specific behavior of the community (e.g. a "5" on the leadership dimension is linked to the behavior of "Leaders are part of a committee or group that addresses this issue").

Anecdotal Evidence: Information passed along by word-of-mouth but not documented scientifically.

Assessment: A systematic collection and analysis of data about a community. Also, Step 1 in the Strategic Prevention Framework planning process.

ATOD: The acronym that stands for the phrase “alcohol, tobacco and other drugs.”

BAC: See “Blood Alcohol Concentration.”

Baseline: Observations or data about the target community or target population prior to intervention, which can be used as a basis for comparison once a strategy has been implemented.

Behavioral Health Region: Nebraska’s Department of Health and Human Services (NDHHS) divides the state into six behavioral health “regions.” These are local units of government that NDHHS partners with to do planning and service implementation. Each county appoints a county commissioner to sit on its regional board. These commissioners represent their county and participate in the decision making of their regional board. Each region is staffed by an administrator who in turn hires additional personnel. See Appendix I on p. 143 for a map of Nebraska’s behavioral health regions.

Binge Drinking: A pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 gram percent or above. For the typical adult, this pattern corresponds
to consuming five or more drinks for males or four or more drinks for females in about two hours.

**Blood Alcohol Concentration (BAC):** A unit of measure commonly used to describe the amount (or concentration) of alcohol in a person’s body. BAC is expressed as a percent (such as 0.02%), which refers to the grams of ethanol (or pure alcohol) per 100 milliliters (one deciliter) of blood.

**Coalition Capacity:** Includes a coalition’s membership and leadership as well as the broad array of skills, abilities and organizational functions that a coalition has at its disposal in order to conduct effective strategic planning for prevention.

**Community Capacity:** Step 4 in the Strategic Prevention Framework planning process. Community capacity is a combination of coalition capacity and community readiness. For Nebraska’s SPF SIG funded coalitions, community capacity encompasses a coalition’s analysis of its coalition capacity score and community readiness score, and is one of three criteria used as the basis for selecting substance abuse prevention priorities.

**CDD:** See “Community Data Document.”

**Center for Substance Abuse Prevention:** Under the umbrella of SAMHSA, CSAP is the lead federal agency for substance abuse prevention, and the federal sponsor of the SPF SIG program. CSAP makes grants to tribal, state and local governments and private organizations to engage in a wide variety of prevention activities. The mission of CSAP is to decrease substance use and abuse and related problems among the American public by bridging the gap between research and practice. CSAP fosters the development of comprehensive, culturally appropriate prevention policies and systems that are based on scientifically defensible principles and target both individuals and the environments in which they live.

**Champions:** Those collaborators and/or key stakeholders who will support and promote the coalition’s cause.

**Changeability:** The degree to which a coalition believes it can measurably influence a contributing factor.

**Coalition:** A group of individuals and organizations that create an alliance in order to work cooperatively for a common cause.

**Community:** A group of individuals who share cultural and social experiences within a defined geographic or political jurisdiction.

**Community Data Document (CDD):** A document provided to Nebraska coalitions funded through the SPF SIG that includes a considerable amount of state, regional and county-level data to assist coalitions in the data collection process.
Community Readiness: The degree to which the overall community is prepared to plan for—and take action on—substance abuse prevention issues.

Community Readiness Model: Developed by the Tri-Ethnic Center for Prevention Research, the community readiness model offers tools to measure readiness, develop stage-appropriate methods for enhancing readiness, and selecting prevention strategies that match a community’s current stage of readiness. The steps include: (1) Assess community readiness in order to determine the current stage of readiness; (2) Develop a plan and implement strategies to move the community to higher levels of readiness; (3) Design a community substance abuse prevention plan that uses strategies that match the communities current stage of readiness.

Consequences: The social, economic, and health problems associated with the use of alcohol, tobacco or other drugs (e.g., alcohol related consequences include crime, car crashes, dependence, and hospitalizations). Not all communities will experience exactly the same problems and not all age groups will be equally affected.

Contributing Factors: The seven factors shown to contribute to alcohol use and abuse: (1) Easy retail access to alcohol; (2) Easy social access to alcohol; (3) Low enforcement of alcohol laws (underage drinking and impaired driving); (4) Social norms accepting/encouraging of underage alcohol use, binge drinking, and impaired driving; (5) Low perceived risk of alcohol use and impaired driving; (6) Promotion of alcohol use (advertising, movies, music, etc.); and (7) Low or discount pricing of alcohol.

Coverage Area: The geographical location and boundaries of a community.

CSAP: See “Center for Substance Abuse Prevention.”

Cultural Competence: A set of congruent behaviors, attitudes and policies that come together within a system, agency or among professionals, and enables that system, agency or those professionals to work effectively in cross-cultural situations.

Current Alcohol Use: Refers to the self-reported consumption of alcohol during the previous 30 days.

Data-Driven: Supported by the collection and analysis of objective data.

Demographic Data: Data that describes a place and the people living in it, including population size, gender and racial/ethnic characteristics, age groups, education, economic status, primary languages, etc.

Demographic Gap: A gap among community prevention strategies that occurs when tested, effective strategies do not cover all the races, cultures, genders, languages and economic classes that are represented in your community.
**Developmental Assets:** Developed by the Search Institute (www.search-institute.org), the developmental asset framework is an approach to youth development based on the premise that there are 40 “assets” that represent the relationships, opportunities, and personal qualities that young people need in order to avoid risks and to thrive. According to the Search Institute, these assets can be measured and enhanced through appropriate positive youth development strategies.

**Developmental Gap:** A gap among community prevention strategies that occurs when tested, effective strategies don’t address the appropriate age group for identified priorities.

**Dimensions of Readiness:** Key factors that influence your community’s preparedness to take action on an issue.

**Diversity:** Diversity is the presence of a wide range of variation in human qualities or attributes. Diversity is fostered when a climate of equity, inclusion and mutual respect is genuine and the characteristics and beliefs of those who demonstrate unique and distinctive traits are understood and valued. This includes ethnic and racial backgrounds, age, physical and cognitive abilities, family status, sexual orientation, socioeconomic status, religious and spiritual values, and geographic location.

**Domain Gap:** A gap among community prevention strategies that occurs when tested, effective strategies are not available to address priorities in multiple domains (community, family, school, peer, and individual).

**Driving Under the Influence (DUI):** DUI refers to the operation of a motor vehicle with a blood alcohol concentration above the legal limit. This can also refer to driving under the influence of other substances, such as illicit drugs. The limit for driving under the influence of alcohol varies by state and by age.

**DUI:** See “Driving Under the Influence,”

**Economics:** The economic factors that influence a community’s growth and development, such as major employers or tourist attractions, and trends.

**Economic/Social Impact:** Reflects how the consequences of alcohol misuse impact a community, including productivity within school and the workforce, the health of the population, crime and punishment, and treatment of alcohol dependence and abuse. For Nebraska SPF SIG funded coalitions, prevalence is one of three criteria used to score potential substance abuse prevention priorities.

**Effectiveness Gap:** A gap among community prevention strategies that results when a community has few if any tested, effective strategies to address substance abuse prevention priorities, and/or when there are few if any strategies aimed at one or more of the seven identified contributing factors.
**Enforcement:** Primarily includes the practices of law enforcement agencies and the judicial system with regard to ATOD laws, but can also include the practices of parents, schools, worksites, and other persons or organizations in response to ATOD laws.

**Environmental Strategy:** A type of prevention intervention that works to change the behavior of populations by changing the environment in which people live, work and play (e.g., by doing things such as increasing law enforcement or influencing social norms).

**Epidemiological Data:** Data that describe the distribution and determinants of death, disease, and injury in human populations.

**Evaluation for SPF SIG:** The systematic collection and analysis of data in order to measure the impact of the SPF and implemented programs, policies, and practices. An important part of the process is identifying areas for improvement. Evaluation also emphasizes sustainability since it involves measuring the impact of implemented policies, programs, and practices. Evaluation also includes reviewing the effectiveness, efficiency, and fidelity of implementation in relation to the coalition’s strategic plan, relevant action plans, and measures.

