OHIO PARTNERSHIPS FOR SUCCESS GRANT PROGRAM

Ohio Department of Mental Health and Addiction Services

OHIO SPF-PFS NEEDS ASSESSMENT
ADAMS COUNTY

Prepared by:

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Table of Contents

Introduction ii

Chapter 1: Adams County SFY18 SPF-PFS Problem of Practice (PoP) 1

Chapter 2: Adams County SFY18 Community Readiness Assessment Report 3

Chapter 3: COMs Data for Adams County 14

Chapter 4: Adams County SFY18 Prescription Drug Consequence Data Report 15

Chapter 5: Intervening Variable Data for Adams County 21

Chapter 6: Youth Tobacco, Alcohol, and Drug Prevention Youth Focus Group Report 23

Chapter 7: Youth Tobacco, Alcohol, and Drug Prevention Adult Focus Group Report 40

Chapter 8: Adams County SFY19 Critical Reflection Questions 57

Introduction

The needs assessment is a critical piece of the Strategic Prevention Framework Partnerships for Success Initiative, empowering communities to make data-driven decisions as they set priorities and choose prevention interventions that are impactful, locally relevant, and culturally competent.

Communities took a modular approach to conducting their needs assessments, working on the following eight chapters over a three-year period. The community-driven process allowed community partners to build capacity by expanding data collection infrastructure and developing skills to understand and communicate data and results.

Communities first identified a Problem of Practice (Chapter 1), in which they identified a priority substance or problem, the population of focus, and available data sources relevant to this problem and population. Communities combined these elements into a one-sentence problem statement. The problem statement served as the basis for the Community Readiness Assessment (Chapter 2).

The Community Readiness Assessment required team members to conduct interviews with key informants regarding five dimensions of community readiness: Community knowledge of efforts, leadership, community climate, knowledge about the issue, and resources related to the issue. Based on these interviews, communities assessed their readiness to address their Problem of Practice.

In Chapters 3-5, communities further explored the quantitative data supporting their Problem of Practice by identifying Community Outcomes Measures related to Consumption Data (Chapter 3), Consequence Data (Chapter 4), and Intervening Variables (Chapter 5). All measures were specific to the population of focus identified in the problem statement.

Communities held focus groups with members of the population of focus to collect qualitative data related to the intervening variables identified in Chapter 5. Chapter 6 describes the results of the youth focus group. Chapter 7 includes results from the adult focus group.

Finally, communities were asked to create a narrative of the needs assessment process (Chapter 8) by answering twelve critical reflection questions related to their team's understanding of their consumption data, consequence data, intervening variables, and local conditions.

Chapter 1

Adams County SFY18 SPF-PFS Problem of Practice (PoP)

County Profile

Adams County is a designated Appalachian county that borders the Ohio River in the southern portion of the state of Ohio and has an estimated population of 27,907.

The population is predominantly Caucasian (97.3%), with 1.4% of the county identifying as multiracial. A small percentage (1.0%) of the county reports being of Hispanic or Latino origin.

English is the predominant language, with only 1.4% of residents reporting that another language is spoken at home.

Among residents above 25 years of age, 78.2% have a high school diploma and 10.9% have a bachelor's degree or higher. Both the high school graduation rate and the percentage of higher education degrees in the county are lower than those found across Ohio (89.5% and 26.7%, respectively).

The five-year median household income (2012-2016) is $34,709, which is considerably lower than the state median of $50,674. The five-year estimates for the percentage of the county residents below the Federal Poverty Level is 20.2%, which is above the state estimate of 14.6%.

The county includes two public school districts (Adams County/Ohio Valley School District and Manchester Local School District).

Prevention Data Committee (PDC)

Our PDC has met two times. We plan to meet on a biweekly basis. Our PDC consists of the following members:

Member Name	Organization
Karen Ballengee	School
Jude Endicott	Senior Citizen
SharonAshley	Service Organization
Beth Frazier	Business
Sarah Hood	Medical: Substance Abuse
Randy Chandler	Community Coalition
Sherry Stout	Community Coalition
Linda Naylor	Education

Priority Problem

Ohio's SPF-PFS project focuses on 1) underage drinking among individuals ages 12-20 years and 2) prescription drug abuse among individuals ages 12-25 years.

We have decided to select *Underage Drinking* as our Priority Problem.

Priority Population

We will address underage drinking with both males and females, among 7th through 12th grade students in the Ohio Valley Local School District and the Manchester School District located in Adams County Ohio.

Data Sources Used When Selecting Priority Problem

- 2017 OHYES! Assessment for Adams County
- 2017 Adams County Health Assessment
- Ohio NSDUH 2013/2014
- 2017 OHYES! Assessment for Lawrence County
- National Survey on Drug Use and Health, 2015
- 2015 YouthRisk Behavior Survey
- Youth Online: High School YRBS, 1991-2015

Adams County Problem Statement

In these schools, according to the OHYES! Assessment data, 15.5% of all students drank one or more drinks during the past 30 days. In addition, the 30 day use went from less than 3.2% of 7th grade students to 30.7% of 11th grade students and 32% of 12th grade students.

Why Underage Drinking is an Issue among Priority Population in Adams County

Use of alcohol by youth under the age of 18 is an issue in Adams County Ohio. The Prevention Data Committee compared data from the 2017 OHYES! survey and the Adams County Health Department's 2017 YRBS data and found high percentages of 30 day use along with low percentages of parental and peer disapproval, risk/harm of binge drinking, and communication with parents around drug use, this measure also includes alcohol. The percentages of use are higher than state or national levels.

Outcome Variables

Outcome Variable	Baseline Data	Data Source	Year
Alcohol 30 day use	15.5% of all students drank one or more drinks during the past 30 days.	OHYES! Data	2017
Alcohol 30 day use	30.7% of 11th grade students drank one or more drinks during the past 30 days.	OHYES! Data	2017
Alcohol 30 day use	32% of 12th grade students drank one or more drinks during the past 30 days.	OHYES! Data	2017

Chapter 2

Adams County SFY18 Community Readiness Assessment Report

Introduction

During SFY17, Adams County was one of two Data Mini-Grant communities funded under Ohio's Strategic Prevention Framework-Partnerships for Success (SPF-PFS) Initiative[1]. As part of the SPF-PFS project needs assessment process, each community completed a community readiness assessment. This report provides the results of Adams County's community readiness assessment and provides details about how the community readiness assessment was conducted.

Members of the community readiness assessment team for Adams County include:

- Sherry Stout, Project Director, Interviewer and Report Writer
- Sharon Ashley, CRA Team Member, Scorer
- Beth Pirtle-Frazer, CRA Team Member, Scorer and Report Writer
- Linda Naylor, CRA Team Member, Interviewer

Community Readiness and its Importance

Community readiness is the degree to which a community is willing and prepared to take action on an issue that affects the health and well-being of the community. Community readiness extends traditional resource-based views of how to address issues in communities by recognizing that efforts must have human, fiscal, and time resources, along with the support and commitment of its members and leaders. Community readiness is issue-specific, community-specific, and can change over time.

As prevention science has developed, prevention practitioners have realized that understanding a community's level of readiness is key to selecting prevention programs, efforts, and strategies that fit the community and to realizing positive prevention outcomes. In addition, work by NIDA (1997) highlights that community readiness is a process, factors associated with it can be objectively assessed and systematically enhanced. (National Institute on Drug Abuse, 1997).

Tri-Ethnic Community Readiness Model

The Tri-Ethnic Community Readiness Model is an innovative method for assessing the level of readiness of a community to develop and implement prevention and other intervention efforts. The TE-CRM was developed by researchers at the Tri-Ethnic Center for Prevention Research (Oetting, Donnermeyer, Plested, Edwards, Kelly, and Beauvais, 1995) to help communities be more successful in their efforts to address a variety of important issues, such as drug and alcohol use and HIV/AIDs prevention.

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[1] Funding for the SPF-PFS is provided by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP); Funding Opportunity SP-14-004. The SPF-PFS in Ohio is administered by the Ohio Department of Mental Health and Addiction Services (OhioMHAS).

The TE-CRM measures five dimensions of community readiness:

- Dimension A: Community knowledge of the issue;
- Dimension B: Community knowledge of efforts;
- Dimension C: Community climate;
- Dimension D: Leadership; and
- Dimension E: Resources

In addition to the five dimensions of community readiness, the TE-CRM includes nine stages of community readiness, ranging from "no awareness" of the problem to "high level of community ownership" in response to the issue. Table 1 presents a complete list of the stages of community readiness and a brief example of each stage.

***Table 1*. Stages of Community Readiness**

Stage	Description	Example
1	No awareness	"It's just the way things are."
2	Denial/resistance	"We can't do anything about it."
3	Vague awareness	"Something should be done, but what?"
4	Preplanning	"This is important—what can we do?"
5	Preparation	"We know what we want to do and we are getting ready."
6	Initiation	"We are starting to do something."
7	Stabilization	"We have support, are leading, and we think it is working."
8	Confirmation/expansion	"Our efforts are working. How can we expand?"
9	Community ownership	"These efforts are part of the fabric of our community."

A community can be at different stages of readiness on each of the five dimensions of community readiness. The TE-CRM process (which will be described further below) results in readiness scores for each of the dimensions. The readiness scores for each of the dimensions are then combined to create a final overall readiness score for the community on a particular issue. This overall score provides a snapshot of how willing the community is to address an issue. In addition, the readiness scores for the individual dimensions are useful for understanding more about community readiness around the issue and for identifying and developing strategies to increase readiness.

The Tri-Ethnic Community Readiness Assessment Process

The TE-CRM includes a six-step process for assessing community readiness to address an important issue. These steps include:

1) Identifying a problem of practice to focus the community readiness assessment
2) Defining the community. For this assessment, "community" was defined as Adams County.
3) Conducting and recording structured interviews with key respondents in the Adams County community.
4) Obtaining transcripts of the community readiness interview recordings.

5) Scoring the interviews and calculating overall and dimension-specific readiness scores.
6) Creating a report describing the community readiness assessment process and presenting the community's readiness scores.

Selecting a Problem of Practice

Because community-readiness is issue-specific, communities first worked through a data-driven process to identify a problem of practice to guide the community readiness process. This process involved conducting a scan of available data to identify a priority problem (issue); identifying a priority population; mapping outcome variables associated with that priority problem; and creating a problem statement that detailed how the community was defined, what the key issue of focus was, and why it was an issue. Communities were required to focus their efforts on either underage drinking or prescription drug misuse/abuse among persons aged 12-25.

Key Informant Interviews

A key component of the TE-CRM is conducting interviews with 5-8 key informants in the community. Key informants are often individuals in the community who are knowledgeable about the community, but not necessarily leaders or decision-makers. Good key informants for community readiness interviews are community members who are involved in community affairs and who know what is going on—those with "big ears." It is important to note that the purpose of the TE-CRM is to assess the readiness of the *community* and not the *individual* to address the problem of practice; as such, individuals with lived experience with the problem of practice often have difficulty balancing community perspectives with their own experiences. By using a cross section of individuals, a more complete and accurate measure of the level of readiness to address the problem of practice can be obtained. TE-CRM key informant interviews involve approximately 35-40 questions from a structured interview guide developed by the Tri-Ethnic Center that are adapted to the community and the issue being addressed. The TE-CRM interview guide is included in this report (see Appendix A). TE-CRM interviews are recorded so that a transcript can be created for the scoring process. Key informant interviews in Adams County were conducted in April 2018.

Scoring Community Readiness Interviews Using the TE-CRM

After interviews are complete, each interview is transcribed. The TE-CRM community readiness interview transcripts are scored individually by at least two scorers following specific guidance developed by the Tri-Ethnic Center. Each interview is scored on a scale from 1-9 (depending on the stage of readiness) on each of the five dimensions and an overall community score is calculated. Individual scorers then come together and agree on the scores of each dimension for each interview (called a "consensus score" in the TE-CRM). Scores are then averaged across interviews for each dimension, and the final community readiness score is the average across the six dimensions. This final score gives the overall stage of readiness for the community to address this issue.

Community Readiness Results for Adams County

Adams County Problem Statement

During SFY18, Adams County engaged in a data-informed process to select a priority problem and priority population for its SPF-PFS efforts. Adams County selected *Underage Drinking* as the priority problem and chose to focus on 7th through 12th grade students in the Ohio Valley Local School District and the Manchester School District located in Adams County, Ohio. Their approved problem statement is:

According to the 2017 OHYES! Assessment data, 15.5% of all students drank one or more drinks during the past 30 days. In addition, the 30 day use went from less than 3.2% of 7th grade students to 30.7% of 11th grade students and 32% of 12th grade students.

This problem statement is the focus of this community readiness assessment.

Community Readiness Scores

Adams County conducted eight community readiness interviews in April 2018. The table below summarizes the timeframe of the interviews and the community sectors represented by the interview respondents.

Table 2. **Interview Information**

Interview	Date	Community Sector Represented
1	4/19/2018	Other: Casework Supervisor
2	4/19/2018	Member of faith-based community
3	4/19/2018	School and/or education provider
4	4/23/2018	Community member
5	4/25/2018	County government official (from county agency)
6	4/25/2018	Other: Law Enforcement
7	4/25/2018	Business community leader/member
8	4/26/2018	Medical professional

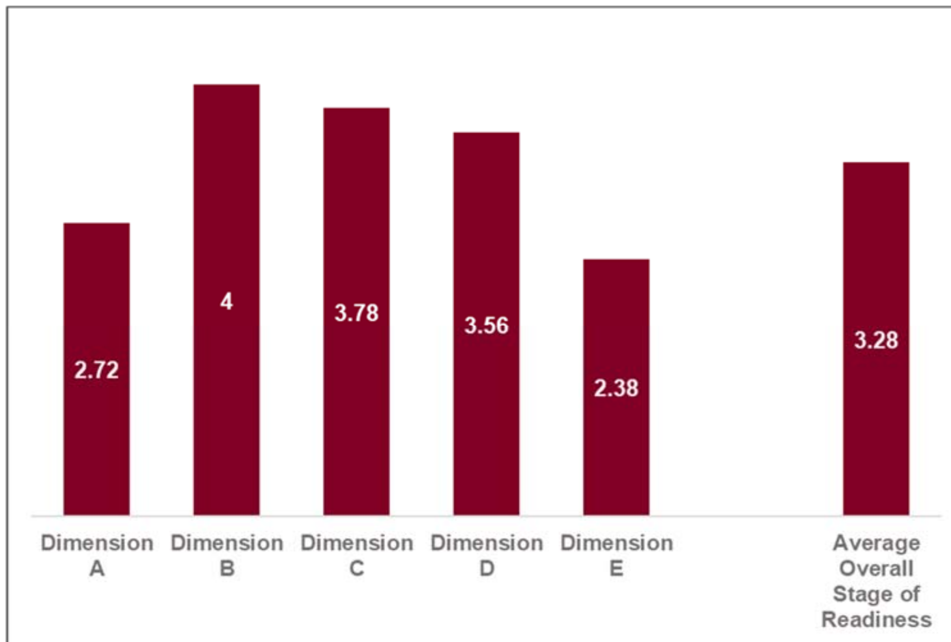
Adams County then scored the interviews using the individual and consensus scoring guidance from the TE-CRM.

The following table is a summary of Adams County's interview scores for each dimension.

***Table 3*. Combined Interview Scores by Dimension**

Dimension	Interview								Combined Total Score of 8 Interviews
	1	2	3	4	5	6	7	8	
Dimension A: *Community Knowledge of Efforts*	4	5	1.75	1	1.5	3.5	3.5	1.5	21.8
Dimension B: *Leadership*	4	4.5	3.5	3	4.5	4	4.5	4	32
Dimension C: *Community Climate*	4	5	3.5	1.25	4	4	4.5	4	30.3
Dimension D: *Knowledge about the Issue*	3.5	3.5	2	3	4	4.5	4	4	28.5
Dimension E: *Resources Related to the Issue*	2	2.5	2	2	2	3	3	2.5	19

***Figure 1.* Calculated Stage Score for Individual Dimensions**



Adams County's Average Overall Stage of Readiness is: 3.28. This score indicates that the community is in **Stage 3: Vague Awareness**.

Highlights from Interview Participants about Readiness to Address Underage Drinking

The quotations below are included to illustrate the scores in Table 4.

