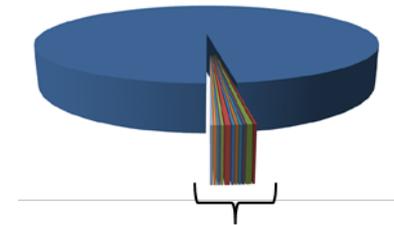




Who's Leading the Leading Health Indicators?

- **Leading Health Indicators are:**
 - Critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable deaths and illnesses
 - Linked to specific Healthy People objectives
 - Intended to motivate action to improve the health of the entire population

1200 Healthy People objectives



LHIs are a subset of
Healthy People
objectives



Who's Leading the Leading Health Indicators?

Featured Speakers:

- **Karen B. DeSalvo, MD, MPH, MSc** – Acting Assistant Secretary for Health, U.S. Department of Health and Human Services
- **Rob Lyerla, PhD** – Associate Director for Science, Center for Behavioral Health Statistics and Quality, Division of Evaluation, Analysis and Quality, Substance Abuse and Mental Health Services Administration (SAMHSA)
- **Chris Wagner** – Policy and Research Coordinator, Project Extra Mile



Substance Abuse

- Related conditions associated with the consumption of mind and behavior-altering substances that have negative behavioral and health outcomes.
- In 2014, SAMHSA estimated:
 - 27.0 million individuals 12 years and older used illicit drugs in the past 30 days
 - 60.9 million individuals 12 years and older engaged in binge drinking in the past 30 days



Substance Abuse

- The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems, including:
 - Cardiovascular conditions
 - Pregnancy complications
 - Teenage pregnancy
 - HIV/AIDS and other STDs
 - Domestic violence
 - Child abuse
 - Motor vehicle crashes
 - Crime
 - Homicide
 - Suicide

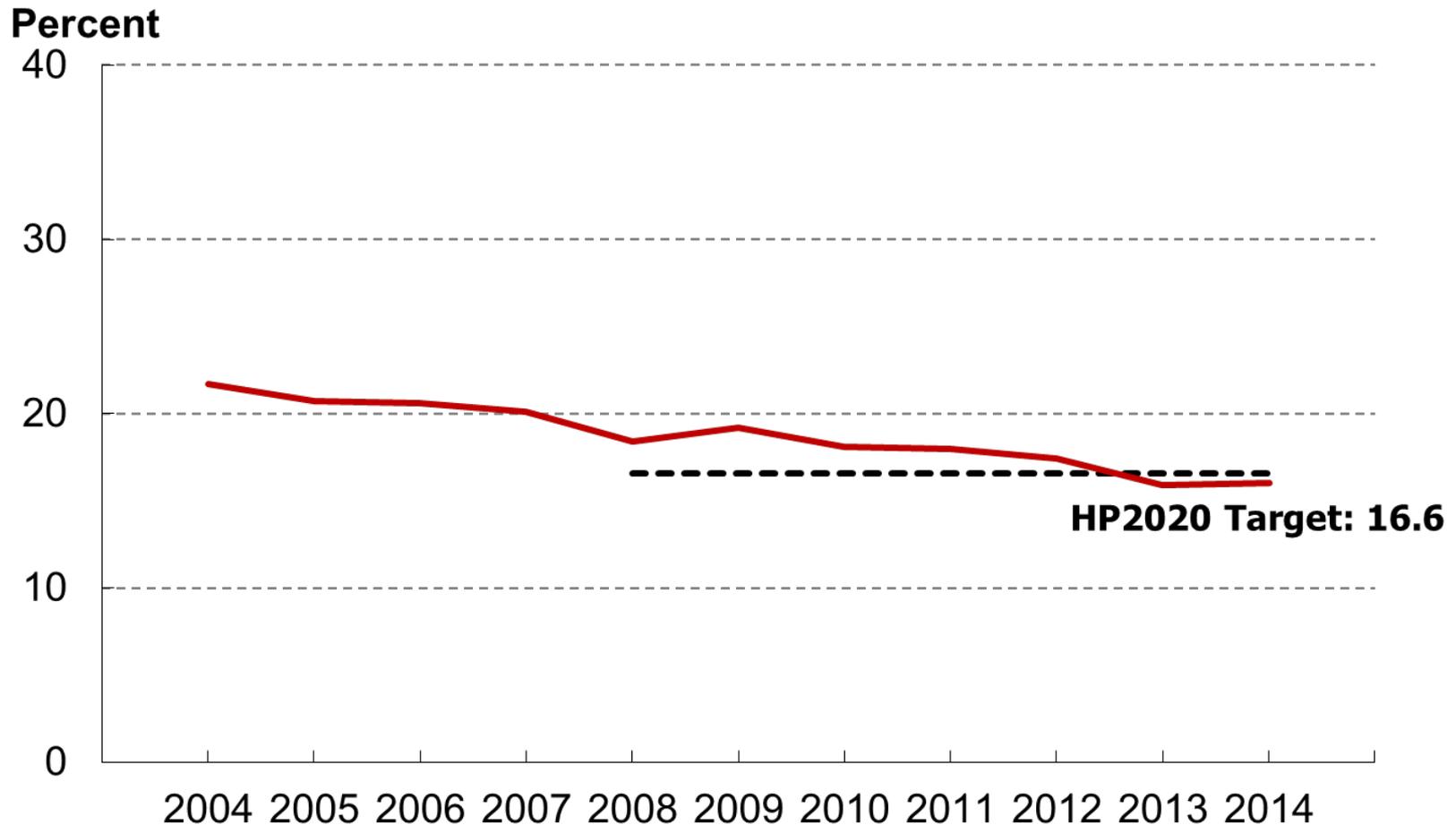


Substance Abuse - Leading Health Indicators

- Adolescents using alcohol or any illicit drugs during the past 30 days
- Adults engaging in binge drinking during the past 30 days