**Evidence-Based:** Supported by the collection and analysis of objective data.

**Evidence-Based Strategies:** Programs, policies or practices that are based on scientific theory and principles, and that have been implemented and found to be effective through formal evaluation.

**Fidelity:** Fidelity is the extent to which an evidence-based prevention strategy is delivered in accordance with the intended (and tested) design. Implementing a strategy with fidelity means that it is delivered the same way that it was implemented in the research that provided evidence of its effectiveness.

**Funding Gap:** A gap among community prevention strategies that occurs when funds are unavailable to implement or maintain tested, effective programs, policies and practices to address priorities.

**Gaps:** Areas (identified through Prevention Strategy Assessment) that are not being addressed by evidence-based programs, policies or practices. There are seven types of gaps that can exist: (1) effectiveness gaps; (2) funding gaps; (3) domain gaps; (4) developmental gaps; (5) demographic gaps; (6) geographic gaps; and (7) implementation gaps.

**Gap Analysis:** The identification of gaps among the available programs, policies and practices throughout a community that address any one or more of Nebraska’s three prevention priorities.
**Geographic Gap:** A gap among community prevention strategies that occurs when the location or coverage area of tested, effective strategies limits or prohibits access and/or participation by relevant target populations.

**History:** The history of major events and forces that affect and help shape a community.

**Impact:** The degree to which you believe your coalition’s work can measurably influence a particular contributing factor. You should consider issues such as your community’s readiness to address the contributing factor (e.g., political will, attitudes among residents, etc.) as well as the resources currently available to address it in your community.

**Implementation:** Implementation involves actually carrying out the coalition’s strategic plan for substance abuse prevention. Also, Step 4 of the Strategic Prevention Framework planning process.

**Implementation Gap:** A gap among community prevention strategies that occurs when tested, effective strategies are not implemented with fidelity—that is, when they are not implemented as designed.

**Inclusion:** Inclusion is the right of all of Nebraska’s diverse populations to participate fully and equally in decision-making, policy development, and implementation of programs, policies and practices.

**Indicators:** Established, quantifiable measures.

**Key Informant Interview:** Interview with someone who is knowledgeable about—often through personal experience—the issue or social phenomena you are investigating.

**Leadership:** The ability to unite individuals in a shared vision and to cultivate an environment that inspires and motivates those individuals.

**Logic Model:** A graphic depiction of a project that maps out the logical sequence of steps linking desired outcomes with chosen strategies.

**Membership:** The people and organizations that lend their time, energy, resources, enthusiasm and collective effort to the coalition process.

**National Registry of Evidence-Based Programs and Practices (NREPP):** NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. It is a service of the Substance Abuse and Mental Health Services Administration (SAMHSA) which developed this resource to help people, agencies, and organizations implement programs and practices in their communities.
Needs Assessment: A part of the overall assessment process that deals with collecting data in order to determine the nature and scope of local alcohol use and related problems.

NREPP: See “National Registry of Evidence-Based Programs and Practices.”

Organizational Structure: The formal and informal policies and procedures that underlie how a coalition operates. This includes practical issues such as by-laws, minutes, job descriptions, accounting procedures and financial reporting, but also addresses decision-making and inter-personal relationships.

Outcomes: Outcomes describe the tangible accomplishments that demonstrate that progress is being made.

Outcomes Based Planning: Planning focuses, first and foremost, on the ultimate outcomes that we desire to achieve (preventing use and negative consequences).

Outcome Evaluation: Describes and documents the degree of change that has occurred as a result of implementing a strategy.

Outcomes Oriented: Designed to ultimately lead to positive change.

Partner: An individual with whom, or organization with which you create an alliance in order to pursue a common interest.

Perceived Risk: The degree to which people perceive that there are risks associated with alcohol, tobacco and other drug use.

Planning: Involves developing a comprehensive strategic plan for substance abuse prevention that includes a mission, selected substance abuse prevention priorities, as well as an analysis of contributing factors and root causes. Also, Step 3 of the Strategic Planning Framework planning process.

Policy: Strategies aimed at changing conditions in the larger environment. They are standards for behavior that are formalized to some degree (i.e., written), and embodied in rules, regulations, and operations procedures. Government regulations are one type of policy, but policies can also include nongovernmental regulations put into place at institutions like schools, colleges, liquor stores, bars, restaurants, and workplaces.

Politics: The political factors that make a community unique, including how local decisions are made.

Practice: A procedure or activity that supports existing policy and helps to sustain or change behavior.
**Prevalence:** Incorporates the number of persons involved, comparison with the State of Nebraska, and historical trends. For Nebraska SPF SIG funded coalitions, prevalence is one of three criteria used to score potential substance abuse prevention priorities.

**Prevention:** The active process of creating conditions and fostering personal attributes that promote the well-being of people.

**Prevention Priorities:** Nebraska’s Strategic Prevention Framework State Incentive Grant substance abuse prevention priorities are: (1) Prevent alcohol use among persons 17 and younger; (2) Reduce binge drinking among 18-25 year olds; and (3) Reduce alcohol impaired driving across all age groups.

**Prevention Strategy Assessment:** Provides information about prevention strategies that are currently being implemented in the focus area that target one or more of the coalition’s selected priorities, and one or more selected contributing factors.

**Prevention System:** The coalitions, agencies and organizations that make up the infrastructure that supports prevention efforts (i.e., education, public health, behavioral health, health care, health services, treatment, law enforcement, courts).

**Pricing:** Refers to the cost of alcohol, tobacco and other drugs (ATOD), and the extent to which changes in pricing (e.g., discounting or price increases) affect consumption. Pricing is one of seven contributing factors that influence ATOD use.

**Priority Response Set:** The answers to community readiness survey questions that are associated with a particular prevention priority.

**Process Evaluation:** Describes and documents the degree to which a strategy was implemented as intended (e.g., what was actually done, how much, when, for whom, and by whom). Process evaluation helps to inform outcome evaluation because outcomes can be influenced by the extent to which strategies are effectively implemented.

**Program:** A structured intervention designed to change individual attributes (e.g., knowledge, skills and/or attitudes) or environmental conditions (e.g., social, physical, fiscal or policy conditions) within a defined geographic area or for a defined population.

**Program Survey:** A survey to help collect important details about each program that has been identified in the Resource Assessment Inventory as addressing one of Nebraska’s substance abuse prevention priorities.

**Promotion:** Refers to attempts by purveyors of alcohol, tobacco and other drugs (e.g., alcohol retailers and the alcohol industry) to increase demand through the
marketing of their products. Promotion is one of seven contributing factors known to influence ATOD use.

**Promotional Event:** An event encouraging the increased use of alcohol in retail establishments, including “ladies' night,” “happy hour,” unlimited drinking for a fixed price or over fixed time period, free or reduced priced drinks with a coupon, or “2-for-1 night.”

**Public Health Model:** Implementing comprehensive, multi-strategy approaches that work to reduce substance use in the overall community, thereby positively impacting the public’s health.

**Qualitative Data:** Non-numerical data rich in detail and description, usually presented in a textual or narrative format, such as data from case studies, focus groups, or document review.

**Quantitative Data:** Information that can be expressed in numerical terms, counted, or compared on a scale.

**Resource:** Human, social, and material assets, as well as programs, policies, and practices that exist in the community or need to be obtained to address identified substance abuse prevention needs.

**Retail Access:** Retail access refers to how available alcohol is in the community and how easy it is to obtain by purchasing. Retail access is one of two types of access (along with social access) that have been shown to contribute to the misuse of alcohol.

**Risk and Protective Factors:** This framework, developed by J. David Hawkins and Richard F. Catalano, identifies conditions that may contribute to, or safeguard against, substance abuse. These underlying conditions are called risk and protective factors. To prevent a problem from occurring, it is necessary to identify both the factors that increase the likelihood of that problem developing (risk factors), and those factors that decrease that likelihood (protective factors). These risk and protective factors are organized into the important areas – or domains – of a young person's life: (1) individual/peer; (2) family; (3) school; and (4) community.