Dimension	Quotation
Dimension A: *Community Knowledge of Efforts*	"I don't think there's a lot of prevention efforts. The community thinks that the drug problem is a lot worse than the alcohol problem."
Dimension B: *Leadership*	"There is a lot of passive support for issues. Community is more 'focused on the money problem with the power plants leaving.'"
Dimension C: *Community Climate*	"Oh, its just beer. It's alright." "Everybody has done it through the years."
Dimension D: *Knowledge about the Issue*	"Don't think a lot of people understand the consequences [of underage drinking] at all."
Dimension E: *Resources Related to the Issue*	"I am not aware of any funding for efforts to deal with underage drinking [two people used this same phrase]."

Using Assessment Results to Develop Strategies to Build Readiness

With the information from this assessment, strategies can be developed that will be appropriate for Adams County. The first step in determining possible strategies to build readiness is to look at the distribution of scores across the five readiness dimensions. To move ahead with prevention programs, strategies, and interventions, community readiness levels should be similar on all five dimensions. If one or more dimensions have lower scores than the others, efforts should be focused on identifying and implementing strategies that increase the community's readiness on that dimension (or those dimensions).

After reviewing these results, the Adams County team felt the community had little to no knowledge of efforts. The Health & Wellness Coalition was mentioned twice because those people (interviewees) had been or are members. Most people did mention the sheriff's young deputy boot camp program. This receives a lot of press coverage each summer. Dimension E was also low indicating people may think this is problem, but it is not a priority.

People stated there was no leadership on a county level. It appears adults are apathetic and thankful that the underage drinking is not opioid drug use.

Appendix A: TE-CRM Interview Guide

Ohio SPF-PFS Initiative - Community Readiness Interview Questions

***REMINDER*: Where you see "(issue)," fill in with the issue you would like to address and any specifics about that issue (i.e., underage drinking among 12-18 year olds). Where you see "(community)," please make sure to insert the name of the county or community you are focusing on.**

1. **For the following question, please answer keeping in mind your perspective of what community members believe and not what you personally believe.**

   On a scale from 1-10, how much of a concern is (*issue*) **to members of** *(community),* **with 1 being "not a concern at all" and 10 being "a very great concern"?** *(Scorer note: Community Climate)*

   Can you tell me why you think it's at that level?

   Interviewer: Please ensure that the respondent answers this question in regards to ***community members*** *NOT in regards to themselves or what they think it should be.*

COMMUNITY KNOWLEDGE OF EFFORTS

I'm going to ask you about current community efforts to address *(issue)*. By efforts, I mean any programs, activities, or services in your community that address *(issue)*.

2. **Are there efforts in** (*community)* **that address** (*issue*)**?**

   *If **Yes**, continue to question 3; if **No**, skip to question 16.*

3. **Can you briefly describe each of these?**

   Interviewer: Write down names of efforts so that you can refer to them in #4-5 below.

4. **How long have each of these efforts been going on?** *Probe for each program/activity*.
5. **Who do each of these efforts serve (e.g., a certain age group, ethnicity, etc.)?**
6. **About how many community members are aware of each of the following aspects of the efforts - none, a few, some, many, or most?**
   - **Have heard of efforts?**
   - **Can name efforts?**
   - **Know the purpose of the efforts?**
   - **Know who the efforts are for?**
   - **Know how the efforts work (e.g. activities or how they're implemented)?**
   - **Know the effectiveness of the efforts?**
7. **Thinking back to your answers, why do you think members of your community have this amount of knowledge?**
8. **Are there misconceptions or incorrect information among community members about the current efforts?** *If yes:* What are these?
9. **How do community members learn about the current efforts?**

10. **Do community members view current efforts as successful?**

    Probe: What do community members like about these programs?

    What don't they like?

11. **What are the obstacles to individuals participating in these efforts?**
12. **What are the strengths of these efforts?**
13. **What are the weaknesses of these efforts?**
14. **Are the evaluation results being used to make changes in efforts or to start new ones?**
15. **What planning for additional efforts to address** (*issue*) **is going on in** (*community)*?

<u>*Only ask #16 if the respondent answered "No" to #2 or was unsure.*</u>

16. **Is anyone in** (*community)* **trying to get something started to address** (*issue*)? **Can you tell me about that?**

LEADERSHIP

I'm going to ask you how the leadership in *(community)* perceives *(issue)*. By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in the community and/or who lead the community in helping it achieve its goals.

17. **Using a scale from 1-10, how much of a concern is** (*issue*) **to the leadership of** (*community)*, **with 1 being "not a concern at all" and 10 being "a very great concern"?**

    Can you tell me why you say it's a _____?

    17a. How much of a priority is addressing this (*issue*) **to leadership?**

    Can you explain why you say this?

18. **I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address** (*issue*)**.**

    Can you please tell me whether none, a few, some, many or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through the list.

    How many leaders…

    - **At least passively support efforts without necessarily being active in that support?**
    - **Participate in developing, improving or implementing efforts, for example by being a member of a group that is working toward these efforts?**
    - **Support allocating resources to fund community efforts?**
    - **Play a key role as a leader or driving force in planning, developing or implementing efforts? (**prompt: How do they do that?**)**
    - **Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?**

19. **Does the leadership support expanded efforts in the community to address** (*issue*)**?**

    If yes: **How do they show this support? For example, by passively supporting, by being involved in developing the efforts, or by being a driving force or key player in achieving these expanded efforts?**

20. **Who are leaders that are supportive of addressing this issue in your community?**

21. **Are there leaders who might oppose addressing** (*issue*)**? How do they show their opposition?**

COMMUNITY CLIMATE

For the following questions, again please answer keeping in mind your perspective of what community members believe and not what you personally believe.

22. **How much of a priority is addressing this issue to community members?**

    Can you explain your answer?

23. **I'm going to read a list of ways that community members might show their support or their lack of support for community efforts to address** (*issue*)**.**

    Can you please tell me whether none, a few, some, many or most community members would or do show their support in this way? Also, feel free to explain your responses as we move through the list.

    How many community members…

    - **At least passively support community efforts without being active in that support?**
    - **Participate in developing, improving or implementing efforts, for example by attending group meetings that are working toward these efforts?**
    - **Play a key role as a leader or driving force in planning, developing or implementing efforts? (prompt: How do they do that?)**
    - **Are willing to pay more (for example, in taxes) to help fund community efforts?**

24. **About how many community members would support expanding efforts in the community to address** (*issue*)**? Would you say none, a few, some, many or most?**

    If more than none: **How might they show this support? For example, by passively supporting or by being actively involved in developing the efforts?**

25. **Are there community members who oppose or might oppose addressing (*issue*)? How do or will they show their opposition?**

26. **Are there ever any circumstances in which members of** (*community)* **might think that this issue should be tolerated? Please explain.**

27. **Describe** (*community*)**.**

KNOWLEDGE ABOUT THE ISSUE

28. **On a scale of 1 to 10 where a 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about** (*issue*)**?**

    Why do you say it's a ____?

29. **Would you say that community members know nothing, a little, some or a lot about each of the following as they pertain to** (*issue*)? (*After each item, have them answer.)*

    - **(*issue*), in general *(Prompt as needed with "nothing, a little, some or a lot".)***
    - **the signs and symptoms**
    - **the causes**
    - **the consequences**

- **how much (*issue*) occurs locally (or the number of people living with (*issue*) in your community)**
- **what can be done to prevent or treat (*issue*)**
- **the effects of (*issue*) on family and friends?**

30. **What are the misconceptions among community members about** (*issue*)**, e.g., why it occurs, how much it occurs locally, or what the consequences are?**
31. **What type of information is available in** (*community)* **about** (*issue*) **(e.g. newspaper articles, brochures, posters)?**

    If they list information, ask: Do community members access and/or use this information?

RESOURCES FOR EFFORTS *(time, money, people, space, etc.)*

If there are efforts to address the issue locally, begin with question 32. If there are no efforts, go to question 33.

32. **How are current efforts funded? Is this funding likely to continue into the future?**
33. **I'm now going to read you a list of resources that could be used to address** (*issue*) **in your community. For each of these, please indicate whether there is none, a little, some or a lot of that resource available in your community that could be used to address** (*issue*)**?**
    - **Volunteers?**
    - **Financial donations from organizations and/or businesses?**
    - **Grant funding?**
    - **Experts?**
    - **Space?**
34. **Would community members and leadership support using these resources to address** (*issue*)**? Please explain.**
35. **On a scale of 1 to 5, where 1 is no effort and 5 is a great effort, how much effort are community members and/or leadership putting into doing each of the following things to increase the resources going toward addressing** (*issue*) **in your community?**
    - **Seeking volunteers for current or future efforts to address** (*issue*) **in the community.**
    - **Soliciting donations from businesses or other organizations to fund current or expanded community efforts.**
    - **Writing grant proposals to obtain funding to address** (*issue*) **in the community.**
    - **Training community members to become experts.**
    - **Recruiting experts to the community.**
36. **Are you aware of any proposals or action plans that have been submitted for funding to address** (*issue*) **in** (*community)***?**

    If Yes: Please explain**.**

Additional policy-related questions:

37. **What formal or informal policies, practices and laws related to this issue are in place in your community?** (*Prompt*: An example of ―formal‖ would be established policies of schools,

police, or courts. An example of ―informal‖ would be similar to the police not responding to calls from a particular part of town.)

38. **Are there segments of the community for which these policies, practices and laws may not apply, for example, due to socioeconomic status, ethnicity, age?**
39. **Is there a need to expand these policies, practices and laws? If so, are there plans to expand them? Please explain.**
40. **How does the community view these policies, practices and laws?**

***DEMOGRAPHICS OF RESPONDENT* (optional)**

1. Gender:

2. What is your work title? ____

3. What is your race or ethnicity?

___ Anglo ___ African American

___ Hispanic/Latino/Chicano ___ American Indian/Alaska Native

___ Asian/Pacific Islander ___ Other___________________________

4. What is your age range?

___ 19-24 ___ 25-34

___ 35-44 ___ 45-54

___ 55-64 ___ 65 and above

5. Do you live in (*community*)? YES NO If no: What community? ________________

6. How long have you lived in your community? ________________________

7. Do you work in (*community*)? YES NO If no: What community? _________________

5. Do you live in (*community*)? YES NO If no: What community? _________________

Chapter 3

COMs Data for Adams County

Data for this report come from the Ohio Healthy Youth Environments Survey (OHYES!, SFY 2017).

All items asked in a continuous fashion were dichotomized. Frequency items were dichotomized at occurring vs. not occurring.

Table 1. Percentages for 30 Day Binge Alcohol Use

2017	N = 818
Valid N	758
Overall	5.9
Females	5.9
Males	6.4
Grade 6	-
Grade 7	-
Grade 8	-
Grade 9	-
Grade 10	-
Grade 11	10.7
Grade 12	-

Table 2. Percentages for 30 Day Alcohol Use

2017	N = 818
Valid N	786
Overall	14.9
Females	13.5
Males	16.9
Grade 6	-
Grade 7	-
Grade 8	10.6
Grade 9	-
Grade 10	-
Grade 11	30.7
Grade 12	32.0

Chapter 4

Adams County SFY18 Prescription Drug Consequence Data Report

Introduction

During SFY18, Adams County was one of ten communities funded as part of Ohio's Strategic Prevention Framework-Partnerships for Success (SPF-PFS) Initiative.[1] As part of the SPF-PFS project needs assessment process, OSET worked with OhioMHAS and other partners across the state of Ohio to identify sources of data on prescription drug consequences and to compile these data. This report provides prescription drug consequence data for 2012-2016 and provides instructions on how to utilize and interpret these data.

Consequence Indicators, Years, and Sources

Secondary data on prescription drug consequences were collected from several sources, which appear in Table 1. Proportions were calculated by dividing the number experiencing the consequence (or numerator) by the population size or a count of events (or denominator). This number is then sometimes multiplied by 100,000 if the resulting numbers are very small (e.g., 1 in 10,000 is .01%, but 10 per 100,000). Norming these numbers by the population size or number of events allows for the numbers for your county and the state to be compared.

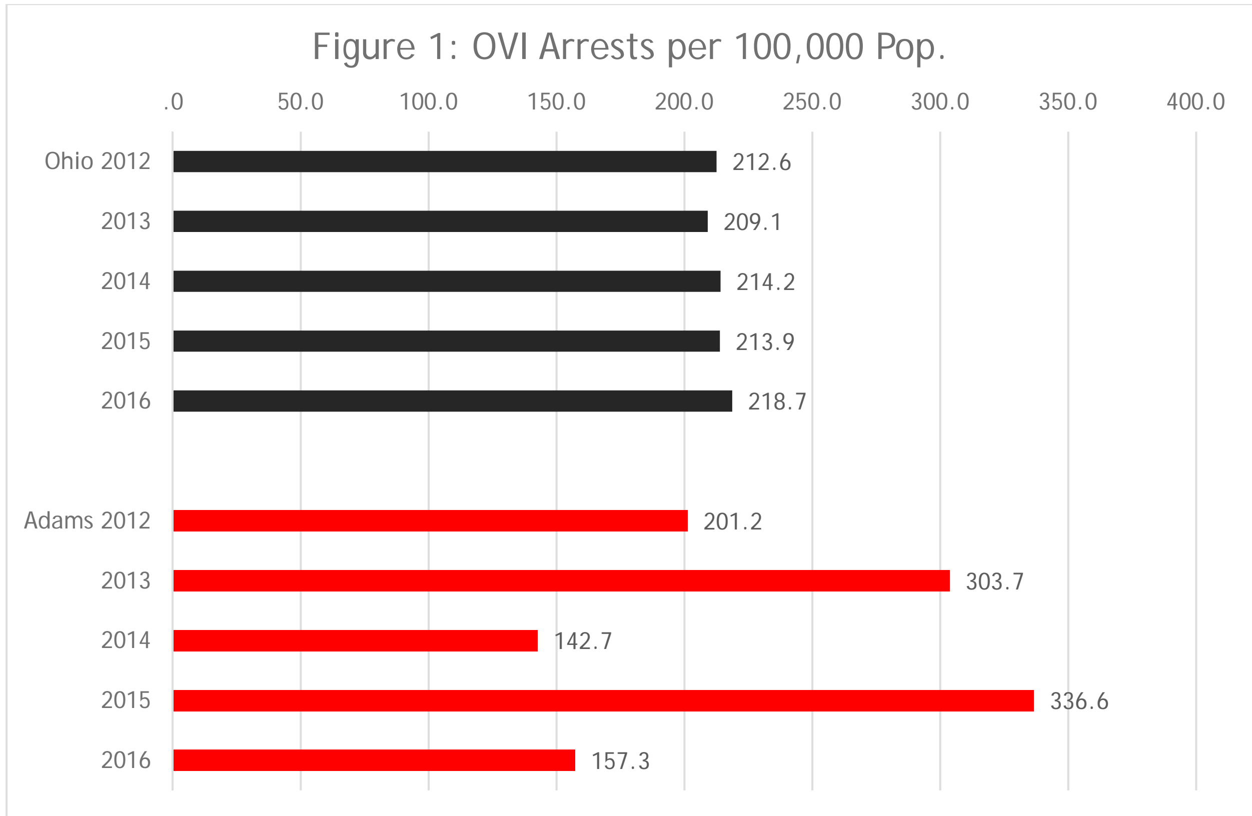
Table 1. **Consequence Indicators, Years, and Sources**

	Denominator	Years	Source
Prescription Drug Indicators			
Rx arrests per 100,000 Pop.	Population size	2012-2016	Ohio Incident-Based Reporting System
Drug Overdose Death per 100,000 Pop. Past 6 Yr. (Age Adj.)	Population size	2015-2016	Ohio Department of Health Drug Overdose Report
Unintentional Drug Overdose Deaths per 100,000 Pop.	2010 population size	2012-2016	
OVI Arrests per 100,000 Pop.	2010 population size	2012-2016	Ohio Department of Public Safety. Ohio Traffic Crash Facts Annual Reports.
% Overdose Deaths with Prescription Opioids	Number of deaths due to unintentional overdoses	2012-2016	Ohio Department of Health Bureau of Vital Statistics
% Overdose Deaths with Fentanyl and Related Drugs			
% Overdose Deaths with Benzodiazepines			
Fentanyl and Related Drug Deaths per 100,000 Pop.	Population size	2016	Ohio Department of Health Bureau of Vital Statistics

[1] Funding for the SPF-PFS is provided by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP); Funding Opportunity SP-14-004. The SPF-PFS in Ohio is administered by the Ohio Department of Mental Health and Addiction Services (OhioMHAS).