Adolescent Alcohol or Illicit Drug Use in the Past 30 Days, 2004-2014

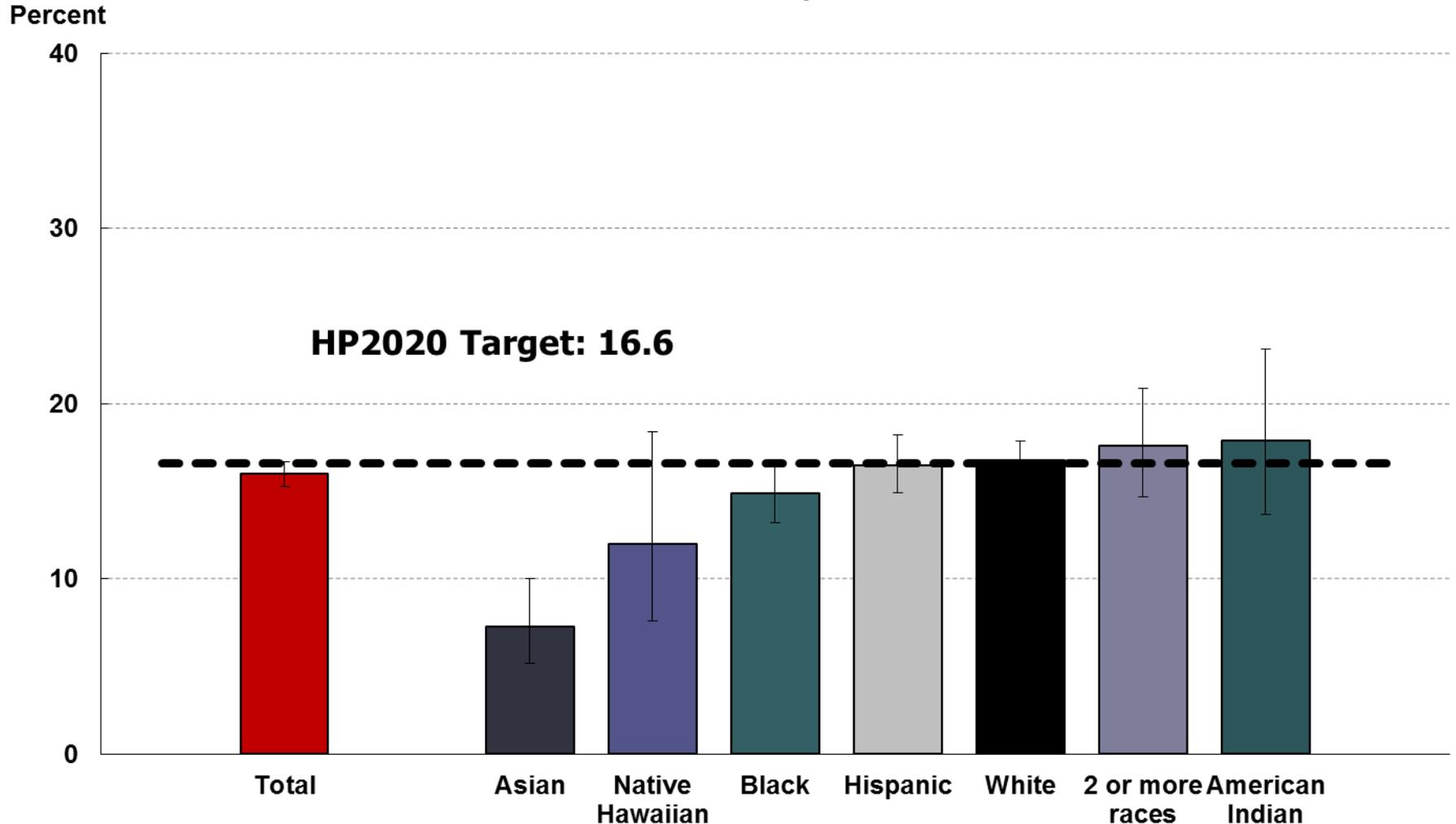


NOTES: Data are for persons who reported using at least one of the following substances in the past 30 days: alcohol, marijuana or hashish, cocaine (including "crack"), inhalants, hallucinogens (including PCP & LSD), heroin, or any nonmedical use of analgesics, tranquilizers, stimulants, or sedatives.

SOURCE: National Survey on Drug Use and Health (NSDUH), SAMHSA.

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Adolescent Alcohol or Illicit Drug Use in Past 30 Days, Race/Ethnicity, 2014

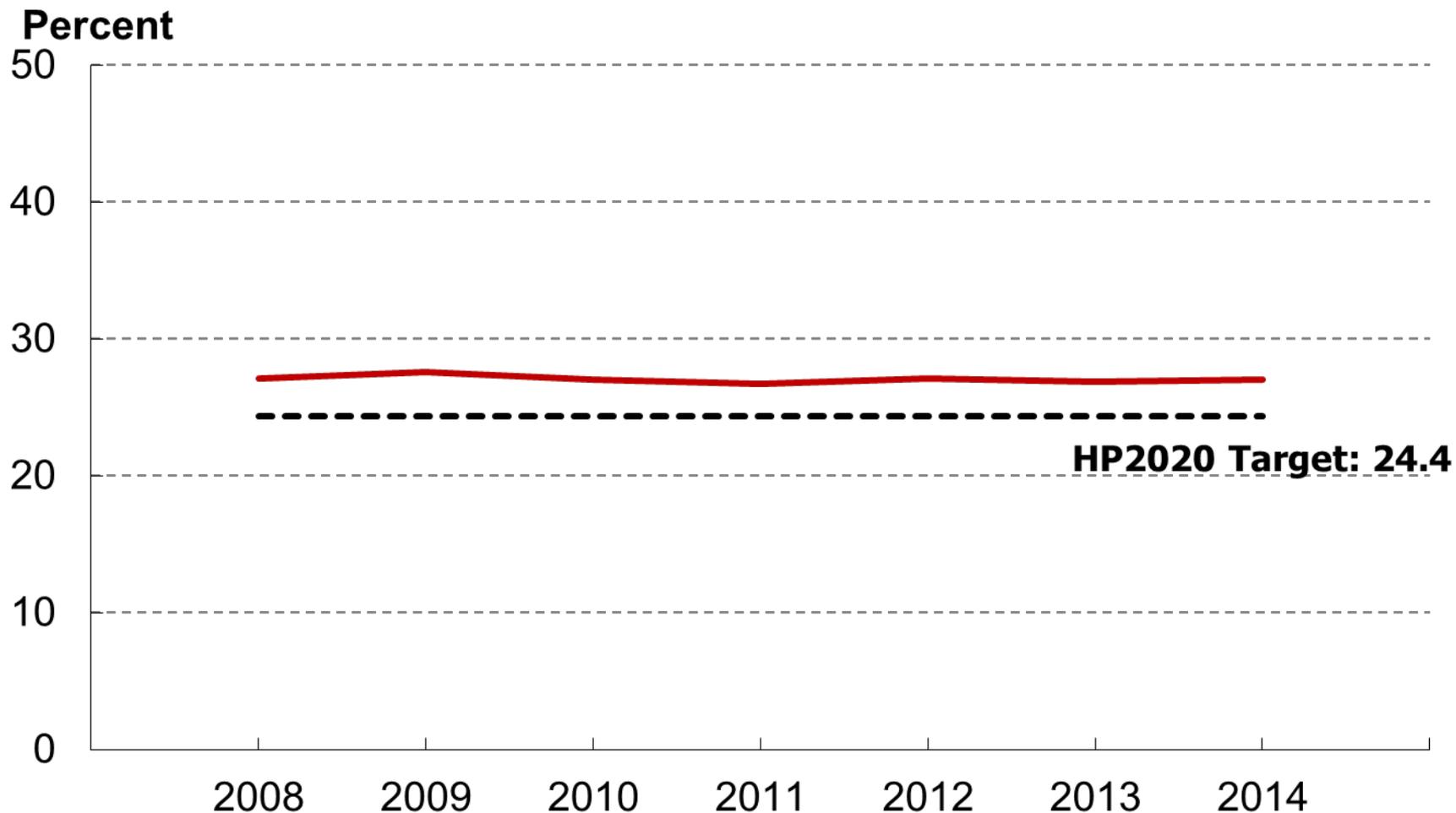


NOTES: I is 95% confidence interval. Data are for persons who reported using at least one of the following substances in the past 30 days: alcohol, marijuana or hashish, cocaine (including "crack"), inhalants, hallucinogens (including PCP & LSD), heroin, or any nonmedical use of analgesics, tranquilizers, stimulants, or sedatives. Black and White exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. American Indian includes Alaska Native. Native Hawaiian includes Other Pacific Islanders. Respondents were asked to select one or more races. Single race categories are for persons who reported only one racial group.

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SOURCE: National Survey on Drug Use and Health (NSDUH), SAMHSA.