**Root Causes:** The actual factors or conditions that are driving the problem and that an evidence-based prevention strategy will directly try to affect.

**SAMHSA:** See “Substance Abuse and Mental Health Services Administration.”

**Social Access:** Social access includes the obtaining of alcohol from friends, associates, and family members, but it also refers to the availability of alcohol gatherings such as parties and other social events where the alcohol is available as
part of the event. Social access is one of two types of access (along with retail access) that have been shown to contribute to the misuse of alcohol.

**Social/Community Norms:** The acceptability or unacceptability of certain behaviors in a community.

**SPF:** See “Strategic Prevention Framework.”

**SPF SIG:** See “Strategic Prevention Framework State Incentive Grant.”

**Sponsorship:** An arrangement whereby a corporation, business, agency, organization or individual funds a popular event in exchange for advertising at the event. Sponsorship is a type of promotion.

**Stages of Readiness:** The nine developmental stages that a community has to work through in order to move forward to successfully achieve and maintain desired prevention outcomes: (1) No awareness; (2) Denial/resistance; (3) Vague awareness; (4) Pre-planning; (5) Preparation; (6) Initiation; (7) Stabilization; (8) Confirmation/expansion; and (9) High level of community ownership.

**Stakeholder:** All members of the community who have a vested interest (or stake) in the activities and/or outcomes of a coalition’s substance abuse prevention plan.

**Strategic Prevention Framework (SPF):** A five-step, data-driven prevention planning model developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The five steps of the process are: (1) Assessment; (2) Capacity; (3) Planning; (4) Implementation; and (5) Evaluation. Cultural competence and sustainability are the two cross-cutting components at the center of the SPF model because these concepts must be addressed at every step of the process.

**Strategic Prevention Framework State Incentive Grant (SPF SIG):** The purpose of the SPF SIG project, nationally, is to reduce substance abuse at the state and local levels by implementing evidence-based policies, programs, and practices. The national goals developed by the Center for Substance Abuse Prevention are (1) Prevent the onset and reduce the progression of substance abuse, including underage drinking; (2) Reduce substance abuse related problems in communities; and (3) Build prevention capacities and infrastructure at the state/tribal and community levels. In October of 2006, Nebraska was awarded SPF SIG from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention in the U. S. Department of Health and Human Services.

**Strategy:** A course of action, based on theory that is selected in order to achieve a goal. Strategies include all policies, programs, and practices that promote the well-being of people by reducing the consumption of—and the problems associated with—alcohol, tobacco and other drugs.
**Substance Abuse:** Substance abuse encompasses: (1) the illegal use of alcohol, tobacco or other drugs, or (2) any use by minors of alcohol, tobacco or other drugs, including hazardous chemicals such as inhalants.

**Substance Abuse and Mental Health Services Administration (SAMHSA):** SAMHSA is an operating division within the federal Department of Health and Human Services. As the umbrella agency housing the Centers for Mental Health Services (CMHS), Substance Abuse Prevention (CSAP), and Substance Abuse Treatment (CSAT), SAMSHA works to improve the quality and availability of substance abuse prevention, alcohol and drug addiction treatment, and mental health services.

**Sustainability:** The process of ensuring an adaptive and effective prevention system that achieves and maintains the human, social and material resources needed to achieve your coalition's long-term goals.

**Target Population:** The individuals (either singly or in groups), who will be the focus of a coalition's prevention efforts.

**Tri-Ethnic Center Readiness Model:** The Tri-Ethnic Center for Prevention Research in Colorado found that as communities reach higher levels of readiness to plan for and take action on issues of importance, they were increasingly better able to achieve their desired prevention outcomes. The Center’s model includes processes to: (1) Assess community readiness in order to determine the current stage of readiness; (2) Develop a plan and implement strategies to move the community to higher levels of readiness; and (3) Design a community substance abuse prevention plan that uses strategies that match the communities current stage of readiness.
Qualitative Data Collection Methods

- **Town Hall Meetings**: Coalitions funded through Nebraska’s SPF SIG are required to conduct a minimum of one town hall meeting for a single county applicant or tribe, and two for a multi-county applicant. The goal of a town hall meeting is to gather a wide variety of community views regarding factors that may be influencing the prevention priorities you have chosen to address in your community. Town hall meetings are listening sessions designed for larger groups. An issue is announced and the community is invited to come learn and share about the topic. Holding a town hall meeting is an efficient way to gather qualitative data through the use of a group discussion focusing on a particular subject or idea. Through a town hall meeting, you can access information not only about what people feel, but also about why they feel the way they do. Group discussions have the potential to provide both accurate and in-depth data. A sample protocol for this meeting can be found in Appendix D on p. 122.

- **Observational and Library Research**: Coalitions funded through Nebraska’s SPF SIG must observe and analyze data from newspapers, billboards, bars/restaurants, and stores/retail outlets to help you better understand the promotion and pricing of alcohol in the community. The goal is to help you better understand contributing factors within your community using locally attainable and readily available sources of information. These methods of data collection are described in further detail in the Needs Assessment section of this Toolkit.

- **Law Enforcement Interviews**: A minimum of two key informant interviews with law enforcement personnel is required for coalitions funded through Nebraska’s SPF SIG. The goal is to conduct interviews that would be most appropriate and informative for your community. This may consist of a representative from the local police department and county sheriff’s office within a single county, or it may consist of an officer from each of the two or three counties that your coalition represents. You may also want to consider interviews with persons working in your local judicial system, emergency rooms, schools, and treatment facilities. (Note: Key informant interviews of other stakeholders in your community may be an excellent way to collect additional qualitative data, but—other than those key informant interviews that you have already completed as part of your Community Readiness Assessment—they are not required for SPF SIG funded coalitions.) A sample protocol for the law enforcement interviews can be found in Appendix F on p. 130.

- **Focus Groups**: These are encouraged but—for SPF SIG funded coalitions—are *not* required. Focus groups are facilitated discussions of 5-10 individuals from similar backgrounds led by a trained moderator who guides the group into
increasing levels of focus and depth on key issues. Like key informant interviews, focus groups can help you go beyond quantitative data and allow you to learn more about a particular problem. For example, a survey of 10th and 12th grade students reveals high levels of binge drinking. You want to understand more about settings in which youth are binge drinking and how and where they have access to alcohol, so you conduct a series of focus groups of 9th and 11th graders from the community. You may find it helpful to conduct one or more focus groups of persons in your target population. For example, you may want to conduct a focus group of high school students if you chose underage drinking as a priority, college students or other young adults if you chose binge drinking as a priority, or persons of any appropriate age if you chose alcohol impaired driving as a priority. A sample protocol for collecting focus group data from youth and young adults can be found in Appendix G on p. 135.

Quantitative Data Collection Methods

Additional data collection methods that can be used (but are not required for SPF SIG funded coalitions) include:

- **Surveys:** Conducting surveys can provide quantitative data about how a particular group or groups think, behave, or react. Surveys can be good tools to describe populations, show prevalence of behaviors, and assess levels of knowledge about specific issues. SPF SIG funded coalitions will have access to a variety of survey data through their Community Data Documents.

- **Mapping:** Geographical Information Systems (GIS) software can help you create a map of your community showing, for example, the concentration of alcohol outlets, problem outlets, the proximity of police calls for alcohol-related problems and arrests, and location of alcohol-related traffic crashes. Your coalition can access data at the level that can be mapped within your community from the state or from a local agency that holds the data in which you are interested.
1. **Legal Drinking Age**: 21

2. **Blood Alcohol Concentration Limit**: Alcohol BAC limit = 0.08; a BAC level at or above the limit is conclusive evidence of a violation.