The following figures provide data for your county and the state. Note that "#N/A" indicates that either the data were not available or the data were suppressed by the provider due to a small number of cases. You will want to consider both (1) whether your county changes over time and (2) whether your county differs substantially from the state proportion.

Prescription Drug Indicator Data for Adams County



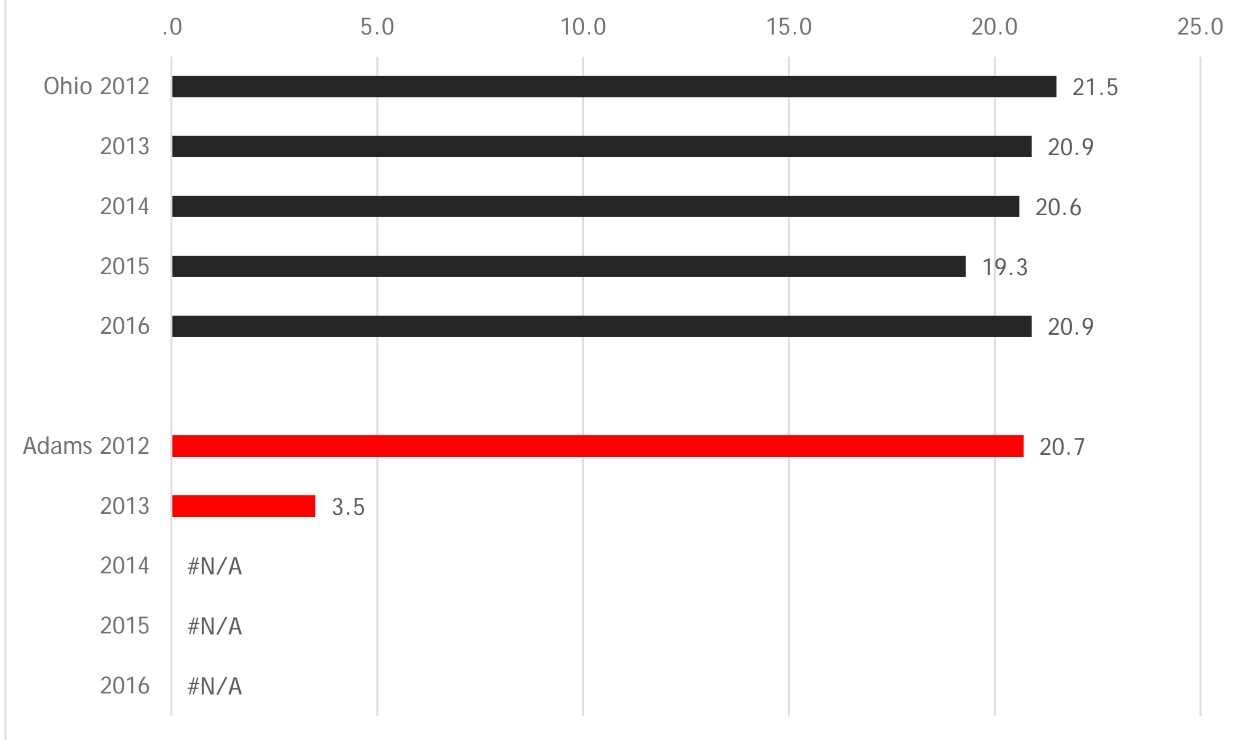


Figure 2: Rx arrests per 100,000 Pop.
.0
5.0
10.0
15.0
20.0
25.0
Ohio 2012
2013
2014
2015
2016
Adams 2012
2013
2014
2015
2016
21.5
20.9
20.6
19.3
20.9
20.7
3.5
#N/A
#N/A
#N/A

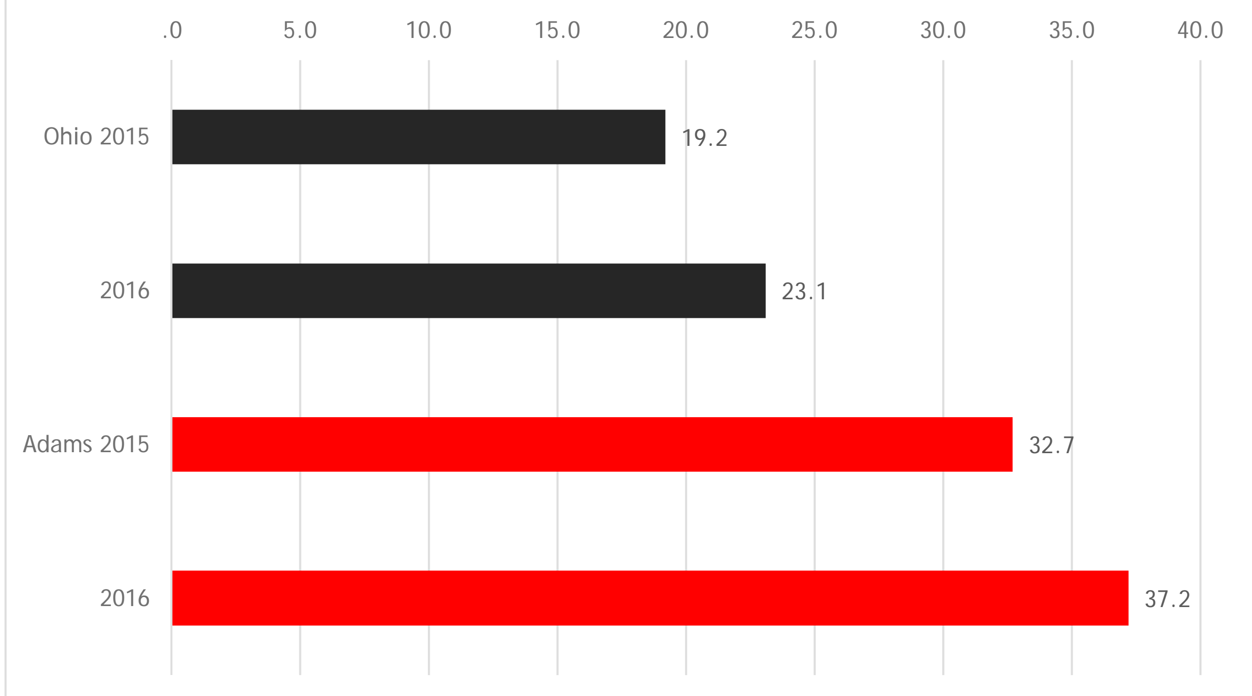


Figure 3: Drug Overdose Death per 100,000 Pop. Past 6 Years (Age Adj.)
.0
5.0
10.0
15.0
20.0
25.0
30.0
35.0
40.0
Ohio 2015
2016
Adams 2015
2016
19.2
23.1
32.7
37.2

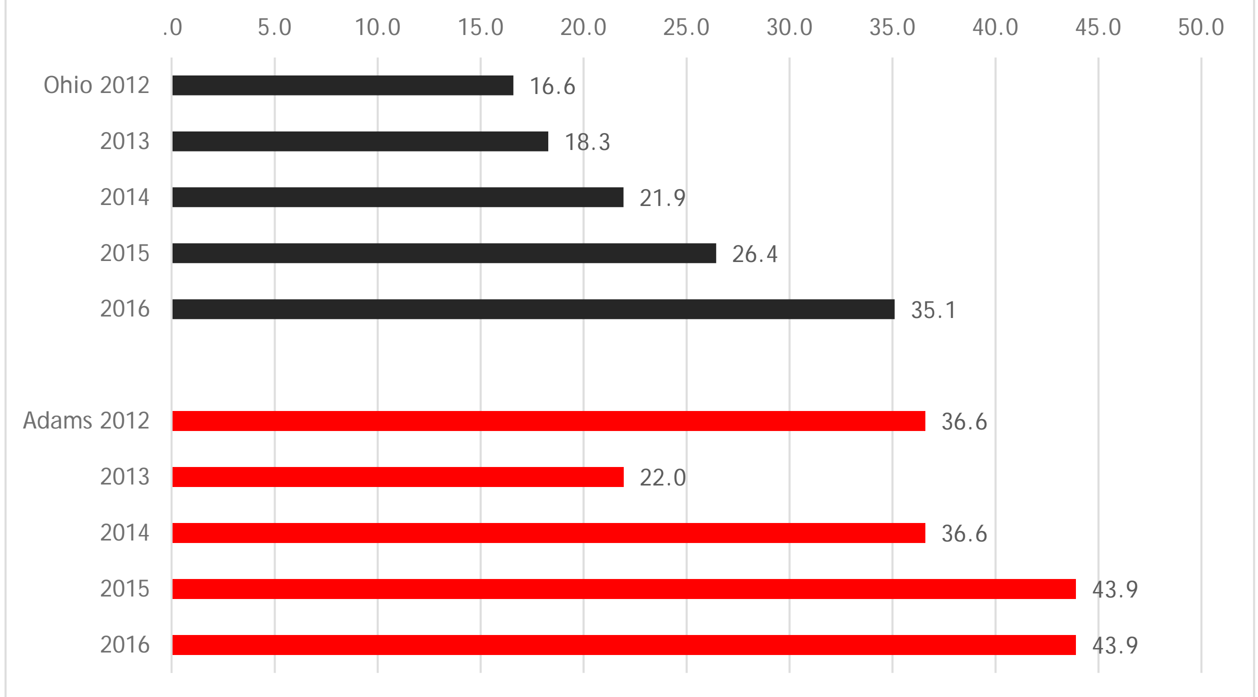


Figure 4: Unintentional Drug Overdose Deaths per 100,000 Pop.
.0
5.0
10.0
15.0
20.0
25.0
30.0
35.0
40.0
45.0
50.0
Ohio 2012
16.6
2013
18.3
2014
21.9
2015
26.4
2016
35.1
Adams 2012
36.6
2013
22.0
2014
36.6
2015
43.9
2016
43.9

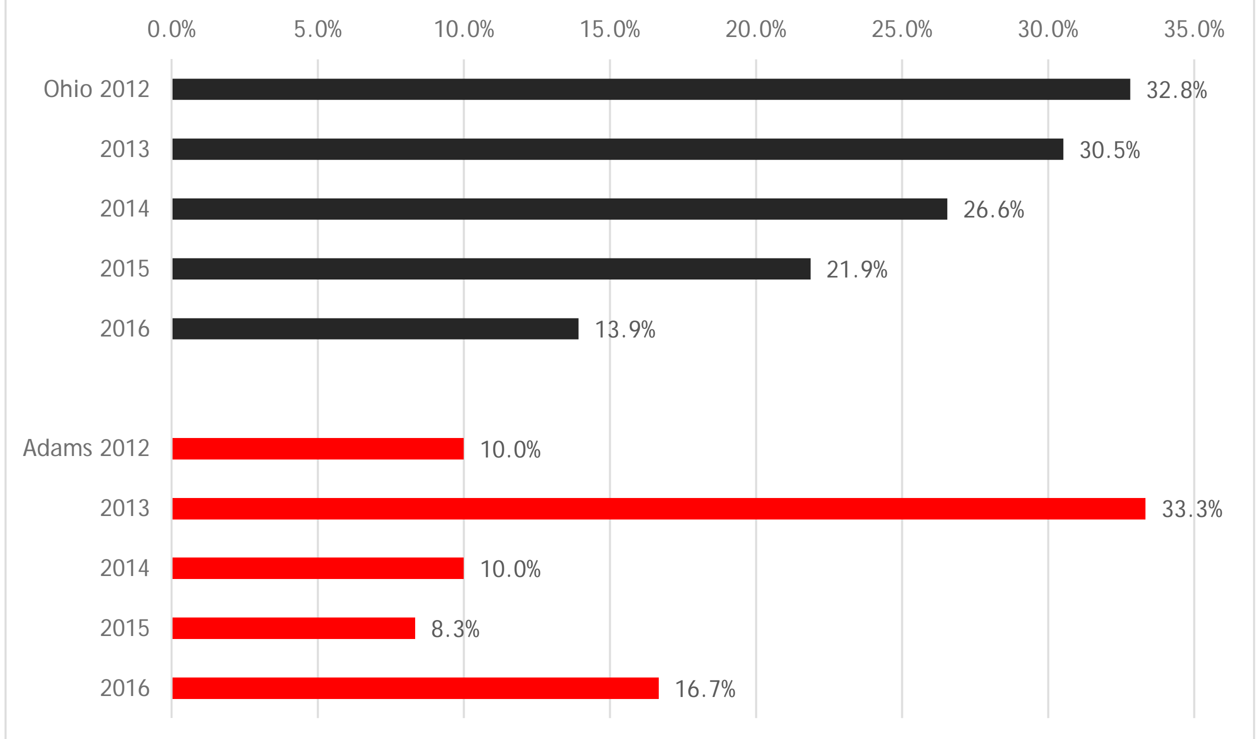


Figure 5: % Overdose Deaths with Prescription Opioids
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
30.0%
35.0%
Ohio 2012
32.8%
2013
30.5%
2014
26.6%
2015
21.9%
2016
13.9%
Adams 2012
10.0%
2013
33.3%
2014
10.0%
2015
8.3%
2016
16.7%

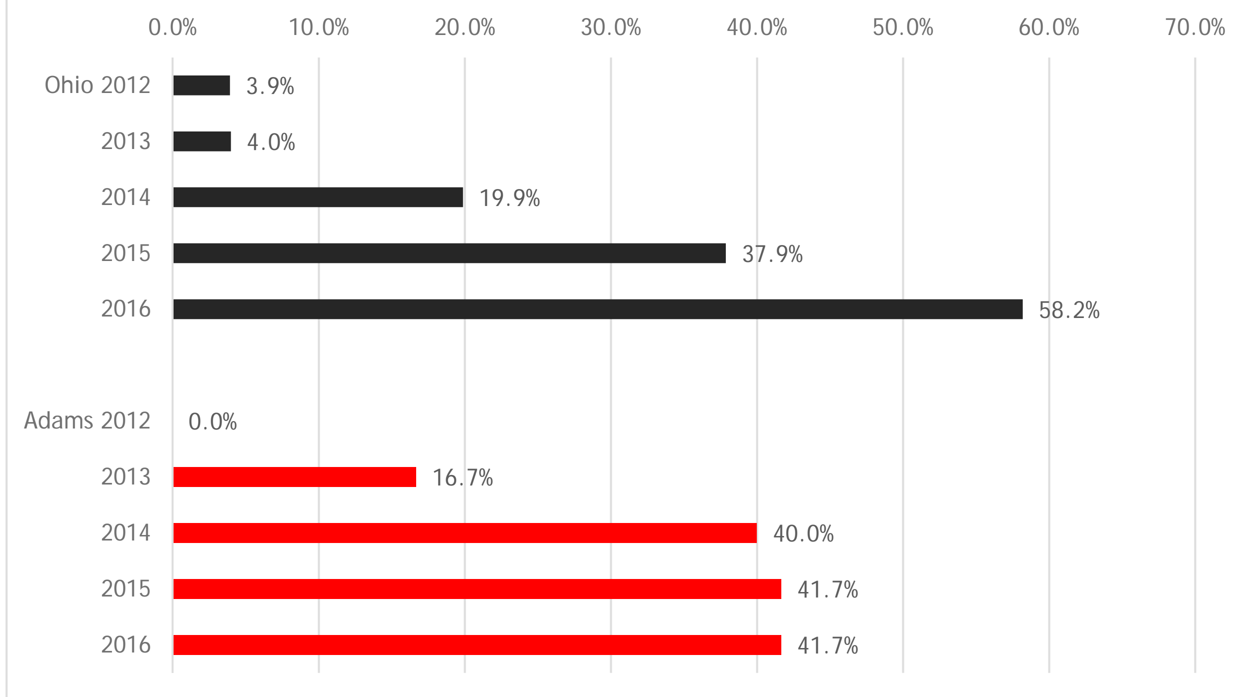


Figure 6: % Overdose Deaths with Fentanyl and Related Drugs
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
Ohio 2012
2013
2014
2015
2016
Adams 2012
2013
2014
2015
2016
3.9%
4.0%
19.9%
37.9%
58.2%
0.0%
16.7%
40.0%
41.7%
41.7%