Adult Binge Drinking in the Past 30 Days, 2008-2014

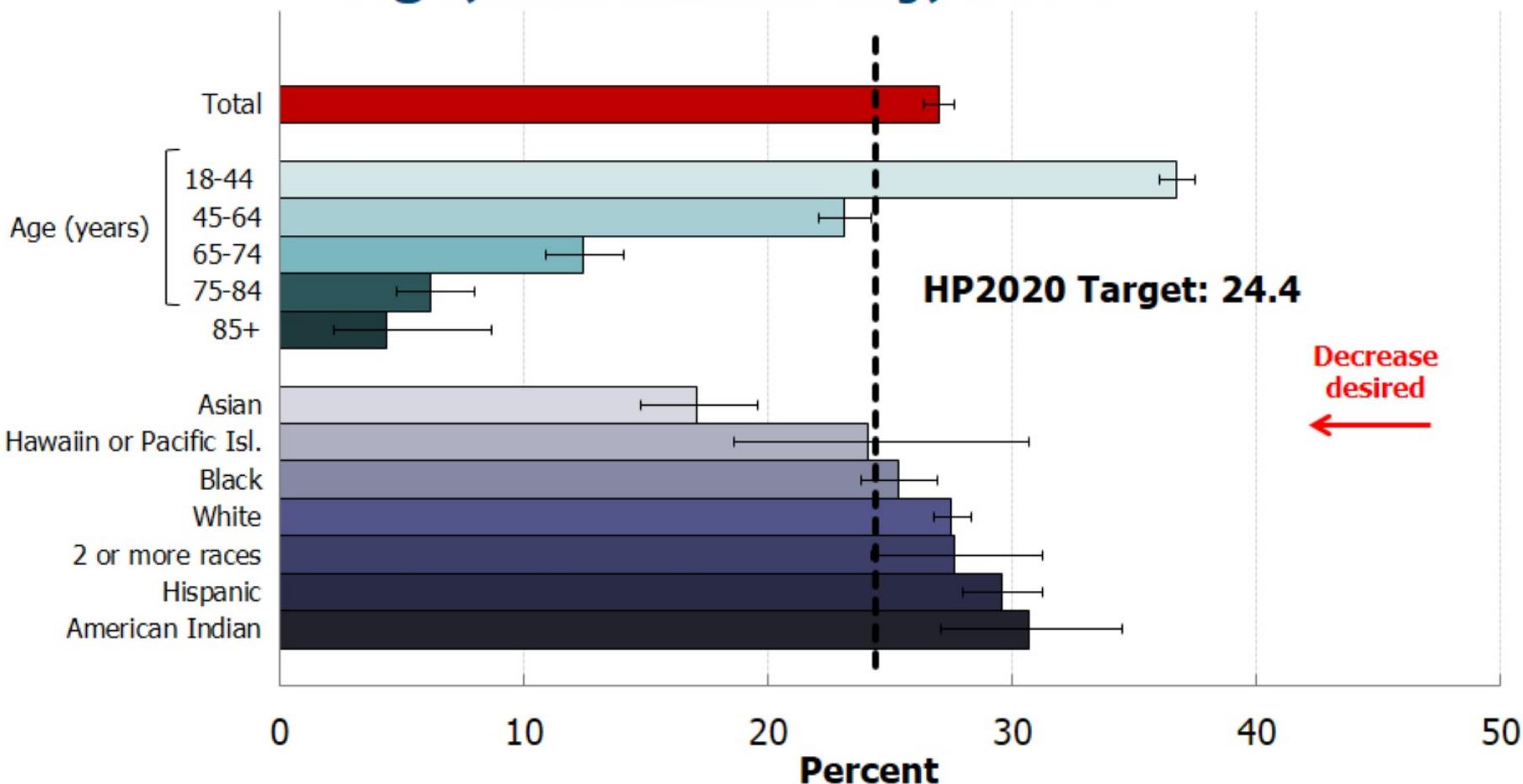


NOTES: Data are for persons who reported having five or more drinks (for men) or four or more drinks (for women) at the same time or within a couple of hours of each other during the past 30 days.

SOURCE: National Survey on Drug Use and Health (NSDUH), SAMHSA.

Obj. SA-14.3
Decrease desired

Adult Binge Drinking in the Past 30 Days, Age, Race/Ethnicity, 2014



NOTES: — is 95% confidence interval. Data are for persons who reported having five or more drinks (for men) or four or more drinks (for women) at the same time or within a couple of hours of each other during the past 30 days. Black and White exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. American Indian includes Alaska Native. Native Hawaiian includes Other Pacific Islanders. Respondents were asked to select one or more races. Single race categories are for persons who reported only one racial group.

SOURCE: National Survey on Drug Use and Health (NSDUH), SAMHSA.

Obj. SA-14.3



Activities Supporting Behavioral Health Indicators Related to Substance Abuse and Mental Health

**Rob Lyerla, PhD
CAPT, USPHS**

**Associate Director for Science
Center for Behavioral Health Statistics and Quality**

Substance Abuse and Mental Health Services Administration (SAMHSA's) Mission

Reduce the impact of substance abuse and mental illness on America's communities

The screenshot shows the SAMHSA website homepage. At the top, there is a navigation bar with links for Home, Newsroom, Site Map, and Contact Us. Below this is a search bar and social media icons for Facebook, Twitter, YouTube, and RSS. A secondary navigation bar contains links for Find Help & Treatment, Topics, Programs & Campaigns, Grants, Data, About Us, and Publications. The main content area features a large banner for the SAMHDA website returns, a sidebar with a Treatment Locator, and several news and resource sections. The news section includes articles from 07/08/16, 07/07/16, and 06/28/16. The featured resource section highlights the NCTSI infographic. The sidebar also includes links to the National Suicide Prevention Lifeline, National Helpline, and Disaster Distress Helpline.

<http://www.samhsa.gov/>

Offices and Centers

- **SAMHSA Headquarters Offices**
 - Office of the Administrator
 - Office of Communications
 - Office of Financial Resources
 - Office of Management, Technology, and Operations
 - Office Policy, Planning, and Innovation,
 - Behavioral Health Equity
 - Tribal Affairs and Policy (OTAP)
 - ***Regional Administrators***

Offices and Centers

- **SAMHSA Headquarters Center**
 - Center for Mental Health Services
 - Center for Substance Abuse Prevention
 - Center for Substance Abuse Treatment
 - Center for Behavioral Health Statistic and Quality

CBHSQ Supports SAMHSA's Mission

- **Federal Statistical Reporting Unit**
 - *Provides national leadership in behavioral health statistics and epidemiology*
 - *Promotes basic and applied research in behavioral health data systems and statistical methodology*
 - *Designs and carries out special data collection and analytic projects to examine issues for SAMHSA and other federal agencies*
 - *Participates with other federal agencies in developing national health statistics policy*
 - *Consults and advises SAMHSA's Administrator and the Department of Health and Human Services' Secretary on statistical matters*

SAMHSA/CBHSQ Data Sources

- **National Survey on Drug Use and Health (NSDUH)**
- **Treatment Episode Data Set (TEDS)**
- **National Survey on Substance Abuse Treatment Services (N-SSATS)**
- **National Mental Health Services Survey (N-MHSS)**
- ***Current Realities- Emerging Behavioral Health Issues***

Public Use Files



samhsa.gov [contact us](#)

Search

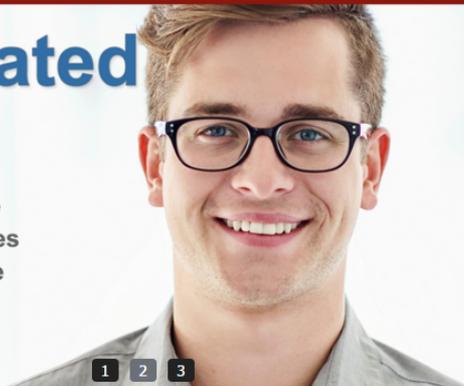
[SAMHDA HOME](#) [ABOUT](#) [DATA](#) [LATEST](#) [ANALYZE](#) [DATA PORTAL](#)

New & Updated Data

Prev

New NSDUH 2014 Public-Use File
Updated N-SSATS Public-Use Files
New TEDS-A 2013 Public-Use File

Next



1 2 3

Quick Start

[Browse & Download Data](#)

[Analyze Data Online](#)

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[FAQs](#)

SAMHDA Home

Welcome back to SAMHDA—the Substance Abuse and Mental Health Data Archive!

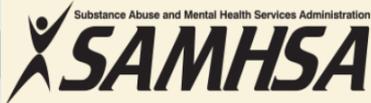
The Substance Abuse and Mental Health Services Administration (SAMHSA) and RTI International are proud to launch the redesigned SAMHDA website with new designs, streamlined menus, and simplified navigation. We want to offer our users an easy way to get to the data they need for their analyses.

We encourage legacy and new users to return to the site often to explore the spectrum of available data offerings. We will update and expand our resources, tools, and documentation frequently to deliver the most relevant data for your needs.

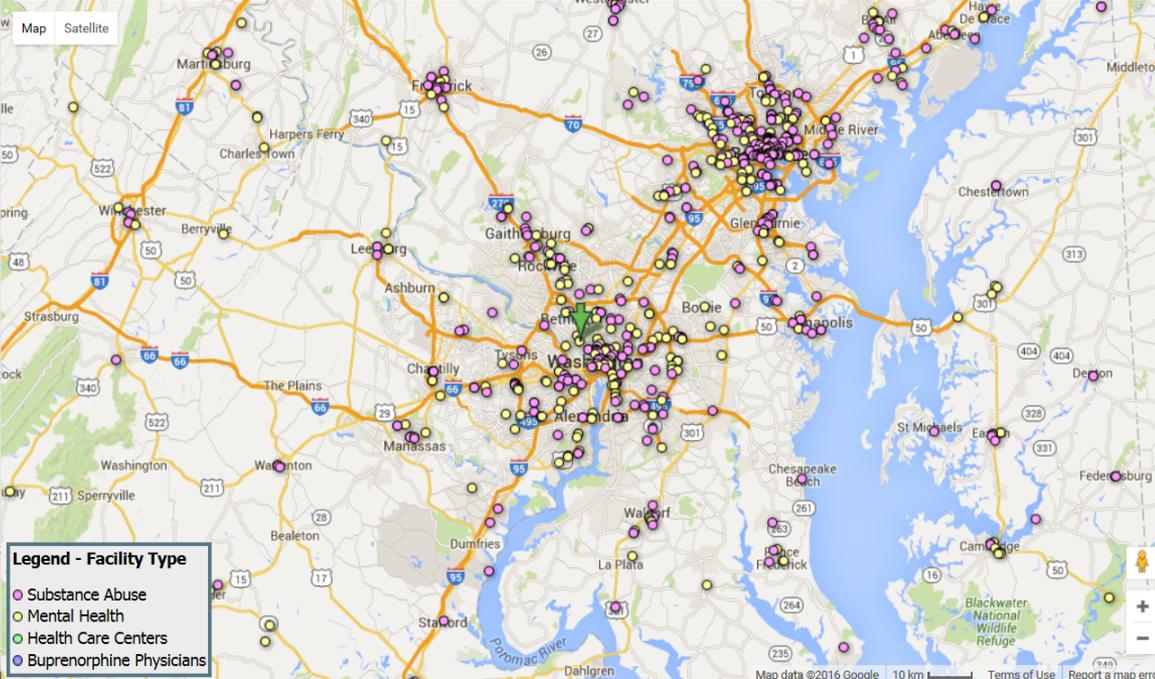
The SAMHDA help desk is available to answer questions via our [online technical assistance form](#) or by calling 888.741.7242.