3. **Driving Under the Influence (DUI)**:
   - **First offense**: Class W misdemeanor; mandatory minimum 7 days in jail; 6-month revocation; $400 fine
   - **Second offense**: Class W misdemeanor; mandatory minimum 30 days in jail; 1-year license revocation; $500 fine
   - **Third offense**: Class W misdemeanor; mandatory minimum 90 days in jail; 15-year license revocation; $600 fine
   - **Fourth offense**: Class W misdemeanor; mandatory minimum 180 days in jail; 15-year license revocation
   - **Fifth offense**: Class III felony; mandatory minimum 1 year in jail; 15-year license revocation

4. **Driving Under the Influence (DUI) with Alcohol BAC Level 0.15 or Higher**:
   - **First offense**: Class W misdemeanor; mandatory minimum 7 days in jail; 1-year license revocation; $400 fine
   - **Second offense**: Class I misdemeanor; mandatory minimum 90 days in jail; 1-year license revocation
   - **Third offense**: Class IIIA felony; mandatory minimum 180 days in jail; 15-year license revocation
   - **Fourth offense**: Class III felony; mandatory minimum 1 year in jail; 15-year license revocation
   - **Fifth offense**: Class II felony; mandatory minimum 1 year in jail; 15-year license revocation

5. **Driving Under the Influence Violation and Motor Vehicle Crash**: If serious bodily injury is caused to another person, this is a Class IIIA felony, with mandatory minimum 60 days to 15-year license revocation.

6. **Motor Vehicle Homicide**:
   - Class III felony if there is no prior DUI conviction, with a mandatory minimum 60 days to 15-year license revocation and 1 year in prison
• Class II felony if there is a prior DUI conviction, with a mandatory minimum 1 year in jail

7. **Administrative License Revocation Law (ALR):** The ALR allows a law enforcement officer to confiscate the license of a drinking driver on the spot. The penalties for the ALR are separate and distinct from any penalties assigned for a conviction of driving under the influence.

• A driver pulled over by a police officer for suspected drunken driving will be asked to take a breath, blood or urine test.

• If the driver refuses the test, the license is revoked for one year.

• If the driver fails the test, the license is revoked for 90 days for a first offense. Second offense is 1 year revocation.

8. **Furnishing of Alcohol to Minors:** Furnishing is prohibited and will result in administrative penalties for retail establishments that provide alcohol to minors, including suspension, cancellation and revocation of the liquor license.

9. **Open Container Law:** It is prohibited for anyone in the passenger area of a motor vehicle to possess an open container of alcohol. This includes beer, wine, and liquor.

10. **Minimum Ages for On-Premise Servers and Bartenders:** Beer, wine and spirits (server and bartender) = age 19

11. **Minimum Ages for Off-Premise Sellers:** Beer, wine and spirits = age 19

12. **False Identification for Obtaining Alcohol:** Use of false ID to obtain alcohol is a criminal offense; no driver’s license suspension procedure.

• Provision targeting suppliers:
  ✓ It is a criminal offense to manufacture or distribute false ID

• Retailer support provisions:
  ✓ Specific Affirmative Defense—the retailer inspected the false ID and came to a reasonable conclusion based on the appearance that it was valid

13. **Keg Registration (keg definition: five or more gallons; provisions do not specifically address disposable kegs):**

• Prohibited to destroy the label on a keg—a person guilty of doing so is guilty of a Class III misdemeanor—maximum fine/jail = $500 or 3 months; it is also a Class III misdemeanor to be in possession of a keg with an altered or removed keg identification number

• Purchaser information collected includes purchaser’s name and address, verified by a government-issued ID
• Warning information to purchaser is passive (no purchaser action is required)
• Deposit is not required

14. **Mandatory interlock ignition devices:**
   • All first time drunk driving offenders will have their licenses revoked or impounded for 30 days
   • For the following 5 months, they can drive only in a vehicle fitted with an interlock ignition device (an “in car breathalyzer” that detects if the person behind the wheel has a blood alcohol level above .02)

15. **Youth Blood Alcohol Concentration Limits (underage operators of noncommercial motor vehicles):** Alcohol BAC limit = 0.02; a BAC level at or above the limit is conclusive evidence of a violation; applies to drivers under age 21.

16. **Underage Possession of Alcohol:** Possession is prohibited with the following exceptions:
   • In the youth’s permanent place of residence
   • As part of a bona fide religious rite, ritual or ceremony

17. **Underage Consumption of Alcohol:** Consumption is prohibited with the following exceptions:
   • In the youth’s permanent place of residence
   • As part of a bona fide religious rite, ritual or ceremony

18. **Underage Purchase of Alcohol:** Purchase is prohibited with the following exception:
   • For law enforcement purposes

19. **Social Host Liability and Underage Dram Shop:** Civil liability for adults and retail establishments that provide alcohol to a minor who is later involved in an alcohol-related incident that damages property, or injures or kills an innocent third party.

This list was compiled from information provided by MADD Nebraska and Pride Omaha, Inc., as well as from information available on the websites of the Alcohol Policy Information System (APIS) and the Nebraska Office of Highway Safety.
The following tables identify root causes for each of the seven contributing factors for alcohol use. However, this list is not necessarily all-inclusive. Other root causes may exist that are specific to your community.

1. **Easy Retail Access**

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID issues</td>
<td>Use of fake IDs; failure of retailers to properly check IDs</td>
</tr>
<tr>
<td>Compliance with laws/regulations</td>
<td>Sales to minors; sales to intoxicated persons</td>
</tr>
<tr>
<td>Density</td>
<td>High-density of package sales locations; high-density of open-container sales locations</td>
</tr>
<tr>
<td>Employees</td>
<td>Clerks have underage friends and sell to them</td>
</tr>
<tr>
<td>Product placement</td>
<td>Ease of shoplifting; alcohol placement in store (behind counter)</td>
</tr>
</tbody>
</table>

2. **Easy Social Access**

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of alcohol to minors</td>
<td>Parents, older siblings, and other relatives provide alcohol to or purchase alcohol for underage persons; legal age friends and acquaintances provide alcohol to or purchase alcohol for underage persons; strangers purchase alcohol for underage persons when asked</td>
</tr>
<tr>
<td>Adults unaware of penalties for providing alcohol to minors</td>
<td>Adults do not know that they can be arrested and jailed for providing alcohol to a minor</td>
</tr>
<tr>
<td>Community celebrations</td>
<td>Alcohol is obtained by underage person at community celebrations where there is little supervision; binge drinking is often acceptable</td>
</tr>
<tr>
<td>Availability of unsupervised drinking locations</td>
<td>Numerous party settings that are unsupervised (vacant lots/buildings, parks, fields); friends with their own apartments</td>
</tr>
<tr>
<td>Lack of parental monitoring of alcohol supply in the home</td>
<td>Take or steal alcohol from parents' home</td>
</tr>
</tbody>
</table>
## 3. Enforcement of Alcohol Laws

### Table 3: Examples of Root Causes to Low Enforcement of Alcohol Laws

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resources</strong></td>
<td>Shortage of law enforcement personnel; lack of training on alcohol issues; low priority among community leaders; few or no retail compliance checks</td>
</tr>
<tr>
<td><strong>Law enforcement practice</strong></td>
<td>Inconsistent application of underage drinking laws, laws regarding selling to intoxicated persons, DUI, and social host laws; low number of arrests/citations for alcohol use by minors; low agency priority</td>
</tr>
<tr>
<td><strong>Judicial practice</strong></td>
<td>No prosecution by county/district attorney of filed cases; inconsistent application of legal consequences; few first-offender consequences</td>
</tr>
<tr>
<td><strong>Parental enforcement</strong></td>
<td>Parents have few rules, if any, around drinking; parents don’t enforce underage drinking laws</td>
</tr>
</tbody>
</table>