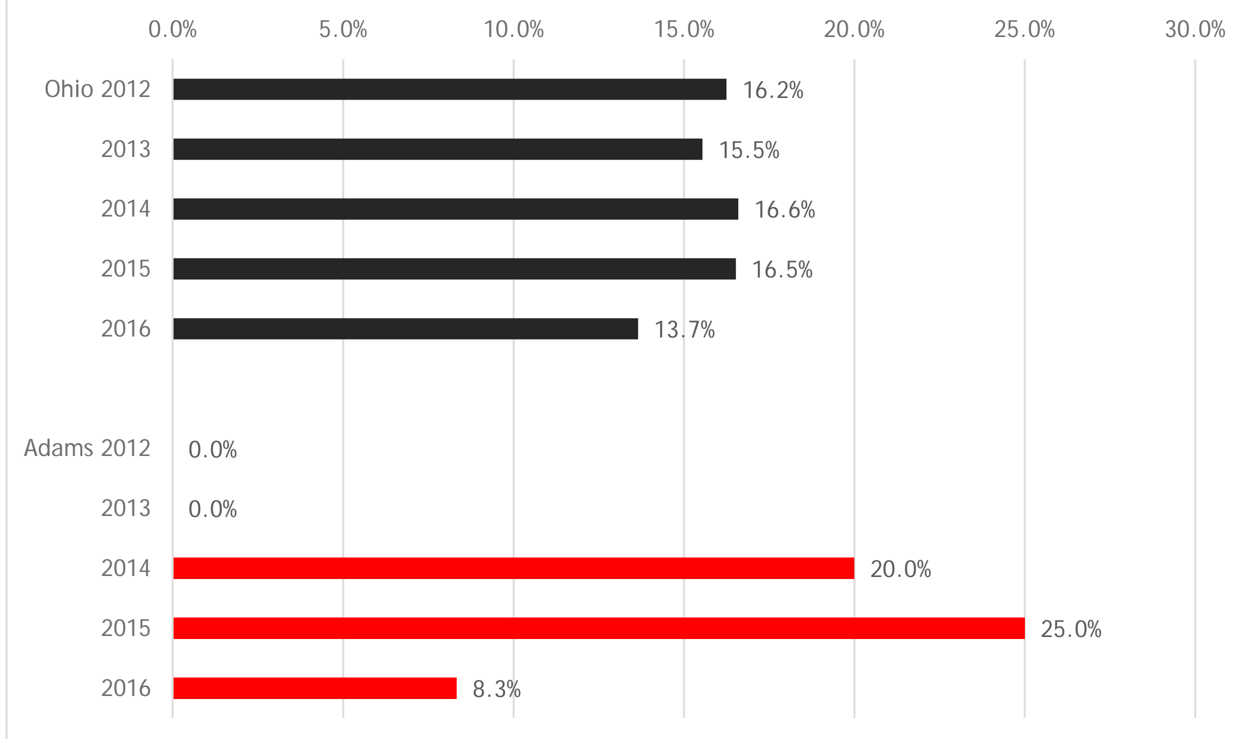


Figure 7: % Overdose Deaths with Benzodiazepines
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
30.0%
Ohio 2012
2013
2014
2015
2016
Adams 2012
2013
2014
2015
2016
16.2%
15.5%
16.6%
16.5%
13.7%
0.0%
0.0%
20.0%
25.0%
8.3%

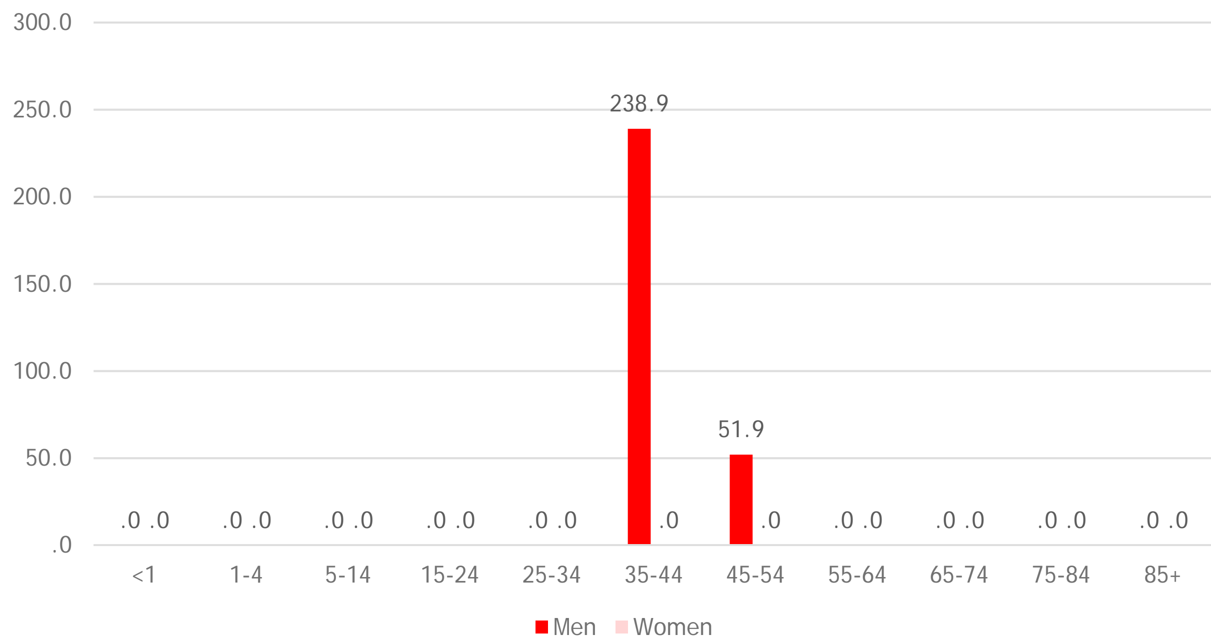


Figure 8: Overdose Deaths per 100,000 Population
with Fentanyl & Related Drugs by Sex & Age for County
300.0
250.0
200.0
150.0
100.0
50.0
.0
238.9
51.9
.0 .0
.0 .0
.0 .0
.0 .0
.0 .0
.0
.0
.0 .0
.0 .0
.0 .0
.0 .0
<1
1-4
5-14
15-24
25-34
35-44
45-54
55-64
65-74
75-84
85+
Men
Women

Chapter 5

Intervening Variable Data for Adams County

Data for this report come from the Ohio Healthy Youth Environments Survey (OHYES!, FFY 2017).

All items asked in a continuous fashion were dichotomized. Frequency items were dichotomized at occurring vs. not occurring, risk items were dichotomized at moderate or great risk vs. otherwise, and perceptions of disapproval were asked as wrong or very wrong vs. otherwise.

Table 1. Percentages for Perceived Risk/Harm of Use - Binge Drinking

2017	N = 818
Valid N	763
Overall	48.2
Females	60.2
Males	43.9
Grade 6	-
Grade 7	57.1
Grade 8	49.4
Grade 9	53.3
Grade 10	53.0
Grade 11	48.7
Grade 12	49.0

Table 2. Percentages for Perception of Peer Disapproval of Alcohol Use

2017	N = 818
Valid N	747
Overall	57.6
Females	72.2
Males	54.3
Grade 6	-
Grade 7	80.4
Grade 8	68.6
Grade 9	77.0
Grade 10	63.9
Grade 11	43.0
Grade 12	42.1

Table 3. Percentages for Parental Disapproval of Alcohol Use

2017	N = 818
Valid N	754
Overall	75.3
Females	87.1
Males	76.9
Grade 6	-
Grade 7	91.9
Grade 8	82.4
Grade 9	91.2
Grade 10	81.4
Grade 11	68.0
Grade 12	75.8

Table 4. Percentages for Family Communication about ATOD Use

2017	N = 818
Valid N	768
Overall	41.2
Females	47.3
Males	41.7
Grade 6	-
Grade 7	45.0
Grade 8	39.9
Grade 9	52.3
Grade 10	44.1
Grade 11	39.5
Grade 12	46.3

Chapter 6

Youth Tobacco, Alcohol, and Drug Prevention
Youth Focus Group Report

Voinovich School of Leadership and Public Affairs

Adams County, Ohio

February 2018

Submitted by:

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Most importantly, we offer our sincerest appreciation to the providers, parents, and youth who participated in the process. Without you, this report would not have been possible.

Table of Contents

Introduction 26

Method 26

Data Analysis 27

Results 27

Guiding Question #1: How do young people form their perceptions of parental permissiveness or disapproval regarding underage drinking? What cues do they follow to know that their parents are more or less restrictive with alcohol? 27

Guiding Question #2: What kind of social cues are young people using to gain approval or disapproval from peers regarding underage drinking? What strategies can be put in place to increase positive peer influence? 28

Guiding Question #3: What is the tone, demeanor, and perceived effectiveness of family conversations around using prescription drugs? How can these conversations be made more meaningful and impactful for youth? 29

Guiding Question #4: What are the strategies that most youth perceive as effective to decrease the harmful effects of underage drinking? What negative consequences of underage drinking are perhaps being neglected by youth? 30

Conclusion 31

References 33

Appendix A: Underage Drinking – Youth Interview Guide 34

Appendix B: Parent Consent / Youth Assent Form 37

Introduction

During SFY17 and 18, Adams County Medical Foundation was one of two data mini-grantee communities funded as part of Ohio's Strategic Prevention Framework-Partnerships for Success (SPF-PFS) Initiative[1]. As part of the SPF-PFS project needs assessment process, each community completed listening sessions/focus groups on underage drinking with youth in the community. This report synthesizes the results of Adams County's Youth listening sessions and provides details about how the listening sessions were conducted. These listening sessions were designed to provide information on local/community conditions that are contributing to the problem of underage drinking in Adams County.

Method

Guiding Questions

The focus groups were designed to capture information relating to four intervening variables as required by SAMHSA. As such, the guiding questions for each focus group were:

1. How do young people form their perceptions of parental permissiveness or disapproval regarding underage drinking? What cues do they follow to know that their parents are more or less restrictive with alcohol?
2. What kind of social cues are young people using to gain approval or disapproval from peers regarding underage drinking? What strategies can be put in place to increase positive peer influence?
3. What is the tone, demeanor, and perceived effectiveness of family conversations around underage drinking? How can these conversations be made more meaningful and impactful for youth?
4. What are the strategies that most youth perceive as effective to decrease the harmful effects of underage drinking? What negative consequences of underage drinking are perhaps being neglected by youth?

Interview Protocol

For each listening session, the research team utilized a standard, open-ended group interview protocol to facilitate the group. Patton (2002) advocates the use of an interview guide for the following three reasons: (a) the limited time in an interview session is optimally utilized; (b) a systematic approach is more effective and comprehensive; and (c) an interview guide keeps the conversation focused. The facilitation guides (Appendices A-B) included questions designed to elicit responses regarding the questions guiding the evaluation.

Participants

Information from key informants (i.e., students) guided this listening session report. To collect information from the informants, we conducted two focus groups with youth ages 12-18.

The Project Coordinator invited informants to participate in the focus groups, scheduled the interviews, and coordinated the times and locations with the informants and the focus group team. In order for youth to participate in the group interviews, they had to have a signed parental consent form / student assent form (Appendix C). At the beginning of each focus group, the focus group team read a script which clearly stated that informants were participating voluntarily and had the option to refuse to answer any of the questions. Through the course of the project, two group sessions were completed and a total of twelve (12) youth participated. Students received no incentives for their participation in the study.

[1] Funding for the SPF-PFS is provided by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP); Funding Opportunity SP-14-004. The SPF-PFS in Ohio is administered by the Ohio Department of Mental Health and Addiction Services (OhioMHAS).

Data Analysis

Qualitative data analysis techniques were used to analyze the data collected from the group interviews. Content analysis was used to analyze responses to the open-ended items. Patton (2002) describes content analysis as "searching for recurring words or themes." Text was analyzed to see what phrases, concepts, and words are prevalent throughout the informants' responses. During this stage of the analysis, coding categories were identified. Through this coding process, data was sorted and defined into categories that were applicable to the purpose of the research. Codes were defined and redefined throughout the analysis process as themes emerged. At the end of the analysis, major codes were identified as central ideas or concepts (Glesne, 2006). These central ideas were assembled by pattern analysis for the development of major themes. From the major themes, we drew conclusions (Patton, 2002). To ensure credibility of both the procedures and the conclusions, we used analyst triangulation. Patton (2002) defines analyst triangulation as "having two or more persons independently analyze the same qualitative data and compare their findings." Teamwork, as opposed to individual work, is likely to increase the credibility of the findings (Lincoln & Guba, 1985).

Results

The following sections describes what informants perceived as the local conditions affecting perceived parental perceptions, peer perceptions, family communication, and risk/harm. These include personal risk and protective factors as well as potential strategies for enhancing prevention efforts in our community. Risk and protective factor-focused prevention is based on the work of Hawkins, Catalano, and Miller (1992). Risk factors are factors that increase the likelihood of adolescent substance abuse, teenage pregnancy, school drop-out, youth violence, and delinquency (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Protective factors provide the counter to risk factors; the more protective factors that an individual has present, the less risk for unhealthy behavior (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Research-based *risk factors* are frequently divided into four domains: community, family, school, and individual/peer risk factors (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Research has also identified four personal characteristics as *protective factors*: gender, a resilient temperament, a positive social orientation, and intelligence (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Because these factors are largely innate, we will focus on two additional protective factors described by Hogan et al.: bonding and healthy beliefs/clear standards.

Guiding Question #1: How do young people form their perceptions of parental permissiveness or disapproval regarding underage drinking? What cues do they follow to know that their parents are more or less restrictive with alcohol?

For this section, we focus on the personal risk and protective factors related to substance use and abuse that include family factors and bonding (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Family factors can include the way parents and children elate and interact as well as the level of parental supervision (HHS Publication No. (SMA) 10–4120).

The Adams County Team held two student focus groups. The first group was held at the Ohio Valley Career Center with five student participants and the second group was held at Manchester High School with seven student participants. Overall, the majority of students formed their perceptions of parents' permissiveness based on their conversations with their parents and based on whether parents allowed underage drinking in their homes.

Personal Risk Factors

The majority of students in both focus groups spoke about some "families allowing underage drinking in their homes." Students stated that "they believe the parents do this to protect their kids from the dangers of drinking and driving." However, another point that most of the students made is "they (parents) drink and they

don't care if their kids do." Several students pointed out that kids who drink "get their alcohol from their parents" and that it is easy to get alcohol because their "parents are careless." One student said that students "take alcohol from their homes in small amounts" so their parents don't notice it is missing. Another aspect pointed out by several students is that "drinking is seen as normal" in many homes. Several of the students spoke about family members who are alcoholic and how they "see the negatives" of alcohol use first hand in their homes.

Family. The students all knew families that allowed underage drinking or hosted underage teens. One said, "I feel like it's based on how often it is around your life and how, like me, how often you see it and how normal it is to you…but if it's like, out of control then that could shape your form. Like if you have an alcoholic parent but then, my parents drink occasionally and it's common in my life so I just see it as another drink." In both groups there were students who said they, "have friends that their parents let 'em drink with 'em, and that's mainly because the parents are used to it."

Personal Protective Factors

The majority of the students in the focus groups, both male and female, have talked with one of their parents about underage drinking and they feel that their parents "want them to have a better life." One male student stated that "he got mad if his parents thought he would drink" and another male student stated that "he would be hurt if his parents thought he drank." Another male student said "Some parents have allowed a taste" of alcohol during these conversations about underage drinking. A female student responded that the "taste is awful but felt their taste would change when older." A female student stated that her parents talked against alcohol but that her brother "was supporting her to drink." An interesting twist about student's conversations with their parents about underage drinking came from one young lady who said she felt "pressured to pick a parental side, drink or have religion."

Bonding

Overall, males and females from both sessions said they were, "glad that their parents cared enough to talk with them" about the issue of underage alcohol use. Students related that their parents conversed with them about their feelings on underage drinking and warned them of its risks. One student related, "It's two-way. You know, I let them know that I am listening and that I am paying attention. And I just try and comfort them and let them know, you know, this isn't really affecting me. You know, I'm still listening. I'm still not gonna make those decisions, but it's not something that I really worry about." Other students talked about parents sharing their experiences with alcohol, for example, "My mom's told me that like-and my dad, too, but, like, they've both said they've done stupid stuff in high school and stuff. They said they want us to have a good life, and they don't want us to end up being a bad kid when we get older."