In an upcoming release, we will implement a user-friendly application for performing online analysis. The application will allow users to create cross tabs and perform logistic regression, chi-square tests, and t-tests from their web browsers, as well as download output and underlying data in .csv format.

Behavioral Health Treatment Services Locator



Home About FAQs State Agencies Widgets Contact Us Help Video Tutorial



Find Facility

Washington, DC 20008, USA

State County Distance 5 miles | [Options](#)

Service: Substance Abuse (SA) Mental Health (MH) SA & MH
 Health Care Centers Veterans Affairs
 Buprenorphine Physicians

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Facility Listing Information		
1	Psychiatric Institute of Washington 4228 Wisconsin Avenue NW Washington, DC 20016 Main Tel: 202-885-5600 Intake Tel 1: 202-885-5610 Website Directions	0.86 miles More Information
2	Executive Addictive Disease Progs Inc 4335 Wisconsin Avenue NW Washington, DC 20016 Main Tel: 202-362-2588 Website Directions	0.87 miles More Information
3	Circles of Hope Psychotherapy and Addictions Services 3000 Connecticut Avenue NW Suite 321 Washington, DC 20008 Main Tel: 202-265-2343 Intake Tel 2: 202-841-1673 Website Directions	1.11 miles More Information
4	Intensive In/Home Circles of Hope Psychotherapy and Addictions Services 3000 Connecticut Avenue NW Suite 321 Washington, DC 20008 Main Tel: 202-265-2343 Intake Tel 2: 202-841-1673 Website Directions	1.11 miles More Information

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<https://findtreatment.samhsa.gov/>

Short Reports

National Survey on Drug Use and Health The NSDUH Report

April 28, 2011

Major Depressive Episode and Treatment among Adolescents: 2009

In Brief

- An estimated 2 million adolescents, or 8.1 percent of the population aged 12 to 17, had major depressive episode (MDE) in the past year
- Rates of past year MDE increased between the ages of 12 and 15 (from 3.6 to 10.4 percent), and females aged 12 to 17 were over twice as likely as their counterparts to have had past year MDE (11.7 vs. 4.7 percent)
- Adolescents who had past year MDE were 3 times as likely as those without past year MDE to have had a substance use disorder in the past year (18.9 vs. 6.0 percent)
- About one third (34.7 percent) of adolescents who had MDE in the past year received treatment for depression in the past year

The NSDUH Report is published periodically by the Center for Behavioral Health Statistics and Quality, Division for the Office of Applied Research and Statistics, Substance Abuse and Mental Health Services Administration (SAMHSA). For more information regarding the content of this report, please contact the SAMHSA Office of Applied Research and Statistics, Division for the Office of Applied Research and Statistics, at 204 E. Street, Suite 1000, Washington, DC 20002. For a complete list of SAMHSA's products and services, please visit www.samhsa.gov. Contact the SAMHSA Office of Applied Research and Statistics for questions about this report. Please email osr@samhsa.gov.

Depression affects millions of adolescents every year and has been shown to affect

adolescents' physical, social development, and ability to learn. Adolescents who suffer from depression are at risk for substance use, behavior problems, and suicide attempts.^{1,2} Because of the signs of adolescents among parents, caregivers, and mental health professionals, it is important to identify adolescents who have had past year MDE and to provide them with treatment services for depression and substance use disorders. The National Survey Health (NSDUH) provides estimates of major depressive episode (MDE) and treatment in adolescents with MDE in the past year. The diagnostic criteria in editions of the *Diagnostic Manual of Mental Dis-*

Treatment Episode Data Set

The TEDS Report

September 28, 2010

Length of Time from First Use to Adult Treatment Admission

In Brief

- Among adult first-time treatment admissions, an average of 15.6 years elapsed between first use of the primary substance of abuse and treatment entry
- The length of time between first use and treatment entry was longer for males than for females (16.3 vs. 15.0 years), and ranged from 12.3 years among Asian or Pacific Islander admissions to 17.4 years among American Indian/Alaska Native admissions
- Non-Hispanic Black admissions had a longer length of time between first use and treatment entry than other racial/ethnic groups for primary cocaine abuse (17.0 vs. 14.5 years or less) and primary heroin abuse (21.1 vs. 15.2 years or less)
- Male admissions had a longer time between first use and treatment entry than female admissions for primary cocaine abuse (15.7 vs. 12.6 years), primary heroin abuse (23.4 vs. 19.2 years), and stimulants (13.0 vs. 10.6 years)

The TEDS Report is published periodically by the Center for Behavioral Health Statistics and Quality, Division for the Office of Applied Research and Statistics, Substance Abuse and Mental Health Services Administration (SAMHSA). For more information regarding the content of this report, please contact the SAMHSA Office of Applied Research and Statistics, Division for the Office of Applied Research and Statistics, at 204 E. Street, Suite 1000, Washington, DC 20002. For a complete list of SAMHSA's products and services, please visit www.samhsa.gov. Contact the SAMHSA Office of Applied Research and Statistics for questions about this report. Please email osr@samhsa.gov.

To reduce the negative consequences of substance abuse, it is important for individuals who need treatment

to receive services as soon as possible. However, the length of time from first use of a substance to treatment entry is a key indicator of the duration of substance abuse. Research emphasizes the importance of early diagnosis and intervention to reduce the duration of substance abuse.¹ Data from the Treatment Episode Data Set (TEDS) can be used to estimate the duration of use prior to treatment and identify points in treatment across the TEDS Report examine the length of time between first admission to substance treatment and age of first primary substance of abuse.

National Survey of Substance Abuse Treatment Services

The N-SSATS Report

December 1, 2010

HIV Services Offered by Substance Abuse Treatment Facilities

In Brief

- In 2008, eighty-seven percent (87 percent) of all substance abuse treatment facilities provided HIV/AIDS education, counseling, or support, about one quarter provided on-site HIV testing (28 percent) or early intervention for HIV (28 percent), and 9 percent provided special programs or groups for persons with HIV/AIDS
- Non-hospital residential treatment facilities were more likely than hospital inpatient or outpatient facilities to provide HIV/AIDS education, counseling, or support, early intervention for HIV, and special programs or groups for persons with HIV/AIDS. Residential treatment facilities (79 percent) were more likely than non-hospital residential (61 percent) and outpatient (51 percent) facilities to provide HIV testing
- Facilities with a primary focus of general health care were more likely than facilities with a primary focus of substance abuse treatment services, mental health services, or a mix of mental health and substance abuse treatment services to provide HIV services

The N-SSATS Report is published periodically by the Center for Behavioral Health Statistics and Quality, Division for the Office of Applied Research and Statistics, Substance Abuse and Mental Health Services Administration (SAMHSA). For more information regarding the content of this report, please contact the SAMHSA Office of Applied Research and Statistics, Division for the Office of Applied Research and Statistics, at 204 E. Street, Suite 1000, Washington, DC 20002. For a complete list of SAMHSA's products and services, please visit www.samhsa.gov. Contact the SAMHSA Office of Applied Research and Statistics for questions about this report. Please email osr@samhsa.gov.