## 4. Social/Community Norms Related to Underage Alcohol Use, Binge Drinking, and Impaired Driving

### Table 4: Examples of Root Causes to Accepting and/or Encouraging Social / Community Norms

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acceptance</strong></td>
<td>Parents permit underage drinking at home; parents/community residents do not care if teenagers drink; drinking is better than drug use (i.e., lesser of two evils); workplaces promote drinking and binge drinking as part of the culture; alcohol is expected to be available at community events; drinking and driving is not discouraged</td>
</tr>
<tr>
<td>“Rite of passage”</td>
<td>Using alcohol and binge drinking are what kids do</td>
</tr>
<tr>
<td><strong>Public alcohol use</strong></td>
<td>Adults of all ages drink in public, highly visible in the community</td>
</tr>
<tr>
<td><strong>Youths’ attitudes and perceptions</strong></td>
<td>Drinking helps you bond with others and make new friends; binge drinking is normal, most kids are doing it; drunkenness/excessive alcohol consumption is OK; alcohol equals fun</td>
</tr>
</tbody>
</table>
5. Perceived Risk of Alcohol Use and Impaired Driving

Table 5: Examples of Root Causes to Low Perceived Risk

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low perceived risk of legal consequences</td>
<td>Belief that there is a low risk of getting caught drinking (if underage) or drinking and driving; belief that penalties for underage drinking are not serious; belief that police won’t actually arrest them or give them a citation; adults do not know laws related to providing alcohol to minors.</td>
</tr>
<tr>
<td>Low perceived risk of health problems</td>
<td>Belief that alcohol is less dangerous than other drugs; belief that alcohol is safe as long as you are not driving; belief that alcohol is good for you; belief that hard liquor is dangerous but beer is not.</td>
</tr>
</tbody>
</table>

6. Promotion of Alcohol Use

Table 6: Examples of Root Causes to the Promotion of Alcohol Use

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local promotion</td>
<td>Retail establishments have excessive numbers of alcohol ads and alcohol signage; large number of alcohol ads on college campuses; community events often have alcohol sponsorship; drinking is promoted at community events; highly visible placement of alcohol in convenience stores; large number of billboards promoting alcohol products; local advertising encourages excessive consumption (drink specials).</td>
</tr>
<tr>
<td>National promotion</td>
<td>Pro-alcohol messages from alcohol industry, including alcohol use as sexy and fun-filled; television and movie content promotes binge drinking; Internet websites (e.g., MySpace and YouTube) create expectations for youth and young adults around binge drinking.</td>
</tr>
</tbody>
</table>

7. Pricing of Alcohol

Table 7: Examples of Root Causes to Low Pricing of Alcohol

<table>
<thead>
<tr>
<th>Category</th>
<th>Root Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink pricing</td>
<td>Bars near campus compete for student purchasers with drink specials; pricing specials that target young adults (e.g., 50-cent drafts); happy hours; high density can lead to competition and low pricing.</td>
</tr>
<tr>
<td>Container pricing</td>
<td>Discount pricing is available for large quantities (24-packs of beer or large bottles of hard liquor); convenience stores price beer cheaply to attract customers; holiday discounts of alcohol; high density can lead to competition and low pricing.</td>
</tr>
</tbody>
</table>
Overview

Town hall meetings are listening sessions designed for larger groups. An issue is announced and the community is invited to come learn and share about the topic. Holding a town hall meeting is an efficient way to gather qualitative data through the use of a group discussion focusing on a particular subject or idea. Through a town hall meeting, you can access information not only about what people feel, but also about why they feel the way they do. Group discussions have the potential to provide both accurate and in-depth data.

Needs Assessment Requirements

As stated in the needs assessment section of this Toolkit, SPF SIG funded coalitions are required to hold a minimum of one town hall meeting for a single county applicant or tribe, and two for a multi-county applicant. If you recently completed or are schedule to host a SAMHSA funded town hall health meeting in your community it can be substituted in place of this town hall meeting. However, even if you completed a SAMHSA funded town hall meeting, you are encouraged to conduct additional town hall meeting(s) to collect information that will help you with your SPF SIG assessment and planning process.

The remainder of this appendix provides a general protocol that will help you to for run a successful town hall meeting.

The Moderator

Fundamental to the town hall meeting is a moderator who facilitates the discussion. This person should feel at ease speaking in front of a group, but he or she will not be teaching. The moderator’s goal is to make the participants feel comfortable in expressing themselves openly while keeping the discussion on track. Staying objective (i.e., holding back one’s own opinions) is important.

Becoming a talented moderator takes practice. For most novices the best strategy is to play the role of a seeker of wisdom. This role assumes that the participants have the wisdom you need and will share it if asked the right questions.

Most importantly, moderators must learn to listen and not talk.

Choosing the Participants

Town hall meetings should consist of at least 10 people who either volunteer to come or who have been specifically chosen. While most town hall meetings are made up of a
homogeneous group of strangers, don’t be afraid to invite specific individuals to attend the meeting. Key participants may include a community member, a police officer, a parent, an adolescent, someone from your coalition advisory council, a bar owner, and any other individuals who may have insight on the topic.

Setting the Rules

Prior to starting the discussion, the moderator should lay down a few ground rules. Generally, rules should include the following:

- Only one person talking at a time;
- No side discussions among participants;
- No member should be put down because of their opinions;
- All thoughts and ideas are valued; and
- There are no wrong or right answers.

As with the selection of group members, care and creativity should be used when setting rules.

Conducting the Discussion

The discussion itself should last between 1 and 2 hours and follow a structured format. The moderator should make every attempt to find a balance between keeping the group discussion on track and allowing it to flow naturally. In order to accomplish this, a “funnel” structure is often used. This approach is best outlined as a series of questions that move from general to specific, and consists of the following types of questions:

Opening Question: This is a “round robin” question that everyone answers at the beginning of the meeting. It is designed to be answered quickly and to identify those characteristics that participants have in common. It should make everyone in the group feel more at ease.

Introductory Questions: These are questions that introduce the topic for discussion. Usually they are not critical to the data collection effort; rather, they are intended to foster conversation and interaction among the participants.

Key Questions: These are questions that drive the collection of new information. Their answers provide the best data for later analysis. They should be focused on the topic of interest and open-ended. The moderator’s goal with these questions is to illicit discussion among the participants. You should avoid both questions that allow for short answers and yes/no questions.

Ending Questions: These questions bring closure to the discussion and enable participants to look back upon previous comments. Once again a “round robin”
approach is best, and participants should be asked to summarize their thoughts in some way.

Sample Protocol for a Town Hall Meeting

Below, you will find a sample protocol that you may use to run your town hall meeting. The protocol includes specific questions you may want to ask during your town hall meeting. There are more questions here than you could likely get through in one meeting, so decide which questions you are most interested in (or which important questions are missing), and focus on those. If you have already selected your SPF SIG prevention priorities, try and focus the questions on your priorities. If you have not yet selected your priorities, try and focus the questions on all three potential priorities.

**Meeting Introduction:** The moderator should welcome the group and briefly explain why the meeting is being held, discuss the SPF SIG community grant, describe the prevention priorities if selected, and review the ground rules for discussion.

**Opening Question:** Tell us your name and what brought you here today. (Round Robin)

**Introductory Questions / Comments:**

- What are the alcohol-related problems in our community?
- What factors are causing these problems?
- A number of alcohol-related concerns and possible causes for those concerns have been mentioned. Let’s think about three possible causes of alcohol misuse in particular. For the remainder of this discussion, let’s think about access to alcohol among youth and young adults, community norms around alcohol consumption, and the enforcement of alcohol laws in our community.

**Key Questions:**

- *Let’s start with access to alcohol.* There are two types of access that have been shown to contribute to the misuse of alcohol, retail access and social access. Retail access refers to how available or easy it is to purchase in the community. In contrast, social access refers to obtaining of alcohol from friends, associates, and family members, but it also refers to the availability of alcohol-related gatherings such as parties and other social events where alcohol is available as part of the event.
- Where do youth in our community, high school age and younger, get alcohol? Give examples.
- Where do underage youth who are out of high school (typically 18, 19, and 20) get alcohol? Give examples.
How often are underage youth in our community getting alcohol from their parents?

What have you heard about underage youth in our community purchasing alcohol from retail establishments?