Guiding Question #2: What kind of social cues are young people using to gain approval or disapproval from peers regarding underage drinking? What strategies can be put in place to increase positive peer influence?

This section will focus on personal risk and protective factors in the following domains: school, individual/peer, and healthy beliefs/clear standard. These risk and protective factors are related primarily to peer relationships which affect youth's individual and environmental factors (HHS Publication No. (SMA) 10–4120).

The participants in both groups communicated that if teens want to drink they will despite peer input. They communicated that among their peers, there were only a few who engaged in underage drinking with regularity but there were more who participated during parties or social events. "One reason they do it-it makes 'em feel like they're actually gonna be accepted, stuff like that. Though you may have someone that's bullying you to-

and them making peer pressure against you to make you drink to try it." Another students said, "It's like whiskey, when you get drunk, you're 10-foot tall and bulletproof but that ain't the case in real life.

Personal Risk Factors

School

Student participants in both groups talked about peer pressure to "be cool" which meant drinking alcohol at parties and after school events. Most drinking occurs on "the weekends." When asked about prevention efforts, participants in both groups who had an opinion thought information about consequences and prevention information should be introduced in either fifth or sixth grades.

Individual/Peer

A female student talked about how her boyfriend influenced her decision not to drink. He told her alcohol would "ruin her life; you never know what will happen." This student talked about being undecided about drinking due to her boyfriend's influence and to her brother's influence; her brother is an advocate of alcohol consumption. A male student in the first group stated that if he drank, his female friend would say "never do that again."

The teens in both groups related that they were concerned that their parents would be disappointed if they participated in underage drinking. They did not think that peer pressure had as much of an impact unless people were at a party. They talked about being at parties and witnessing drinking at parties where, "everybody's being crazy."

Personal Protective Factors

Responses from participants in both sessions stated they "want to please their parents" and feel the pressure to be "responsible." There was no difference in male verses female attitudes on this measure or between the groups in the different sessions.

Healthy Beliefs and Clear Standards

The majority of the students, both male and female, talked about the dangers of underage alcohol use. They used the following words and phrases when describing the dangers of underage drinking, "stupid; hurt someone else; one party can affect your entire life; not really you when you drink; and one wrong move will change your life forever." One female student expressed the opinion that it would be okay to drink, "if they had a person supervising the drinking such as a trusted, mature friend or a sibling."

The students related that the feelings of boyfriends or girlfriends toward drinking had impact on their actions. When questioned about people who had talked about the dangers of underage drinking, one young woman related that her boyfriend had talked with her, "He's really religious and he's really against it. And he's –he's 19. So, he is very, like-that it just could ruin your life and the effects you'll never know what will happen."

Guiding Question #3: What is the tone, demeanor, and perceived effectiveness of family conversations around underage drinking? How can these conversations be made more meaningful and impactful for youth?

This guiding question sought to identify personal risk and protective factors in the following domains: family, bonding, and healthy beliefs/clear standards. In addition to the aforementioned, family factors also include unity, warmth, and attachment, and contact and communication between parents and children (HHS Publication No. (SMA) 10–4120).

Teen responses to family communication around alcohol were mixed. Some teens related they were offended their parents would bring up the subject of underage drinking as though they had participated. Others said they appreciated the conversation because it made them feel their parents cared. One boy related, "It made us feel like they actually cared and showed that they are willing to give you time to pay attention to ya." In some instances, they said parents had shared what happened when they had engaged in underaged drinking. Several students referred to having conversations where their parents shared their experiences with underage drinking and they stated they appreciated their confidences. One student related a conversation with her mom, "she used to drink when she was in college and …she went through some, like, bad times with it, and she doesn't want me to go through that. So she'll talk to me about what happened to her and how she wants to prevent it for all her kids. I take it like, I don't want my life to be, just around alcohol. Like, 'cause people spend so much money on it and there's no good effects to it either."

Personal Risk Factors

Family. Many teens felt parents were showing they cared by talking with them but they also said they felt "pressured to be responsible." Another said, "My dad-my mom …hasn't really talked about it but she doesn't drink that often. My dad does pretty often but he's-I feel like my dad would be okay with it, as long as I'm of the ages. But, until then, I'm still his little girl and he doesn't want anything to happen." The students also said, "Whenever parents pressure you, that's usually what leads kids to try it, and then they start liking it, and that's what leads to it. 'Cause kids think, 'Oh, this is so rebellious,' 'cause their parents have talked about, all their life, about not drinking and doing stuff like that and not to do it, they're pressuring 'em not to do it, but at the same time their friends have some, and then they're like, 'Oh, hey, let me try it."

Personal Protective Factors

Bonding. Most of the teens in both groups voiced respect for parents who related their own experiences with alcohol. They listened. One student said, "It made us feel like they actually cared and showed that they are willing to give you time to pay attention to ya, stuff like that, and try and warn you about things that could ruin your life or like, ruin someone else's."

Healthy Beliefs and Clear Standards

Some teens mentioned that parents telling kids the risks and consequences more than a couple times became ineffective, as though parents were badgering them with the message. They made the same comments about prevention programming at school even mentioning that posters and constant messaging was annoying. "Just don't say it too often, 'cause then the kid will wanna do it, because they don't listen. Just be kind of, every once in awhile, just put it in there, but don't do it all the time." They suggested that peers or people closer to their ages should teach prevention programs.

Guiding Question #4: What are the strategies that most youth perceive as effective to decrease the harmful effects of underage drinking? What negative consequences of underage drinking are perhaps being neglected by youth?

The Center for Substance Abuse Prevention (CSAP) has identified six strategies that comprise a comprehensive prevention program: information dissemination, prevention education, alternative activities, community-based process, and environmental approaches (CSAP, 1993).

Students in our conversations indicated that stories and related experiences were more powerful messaging than someone just telling them about the risks and consequences. They also indicated that the threat of juvenile court or juvenile detention was not a deterrent but they did indicate that jail had more impact. All mentioned that teens typically do not think about the consequences or they think it won't happen to them, Like, I think they think…they don't think anything's bad gonna happen to me."

Information Dissemination

The students of both groups agreed that beginning information programs in the fifth or sixth grades as kids begin becoming independent, was the best time. Many remembered the DARE program but could not share specific information about what they learned, just that it was about drugs and alcohol. They felt high school is too late for information programs. A female student in the Career Center session, stated that she has seen "seventh graders bringing in moonshine."

Prevention Education

The students in both groups suggested using actual people's stories to illustrate consequences. They also agreed that speakers who are close to students' ages have more influence and that their stories have more impact, "I feel like kids are gonna listen to peers so maybe if we could look into something that's taught by kids to kids, you know." In both groups they related that signs or posters are not effective and that programs should be used only once during a school year. Otherwise, students said they were just annoying and preachy. Students mentioned remembering the DARE program but did not credit it with having an effect.

Alternative Activities

Students of both groups thought graphic videos of car accidents and other consequences of drinking have more impact than lectures or group sessions. One said, "When I went to driving school, our teacher showed us these videos of teenagers drinking and driving and how messed up they were. And some of them got killed. It was a very graphic video." They also indicated having people close to their ages who have experienced negative consequences of underage drinking had more impact than adults' instructions.

Community-based Process

Students in both groups did not indicate any community-based information, except as noted above. Messages from the community included perceived endorsement of underage drinking from parents who hosted or shared alcohol with youth, and the general perception that drinking was normal. Students also reported that most of their parents had spoken to them about potential consequences of underage drinking which made students feel connected and cared for by their parents, though the effectiveness of these conversations seemed to vary. One student indirectly identified the faith-based sector as being against underage drinking. Students participating in the focus groups acknowledged an awareness of prevention messaging as well as different prevention tactics, such as a teacher showing a graphic video of the consequences of drinking and driving. The effectiveness of prevention messaging was mixed with many students reporting that too much messaging had the opposite effect, serving instead as a catalyst for teens to act rebelliously and to try drinking.

Environmental Approaches

Students thought that workers at liquor stores and convenience stores did not care enough about their jobs to stop underage purchases of alcohol, "Honestly, some places, the workers don't even care. At places you can purchase alcohol, like, they don't even care."

Problem Identification and Referral

Students did not provide any information.

Conclusion

Based on the listening sessions, students felt teens engaged in the risky behavior of drinking more to fit in at parties and social events. If there were fewer teens in the group, they were more likely to engage in more positive activities. In fact, some students talked about trying to encourage peers not to drink and a couple even said "I worry about friends who drink." Students also said beer was the easiest to get due to many parents who have it in the house and to it being easily purchased from lax employees,"…their parents got alcohol, they take little bits at a time so they don't notice. It can be from the back of the fridge." They also related, in regards to having people buy for them or from lax employees, "They have people over the age of 21 that if they are a bad

influence, some go buy it for ‘em…or they have fake IDs. We have some people in my grade that look like they could be over 21 that could have a fake ID, walk in and then walk right back out.” Students were asked what youth drink most, “There’s people that, like, most of the guys will drink like Bud Light, stuff like that. But most of the girls, whenever you see ‘em, if they do, either they drink Smirnoff’s and sometimes they’ll drink a little bit of Bud Light but not much.”

Parents who talked with the students about alcohol and who related their own experiences were taken seriously and the students felt they cared enough to talk with them but they didn’t like feeling that their parents were talking with them because they thought they were drinking. Teens realized that parents who abetted underage consumption, who hosted parties or who did nothing to stop it are part of the problem and are, in a sense, advocating that behavior, “’cause, like, the parents that buy their kids alcohol obviously don’t care. So I’m glad my parents are the ones that care and want me to do well and want other kids to do well. And I’m glad my parents have trust. Ours is just a hope/trust thing.”

Teens placed value on hearing stories about actual consequences from peers or people close to the same age about their personal experiences with alcohol. “You know, ‘cause they’re gonna listen more to kids their age, versus an adult. Or maybe the people who’ve experienced this, like, come in every so often, just, like, say their story…but it would be a real story. They understand that people can easily become addicted to alcohol and they realize that some people may have other problems that lead them to like the feeling they get from drinking.

Although many of the adults cited a lack of activities for teens as a reason for underage drinking, that comment wasn’t made by the students who participated in the groups. The teens identified fifth and sixth grades as when prevention education should start because that is when children are becoming more independent. Although they identified the DARE program, most stated that it had no real impact on behavior, although one student did say, “I remember most of the stuff though.”

References

Glesne, C. (2006). *Becoming qualitative researchers: An introduction (*3rd ed.). New York: Addison Wesley Longman, Inc.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112,* 64-105.

Hogan, J. A., Gabrielsen, K. R., Luna, N., & Grothaus, D. (2003). *Substance abuse prevention: The intersection of science and practice.* Boston, MA: Allyn & Bacon.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry.* Boston, MA: Allyn & Bacon.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Substance Abuse and Mental Health Services Administration, Focus on Prevention. HHS Publication No. (SMA) 10–4120. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, Revised 201

Appendix A: Underage Drinking – Youth Interview Guide

Ohio's SPF-PFS Needs Assessment Process: Listening Sessions
Underage Drinking – Youth

Guiding Questions:

1. How do young people form their perceptions of parental permissiveness or disapproval regarding underage drinking? What cues do they follow to know that their parents are more or less restrictive with alcohol?

2. What kind of social cues are young people using to gain approval or disapproval from peers regarding underage drinking? What strategies can be put in place to increase positive peer influence?

3. What is the tone, demeanor, and perceived effectiveness of family conversations around underage drinking? How can these conversations be made more meaningful and impactful for youth?

4. What are the strategies that most youth perceive as effective to decrease the harmful effects of underage drinking? What negative consequences of underage drinking are perhaps being neglected by youth?

Hello. Thank you for letting us to talk with you this morning/afternoon. My name is _______________ and I am a part of the Adams County Medical Foundation. This is ________________ and she/he will be assisting with the group today. In this focus group, we are going to be asking you questions about your thoughts and feelings regarding people your age drinking alcohol. This information will be used for my research. I'm trying to learn more about what youth think about underage drinking, so your honest answers are important to me.

How many of you have participated in focus group before? [If yes, ask them to explain what it was like.] How would you describe what a focus group is?

Focus groups are just like conversations. I'll ask some questions for you all to respond to. It's ok to also respond to each other's statements and ideas – in fact, it makes for a better conversation if you do. At times throughout this focus group, I'll also pause and let you each record some of your thoughts before sharing them with the group. Sometimes this allows us to give more thoughtful answers.

There are a few rules, however, to help make sure things go smoothly. First, we only want one person to talk at a time. If multiple people speak at once, it's hard to hear each other and it's really hard to record the conversation. It's also important that we are respectful of each other's ideas - everyone's ideas are important, and they should be allowed to freely express their thoughts and feelings. Everyone has their own opinion and I want to hear each unique opinion. It's also important to remember that no one has to talk. If you feel uncomfortable at any time during the discussion, remember that you do not have to answer every question. Finally, it's important that what is said in this room, remains in this room. That means when we leave here, we aren't going to tell people what other individuals said. That applies to me and to you so anything that is recorded won't have any of your names on it and anything that you hear in this room won't be repeated by any of you. Does that sound good to each of you?

<u>Introductory Questions</u>

As I said earlier, the purpose of the group today is to talk about people your age drinking alcohol and how drinking affects young people in our community. To begin, I am going to ask you some general questions about what you think of underage drinking.

1. When I mention the phrase, "underage drinking" what kinds of alcoholic products do you think of?
    a. Do a lot of people your age drink alcohol?
    b. What kinds of alcoholic products do you see people your age drinking?
    c. What kinds of alcoholic beverages do people your age drink that are the most dangerous?
    d. What kinds of alcoholic beverages do people your age drink that are the least dangerous?

2. How do you feel about others your age drinking alcohol?
    a. When is it 'okay' for people your age to drink alcohol? Tell me about those times.

<u>Transition Questions</u>

3. How do you think that people your age get alcohol?
    a. Probe for:
        i. Where are they getting the alcohol?
        ii. From whom are they getting the alcohol?

4. Now that you've told me a bit about how people your age are getting alcohol, let's discuss how easy it is for them to get the alcohol. How easy do you feel it is for people your age to get alcohol from friends or peers?
    b. How about from their parents?
    c. What about from other sources you mentioned? (probe for other sources that they mentioned above in 3ii)

5. Tell us the most recent experience you have had where someone either at school, work, home, or in the community has talked to you about the dangerous of underage drinking?

    a. If you had to explain to a friend the dangers of underage drinking what would you say?

<u>Key Questions</u>

6. We've had a great discussion about the kinds of alcohol that people your age might be drinking and where they are getting the alcohol. Now let's talk about how your parents talk to you about drinking alcohol. Do you have these kinds of conversations with your parents? How do your parents talk to you about drinking and using alcohol?
    a. What kinds of conversations do you have?
    b. What do your parents say?
    c. How do these conversations make you feel?
    d. How could these conversations be better for you?

7. On a scale of 1 to 10, 1 being no risk and 10 being very great risk. How much do people your age risk harming themselves when they drink alcohol?
    a. What are some of the possible risks/consequences/dangers of people your age drinking alcohol?
    b. When are times when people your age drinking alcohol are more dangerous? Tell me about those times.
    c. What are some of the times when people your age drinking alcohol would not be too risky?
    d. What are some of the times when people your age drinking alcohol would be very risky?

8. What kinds of messages do you see in the community that help stop people your age from drinking alcohol?
    a. How effective do you think that these messages are?

9. What kinds of programs are there in the cmmunity to help stop or prevent people your age from drinking alcohol? What kinds of assistance/support programs are available in our community for people your age?
   (this includes any program that offers assistance from education to finances to food to child care etc. that would be considered a supportive factor in their lives)

Closing Questions

10. We are working on addressing underage drinking in our community, what resources would you suggest to help address this issue?

Earlier I explained that the data from focus groups as well as other sources will be used to drive prevention strategies in our community, to end our discussion today I would like to provide some time for you to ask any questions that you may have.

1. What would you do to solve the underaged drinking problem?

2. Was there any question that you had that you wanted to ask the group?

This concludes our focus group. Thank you for your time and thoughts today. As mentioned at the beginning of the group, please keep everything that you heard at this group confidential and we will do the same.