The Centers for Disease Control and Prevention (CDC)

estimates that 19 percent of the more than 1 million people who currently live with the human immunodeficiency virus (HIV) in the United States are injection drug users. Injection drug users also represent approximately 12 percent of the estimated 36,300 new HIV cases each year in the United States.^{1,2}

The behaviors associated with injection drug use, such as sharing needles and other drug equipment, place injection drug users at risk for spreading or contracting HIV.³ Therefore, substance abuse treatment facilities that include HIV prevention education as part of their treatment programs and perform HIV screenings and HIV risk assessments can play a vital role in the control, prevention, and treatment of HIV.

Drug Abuse Warning Network

The DAWN Report

February 8, 2011

Monthly and Seasonal Variations in Emergency Department Visits for Drug-Related Suicide Attempts: 2004 to 2008

In Brief

- Combined data from 2004 to 2008 indicate that there was an annual average of 178,423 ED visits for drug-related suicide attempts by patients aged 12 or older. The number of these visits ranged from a high of 16,812 visits in September (5.4 percent) to a low of 12,556 visits in February (7.1 percent)
- Among adolescent males aged 12 to 17, the percentage of drug-related suicide attempt visits ranged from 2.5 percent in February to 18.9 percent in December
- Although there was considerable gender variation by month, there were no significant gender differences by season (autumn, winter, spring, or summer) for any age group

Many U.S. and international researchers have tried to discern seasonal suicide patterns, but they have reached no clear consensus.¹ Traditional social and family events that occur seasonally, such as holidays and school activities, may influence depression and suicidal behaviors. Media reports, such as the "Holiday without Christmas" story run by CBS News in 2002, have suggested that these episodes occur more frequently during the winter holiday season.² Additionally, fluctuations in weather and daylight caused by the changing seasons can influence depressive symptoms, such as those experienced by people with seasonal affective disorder.³

Some mortality data research supports the existence of a relationship between seasonality and completed suicides.⁴ However, suicide attempts that do not result in death are more common than completed suicides and often require emergency medical attention.⁵ Data from emergency departments (EDs) can provide information about risks for suicide attempts, including monthly and seasonal trends.

The DAWN Report is published periodically by the Center for Behavioral Health Statistics and Quality, Division for the Office of Applied Research and Statistics, Substance Abuse and Mental Health Services Administration (SAMHSA). For more information regarding the content of this report, please contact the SAMHSA Office of Applied Research and Statistics, Division for the Office of Applied Research and Statistics, at 204 E. Street, Suite 1000, Washington, DC 20002. For a complete list of SAMHSA's products and services, please visit www.samhsa.gov. Contact the SAMHSA Office of Applied Research and Statistics for questions about this report. Please email osr@samhsa.gov.

Barometers



Behavioral Health Barometer
United States



Behavioral Health Barometer
EXECUTIVE SUMMARY
Region VII, 2014



Behavioral Health Barometer
Nebraska, 2015



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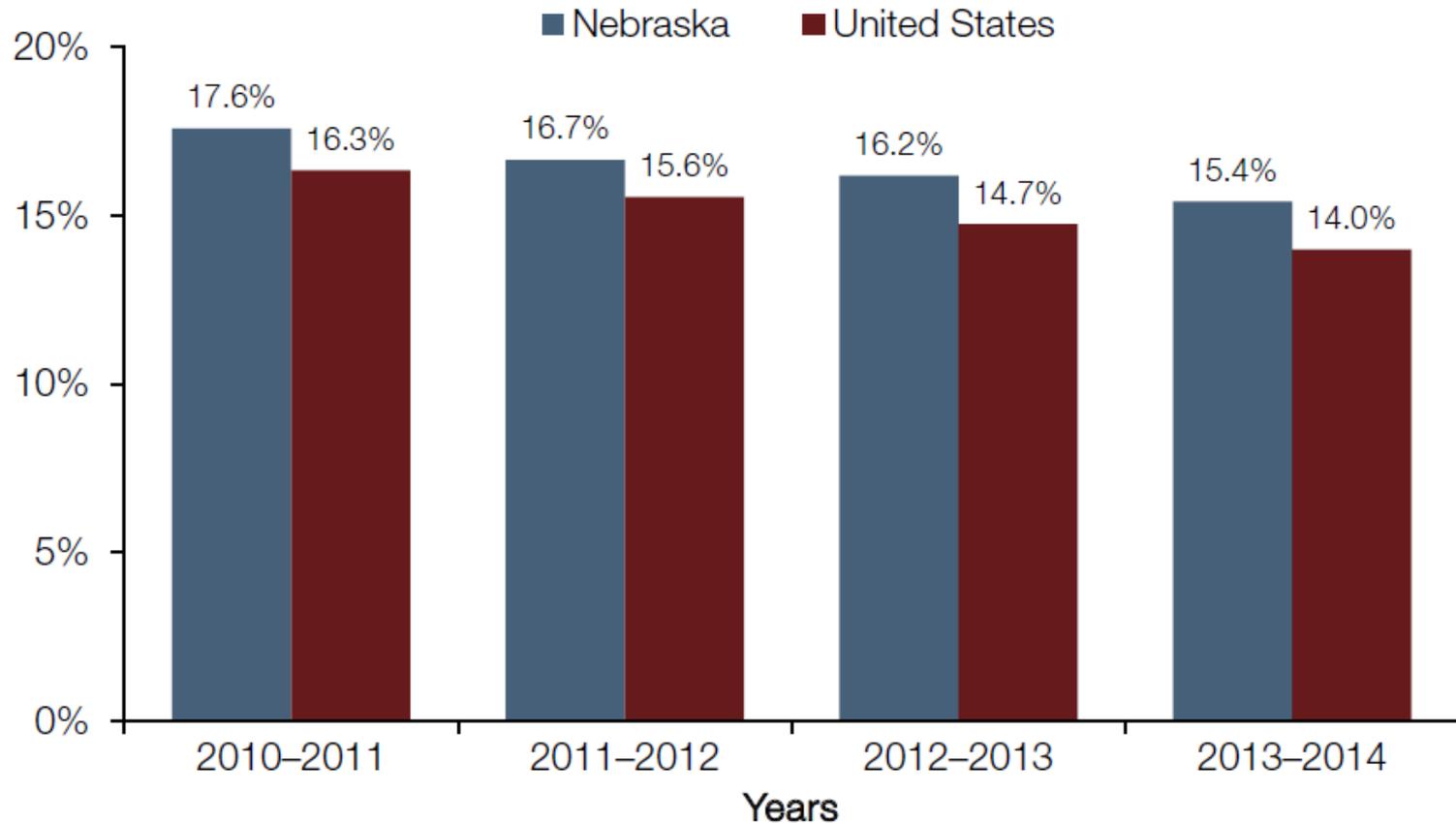
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Past Month Binge Alcohol Use Among Individual Aged 12–20 in Nebraska and the United States (2010–2011 to 2013–2014)



Source: <http://www.samhsa.gov/data/behavioral-health-barometers>

Major publications



Morbidity and Mortality Weekly Report

Weekly / Vol. 64 / No. 48

December 11, 2015

Driving Under the Influence of Alcohol, Marijuana, and Alcohol and Marijuana Combined Among Persons Aged 16–25 Years — United States, 2002–

Alejandro Azofeifa, DDS¹; Margaret E. Matson, PhD¹; Rob Lyebera, PhD¹

Motor vehicle accidents are the leading cause of death among youths and young adults aged 16–25 years in the United States (1). The prevalence of drinking and driving among high school students aged 16–19 years has declined by 54%, from 22.3% in 1991 to 10.3% in 2011 (2). However, the prevalence of weekend nighttime driving under the influence of marijuana (based on biochemical assays) among drivers aged ≥16 years has increased by 48%, from 8.6% in 2007 to 12.6% in 2013–2014 (3). Use of marijuana alone and in combination with alcohol has been shown to impair driving abilities (4–9). This report provides the most recent self-reported national estimates of driving under the influence of alcohol, marijuana, and alcohol and marijuana combined among persons aged 16–25 years, using data from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH) from 2002–2014. Prevalence data on driving under the influence of both substances were examined for two age groups (16–20 years and 21–25 years) and by sex and race/ethnicity. During 2002–2014, the prevalence of driving under the influence of alcohol alone significantly declined by 59% among persons aged 16–20 years (from 16.2% in 2002 to 6.6% in 2014; $p < 0.001$) and 38% among persons 21–25 years (from 29.1% in 2002 to 18.1% in 2014; $p < 0.001$). In addition, the prevalence of driving under the influence of alcohol and marijuana combined significantly declined by 39%, from 2.3% in 2002 to 1.4% in 2014 ($p < 0.001$) among persons aged 16–20 years and from 3.1% in 2002 to 1.9% in 2014 ($p < 0.001$) among persons aged 21–25 years. The prevalence of driving under the influence of marijuana alone declined 18%, from 3.8% in 2002 to 3.1% in 2014 ($p = 0.05$) only among persons aged 16–20 years. Effective public safety interventions, such as minimum legal

drinking age laws, prohibition of driving with any >0 for persons aged <21 years, targeted mass roadside testing (e.g., sobriety checkpoints), an driver licensing programs (10) have contributed to driving under the influence of alcohol in this. These or similar interventions might be useful to driving under the influence of other substances, such alone or combined with other substances.