What are your experiences with underage drinking at parties?

Where is alcohol most often consumed in our community? For youth and adults?

There’s been a lot of talk about the misuse of alcohol as a problem in our community, but to what extent do you think access to alcohol really contributes to the problem? (Round Robin).

— Transition to discussion of community norms—

Next, let’s talk about community norms. Community norms reflect general attitudes about alcohol use and societal expectations regarding the level and type of use that is considered appropriate.

What are the general attitudes about drinking in our community?

What are the general attitudes about drinking and driving in our community?

How do most adults in our community view underage alcohol use?

In our community, is it okay to provide alcohol to someone who is underage, and if so, under what circumstances?

In our community, at what age is it acceptable to use alcohol?

What is our community’s attitude toward binge drinking? (if necessary ask, Is it acceptable to drink until you get drunk in our community?)

What kind of groups or organizations promote the use of alcohol in our community?

What are the community expectations around alcohol availability at community events? (Examples: sporting events, rodeos, fairs, and carnivals.)

Now that we’ve had this discussion, to what extent do you think community norms contribute to the misuse of alcohol in our community? (Round Robin)

— Transition to discussion of enforcement—

Last, lets think about the enforcement of alcohol laws in our community.

How do you think local law enforcement views underage drinking?

How do you think local law enforcement views drinking and driving?

What are some of the challenges that make it difficult for law enforcement to address underage drinking?...drinking and driving?
• How does the local court system handle alcohol arrests and citations? (*If necessary ask, How is minor in possession handled? Providing alcohol to a minor? Driving under the influence?)

• How do schools address alcohol use among students? What responsibility does the school have to address alcohol use among students?

Ending Questions:

• Considering the three factors that we’ve talked about today—access, community norms, and enforcement of alcohol laws—which one do you feel is the leading cause of the misuse of alcohol in our community? (Round Robin)

• Our goal is to find out what is contributing to the misuse of alcohol in our community. Have we missed anything? Do you have any final comments?

Thank You: Thank the participants for coming.

Recording and Using the Information

Every effort should be made to record the town hall meeting by having a colleague take notes and through the use of a tape or video recorder. The use of recording equipment allows the meeting to be revisited when needed. This discussion can also be transcribed or at least listened to for quotes and general ideas. We suggest using a data matrix like the one found on the next page to keep track of major themes and quotes from the discussion. Feel free to expand the table as needed.

The information gathered from this meeting should be used to compliment other assessment data collection through the use of participant quotes and the grouping of ideas from the meeting. The grouping of ideas refers to the categorizing of attitudes, feelings, or beliefs of the group toward the topic. This may simply involve discussions that revolved around a single question. In other cases this may involve outlining the major topics brought up by the group.
Notes for Town Hall Meeting about Alcohol Misuse

<table>
<thead>
<tr>
<th>Question Topics</th>
<th>Major Ideas or Themes</th>
<th>Quotes</th>
<th>Consensus or Disagreement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other thoughts, ideas, comments, or themes that arose during the town hall meeting:
This tip sheet provides a series of hints on how to successfully prepare for, carry out, and follow up on key informant interviews.

1. Prior to the interview, contact the interviewee to:
   - Introduce yourself;
   - Explain the purpose of the interview;
   - Explain what your own role will be as interviewer;
   - Explain what is expected of the interviewee;
   - Describe the expected length of the interview;
   - Schedule a date for the interview.

2. In between that introductory call and the interview, you may want to send the interviewee a copy of the interview questions, along with a reminder of the date and time of the interview, and a note about whether the interview will be face-to-face or via phone. This helps to prevent cancellations and no-shows.

3. If possible, practice running through the interview with another coalition member. This will help you to feel more comfortable with taking notes at the same time that you are guiding the interview. It’s helpful to practice listening, clarifying, probing AND writing all at the same time!

4. It is best to take detailed written (or typed, if you have a laptop) notes, and not to depend on a tape recorder. Batteries die, tapes get corrupted, people are hard to hear, and sometimes interviewers forget to turn on the machine! In addition, it can be much harder than it sounds to go back and transcribe a tape. You may use a tape recorder for back up, but please make sure your hand-written or typed notes are accurate and comprehensive.

5. If appropriate (e.g., with youth), an incentive—such as food—is recommended. The incentive can be provided either during or after the interview. With adults, an incentive is not necessary.

6. Sometimes an interviewee will answer a question incompletely. He or she might provide a one-word answer, or you may not understand exactly what is meant. In other instances, the interviewee might not understand the question, so his or her response may not “fit.” In cases like this, it is important to probe—that means asking...
additional questions in order to make sure that you understand, and to make sure that you have a complete answer. Here are some suggestions for ways to probe:

- Tell me more about that.
- It sounds like you’re saying _____. Is that what you meant?
- I’m not sure that I exactly understand what you mean…would you explain that again?
- Okay, I hear what you’re saying…but this question is asking _____ (re-word the question, if necessary).

7. Interviewees can get off track, which will make the interview last a lot longer. Some polite ways to help folks keep on track include saying things like:

- Okay, we still need to get through all of these questions…what do you think about [next question]?
- We’re almost done, here—just another couple of questions…what do you think about [next question]?
- That’s interesting—I wish we had time to talk more about that now, but we’ve still got to get through the rest of these questions…what do you think about [next question]?

**NOTE:**

If you are interviewing a tribal elder, it is not appropriate to interrupt that person, even if he or she is getting off track from the subject at hand. Consequently, you should schedule more time for these interviews in order to account for this fact.

8. It is best to transcribe your notes immediately after an interview, when everything is fresh in your mind. As soon after the interview as possible, go back over what you have written and make sure that you understand your own notes. Then, copy your notes into the permanent record that will be used by the Community Readiness Assessment scorers.

9. If you have the luxury of being able to have two interviewers on hand—especially when you are learning to conduct interviews—you can have one person asking questions and guiding the interview, and the other taking notes. The two of you should review the notes, together, right after the interview.

10. Create a thank you note and send it to the interviewee after your meeting.
Overview

One method for obtaining data is the face-to-face interview. With this method, you talk to each participant directly. This can be done in the participant’s workplace, in your office, or any other suitable place. We recommend that you use a semi-structured interview format. This means that you will ask a set of questions prepared in advance. Clarification to follow-up questions may still be used. By asking general questions and having your participants provide answers in their own words, you may gain more complete information. The interview should be structured, but not so structured that it doesn’t allow participants to discuss the misuse of alcohol in the community freely.

Although face-to-face interviews are a valuable way to collect data, they are not without drawbacks. The appearance and demeanor of the interviewer may affect the responses of the participants. Subtle changes in the way an interviewer asks a question may elicit different answers. Also, be aware that the interviewer may not respond similarly to all participants. For example, an interviewer may respond differently to a participant they know versus a participant they have never met before. (Note: Additional tips on conducting key informant interviews are provided in Appendix E on p. 128.)

The Interviewer

Fundamental to the interview is an interviewer who leads the discussion. This person should feel at ease speaking in a one-on-one conversation. The interviewer’s goal is to make the participant feel comfortable in expressing themselves openly while remaining unbiased and keeping the discussion on track. It is recommended that you use someone who has conducted face-to-face interviews before. The interviewer should be able to ask the questions the same way for each participant and be able to read the questions in a neutral manner. The interviewer should also be practiced in active listening techniques that encourage participants to honestly and openly respond to the interview questions.

Choosing the Participants

As stated in the needs assessment section of this Toolkit, a minimum of two interviews with law enforcement personnel is required for SPF SIG funded coalitions. The goal is to select participants that would be most appropriate and informative for your community. This may consist of a representative from the local police department and the county sheriff’s office within a single county or it may consist of an officer from each of the two or three counties that your coalition represents. If possible, interview the
Chief of Police or County Sheriff for one or more of your interviews. In addition to law enforcement personnel, you may also want to consider interviews with persons working in your local judicial system, emergency rooms, schools, and treatment facilities. One thing to consider when you choose your participants may include the length of time they have held their current position. Be careful not to choose someone who is too new to be able to accurately answer your questions. The interviewer should keep in mind the questions they are trying to answer, and they should feel creative in how they choose participants.