Appendix B: Parent Consent / Youth Assent Form

Dear Parent/Guardian,

You are being asked to allow your child to participate in a listening session as part of the Strategic Prevention Framework Partnerships for Success (SPF-PFS) program funded by Substance Abuse and Mental Health Services Administration (SAMHSA). The focus of this listening session will be to determine how youth perceive underage drinking or prescription drug use and misuse in our community. Our project overall aims to create change at the community level that will lead to measurable change at the state level over time. This project is a team-led initiative in partnership with the Ohio Department of Mental Health and Addiction Services (Ohio MHAS), Ohio's SPF-PFS evaluation Team (OSET), Ohio's Coaching and Mentoring Network (OCAM), the SPF-PFS Evidence-Based practices workgroup, The State Epidemiological Workgroup (SEOW), and the Committee for Diversity Inclusion. This project is led in our community by Adams County Medical Foundation.

Your child's participation in in the listening session is completely voluntary and (s)he may choose to discontinue participation at any time. Participating in the listening session is unlikely to cause your child any harm. Should your child disclose personal information to Adams County Medical Foundation staff or a community member that indicates that (s)he or someone else is in imminent danger, the staff will make appropriate referrals.

Personal health or mental health data will not be collected. No identifiable data or information will be made public; all data will be reported in aggregate. All evaluation data will be securely stored at the servers at Adams County Medical Foundation. Only assigned project staff who have signed a confidentiality agreement including awareness of secure data management protocols are granted access.

This form requests parental/guardian consent and all participating youth assent to participate in the recorded listening session.

Parent/Guardian: By signing the consent signature page, you indicate your consent for your child to participate in the recorded listening session.

Youth: By signing the assent signature page, you indicate your assent to participate in the recorded listening session.

If you have questions regarding this evaluation, please contact Sherry Stout, Executive Director, Adams County Medical Foundation, 230 Medical Center Drive, Seaman, OH 45679, 937.386.3701. Thank you again for your participation.

Sincerely,

Sherry Stout, Executive Director
Adams County Medical Foundation

Consent Signature Page - Parent/Guardian
Listening Session for Ohio SPF-PFS

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered
- you have been informed of potential risks to your child and they have been explained to your satisfaction.
- you understand Adams County Medical Foundation has no funds set aside for any injuries your child might receive as a result of participating in this study
- you are 18 years of age or older
- your child’s participation in the listening session is completely voluntary.
- you understand that data collected through the listening session will be used for the Ohio SPF-PFS project.
- your child is being asked to participate in a listening session. Participation in this activity is completely voluntary.
- your child may leave the session at any time. If your child decides to stop participating in the session, there will be no penalty to your child.

I have read the informed consent letter. By signing the consent signature page, I agree that my child's data, information and feedback will be used in the listening session.

Name of Youth:______________________________

_________________________ _________________________ ____________

(Name of Parent / Guardian) (Signature) (Date)

Assent Signature Page - Youth
Listening Session for Ohio SPF-PFS

By signing below, you agree that:

- you have read the attached consent form letter and have been given the opportunity to ask questions.
- known risks to you have been explained to your satisfaction.
- your participation in the listening session is completely voluntary.
- you understand that data collected through the listening session will be used for the Ohio SPF-PFS project.
- you are being asked to participate in a listening session. Participation in these activities is completely voluntary.
- you may change your mind and stop participation at any time without penalty or consequence.

I have read the informed consent letter. By signing the assent signature page, I agree that my data, information and feedback will be used in the listening session.

______________________	______________________	__________
(Name of Participant)	(Signature)	(Date)

Chapter 7

Youth Tobacco, Alcohol, and Drug Prevention
Adult Focus Group Report

VOINOVICH SCHOOL *of* Leadership *and* Public Affairs

Adams County, Ohio

February 2018

Submitted by:

Adams County Medical Foundation
230 Medical Center Drive, Seaman, OH 45679
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Most importantly, we offer our sincerest appreciation to the providers, parents, and youth who participated in the process. Without you, this report would not have been possible.

Table of Contents

Introduction 43
Method 43
Data Analysis 43
Results 44
Guiding Question #1: How do young people form their perceptions of parental permissiveness or disapproval regarding underage drinking? What cues do they follow to know that their parents are more or less restrictive with alcohol? 44
Guiding Question #2: What kind of social cues are young people using to gain approval or disapproval from peers regarding underage drinking? What strategies can be put in place to increase positive peer influence? 45
Guiding Question #3: What is the tone, demeanor, and perceived effectiveness of family conversations around underage drinking? How can these conversations be made more meaningful and impactful for youth? 46
Guiding Question #4: What are the strategies that most youth perceive as effective to decrease the harmful effects of underage drinking? What negative consequences of underage drinking are perhaps being neglected by youth? 47
Conclusion 49
References 51
Appendix A: Underage Drinking – Parents/Guardians Interview Guide 52
Appendix B: Adult Consent Form 55

Introduction

During SFY17 and 18, Adams County Medical Foundation was one of two data mini-grantee communities funded as part of Ohio's Strategic Prevention Framework-Partnerships for Success (SPF-PFS) Initiative[1]. As part of the SPF-PFS project needs assessment process, each community completed listening sessions/focus groups on underage drinking with parents of youth in the community. Two sessions were held: one in West Union where seven attended and a second in Manchester where ten attended. This report synthesizes the results of Adams County's Adult listening sessions and provides details about how the listening sessions were conducted. These listening sessions were designed to provide information on local/community conditions that are contributing to the problem of underage drinking in Adams County.

Method

Guiding Questions

The focus groups were designed to capture information relating to four intervening variables as required by SAMHSA. As such, the guiding questions for each focus group were:

1. How do young people form their perceptions of parental permissiveness or disapproval regarding underage drinking? What cues do they follow to know that their parents are more or less restrictive with alcohol?
2. What kind of social cues are young people using to gain approval or disapproval from peers regarding underage drinking? What strategies can be put in place to increase positive peer influence?
3. What is the tone, demeanor, and perceived effectiveness of family conversations around underage drinking? How can these conversations be made more meaningful and impactful for youth?
4. What are the strategies that most youth perceive as effective to decrease the harmful effects of underage drinking? What negative consequences of underage drinking are perhaps being neglected by youth?

Interview Protocol

For each listening session, the research team utilized a standard, open-ended group interview protocol to facilitate the group. Patton (2002) advocates the use of an interview guide for the following three reasons: (a) the limited time in an interview session is optimally utilized; (b) a systematic approach is more effective and comprehensive; and (c) an interview guide keeps the conversation focused. The facilitation guides (Appendices A-B) included questions designed to elicit responses regarding the questions guiding the evaluation.

Participants

Information from key informants (i.e., parents/guardians) guided this listening session report. To collect information from the informants, we conducted two focus groups with parents of youth ages 12-18.

The Coalition Coordinator invited informants to participate in the focus groups, scheduled the interviews, and coordinated the times and locations with the informants and the focus group team. In order for Adults to participate in the focus group, they completed a consent form (Appendix F). At the beginning of each focus group, the focus group team read a script which clearly stated that informants were participating voluntarily and had the option to refuse to answer any of the questions. Through the course of the project, two group sessions were completed and a total of seventeen (17) individuals participated. For their participation in the study, adults in one group received light refreshments and in the other group they received pizza.

Data Analysis

Qualitative data analysis techniques were used to analyze the data collected from the group interviews. Content analysis was used to analyze responses to the open-ended items. Patton (2002) describes content

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[1] Funding for the SPF-PFS is provided by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP); Funding Opportunity SP-14-004. The SPF-PFS in Ohio is administered by the Ohio Department of Mental Health and Addiction Services (OhioMHAS).

analysis as “searching for recurring words or themes.” Text was analyzed to see what phrases, concepts, and words are prevalent throughout the informants’ responses. During this stage of the analysis, coding categories were identified. Through this coding process, data was sorted and defined into categories that were applicable to the purpose of the research. Codes were defined and redefined throughout the analysis process as themes emerged. At the end of the analysis, major codes were identified as central ideas or concepts (Glesne, 2006). These central ideas were assembled by pattern analysis for the development of major themes. From the major themes, we drew conclusions (Patton, 2002). To ensure credibility of both the procedures and the conclusions, we used analyst triangulation. Patton (2002) defines analyst triangulation as “having two or more persons independently analyze the same qualitative data and compare their findings.” Teamwork, as opposed to individual work, is likely to increase the credibility of the findings (Lincoln & Guba, 1985).

Results

The following sections describes what informants perceived as the local conditions affecting perceived parental perceptions, peer perceptions, family communication, and risk/harm. These include personal risk and protective factors as well as potential strategies for enhancing prevention efforts in our community. Risk and protective factor-focused prevention is based on the work of Hawkins, Catalano, and Miller (1992). Risk factors are factors that increase the likelihood of adolescent substance abuse, teenage pregnancy, school drop-out, youth violence, and delinquency (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Protective factors provide the counter to risk factors; the more protective factors that an individual has present, the less risk for unhealthy behavior (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Research-based *risk factors* are frequently divided into four domains: community, family, school, and individual/peer risk factors (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Research has also identified four personal characteristics as *protective factors*: gender, a resilient temperament, a positive social orientation, and intelligence (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Because these factors are largely innate, we will focus on two additional protective factors described by Hogan et al.: bonding and healthy beliefs/clear standards.

Guiding Question #1: How do young people form their perceptions of parental permissiveness or disapproval regarding underage drinking? What cues do they follow to know that their parents are more or less restrictive with alcohol?

For this section, we focus on the personal risk and protective factors related to substance use and abuse that include family factors and bonding (Hogan, Gabrielsen, Luna, & Grothaus, 2003). Family factors can include the way parents and children relate and interact as well as the level of parental supervision (HHS Publication No. (SMA) 10–4120).

Overall adults who participated in the listening sessions were concerned that other adults were contributing to underage drinking by hosting and by purchasing for their teens. The participating adults mentioned that many other adults who are their peers, had an attitude of, “at least it’s not drugs,” or, “that’s what we did.” They were concerned that they were not talking with their teens in ways that would keep them from drinking while underage. Most parents who participated in the listening sessions felt they had communicated their feelings about alcohol to their teens and that they had an open dialogue with them. A few mentioned that their teens felt ostracized because they did not drink. One parent talked about a situation where her teen went to a friend’s house, “she went to her friend’s house and the mother let them drink. Well, I caught wind of it and I blew up. And I’m like, you’re not going back.”

Personal Risk Factors

A risk factor for students is their home environment. Most participants had experienced other family environments that treat underage alcohol use as normal and facilitated it so young people are not drinking out in the community; “at home with supervision” is seen as safer by some parents. Other participants noted, I really don’t think that a lot of these parents talk to their kids…because they don’t think they’re gonna do that.”

Another risk factor is the attitude that "we did that when we were teens," or where drinking is seen as a rite of passage. Many adults mentioned that homes where a family member is an alcoholic see drinking as normal. For instance, one person said, "her father is an addict, and she's been exposed to about everything. At my house she hasn't been but she's been exposed to it all." They also talked about parents and adults thinking alcohol is a safer alternative to drugs, "it's just alcohol."

Personal Protective Factors

Personal protective factors for teens included open communications, clear rules and guidance, and strong relationships with teens. Most participants believed that communication between parents and teens, both their own children and communicating expectations with other parents' children was a way to counter peer pressure to drink. Parents stated that they talk to their teens, but they want guidance on what to say or do. One parent related a conversation with her daughter. She said, "when she turned 16, I was just honest with her. I told her what I did. And I told her that it's really not fun. I asked her what happens when you wake up the next morning and you're vomiting or you don't remember what you did? It's not fun." However, during one session a parent related, "I wanted to come and do this to get tips on how to handle it 'cause my son, hasn't to my knowledge."

Clear Rules and Guidance

Parents stated that they do set clear rules for their teens but peer pressure to drink is very powerful. One person related that their child told them she thought "it's not cool to drink" but she related that the teens who don't drink don't have a large network of friends. Another parent supported the previous statement by saying that her son "had a few select friends that, no matter what, kinda still stood by him, but he just didn't partake in it. And it was - it was a struggle for him, because of that."

Participants felt that having a strong relationships with teens helped counter drinking, especially when they shared their own experiences. Most parents stated they have an "open door" to talk with their teens; however, "kids do what they want and don't think ahead to the consequences of their actions." Other parents stated that good kids make bad choices as a part of life. One stated that she told her child, "Yes, Dad did it but he learned from his mistakes. And I don't want you to follow that."

Guiding Question #2: What kind of social cues are young people using to gain approval or disapproval from peers regarding underage drinking? What strategies can be put in place to increase positive peer influence?

This section will focus on personal risk and protective factors in the following domains: school, individual/peer, and healthy beliefs/clear standard. These risk and protective factors are related primarily to peer relationships which affect youth's individual and environmental factors (HHS Publication No. (SMA) 10–4120).

Many of the adults talked about students who participate in sports or cheerleading being the teens who participated in underage consumption the most. They felt these students did not have enough consequences when coaches were aware of parties and that there was little to no accountability. One said and many others agreed, "I think that if you know and you know as a coach or a parent who hears this stuff and the kids were all at the party and they're all on the basketball team, then why are they playing…there's no accountability."

In one listening group, there were unexpected comments about the relationships students who are in dual credit program (College Credit Plus where they are attending college classes), formed with college students. In some cases, these college-aged students are purchasing alcohol for underage people and they are inviting them to parties where alcohol is available. Other parents agreed; the conversation was:

The facilitator asked, "So you're saying is that you basically feel like these, the exposure to the older college kids is where they're getting their alcohol."

I know for a fact it is," an adult responded. And another parent stated, "Right now, most of our college kids are best friends with our high school kids. Both boys and girls who are underage are frequently dating college-age people." Another parent stated that his daughter, "went to college as a junior. She lost her friends in high school 'cause all her stuff was done at college."

Personal Risk Factors

School. Students have relationships with college-aged students who invite them to parties and who purchase alcohol for them. Some students who participate in extracurricular activities engage in underage drinking with few consequences and little accountability, although it is thought that adults are aware of their activities. Teens use alcohol with other products so that it is undetectable, "energy drinks with the vodka, 'cause you can't taste the vodka or smell it on a kid." Also, alcohol is not detected through drug testing, only by smell.

Individual/peer. Older teens and young adults purchase and encourage underage alcohol use in some cases. Beer or other alcohol is easy to purchase; according to one parent, "They (store employees) do not card the way they're supposed to. They (underage purchasers) get to walk right in and get it." Teens pay people to buy people to buy their alcohol, "older cousins, older siblings." This was supported in the student listening sessions where they stated that alcohol was easy to get either by sneaking it out of their parents' supplies or by having others purchase it. The students also noted that employees of convenience stores frequently do not ask for identification.

Parents of one group identified undiagnosed mental health problems as a possible reason for underage drinking. In many instances, there are underlying issues with alcohol use such as mental health issues. "If we [as adults] talk to them, we might see, hey this kid drinks because when he goes home his dad is beating his mom to death or something." Another noted, "Some of these kids are like some adults. They are drinking because they have other underlying issues. There's mental health issues…that we're not catching, whether it is depression, bipolar, they've been abused, they've been exposed to trauma. They're doing it because they are fighting something that no one is aware of." The parents of one group agreed that mental health professionals need to be in the schools and they need to be available for students, "there is an FRS counselor at one school two days a week; it was five days a week but there was a funding problem so the time was cut."

Personal Protective Factors

Adults in the listening sessions related that teens working together and offering a peer or buddy system so they could talk with each other about problems might be more effective than teens talking with adults. For example one said, "…I would think that if I had a problem, or I was going through peer pressure and wanting to drink because of that, wouldn't it also be my peers who I would want to turn to and talk to about it? Is there any type of peer groups that could be established in a school?" Another said, "…all kids are different but if my son were to get in trouble…I would think that he would be more open to talking up here [meaning at school] about it than he would be open to talking to me,…he's not gonna think, 'well, mom's gonna understand; I'm just gonna be punished.'" Another parent mentioned his step-daughter, whose biological father is an alcoholic, having a different story. "Her real father is the picture-perfect alcoholic. She doesn't want to be like that. We don't have to do too much talking to her, you know, she doesn't have hardly any friends, because anybody that has anything to do with…alcohol, she doesn't like 'em."

Guiding Question #3: What is the tone, demeanor, and perceived effectiveness of family conversations around underage drinking? How can these conversations be made more meaningful and impactful for youth?

This guiding question sought to identify personal risk and protective factors in the following domains: family, bonding, and healthy beliefs/clear standards. In addition to the aforementioned, family factors also

include unity, warmth, and attachment, and contact and communication between parents and children (HHS Publication No. (SMA) 10–4120).