NSDUH collects annual information about the drugs,¹ alcohol, and tobacco among the noninstitutionalized U.S. civilian population aged ≥12 years via face-to-face interviews, using a computer-assisted interviewing system.⁵ Unweighted sample sizes for

¹ Illicit drugs are defined in the NSDUH as marijuana, cocaine (heroin, hallucinogens, inhalants, or prescription-type psychotropic nonmedically.

⁵ Detailed information regarding NSDUH is available at <http://www.samhsa.gov/data/population-data-modules/reports>.

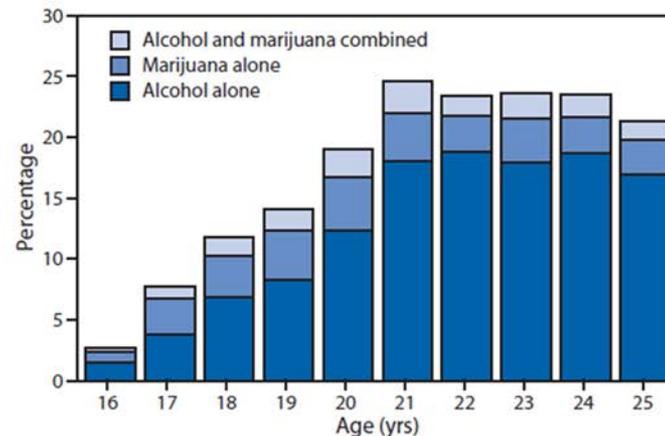
INSIDE

- 1330 College Sports–Related Injuries — United States, 2009–10 Through 2013–14 Academic Year
- 1337 Syringe Service Programs for Persons Who Use Illicit Drugs in Urban, Suburban, and Rural Areas — United States, 2013
- 1342 Update: Influenza Activity — United States, October 4–November 28, 2015
- 1349 Notes from the Field: Concurrent Outbreaks of Louis Encephalitis Virus and West Nile Virus — Arizona, 2015
- 1351 QuickStats

Continuing Education examination available at http://www.cdc.gov/mmwr/cme/contd_info.htm

⁴ Detailed information regarding motor vehicle-related injury prevention by the Community Preventive Services Task Force is available at <http://www.thecommunityguide.org/nvool/AID/index.html>.

FIGURE 2. Percentage of persons who reported driving a vehicle under the influence of alcohol alone, marijuana alone,* and alcohol and marijuana* combined in the past year by age (years) — National Survey on Drug Use and Health, United States, 2014



Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2014.

* Analysis limited to marijuana users.

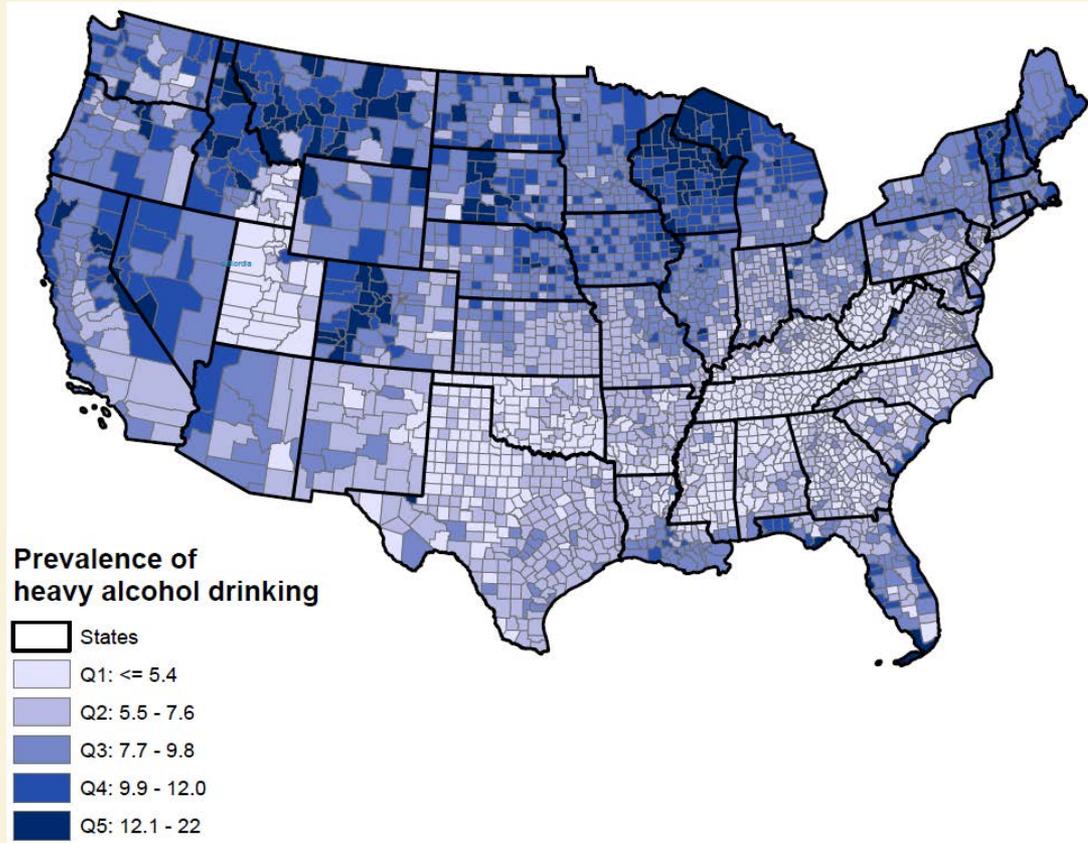


U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



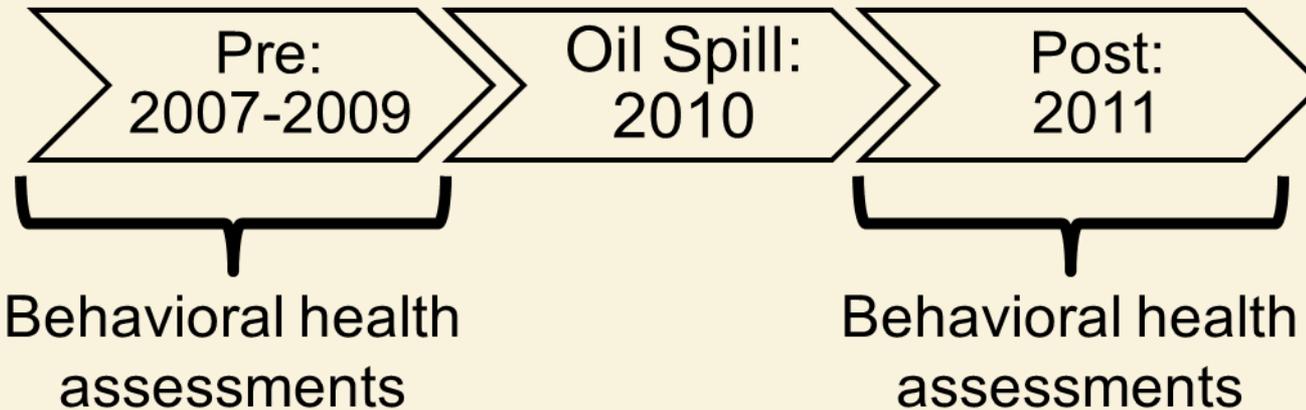
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Original research: Quintile distribution of heavy alcohol drinking prevalence



Emerging issues

Deepwater Horizon Oil Spill, 2010



SAMHSA (CBHSQ)-Partners



“is an organization of member states and territories representing public health epidemiologists” that “works to establish more effective relationships among state and other health agencies”.