**Conducting the Interview**

The interview should last about 30 minutes and follow a semi-structured format. Only the interviewer and the participant should be present during the interview, and the interviewer should make sure the interview is being conducted in a private location where others cannot hear the conversation. The interviewer should ask the questions and let the participant respond without interrupting. The interviewer should allow the participant to talk freely but not ramble about unrelated issues. The interviewer should make every attempt to find a balance between keeping the conversation on track and allowing it to flow naturally. To accomplish this, a “funnel” structure is often used. This approach is best outlined as a series of questions that move from general to specific and consists of the following types of questions:

**Introductory Questions:** These are questions that introduce the topic for discussion. They should make the participant feel at ease with the interviewer. Usually they are not critical to the data collection effort; rather, they are intended to foster conversation and get the participant to start thinking about the topic.

**Key Questions:** These are questions that drive the collection of new information. Their answers provide the best data for later analysis. They should be focused on the topic of interest and open-ended. The interviewer’s goal with these questions is to illicit open responses from the participant. You should avoid both questions that allow for short answers and questions that can be answered with a yes/no.

**Ending Questions:** These questions bring closure to the discussion and enable the participant to look back upon previous comments. The participant should be asked to summarize their thoughts in some way.

**Sample Questions You May Choose to Use for Your Interviews**

**Introductory Questions:**

- What alcohol-related problems do you see in our community?
- What factors do you believe are causing these problems?
- How frequently is alcohol involved in crimes in our community?
Key Questions:

- How many alcohol-related offenses occur in our community?
- How many alcohol-related offenses do you think go undetected in our community?
- Are any officers assigned specifically to alcohol-related issues or offenses in our community?
  - If yes, How many officers are assigned?
  - If yes, What does their work consist of?
- What special training do officers have in order to deal with alcohol-related offenses?
- Do you hold sobriety check points in our community?
  - If yes, How many sobriety check points were held in 2007?
  - If yes, How many drivers were tested and found to be under the influence?
  - If yes, Where were the sobriety check points held?
- Have you conducted any compliance checks for sales to intoxicated patrons?
  - If yes, How many compliance checks for sales to intoxicated patrons were conducted in 2007?
- Have you conducted any compliance checks for sales to minors?
  - If yes, How many compliance checks for sales to minors were conducted in 2007?
- What else are law enforcement officers doing around the misuse of alcohol in our community?
- Are there particular locations or people that are known for having alcohol-related incidents? If yes, what do you do to keep track of these locations and/or people?
- What kind of support does law enforcement receive to address alcohol-related crimes from members of the community? (...probe if necessary...Describe the support from community leaders such as the mayor, the city council, or the county commissioner; describe the support parents and other community groups.)
- How do you think law enforcement could better address the alcohol-related problems in our community?

Ending Questions:

- How important do you think enforcing alcohol laws is to the overall prevention of alcohol misuse in our community? Who else needs to play a critical role in preventing alcohol misuse in our community?
• Our goal is to identify and address the factors that are contributing to the misuse of alcohol in our community. Is there anything you would like to add or do you have any final comments?

Thank You: Thank you for your time and input.

Recording and Using the Information

In addition to taking notes, every effort should be made to record the law enforcement interview, but first you should seek permission from your participant. The use of recording equipment is important because it will allow you revisit the conversation and will also allow you to pull direct quotes made by the participant. This discussion can also be transcribed or at least listened to for quotes and general ideas.

At the end of each interview, summarize the information into manageable themes, issues, and recommendations. Each summary should provide information about the key informant’s position on different topics, themes that surfaces or were repeated, main points made, and any insights or ideas that the interviewer had about the interview. We suggest using a format similar to the one found one the next page to keep track of major themes and quotes from the discussion. Feel free to modify this format in a way that works best for you. Once all of your interviews are complete, it may be helpful for you to compile an overall summary using a similar format.

The information gathered from these interviews should be used to compliment other needs assessment data collection through the use of participant quotes and the grouping of ideas. Once complete, see how feedback given during the town hall meeting or other interviews (including those from the Community Readiness Assessment) match the feedback given by law enforcement personnel.
Notes for Law Enforcement Interview

Date: _______________      Location: ________________________
Participant’s Title: _____________________ Interviewer: ______________________

Themes (e.g., major issues, ideas, attitudes) that emerged during the interview:

• **Theme 1**: (example, limited resources (staff/funding) to address alcohol-related crimes in the community)
  - Quotes related to theme 1:
  - Possible solutions or recommendations noted by the participant:

• **Theme 2**:
  - Quotes related to theme 2:
  - Possible solutions or recommendations noted by the participant:

• **Theme 3**:
  - Quotes related to theme 3:
  - Possible solutions or recommendations noted by the participant:

…Note: copy and paste from above, as needed in order to record additional themes…

**Other relevant quotes:**

**Other thoughts or impressions about the interview:**
Overview

Focus groups are facilitated discussions of 5-10 individuals from similar backgrounds led by a trained moderator who guides the group into increasing levels of focus and depth on key issues. Like key informant interviews, focus groups can help you go beyond quantitative data and allow you to learn more about a particular problem. For example, if a survey of 10th and 12th grade students revealed high levels of binge drinking, you might conduct a focus group of high school students to learn more about settings in which youth are drinking and how and where they have access to alcohol.

As a result, your coalition may find it helpful to convene one or more focus groups with youth in your community. These focus groups could consist of high school students or young adults who are out of high school, and the topics may depend on what you have chosen as your SPF SIG priorities. The following age groups would work well for a focus group: 15- to 17-year-olds (in high school), 18- to 20-year-olds (underage for buying alcohol and of college age), and 21- to 24-year-olds (of legal age).

Steps to Run a Focus Group

1. **Find an individual who is comfortable talking in front of groups to lead the discussion.** Some things to look for when choosing a discussion leader are:
   - Experience leading discussions;
   - Knowledge of the topic to be discussed; and
   - Ability to relate to the group participants.
   
   Try and avoid choosing a discussion leader who might make the participants uncomfortable. For example, the discussion leader should not be someone who has authority over any of the participants (e.g., a local police officer or local teacher), because such a person is not likely to elicit open and honest responses.

2. **Find a note-taker.** A lot of important information will be discussed at a fast pace, so you’ll need someone experienced at taking notes to make sure important information is not lost. Also, try to tape record the group discussion so you can go back and listen to it.

3. **Invite people who represent the community you’re working with.** Select people that are similar to the population or community you are working with (e.g., age range, education level, smoking status). This will help ensure that you get opinions that are representative of the different subgroups within the community. Other things to consider:

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Appendix G: Youth Focus Group Protocol (Optional)
• Divide participants into groups based on gender, race, education level, or other characteristics that may affect their ability to speak openly and honestly. This can be an issue when discussing sensitive topics, such as sex. For example, some women may be uncomfortable talking openly if men are present.

4. **Decide whether to give incentives.** Depending on your budget, you may choose to reward people for participating. This can be money, a gift certificate, or something else of value to your audience.

5. **Plan the group meeting.**
   - **Day:** What is the best day to hold the group session? Are certain days of the week not very convenient?
   - **Place:** The meeting should be held in a central location that is easy for people to get to.
   - **Time:** What time of day is best? Do members of the community generally work day or night hours?
   - **Length:** Groups should be scheduled for 1 to 2 hours, depending on the amount of material you have to cover.
   - **Number of groups:** It is a good idea to conduct a minimum of two groups with each set of people (if you are conducting separate groups with men and women, you will want to have at least four groups—two with men and two with women).

6. **Prepare for the topics you want to discuss ahead of time.** You should always make sure you have a discussion guide that the leader refers to in the group. A discussion guide usually consists of a list of topics and some questions you want to be sure to ask.