All but one of the participating adults are parents. They related that they had conversations with their teens about drinking and about consequences. They are trying to keep the lines of communication open but they feel they do not have enough information to be effective communicators. Most participants in both groups felt giving youth examples of consequences and telling them of their own experiences had an impact with their teens and any of their teens' friends who heard it. Some adults in one group related that they did not engage in underage drinking because they didn't want to "disappoint" their parents and they felt their children did not engage in drinking for the same reason.

One of the adults was not a parent. He had been arrested for underage drinking as a young teen. While relating his experience, he indicated his parent was not upset that he had been arrested instead, she was angry that he told the truth to police that he had gotten the alcohol from her. He agreed with other adults in the group who were parents that youth should learn about the consequences of underage drinking from people who are close to their age, that "they should watch a court session and that they should experience a jail."

Personal Risk Factors

Family. Adults in both groups indicated peer pressure may have as much influence over teens as family. Teens want to be liked and considered "cool" within their peer groups. Many parents in both listening sessions mentioned or referenced alcoholism in teens' families; therefore, teens see alcohol use on a daily basis so it is seen as normal. Other adults noted that Manchester is the only village that has bars and for many years, it was the only place in the county to purchase alcohol, "…'cause I didn't grow up in Manchester. I grew up in West Union. And that was the trip to Manchester, every Friday or Saturday night was the thing, you know…who are we gonna get to buy us beer or whatever." Some adults noted that if parents engage in daily drinking or in risky behaviors as a result of drinking, their conversations about the dangers of alcohol will not be taken seriously by teens. One adult observed and others agreed, "…maybe they were raised in an atmosphere where drinking was just no big deal. You know, it was just a daily thing."

Personal Protective Factors

Bonding. Parents love their children and have conversations about alcohol but they want more education on how to be effective. Several parents talked about their own experiences with underage drinking and the negative consequences of their actions. One parent related, "…my oldest daughter is 13 and I've already had the conversation with her, telling her that alcohol isn't allowed but if she does get in that situation, she needs to call me or a neighbor, someone…to let her know there's a better way than driving home or something like that." Another parent noted, "to say 'you're not going to drink alcohol,' that doesn't go very far." Other adults stated, "…one of the reasons I wanted to come and do this was to get tips on how to handle" the situation if my child does make a bad choice.

Healthy beliefs and clear standards. A few parents mentioned that church attendance didn't guarantee that teens stayed away from alcohol. Many parents mentioned that strong morals were important to teach to their teens but that adults can't be blind and say, "we go to church; my kid is in the band; they do this and they do that so they're not gonna drink…I know for a fact one parent that says this. Their child drinks like crazy. They have no clue." Parents in both groups indicated they had opened the conversation about not drinking with their teens and they had tried to guide them about what to do if they needed to get out of a situation where alcohol was involved.

Guiding Question #4: What are the strategies that most youth perceive as effective to decrease the harmful effects of underage drinking? What negative consequences of underage drinking are perhaps being neglected by youth?

The Center for Substance Abuse Prevention (CSAP) has identified six strategies that comprise a comprehensive prevention program: information dissemination, prevention education, alternative activities, community-based process, and environmental approaches (CSAP, 1993).

The participating parents felt it would be helpful for them to have education about how to have conversations about alcohol use. They wanted to see prevention programs in the schools beginning in third or fourth grades about the harm alcohol does and possible consequences.

Information Dissemination

Parents and a non-parent in one of the groups suggested that students watch a court trial to see the real consequences. Parents in both groups suggested the sheriff's department should work with alcohol retailers to strictly enforce the laws regarding the sale of alcohol. They suggested employees should receive training to spot fraudulent identification, to frequently request proof of age and to educate them about the consequences of selling to minors.

Parents in both listening sessions felt they needed support through educational programs and information sharing to make sure they were framing the conversations about drinking in ways that would "get through" to their children. As noted, parents from both groups indicated they are using examples from their own experiences with underage drinking to discourage it by their children but they related that they worried whether this is an effective method. One adult related, "I got out of a car with a guy one time that wrecked and killed two people…I would have rode with that particular friend going home and I use my life experience, more than anything." Parents in both listening sessions indicated it would help them if the schools would merge drug and alcohol education into the classroom curriculum in the early grades, perhaps as early as fifth and sixth grades.

Prevention education. Parents believe that students needed education programs as early as fifth or sixth grade. One parent asked why the survey was focusing on seventh through twelfth grade students and said, "I think you're missing the boat." Another spoke up and said, "you should be startin' in the kindergarten." This theme continued to resurface throughout the listening session when another parent stated, "a program in the schools, startin' early….you're wasting your time in high school." The idea of teens talking to elementary kids was suggested and supported by the majority of the participants. One parent suggested, "if you can get your teens to talk to other teens, and then those teens could go to the elementary school and talk – the buddy system for the elementary kids, as well." Another parent stated that her son was in the sixth grade and did a buddy system before they moved to Adams County and, "they did things together . . . they're like this is cool." "Even to younger than seventh grade, starting sixth grade/fifth grade, they're gonna be more apt to listen to them, then they are to me."

Alternative Activities

Adults in both listening sessions were dismayed there were few activities in the county for all teens. "Yes, there needs to be activities. When we were teenagers, we'd cruise town and you know, did whatever. And if there wasn't something to do that's when we went and drank. If they actually had something…yeah they don't have really anything to do." After the listening sessions as people were leaving but still engaged, they pointed out that there are activities for high-performing students (Beta Club), for students whose families had resources that allowed them to participate in sports and for students whose families supported them in 4H but there were not activities focusing on all students, for example a teen club that had dances and bands. Some parents want to find ways for communities to offer alternatives. One parent said, "But there needs to be a place that they can truly go. I think an activity center. But if you're a ten year old kid and your mom doesn't get home until 10 at night…you can't go."

Community-based Process

Adults in one group suggested that schools and courts determine a next step for kids who get into trouble so that they have a positive support system instead of just punishment. They also noted that teachers can have a positive impact on students, "'Cause that one teacher says that right word that one day or says, you know, the right thing to a kid, and they're like, 'you know what, someone really is listening to me…I do think the teachers

make more of a difference than they realize they do." One of the male participants mentioned groups in other counties that have a, "tremendous relationship with the court system" and here when students get expelled they are just at home, "giving them more reason to drink." "So now they're sitting at home and still not getting' the help they need."

Environmental Approaches

Adults in both groups felt that laws governing purchasing alcohol are not being enforced, for example students are not being carded at stores and restaurants; both the adult groups and both the student groups talked about this. Students from the standpoint of alcohol being easy to acquire either from their parents or from convenience stores. One adult noted, "I do think the law needs to be a little more strict. And, as someone that's been raised in Adams County, no, I did not drink as a kid, as a teenager but my friends would go right in and buy it, and the kids still do-they do not card the way they're supposed to." Both adult groups stated there needed to be more information and awareness of Ohio's hosting laws and of the liability associated with providing underage teens with alcohol, [laws to deter underage drinking include] "liability of the parent or the person holding the party…I mean, that should scare more of 'em because they will lose everything."

Problem Identification and Referral

The adult who was not a parent agreed with the parents that youth should learn about the consequences of underage drinking from people who are close to their age, that "they should watch a court session and that they should experience a jail." Parents and a non-parent in one of the groups suggested that students watch a court trial to see the real consequences.

Parents in both groups suggested the sheriff's department should work with alcohol retailers to strictly enforce the laws regarding the sale of alcohol. They suggested employees should receive training to spot fraudulent identification, to frequently request proof of age and to educate them about the consequences of selling to minors.

Parents of one group identified undiagnosed mental health problems as a possible reason for underage drinking. In many instances, there are underlying issues with alcohol use such as mental health issues. "If we [as adults] talk to them, we might see, hey this kid drinks because when he goes home his dad is beating his mom to death or something." Another noted, "Some of these kids are like some adults. They are drinking because they have other underlying issues. There's mental health issues…that we're not catching, whether it is depression, bipolar, they've been abused, they've been exposed to trauma. They're doing it because they are fighting something that no one is aware of." The parents of one group agreed that mental health professionals need to be in the schools and they need to be available for students, "there is an FRS counselor at one school two days a week; it was five days a week but there was a funding problem so the time was cut."

Conclusion

In both adult listening sessions, the most consistent themes were: the lack of alternative activities for teens, teens felt left out if they did not engage in underage drinking, the actions of parents who host teens, the ease of access to alcohol, the need for mental health services that target teens in the schools and parents' desire for information and education about talking with their teens in effective ways to discourage underage drinking. The Manchester adult group cited the cultural acceptance of alcohol consumption in its community as more of a risk factor than the West Union group. Manchester, since the repeal of Prohibition, was the only community in Adams County where alcohol could be legally purchased until recently.

Adults felt that every village needed alternative teen activities, especially around prom, ballgames, and graduation. They acknowledged there were clubs and activities for students with high grades and for students whose families had sufficient financial resources for them to participate in sports or 4H but there were no clubs that welcomed everyone.

Parents stated that they do set clear rules for their teens but peer pressure to drink is very powerful. One person related that their child told them she thought “it’s not cool to drink” but she related that the teens who don’t drink don’t have a large network of friends. Another parent supported the previous statement by saying that her son “had a few select friends that, no matter what, kinda still stood by him, but he just didn’t partake in it. And it was - it was a struggle for him, because of that.” Another parent mentioned his step-daughter, whose biological father is an alcoholic, having a different story. “Her real father is the picture-perfect alcoholic. She doesn’t want to be like that. We don’t have to do too much talking to her, you know, she doesn’t have hardly any friends, because anybody that has anything to do with…alcohol, she doesn’t like ‘em.”

They also thought that teen mentors or a buddy system for younger students is needed, starting early around fifth or sixth grade. Most of the parents in one group thought that peer support systems would be more effective in decreasing underage drinking and would offer students more support with other problems. This would take the form of peer support either in groups or with trained peers. These teens could help others address problems at home, address problems with other teens or they would just be a friendly person to talk through issues. Both groups identified programs that incorporated “listening teams” of students for their peers. These teams were present when the parents were teens but the teams now do not exist. They related that students at the time, were minimally trained in listening skills and in helping others but that at least there were peers that understood.

All the adults stated that students with mental health problems needed to receive additional attention and that there is a need for mental health professionals and for social workers in the schools. They identified a need for social workers and for mental health professionals, both of whom could visit families, if there were identified problems with students, especially regarding substance use or abuse.

Some adults felt uncomfortable or inadequate talking with their children about alcohol use and suggested a programs for parents that would teach them how to effectively address underage drinking with their children. They were focused on helping their kids, keeping them safe and helping kids learn how to handle situations where there was underage drinking occurring. They also felt it would be beneficial for parents to understand hosting laws and for store employees to be trained in asking for identification and about the liability of selling to underage teens.

A non-parent who had been arrested for underage drinking felt that being confronted with the consequences of that decision and having contact with the justice system made a difference. He advocated showing teens a court session, and the jail, and having young people who had negative experiences while drinking underage talk with them were effective ways to communicate information about the consequences. Some adults mentioned that existing programs, such as the Summer Recreation program needed to incorporate prevention education (it does).

Finally, the Manchester group identified dual credit opportunities for students which allow them to attend college classes as a way that teens were introduced to drinking and as a way teens could easily access alcohol. No solutions for this were identified.

Note: Manchester is the only community in Adams County where alcohol has been sold legally since the repeal of Prohibition and most adults who were raised there experienced a community where alcohol was consumed openly, many times publicly, and its use is culturally accepted. Other areas of Adams County only recently have been able to sell alcohol. This decision is made by townships voting to approve its sale; as a result, not all townships in the county allow alcohol sales.

References

Glesne, C. (2006). *Becoming qualitative researchers: An introduction (*3rd ed.). New York: Addison Wesley Longman, Inc.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112,* 64-105.

Hogan, J. A., Gabrielsen, K. R., Luna, N., & Grothaus, D. (2003). *Substance abuse prevention: The intersection of science and practice.* Boston, MA: Allyn & Bacon.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry.* Boston, MA: Allyn & Bacon.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Substance Abuse and Mental Health Services Administration, Focus on Prevention. HHS Publication No. (SMA) 10–4120. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, Revised 2017

Appendix A: Underage Drinking – Parents/Guardians Interview Guide

Ohio's SPF-PFS Needs Assessment Process: Listening Sessions
Underage Drinking – Parents/Guardians

Guiding Questions:

1. How do young people form their perceptions of parental permissiveness or disapproval regarding underage drinking? What cues do they follow to know that their parents are more or less restrictive with alcohol?

2. What kind of social cues are young people using to gain approval or disapproval from peers regarding underage drinking? What strategies can be put in place to increase positive peer influence?

3. What is the tone, demeanor, and perceived effectiveness of family conversations around underage drinking? How can these conversations be made more meaningful and impactful for youth?

4. What are the strategies that most youth perceive as effective to decrease the harmful effects of underage drinking? What negative consequences of underage drinking are perhaps being neglected by youth?

Hello. Thank you for letting us to talk with you this morning/afternoon. My name is ______________ and I am a part of the Adams County Medical Foundation. This is _______________ and she/he will be assisting with the group today. We hope this discussion can help us gain insight into awareness, perceptions, and access surrounding underage drinking as it relates to youth in our community. The data will then be used to drive local grant funded underage drinking prevention strategies. How many of you have participated in focus group before? [If yes, ask them to explain what it was like.] How would you describe what a focus group is?

One important thing to remember during our conversation is that everyone's ideas are important, and they should be allowed to freely express their thoughts and feelings. Your experiences and observations are important to us because, as residents, you know the needs and services – what is available, what is needed, and what could be managed better – first hand. The ideas expressed here may be personal and should not be used against anyone inside or outside of this meeting. From time to time we may interrupt to allow someone to speak who may not have said anything for a while. Also, we may have to interrupt someone to move on to another question because of a time limit under which we are working. We apologize in advance if this happens.

The discussion will be digitally recorded. The recording will be used for our reference only and will be erased once the research report is complete. In addition, ____________ of the Adams County Medical Foundation will be facilitating the process by taking notes. Our reports to the research team will not include actual names of participants, so your individual comments will be strictly confidential. Should you feel uncomfortable at any time during the discussion, remember that you do not have to contribute to the discussion. Does anyone have a concern about this procedure? (Wait for responses) If not, then let us begin.

Introductory Questions

As I mentioned earlier, the purpose of the group today is to talk about underage drinking issues and how they affect youth in our community. To begin, I am going to ask you some general questions about your perceptions of underage alcohol use.

1. How big of a problem is UAD in our community?
    a. What information led you to make this assertion?

    b. Do a lot of youth in our community drink alcohol?
    c. What kinds of alcoholic products do you see youth in our community drinking?
    d. What kinds of alcoholic beverages do youth in our community drink that are the most dangerous?
    e. What kinds of alcoholic beverages do youth in our community drink that are the least dangerous?
    f. What circumstances make it more acceptable for youth to drink alcohol? Less acceptable?
    g. How do you feel about your children drinking alcohol?

2. How did you make the rules about underage drinking for your children? What laws and/or policies exist in our community that deter underage drinking?
    a. What laws or rules exist or could be put into effect that, with better enforcement, would make a difference?

Transition Questions

3. We talked about the problem of underage drinking in our community. Now, generally speaking, what do you think are some of the reasons youth in our community drink alcohol?
    a. How do you think that youth feel about drinking alcohol?
    b. Do you think that youth encourage each other to drink? Discourage each other to drink?

4. How do you think that youth in our community are obtaining alcohol?
    a. Probe for:
        i. Where are they getting the alcohol?
        ii. From whom are they getting the alcohol?

5. How easy do you feel it is for youth in our community to obtain alcohol from friends or peers?
    b. How about from their parents?
    c. What about from other sources? (probe for other sources that they mentioned above in 4ii)

Key Questions

Thank you for telling me about some of the reasons you think youth are drinking and where they are getting alcohol. Now I'd like to discuss your feelings about the risks of underage drinking and how you talk to your children about those risks.

6. On a scale of 1 to 10, 1 being no risk and 10 being very great risk. How much do youth risk harming themselves when they drink underage?
    a. What are some of the possible risks/consequences of underage drinking?
    b. What are some of the circumstance sunder which underage drinking would not be too risky?
    c. What are some of the circumstances under which underage drinking would be considered high-risk?