CSTE works along with tribal, state, jurisdictions and federal officials to help advance public health policy and epidemiological capacity.

In progress/completed

- **CSTE voted on and approved list of Behavioral Health Indicators**
- Paper in progress to call for national Behavioral Health Surveillance System (like Infectious disease Surveillance system)
- Consultation this summer on updating guidelines for surveillance systems to include specifics unique to Behavioral Health Surveillance
- **Pilot testing of data collection at county level**
- National assessment of ownership of data
- Mathematical modeling to establish thresholds

Last thoughts

- **Federal responsibility to be good stewards of the public trust**
- **Large, reliable, national surveys**
- **Data dissemination for decision making**
- **Cutting edge responses to the needs of public health providers and their constituents**

Thank You!

Substance Abuse and Mental Health Services Administration

5600 Fishers Lane

Rockville, MD 20857

Toll-Free Numbers

877-SAMHSA-7 (877-726-4727)

800-487-4889 (TDD)



Shaping the landscape to prevent excessive alcohol consumption in Nebraska

Chris Wagner
Policy and Research Coordinator

July 21, 2016

History of Project Extra Mile

1995 - Omaha was selected as one of five demonstration sites in the country by National Association of Governors' Highway Safety Representatives (now the Governors' Highway Safety Association). A community coalition was formed shortly thereafter.

2001 - Project Extra Mile became a statewide network of community coalitions and lead coalition activities in the following counties: Cedar, Dawson, Dodge, Douglas, Hall, Madison, Sarpy, Saunders, Scotts Bluff, Washington and Wayne.

2012 - the organization transitioned to focus on its community partnerships and providing TA to partnerships to lead their own underage drinking prevention initiatives. The Omaha metro area coalition continues to meet monthly.

2016 - the organization expanded its mission from focusing on the prevention of underage drinking to focusing on the prevention of all alcohol-related harms.

Our Mission

*Advocating for evidence-based policies
and practices to prevent and reduce
alcohol-related harms.*

About Us

Project Extra Mile is a statewide network of community partnerships in Nebraska working to prevent alcohol-related harms through the use of science- and evidence-based strategies.

Community organizing is the foundation to our efforts. We focus our work on **policy initiatives, enforcement collaborations, media advocacy, education and awareness** and **youth leadership**.

Topics to Cover

- Excessive Alcohol Consumption
- Enhanced underage drinking enforcement operations
- Community engagement
- Screening and counseling for alcohol misuse

What is excessive consumption?

- Binge drinking
 - 5 or more drinks in a sitting for males
 - 4 or more drinks in a sitting for females
- Heavy drinking
 - More than 2 drinks per day (on average) for males
 - More than 1 drink per day (on average) for females
- Underage drinking
 - Consuming alcohol under the legal drinking age of 21
- Drinking by pregnant women
 - Consuming alcohol at any time during a pregnancy (CDC)

Why is it important?

- Excessive drinking is the third leading preventable cause of death in the U.S. (Mokdad et al., 2004)
- Caused 88,000 deaths and 2.5 million years of potential life lost each year from 2006-2010 (CDC, 2013)
- 9 out of 10 excessive drinkers are not dependent on alcohol (Esser et al., 2014)

Short- and Long-term Consequences

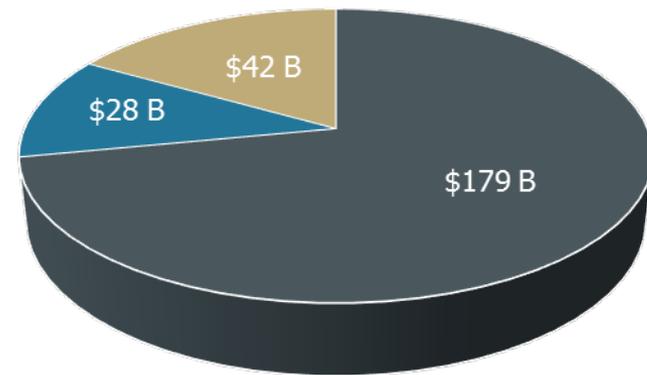
- Short-Term
 - Injuries
 - Violence
 - Alcohol poisoning
 - Reproductive risks
- Long-Term
 - Chronic diseases
 - Cancers
 - Learning and memory problems
 - Mental health conditions
 - Social problems
 - Alcohol dependence (CDC, 2015)

Excessive Consumption: The Costs

- Excessive drinking cost the US \$249 billion in 2010...
- ...\$100 billion of which was borne by government

(Sacks et al., 2015)

Cost of Excessive Drinking to the United States in 2010 (billions of dollars)



■ Lost Productivity ■ Healthcare ■ Other

Alcohol use by Youth in Nebraska

- 1 out of 5 high school students reported using alcohol in the last 30 days in 2015
- In 2015, current alcohol use among NE high school students continued to decline and was lower than high school students nationally.

	1991	2005	2011	2015
NE	53%	43%	27%	23%
US	51%	43%	39%	33%

Source: 2011 and 2014/2015 Nebraska Youth Risk Behavioral Surveys (YRBS)

Binge Drinking by Youth in Nebraska

- 1 out of 6 high school students reported binge drinking during the past 30 days.
- In 2015, a lower percentage of high school students in NE reported binge drinking than high school students nationally.

	1991	2005	2011	2015
NE	37%	30%	16%	14%
US	31%	26%	22%	18%

Source: 2014/2015 Nebraska Youth Risk Behavioral Survey (YRBS)

Binge Drinking by Adults (18+) in Nebraska

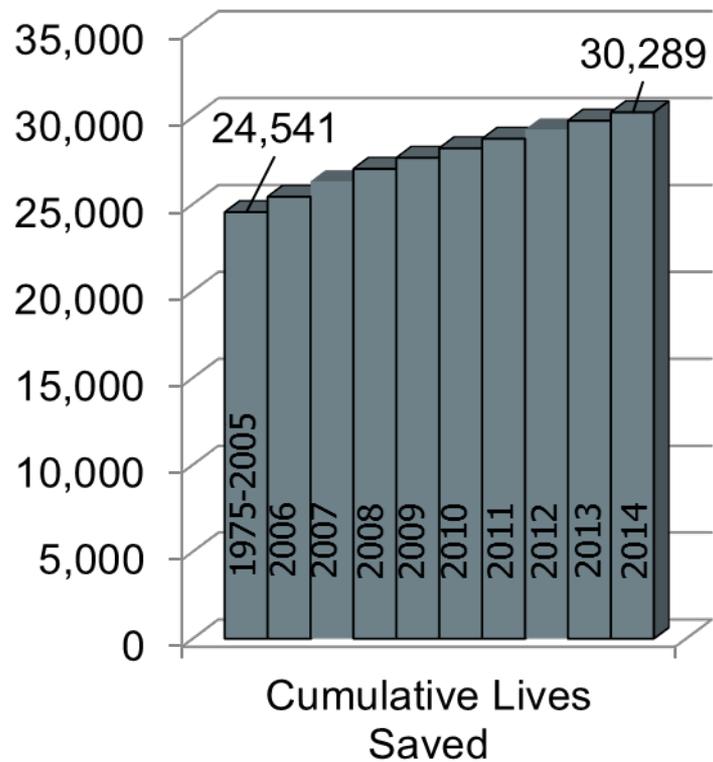
- 1 out of 5 adults aged 18 and older reported binge drinking during the past 30 days versus 1 out of 6 nationally.
- Nebraska jumped from 8th to 5th worst in terms of its binge drinking rates among the 50 states and D.C. in 2014. Four of Nebraska's communities (Omaha, Lincoln, Grand Island, and Norfolk) ranked in the top 15 of nearly 200 cities indexed for binge drinking rates across the country. (CDC, 2014; CDC, 2012)

	2011	2012	2013	2014
NE	23%	22%	20%	20%
US	18%	17%	17%	16%

Source: 2014 Behavior Risk Factor Surveillance System

Key Programs

- Enhanced underage drinking enforcement operations
 - Compliance checks
 - Selective enforcement
 - Community engagement
 - Monitor liquor licensing and regulatory processes
- Screening and counseling for alcohol misuse
 - CHI Pilots
 - Data analysis
 - Literature review



Cumulative Estimated Number of Lives Saved by Minimum Legal Drinking Age Laws, 1975-2014