7. **Use the information that you gain.** After the session is over, it is helpful for the leader and note-taker to meet briefly to discuss how the group went and compare observations. The next step is to review the notes and tapes to look for patterns in what participants said.

**Focus Group Protocol**

**Instructions to Read to Participants:**

I am going to ask you some questions around drinking alcohol. You will not be asked questions about your own behavior, but rather your views about what people your age in your community think and do.
**Guiding Questions:**

1. When you think about people your age, where do you think that they usually obtain alcohol?

   **PROMPTS**
   a) a liquor store  
   b) a grocery store  
   c) a bar  
   d) a restaurant  
   e) friends  
   f) parents  
   g) other family members  
   h) strangers

2. How easy would it be for people your age to get alcohol from those sources?

   **PROMPTS:** Reflect sources they mentioned in Q1.

3. If people your age in your community drink alcohol, how likely do you think it would be that people would find out?

   **PROMPTS**
   a) parents  
   b) other family members  
   c) the police  
   d) teachers at school (if applicable)  
   e) your employer (if applicable)

4. How much do you think that people would disapprove if people your age were to drink?

   **PROMPTS**
   a) your parents  
   b) other family members  
   c) your friends  
   d) teachers at school (if applicable)  
   e) your employer (if applicable)

5. How much do you think that drinking and driving is a problem for people your age?

6. How much do you think that people would disapprove if people your age were to drink and drive?
PROMPTS
a) parents
b) other family members
c) your friends
d) teachers at school (if applicable)
e) your employer (if applicable)

7. If you were to drink and drive, what do you think would happen to you?

PROMPTS
a) the police would catch you
b) you would get a ticket and pay a fine
c) (FOR MINORS) your parents would find out and punish you in some way (such as taking away your car)
d) anything else?
Appendix H: Pricing Assessment Tools & Instructions

This appendix includes instructions for conducting both on-premise and off-premise pricing assessments. The actual tools you must fill out follow the instructions.

Instructions for Completing the On-Premise Pricing Assessment Tool

Step 1: Choose two establishments to observe. Select two of the more popular alcohol establishments (e.g., bars, restaurants) where young adults in your community (21-25 years of age) consume alcohol on-premise.

Step 2: Choose someone to conduct the observations. The person you choose does not have to be a coalition member, but you must trust that they will accurately collect and report the information back to your coalition. This individual is encouraged to visit the establishments along with one or more other people.

Step 3: Choosing your observation dates. Each establishment must be visited twice—one during the week (a Monday through Thursday) and once during the weekend (a Friday or Saturday). This will allow your coalition to better understand pricing and price promotion during the week compared to the weekend.

Step 4: Choosing your observation times. While you can visit the establishments during any of the normal business hours, try and plan your visits during evening hours (after 5:00 pm) when price and promotional discounts are more likely to occur.

Step 5: Log your observations. Use the On-Premise Assessment Tool provided, below.

Substitution: It is conceivable that you could collect this information by interviewing an employee or regular customer of the establishments you select, rather than by visiting the establishment to make observations in person. You may collect the information this way, but you must clearly document who you spoke with and why they are a person knowledgeable about the establishment. If you are unsure about the accuracy of information shared during an interview, you are encouraged to visit the establishment to verify answers.

Instructions for Completing the Off-Premise Pricing Assessment Tool

Step 1: Choose two establishments to observe. Select two of the more popular alcohol establishments (e.g., gas stations, liquor stores, grocery stores) where young adults in your community (21-25 years of age) purchase alcohol for off-premise consumption.
**Step 2: Choose someone to conduct the observations.** The person you choose does not have to be a coalition member, but you must trust that he or she will accurately collect and report the information back to your coalition.

**Step 3: Choosing your observation dates/times.** Each establishment only needs to be visited once, and the visit can occur at any time during normal business hours on any day of the week.

**Step 4: Log your observations.** Use the Off-Premise Assessment Tool provided, below.

### NOTE:

For on- and/or off-premise assessments, you may choose to conduct additional observations to gain a better understanding of price and price promotion of alcohol in your community.
The next several questions ask about the price of alcohol at two of the more popular establishments (e.g., bars, restaurants) where young adults (21-25 years old) in your community consume alcohol on-premise. Circle the appropriate answer.

### On-Premise Pricing Assessment Tool

<table>
<thead>
<tr>
<th>Establishment 1: (name and location)</th>
<th>Observation 1: (date M, T, W, R / time)</th>
<th>Observation 2: (date Fri or Sat / time)</th>
<th>Establishment 2: (name and location)</th>
<th>Observation 1: (date M, T, W, R / time)</th>
<th>Observation 2: (date Fri or Sat / time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Offered happy hour with discounted drinks?</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>2. Offered “all you can drink” specials?</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>3. Offered “two for one” drink specials?</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>4. Offered a daily drink special(s) that was available until closing time?</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>5. Offered specials on larger quantity drinks (20 oz beers) but not smaller quantity drinks (12 oz beers)?</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>6. Offered specials for certain groups (e.g., ladies night, college night, etc.)?</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>7. Had promotional signage on the outside of the building advertising sale or discounted drink prices?</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
<td>Yes No Unknown</td>
</tr>
<tr>
<td>8. Notes on the price of alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The next several questions ask about the price of alcohol at two of the more popular establishments (e.g., gas stations, liquor stores, grocery stores) where young adults (21-25 years old) in your community purchase alcohol to consume off-premise. Circle the appropriate answer.

<table>
<thead>
<tr>
<th></th>
<th>Establishment 1: (name, location, date)</th>
<th>Establishment 2: (name, location, date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was beer on sale?</td>
<td>Yes  No  Unknown</td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td>2. Was wine on sale?</td>
<td>Yes  No  Unknown</td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td>3. Was hard liquor on sale?</td>
<td>Yes  No  Unknown</td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td>4. Were there any instances where larger quantities (18 or 24 packs of beer) were on sale but not smaller quantities (6 or 12 pack) of the same product?</td>
<td>Yes  No  Unknown</td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td>5. Could you buy a bottle of wine for under $5.00?</td>
<td>Yes  No  Unknown</td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td>6. Could you buy an 18-pack of beer for under $10.00?</td>
<td>Yes  No  Unknown</td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td>7. Was there promotional signage on the outside of the building advertising sale prices?</td>
<td>Yes  No  Unknown</td>
<td>Yes  No  Unknown</td>
</tr>
<tr>
<td>8. Notes on the price of alcohol</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix I: Nebraska Behavioral Health Regions

Regional Behavioral Health Authorities Prevention Coordinators
June, 2008

Map created by Karla Bowen
DHHS GIS - 308

Region I
Faith Mills
Prevention Coordinator
Region I Behavioral Health Authority Prevention Coordination
1517 Broadway Suite 124
Scottsbluff, NE 69361
1-308-632-3044 x 2
1-308-632-7084 fax
faith.mills@allophone.com
Email: swohlers@pmhc.net

Region II
Marlo Roberts
Prevention System Coordinator
110 North Bailey Street
North Platte, NE 69103
(308) 5532-4860 (x304)
(306) 534-8775 Fax
marlo@r2hs.com

Region III
Tiffany Gressley
Prevention System Coordinator
4009 6th Avenue, Suite 65
P.O. Box 2355
Kearney, NE 68848
(308) 237-5113 ext. 237
(308) 236-7669 fax
tgressley@region3.net

Region IV
Kim Kwapnioski
Prevention System Coordinator
206 Monroe Avenue
Norfolk, NE 68701
(402) 649-5308
(402) 370-3125 fax
kkwapnioski@region4bhs.org

Region V
Sandy Morrissey
Prevention Director
Region V Systems
1645 "N" Street, Suite A
Lincoln, NE 68508
(402) 441-9434
FAX: (402) 441-4368
smorrissey@rpc.region5systems.net

Region VI
Jeffrey W. Helaney
Manager of Prevention System Services
3801 Harney Street
Omaha, NE 68131
Office (402) 996-8381
Fax (402) 444-7722
jhelaney@regionsix.com