7. We know that a primary source for youth learning about drinking is from their parents. How do you talk to your children about alcohol?
    c. What kinds of conversations do you and your children have?
    d. What do you say?
    e. How could conversations about underage drinking with your children be more productive for you?

8. Tell us the most recent experience you have had talking to your children about alcohol.
    f. How did you feel about this conversation?

g. What did you talk about?

9. If you had to explain to your child the dangers of underage drinking what would you say?
    h. What would be the greatest risk of underage drinking that you would discuss?
    i. How would you communicate your perception of underage drinking to your child?

10. What prevention programs/services are available to address underage drinking for youth in our community?

11. What assistance/support programs are available for youth in our community for UAD?
    (this includes any program that offers assistance from education to finances to food to child care etc. that would be considered a supportive factor in their lives)

Closing Questions

12. Thank you for all your time and feedback so far. As we continue working on addressing underage drinking in our community, what resources would best help you, as parents to assist in talking to your children about the risks of underage drinking?

Earlier I explained that the data from focus groups as well as other sources will be used to drive prevention strategies in our community, to end our discussion today I would like to provide some time for you to ask any questions that you may have.

13. As we wrap up this time, was there any question that you came prepared to answer that I didn't ask?

14. Was there any question that you had that you wanted to pose to the group?

This concludes our listening session. Thank you for your time and thoughts today. As mentioned at the beginning of the group, please keep everything that you heard at this group confidential and we will do the same.

Appendix B: Adult Consent Form

Dear Participant,

You are being asked to participate in a listening session as part of the Strategic Prevention Framework Partnerships for Success (SPF-PFS) program funded by Substance Abuse and Mental Health Services Administration (SAMHSA). The focus of this listening session will be to determine how youth perceive underage drinking or prescription drug use and misuse in our community. Our project overall aims to create change at the community level that will lead to measurable change at the state level over time. This project is a team-led initiative in partnership with the Ohio Department of Mental Health and Addiction Services (Ohio MHAS), Ohio's SPF-PFS evaluation Team (OSET), Ohio's Coaching and Mentoring Network (OCAM), the SPF-PFS Evidence-Based practices workgroup, The State Epidemiological Workgroup (SEOW), and the Committee for Diversity Inclusion. This project is led in our community by the Ohio Coalition.

Your participation in in the listening session is completely voluntary and you may choose to discontinue participation at any time. Participating in the listening session is unlikely to cause any harm. Should you disclose personal information to Ohio Coalition staff or a community member that indicates that you or someone else is in imminent danger, the staff will make appropriate referrals.

Personal health or mental health data will not be collected. No identifiable data or information will be made public; all data will be reported in aggregate. All evaluation data will be securely stored at the servers at the Ohio ADAMHS Board. Only assigned project staff who have signed a confidentiality agreement including awareness of secure data management protocols are granted access.

This form requests your consent to participate in the recorded listening session.

By signing the consent signature page, you indicate your consent to participate in the recorded listening session.

If you have questions regarding this evaluation, please contact Sherry Stout, Executive Director, Adams County Medical Foundation, 230 Medical Center Drive, Seaman, OH 45679, 937.386.3701.

Thank you again for your participation.

Sincerely,

Sherry Stout, Executive Director
Adams County Medical Foundation

Consent Signature Page
Listening Session for Ohio SPF-PFS

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered
- you have been informed of potential risks to you and they have been explained to your satisfaction.
- you understand Ohio Coalition has no funds set aside for any injuries you might receive as a result of participating in this study
- you are 18 years of age or older
- your participation in the listening session is completely voluntary.
- you understand that data collected through the listening session will be used for the Ohio SPF-PFS project.
- You are being asked to participate in a listening session. Participation in this activity is completely voluntary.
- You may leave the session at any time. If you decide to stop participating in the session, there will be no penalty.

I have read the informed consent letter. By signing the consent signature page, I agree that my data, information and feedback will be used in the listening session.

________________________	________________________	____________
(Name of Participant)	(Signature)	(Date)

Chapter 8

Adams County SFY19 Critical Reflection Questions

Introduction

During FFY19, Adams County was one of two Data Mini-Grant communities funded as part of Ohio's Strategic Prevention Framework-Partnerships for Success (SPF-PFS) Initiative[1]. As part of the SPF-PFS project needs assessment process, community project directors reflected on the data collected as part of their community's needs assessment process by answering a series of guiding questions that were developed by the SPF-PFS SEOW Workgroup. This brief report provides background on the guiding questions and presents the answers to each question for Adams County.

Method

The critical reflection questions were developed by the SPF-PFS SEOW Workgroup in partnership with the SPF-PFS Project Leadership Team. A total of 12 critical reflection questions were developed for SPF-PFS community project director to reflect on their community's COMs data (consumption measures and intervening variables), local conditions data, and consequence data. These questions were designed to be answered in narrative form and focused on assessing each community's understanding of their needs assessment data as well as connections project directors may have made across the various sources of quantitative and qualitative data in the needs assessment process.

Adams County developed answers to each of the questions and shared the answers with their local OSET evaluator and/or their OCAM coach. The project team received constructive feedback that was designed to improve the answers to each question. Additional drafts were iterated as needed between the project team and the local OSET evaluator. The final draft was then uploaded into an online interface which facilitated production of Adams's answers into this report.

Critical Reflection Question Answers

Question 1: As you have reviewed your baseline data and your COMs data for FFY16 and FFY17 around your community's problem of practice what data stood out as most important?

a. Underage Drinking:

i. Past 30 Day Use of Alcohol 14.9% of 818 students

ii. Past 30 Day Binge Alcohol 6.3% of 758 students

[1] Funding for the SPF-PFS is provided by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP); Funding Opportunity SP-14-004. The SPF-PFS in Ohio is administered by the Ohio Department of Mental Health and Addiction Services (OhioMHAS).

Question 2: What differences do you see in your consumption data related to your problem of practice by gender or grade? How are those differences evident (or not evident) across all years in which you have data?

The 30 day use increased drastically from eighth grade to eleventh grade in 2016-17. Use rose from 10.6% in eighth grade to 30.7% in eleventh and rising slightly by twelfth grade to 32%. The comparison by gender indicated higher male than female use, 16.9% versus 13.5%, respectively. Binge drinking was the highest in eleventh grade, 10.7%. There was little gender difference in binge drinking, 6.4% male and 5.9% female.

Question 3: How has your PDC helped you review and interpret your COMs data? If they have not helped, how might they help in the future?

The eight PDC members reviewed the COMs data to determine which problem of practice would be addressed. The members determined that underage drinking would be the problem of practice based on the information from the data reports. The PDC met quarterly in 2017 and had electronic communications between the face-to-face conversations. The PDC did not have face-to-face meetings in 2018; however, the members of the PDC are members of the Adams County Health and Wellness Coalition along with the Project Director and the Project Coordinator and they shared information at these monthly meetings. Members of the PDC participated in the Community Readiness Assessment interviews and scoring during 2018 and have reviewed all results. The PDC will play an important role in the next phases of the planning, particularly by providing information and input to the strategic plan.

Question 4: Which of the four SAMHSA-required intervening variables seem most important to your work around your problem of practice? Please support this choice with your data:

Perception of Parental Disapproval/Attitude

The intervening variables that seem most important to the work around Adams County's problem of practice are the Perceived Risk/Harm of Use and Perception of Parental Disapproval/Attitude. The OHYES! survey data found that only 51.6% of all students perceive binge drinking as a moderate or great risk and that only 43.9% of all students have talked with at least one of their parents about the dangers of tobacco, alcohol, or drug use.

Based on the collected data, only 51.6% of all students perceive binge drinking as a moderate or great risk. These data are supported by information gathered during the listening sessions. Students felt teens engaged in the risky behavior of drinking to fit in at parties and social events. Peer pressure to be "cool" is real and students who do not drink report that they do not have a large network of friends. All students in the focus groups mentioned that teens typically do not think about the consequences or they think it will not happen to them. Another factor that impacts how risk or harm of use is perceived is that many students reported having family members who drink or who are alcoholics, so alcohol consumption is seen as normal.

Only 43.9% of all students reported that they talked with at least one of their parents about the dangers of tobacco, alcohol or drug use. Although all the teens and all the parents in the listening sessions communicated regarding the risks and consequences of underage consumption, parents were unsure whether they were communicating adequately to dissuade their teens from engaging in this negative behavior. The listening sessions indicated parents were not comfortable discussing underage alcohol use and felt they needed additional information about how to talk

with their teens effectively. However, the teens felt that their parents did care about them when they had conversations about underage drinking and overall these conversations were perceived as positive.

Question 5: What intervening variables did you learn about that you or your community had not considered before? What about your intervening variables was new and why?

The PDC had not considered that parental communication with their teens about underage drinking would be low. The COMs data reported that only 43.9% of all students have talked with at least one of their parents about the dangers of tobacco, alcohol, or drug use. The listening session feedback, from both the adults and students, stated that alcohol use is seen as normal within many homes because one or both of the parents drink alcohol or are an alcoholic.

Question 6: Based on the data from your listening sessions, what are 3-4 local conditions that are contributing to your problem of practice?

Parental disapproval of underage drinking was apparent in both the adult and youth focus groups. Parents stated that they do set clear rules for their teens but peer pressure to drink is very powerful especially at parties and social events. Many parents said they shared experiences from their own youth when talking with their teens about underage drinking and the youth stated that they appreciated that their parents shared their experiences and wanted a better life for them. Many students stated that they did not drink because they did not want to disappoint their parents.

Although all of the parents in the listening sessions disapproved of underage drinking, participants in both the adult and youth sessions mentioned that some parents host parties in their homes where they allow their teens to drink alcohol under adult supervision. The parents in the sessions believed that the other parents see this situation as safer for their youth. However, the youth listening group participants pointed out that the youth who do drink get most of their alcohol from their parents' homes and that when they taste it they start liking it.

While youth that drink alcohol are perceived as cool, the flip side for students who do not drink is social isolation. The social stigma of not drinking isolates these teens and they report having only a small close network of friends. Students and parents alike stated that these teens do not have a large network of friends and that it is a struggle for them.

Many parents in the listening sessions stated that they communicated with their teens in ways that they thought would keep them from drinking while underage and kept an open dialogue with them. However, they want guidance on what to say or do. The need for information to parents about how to talk to kids came through in both listening sessions. Parents were unsure whether they were communicating adequately to dissuade their teens from engaging in this negative behavior. On the other hand, several students stated that if their parents pressured them too much, they became rebellious and wanted to try it. Students also wanted the communication to come from peers or people closer to their age.

Other local conditions to consider include first, both adult and youth listening sessions and some community readiness assessment interviews indicated, local retail stores that sell alcohol do not appropriately and consistently check the ages of people purchasing alcohol. Finally, in both adult listening sessions, participants mentioned the lack of school-based resources in the county to address mental health problems of teens.

Question 7: What local conditions did you hear about in the listening sessions that you had not considered before?

Dual credit participation is exposing underage students to college age students who invite the high school students to parties and either encourage underage drinking or purchase alcohol for underage students.

Question 8: How does the local conditions information you obtained from your listening sessions align or not align with your consumption data, your intervening variable data, and what you learned from your community readiness assessment?

The local conditions information aligned with the consumption data, the intervening variable data and the community readiness assessment. Youth indicated in the OHYES! that their perception of parental disapproval was very high from seventh grade (91.9%) until tenth grade (81.4%); however, by eleventh and twelfth grades, youth perception of disapproval had dropped to 68% and 75.8%, respectively. This coincides with the rise of underage consumption in eleventh and twelfth grades. Furthermore, the perception that their peers feel consumption would be wrong also dropped from a high of 80.4% in seventh grade to 43% in eleventh grade and to 42.1% in twelfth grade.

An additional aspect to the data regarded students who begin taking dual credit courses as juniors (eleventh grade) and seniors. This information aligned with the increase in underage alcohol consumption which rose dramatically from eighth to eleventh grades.

Question 9: What consequences of underage drinking or prescription drug use (specific for your community) are more prevalent (common) in your community?

While there are incidents of auto accidents linked to alcohol or other drugs that result in injuries or death involving teens, the more prevalent consequences are related to substance misuse. According to the listening sessions, community readiness assessment and the gathered OHYES! data, students engage in underage drinking to be accepted by peers and because there are limited community-based activities that welcome all students. Exposure to college-age peers as a result of participation in dual credit high school programs also is contributing to underage consumption. In addition, the participants in the listening sessions, both adults and youth, indicated some teens are drinking in response to mental health problems.

Question 10: How did your consequence data compare with state-wide data?

Adams County experiences a small number of fatal car crashes annually. In 2016, there were five, which is the highest number from 2012 through 2016. Of the fatal crashes in 2016, two involved alcohol. There were 190 crashes that resulted in injury in 2016; of these, eleven involved alcohol.

In 2014 and 2015, two fatal crashes (50% of the four total) involved both alcohol and people ages 15 to 24. Although the percentage of fatal crashes in Ohio was much lower for the two years, 20.5% and 22% respectively, there are many more crashes statewide.

For the five years, 2012 through 2016, there were four fatal crashes involving people between the ages of 15 and 24. In three of those years, 2012, 2013 and 2016, there were no fatal crashes involving alcohol of people between the ages of 15 and 24.

Question 11: How does the consequence data relate to your problem of practice and outcome data? What does it tell you about the impact of your problem of practice in your community?

The consequence data indicate underage drinking contributes to injury and fatal crashes of people ages 15-24. In the two years when there were fatal crashes, 2014 and 2015, there were also high totals of crashes involving alcohol. In 2014, there were 15 crashes of 15-24 year olds where alcohol was involved and in 2015, there were 18 crashes of 15-24 year olds where alcohol was involved. By 2016, incidents decreased to 10 crashes with this age group that involved alcohol. Unfortunately, the data do not break down the numbers of OVI arrests for this age group.

Question 12: How does your consequence data support (or not support) the intervening variables and local conditions do you are planning to prioritize?

The consequence data show that while there are incidents of people ages 15-24 involved in auto accidents with alcohol as a contributing factor, most result in injury not death. Not all people who drink and drive are involved in accidents; however, the more often people drink and drive, the more likely they are to be involved in an accident. With younger drivers, the presence of alcohol impairs their ability to drive more severely since it is coupled with inexperience.

APPENDIX: Ohio SPF-PFS SEOW Workgroup

Critical Reflection Questions on SPF-PFS Needs Assessment

Please collaborate with the coalition and your Prevention Data Committee to respond to the following questions.

CONSUMPTION DATA

1. As you have reviewed your baseline data and your COMs data for FFY16 and FFY17 around your community's problem of practice what data stood out as most important?

   [COMMUNITIES ONLY SHOULD RESPOND TO DATA RELATED TO THEIR POP]

      a. Underage Drinking:
         i. Past 30 Day Use of Alcohol
         ii. Past 30 Day Binge Alcohol
      b. OR Prescription Drug Misuse:
         i. Past 30 Day Prescription Drug Misuse/Abuse
         ii. Past 12 Month Prescription Drug Misuse/Abuse
2. What differences do you see in your consumption data related to your problem of practice by gender or grade? How are those differences evident (or not evident) across all years in which you have data?
3. How has your PDC helped you review and interpret your COMs data? If they have not helped, how might they help in the future?

INTERVENING VARIABLES

1. Which of the four SAMHSA-required intervening variables seem most important to your work around your problem of practice? Please support this choice with your data:
   a. Perceived Risk/Harm of Use
   b. Perception of Parental Disapproval/Attitude
   c. Perception of Peer Disapproval/Attitude
   d. Family Communication around Drug Use
2. What intervening variables did you learn about that you or your community had not considered before?
   a. What about your intervening variables was new and why?

LOCAL CONDITIONS

1. Based on the data from your listening sessions, what are 3-4 local conditions that are contributing to your problem of practice?
2. What local conditions did you hear about in the listening sessions that you had not considered before?

3. How does the local conditions information you obtained from your listening sessions align or not align with your consumption data, your intervening variable data, and what you learned from your community readiness assessment?

CONSEQUENCE DATA

1. What consequences of underage drinking or prescription drug use (specific for your community) are more prevalent (common) in your community?
2. How did your consequence data compare with state-wide data?
3. How does the consequence data relate to your problem of practice and outcome data? What does it tell you about the impact of your problem of practice in your community?
4. How does your consequence data support (or not support) the intervening variables and local conditions you are planning to prioritize?