Source: National Highway Safety Administration

Compliance Checks

- One of the most effective ways to deter commercial alcohol sales to underage youth
- Underage Cooperating Individuals (CIs) working with law enforcement to ensure compliance with Minimum Legal Drinking Age laws
- Coalition involvement in underage drinking enforcement operations demonstrates strong community support for these efforts



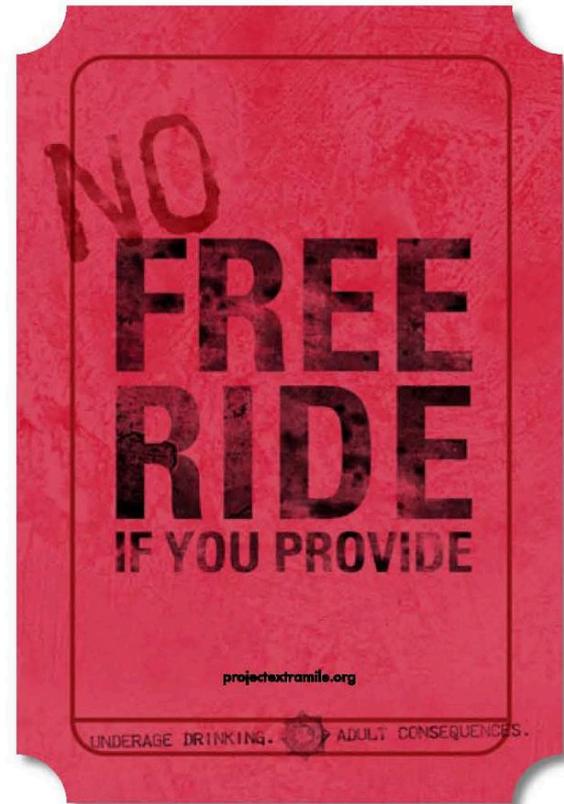
Compliance Checks

PEM has worked since 1997 to coordinate multi-agency underage drinking enforcement efforts in communities across the state

- Current operations focus on Douglas and Sarpy Counties (approximately 1,500 retail licenses)
 - Goal of up to 6 operations per year involving 6 law enforcement agencies
- Media advocacy before and after
- Follow up for non-compliant businesses
- Continue to provide technical assistance to law enforcement agencies and coalitions across the state
 - Guidelines for cooperating individuals
 - Mini-grant application process
 - Community support

Selective Enforcement

- Saturation/party patrols
 - @ parks, residential areas, parking lots
 - Target times of year when youth access to alcohol increases
 - Holidays
 - Homecoming
 - Prom
 - Graduation
- T.R.A.C.E. -- Address social access
- Hold adults accountable – No Free Ride if You Provide



Community Engagement

- Over 500 neighbors, youth and community organizations are members of the Project Extra Mile coalition
- Monthly coalition meetings are attended by law enforcement
- Law Enforcement Workgroup identifies dates for underage drinking enforcements and topics for annual law enforcement training



Monitoring Licensing & Regulatory Processes

- PEM monitors the licensing process from the municipal level to the state Liquor Control Commission, which has the final say on applications
- Communities of 10,000+ residents; three most-populous counties
- Community organizing around local ordinances or liquor license applications of potential concern
- Provide latest research and training opportunities to communities

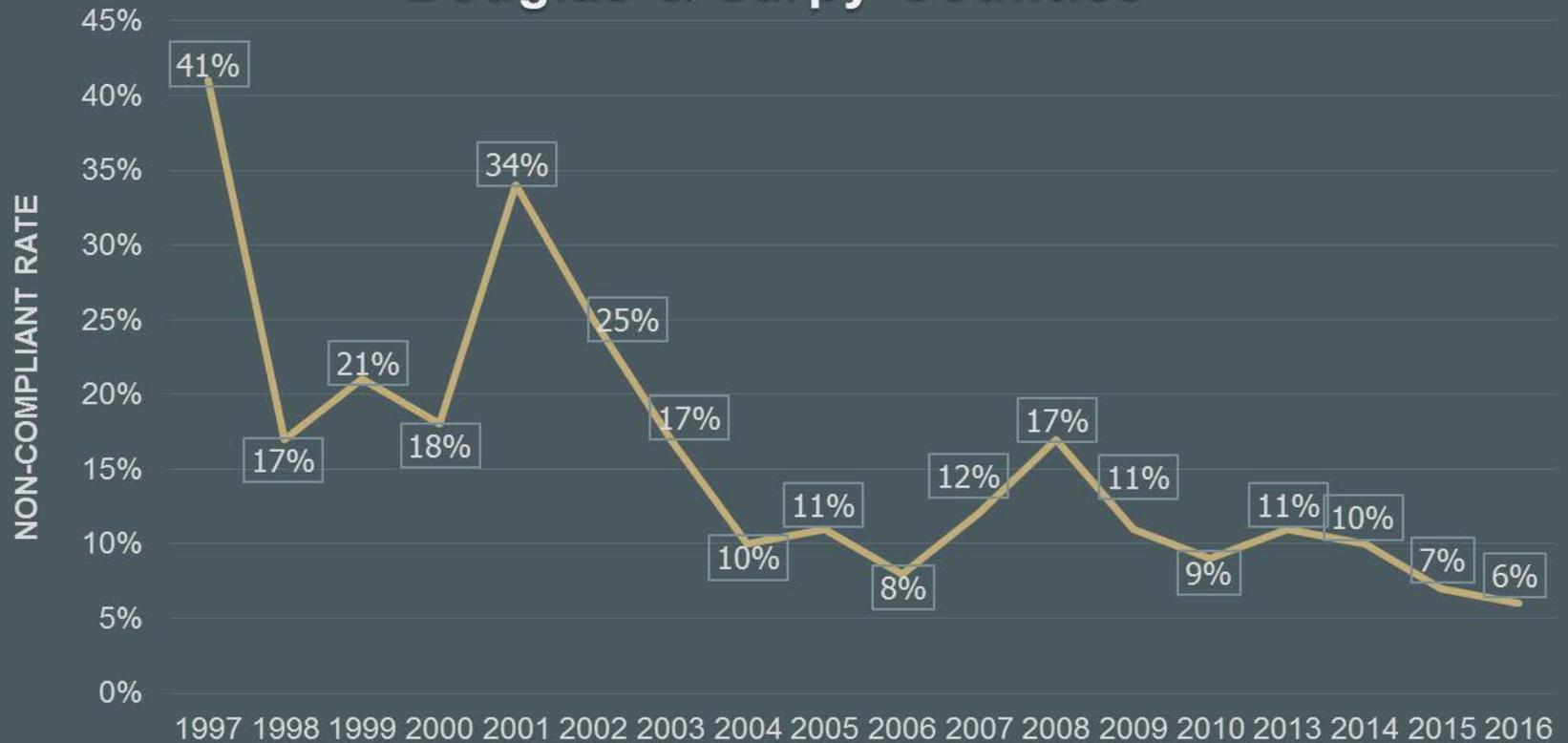
Screening and Counseling

- Goal: Implementation of screening and counseling for alcohol misuse in all health systems in Douglas County with subsequent statewide expansion
- Partners: CHI Health, University of Nebraska Medical Center's College of Public Health, UNMC Binge Drinking Collective Impact Workgroup
- CHI provided \$30,000 for implementation of SBIRT pilot projects at its clinics, as well as to study the pilot project data and to review use of SBIRT across the country
- CHI currently piloting SBIRT at two clinics with plans to expand to 10 additional clinics over the next year; UNMC Midtown Clinic working to implement SBIRT pilot

Key Findings

- Since 1997, PEM has coordinated compliance checks at over 10,000 businesses licensed to sell alcohol
- In 1997, the non-compliant rate was 41% vs. 8% in 2015
- Citations for youth-related alcohol violations during selective enforcement patrols have declined by 39% between 2006 and 2014

Project Extra Mile Alcohol Compliance Checks Douglas & Sarpy Counties



Lessons Learned

- Evidence-based policies and practices are the most effective and efficient ways to prevent and reduce alcohol-related harms
- Importance of good working relationships with law enforcement and their active involvement in coalition
- Local data is essential
- Leave no stone unturned – If you want to be effective, you must seize every opportunity to advocate

Challenges

- Limited resources
- “Call Tree” obsolete but social media in full force

Thank You!

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Project Extra Mile



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Maximizing Inclusion and Participation to Improve Outcomes

Thursday, August 11 | 12:30 PM EDT

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Disability and Health and
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